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# The development of community mental health nursing services in Western Australia : A history (1950-1995) and population profile

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# THE DEVELOPMENT OF COMMUNITY MENTAL HEALTH NURSING SERVICES IN WESTERN AUSTRALIA: A HISTORY (1950 to 1995) AND POPULATION PROFILE.

BY

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# USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

# Abstract

This descriptive study discusses the development of community mental health (CMH) in Western Australia (WA) and describes the current practising population of CMH nurses. The study explores literature pertaining to the emergence of the CMH movement and the deinstitutionalisation of the mentally ill. A conceptual framework was developed by adapting Lewin's change theory. CMH nurses practising in WA (n= 130), were invited to participate in the study and were asked to complete a survey questionnaire. This resulted in a 66% responce rate (n = 86). Quantitative data was analysed using the Statistical Package for the Social Sciences (SPSS). Open ended questions were analysed using Colaizzis steps. The study found that mental illness has been treated according to contemporary beliefs. In the 1950s multiple forces within society led to the movement away from institutionalisation of the mentally ill toward deinstitutionalisation. The first community clinic was established in 1956 to manage the deficit between the ever expanding population needing mental health care and the paucity of available hospital beds. The need for follow up of clients in the community resulted in the development of CMH nursing. The study also provides a profile of the current practicing population of CMH Nurses in WA, demographic details, qualifications, the work environment, educational needs, work role and job satisfaction have been described. Recommendations have been developed from the findings and are directed towards, the dissemination of information, the need for role identification/development, staff development needs, future education needs, industrial issues, clinical practice issues and areas for further nursing research.

## Declaration

"I certify that this thesis does not incorporate, without acknowledgment, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in text."

Phillip Michael MAUDE

Date: 28/3/96

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# Table of Contents

CHAPTER SIX - POPULATION PROFILE OF COMMUNITY MENTAL HEALTH NURSES PRACTICING IN WESTERN AUSTRALIA

CHAPTER EIGHT - CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND IMPLICATIONS FOR NURSING PRACTICE

## LIST OF APPENDICES

# LIST OF FIGURES

## LIST OF TABLES

# Chapter 1

## Introduction

The final years of the 20th Century will be a time of challenge and change for Western Australian Community Mental Health (CMH) nurses. The role and function of this nursing specialty is in question while its potential to make a valuable contribution to health care and promotion remains (Pothier, Stuart, Puskar & Babich, 1990).

Historically, the care of the mentally ill has been determined by society's beliefs concerning the nature of mental illness (Peplau, 1952). This thesis describes past diagnoses for mental illness from demonic possession to chemical imbalance, with treatment modalities developed to suit the contemporary belief. The economic status of a society also influences its treatment of the mentally ill (Monat-Taylor, 1990). As an example, primitive man had no means to store food and those who could not fend for themselves perished, whereas an affluent society such as modern day Western Australia (WA) should be able to provide the best possible treatment for its people regardless of the contribution each person makes to society. Both Burdekin (Human Rights Commission, Australia,1993) and Hoult (1994) disagree with this statement in relation to WA's contribution to the care of its mentally ill. In each of their report findings they found WA as being the poorest provider of modern mental health care in Australia. In general they identified problems related to the availability and quality of mental health care provisions especially in the community.

Mental illness is not a minor problem in Australian contemporary society. The Australian Bureau of Statistics reported (1991) that of a total population of 16,988,800, there are 306,600 (1.8%) people experiencing the

long term effects of mental illness in Australia. Within WA, 21,900 people out of a total population of 1,623,600 (1.35%) are experiencing this challenge. These figures fail to show the complete picture as no account is made of incidental episodes of mental illness.

As people who experience the challenge of mental illness are, by the nature of their disorder, possibly the most politically powerless and vulnerable group within our society (Human Rights Commission, Australia, 1993) advocates need to ensure that where future closures of hospital treatment facilities occur, adequate resource allocation to community mental health services is made.

This research study was conducted to trace the development of CMH nursing in WA and define the population of CMH nurses currently practicing. It is important to note that not all CMH nursing services in WA have been long established. Services, particularly in rural areas, are fledgling and have been established by independent CMH nurse practitioners with distant back up psychiatric support. Working conditions for each CMH nurse varies from location to location. Some CMH nurses work in clinic settings with other CMH nurses and health team members while others are sole practitioners attached to a psychiatric or general hospital, or practice alone in rural settings with limited supports. These rural CMH nurses are often solely responsible for the provision of psychiatric assessment and care for the local community. In all cases, CMH nurses are expected to provide support to general practitioners, local councils and other health care providers in their district.

Studies have been conducted in WA concerning general community nurses in metropolitan and rural settings (Kreger, 1991; Magee 1992; McMurray, 1991; Philp, 1988) but there is a paucity of published literature referring to the development of CMH nursing (Lewis, 1988) and only fragmented reports as to the type of service CMH nurses deliver (Ellis, 1984;

WA Government, 1902-95). According to Brooker and White (1993, p. 11) CMH nurses can be described as a group of autonomous practitioners "who work with a multi-disciplinary and multi-professional approach to provide care and to alleviate the problems of people experiencing mental illness." Currently this researcher sees the role of the CMH nurse in WA undergoing change with three recent industrial developments:

1. inclusion into the mental health nurses award;
2. development of a career structure; and
3. recent expansion of CMH nursing services to various rural areas.

CMH nurse's have extensive contact with the mentally ill living within the community and are often the primary health care provider for this group (Flaskerud, 1986). An understanding of the experience of this population of nurses, and its role within the health care system, may enable the implementation of realistic programs to develop health care services for the mentally ill.

## Background

Deinstitutionalisation of the mentally ill has been described as the most significant development in the delivery of mental health care since the establishment of the asylum in the early 19th century (Moffett 1988).

Multiple forces in modern day society have led to the deinstitutionalisation of WA's mentally ill. Community based treatment programs such as CMH nursing developed out of a need to provide health care to those discharged from the hospital setting.

CMH nursing has long been established in Europe and North America and from these sources there is a wealth of published literature documenting the history and development of CMH nursing services (Brooker & White, 1990; Greenblatt, 1963; Pasamanick, 1964; Paykel, 1983; Singer et al, 1970). In contrast to the situation in Europe and North America, Australian

studies have only documented the quality of work provided by CMH nurses (Arthur et al, 1992; Barclay, 1989) and evaluated the effectiveness of CMH nursing services (Daniels, 1986; Daniels 1988; Gray, 1986).

## Significance of the Study

CMH nursing began in WA in 1956 in response to the increasing inability of institutions to cater for the needs of the mentally ill (Curry, 1993). Forty years later, no studies have been conducted in WA to describe CMH nursing practice or its development.

This study is significant because it fills the gap in current knowledge by exploring CMH nursing development and practice in WA as there are no other published studies which examine CMH nursing in this state.

## Purpose of the Study

The purpose of the study was to discuss the history of the development of CMH nursing in WA, and to identify the population profile of CMH nurses currently practicing in WA. As well, the study describes the work activities of WA CMH nurses and their level of job satisfaction.

## Research Questions

The research questions relating to this study are:

1. What themes can be identified from the literature concerning the development of CMH nursing in Western Australia?

2. What is the population profile of CMH nurses currently practicing in Western Australia?

3. How do Western Australian CMH nurses describe their usual work activities?

4. How do Western Australian CMH nurses describe their level of job satisfaction?

## Assumptions

In order to develop a profile concerning a cohort of CMH nurses in WA, this study assumes that the participants responded truthfully to the questionnaire and to the best of their ability.

## Definition of Terms

**Community mental health nurse.** - is a registered mental health nurse who practices within a community setting (Bullough & Bullough, 1990).

**Community mental health nursing.** - is an approach to community based mental health using a professional model which incorporates a range of therapeutic modalities including nursing/medical and psychological interventions (Monat-Taylor, 1990).

**Deinstitutionalisation.** - refers to the change in locus of mental health care from an institutional setting to a community based setting (Monat-Taylor, 1990).

**Health care districts.** - geographical areas established, throughout the state of WA, in an endeavour to decentralise health care provision.

**Health care providers.** - WA Government agencies responsible for the budgeting and provision of health care to individual districts of the state.

**Institutionalisation.** - concerns having people, experiencing mental illness, housed in institutions for such an extensive time that they are unable to adapt to new environments in the community ( Monat-Taylor, 1990).

**Mental health.-** can be described as a state of being where the individual is able to adjust to new situations, find success at working, loving, creating and resolving conflicts without undue anxiety and have remaining energy to pursue his/her role as a member of society (Morgan & Johnston, 1976; Monat-Taylor, 1990).

**Mental illness.** - refers to "Illness with psychological or behavioural manifestations and/or impairment in functioning due to a social, psychological, genetic, physical/chemical or biological disturbance" (Monat-Taylor, 1990, p. 476)

**Psychotrophic medication.** - are drugs that are believed to alter the chemistry of the brain and therefore the emotions and behaviour of the person who ingests them (Monat-Taylor, 1990).

**Therapeutic.** - "beneficial" (Monat-Taylor, 1990, p 41)

**Therapeutic community.** - is a treatment approach in which the environment is used as a treatment. In addition the staff and the policies of the health care setting influence the functioning of the individual (Monat-Taylor, 1990).

## Organisation of the Thesis

The thesis is organised into six chapters including this introductory chapter. Chapter two contains a review of the available literature related to the study. Chapter three discusses the conceptual framework that has been utilised to guide the study. Chapter four describes the methodology which includes the study's design, setting, sample and data collection methods and analysis of data. Chapter five contains a discussion of the study's findings. Chapter six discusses the study's findings in relation to other research. Chapter seven contains the study's conclusions, implications for nursing practice and recommendations for future research. Limitations of the study are also discussed.

# Chapter 2

## Review of Literature:

In this chapter an overview of the available literature concerning relevant events in world and WA history will be presented.

### Locus of Mental Health Care Throughout History

The function of nursing has most likely been part of mans existence since the beginning of time. Because of the mortal nature of mankind there has always been a need for such care. The care and treatment of the mentally ill has been traditionally influenced by human belief about oneself, the world we live in and the significant others in our environment (Perko & Kreigh, 1988).

In order to understand society's contemporary belief patterns concerning mental health and illness, it is important to have an understanding of past beliefs concerning mental illness. These beliefs often surface in present day society and can be seen as a major cause of misunderstanding of mental illness. The treatment of the mentally ill has evolved from the beliefs of each contemporary human society. For example, a constant theme in contemporary beliefs concerning the treatment of the mentally ill is concern for the effects of environments on behaviour, and thus extensive remodeling of hospitals and concerns for aesthetic detail have evolved (Perko & Kreigh, 1988).

In prehistoric societies those experiencing mental illness were often cast out from the tribal group or in the case of nomadic tribes simply abandoned (Morrisey & Goldman, 1984). Anthropological studies reveal that

the mentally ill were considered to be possessed by demonic entities (Mark, 1980). This demonic possession was seen as punishment for sins and those possessed were shunned by their peers. Treatment consisted of beating, starving, burning and amputation of limbs in an effort to destroy the corporeal body so it would no longer be a suitable habitat for the demon.

As humans formed more social structures, religious influences provided treatment for the mentally ill such as, chants, burnt offerings and elaborate rites. Some cultures saw the mentally ill as being possessed by a benevolent spirit and so those afflicted were revered as holy people (Perko & Kreigh, 1988). Hippocrates in ancient Greece, was possibly the first to challenge the popular idea that mental illness was sent from the Gods. He wrote that since disorders such as epilepsy had identifiable symptoms they were medical disorders that could be treated (Davies & Janosik, 1991). The Romans perpetuated the traditional superstitious fears of mental illness and made legal provision to control the mentally ill. The mentally ill could be deemed incapable and be incarcerated. The relatives of the mentally ill, or court officials, could be appointed by the courts as legal guardians.

The Middle Ages saw little change to the superstitious beliefs of the ancients but the majority of the European population now worshipped one God instead of many (Davies & Janosik, 1991). Monastic orders developed and provided care for the poor and sick. The study of theology by monastic orders developed new concepts in perception and explanation of the world. The church advocated that each human had a body [soma] and a soul [psyche].

By 1500 there was widespread interest throughout Europe in demonology and witchcraft. People with any type of illness were seen as having evil demons competing for their immortal soul. This placed the Christian church in a position of power as the population increasingly looked

to the church for healing and salvation of the soul. Various ways to exorcise evil spirits were developed, often resulting in the death of the afflicted.

Preoccupation with witchcraft and demonology in Europe persisted until the 1700's. The belief that mental illness was largely the result of demons was a probable cause for the poor treatment of the mentally ill who were often abandoned or left to forage on the edge of the village (Coleman, Butcher & Carson, 1984).

Confinement of the mentally ill became the usual treatment in the 1700's. Interestingly, Mora (1990), reports that in England certain groups of the mentally ill were placed on sailing ships and told to go in search of their lost reason, thus giving rise to the expression "ship of fools".

Institutions for the mentally ill were shared with the poor, the physically and mentally handicapped as well as the elderly who had no means to support themselves (Church, 1987). Society at this time believed in high moral standards and saw hard work instead of idleness as a remedy for madness. Workhouses for the mentally ill were developed. Church (1987, p. 48) believed that the mental institution at this time was "where the morality of the majority in society could be imposed on the minority". This was a time when society shunned the mentally ill as being amoral. Mora (1990), wrote that society had a fear of contamination and thus the myth was born that a deranged person may invoke similar amoral behaviour in those caring for the mentally ill. Pioneers in reform at this time such as Philippe Penel and the Society of Friends established humane treatment facilities in France and England respectively. Benjamin Franklin promoted the establishment of the first treatment facility in the United States for the mentally ill at Pennsylvania Hospital in Philadelphia. Benjamin Rush who worked at that institution as a physician, is considered the father of psychiatry in the United States. Rush established a treatment known as "moral management" which has similar goals to present day "milieu therapy" (Davies & Janosik, 1991).

The 1800s in Australia were a time when English beliefs and practices were central to the way of life. The British continued to consider mental illness as moral depravity and this influenced the colonies. "From the outset, criminality and insanity were closely associated in the Australian colonies" (Lewis, 1988, p. 1). In WA, following the establishment of the Swan River Colony in 1829, the mentally ill were first housed in gaols such as the old Round House at the port of Fremantle (Lewis, 1988). Ellis (1984) mentions a colonial medical officer, Dr Langley, as the first cited case of mental illness. Dr Langley became disturbed on the journey to Australia from England and having no place to put him, the colonial authorities housed him on a boat in the Swan River. Because he kept swimming to the river bank, he was later placed on a larger ship and moored in the shipping lanes off the coast of Rottnest Island. In 1850 the convict system was introduced to the colony. At first a requirement of a convicts transportation was good health and a sound mind. Within a few years demand was so great for convict labour that many convicts were transported despite their experiencing mental illness. In addition, the dreadful conditions of transport, harsh environment and treatment, ensured many convicts became mentally unbalanced after arriving in the colony (Oldham & Oldham, 1980). The number of the mentally ill grew considerably and a new asylum was constructed in 1865 at Fremantle, the original building designed by Colonel E.Y.W. Henderson and Officers of the Royal Engineers, with major extensions after 1886 designed by Australia's most prolific colonial architect, George Temple-Poole. This building, now the Fremantle Arts Centre, was originally known as the Insane Asylum for the Convict Establishment and later The Old Women's Home (Oldham & Oldham, 1980).

## Background and History of CMH Nursing

Since the early 1950s there has been a well documented shift from psychiatric care provided within institutions to mental health promotion in community orientated care settings in the United Kingdom and United States of America (Brooker, 1990; Martin, 1985). This shift from the institution to the community has been hailed as having the intrinsic value of "providing small scale, personal care which was non stigmatised and valued individual autonomy" (Illing, 1990, p. 145). A British author cites cost effectiveness as the major incentive for governments to develop CMH nursing services (Brooker,1990).

CMH nursing more than likely commenced at Warlingham Park Hospital, United Kingdom in 1954 (Illing, 1990; Paykel, 1983; Sharpe,1982). Due to a shortage of available beds it is reported that two psychiatric nurses were seconded to working in the community for the Burrough of Croydon in Surrey (Moore, 1960). Their work included "supervision of patients, supervision of patient attendance at out patient clinics and visiting of those patients who failed to attend, job and accommodation finding, attendance at evening after care groups and social clubs" (Paykel, 1983, p. 10).

In 1957 it was reported that 44 people with schizophrenia were being supported in the community by psychiatric nurses at Moorhaven Hospital, Devon, in the United Kingdom (Hunter, 1974). In the United Kingdom a number of CMH nursing services were established in the 1960's and by 1982, CMH nursing availability was widespread (Paykel, 1983).

Greenblatt (1963) described an early 1960's United States of America based project in which 128 patients were referred to community nursing instead of being hospitalised. It was found that 52% of these patients remained within the community with no episodes of hospitalisation when they were contacted 12 months later.

**Deinstitutionalisation**

Until the 1960s, Australian governments, both State and Federal, placed strong emphasis on building larger institutions to house the "insane". Over the last 30 years Australian governments have strived to close down asylums and "return the mentally ill to the care of the community" (Benson, 1994, p. 29). This has been welcomed by many members of the public as people incarcerated in asylums have been seen to have no political power and therefore, are unable to empower themselves. Taking into consideration the effect of incarceration, the stigma attached to mental illness and the debilitating nature of the psychiatric disorders, it is little wonder that Burdekin, in his report of the National Inquiry into the Rights of People with Mental Illness found so many inequalities (Human Rights Commission, 1993). The Burdekin report found that people experiencing mental illness, "are among the most vulnerable and disadvantaged in Australia, that they suffer from widespread, systematic discrimination and that they are constantly denied the rights to which they are entitled". (Clinton, 1994, p. 1).

Deinstitutionalisation, according to Fuller-Torrey is "a nice idea, an idea founded on the best intentions. Many people who had spent most of their lives in institutions could enjoy a better quality of life" (cited in Benson,1994, p. 33). It could be argued that the community has been ill prepared for the shift to deinstitutionalisation, that prejudice abounds and resources within the community for services such as CMH nursing are scarce. In WA, mental health clinics developed in metropolitan areas followed by satellite towns around Perth. It was only recently that the WA government expanded CMH nursing services to rural areas such as the north west of the state (Health Department of WA, 1990). This is astounding, considering that this state is a third of the continent and distances between towns are great.

In 1986, the WA government released a discussion paper addressing the need for a shift to community based practice (Health Department of WA, 1986). This report described a community based service as needing to be state-wide and having an "emphasis on the protection, promotion maintenance and improvement of health" (p. 22). The paper also addresses the problem of public rejection of a community mental health program stating "over the next decade community attitudes towards mental health and mental illness must change" (p. 78). Health promotion is seen as the way to make this change in community attitudes. Very little reference to the role of the CMH nurse is made in this paper. Therefore, this research is essential to determine what the role of the CMH nurse is in health care delivery to people experiencing mental illness. It appears that little has changed in the nine years since the report was written as governments have provided little funding for health promotion campaigns and limited liaison has occurred between policy making and the community. Given that the ten year plan (Health Department of WA, 1986) identified major problems in the delivery of care to the mentally ill and illustrated the fact that the mentally ill in WA are at great disadvantage, it is surprising that no follow up study has occurred.

## Mental Health and the Health Care System

Expressed in its simplest terms, mental health is the balance between the challenges the individual faces daily and the resources that person has to meet these demands (Reynolds et al, 1990). The pressures of our physical environment, social interactions and the opportunities, resources and personal constitution of each individual all in some way form part of our mental well being. A truly social model of mental health care should take into account the interconnection between the world we live in, the social networks of the individual, the individual's place in society as well as the individual's strengths and weaknesses (Baum, 1992; World Health Authority,

1986). Governments are often criticised for not addressing the needs of the individual experiencing mental illness. This is largely because issues arising in mental health care delivery do not fit easily within a health care system that is tailored to the needs of the physically unwell (Ovadia & Owen, 1992). People experiencing the often debilitating nature of mental illness face the same economic challenges as all Australian citizens, but they have the added burden of stigma and the personal cost of their illness. Issues such as equity in access to health care, affordable accommodation, adequate income and meaningful work are all made so much harder with the complication of mental illness. Although these fundamental needs may be tenets of primary health care delivery, they are not often under the control of the health care system.

The Richmond Report was published in 1983 and was possibly one of the major factors contributing to the closure of hospital based beds and transfer of services to the community (Benson, 1994). This report reviewed existing services, identified needs for services and established a strategy for implementation of recommendations. Richmond (1983) wrote of the inequality the mentally ill experience in fundamental areas such as adequate housing and for the first time exposed the massive readmission rate to treatment facilities. It was found that the mentally ill faced social isolation and were discharged by ever shrinking hospital facilities to be supported by poorly funded and staffed community mental health services (Simmons, 1994).

Hoult, Reynolds, Charbonneau-Powis, Weekes, Briggs, Cass, Lapsley and Rosen (1983) compared traditional hospital based care with community mental health supports in a controlled study of 120 people experiencing mental illness, and found community based care to be of greater benefit and assisted with a reduction in readmission rates.

In the 1990s, state and federal relations continue to complicate issues in mental health care delivery but major developments have occurred. 1990 saw the publication of a strategy paper by the Australian Health Ministers Advisory Council which has formed the basis for negotiation between the commonwealth and the states. In this year Burdekin began his inquiry concerning the human rights of people with mental illness. This report challenged current practices in mental health in all spheres of health care delivery and generated major debate in all aspects of Australian society. In 1992, the Australian Health Ministers launched the historic National Mental Health Strategy which committed them to co-operation to improve the lives of people with mental illness. The federal government committed AUS$269 million to help restructure services to meet strategy goals. Of this money, AUS$189 million has been provided directly to the states and territories. Even with these monetary resources the differences between state mental health legislation remain, creating legal inequality between the states.

