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THE LIVED EXPERIENCE OF RURAL MENTAL HEALTH NURSES

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ABSTRACT

The lived experiences of five registered mental health nurses employed in community settings in the southwest region of Western Australia were examined in this study. The study was generated in response to concerns of clinicians working in the area about their scope of practice. Study participants were interviewed concerning their everyday “lived experience.” Interviews were audio taped, transcribed and coded numerically to ensure participant confidentiality. Data was analysed using van Manen’s hermeneutic phenomenological approach. Five essential themes were identified. They were holistic care of clients; isolation, autonomy and advanced practice; professional development and status recognition; educational support; and caseload numbers and caseload composition. The purpose of the study was to determine whether Community Mental Health Nurses (CMHN) employed in the southwest region of Western Australia encountered similar problems and role demands to those of generalist nurses working in rural Australia.

INTRODUCTION

Nurses working in rural and remote areas of Western Australia (WA) are often sole practitioners and are, therefore, expected to function at higher levels than nurses employed in urban areas (Health Department of Western Australia, 2000a). Although the Health Department of Western Australia acknowledges the advanced scope of practice of rural and remote area nurses and is currently developing competencies to validate an advanced practice role, not all clinicians working in rural or remote areas have the experience or training to work at an advanced level. Within the nursing career structure in Western Australia, Community Mental Health Nurses (CMHN) are most commonly appointed at Level 2, whereas an advanced practitioner would be appointed at Level 3. The region identified in this study has four Level 3 CMHN appointments and eleven Level 2 appointments. Three Level 3 nurses and two Level 2 nurses were interviewed for this study. Previous studies have focused on the generalist nurse in these areas and not on the specialist mental health nurse. The purpose of this paper is to describe nursing roles of registered mental health nurses working in rural and remote areas of WA using a phenomenological approach. Information gathered from this study will be helpful in defining roles and may give guidance to nurses who practice in these areas.

BACKGROUND AND SIGNIFICANCE

Although there is available literature regarding roles and responsibilities of mental health nurses working in urban areas (Australian and New Zealand College of Mental Health Nurses, 1995; Martin, 1985; Nurse's Board of Western Australia, 1999; Puskar, 1996; Taylor, 1995) and the role of generalist nurses working in rural and remote areas (Bradley & McLean, 2000; Gray & Pratt, 1989, 1991; McCoppin & Gardner, 1994), an extensive literature search using CINAHL and MEDLINE failed to find any literature specifically addressing roles and responsibilities of registered mental health nurses working in rural and remote areas of Australia.

The Mental Health Division (MHD) of the Health Department, WA (HDWA), has made a commitment to the rural sector to provide cost effective community based care. The MHD, Framework for Reform (1998) acknowledges the difficulties faced in WA due to the dispersal of the population, vast geographical distances and diversity within varying rural sectors in relation to isolation, economic level and lifestyles. Investigation of educational and research priorities of rural nurses and all that it encompasses suggests that a reason for the failure to address issues of importance in rural nursing is that little is known about the conditions of rural nursing practice (Bell, Daly, & Chang, 1997b; Hegney, 1998). This study will partially fill that gap.

Defining Rural and Remote Nursing

There appears to be no universally accepted definition of rural and/or remote nursing; however, the literature reveals a commonality in themes of diminished services, autonomy of practice, limited medical and allied health support and distance from tertiary services (Alcorn & Hegney, 2000; Bell et al. 1997b; Bradley & McLean, 2000). Taking this and the rural and remote literature into account, the definition accepted for this study was that "rural nursing...is carried out by a nurse who works in a health facility where the support services (medical and allied health) are predominantly visiting, and in a community or district nursing service in a non metropolitan area" (Hegney, 1998, p145).

Nursing in Rural Australia

There is a current shortage of trained and experienced nurses worldwide (Bussert, 2001; Daly, 2000; Nevidjohn & Erickson, 2001). Less than 25% of registered nurses in Australia work in rural areas and this number is expected to decline further in the future due to the current age of the nurses and recruitment issues (Borland, 2000b; Hegney, 1998; National Rural Health Alliance, 2002a). Federal and state governments in Australia have been forced to recognize and address the problems of attracting medical practitioners to rural and remote areas by offering incentives for doctors to practice in rural areas. However, they have failed to respond to the lack of nurses in these areas (Alcorn & Hegney, 2000; Bradley & McLean, 2000; McCoppin & Gardner, 1994). The HDWA designates all areas outside the Perth metropolitan region as either rural or remote and acknowledge that nurses provide the highest proportion of health care in rural and remote regions (Health Department of Western Australia, 2000b; National Rural Health Alliance, 2002a, 2002b).