The major impact of the changes in health care policy should be seen in the community setting. The National Mental Health Strategy aims to reduce the incidence of stigma of mental illness by wherever possible treating the person in general hospital settings, rather than specialised psychiatric settings. The Strategy also outlines how in the past people with mental illness were isolated and treated in psychiatric institutions but will now have access to a range of services in the community. This would seem to imply that hospital based services for psychiatric clients will be scaled down. Reports have highlighted that if deinstitutionalisation is to work, money formerly provided for institutions must be channelled into community services (Roth, 1986). The break down of institutional services should not be replaced by private hostel and boarding house care. This in effect is replacing one socially unacceptable institution with another. People with mental illness need suitable accommodation with supports.

**Summary**

Studies have been conducted with groups of CMH nurses in the United Kingdom (Moore, 1960; Paykel, 1983) and one in the United States of America (Greenblatt, 1963). However, no study has addressed the development of CMH nursing in WA or described this population. This research provides a background for understanding the development of CMH nursing services and will provide a snapshot profile of the current practicing population.s Research is an important contribution toward advancing recognition of the CMH nurses role in health care delivery (Butterworth, 1991). This descriptive research study will expand the available literature in this area of nursing thus adding to the knowledge base of nursing.

"If no use is to be made of the labours of the past ages the world must remain in the infancy of knowledge."

(Marcus Tullius Cicero 106 - 43 BC)

# Chapter 3

## Conceptual Framework

This chapter discusses the conceptual framework which was utilised to guide the study.

Wilson (1989, p. 724) defines a conceptual framework as a "preliminary stage of theory wherein interrelated concepts provide a structure for organising phenomena of interest in nursing practice or research." For this study, an exploration of the shift in psychiatric care delivery from an illness model manifested by institutional care to a social model of community mental health, has been explored. As one of the aims of this study was to discover what forces were instrumental in the development of CMH nursing in WA, a framework that explores change and adaption to change was needed. Change can be defined as development over time in one or more of three dimensions, social organisation, culture or technology (Stokes, 1984,).

Nursing research concerning organisational change provides analysis of the process of change and evaluation of its outcomes. This can provide strong leads for predictions of future directions in health care delivery (Swansburg, 1990). The theoretical work of Kurt Lewin (1890-1947) has been adapted for this study, which utilises his social change theory to analyse the development of CMH nursing.

## Social Model of CMH Nursing

Before the development of community based mental health services, the primary mode of treatment for the mentally ill in the late 19th and early 20th century was long term in-patient hospitalisation (Haak-Flaskerud &

Marram van Servellen, 1985, p. 3). This mode of treatment was characterised as custodial care in state run hospitals with clients experiencing institutionalisation, chronicity, and overcrowding (Krause & Slavinsky, 1982, p. 72). This researcher considers this form of treatment as "warehousing" the mentally ill away from society thus perpetuating an illness model. At this point in time concepts from influential writers such as Karl Marx, a conflict social change theorist, were being discussed. Marx believed that sending people to mental hospitals was a form of labelling and resulted in an act of political oppression (Goffman, 1961).

The movement for the breakdown of the mental institution occurred suddenly in the 1950s amidst an atmosphere of social change still remaining from the end of the Second World War. At this time the World Health Authority (WHO, 1956) prepared a report offering a new model for the future of mental health services. This model was revolutionary as it proposed the dismantlement of the closed systems of asylums. The WHO proposed that large centralised institutional psychiatric hospitals should be dismantled and be replaced with decentralised community based services. This had major implications for the WA government, as at the time WA offered centralised mental health services in Perth (WA Government, 1952).

In the early 1950s, social psychological theorists such as Foucault, Goffman, Szasz, Laing and Lewin questioned the very nature of psychiatry. Principles subsequently developed from social psychological research have been applied to multiple settings including CMH nursing. The work of social psychologists has been attributed with providing much of the impetus for the trend toward deinstitutionalisation of the mentally ill (Monet-Taylor, 1990).

Kurt Lewin's life work involved the manipulation of social climates under laboratory settings. He was one of the first theorists to utilise the principles of a general systems theory (Monat-Taylor, 1990, p. 126). Organisations such as the Health Department of WA are systems in

themselves which have values and goals that are capable of change in response to outside influences. Lewin conceptualised social change theory which focussed on driving and restraining forces resulting in either equilibrium when forces were in harmony or break down when forces were in conflict. "Social change occurs when one of the restraining forces weakens or disappears, or when the driving forces are strengthened" (Pendleton, 1990, p. 210) [see Figure 1].

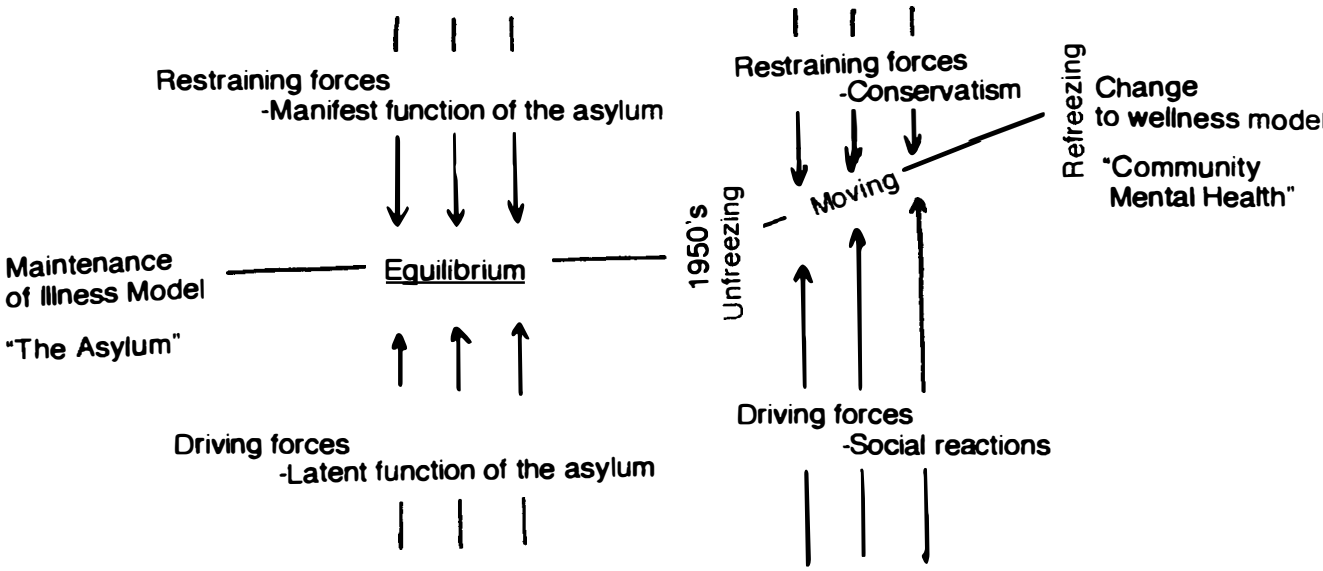


Figure 1. An adaption of Lewin's conceptual framework showing the change process which occured in society to bring about the development of community based care for the mentally ill. Adapted from Pendleton (1990).

Figure 1 shows how Lewin's theory has been adapted to describe the development of CMH services. During the era of the asylum, equilibrium was maintained by the manifest functions of the asylum to care for patients (restraining forces) and the latent function of the asylum was to control and socially isolate patients (driving forces) (Davies & Janosik, 1991, p. 78). This equilibrium was disrupted by changes in social thought (driving forces) which successfully challenged the conservative call for equilibrium (restraining forces). Thus change toward a new model of health care (CMH) occurred. This change involved three stages identified by Lewin as:

1. The unfreezing stage, where change agents are motivated to create change. This occurs when disequilibrium is introduced into the system creating a need for change (Spradley, 1979);

2. The moving stage, when a powerful person or movement influences the change agent. Because of this people are prepared to examine the concept of change as an innovative idea (Swansburg, 1990);

3. The refreezing stage, occurs when changes have been integrated and the process of change has been stabilised within the system. Driving forces are at equilibrium with forces to impede change (restraining forces) (Swansburg, 1990).

Although it is more than probable that CMH nursing developed out of the fiscal need to reduce the patient population in mental hospitals and the need to monitor patient progress in the community (Curry, 1993), this researcher purports that multiple "driving forces" were important in influencing the change of health care from an illness model to a health promotion model in WA [see Figure 4]. During the unfreezing stage of the change process, these driving forces resulted in change from institutional based mental health care to community based care. Without these changes in social attitude and the availability of treatment modalities, the transfer of mental health care delivery to the community may not have manifested.

# Chapter 4

## Method

This chapter discusses the study design, setting, and population as well as the development of the questionnaire, the data collection and analysis procedures. The ethical considerations of the study are also discussed.

### Study Design

This study used an exploratory descriptive design with a quantitative approach. A descriptive design was selected as it was considered an appropriate method to answer the research questions and develop a profile of CMH nurses in WA. The design is appropriate when little knowledge is available to answer the researchers inquiry (Burns & Grove, 1993).

### Study Population

All CMH nurses practicing in WA were invited to participate in the study. This was because CMH nurses practice in varied locations and with diverse populations of clients. Therefore a sample of the population would not have captured a true picture of the practicing population.

### Study Setting

CMH nurses practice in various settings throughout WA, including the Perth metropolitan area, regional centres and rural settings. The setting for this study includes the various locations throughout WA where CMH nurses practice [see Figure 2& 3].

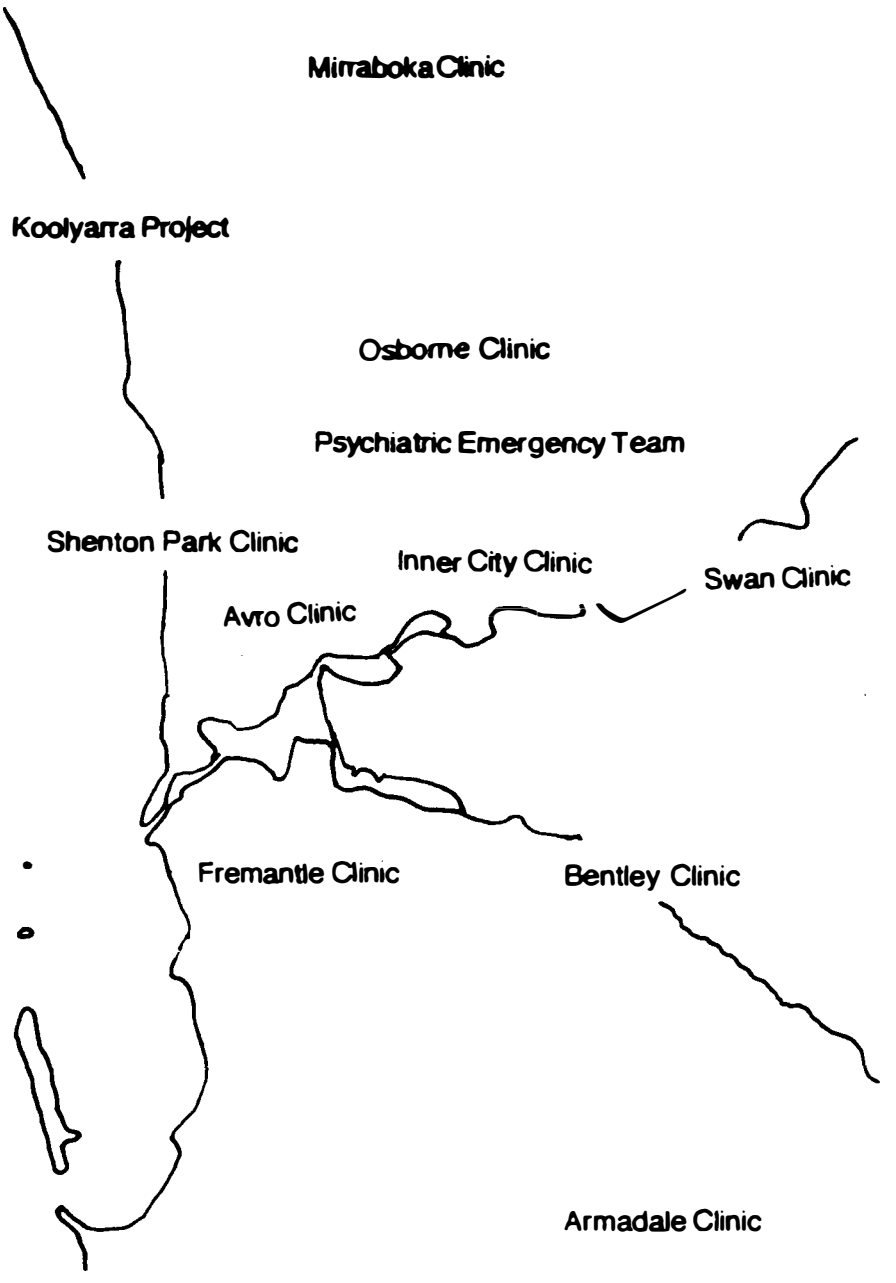


Figure 2. Location of CMH nursing clinics in the Perth metropolitan area.

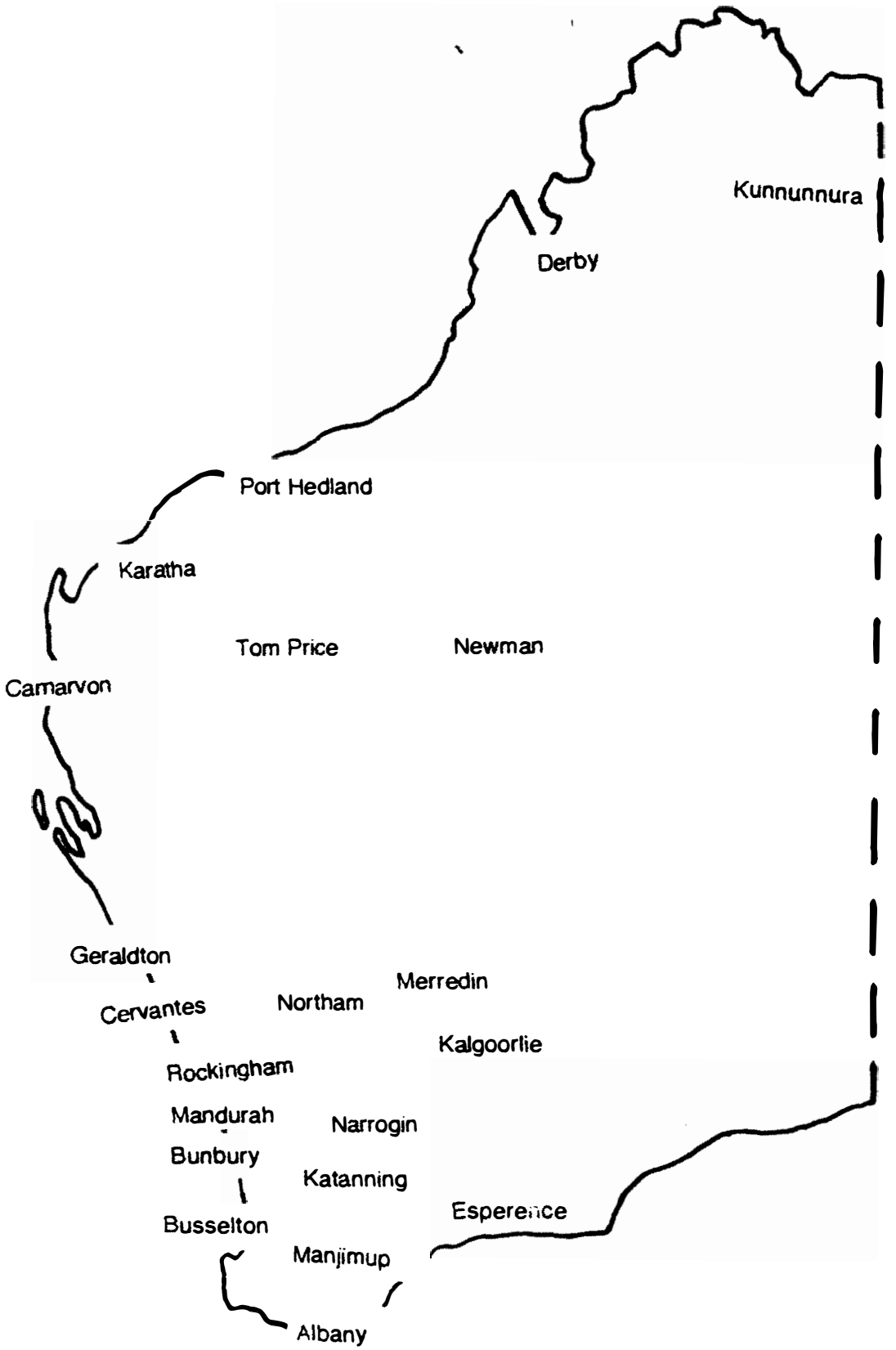


Figure 3. Location of CMH nursing clinics in WA.

## Instrumentation

In order to collect data from the CMH nurses, a questionnaire was designed by the researcher as a search of relevant literature failed to identify a suitable instrument for this study. This was considered to be the most effective way to reach a population spanning one third of the Australian continent. Content of the questionnaire was determined by themes identified from the literature, the researchers personal experience as a CMH nurse and documentation such as duty statements and policies. The questionnaire was structured and contained sections regarding personal and professional information, education and training, personal perceptions, work role and job satisfaction. Space was provided at the end of the questionnaire for the participants to make any additional comments [See Appendix A].

### Validity and reliability.

Content validity of the questionnaire was determined by an independent panel of ten experts. According to Lynn (1986) the proportion of experts whose endorsement is required to establish content validity depends on the number of experts chosen. "The number of the experts often depends on how many accessible and agreeable persons the instrument developer or user can identify, not on a population estimation principle" (Lynn, 1986, p. 383). Lynn provides guidelines as to the number of experts needed suggesting a minimum of five and a maximum of ten for most studies. For studies with little known content areas, three are recommended. Ten experts were chosen for this study. According to Lynn's guidelines (1986), at least seven of these ten were required to rate each question a "3" (relevant, but needs alteration) or "4" (relevant) to endorse the question as valid to the study. Specific criteria utilised to select each appointed expert is shown in Appendix B. All chosen experts had experience in CMH nursing, held a higher degree or had significant experience in teaching mental health

nursing at a tertiary level. A covering letter invited each expert to participate in the study and explained the purpose of the research. A copy of the questionnaire and content validity document, developed by this researcher using Lynn's (1986) guidelines for establishing content validity, was mailed to each of the experts (Appendix C)

Each expert was asked to measure the relevance of each question utilising a four point scale as described by Lynn (1986). See notes for Table 2, which describe the relevance of the scores. If the expert scored the question anything less than a "4", a comment was requested as to why a lesser score was chosen, and the expert was asked if the question should be changed to make it more relevant to the study. Once the experts had scored each question, they were asked if they could identify any areas relating to the research questions that had been omitted from the questionnaire. The experts were also invited to make further comments concerning the questionnaire that they thought might be of relevance.

Return of the documentation for content validity was slow but with follow up reminder telephone calls, all ten experts had returned the required information within four weeks of the initial mail out. Results from the analysis of the returned statements from the experts are shown in Table 1.

Table 1

Results from content validity analysis

| | Panel of experts assessment of question content validity | | | |
|---|---|---|---|---|
| Questions | 4 | 3 | 2 | 1 |
| 16,17,18,19,20, 21 & 25 | 10 | | | |
| 4,5,9,11,12,13, 14, 15 & 22 | 9 | 1 | | |
| 23 & 24 | 9 | | 1 | |
| 1, 6 & 9 | 8 | 2 | | |
| 2 & 3 | 8 | 3 | 1 | |
| 7 | 7 | 3 | | |

Note. Scoring the individual question a "1" meant the question was deemed not relevant to the study; scoring a "2" meant the expert was unable to assess the relevance of the question; scoring a "3" meant the question was relevant but needed alteration; and scoring a "4" meant the question was relevant to the study (Number of experts = 10).

By utilising the Content Validity Instrument (Lynn,1986, p. 384), this researcher was able to demonstrate that the entire questionnaire was judged by the panel of experts as content valid.

Any other suggestions made by the experts were clarified with the expert and discussed with the researcher's two supervisors. This process enabled a fair review of each comment and provision for any necessary adjustments to the questionnaire prior to pilot testing of the questionnaire. The questionnaire required minimal adjustments to phraseology.

In addition, face validity is claimed by the researcher as development of the questionnaire was based on available literature, documents such as policy and duty statements and the researchers own experience as a CMH nurse (Burns & Grove, 1993, p. 343).

**The pilot study.**

The usefulness of conducting a pilot study is stressed by Burns & Grove (1993). Therefore, in an effort to refine the data collection instrument, pilot testing of the questionnaire was carried out by the researcher. The questionnaire was pilot tested with a randomly selected group of thirteen CMH nurses, who represented 10% of the entire CMH nursing population (130). Seven CMH nurses were from the Perth metropolitan region and six from rural areas. Of the six rural CMH nurses, three were from regional centres and three from isolated areas. These nurses were surveyed for the pilot study once consent to proceed had been obtained by relevant regional district managers. The pilot study proved useful in indicating the length of time required for future data collection and in updating the research schedule. All 13 pilot study questionnaires were returned (100%).

Respondents followed the questionnaire instructions correctly in all but one instance. It was decided not to utilise the responses from this questionnaire because interpretation of the responses was too difficult. Difficulties in the interpretation of question twenty was identified by three respondents, consequently this question was developed into two separate questions in an effort to eliminate ambiguity. One respondent did not answer question 23 which referred to the age of the person surveyed. This was seen by the researcher as reasonable and probably a personal choice of the respondent. Thus question twenty three remained unchanged. All other questions were interpreted without difficulty and responses were easily understood. Minor adjustments were made to the questionnaire as mentioned but the original questions remained constant. Because the changes made by the researcher to the questionnaire were minor it was decided not to retest the questionnaire.

The data collected from the pilot study was included with the data from the main study. This was for two reasons. Firstly, the pilot sample

comprised 10% of the total population of CMH nurses practicing in WA and the data obtained was too large to be excluded. Secondly, the questionnaire content was not changed so it was appropriate that the pilot study data be included.

**The Main Study**

Data collection was conducted by means of a literature review and a mailed out survey questionnaire to survey the population. The data was collected over a period of three months as there was a delay in obtaining consent from the managers of some health care districts. As all the questionnaires were not mailed out at the same time, the researcher was able to keep a record of mail outs and returns, and ensured each participant was provided with the same information. Each participant was assigned an individual number in an attempt to ensure they did not photocopy the original and return multiple questionnaires. This was identified as a possible problem as the researcher had witnessed this practice on a previous occasion.

The questionnaire was posted to all CMH nurses practicing in WA. Although there are well reported advantages and disadvantages in the conduct of postal surveys ( Hoinvill & Jowell,1988), distance more so than economic constraints primarily determined this choice of methodology. A major problem with mail questionnaires can be non-response (Brooker & White, 1990). To improve response to the survey, the following strategies were adopted:

1. a reply paid service was established at the Mount Hawthorn Post Office;
2. a covering letter [see Appendix D] providing information pertaining to the study was mailed to all potential participants with a copy of the questionnaire;

3. instructions were provided concerning questionnaire completion on the covering page [see Appendix A];

4. reminder letters attached to pictorial cards depicting early student life at Edith Cowan University [see Appendix E] were mailed out four weeks after the questionnaire was posted;

5. all co-ordinators of CMH nursing services were contacted by phone and requested to promote the return of questionnaires by their colleagues.

**Data Analysis**

Data analysis for the purpose of this study was conducted to summarise the findings. Burns & Grove (1993) consider that data analysis of explorative or descriptive studies such as this research, only require summary statistics.

In this study, the data from the questionnaire was analysed using SPSS (Statistical Package for the Social Sciences), using summary statistics. Frequency distributions were conducted for each variable of the questionnaire. Cross tabulations were conducted between relevant variables to identify possible relationships and trends in the data. Information was written up pertaining to the results from each question and illustrated by means of graphical and pictorial representations. The mean was calculated for the variable of age. Any missing data was recognised as such and has been noted in the findings.

The open ended questions within the paper were analysed by searching for common themes after several readings of the responses (Barnum, 1990; Polit & Hungler, 1989). Rosenbaum (1988) cites Colaizzi as having developed a framework for this type of data analysis described as "Colaizzi's Steps". This form of data analysis was utilised for interpreting the descriptive data provided when a question asked for an explanation. Responses were read and re-read to acquire a sense of the essence of the

dialogue. Significant statements and phrases were extracted from each response. These statements and phrases were then developed into themes. In order to collapse the data down to raw essential data, themes were combined whenever possible. The researcher found that some respondents chose not to answer a question that required written information but would readily complete the closed questions of the questionnaire. Despite this, common themes were found in responses, as well as unique comments that would not have been provided if all the questions in the questionnaire had been closed.

### Elimination of bias.

The researcher is aware of his personal involvement in the study and working relationships with the participants. Irurita (1990) suggests that researchers who are involved in working relationships with their study participants should take regular breaks in data collection and analysis so that study objectives can be reviewed and reconfirmed. This practice was adopted by the researcher for this study.

Chenitz and Swanson (1986) stress the need for bracketing of the researcher's biases during data collection and data analysis (Burns & Grove, 1993). This process is achieved by constantly being aware of the potential for personal bias to influence the study and interpretation of the study results. Bracketing was achieved by the use of a journal and self interview on tape following each stage of the research process.

## Ethical Considerations

Several methods were utilised prior to the commencement of this study to ensure protection of human rights for all participants.

**University approval.**

Firstly the proposal was passed by the Edith Cowan University Faculty of Health and Human Sciences Higher Degrees Committee. Next the proposal was submitted to the Edith Cowan University Committee for the Conduct of Ethical Research for review and consideration. This committee ensured that appropriate attention was paid to the rights of all participants in the study, assessed the ethical appropriateness of the methodology and considered if the researcher had taken into account any risks or benefits the study may bring to participants. Written approval to proceed with the research was gained from the Edith Cowan University Committee for the Conduct of Ethical Research [see Appendix F].

**Consent to proceed.**

Once permission to proceed with the study was obtained from Edith Cowan University, the researcher sought permission to proceed from the Health Department of WA's Ethical Review Committee as this was the sole employer of CMH Nurses in WA. Permission was granted but later withdrawn as the Health Department of WA was restructured into districts with appointed area managers responsible for the administration of each individual district (this was in response to the 1994 Health Purchaser Provider Policy of the Health Department of WA). The Corporate Information Unit of the Health Department of WA was contacted by the researcher and a list of health care providers and their contact addresses was obtained.

It was discovered that of the 42 health care providers, 32 needed to be contacted for consent as they were responsible for providing a CMH nursing service. Each health care provider was contacted by mail and sent a copy of the survey questionnaire, an explanatory letter and a form for them to complete which gave consent to proceed with the research in their district [see Appendix G]. The consent form was designed so that it could be easily

completed with necessary information and returned via a fax service. Provision of copies of the research proposal were made available to all health care providers.

The first mail out resulted in 15 (46.875%) of the 32 health care providers providing consent to proceed. Two of the 32 (6.25%) health care providers sought further information and a remaining 15 (46.875%) did not respond. These final 15 health care provider managers were contacted individually by telephone and any required information was supplied by the researcher by return mail. The major problem stated by the managers was failure to receive the first mail out. This method of obtaining consent from multiple health care providers resulted in a 100% provision of consent to proceed with the research in all thirty two health care districts that provide a CMH nursing service in WA. No CMH nurse was contacted until the necessary consent was obtained.

**Confidentiality.**

In order to keep a record of the questionnaire mail out, a data base was established utilising Microsoft Access Version 2.0 for IBM. This program enabled the researcher to place a security code on the data. Only the researcher had knowledge of the password. The data base was stored on a diskette with a second back up copy and both are stored in separate locked drawers.

Each health care provider was given an individual two letter code. The first letter identified if the returned questionnaire came from metropolitan Perth (M) or rural WA (R) and the second coded letter identified individual health care providers. Each individual CMH nurse participant was provided with a numerical four digit code.

**Information provided to participants.**

An explanatory letter was sent with the questionnaire and a Reply Paid envelope directly to individual CMH nurses. The explanatory letter (Appendix D ) outlined the nature of the research project, explained how anonymity and confidentiality were assured and stated that consent was implied by return of the questionnaire. To maximise anonymity, each respondent was asked to not identify themselves on the questionnaire, but were made aware that a coded number was being utilised to differentiate each questionnaire.

**Right to withdraw.**

All participants were provided with the researchers home and business telephone contact numbers and a Reply Paid postal address should they need to contact the researcher. Individuals wishing to withdraw from the study could do so as the researcher was able to destroy the questionnaire keeping only a record of the coded number.

**Storage of data.**

Throughout the study, data and coding systems were only accessible to this researcher. It is the intention of the researcher to store this information securely for the next five years and then all returned questionnaires will be shredded and the coding system that has been stored on disks will be destroyed by reformatting the disks.

# Chapter 5

## The Development of Community Mental Health Nursing in Western Australia

This chapter will review available literature in order to answer the first research question: "What themes can be identified from the literature concerning the development of CMH nursing in Western Australia?"

## The 1900s and the Evolution of the Social Model of CMH

Prior to the development of community based mental health services, the mentally ill were substantially housed in large institutions. The deinstitutionalisation of the mentally ill occurred in a complex way. The evolution of a community based mental health social model comprised several major milestones in development (Baum, Fry & Lennie, 1992) as shown in Figure 4.

The mental hygiene movement of 1909 (Krause & Slavinsky, 1982) was founded in the United States, by Clifford Beers, a psychiatric patient who had experienced hospitalisation several times. Beers wrote a book entitled "A Mind That Found Itself" and later founded the National Committee for Mental Hygiene. He was said to be a most enthusiastic leader of this movement and under his direction the movement became worldwide. "For the first time emphasis was placed on prevention of mental illness and early intervention" (Monat-Taylor, 1990, p. 7). At this time the theories of Sigmund Freud were also being debated. Freud challenged orthodox concepts of the mind and proposed ways of exploring thought processes.

This brought the "subject of human behaviour to the attention of lay persons for the first time" (Monat-Taylor, 1990, p. 7).

During World War II, more men in the armed forces were diagnosed as being affected by mental illness than at any other time in history, thus causing a corresponding increase in the need for the availability of short term therapy (Miller,1981). Authorities were alerted to the need for more trained professionals working in the area of psychiatry, the lack of effective treatment options and the need for knowledge in the area of cause and prevention of mental illness (Monat-Taylor, 1990).

The increase in the proportion of the population needing mental health care after World War II led to an increase in public awareness of mental illness (Miller, 1981). For the first time the mentally ill were not locked away and forgotten. Lay people were demanding effective services for their relations and this led to political debate as to how these services should be provided.

Development of the concept of the therapeutic community by Dr Maxwell Jones in 1947 (Devine,1981) where the actual milieu of the environment was used as a therapeutic tool, led to the opening of doors of mental asylums that had previously been secure units.

The severe overcrowding of mental hospitals experienced in WA during the 1950s (WA Government, 1956) was a world wide phenomena. The Inspector General of the Insane for WA in 1950 (WA Government, 1950) lamented the need for a new mental asylum at Guildford. By 1952 the new Inspector General, influenced by the British model, experimented with the opening of the Havelock Community Mental Health Clinic to resolve the problem of overcrowding at WA's two asylums, Heathcote and Claremont (WA Government, 1952).

The advent of psychopharmacology in 1953 with the experimental use of the anti-psychotic agent Chlorpromazine, for the first time provided

psychiatry with a means of treatment. Krause & Slavinsky (1982) claim that the availability of psychopharmacology in the 1950s was the single most important event leading to deinstitutionalisation. It can be argued that the successful use of anti-psychotic medication provided the setting for the development of the nurse client relationship. For the first time nurses were not just custodians but could talk with clients and collaborate on discharge planning and thus a therapeutic nurse/client relationship could evolve.

Although developments in treatment and changes in health policy delivery have occurred, there still exists in Australia a schism between state and commonwealth policy (Baum, Fry & Lennie, 1992). Funding still favours institutions, where 75% of the budget is spent despite the fact that 75% of patient consultations occur in the community (Baum, Fry & Lennie, 1992; Human Rights Commission Australia, 1993).

Figure 4 shows the influences that brought about the change in mental health treatment from an illness model to a wellness model.

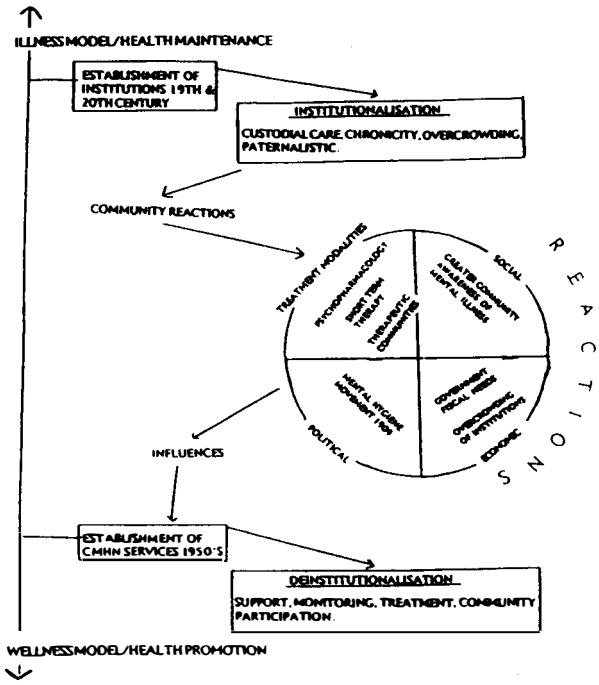


Figure 4. Community reactions and influences that brought about the change from institutional based care of the mentally ill to community based treatment.

## The Emergence of CMH Nursing in WA

Events occurring in psychiatry within WA in the 1950s mirrored the United Kingdom's model of deinstitutionalisation. This was more than likely due to the influence of emigrating psychiatrists and medical staff from Europe. Ellis (1984) describes the positive impact of British immigrant psychiatrists on mental health services as having brought with them knowledge of the deinstitutionalisation movement in the United Kingdom. Many of these men can be thanked for WA's ability to keep up with contemporary world wide change. Van Aken (1995) considers that deinstitutionalisation of the mentally ill occurred in the 1950s at a time when the literature was abundant with discussion and critical analysis of the long term effects of institutionalisation.

The following section describes the events occurring in WA since 1950, the decade when CMH nursing commenced. There is limited documented evidence concerning these events. Ellis (1984) wrote an extensive history of psychiatric services in WA, but little is mentioned of nursing. Although Ellis (1984) has given WA the fruits of an extensive search of government documentation, memoirs, health reports, health records and his own opinions, these record the history from a medical point of view. Lewis (1988) makes reference to Western Australian developments in his history of Australian psychiatry from colonial times to 1980.

### 1950s

In 1950 there were 1,567 incarcerated people with mental illness housed at Claremont Mental Asylum (1,428), Lemnos (84), Whitby Falls (37) and Greenplace (18). No institutions or permanent services existed in regional areas of WA. In that year, a child guidance clinic was established in Perth (Ellis, 1984).

During 1952, the Superintendent of Psychiatry lamented the need for a new mental asylum despite the fact that two new wards had been built at Claremont that year. It was estimated that a further 1,200 beds would be needed by 1960. Comments from the Superintendent of Psychiatry speak for themselves, "It cannot be emphasised that the increase in patients is outstripping the provision being made to accommodate them in suitable institutions and to decrease the present grossly overcrowded state and the unhygienic conditions particularly at Claremont" (WA Government, 1952, p. 3). As with contemporary society the aged were blamed for daring to live too long, "The problem of geriatrics, brought upon the community by the increased expectancy of life is one which requires review if the community is to be saved the increasing costs of the maintenance of old age" (WA Government, 1952, p. 4).

1953 was a year when the institutions in Perth were so overcrowded that waiting lists for admission were constantly in place. The first mention of an outpatient clinic occurred that year in the annual report, "Effective organisation of outpatient clinics may well be a factor in lessening the necessity for hospital residential treatment" (WA Government, 1953, p. 4). There was still no positive outlook as to how outpatient services could avoid hospitalisation of those with mental illness. Ministerial approval to open an outpatient clinic on the British model was given in 1954 (Ellis, 1984). During 1955 the Commonwealth Government released a report concerning the state of mental health facilities and future needs of Australians (Stoller & Arscott, 1955) which drew attention to the poor conditions the mentally ill were living in. This report received wide public debate and journalistic scrutiny of contemporary mental health services (Lewis, 1988). The Stoller report (cited in Eisen, 1988) lamented that the split in state and federal responsibility for mental health had led to major problems in the delivery of coordinated care . The publication of this report also began the long

negotiation between the federal and state governments which has resulted in a national mental health policy.

On the 26th of March 1956, the Havelock Street Clinic was opened in West Perth by the then Minister of Health. The clinic returned promising results with 746 patients seen in the first nine months and a reported 5.6% of cases seen needing hospitalisation. Reported treatments conducted at the clinic included electro convulsive therapy, psychotherapy, hypnosis, abreaction and some group work. No mention of nursing staff involvement is made in the annual report (WA Government, 1956).

The Havelock Street Clinic continued to be busy seeing 828 clients in 1957 and 833 in 1958. The clinics hours were extended to 9 pm three nights per week. Dr Gray, the Acting Medical Superintendent, commented that the clinic was "the first forwards step in preventative psychiatry in WA" (Ellis, 1984, p. 146). The policy of institutional care for the mentally ill was continued with the Inspector General of the Insane speculating on the establishment of a new asylum at Guildford. 1957 saw the establishment of the Mental Health Association and thus a consumers voice in health care provision (WA Government, 1957; WA Government, 1958).

In 1958 Dr Moynagh, the new Inspector General for the Insane, addressed the problems of overcrowding of hospitals with a new point of view. He suggested that possible solutions would be to increase community based services, establish new outpatient clinics, provide day care facilities, hostels for people on after-care, and domiciliary services. Apart from overcrowding of mental institutions there were severe nursing staff shortages as well as limited available allied health members such as occupational therapists and social workers (WA Government, 1958). Also in 1958 the surgical procedure of leucotomy was introduced for the first time to WA. This involved cutting nerve fibres connecting the frontal lobes of the brain with the central nervous system (Ellis, 1984). This was probably an

attempt to control violent patients with a view of eventually discharging them. Ellis (1984) comments that there was success with the use of leucotomy but few rehabilitation services existed to provide any realistic discharge supports for the mentally ill. In 1959, two mental health nurses, Mrs P Paltridge and Mr P Harrison were appointed as Mental Health Officers. Dr Gray commented that "these officers though not being trained in social work, are selected for strong and mature personalities. They will assist in admission, discharge and after care difficulties of patients" (WA Government, 1959, p 5). Dr Gray was the first person to publicly comment on the nursing staff of the Havelock Street Clinic. He made a quaint comment concerning a clinic nurse, which provides little insight into her role wihtin the clinic. Dr Gray commented that this nurse was a "Sister who has a pleasant and efficient personality" (WA Government, 1959, p. 10).

**1960s**

In 1960 ten mental health nurses were employed in the role of "mental health officers" to replace the shortage of graduate social workers. The following year sheltered workshop programs began at Claremont Hospital and a new occupational therapy block was purpose built at Heathcote Hospital. A day hospital psychiatric course, for mental health nurses, was commenced at Claremont Hospital. In his annual report, Dr Gray outlined that admission rates to hospitals were still too high, and stressed the need for outpatient facilities with therapeutic group work. He also stressed the need for such group programs to cause the least disruption to work and home life for patients. The nursing staff at the Havelock Street Clinic were conducting group work and had implemented social therapy. Groups were run specifically for women and in the evenings for those who worked (WA Government, 1960).

A much forgotten player in the evolution of community based care for the mentally ill was Ruby Hutchinson who could be described as a woman with vision and one who advocated for the needs of the mentally ill. Ellis described her as someone who "has a fierce concern for the underprivileged" (1984, p. 131). In 1952, at the age of 61, she was the first woman to be elected to the Legislative Council of WA. She had been a member of the Australian Labor Party since the age of 16. During 1961 she embarked on a world tour looking at new trends in mental health. Her recommendations for reforms read like a blue print for the future of mental health services in WA. She advocated that the Claremont Hospital be demolished, that the intellectually handicapped and elderly be taken out of mental institutions and be appropriately housed and cared for. She called for community based treatment teams that would provide continuity of care following discharge from the hospital, and the establishment of non-institutional community based assessment and care (Ellis, 1984).

It was in 1962 that the Havelock Street Clinic first recorded over 1,000 clients (1,027). On average, 86 clients attended weekly groups run by the nursing staff. The women's re-socialisation group continued and a new evening group for young people with mental illness commenced. At Heathcote, three nurses were employed full time as "mental health officers" and extended their role to include home visiting and follow up of clients following discharge. The new Mental Health Act of 1962 superseded the old Mental Treatment Act of 1927 which, in turn, had replaced the Lunacy Act of 1903. After-care provisions provided by the Mental Health Act 1962, required greater emphasis on community based supports if discharge under after-care was to be successful (WA Government, 1962; Ellis, 1984). Although many attempts have been made to review it, the 1962 Mental Health Act remains in force in 1995.

Construction of a Day Centre at Shenton Park commenced in 1963 and plans for a departmental hostel for men with chronic mental illness were discussed. Proposed plans for a visiting country psychiatric consultancy were deferred. The Havelock Street Clinic had a two to three week waiting list and had reached saturation level. Calls for a new clinic were made.The Industrial Training Centre at Claremont Hospital had long reached maximum capacity. There was an atmosphere of great need for new community based services (WA Government, 1963).

1965 saw the opening of the much needed Stirling Street Clinic at Fremantle. Dr Rolls was appointed Superintendent of the clinic and his first annual report provides an insight into the treatment modalities of the time when attention was made to the inability of the clinic to provide electro convulsive therapy due to a shortage of nursing staff. Havelock Street Clinic recorded seeing 1,130 clients and 19 therapy groups were being conducted. Despite the opening of the Fremantle Clinic, the demand for services at Havelock Street increased with a reported waiting list of six weeks in 1966. After undergoing two amendments, the Mental Health Act of 1962 came into operation on the 1st of September,1966, consolidating the need for provision for after-care services. This new WA Act was based on the recently revised British Mental Health Act of 1959 and the Victorian Mental Health Act of 1959 ( Ellis, 1984; Lewis, 1988; WA Government, 1966).

Integration of male and female patients occurred for the first time at Claremont Hospital in 1967. In retrospect, this simple change in patient housing can be seen as a movement toward normalisation of the treatment of the mentally ill. An outpatient clinic and after-care service was established within the Claremont Hospital grounds. The consultant, Dr Blackmore, referred to the nurses working as "mental health officers" as "welfare officers". This may have indicated the beginning of the transfer of traditional nursing roles to the emerging allied health professionals. The new clinic

provided services for Claremont hospital patients and did not have an extended role into the community. This observation is supported by Dr Blackmore's comment: "A logical extension of this service [the Claremont Out Patient Clinic] is the development of a domiciliary program in which psychiatric nurses visit homes and hostels" (WA Government, 1967, p. 18).

In 1968, the Havelock Street Clinic reported having 3,406 clients and Fremantle Clinic 888 clients. For the first time in recorded history the number of discharges [more than 1,000] at Claremont Hospital exceeded the number of admissions. Group therapy was being conducted at the Selby Day Hospital complimenting community support provided by Havelock Street Clinic (WA Government, 1968).

In 1969 the first mention of community care nurses is made in the annual report of Claremont Hospital. These nurses were employed from the ranks of senior nurses at ward charge nurse level (WA Government, 1969). This is historical evidence that senior nurses were considered to be needed for the community role. This supports contemporary CMH nurses who are now struggling to have their role recognised within a career structure, by the WA Government. An out patient clinic was opened at Kalgoorlie in December (Ellis, 1984) and a proposal was made for one in Perth at Bentley.

## 1970s

At the beginning of the 1970s, Claremont Hospital remained a large institution of 30 inpatient wards. Eighteen hostels for the mentally ill accommodated 470 ex-patients in the Perth metropolitan area. Community nursing services were greatly expanded in the 1970s with the establishment of many regional centre services (Ellis, 1984; Lewis, 1988).

In August 1970, the new Bentley Clinic opened and during this year the first male superintendent of psychiatric nursing was appointed. On the

14th January 1971, Fremantle Clinic moved to more appropriate premises, and in November an out patient clinic commenced in Geraldton. This move to regional centres outside the Perth metropolitan area created much discussion in 1972 as to the need to extend regional mental health services (WA Government, 1970; WA Government, 1971; WA Government, 1972).

The most significant event of 1973 was the closure of Claremont Hospital [established 1903] (Ellis, 1984; Lewis, 1988) and the establishment of two new hospitals, these being Graylands and Swanbourne, utilising the existing buildings and resources. Graylands was to provide psychiatric care for people up to the age of 65 and Swanbourne for people 65 years and over. Swanbourne also housed a sizeable population of people with intellectual handicaps (Lewis, 1988). Dr Blackmore travelled to the far north of the state looking at mental health needs of communities at Port Hedland, Broome, Derby, Kunnanurra and Wyndham. A Community Development Centre was opened at Graylands. A Stress Referral Service was established at the new Community Development Centre in Perth (WA Government, 1973).

In 1974, outpatient clinics commenced at Rockingham [once a fortnight from Fremantle Clinic] and Port Hedland [once a month from Havelock Clinic]. The Community Psychiatric Division was established at Graylands Hospital in January with Dr Ellison appointed Community Psychiatrist. Two community care nurses were employed at Swanbourne Hospital within the Social Welfare Department. An outpatient clinic was established at Heathcote Hospital in November (WA Government, 1974).

Sessional visits by a psychiatrist and psychologist were commenced at Balga and Lockridge in 1975, and provided a valuable service through the Community Health Centres. In January, an outpatient clinic opened at Bentley. Graylands Hospital established the Creative Expression unit in May with an emphasis on art therapy and rehabilitation. Former patients could

learn new skills in a supportive environment and even pursue education in the Arts. The Community Psychiatric Division at Graylands employed six community care nurses to provide rehabilitation for former patients discharged to hostels. These community nurses supported three to four hostels each and provided assistance to hostel owners, follow up of patients as well as social outings and organised activities. Several hostels had been established in the Guildford area which was far from the centrally located services of Perth. The Guildford Occupational Therapy Centre opened in January to meet this need. At Heathcote, six community care nursing positions were established. The Hospital Superintendent commented how "this emphasises the hospital's [Heathcote] changing orientation towards community support for outpatients" (WA Government, 1975, p. 19). At Swanbourne, the two CMH nurses were reported to be conducting pre-admission assessment with impressive results of a 30% admission rate. The remaining 70% were either being supported with community nursing follow up or the CMH nurse was arranging direct admission to private nursing homes and hostels. Havelock Clinic was servicing a staggering 14,870 clients and the three CMH nurses at the Bentley Clinic were seeing 50 patients a month (WA Government, 1975).

Armadale Clinic opened in June 1976 with two CMH nurses employed. The three CMH nurses at Bentley conducted between them 500 home visits during this year. Once a month a bus trip was organised for patients living in the area and recreational, socialisation, discussion and yoga groups were conducted. The Community Psychiatric Division at Graylands received one of 25 Commonwealth Government grants for community based mental health projects and increased support for people living in hostels, particularly targeting women with mental illness. The Rockingham Clinic was temporarily discontinued but a new monthly clinic was established at Mandurah and Bunbury. A mental health nurse was

seconded from Graylands to provide a full time CMH nursing service at Balga (WA Government, 1976).

By 1977, there were 550 residents in hostels and 270 living in nursing homes supported by CMH nurses. Interestingly this is equivalent to just over 27, 30 bed inpatient wards. Heathcote's outpatient clinic provided a service for profoundly deaf people with mental illness. At Armadale Clinic, outpatient services were extended for children and adolescents. The CMH nurses at Bentley ran a weight reduction group and 239 people were attending their yoga classes per year. The clinics in the Perth metropolitan region reported a significant increase in the number of self referrals for services other than psychiatric care. Swan Clinic opened on 24th January 1977 and saw 629 patients in its first year. The Community Psychiatric Division stated in its annual report that reviews of after-care status were being conducted, with each CMH Nurse responsible for over 100 patients in the community (WA Government, 1977).

It was not until 1978 that integration of male and female clients took place at Swanbourne Hospital. The old hospital housed 491 patients and the CMH nurses admission rate, following pre-admission assessment, had deteriorated to 63% (30% in 1975). This deterioration was despite the fact the CMH nursing population had doubled to four. A second mental health nurse was seconded to Balga Clinic as a CMH nurse as the "facility was only scratching the surface of the needs of the community in that district" ( WA Government, 1978, p. 13). Of the 344 new referrals to Armadale Clinic, 132 (38%) were under the age of 18, proving the need for expansion of this service. The CMH nurse was active in running groups for this population. Bentley reported 632 new patients in 1978 and introduced a policy that all new referrals would first be screened by the three CMH nurses for triage. At Swan Clinic an innovative service was established to enable the Midland Court of Petty Sessions to refer people for psychiatric assessment under

Section 36 of the Mental Health Act [Remand]. This provided a psychiatric review and consideration of support services rather than the traditional 28 day admission to Graylands Hospital. The literature does not report how long this service was maintained. Due to regionalisation of services, Swan Clinic also took over the community service at Lockridge Clinic. Also in this year, the WA Government passed legislation to provide ongoing review of conditions within psychiatric hostels (WA Government, 1978).

Although Graylands and Swanbourne were running as separate hospitals, any services they shared were finally split in 1979. Both hospitals embraced the Bentley Clinic triage policy requiring a CMH nurse to first assess all new referrals, with the modification of including a social work assessment as part of the decision to admit. Graylands provided new accommodation for its CMH nurses and employed an extra five. For the first time the Havelock Street Clinic reported a reduction in attendances probably due to new suburban clinic services. The Community Psychiatric Division reported that due to decreased available funding, CMH nurses could only provide a limited service with token support for the hostels. During this year 20 rural communities were targeted by the Community Development Centre with greatest concentration on the Northam area. Educational packages were developed for mental health promotion, stress reduction, understanding mental illness and effective parent/child relationship building. The Stress Referral Service reported having made 14,138 contacts between January 1973 and June 1979 (WA Government, 1979).

## 1980s

In 1980, Perth hosted the 5th National Convention of the Mental Health Nurses Congress [later the Australian and New Zealand College of Mental Health Nurses]. A proposed new Mental Health Act was debated in the WA parliament. With the co-operation of the CMH nurses, Graylands

Hospital commenced a pre-discharge program on two wards to facilitate the rehabilitation of clients with a long standing mental illness into the community. The Kwinana Community Health Clinic which was opened on the 21st July 1979, re-established full time services for the Rockingham area. Swan Clinic reported a 10% increase in new referrals and noted having many clients travelling from nearby regional areas such as Toodyay and Gidgeganup. The Progressive Community Development Centre targeted Aboriginal leaders concerning education about alcohol and a community support service was established in Leederville for migrants (WA Government, 1980).

A proposal to close the old and run down psycho-geriatric service at Swanbourne Hospital was put forward in 1981. This outlined plans to establish small assessment units located near metropolitan general hospitals called Psychiatric Extended Care Units (PECU's). These PECU's would provide day hospital care, treatment, assessment, respite and community services including CMH nursing. Fremantle Clinic conducted a statistical analysis of their clients and established that the majority of clients were single females in their 30's. At Geraldton the clinic was running without CMH nurses and Mental Health Services only provided twice monthly psychiatric consultations from Perth for an average 800 referrals a year. One can only speculate as to how many of these referrals primarily needed the services of a psychiatrist over a full time CMH nurse working within the Geraldton community (WA Government, 1981). Unfortunately, this belief by WA Health Ministers that a mental health service must be provided by a psychiatrist persist. In 1995, the Court Government has withdrawn services for children and adolescents, in the Eastern Health Region, due to the lack of an available psychiatrist. The Community Psychiatric Division continued with decreased funding. The development of a senior position of "Superintendent of Community Nursing" (WA Government, 1981, p. 32) was considered an

important priority. This position may have established evaluation of CMH nursing services and direction, as well as planning for new services. The Association of Relatives and Friends of the Mentally Ill (ARAFMI) was established and provided a much needed support service for carers of the mentally ill and interested parties.

After severe depletion of funding during the previous five years, the Community Development Centre was closed in 1982. Demand for CMH nursing services was on the increase with both Bentley, Swan and Havelock reporting a 10% increase in work load but no new CMH nursing positions. Clients at Swan now waited up to 14 days to be initially seen. Swanbourne Hospital finally acted on Ruby Hutchinson's 1961 recommendations and transferred its intellectually handicapped to the newly established Department of the Intellectually Handicapped at Pyrton. This year also saw the establishment of a weekly activity service in nursing homes north of the Swan River provided by a CMH nurse and an occupational therapist. This program was designed to support nursing homes and provide suitable activities for people with dementia, mental illness or behavioural problems (WA Government, 1982)

Following a change of Government in 1983, the proposed new Mental Health Act of 1981 was not proclaimed, leaving WA with a 21 year old Mental Health Act. It is true that history does repeat itself. In 1883, Louisa Lowe, a former nursing matron and Honourable Secretary of the British Lunacy Reform Association lamented that "as governments change, promised reforms are consigned to oblivion" (Lowe, 1883, p. 3). Matron Lowe had been advocating for reform of the British Lunacy Act since 1857. On a more positive and contemporary note, cluster homes were established at Eden Hill in Perth on the 24th September 1983, with the purpose of providing rehabilitation for highly functioning elderly clients. The Mobile Day Hospital reported having 85 clients and CMH nurses from Swanbourne

were providing support for 360 clients in the community and nursing homes. Warwick Clinic opened with one CMH nurse on the 12th July 1982 and a Multicultural Clinic opened in Leederville on 17th January 1983. This clinic was to meet the needs of migrants and non English speaking people with mental illness in Perth (WA Government, 1984).

From 1985 the Psychiatric Services were amalgamated into the Health Department of WA. From this year on, the annual reports provide progressively less information concerning mental health and psychiatric care. Regional hospitals, despite developing psychiatric services in subsequent years, have made little comment on this part of their service. This year saw the closure of Swanbourne Hospital and the transfer of 168 clients to PECU's at Shenton Park, Osborne Park, Swan Districts, Bentley and Armadale. All five PECU's provided a day hospital service and employed one CMH nurse each. The annual report stated that "CMH nursing was moving toward a preventative model despite limitations in staff and resources" (WA Government, 1985, p. 22). CMH nursing clinics were now established in the Perth metropolitan area at Bentley, Armadale, Fremantle, Havelock Street West Perth, Balga, Swan and the Multicultural Clinic at Leederville with Osborne Park Clinic opening on the 21st June 1985 (Gava, 1989). Gava comments that "when planning the original Osborne Park Hospital in 1961 a Health Department memo stated there was no need for a psychiatric unit at Osborne Park or at any regional hospital. The policy was for regional hospitals to have a single room merely to hold patients until they could be transferred to Perth" (Gava, 1989, p. 115)

In 1986 the Convention of the Australian Congress of Mental Health Nurses was held for the second time in Perth. A working party was established by the WA Government looking at the needs of the mentally ill. The working party advocated that the needs of the psychiatrically ill should be met at a local community level. CMH nursing services were permanently

established at Geraldton and Bunbury with a visiting service to Albany (WA Government, 1986).

In 1987 the Multicultural Centre reported seeing 222 clients a month. A CMH nursing service was established at Esperance (WA Government, 1987).

The 1988 annual report called for the establishment of CMH nursing services in Derby and Broome. Little more was reported (WA Government, 1988). Around this time services at the Havelock Street Clinic were transferred to Avro in Nicholson Road, Subiaco and the Balga Clinic transferred services to Mirrabooka. This researcher can find no primary source documentation to verify this.

In 1989, the need for a 24 hour psychiatric emergency service in the Perth metropolitan area and increased access to psychiatric services in rural WA was raised (WA Government, 1989).

**1990s**

The Psychiatric Emergency Team was established in 1990 (WA Government, 1990) and the Zelestis report of inquiry into psychiatric services in WA was released (Zelestis, 1989).

In 1991, the Psychiatric Emergency Team was expanded and commitments were made for CMH nursing services to be established in regional centres throughout WA. A community psychiatric team employing one CMH Nurse commenced in Albany (Mackay, 1992). The Mental Health Act (1962) was again under review and submissions were made by interested parties including CMH nurses to a proposed Bill to reform the Act (WA Government, 1991). Two CMH nurses working at Shenton Park Psychiatric Services for the Elderly received funding from the WA Minister of Health to develop a program designed to provide support and education for carers of people with dementia. The program was timely as the numbers of

people with dementia was on the rise and the literature estimated that 90% of aged care funds were directed to institutions which catered for less than 10% of the population (Lee, 1990). This is an excellent example of the adaptability of CMH nurses and their ability to expand their role.

In 1992, a Rural Health Policy Unit was established in Geraldton and rural health services providing CMH nursing were established in the Pilbarra, Central Wheatbelt and Great Southern health regions at Narrogin (WA Government, 1992). In Perth, the Inner City CMH Clinic opened with Dr White commenting that "many readmissions have been prevented due to continuity of care which is now available to patients when they are discharged from hospital" (Royal Perth Hospital, 1993, p. 14).

During 1994, plans were made for the expansion of services at Mirrabooka for a purpose built clinic as well as a new clinic at Joondalup (Osborne Park Hospital, 1994, p. 3). The CMH nursing service at Katanning was established. The Inner City Clinic was integrated with Royal Perth Hospital and took over some of the services of the now defunct Multicultural Clinic. An acute psychiatric day hospital was established at Royal Perth Hospital (Royal Perth Hospital, 1994; WA Government, 1994; WA Government, 1995).

Table 2 provides a time line, showing important events that have occurred since the establishment of the Havelock Street Clinic.

Table 2. Time line of events occurring, concerning Community Mental Health Nursing since the opening of the Havelock Street Clinic in 1956.

| | |
|---|---|
| 1950 | Literature discusses harmful effects of institutionalisation. 1,567 people incarcerated in psychiatric institutions in WA. |
| 1952 to 53 | Severe overcrowding of psychiatric institutions at Perth. |
| 1954 | British CMH nursing commences at Warlingham Park, Surrey. |
| 1955 | Stoller report and beginning of negotiation between federal and state governments. |

| | |
|---|---|
| 1956 | Havelock Street Clinic opens at West Perth (26/3/56). |
| 1957 | Establishment of WA Mental Health Association. |
| 1959 | 2 MH nurses appointed as MH officers at Claremont. |
| 1960 | 10 MH nurses working as MH offices. |
| 1961 | Group therapy at Havelock Street Clinic. R. Hutchinson makes recommendations to Parliament for community based care in WA.Sheltered workshops open at Claremont. |
| 1962 | MH Act tabled in Parliament. |
| 1963 | Day centre opens at Shenton Park. |
| 1965 | Fremantle clinic opens. |
| 1966 | MH Act of 1962 proclaimed (1.9.66). |
| 1967 | O.P & aftercare service established at Claremont. |
| 1969 | O.P service established at Kalgoorlie. |
| 1970 | O.P service established at Bentley. |
| 1971 | Fremantle Clinic moved (14.1.71). O.P service at Geraldton. |
| 1973 | Claremont split into Graylands & Swanborne. Community Development Centre & Stress Referral open at Graylands. |
| 1974 | Community Psychiatric Division opens at Graylands, O.P Clinics at Rockingham once 2/52 & Port Hedland once 1/12. |
| 1975 | Bentley, Balga & Lockridge O.P opens. Creative Expression opens at Graylands (May). Community Psychiatric Division employs 6 CMH nurses, |
| 1976 | Armadale Clinic opens. CMH nurse at Balga. Rockingham discontinued and monthly clinics at Mandurah & Bentley. |
| 1977 | Swan Clinic opens (24.1.77). |
| 1978 | Two CMH nurses working at Balga. |
| 1980 | 5th National Convention of the MHN Congress, Perth. Kwinnana clinic opens. |
| 1981 | ARAFMI commences. Proposed new MH Act. |
| 1982 | Warrick Clinic (12.7.82). Community Development Centre closes due to lack of resources. Mobile day hospital commences. Intellectually handicapped move to Pyrton. |
| 1983 | Multi Cultural Clinic opens (17.1.83). Eden Hill opens (24.9.83) |
| 1985 | Osborne Park Clinic opens (21.6.85). Psychiatric services amalgamated with Health Department. Opening of PECU's. |
| 1987 | CMH nursing commences at Esperance. |
| 1988 | Havelock Street Clinic closes & Avro opens. Balga Clinic service transferred to Mirrabooka. |
| 1990 | Psychiatric Emergency Team established. Zelestis report. |
| 1991 | CMH nursing commences at Albany and Dementia Carers Support Program established at Shenton Park. |
| 1992 | Rural Health Policy Unit opens in Geraldton & CMH nursing commences at Narrogin, Pilbarra, Central Wheatbelt and Great Southern Regions of WA. |
| 1993 | Perth Inner City Clinic opens and Multicultural Clinic closes. |
| 1994 | CMH nursing at Katanning & Koolyarra Project commences. |
| 1995 | Joondulup Clinic opens. |

Note. MH = mental health; MHN = mental health nurse; OP = out patient;

ARAFMI = Association for the relatives and friends of the mentally ill.

# Chapter 6

## Population Profile of Community Mental Health Nurses Practicing in Western Australia

### Introduction

This chapter will report the study findings, presented in three sections each relating to the following research questions:

- "What is the population profile of CMH nurses currently practicing in Western Australia?"
- "How do Western Australian CMH nurses describe their usual work activities?"
- "How do Western Australian CMH nurses describe their level of job satisfaction?"

### Questionnaire Responses

Questionnaires were posted to the total population of 130 CMH nurses practicing in WA. Of these, 95 (73%), were sent to CMH nurses practicing in metropolitan Perth and 35 (27%), were sent to the CMH nurses in rural areas.

Eighty six questionnaires were returned resulting in a response rate of 66%. Fifty seven (60%) returns were received from metropolitan based CMH nurses and 29 (83%) returns were received from rural CMH nurses. For the purpose of reporting the study findings, returns from regional centres are included with rural returns as regional centres are located in rural areas, that is, outside the metropolitan area.

## Population Profile

The following section will report findings related to the research question, "What is the population profile of CMH nurses currently practicing in WA?"

### Age of respondents.

The age of respondents ranged from 23 to 58 years. The mean age was calculated to be 37.5 years. Two participants (1 metropolitan and 1 rural ), did not provide their age.

### Gender.

Of the respondents, 46 (53.5%) were male and 40 (46.5%) were female. Table 3 shows the gender of metropolitan and rural CMH nurse respondents.

Table 3

Gender of Metropolitan and Rural CMH Nurse Respondents

| Gender | Metropolitan | Rural |
|---|---|---|
| Male | 31 | 15 |
| Female | 26 | 14 |
| Total | 57 | 29 |

### Current work location.

Participants were asked to state their work location. Fifty seven (66%) stated they were practicing in the Perth metropolitan area, 17 (20%) reported they were practicing in a regional centre and 12 (14%) advised they were located in a rural area.

**Length of time employed in current position.**

Thirty five (41%) respondents reported they had been employed in their current position for more than 5 years. Of these, 29 were from the metropolitan areas and 6 were from rural areas. In addition, 13 respondents stated they had been employed in their current position for between 10 and 18 years. Two of these 13 were from the rural areas.

Table 4 shows the length of time respondents have been employed in their current position. In the Perth metropolitan area, 24 (42%) reported they had less than three years experience, and in the rural areas 20 (69%) reported being in their current position for less than three years. Fourteen of the 20 were found to have two years experience or less.

Table 4

Length of Time Employed in Current Position

| Years of service | Metropolitan | Rural | Total Population |
|---|---|---|---|
| <= Six months | 9 | 4 | 13 (15.1%) |
| 7 to 12 months | 5 | 5 | 10 (11.6%) |
| 13 to 24 months | 5 | 5 | 10 (11.6%) |
| 25 to 36 months | 5 | 6 | 11 (12.7%) |
| 37 to 60 months | 9 | 4 | 13 (15.1%) |
| 61 to 120 months | 16 | 5 | 21 (24.4%) |
| > 120 months | 8 | | 8 ( 9.3%) |
| Total | 57 | 29 | 86 ( 100%) |

**Current employment contract.**

Of the 86 respondents, 75 (87%) reported they were contracted as permanent staff of various divisions of the WA Health Department. Fifty eight (67%) stated they were contracted as full time permanent staff, 17 (20%)

were full time temporary, 7 (8%) were permanent but part time, 1 (1%) was on a part time temporary contract, 2 (3%) were casual and 1 (1%) was on secondment from a major teaching hospital. Table 5 shows a beakdown of the employment contracts for the participants, differentiating those practicing in the Perth metropolitan area from the rural areas.

Table 5

Current Employment Contract for Metropolitan and Rural Participants

| Contract | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Full time permanent | 34 | 24 | 58 (67.4%) |
| Full time temporary | 14 | 3 | 17 (19.8%) |
| Part time permanent | 7 | | 7 ( 8.1%) |
| Part time temporary | 1 | | 1 ( 1.2%) |
| Casual | | 2 | 2 ( 2.3%) |
| Other | 1 | | 1 ( 1.2%) |
| Total | 57 | 29 | 86 ( 100%) |

Note. No respondent chose the option "sessional relief", therefore this does not show in the table. "Other" refers to a CMH nurse on secondment.

**Experience as a registered nurse in a community setting prior to current position.**

Fifty two respondents stated they had worked in a community based setting prior to their current CMH nursing position. Of these, 44 (84%) had previously worked as a CMH nurse, 3 (6%) had practiced as a community generalist, 2 (4%) had worked in a rehabilitation role, 1 (2%) had worked in a community day care centre and 2 (4%) stated they had worked in the community but did not provide information as to what this position entailed.

**Accessibility to other CMH nursing colleagues at current work site.**

In response to the survey question, do you work alone as a CMH nurse or with other CMH nurses, 72 (84%) reported they worked in contact with other CMH Nurses. Of these 72, 54 (75%) were practicing in the Perth metropolitan area and 18 (25%) in rural areas.

Fourteen (16%) worked alone with no other CMH nurse, and of these 3 (22%) were practicing in the Perth metropolitan area and 11 (78%) in rural areas. Of the 14 CMH nurses who reported practising alone, 11 were males and 3 were females.

A cross tabulation was conducted to identify the length of experience in their current position of the 14 nurses who reported they worked alone. This is shown in Table 6.

Table 6

Length of Employment in Current Position of CMH Nurses Who Reported They Worked Alone

| Length of experience | Number of CMH Nurses |
|---|---|
| 3 months or less experience | 2 |
| 4 to 12 months experience | 2 |
| 13 to 18 months experience | 2 |
| 19 to 36 months experience | 5 |
| 37 to 48 months of experience | 1 |
| 6 years of experience | 1 |
| 10 years of experience | 1 |
| Total | 14 |

**Major way CMH nurses who work alone make contact**

The 14 CMH nurses who reported they were working alone were asked to report how they made contact with other CMH nurses. Eleven (78%) reported the use of telephone, 2 (14%) indicated they had face to face meetings and 1 (8%) declined to respond. None of the respondents selected "written material/fax".

**CMH nurses first choice of consultation with other health care workers.**

The participants were asked to select from a list of health care workers the first person they would choose to consult with for a clinical problem and to state why they selected that person. Table 7 shows the responses concerning first choice of consultation.

Table 7

Health Care Worker a CMH Nurse Would Primarily Choose to Consult With Over a Clinical Problem

| Health Care Worker | Metropolitan | Rural | Total Population |
|---|---|---|---|
| General practitioner | | 6 | 6 ( 7.0%) |
| CMH Nurse colleague | 39 | 12 | 51 (59.3%) |
| Consultant psychiatrist | 13 | 7 | 20 (23.3%) |
| Registrar | 2 | 1 | 3 ( 3.5%) |
| Psychologist | | 1 | 1 ( 1.2%) |
| Carer | | 1 | 1 ( 1.2%) |
| Other | 3 | 1 | 4 ( 4.7%) |
| Total | 57 | 29 | 86 ( 100%) |

Note. The options of "social worker" and "occupational therapist" were not selected by any of the respondents, therefore are not shown in the table.

Table 8 shows the reasons given by the respondents for choosing a particular health care worker to primarily consult with for a clinical problem.

Table 8

Reason for Primary Consultation With Health Care Worker

| Profession | a | b | c | d | e | f | g |
|---|---|---|---|---|---|---|---|
| General Practitioner | | 2 | | | 4 | | |
| CMH Nurse Colleague | 31 | 17 | 3 | | | | |
| Consultant Psychiatrist | 2 | 5 | | 10 | | | 3 |
| Registrar | 1 | | | | 2 | | |
| Psychologist | 1 | | | | | | |
| Carer | | | | | | 1 | |
| Other | | | | | | | 4 |
| Total | 35 | 24 | 3 | 10 | 6 | 1 | 7 |

Note. In reference to Table 8: a =clinical expertise; b = only other health care worker available in my area; c = accessibility of this person; d = leader of clinical team; e = seen to be clinically responsible for the client; f = work together to plan care; and g = no reason given.

**Nursing qualifications.**

All 86 (100%), respondents were registered with the WA Nurses Board as a mental health nurse. Of the 86 respondents, 30 (34.8%) were also registered as a general nurse, 5 (5.8%) had previously held registration as an enrolled general nurse, 2 (2.3%) had previously been registered mental retardation nurses and 2 (2.3%) had previously registered as an enrolled mental health nurse. Ten (11.6%) of the respondents held a third qualification in nursing.

**Courses completed by CMH nurses.**

Fifty five (64%) of the respondents had completed a course since registration as a registered nurse and 31 (36%) had not. Forty three (50%) held an award from a tertiary educational institution. Of these 43, 20 reported holding a certificate or diploma, 19 held a graduate degree, three held a postgraduate diploma and one reported having a masters degree. The distribution of these findings with a comparison between metropolitan and rural responses is shown in Table 9.

Table 9

Awards From Tertiary Institutions Held By CMH Nurses

| Award | Metropolitan | Rural | Total |
|---|---|---|---|
| Teaching Certificate | 2 | | 2 |
| Certificate of Health Promotion | | 1 | 1 |
| Certificate of Management | 1 | | 1 |
| Certificate of Addiction Studies | 1 | | 1 |
| Diploma of CMH Nursing | 5 | 4 | 9 |
| Diploma of Counselling | 1 | 2 | 3 |
| Diploma of Advanced MH Nursing | 2 | | 2 |
| Diploma of Hospital Administration | 1 | | 1 |
| Bachelor Degree (Nursing) | 12 | 3 | 15 |
| Other Bachelor Degrees | 4 | | 4 |
| Post Graduate Diploma (Nursing) | 2 | | 2 |
| Post Graduate Diploma Counselling | 1 | | 1 |
| Master of Health | 1 | | 1 |

The respondents were also asked to list any informal courses they had completed which they felt was of benefit to their current role as a CMH Nurse. The responses are shown in Table 10.

Table 10

Informal Courses Completed by CMH Nurses

| Course Title | Metropolitan | Rural | Total |
|---|---|---|---|
| Management | 13 | 8 | 21 |
| Counselling | 13 | 4 | 17 |
| Alcohol & Drug Issues | 12 | 5 | 17 |
| Computer Education | 7 | 1 | 8 |
| Behavioural Management | 5 | | 5 |
| Gerentology | 2 | 3 | 5 |
| Family Planning | 1 | 2 | 3 |
| Psychotherapy | 1 | 1 | 2 |
| Sexual Assault Counselling | | 2 | 2 |
| Youth Suicide Prevention | | 2 | 2 |
| Occupational Health & Safety | 1 | 1 | 2 |
| Family Therapy | 1 | 1 | 2 |
| Aggression Management | 1 | 1 | 2 |
| Public Speaking | 2 | | 2 |
| Cardio Pulmonary Resuscitation | 2 | | 2 |
| Train the Trainer | 2 | | 2 |
| Massage | 1 | 1 | 2 |
| Case Management | 2 | | 2 |
| Health Promotion | | 2 | 2 |
| Staff Appraisal | 1 | | 1 |
| Child & Adolescent Psychiatry | 1 | | 1 |

| | | |
|---|---|---|
| Quality Assurance | 1 | 1 |
| Domestic Violence | 1 | 1 |
| Remote Area Nursing | 1 | 1 |

**Courses that CMH nurses are currently studying.**

Thirty one (36%) respondents reported currently studying toward some qualification. Of these, 6 (20%) reported working toward a certificate course, 22 (71%) toward a Bachelor of Nursing, 2 (6%) are engaged in post graduate studies and 1 (3%) is conducting masters research in health promotion.

**Perception of staff development availability.**

In response to the survey question which asked if the participants believed that their current employer provides ongoing staff development, 25 (29%) of respondents strongly agreed or agreed with the statement and 61 (71%) disagreed or strongly disagreed with the statement. The responses of the participants is shown in Table 11.

Table 11

Respondents Perception of the Availability of Staff Development

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 2 | 5 | 7 (8.1%) |
| Agree | 13 | 5 | 18 (20.9%) |
| Disagree | 22 | 14 | 36 (41.9%) |
| Strongly Disagree | 20 | 5 | 25 (29.1%) |
| Total | 57 | 29 | 86 (100%) |

**Perception of how staff development received has enhanced the role of the CMH nurse.**

Thirty three (38%) respondents strongly agreed or agreed that the staff development they had received had assisted in enhancing their role as a CMH Nurse, and 53 (62%) disagreed or strongly disagreed with the statement. Table 12 shows the distribution of responses to this question.

Table 12

Metropolitan and Rural CMH Nurses Perception of Role Enhancement From Available Staff Development

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 3 | 6 | 9 (10.5%) |
| Agree | 16 | 8 | 24 (27.9%) |
| Disagree | 19 | 8 | 27 (31.4%) |
| Strongly Disagree | 19 | 7 | 26 (30.2%) |
| Total | 57 | 29 | 86 (100%) |

**Perception whether tertiary based education was available to assist in providing advanced CMH nursing practice.**

Eighty two (95.4%) respondents felt that tertiary education available in WA was not designed to assist nurses develop advanced CMH nursing practice. Responses are shown in Table 13.

Table 13

Respondents Perception of the Availability of Tertiary Based Education and Its Relevance to Providing Advanced CMH Nursing Practice.

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 2 | | 2 ( 2.3%) |
| Agree | | 2 | 2 ( 2.3%) |
| Disagree | 20 | 16 | 36 (41.9%) |
| Strongly Disagree | 35 | 11 | 46 (53.5%) |
| Total | 57 | 29 | 86 (100%) |

**Perception of whether nursing education has adequately prepared CMH nurses for their current position.**

Table 14 shows the response to the survey question which asked if each CMH nurse felt their nursing education had adequately prepared them for their current position as a CMH nurse. Forty six (54%) agreed or strongly agreed with this statement with 40 (46%) disagreeing or strongly disagreeing.

Table 14

Respondents Perception of Adequacy of Educational Preparation For Current Position

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 4 | 3 | 7 ( 8.1%) |
| Agree | 27 | 12 | 39 (45.3%) |
| Disagree | 21 | 14 | 35 (40.7%) |
| Strongly Disagree | 5 | | 5 ( 5.8%) |
| Total | 57 | 29 | 86 (100%) |

## Work Activities

The following section of findings relates to the research question: "How do Western Australian CMH nurses describe their usual work activities?"

One of the survey questions asked respondents to list activities they had performed in the past working week.

### Liaison with other services.

Eighty two (95.3%) of the respondents stated they had been engaged in liaison with other health care services, and 4 (4.7%) indicated they had not.

### Follow up of community clients.

Eighty four (97.7%) of the respondents reported they had conducted community client follow up in the previous working week, two (2.3%) had not.

### Admission of clients to hospital.

Sixty two (72.1%) of the respondents reported being involved in admitting clients to hospital in the previous working week whilst 24 (27.9%) had not.

### Report writing.

All 86 (100%) respondents reported they had been involved in report writing in the previous working week.

### Telephone counselling.

Seventy eight (90.7%) respondents reported they had provided telephone counselling and 8 (9.3%) had not.

**Travelling to appointments.**

Seventy eight (90.7%) respondents had been engaged in travelling within the community whilst engaged in their course of work. Eight (9.3%) of the respondents did not select this option.

**Meetings.**

Of the 86 respondents, 83 (96.5%), advised they had been engaged in formal meetings as part of their duties in the previous week whereas three (3.5%) reported they had not.

**Group work.**

Eighteen (21%) reported that they had been engaged in conducting group work with clients in the previous working week, however 68 (79%) stated they had not.

**Nursing procedures.**

Sixty seven (78%) respondents reported having carried out general nursing procedures such as administration of intramuscular injection in the previous week, whilst 19 (22%) reported they had not.

**Case review.**

Seventy one (82.6%) respondents reported having conducted some form of case review in the previous working week with 15 (17.4%) advising they had not.

**Home visits.**

Eighty four (97.7%) of the CMH nurses surveyed reported they had conducted home visiting in the previous working week and 2 (2.3%) had not.

**Primary assessment of clients.**

Seventy one (82.6%) respondents had been engaged in conducting primary assessment of community clients in the previous working week, and 15 (17.4%) had not.

**Supervision of staff.**

Forty two (48.8%) respondents reported having provided some direct supervision of staff in the previous working week. Forty four (51.2%) reported they did not supervise staff.

**Supervision of student nurses.**

Forty five (52.3%) of the respondents stated they normally supervise student nurses during the course of their work. Of these,16 reported they had supervised student nurses during the previous working week. The survey was conducted at a time when student nurses would be participating in normal semester activities.

**Client education.**

Seventy four (86%) of the respondents reported having provided client education as part of their duties in the previous working week and 12 (14%) reported they had not.

**Carer support.**

Seventy four (86%) of the respondents advised they had provided support services for their client's carers and 12 (14 %) had not.

**Liaison.**

Sixty nine (80%) respondents reported they had been involved in community liaison activities with other services on behalf of clients, and 17 (20%) reported they had not.

**Additional activities not listed.**

Twenty three (27%) of the respondents provided information regarding other areas they felt needed to be recognised as activities for the previous working week. These responses are shown in Table 15.

Table 15

Additional Activities Conducted by CMH Nurses

| Activity | Number of Responses |
|---|---|
| Preparing statistics | 4 |
| Education to outside agencies re mental health/illness | 3 |
| Rehabilitation of clients | 3 |
| Care planning | 2 |
| Health screening for disease and mental illness | 2 |
| Interviewing for new staff | 2 |
| Preparing media releases | 2 |
| Transporting patients | 1 |
| Computer work | 1 |
| Supervision of non nursing staff | 1 |
| Discharge planning | 1 |

Respondents were asked to list all activities that they perceived as going beyond the requirements of their job description during the previous 12 months. Provision was made for each nurse to provide additional information if the list was deemed to be incomplete. One rural CMH nurse stated that they wished to expand their role but had not been in the position long enough to do this.

**Facilitating therapy groups.**

Eight (9.3%) respondents listed this as an area they had been engaged in over the past year. The majority of respondents, 78 (90.7%), had not conducted therapy groups with their clients.

**Facilitating support groups.**

Twenty five (29.1%) respondents had conducted some form of support group in the past 12 months, but 61 (70.9%) had not.

**Research.**

Eight CMH nurses reported having been engaged in research in the previous year whilst 78 (90.7%), stated they had not.

**Public speaking.**

Thirty one (36%) respondents reported having conducted public speaking in the previous year whilst 55 (64%) reported they had not.

**Quality assurance programs.**

Twenty six (30.2%) respondents reported having conducted quality assurance programs and 60 (69.8%) had not.

**Client satisfaction surveys.**

Eighteen (20.9%) CMH nurses had assessed their service using client satisfaction surveys in the past year but the majority, 68 (79.1%) had not.

**Carer support services.**

Thirty two (37.2%) CMH nurses were engaged in carer support activities in the previous year and 54 (62.8%) reported they had not provided this service.

**Self help groups.**

Eleven (12.8%) respondents reported having been involved in the establishment or continuity of self help groups with their clients but the majority 75 (87.2%) reported they had not been involved in any self help group activities as part of their duties.

**Social outings designed to rehabilitate clients.**

Twenty eight (32.6%) reported having conducted or organised social outings designed to rehabilitate their clients and 58 (67.4%) had not.

**Advice to other professionals regarding the prescribing of psychotrophics.**

Fifty five (64%) of all respondents reported giving advice regarding the use of psychotrophic medication within the previous year, and 31 (36%) reported they had not.

**No indication of an expanded service.**

Of the 86 respondents, 17 (19.8%) did not report any activities perceived as going beyond the responsibilities of their job description.

**Other activities not listed.**

Seventy three respondents reported that they had not been involved in any other activities, and 13 (15.1%) provided information as to other activities they felt needed to be recognised as duties they were engaged in during the previous working year. These activities are shown in Table 16.

Table 16

Additional Activities CMH Nurses Feel Warrant Recognition.

| Activity | Number of Responses |
|---|---|
| Advise Re. The Mental Health Act | 9 |
| In Service Education For Local Hospital Staff | 6 |
| Teaching Clients Self Advocacy | 6 |
| Dispensing Medication on Weekends When No Pharmacist Or Doctor Available | 5 |
| Designing And Implementing Education Packages For Outside Agencies Re. Mental Illness | 2 |
| Running Family Therapy Meetings | 2 |
| Membership Of Committees | 1 |
| Supporting Migrant Services | 1 |

**Perception of effective orientation to CMH nursing area.**

In response to the question as to whether new CMH nurses received an adequate orientation, 47 (55%) respondents either strongly agreed or agreed with this statement and 39 (45%) disagreed or strongly disagreed.

Table 17 shows the response to this question for metropolitan and rural CMH nurses.

Table 17

Metropolitan and Rural CMH Nurses Perception as to the Availability of Adequate Orientation for New Staff

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 6 | 3 | 9 (10.5%) |
| Agree | 22 | 16 | 38 (44.2%) |
| Disagree | 21 | 7 | 28 (32.6%) |
| Strongly Disagree | 8 | 3 | 11 (12.8%) |
| Total | 57 | 29 | 86 ( 100%) |

**Availability of policy and procedure manuals at CMH nursing work sites.**

The distribution of responses as to whether policy and procedure manuals were available to CMH nurses was almost even, with 45 (52%) agreeing to some extent and 41 (48%) disagreeing to some extent with the statement. Table 18 shows the responses for the participants comparing Perth metropolitan and rural CMH nurses responses

Table 18

Availability of Policy & Procedure Manuals at CMH Nurses Work Sites

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 4 | 5 | 9 (10.5%) |
| Agree | 27 | 9 | 36 (41.9%) |
| Disagree | 17 | 13 | 30 (34.9%) |
| Strongly Disagree | 9 | 2 | 11 (12.8%) |
| Total | 57 | 29 | 86 (100%) |

**Access to a current job description**

Fifty (58%) respondents agreed or strongly agreed that they had access to a current job description. The distribution of these results with comparisons between metropolitan and rural CMH nurses responses is shown in Table 19.

Table 19

Access to a Current Job Description

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Strongly Agree | 5 | 3 | 8 ( 9.3%) |
| Agree | 30 | 12 | 42 (48.8%) |
| Disagree | 16 | 14 | 30 (34.9%) |
| Strongly Disagree | 6 | | 6 ( 7.0%) |
| Total | 57 | 29 | 86 ( 100%) |

## Job Satisfaction

The final section of the findings chapter relates to the research question: "How do Western Australian CMH nurses describe their level of job satisfaction?" Job satisfaction was measured by asking the respondents to rate their actual level of job satisfaction and to predict if they would still be in their current position in 12 months time. Each respondent was asked to make further comment as to the reason for their answer to this question.

### Level of job satisfaction.

Respondents were asked to rate their level of job satisfaction. Table 20 shows that the majority of respondents were either satisfied or very satisfied with their current position.

Table 20

Stated Level of Job Satisfaction Amongst CMH Nurses in WA

| Response | Metropolitan | Rural | Total Population |
|---|---|---|---|
| Very satisfied | 11 | 6 | 17 (19.8%) |
| Satisfied | 35 | 19 | 54 (62.8%) |
| Dissatisfied | 6 | 3 | 9 (10.5%) |
| Very dissatisfied | 5 | 1 | 6 ( 7.0%) |
| Total | 57 | 29 | 86 (100%) |

Table 21 shows comparison of comments made in support of each CMH nurses claim for level of job satisfaction. Responses have been categorised into positive and negative themes.

Table 21

Statements Made Regarding Level of Job Satisfaction

| Themes | Metropolitan | Rural | Total |
|---|---|---|---|
| **Positive Themes** | | | |
| Enjoyable Work | 20 | 14 | 34 |
| Autonomy | 13 | 6 | 19 |
| Able To Utilise Skills | 8 | | 8 |
| Able To Help Clients | 4 | 3 | 7 |
| Supportive Colleagues | 3 | 4 | 7 |
| Increasing My Knowledge | 5 | | 5 |
| **Negative Themes** | | | |
| Lack of Resources | 14 | 10 | 24 |
| Feeling Over-burdened | 11 | 8 | 19 |
| Lack Of Management Support | 14 | | 14 |
| No Career Structure | 13 | | 13 |
| No Recognition Of Role | 5 | 3 | 8 |
| Isolation | | 8 | 8 |
| Poor Morale | 7 | | 7 |
| Constant Threat Of Aggression | 5 | 1 | 6 |
| No Staff Development | 1 | 5 | 6 |

**CMH nurses prediction as to whether they will continue to practice within this role in twelve months time.**

Seventy four (87%) respondents reported they would be working as a CMH nurse in twelve months time and 11 (13%) stated they would not. One respondent declined to record an answer to this question.

Respondents were asked to state why they had perceived that they would or would not continue to practice as a CMH nurse in 12 months time. Responses are shown in Table 22.

Table 22

Respondents Intentions to Continue Practice

| Themes | Metropolitan | Rural | Total |
|---|---|---|---|
| **Intending To Stay** | | | |
| Job Satisfaction | 18 | 10 | 28 |
| Able To Help Clients | 3 | 7 | 10 |
| Great Need For CMH Nursing | | 6 | 6 |
| Enjoy Living In Location | | 6 | 6 |
| Autonomy | 3 | | 3 |
| **Intending To Leave** | | | |
| Contract Ending | 3 | 1 | 4 |
| Skills Undervalued | 2 | | 2 |
| Wish To work Part Time | 2 | | 2 |
| Lack Of Professional Growth | 1 | | 1 |
| Retiring | 1 | | 1 |
| Leaving Australia | | 1 | 1 |

## General Comments Made by Metropolitan Respondents

### Resources.

"The demand for CMH nursing is ever on the increase in my area".

### Looking toward the future.

"It is vital to have a consumer focus and be up to date with current research in mental health".

"We must have a unique nursing role recognised or we will have takeover of our professional role by generic health workers".

"CMH nurses need to form a strong professional collective voice in order to have a say in the political process of mental health policy and planning".

"I believe the future for psychiatry is in the community with less hospital admissions".

"The move toward community based psychiatry still requires re-education of the public and other mental health professionals who constantly obstruct this process".

### Work focus.

"CMH nursing needs to become more client centred with more emphasis on preventative work".

"I don't like working in rehabilitation as an exclusive role. It should be part of the extended role of the CMH nurse".

" I only do crisis work nothing preventative or therapeutic".

"We have no career path and no career structure".

**Management.**

"More and more we are being advised that cost matters more than care".

"There is poor communication between CMH nursing centres and psychiatric hospitals".

"CMH nursing has now been fragmented into areas. We need a centralised management to co-ordinate the development of this service".

**Education.**

"We need courses to assist with our counselling role",

"No staff development ever".

## General Comments Made by Rural Respondents

**Resources.**

"More funding and services are needed in the rural areas of WA".

"CMH nursing is in an infantile stage in my region. I enjoy working as a sole practitioner although the work load is extremely high".

**Looking toward the future.**

"Psychiatric patients will always be the Cinderellas if we don't fight for better services for them".

**Work focus.**

"The constant erosion of my award and entitlements leads me to believe that CMH nursing work is undervalued".

"Many rural CMH nurses are employed under different conditions and awards. Also major differences in philosophy and work styles exist between districts" .

**Management.**

"Management need a broad mental health background to understand the real issues in the rural area".

"Our CMH nursing service is being mismanaged because decisions are made by people who have no concept of mental health needs in the rural community".

"New positions are being advertised as generic but this job needs the broad background of nursing".

**Education.**

"There needs to be ability to transfer down to Perth for short terms and update skills".

"There is a huge need for post graduate education opportunities".

"There needs to be more collaboration between the Universities and the field workers".

"I would study if a tertiary based course was offered for CMH nurses".

**Miscellaneous.**

"I feel the main issues confronting rural CMH nursing is lack of supports, isolation, extremely poor staff development and no education opportunities".

## Summary

This chapter has provided a description of the current population of CMH nurses practicing in WA. These findings have been presented in relation to the research questions, in order to establish a population profile of the surveyed respondents. The questionnaire developed for this study provided a means to explore these research questions. The next chapter will discuss the study's findings

# Chapter 7

## Discussion

This chapter will discuss the most important findings presented in previous chapters of this thesis. The subject headings from the findings chapter have been retained for ease of reference. The results of the questionnaire will be discussed first.

## Population Profile

The study participants were CMH nurses practicing in the Perth metropolitan and rural areas of WA. The following section will discuss the findings related to the research question: "What is the population profile of CMH Nurses currently practicing in WA?"

### Gender.

The majority of the respondents were male (53.5%). This was an unexpected finding not supported by other studies. Johnson, Temple-Smith and Dunt (1987), reported in their study which explored working conditions of Victorian community nurses, that of a sample of CMH nurses only 73 out of 218 (33.5%) were male. But when comparing all community nursing areas, male nurses were more predominant in mental health. A Victorian study by Daniels (1986), examining CMH nursing role development, found 38% of respondents to be male. This researcher has found a paucity of discussion of gender issues in nursing research thus assuming populations of nurses are largely female. For example White's national survey of 191 CMH nurses in the United Kingdom did not report gender issues (1990).

Churchhouse (1993, p. 1) comments that studies are often "negligent in not adequately representing men in nursing."

**Length of time employed in current position.**

The average length of time respondents had been employed in their current position was three years. The response to this question, from metropolitan and rural nurses, was similar. Buckley and Gray (1993) reported that of the community generalist nurses surveyed in South Australia, the average length of time with the current employer was 6.4 years. This disparity of finding between the two studies [three years & 6.4 years] is probably due to the recent expansion of CMH nursing services in WA in support of the National Mental Health Strategy and the recency of the role within many communities.

**CMH nurses first choice of consultation with other health care workers.**

CMH nurses largely work within multipurpose facilities and a multi-disciplinary team of health care professionals. The literature describes multi-disciplinary teams as where health practitioners from differing disciplines work together in a coordinated way to meet the clinical health needs of the community they service (Baum, Fry & Lennie, 1992).

The majority of respondents (59.3%) advised that if a clinical problem arose with a client, they would first choose to consult with a fellow CMH nurse. This was because this person was seen to have clinical expertise or was the only available health care worker to discuss issues with. Fourteen of the respondents were working in a setting where there was no other CMH nurse. Of the respondents, six had 18 months or less experience in their position, 11 were practising in rural areas and thus were isolated from other CMH nurses. Seven of these 11, reported being the only person with mental

health qualifications in their region. Contact with other CMH nurses was reported to be maintained by telephone, and only two respondents had face to face meetings.

Almost one quarter of respondents (23.3%) would primarily consult with a consultant psychiatrist because this clinician was seen as the leader of the clinical team and had clinical expertise, or was the only other health care worker available. Interestingly, only 3 (3.5%) respondents would consult with a psychiatric registrar, as they felt this health care worker had clinical expertise or was clinically responsible for the client.

According to White (1990), general practitioners provided 35% of all referrals for CMH nursing services in the United Kingdom. But only six respondents in this study reported that they would choose to primarily consult with the local general practitioner concerning a clinical problem with a client. Interestingly, these six respondents were all from the rural areas. These clinicians were seen to be accessible or to have direct clinical responsibility for the client in question. With the proposed Mental Health Bill calling for a larger role for general practitioners in the management of mental illness in the community, it would be of benefit for CMH nurses to establish closer working relationships with General Practitioners. Only one rural respondent would choose to primarily consult with a carer.

**Education and training.**

Hospital based pre-registration programs for mental health nurses have been phased out in WA (Commonwealth Department of Human Services and Health, 1994) in response to a national trend toward tertiary based pre-registration undergraduate comprehensive courses. Mental health is now a part of undergraduate nursing curriculam with graduates having the opportunity to work in general and mental health areas. A tertiary based post graduate course is available in WA, and leads to a Masters of

Nursing. One WA University offers an elective post graduate unit in CMH nursing and this is organised as an independent study unit. However, this unit does not provide the opportunity for students to workshop ideas and share information. Monat-Taylor (1990) comments that unless there is commitment to mental health in post-graduate nursing courses, fewer nurses will be adequately prepared at graduate level. This would lead to fewer nurses being available to teach mental health in undergraduate curriculums, which in turn may result in poorer preparation of beginning registered comprehensive nurses in aspects of mental health. This has the potential to reduce confidence within the novice nursing population and result in fewer nurses selecting mental health nursing as a career path.

According to the Nurse Education Review Secretariat (Commonwealth Department of Human Services and Health, 1994) the Department of Employment, Education and Training reported that in 1993 only 81 students were enrolled in graduate diplomas with majors in mental health, within six institutions Australia wide. This researcher welcomes the announcement of a review of the changing education and training needs of mental health nurses by the Australian Health Ministers Advisory Council (Commonwealth Department of Human Services and Health, 1993)

The Chief Nursing Officer of WA expressed the view that post graduate courses should exist in specialty mental health areas, such as "forensic, adolescent, psychogeriatric/dementia, community and health promotion" (Commonwealth Department of Human Services and Health, 1994, p. 276). She also considered the need for clinical chairs to ensure research continues in mental health, "especially with the move to community based care and case management methods" (Commonwealth Department of Human Services and Health, 1994, p. 276).

McMurray (1991, p. 296) considered that education for nurses needs to "serve as a role model to inspire creative and critical thinking and offer

encouragement to those individuals with a predisposition to strive for higher levels of competence and ultimately expertise". If Australia is to continue with a deinstitutionalisation policy this needs to be reflected in both undergraduate and post graduate curriculum. There is a need to prepare nurses for both hospital and community practice. Such courses need a strong community orientation and dedicated time to the principles and practice of CMH nursing (Speedy, 1993).

**Courses completed by CMH nurses.**

The respondents were diversely educated with 50% holding a qualification from a tertiary based institution. It is interesting to note that no respondent identified having completed any training in Aboriginal culture despite the fact several CMH nurses in the rural areas had verbally advised the researcher that this was much needed. Similarly, McMurray (1984) reported that her sample of WA generalist community nurses identified the need for education concerning cross cultural and Aboriginal communities. McMurray's study was conducted to identify tasks required of community based nurses in an effort to develop curricula and improve available education for these nurses.

**Perception of staff development availability.**

The majority of respondents (71%) reported that staff development was not available to them and 62% also reported that staff development education they had received was not adequate to enhance their clinical practice. In other studies involving rural community nurses, the content of inservice and continuing education courses was also described as inadequate by respondents (Health Department of Victoria, 1991; Kreger, 1991). The role of the CMH nurse is a demanding one and requires diverse skills. The development of effective staff development is essential if the role

of the CMH nurse is to continue to expand. A paucity of inservice, post basic and continuing education courses for WA mental health nurses have been reported extensively in the literature (Baldwin, 1987; Sellick, 1986; Western Australian Post Secondary Education Committee, 1984; Zelestis, 1989) The findings of this study add to this evidence and support that there remains a need for effective in-service education for mental health nurses.

**Perception whether tertiary based education was available to assist in providing advanced CMH nursing practice.**

Eighty two (95.4%) respondents reported that they had no access to tertiary based education to assist them in developing advanced skills.It was reported that there was limited liaison between universities and clinical work sites. In a report concerning nursing education in Australian universities (Commonwealth Department of Human Services and Health, 1994, p 226), the WA Chief Nursing Officer commented that " better communication between universities and the agencies in which students were placed for clinical education might help to develop mutual understanding". CMH nurses need to be self advocates and articulate their needs with universities, so that courses can be developed and universities must continue to foster close working relationships with clinical areas.

There is evidence that nurses are seeking advanced practice education in mental health. A report by the Australian Private Hospitals Association (1992) revealed that of enrolments in private based specialist nursing courses in Australia during 1991, 37% were enrolled in a course concerning mental health.

**Perception of whether education has adequately prepared CMH nurses for their current position.**

A British study by Parnell (1978) describing CMH nursing practice and roles within a clinic setting, found that 63% of respondents reported they had received no preparation for the role of CMH nurse. Percival (1986) found that 37% of rural and 71% of remote WA generalist community nurses reported being inadequately prepared for their role. Similarly, 46% of respondents in this study reported they were inadequately prepared for their role as a CMH nurse, but did not clarify the reasons for this perception.

## Work Activities

The following section will discuss significant findings related to the research question: "How do Western Australian CMH nurses describe their usual work activities?"

White (1990) suggested that the role of the CMH nurse should be based on knowledge developed through research but found that the functions performed by CMH nurses depended greatly on what each individual nurse believed their role to be. So too, this study found the population was involved in a variety of work activities and in many cases had expanded the role beyond that of the job description. Still there is no evidence that CMH nursing is guided by theory, rather the service has developed on an ad-hoc basis, in response to events. There is a great need for evaluation of the role of the CMH nurse and development of a model to guide practice.

**Supervision of staff.**

Forty two respondents reported having provided some direct supervision of staff in the previous working week. A little over half [44] did not

supervise staff. It is also interesting to note that a number of respondents commented that they lacked supervision and support from management.

With current regionalisation of the Health Department of WA and the proposed amalgamation of CMH nursing into the mental health nurses career structure, CMH nurses may not have a senior person within their discipline to liaise with or have line management to. The researcher feels concern for the possibilities of poor communication between clinics if each clinic is to be annexed to separate health regions with emerging and differing clinical goals.

Respondents had been asked to list all activities that they considered as going beyond the requirements of their job description, for the previous 12 months. Of the 86 respondents, 17 (19.8%) did not list any activities they felt went beyond the responsibilities of their job description. This may have been because they were recently employed, they were too busy conducting the regular duties of their job description or they may not have considered expanding their role. As an example, one rural CMH nurse stated, "I would like to expand my role but I haven't been in the position long enough."

**Facilitating support and therapy groups.**

There was a difference in respondents reporting that they had been engaged in support groups (29.1%) in comparison to the populations perception of having conducted therapy groups (8.9%). There is a difference between support and therapy groups but the response is interesting as it demonstrates nursing involvement in facilitating group work in the community. In a grounded theory study by McKelvie (1993), conducted with 30 mental health nurses practicing in WA to discover if nurses involve family members in planned client care, it was reported that 50% of respondents utilised counselling to bring about change in clients. The major objective of this group of mental health nurses was to help the client to problem solve.

**Research.**

The research literature reports that nursing participation in research activities contributes to the development and growth of the profession (Burns & Grove, 1993). Less than 10% of respondents were engaged in research which is surprising considering the role of the CMH nurse is relatively new in mental health care delivery. The many changes that CMH nurses experience in treatment delivery and implementation of care, will require research. Changes in practice will require evaluation of the effectiveness of CMH nursing interventions. Two barriers to the conduction of research can be identified. Firstly, limited amounts of funding are provided for nursing research (Gournay, 1992) and, secondly there is a paucity of experienced and qualified researchers within CMH nursing in WA. If CMH nursing is to develop unique skills and further its claim to quality practice, a high priority must be to encourage the development of research skills in this population.

**Quality assurance programs.**

Quality assurance programs exist within the structure of the Health Department of WA but they are usually carried out by experienced nurses employed in this form of service assessment. This may explain why only 26 (30.2%) of the respondents reported having conducted quality assurance programs and 60 (69.8%) had not. It could be argued that nurses have an individual professional responsibility to conduct quality assurance exercies concerning their provision of care. Kitson (1986) advised that assessment of quality of service delivery is also a way of developing therapeutic awareness by the clinical nurse. A study by White (1993) found that in the United Kingdom more than half (53.4%) of the CMH nursing services did not have any measure for service performance.

**Client satisfaction surveys.**

The conduction of client satisfaction surveys could be considered a form of quality assurance of a service and its inclusion in the questionnaire has highlighted that 18 (20.9%) of CMH nurses have assessed their service using client satisfaction surveys in the past 12 months but the majority, 68 (79.1%) have not.

**Advice to other professionals regarding the prescribing of psychotrophics.**

This question was included in the survey questionnaire arising from personal experience of multiple incidents when health professionals had required advice concerning the prescription of medication or administration of prn medication. This specific advice regarding patient care would not be seen by some CMH nurses as within the domain of their role, but from personal experience the researcher is aware that the decision to medicate clients with prescribed prn drugs is often a regular nursing responsibility within the mental health field. Having made this observation, the researcher was not surprised to find that 55 (64%) of all respondents reported having given advice regarding the use of psychotrophic medication within the previous 12 months. There is debate in the literature as to whether nurses should be provided with prescribing rights. Buckley & Gray (1993) in their study of rural and remote nurses working in South Australia, reported that of 529 community nurses, 52% felt there was a need for nurses to have limited prescribing rights. Also, 13.7% of nurses surveyed were actively prescribing non-prescription drugs to clients. Only 2.2% felt prescribing rights were not a nursing role. Kreger (1991) in her study concerning remote area nurses in Australia, reported that nurse registering authorities were unrealistic in policy formulation and denied that prescription and dispensing of Schedule 4 drugs was expected of remote nurses.

A British report (Department of Health, 1989) recommended that CMH nurses should be able to modify medication prescriptions in relation to timing and dose. In the United States of America, psychologists working for the Defence Department have been given the right to prescribe. There is obviously a need for further research into this area and possibly the establishment of guidelines for the prescription of psychotrophics by nurses.

**Perception of effective orientation to CMH nursing area.**

Although many of the respondents were satisfied that they had an adequate orientation for their current position, nearly half (45%) were dissatisfied with their orientation. This is cause for concern because employers should fulfil their responsibility for orientation of new employees (Kreger, 1991), in particular, where a CMH nurse is required to work as an independent practitioner within the community. Buckley and Gray (1993) found that 34% of community nurses in South Australia reported having little or no orientation to their new position. There is a need for evaluation of orientation packages available to new CMH nurses. Management could easily assess this by implementing a survey of all new staff. If CMH nurses are expected to provide a service and develop a role within the community they will need an orientation to their workplace as well as resources within the community.

**Availability of policy and procedure manuals at CMH nursing work sites.**

Nearly half of the respondents (46.7%) reported having no available policies and procedures at their place of work. Similarly, Buckley & Gray (1993) found that 91% of community nurses in rural South Australia were discontented with the current policies. Kreger (1991) conducted a study with

nurses working in remote areas of Australia and found that the majority of respondents felt concern as to inadequate protocols.

### Access to a current job description.

Almost half (42%) of the respondents reported not having received an up to date job description. This could be related to the development of new job descriptions for the proposed career structure. In hind sight it may have been of interest to ask respondents if they felt their job description adequately reflected their role as a CMH nurse.

## Job Satisfaction

The following section will discuss the findings related to the research question: "How do Western Australian CMH nurses describe their level of job satisfaction?"

### Level of job satisfaction.

The respondents were generally happy in their role as CMH nurses with 82.6% reporting high levels of job satisfaction. The reported levels of job satisfaction between metropolitan and rural respondents was similar. These nurses reported that they enjoyed utilising their initiative and a high degree of autonomy. This was validated by 87% of respondents reporting they would continue working as CMH nurses in twelve months time.

The metropolitan respondents reported lack of resources, feeling overburdened, lack of management support and no career structure as the major reasons for feeling dissatisfied with their job. The respondents have been involved in an ongoing dispute with the Health Department of WA concerning a career structure. In the 1950s and 1960s CMH nurses were recruited from the ranks of charge nurses. The CMH nurses believe their positions to be equivalent to Level 3 nurses, but the Health Department of

WA seeks to grade the majority of CMH nurses at Level 2. The CMH nurses are arguing that if this proposal is successful, the quality and availability of CMH nursing services will suffer and future development will be difficult, as it will be difficult to attract skilled practitioners to CMH nursing.

Themes of isolation were prevalent in explanations for rural CMH nurses not being satisfied with their job, "I miss my family", "Rural CMH nurses are ignored by city health services". These rural nurses also found inadequate resources within their community frustrating their ability to provide care, "I don't like my patients being sent to Perth for hospital treatment". Another isolated rural nurse revealed frustration with lack of resources and supports by stating, "how am I ever going to make this service effective?" Lack of adequate resources was a constant theme in both rural and metropolitan areas. This seemed to indicate that at times services were limited and not meeting the needs of the community, "two CMH nurses service eighty clients so we have to curtail our service as we are horribly under resourced".

Only one comment was made concerning poor remuneration but frustration with no career structure was a constant theme. So too, comments were made as to the inequality between the role of the hospital based nurse and the expectations required of the CMH nurse role, "I'm paid Level 2.4 but do more autonomous work than my colleagues who are Level 2.4 in the local hospital".

Little comment was made as to the potential dangers of the job but when a comment was made it illustrated occupational health and safety issues, "I am required to travel to isolated farms out of mobile phone range. This is potentially dangerous", and "when you are physically abused you're expected to just go on. There's no debriefing. If you expect it your considered useless".

**Application of the Conceptual Model to the Study**

The foci of this study were the factors that contributed to the development of CMH nursing in WA and the current profile of CMH nurses. This community based trend in health care delivery is changing both the role of the mental health nurse and that of the psychiatric hospital (Pendleton, 1990).This study should provide a sense of place and history within the health care system for CMH nurses. A knowledge of the past and analysis of the reasons services have evolved, should assist in developing impetus and direction to evaluate contemporary standards of CMH nursing care, revise decision making and clinical practice skills. Further, this knowledge should assist CMH nurses in providing future services.

The evolution of the community mental health social model comprised of six major milestones in development (Baum, Fry & Lennie, 1992).

1. The mental hygiene movement of 1909 (Krause & Slavinsky, 1982);
2. Availability of short term therapy after World War II (Miller,1981);
3. The increase in proportion of population needing mental health care after the Second World War (Miller, 1981);
4. Development of the concept of the therapeutic community by Dr Maxwell Jones in 1947 (Devine,1981);
5. Severe overcrowding of mental hospitals in 1950s (WA Government, 1956);
6. The advent of psychopharmacology in 1953 (Krause & Slavinsky, 1982).

These six milestones can be considered the driving forces responsible for the change from an illness model, manifesting in long term psychiatric hospitalisation to a wellness model of treatment within the community. It should be noted that each of the driving forces made unique

contribution toward the deinstitutionalisation of the mentally ill, and no single issue could claim sole responsibility for the deinstitutionalisation movement.

## Evolution of CMH Nursing

In order to answer the research question, "What themes can be identified from the literature concerning the development of CMH nursing in Western Australia", this thesis has documented the development of CMH nursing in WA.

The occurrence of mental illness is a major problem within the Australian community and has substantial human and economic costs. This paper has identified a shift in mental health nursing from a custodial to a therapeutic community based approach. Community based treatment and shorter periods of hospitalisation are seen as being cost effective and less traumatic to people experiencing mental illness. CMH nurses are required to meet the mental health needs of rapidly growing urban as well as isolated rural area populations. The level of autonomy and assessment skills needed to make decisions to treat within the community or admit to hospital clearly points to a need for highly skilled nurses to be working in the community. This would ensure the mentally ill of WA and their significant others have access to quality care to which they are entitled. At present CMH services in WA are fragmented and remain inadequately resourced (Human Rights Commission, 1993). The role of the CMH nurse has developed to provide services, demanded by consumers, such as rehabilitation, case management, community liaison and crisis intervention. This has resulted in responsibilities which differ from the role of the hospital based mental health nurse, and often requires a higher level of autonomy. CMH nurses have developed a unique service for the community of WA despite a paucity of relevant post registration formal education and staff development.

CMH nursing is at a crucial point in its development as part of the deinstitutionalisation movement. Prejudice toward the deinstitutionalisation of the mentally ill is evident when communities oppose group housing within their neighbourhood for fear of devaluation of surrounding property and the perceived violence of the mentally ill. Staff of institutions have also opposed deinstitutionalisation as it has led to reduced job opportunities within these institutions (Bullogh & Bullough, 1990). Economic factors have possibly been the greatest threat to the success of the deinstitutionalisation movement with changing funding patterns, the Australian federal government competing with state government policies and poor consumer participation (Noble & Conley, 1991). These are all factors which must be taken into consideration when assessing the value of deinstitutionalisation.

In 1995, the psychiatric hospital still exists but is a stark contrast to the large psychiatric hospitals of the past where many thousands lived for most of their adult lives (Monat-Taylor, 1990). Those establishing the old asylums surely had good intentions but they effectively removed people with mental illness from society and created institutionalised behaviour. Prior to 1956, psychiatric treatment was only available in the hospital setting and later moved to a clinic model to assist with the management of the overflow of patients awaiting hospitalisation at Heathcote and Claremont hospitals. The social climate of the times were conducive to the development of community based treatment. New treatments such as chemotherapy and psychotherapy were seen to be of benefit to the client experiencing mental illness and enabled people to be maintained in community settings as opposed to the traditional hospitals (Monat-Taylor, 1990). The word deinstitutionalisation is widely used in the literature to describe the transfer of care and treatment of the mentally ill to the community. The deinstitutionalisation movement in WA grew out of the initial successes in the 1950s with the Havelock Street Clinic and the impetus of the movement towards community based care in the

United Kingdom. This researcher can find no empirical evidence in the literature from the 1950s that the Havelock Street Clinic was ever expected to be the conception of deinstitutionalisation, rather a solution to the overcrowding of the mental asylums and fiscal restraint to build a new asylum at Guildford (WA Government, 1950; 1951; 1952; 1953; 1954; 1955; 1956). It is the early pioneering health care staff of this clinic who are more likely responsible for the evolution of the deinstitutionalisation of the mentally ill.

In contemporary times community mental health care is provided in WA in a variety of settings and has made strong inroads into rehabilitation (Government of WA, 1991). There has been some change in society's beliefs about the mentally ill but stigma and discrimination still persist within the community. Debate presented by the media has increased both discussion within the community and acknowledgment of the needs of the mentally ill (Human Rights Commission, Australia, 1993)

The philosophical basis of providing care for the mentally ill within the community as an effective and humane treatment remain. Monat-Taylor (1990) has argued that to a great extent this care has been largely a transfer of the same treatment philosophies and methods from the institution to the community. So too, studies have agreed that the move from hospital based care has not always benefited the client but left them with limited supports and substandard living conditions (Fabian, 1990; Richmond, 1983; Simmons, 1994; Tantum, 1988). One could argue that the burden of care is being shifted to the carer and charitable organisations, rather than remain the responsibility of the traditional funder of health care, the government. Governments in embarking on a policy of fiscal restraint, will always pursue cheaper options. And community based care is often cheaper than the maintenance and running of institutions and their infrastructure. For example, a North American study with a sample of 3,000 cognitively

impaired elderly, showed average costs of formal health care such as medical, nursing, acute hospitalisation and home care almost doubled following nursing home admission compared to care in the home (Coughlin, 1989).

Although it could be argued that the reduction in institutional care is not a good policy, there is a need to ensure that adequate funding is provided to replace this with effective mental health care within the community. Recently in WA there has been a proliferation of CMH nursing services in the rural areas. Reports from rural CMH nurses in this study point to inadequate supports, lack of referral sources for specialty care such as drug and alcohol counselling and social isolation. Geographical maldistribution of mental health professionals still occurs and major treatment hospitals remain clustered around Perth. As a result of these geographical and demographic circumstances, large groups of WA health care consumers do not have access to continuous mental health services (Lewin & Hobbs, 1992). This limitation in service creates feelings of inadequacy amongst rural staff. As one respondent reported, "I'm so discouraged when I have to transfer my patients down to Perth for inpatient treatment". These rural CMH nurses are often the sole mental health practitioner in their area and are called upon to deliver diverse mental health care to their community. There is a need to ensure these staff have adequate resources, access to intellectual stimulus and social and cultural supports.

Despite the growth in the number of CMH nurses in WA [1995 population 130] the total number is still small considering the geographical vastness of WA and the resulting demands on the rural CMH nurse. If expansion of the Western Australian CMH nursing service is to be embraced by governments, greater clarity and agreement concerning the direction taken by these services is needed.

There is evidence from the findings of this study that some CMH nurses are involved in primary preventative intervention and this has been one way CMH nurses have expanded their role and profile within the community. This important contribution to health care needs to be recognised and financially supported. Another important finding of this study is the involvement of CMH nurses in rehabilitation services for clients. Some respondents report dissatisfaction with the emergence of the role of the rehabilitation nurse and call for recognition of rehabilitation as part of the role of all CMH nurses, "I don't like working in rehabilitation as an exclusive role, It should be part of the extended role of the CMH nurse". Rehabilitation of those who have been institutionalised or have experienced debilitating disorders needs to become a central role of the CMH nurse. To some extent this has been achieved with the introduction of case management. But, fiscal as well as staff resources to implement rehabilitation programs are finite, thus expansion of the CMH nursing role into rehabilitation depletes hours spent in other work based activities (Monat-Taylor, 1990).

Mental health nurses are the largest group of health care professionals caring for the mentally ill in WA (Australian Bureau of Statistics, 1991). The literature often neglects the unique contribution nurses make to health care and suggests, at best, mental health nursing is an appendage to general nursing (Nolan, 1991). Nolan believes that historians have been negligent in not reporting nursing involvement in health care delivery and suggests this neglect is due to nursing being perceived as a subservient and insular discipline within health care. If this is true, it will be up to the nurses of the future to ensure a rejection of this ideology. CMH nurses must be prepared to expand their role and quantify their service. The past pathways that mental health nursing took are not to be forgotten, lest history repeats itself. Let the roads ahead be progressive and not just paved with good intention.

# Chapter 8

## Conclusions, Recommendations, Limitations And Implications For Nursing Practice

This chapter concludes the study and discusses the strengths and limitation of the thesis, recommendations for future research and action as well as the implications of the study for nursing practice.

### Strengths of the Study

The important strengths of this study arise from the attempt to survey an entire population, that is all the practising CMH nurses in WA, and the overall satisfactory response rate of 66%. The study documented the historical origins of CMH nursing in the Australian state of WA and analysed this development utilising a conceptual framework to describe the evolution of this service. Provision of baseline data of the current practicing population should prove useful information for future study with a similar population. There is inadequate data in Australia concerning this population, so this study can make a strong claim for adding to the body of nursing knowledge.

### Recommendations Arising From the Study

The findings of this study have provided valuable information concerning the development of the CMH nursing service within WA. A description of the current practicing population and their responses

concerning questions formulated for the survey questionnaire provide a unique insight into this population.

The study findings lend support for the following recommendations for actions to be taken and for future research.

**Actions.**

1. Dissemination of the findings of the study to the Health Department of WA, the Nurses Board of WA, Australian and New Zealand College of Mental Health Nurses and Regional Directors responsible for CMH nursing be conducted.
2. That the title CMH nurse be applied to all nurses practicing mental health nursing within the community. Generic terminology has fostered disharmony within the population and confusion as to role identification.
3. That the Health Department of WA develop the concept of CMH nursing as a specialty area and support this with adequate staff development.
4. That CMH nursing be given a nursing career structure that recognises its level of expertise and provides conditions of award.
5. That courses be developed specifically for CMH nurses in areas such as therapy, trans-cultural nursing, research methodology, models of practice and advanced clinical practice.
6. That post graduate courses develop adequate electives in CMH nursing to attract nurses into this specialty.
7. That specialty services such as the Alcohol and Drug Authority are adequately funded to provide training and support for rural CMH nurses.
8. That CMH nurses work toward enhancing their role through research and the development of primary preventative services to the community.
9. That close liaison be fostered between CMH nursing clinics through the development of educational special interest and professional

development groups. That these groups encourage participation by grass roots clinical CMH nurses.

10. That networks be established between all CMH nurses practicing within WA. This could be in the form of regular meetings and a special interest news bulletin. Fostering of peer support and sharing of knowledge, resources and skills should be encouraged.

11. That CMH nurses and general practitioners work toward establishing stronger working relationships and referral systems.

12. It should be mandatory that inividual CMH nurses conduct quality assurance concerning their practise. This should form part of their job description.

13. There is a need for all CMH nurses to be given a staff development needs analysis.

14. The WA Nurses Board should consider a discussion paper concerning the role of the nurse in prescription of medication.

15. Orientation packages, orientation for new staff, job descriptions and policy/procedure manuals need to be available and regularly updated.

**Recommendations for further nursing research.**

1. A qualitative study should be conducted to explore the perceived role of the CMH nurse. It would be of interest to further develop this to establish areas of excellence in practice within the population.

2. A study should be conducted to identify theory based practice within this population.

3. An oral history of nurses who were involved in the establishment of CMH nursing services in WA would be a valuable future resource and add to the body of nursing knowledge.

4. There is a need for research within communities to establish satisfaction levels with CMH nursing provision and provide CMH nurses with important needs analysis of their local communities.

5. Research should be encouraged with special interest populations such as Aboriginals, Torres Straight Islanders and migrants as to their health beliefs and health needs. This would encourage clinics to liaise with communities and promote a wider understanding amongst the CMH nursing population, of local trans-cultural issues

6. There is a need to quantify the financial cost of community based care as opposed to institutional models of care delivery.

7. If the mentally ill are to be successfully deinstitutionalised further research must be conducted to identify this populations accommodation and community support needs.

8. That studies be encouraged to recognise both male and female contribution to nursing.

**Limitations**

Limitations of the study were:

1. The broader application of this study is limited as data was collected from a select population in WA. Therefore any generalisations can only be applied to this particular population.

2. The study results are based on a number of participants who chose to return the questionnaire. It is possible that these respondents were motivated by especially strong opinions and that these opinions influenced emerging themes in the chapter of findings.

3. Validity and reliability of the questionnaire utilised in this study would be enhanced through replication of the study.

4. As the response rate for return of the questionnaire was less than 100%, some CMH nurses may disagree with the findings.

5. The study did not attempt to control levels of experience or educational background that may have influenced responses.

6. Respondents may have been of the belief that their answers to the questionnaire reflected in some way on their abilities as nurses. They may have been unable to fully report their beliefs due to difficulty in expressing interpersonal feelings or they may just not have had an opinion on the topic (Woods & Catanzaro, 1988, p 301).

7. Researcher bias must be taken into consideration when interpreting results, as this researcher practiced in the area of CMH nursing. The researcher kept a journal and self interviewed on tape as a method of addressing this issue.

## Implications For Nursing Practice

A lack of empirical evidence of the development of CMH nursing services in WA has resulted in a difficulty to define this service. So too, the role of the CMH nurse has been questioned with a paucity of literature to support it within Australia. Studies have been conducted with generalist nursing populations practicing in WA (Kreger, 1991; Magee, 1992; McMurray, 1991; Philp, 1988) but no study to date has defined the WA CMH nursing population. This study has sought to address this deficit in nursing knowledge and has provided information which would be useful for future research. The study has assisted towards the identification of the CMH nurses role within the WA community and investigated this specialty nursing population's origins.

CMH nurses are a valuable resource for the community and health care system of WA. There is a need for the role of the CMH nurse to be defined so that their specialty area of care delivery can be readily identifiable and thus more accessible to the individuals and communities

they service. The results of this study provide the basis for future research which could identify and project developments needed within the role of the CMH nurse to meet the needs of the rapidly changing Australian health care service.

Nurses are constantly reminded of the need for fiscal restraint within the WA Health Department budget. Deinstitutionalisation of the mentally ill is seen as a cost effective and socially acceptable way of meeting the health care needs of the mentally ill. It would be beneficial for nurses to evaluate the cost of hospitalisation as opposed to community support. This may have a major impact on direction of resources for regional mental health services. Rural services often rely on a limited CMH nursing service and the availability of costly hospital beds in the metropolitan region for the more disturbed client (Lewin & Hobbs, 1992).

## Study Conclusion

An increasing interest in the needs of those in our community experiencing mental illness is reflected in the literature with reference to the role and contribution of CMH nursing in health care delivery and reduction in hospitalisations. Little research to date has examined the functions and attitudes of CMH nurses as a distinct specialty within the nursing profession. This is especially true in WA and is surprising considering the problems CMH nurses must face when delivering coordinated health care to such a large state with a widespread population.

In addition, no study to date has examined the scope of CMH nursing practice in WA or has systematically collected information on the qualifications, working conditions and attitudes of this group of nurses.This study makes a contribution to the research base of nursing practice by providing a sense of place within the health care system for CMH nurses

and has generated recommendations for further development of CMH nursing practice.

If history is a guide, the next century will see changes in the delivery of care to the mentally ill of WA. For example, it is possible that we may see the proliferation of mental health services for individuals who can afford services rather than provision of services for communities. There is a risk that as the mental health hospitals have been increasingly phased out, community based social and support services may be considered too expensive, too paternalistic or unworkable. The problems for the poor, the elderly, people living with chronic mental illness and those experiencing stress to the point where it may trigger a mental illness, will not go away simply because society's political beliefs change. The very nature of our democratic political system in Australia causes potential change of government every three to four years. In addition, WA has a decentralised health care system with each district developing an individual strategic plan. This potential change in health care policy and disparity between district health care goals may precipitate dilemmas for the potentiality of long term planning and sustained effort to address social problems of a state wide nature.

There is a need to look to the future and develop long term policies at a federal level to ensure the Australian nation has commitment to the development of services and self advocacy for the mentally ill. Complex social problems can not be solved by quick fix, short term solutions. Those working in mental health services must be prepared for change in government policy but ensure this does not deter long term policy goals. For as demonstrated by this study, change is not static and change within social, political and economic policies will always result in a change in direction within the health care system.

## References

Arthur, D., Dowling, J., & Sharkey, R. (1992). Mental health nursing: Strategies for working with the difficult client. Sydney: Churchill Livingstone.

Australian Bureau of Statistics. (1991). 1989 - 90 national health survey summary of results: Australia. Canberra: AGPS.

Australian Private Hospitals Association Ltd. (1992). Report on survey of employer sponsored edcuation for private sector nurses. Canberra: The author.

Baldwin, C. (1987). The current and future continueing education needs of the mental health nurse in Western Australia: A working party report. Perth: WA Health Department.

Barclay, W. (1989). Report to the Minister of Health on mental health and developmental disability by the ministerial implementation committee. Sydney: NSW Govt. Pub.

Barnum, B. (1990). Nursing theory: Analysis, application, evaluation. Glenview: Little Brown Higher Education.

Baum, F., Fry, D., & Lennie, I. (Eds.). (1992). Community health: Policy and practice in Australia. Bondi Junction: Pluto Press.

Benson, A. (1994). Two centuries of asylum: The end of an era in the treatment of the mentally ill. Australian Journal of Mental Health Nursing, 3 (1), 29 - 34.

Brooker, C., & White, E. (Eds.). (1990). Community psychiatric nursing: A research perspective. London: Chapman & Hall.

Brooker, C., & White, E. (Eds.). (1993). Community psychiatric nursing: A research perspective. (Volume 2). London: Chapman & Hall.

Buckley, P., & Gray, G. (1993). Across the spinifex: Registered nurses working in rural and remote South Australia. Adelaide: Flinders University of South Australia.

Bullough, B., & Bullough, V. (1990). Nursing in the community. St Louis: C.V Mosby Co.

Burns, N., & Grove, S. (1993). The practice of nursing research: Conduct, critique and utilization. (2nd ed.). Philadelphia: W.B Saunders.

Butterworth, T. (1991). Generating research in mental health nursing. International Journal of Nursing Studies, 28 (3), 237 - 246.

Chenitz, W., & Swanson, J. (1986). From practice to grounded theory: Qualitative research in nursing. Menlo Park: Addison Wesley Publishing Co.

Church, O. (1987). From custody to community in psychiatric nursing. Nursing Research, 36 (6), 48 - 52.

Churchhouse, C. (1993). St. Juan De Dios, 1495 - 1550, the patron saint of nurses. Unpublished honour's thesis, Edith Cowan University, Perth, Western Australia, Australia.

Clinton, M. (1994). Human rights and mental illness. Australian Journal of Mental Health Nursing, 3 (1), 1 - 3.

Coleman, J., Butcher, J., & Carson, R. (1988). Abnormal psychology and modern life. (8th ed.). Glenview, U.S.A: Scott Foresman & Co.

Commonwealth Department of Human Services and Health. (1994). Nursing education in Australian universities: Report of the national review of nurse education in the higher education sector 1994 and beyond. Canberra: AGPS.

Coughlin, T., & Liu, K. (1989). Health care costs of older persons with cognitive impairments. The Gerentologist, 29 (2), 173 - 182.

Curry, G. (1993). Self-actualisation or self-destruction: An historical perspective on psychiatric nursing. The Australian Journal of Mental Health Nursing, 2 (5), 234-242.

Daniels, G. (1986). Perceptions of the role of the community psychiatric nurse. Journal of the Australian Congress of Psychiatric Nurses, 6 (4), 10 - 22

Daniels, G. (1988). Community psychiatric nurses roles in western Sydney. Australian Journal of Mental Health Nurses, 18 - 22.

Davies, J., & Janosik, E. (1991). Mental health and psychiatric nursing: A caring approach. Boston: Jones and Bartlett Publishing.

Department of Health. (1989). Report of the advisory group on nursing prescribing. London: HMSO.

Devine, B. (1981). Therapeutic milieu/milieu therapy: an overview. Journal of Psychiatric Nursing, 19 (3), 20 - 26.

Eisen, P., & Wolfenden, K. (1988). A national mental health services policy: A report to the commonwealth, state and territory Health Ministers. March, Canberra: AGPS.

Ellis, A. (1984). Eloquent Testimony. Nedlands, WA: University of Western Australia Press.

Fabian, E. (1990). Quality of life: A review of theory and practice for individuals with long term mental illness. Rehabilitation Psychiatry, 35 (3), 161 - 170.

Flaskerud, J. (1986). Profile of chronically mentally ill psychotic patients in four community mental health centres. Issues in Mental Health Nursing, 8, 155 - 167.

Gava, D. (1989). The history of Osborne Park Hospital: A community hospital. Perth: Osborne Park Hospital.

Goffman, E. (1961). Asylums: Essays on the social situations of mental patients and other inmates. New York: Anchor Books.

Gournay, K. (1992). Psychiatric nursing in the nineties. Nursing Standard, 6 (36), 50 - 52.

Government of Western Australia. (1991). Areas of excellence: Options for reforming the management of metropolitan health services: A public discussion paper. Perth: WA Government Print.

Gray, D. (1986). Community and institutional roles: Evaluations by Australian psychiatric nurses. Unpublished master's thesis, University of New England, Armidale, New South Wales, Australia.

Greenblatt, H. (1963). The prevention of hospitalisation: Treatment without admission for psychiatric patients. New York: Grune & Stratton.

Haak-Flaskerud, J., & Maram van Servellen, G. (1985). Community mental health nursing: Theories and methodologies. Norwalk, USA: Appleton-Century-Crofts.

Health Department of Victoria. (1991). Nurse labourforce: Requirements and supply projections, Victoria 1990 - 2001. Melbourne: The author.

Health Department of Western Australia. (1986). Community health: A way ahead to 1996. Perth: The author.

Health Department of Western Australia.(1990). A plan for health: Strategic plan of the Health Department of WA 1989 - 1993. Perth: The author.

Hoinville, G., & Jowell, R. (1988). Survey research practice. London: Heinemann.

Hoult, J., Burchmore, H., & Schizophrenia Australia Foundation. (1994). Care of the seriously mentally ill: A rating of state and regional programs. North Fitzroy, Victoria: Schizophrenia Australia.

Hoult, J., Reynolds, I., Charbonneau-Powis, M., Weekes, P., Briggs, J., Cass, Y., Lapsley, H., & Rosen, A. (1983). Psychiatric hospital versus community treatment: A controlled study. Sydney: New South Wales Department of Health.

Human Rights Commission, Australia. (1993). National enquiry into the rights of people with mental illness: The Burdekin report. (Vols 1 &2.). Canberra: AGPS.

Hunter, P. (1974). Community psychiatric nursing in Britain: An historical review. International Journal of Nursing Studies, 11, 223 -233.

Illing, J., Drinkwater, C., Rogerson, T., Forster, D., & Rutherford, P. (1990). Evaluation of community psychiatric nursing in general practice. in Brooker, C. (Ed.). (1990). Community psychiatric nursing: A research perspective. London: Chapman & Hall.

Irurita, V. (1990). Optimizing as a leadership process: A grounded theory of nurse leaders in Western Australia. Unpublished doctorate thesis, University of Western Australia, Perth, Australia.

Johnson, K., Temple-Smith, M., & Dunt, D. (1987). Nursing outside hospitals: The working experience of community nurses. Melbourne: Department of Community Medicine, The University of Melbourne.

Kitson, A. (1986). Indications of quality in nursing care: An alternative approach. Journal of Advanced Nursing, 11, 133 - 144.

Kraus, J., & Slavinsky, A. (1982). The chronically ill psychiatric patient and the community. Boston: Blackwell Publishing.

Kreger, A. (1991). Remote area nursing practice: A question of education. East Fremantle. WA: Council of Remote Area Nurses of Australia.

Lee, T. (1990). The aged care system: Problems and prospects. Aging into the nineties. Symposium and procedings. Centre for Advanced Studies, Division of Health Sciences. Perth, Western Australia: Curtin University of Technology,

Lewin, G., & Hobbs, M. (1992). A study of mental health service needs and resources in the Central Wheatbelt Health region of Western Australia. Perth: Department of Public Health, University of Western Australia.

Lewis, M. (1988). Managing madness: Psychiatry and society in Australia 1788 - 1980. Canberra: AGPS.

Lowe, L. (1883). The bastiles of England: The lunacy laws at work. London: Crookenden and Co.

Lynn, M. (1986). Determination and quantification of content validity. Nursing Research, 35 (6), 382 - 385.

Mackay, T. (1992). More mental health services seen as a priority in the Great Southern Region. Headway, March/April, 18.

Magee, A. (1992). Remote area nursing in Western Australia: An examination of a conceptual model for practice. Unpublished honour's thesis, Edith Cowan University, Perth, Western Australia, Australia.

Mark, B. (1980). From lunatic to client: 300 years of psychiatric patienthood. Journal of Psychosocial Nursing and Mental Health Service, 18 (3), 32 - 36.

Martin, E. (1985). A specialty in decline? Psychiatric - Mental Health Nursing, past, present and future. Journal of Professional Nursing, 1 (1), 48 - 52.

McKelvie, G. (1993). A grounded theory study of mental health nurses utilisation of their clients family within the therapeutic setting. Unpublished master's thesis, Curtin University of Technology, Perth, Western Australia, Australia.

McMurray, A. (1984). Task performance requirements of the community health nurse: Implications for curriculum development. Unpublished master's thesis, University of Western Australia, Perth, Australia.

McMurray, A. (1991). Expertise in Community Health Nursing. Unpublished doctorate study, University of Western Australia, Perth, Australia.

Miller, J. (1981). Theoretical basis for the practice of CMHN. Issues in Mental Health Nursing, 3 (2), 319 - 334.

Moffett, M. (1988). Evaluation of psychiatric community care. Journal of Psychosocial Nursing, 26, 17 - 20.

Monat-Taylor, C. (1990). Mereness' essentials of psychiatric nursing. St. Louis: C. V Mosby Company.

Moore, S. (1960). A psychiatric outpatient nursing service. Mental Health, 20. 51 - 54

Mora, G. (1990). Psychiatry and its history. Springfield: Charles Thomas.

Morgan, A., & Johnston, M. (1976). Mental health and mental illness. Philadelphia: Lippincott.

Morrisey, J., & Goldman, H. (1984). Cycles of reform in in the care of the chronically mentally ill. Hospital and Community Psychiatry, 35 (8), 785 - 788.

New South Wales, Department of Health. (1983). Inquiry into health services for the psychiatrically ill and developmentally disabled: The Richmond report. Sydney: The author.

Noble, J., & Conley, R. (1991). Fact and conjecture in the policy of deinstittuionalisation. Health Policy Quarterly, 8 (1), 17 - 20.

Nolan, P. (1991). Psychiatric nursing: The first one hundred years. Senior Nurse, 11 (3), 30 - 32.

Oldham, R., & Oldham, J. (1980). Western heritage part 2: Geroge Temple-Poole: Architect of the golden years 1885 - 1897. Perth: University of Western Australia Press.

Osborne Park Hospital. (1994). Osborne Park and Mirrabbooka clinic annual report: 1993 - 1994. Perth: North Metropolitan Health Service.

Ovadia, F., & Owen, A. (1992). Mental health and primary care. In Baum, F., Fry, D., & Lennie, I. (Eds.). Community health; Policy and practice in Australia (182 - 198). Bondi Junction: Pluto Press.

Parnell, J. (1978). Community psychiatric nurses: An abriged version of the report of a descriptive study. United Kingdom: University of Surrey.

Pasamanick, B. (1964). Home versus hospital care for schizophrenics. Journal of American Association of Psychologists, 187, 177 - 181.

Paykel, E., & Griffith, J. (1983). Community psychiatric nursing for neurotic patients: The Springfield controlled trial. London: Royal College of Nursing.

Pendleton, S. (1990). Social change and politics. In Bullough, B., & Bullough, V. (Eds.). Nursing in the community (206 - 223). St. Louis: C. V Mosby Company.

Peplau, (1952). Interpersonal relationships in nursing. New York: Putnam.

Percival, P. (1986). The maintenance of registered nurse staffing levels in Western Australian country areas: Related issues. Unpublished master's thesis, Curtin University of Technology, Perth, western Australia, Australia.

Perko, J., & Kreigh, H. (1988). Psychiatric and mental health nursing: A commiment to care and concern. Norwalk: Appleton & Lange.

Philp, A. (1988). Remote area nursing practice in WA: Report to the Royal Australian Nursing Federation. Perth: Unpublished.

Polit, D., & Hungler, B. (1991). Essentials of nursing research: Methods, appraisal and utilisation. Philadelphia: J.B Lippincott Co.

Reynolds, I., Jones, J., Berry, D., & Hoult, J. (1990). A crisis team for the mentally ill: The effect of patients, relatives and admissions. Medical Journal of Australia, 152 (6), 646 - 652.

Richmond, D. (1983). Inquiry into health services for the psychiatrically and developmentally disabled. Sydney: Department of Health.

Rosenbaum, J. (1988). Validity in qualitative research. Perspectives in Nursing, 19 (3), 55 - 66.

Roth, M. (1986). The reality of mental illness. Cambridge: Cambridge University Press.

Royal Perth Hospital. (1993). A report of the operation of the Royal Perth Hospital for the 12 months ending 30.6.1993. Perth: The author.

Royal Perth Hospital. (1994). A report of the operation of the Royal Perth Hospital for the 12 months ending 30.6.1994. Perth: The author.

Sellick, M. (1986). Mental health nursing. Report of the working party to the Honorable Minister of Health and Honorable Minister of Education. Perth: Health department of WA.

Sharp, D. (1982). G.P's view of community psychiatric nurses. Nursing Times, October 6, 1664 - 1666.

Simmons, S. (1994). Quality of life in community mental health care: A review. International Journal of Nursing Studies, 31, 183 - 193.

Singer, P., Holloway, B., & Kolb, L. (1970). The psychiatric team and home care in the Soviet Union and Amsterdam. Journal of Psychiatric Nursing in Mental Health Service, Jan/Feb, 40 -44.

Speedy, S. (1993). Claiming the future: Mental health nursing 2000 and beyond, Inaugral oration. Sydney: Australian College of Mental Health Nurses.

Spradley, B. (1979). Planned change in nursing: The theory. Nursing Clinics of North America, June, 307 - 321.

Stoller, A., & Arscott, W. (1955). Mental health facilities and need of Australia. Canberra: AGPS.

Stokes, R. (1984). Introduction to sociology. Iowa: W. C Brown Group.

Swansburg, R. (1990). Management and leadership for nurse managers. Boston: Jones & Bartlett Publishing.

Tantum, D. (1988). Quality of life and the chronically mentally ill. The International Journal of Social Psychiatry, 34, 243 - 247.

Van Aken, R. (1995). Life at a rural psychiatric hostel: The experience of a group of male residents. Unpublished master's thesis, Edith Cowan University, Perth, Western Australia, Australia.

WA Government. (1902 - 1945). Annual report of the Inspector General of the Insane. Perth: Government Printer.

WA Government. (1946 - 1953). Report of the Inspector General of Mental Hospitals. Perth: Government Printer.

WA Government. (1954 - 1960). Report of the Inspector General of Mental Health Services. Perth: Government Printer.

WA Government. (1961 - 1983). Annual report of the Director of Mental Health Services. Perth: Government Printer.

WA Government. (1984 - 1995). Annual Report of the Health Department of WA. Perth: Government Printer.

Western Australian Post Secondary Education Committee. (1984). Nursing education in Western Australia: Report of the committee into nursing education. Perth: Health Department of WA.

White, E. (1990). Community psychiatric nursing: The 1990 national survey. Warickshire, United kingdom: Community Psychiatric Nurses Association.

Wilson, H. (1989). Research in nursing. Redwood, USA: Addison Wesley Pub. Co.

Woods, N & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: C.V Mosby.

World Heatlh Authority. (1956). Expert committee on psychiatric nursing - first report. Geneva: Technical Report Series 105.

World Health Authority. (1986). The first WHO international conference on health promotion: Charter for health promotion. Ottawa: World Health Authority.

Zelestis, C. (1989). Report of an enquiry into the treatment of psychiatric patients at Graylands hospital and other psychiatric hospitals in Western Australia. Perth: WA Govt Print.

# APPENDIX A

# 1995 SURVEY OF COMMUNITY MENTAL HEALTH NURSES WORKING IN WESTERN AUSTRALIA.

Dear colleague,

Thank you for taking the time to complete this survey. The purpose of the survey is to describe the current population of nurses working in the area of community mental health. Without your co-operation this description would not be possible.

I understand that written responses may take extra time but I am particularly interested in your opinions. Any extra time you take will be greatly appreciated.

Your consent to participate in this study will be assumed upon return of this questionnaire. To ensure anonymity please do not indicate who you are on the questionnaire.

Directions:

1. Print or write all responses and tick appropriate boxes.

2. All responses should relate to your current role as a Community Mental Health Nurse (CMHN). Please do not include other work situations in your response.

3. Please return all questionnaires in the envelope provided. For your convenience I have provided a REPLY PAID service. There is no need to use a stamp as long as the REPLY PAID number (113) is at the top of all addressed mail.

Thank you once again for your time.
Please phone me if you have any questions.

Phil MAUDE
Community Mental Health Nurse
Phone: (

**Please read directions on front cover prior to commencing.**

SECTION A: PROFESSIONAL INFORMATION.

1. How long have you worked as a Community Mental Health Nurse?
Months ..... OR Years .....

2. What is your current contract of employment? (please tick)

[ ] full time permanent [ ] full time temporary

[ ] part time permanent [ ] part time temporary

[ ] casual [ ] sessional holiday relief

[ ] other (please indicate).....

3. Prior to your current position had you ever worked as a registered nurse in a community setting? (Please tick)

[ ] Yes [ ] No

If "Yes", please tick the response(s) that best describes this previous position. (Tick as many responses as appropriate).

[ ] (a) Community Mental Health Nurse

[ ] (b) Day care centre

[ ] (c) Rehabilitation

[ ] (d) Generalist Community Nurse

[ ] (e) Other (please specify

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.....

4. Where do you currently work? (Please tick).

[ ] Perth metropolitan [ ] Regional centre [ ] Rural area

5. Are there other CMHN's at your place of work? (Please tick).

[ ] Yes
(Go to question 7)

[ ] No
(Go to question 6)

6. If you work alone as a CMHN what is the major way you are able to contact other CMHN's?

[ ] Meetings

[ ] Written material/ Fax

[ ] Telephone

[ ] Other (please indicate)

.....

7. In your current position who is the *first person* with whom you consult over *clinical* problems? (Choose one only)

[ ] GP [ ] CMHN Colleague [ ] Psychiatrist

[ ] Registrar [ ] Social Worker [ ] Psychologist

[ ] Carer [ ] Occupational Therapist

[ ] Other (Please indicate)

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8. For your response to question 7, please state why you chose this person?

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SECTION B: EDUCATION.

**9.** I am interested in your training background and nursing experience. Could you please outline all nursing courses you have completed that have led to registration with a nurses board? (Please note *location* refers to the Australian state or overseas country your training was completed in).

| Specialty | Year | Hospital/Tertiary | Location |
|---|---|---|---|
| [ ] (a) Mental Health | 19-- | ---------- | ------- |
| [ ] (b) Enrolled Mental Health | 19-- | ---------- | ------- |
| [ ] (b) General | 19-- | ---------- | ------- |
| [ ] (c) Enrolled General | 19-- | ---------- | ------- |
| [ ] (d) Mental Retardation | 19-- | ---------- | ------- |
| [ ] (e) Midwifery | 19-- | ---------- | ------- |
| [ ] (f) Other, (Please indicate) | | | |
| ..... | 19-- | ---------- | ------- |

**10.** Since your initial registration, have you completed any courses leading to further qualifications? (This should also include courses not directly related to nursing that may in your opinion have enhanced your work practice e.g management, public speaking).

[ ] Yes [ ] No

If you answered "yes" to question 10 , please list

Title of course Institution (if appropriate)

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11. Please list any courses you are currently studying and where you are studying. (Include any course you consider will enhance your work practices).

Title of course Institution Proposed final year

.....

.....

.....

How would you rate questions 12 to 18? (Please tick)

12. New CMHN's to my area receive an adequate orientation.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

13. My current employer provides me with ongoing staff development.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

14. Staff development that I have received in my current position as a CMHN has enhanced my role.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

15. Tertiary education designed to provide advanced CMHN practice is readily available in Western Australia.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

16. CMHN policy and procedures are available at my work place.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

17. Over all, my nursing education has adequately prepared me for my ` current position as a CMHN.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

18. I have been provided with an up to date job description of my current CMHN position.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

SECTION C: WORK ROLE.

19. From the following list please indicate the activities you were engaged in during the past *working week*.

**(Please tick as appropriate)**

[ ] Liaison with other services
[ ] Follow up of Community clients
[ ] Admission to Hospital
[ ] Report writing
[ ] Telephone counselling
[ ] Travelling to appointments
[ ] Meetings
[ ] Group work
[ ] Nursing procedures, e.g IMI
[ ] Case review
[ ] Home visits
[ ] Primary assessment
[ ] Supervision of staff
[ ] Supervision of student nurses
[ ] Client education
[ ] Carer support
[ ] Community liaison with other services
[ ] Other, if so please indicate:

.....
.....
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.....
.....

20. Do you supervise student nurses during your course of work? (Please tick).

[ ] Yes [ ] No

21. I am interested in your involvement with the community. Please indicate any activities you have conducted in the past 12 months that *CLEARLY GO BEYOND* the responsibilities of your job description. (Tick as appropriate).

[ ] (a) Facilitating therapy groups

[ ] (b) Facilitating support groups

[ ] (c) Research

[ ] (d) Public Speaking

[ ] (e) Quality Assurance programs

[ ] (f) Client satisfaction surveys

[ ] (g) Carer support services

[ ] (h) Self help groups

[ ] (i) Social outings designed to rehabilitate your clients

[ ] (j) Advice to other professionals re the prescribing of psychotrophics

[ ] (k) Other (please specify)

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.....

SECTION D: JOB SATISFACTION.

22. How would you describe your level of job satisfaction. (Please tick).

[ ] Very satisfied [ ] Satisfied [ ] Dissatisfied [ ] Very dissatisfied

Would you please elaborate on your response to Question 22?

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23. Do you see yourself working as a CMHN in 12 months time? (Please tick)

[ ] Yes [ ] No

What are the reasons for your response to question 23?

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SECTION E: PERSONAL INFORMATION:

24. What was your age last birthday?

.....

25. What is your gender? (please tick)

Male [ ] Female [ ]

26. Are there any other comments you would like to make?

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THANK YOU VERY MUCH FOR YOUR VALUABLE TIME AND ASSISTANCE.

**PHILLIP M MAUDE.**
**PH:** [redacted]

# APPENDIX B

# Experience and Qualification of Experts Selected to Assess Content Validity of the Instrument.

1. Holds a Master of Nursing. Experience in quantitative research methods. Registered General and Mental Health Nurse. Long experience in nursing staff development. Currently studying toward a PHD in Nursing.

2. Hold a Master of Education. Registered General and Mental Health Nurse. Experience in Mental Health Nursing Education at a Senior level.

3. Registered Mental Health Nurse. Experience as a lecturer for Mental Health and General nursing. Teaches a unit of study in Community Mental Health Nursing.

4. Holds a Master of Education. Registered General and Mental Health Nurse. Experience in nursing education and management. Recent experience in Community Mental Health Nursing.

5. Registered General and Mental Health Nurse. Completing a Master of Nursing. Experience in quantitative research methods.

6. Registered Mental Health Nurse who is now retired but has a long work history as a Community Mental Health Nurse.

7. Registered Mental Health Nurse who is now retired but has a long work history as a Community Mental Health Nurse.

8. Registered General and Mental Health Nurse with experience in nursing education.

9. Registered General and Mental Health Nurse with experience in nursing education. Holds a Bachelor in Nursing

10. Registered General and Mental Health Nurse with experience in nursing education. Holds a Master of Nursing.

# APPENDIX C

Phillip M MAUDE
[redacted]

TO:

_____

_____

_____

Dear _____

As you may be aware I am writing a thesis for a Master of Nursing at Edith Cowan University. The purpose of my study is to describe the social and political influences that led to the establishment of Community Mental Health Nursing in Western Australia by means of a literature review and to describe the current population by a survey questionnaire.

As I have developed my own instrument I am seeking your opinion as to its content validity. The questionnaire should describe the populations demographics, education, work experience, level of job satisfaction, supports and work role.

I have made the questionnaire up into a booklet with the proposed questionnaire appearing on the right hand side and your assessment of each question to be completed on the left hand side of the booklet (*section in italics*). The assessment rating scale is adapted from:

Lynn, Mary. R. (1986). Determination and quantification of content validity. Nursing Research, 35(6), 382 - 385.

Can you please rate each question by circling a choice from 1 to 4.

1. "NOT RELEVANT" - the question is not relevant to the study and should be deleted.

2. "UNABLE TO ASSESS" - you are uncertain if the question should be included.

3. "RELEVANT BUT NEEDS ALTERATION" - you feel the question should be included but be changed.

4. "RELEVANT" - the question should remain and is relevant to the study.

If you score the question with a "1", "2", or "3" could you please make some comment as to why or what changes need to be made.

Please note on the final page of the booklet I have asked you two question. I would appreciate it if you are able to identify any extra question that need to be included and welcome your general comments.

Please contact me if you have the need.

Thankyou once again for your time.

Phillip M MAUDE
Bach. H. Sci, RMHN, RN

*Question 1.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 2.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 3.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 4.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 5.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 6.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 7.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 8.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 9.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 10.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 11. (a)*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 11. (b)*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 11 (c)*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 11 (d)*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 11 (e)*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 12.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 13.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 14.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 15.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 16.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 17.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 18.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Question 19.*

*(1) not relevant;* *(2) unable to assess;*

*(3) relevant but needs alteration;* *(4) relevant*

*Comment:*.....
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*Finally I have two questions to ask.*

*Question 1.*

*Can you identify any areas that have been omitted from the questionnaire that would assist with answering the research question? (Please tick)*

*Yes [ ]* *No [ ]*

*If "Yes" please comment:*

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*Question 2:*

*Are there any other comments you would like to make?*

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# APPENDIX D

[redacted]

Dear colleague

I am inviting you to take part in a research project I am conducting. This research will be part of the requirement for the award of Master of Nursing from Edith Cowan University.

The purpose of the research project is to document the development of Community Mental Health Nursing in Western Australia taking into consideration social, political and fiscal influences and describe the current practicing population.

This research gives **you** the opportunity to provide valuable information. I urge you to complete the questionnaire and forward it back to me **within two weeks.**

Please find enclosed:

1. A questionnaire;

2. One Reply Paid envelope.

Any questions can be directed to Phillip Maude by phoning [redacted]

Thankyou once again for considering my research.

Phillip M MAUDE
CMHN

# APPENDIX E

Mr Phillip MAUDE
[redacted]

DEAR COLLEAGUE,

RECENTLY I SENT OUT SURVEY QUESTIONNAIRES TO ALL COMMUNITY MENTAL HEALTH NURSES PRACTICING IN WESTERN AUSTRALIA. THIS SURVEY FORMS PART OF MY RESEARCH FOR THE AWARD OF MASTER OF NURSING AT EDITH COWAN UNIVERSITY.

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO THANK ALL THOSE COMMUNITY MENTAL HEALTH NURSES WHO HAVE TAKEN THE TIME TO COMPLETE THE QUESTIONNAIRE. I HAVE HAD A FANTASTIC RESPONSE AND ALL YOUR COMMENTS WILL BE CONSIDERED. AS A FELLOW COMMUNITY MENTAL HEALTH NURSE I AM AWARE JUST HOW VALUABLE YOUR TIME IS.

ANYONE WHO HASN'T COMPLETED A QUESTIONNAIRE HAS TIME TO FORWARD THESE BACK AND THIS WILL ENABLE ME TO INCLUDE YOUR DATA IN MY REPORT. I INTEND COMPLETING DATA ANALYSIS IN EARLY JULY 1995. THE REPORT SHOULD BE FINALISED IN NOVEMBER AND WILL BE AVAILABLE THROUGH EDITH COWAN AND THE HEALTH DEPARTMENT OF WA LIBRARIES IN EARLY 1996.

SHOULD YOU WISH ME TO SEND YOU A NEW QUESTIONNAIRE (AS THINGS DO GET LOST IN THE POST!) OR YOU WOULD LIKE ANY INFORMATION CONCERNING THIS RESEARCH PLEASE PHONE ME ON:

[redacted]

THANKING YOU FOR YOUR HELP AND ALL THOSE ENCOURAGING COMMENTS

PHILLIP M MAUDE
CMHN

# APPENDIX F

EDITH COWAN
UNIVERSITY
PERTH WESTERN AUSTRALIA
JOONDALUP CAMPUS

OFFICE OF RESEARCH AND DEVELOPMENT

Joondalup Drive, Joondalup
Western Australia 6027
Telephone (09) 405 5555
Facsimile (09) 300 1257

31 October 1994

Mr Phillip Maude
[redacted]

Dear Mr Maude

The Committee for the Conduct of Ethical Research reviewed your proposal; *Code 94-98" A descriptive study of Community Mental Health Nursing in Western Australia."* on 28 October and I am pleased to advise the project has been cleared for implementation subject to your:

1 changing the wording of the sentence "at no time will your name be used to identify you" in your letter to the Community Mental Health Nurses.

2 disclosure letter including a statement that the Masters of Nursing studies are being done through Edith Cowan.

Please provide a copy of the amended consent form for our records.

Yours sincerely

[redacted]
ROD CROTHERS
Executive Officer
Committee for the Conduct of Ethical Research
Ref. 94-98

cc: Dr Nancy Hudson Rodd
Ms Gerrie Sherratt

# APPENDIX G

Mr Phillip MAUDE
[redacted]

Dear Sir/Madam,

I am writing to you as a Community Mental Health Nurse (CMHN) working for the North Metropolitan Health Service and a Master of Nursing candidate at Edith Cowan University. I propose to carry out a research study that will document the development of Community Mental Health Nursing in Western Australia and survey the current population of CMHN's utilising a questionnaire that I have developed and tested for content validity. The proposal for this research has been approved by the Edith Cowan University Higher Degree Committee and Ethical Review Committee.

As directed by S. Williams, Nursing Officer, Health Department of WA, I am writing for permission to proceed with this research which will involve CMHN's practicing in your region. At no time will patients be involved or contacted.

All CMHN's in WA will be invited to participate by consenting to complete the questionnaire. Confidentiality with anonymity will be ensured through a coded system in place of names. Data will be accessible only to this researcher, kept in a locked store and all documentation will be destroyed five years after data analysis is completed. All future published work utilising this research will not disclose individual participants in any way.

For your convenience I enclose a simple form of consent to proceed with this research which may be quickly completed and faxed back to me

[redacted]

Thankyou for your time and consideration.

Yours faithfully.

Phillip Michael MAUDE.
Bach Health Sci.(Nurs). R.N R.M.H.N

enc: copy of research questionnaire.
consent form for return by mail/fax [redacted]

**CONSENT FORM**

I _____

representing the following Health Region/District of Western Australia.

_____

give permission to Phillip Michael MAUDE, Master of Nursing Candidate at Edith Cowan University (Churchlands Campus) to proceed with the following research in my Region/District:

"A DESCRIPTIVE STUDY OF COMMUNITY MENTAL HEALTH NURSES PRACTICING IN WESTERN AUSTRALIA"

I understand that this consent permits Mr MAUDE to survey Community Mental Health Nurses working in my Region/District by means of a confidential questionnaire. At no time will this research involve patients or other health professionals.

Signed: _____

Title: _____

Date: _____

**Please Fax to : Phil MAUDE CMHN**
**Shenton Park Community**

[redacted]