Borland (2000a, p18) described some of the issues that nurses in rural Australia face: unique challenges to the delivery of quality services – dispersed population, poor health status, diverse cultures, geographic isolation, problematic transport, poor infrastructure, small economic base, limited political clout, harsh extremes of climate, and a high turnover of health professionals. This portrayal validates the perception that rural and remote mental health nursing offers few incentives and few rewards in spite of increased responsibility and accountability.

Many nurses working in rural and remote areas provide the only health service to the area and, out of necessity, are forced to function outside both legislative guidelines and their scope of practice. A major concern discussed in the literature has been the prescribing of medication, particularly antibiotics, by nurses working in rural and remote Australia (Bell et al. 1997b; Health Department of Western Australia, 2000a; Hegney, 1998).

Registered nurses are reluctant to work in rural and remote areas because of a lack of peer and collegial support, and the need to be more autonomous in practice and take on greater responsibility (Clinton, 1999; Shanley, 1999). Shanley (1999) argues that formalized support structures for staff in rural areas would help minimize feelings of isolation and assist rural nurses to identify effective strategies for coping with everyday stressors.

Advanced Standard Practice

There is considerable literature and discussion regarding the nurse practitioner or advanced practitioner role in all areas of nursing practice (Allen, 1998; Australian and New Zealand College of Mental Health Nurses, 1995; Brown, 1998; Health Department of Western Australia, 2000a; Hegney, 1998; Puskar, 1996). Brown (1998) focused on the educational needs of rural mental health nurses in northern New South Wales, while Puskar (1996) developed a rationale for advanced practice from a North American perspective. Studies by these authors have a common theme indicating advanced practice is not a new role. Rather, it is a role that has been performed by nurses for many years that requires clarity of function and identification of responsibilities. Both studies indicate a need for training and education and the development of formal support networks for nurses in this role. Allen (1998), in a study of mental health nurses working in Great Britain, identified that advanced practice included psychiatric diagnosis, prescribing single emergency doses of medication, modifying doses of a wide range of psychotropic drugs, additional powers under the mental health act and enhanced autonomy in admission and discharge of patients. The Western Australian Mental Health Act (1996) ("Mental Health Act 1996," 1996) has already granted additional powers to nurses facilitating best practice within the community; however, these powers do not extend to the skills identified in Allen's (1998) study. The Australian New Zealand College of Mental Health Nurses (1995, p. 4) has developed advanced standards of practice for mental health nurses. According to these standards, advanced practice nurses go beyond specialized competency; they are individual, independent and innovative in their work; and they demonstrate the highest level of achievement in ethics, practice and standards of professional conduct. Gray and Pratt (1991) argue that despite considerable effort by the nursing profession to develop role statements or describe nursing by task or job analysis, a definitive description of advanced practice has not evolved. They reason is that defining practice, paradoxically, has a

limiting effect on the scope of practice. Rather, nurses should move forward, stating what the profession sees as the future role of nursing in Australia.

There is support for nurses in rural Australia to be recognized as advanced practitioners (Alcorn & Hegney, 2000).

RESEARCH METHOD AND DESIGN

An interpretive paradigm, using a hermeneutic phenomenological method, was used for this qualitative study. The researcher, through openness and dialogue with participants, sought to understand, describe, and interpret the relevant meanings of the phenomena as described by the participants. Rather than focusing on statistical relationships, this method enabled the researcher to understand meanings as described by the participants as they are lived in everyday existence.

Van Manen's (1997, p. 37) conceptualization of hermeneutic phenomenology is used in this study as it takes into account the fact that the researcher is concerned with the lived experiences of registered mental health nurses, and the consequent meanings and behavior derived from these experiences. This method generates an understanding of the lives of these registered nurses within their own unique working environment.

Participants and Sampling Method

Selection of participants used purposive sampling whereby participants had to meet three predefined criteria. Five participants were selected. All participants gained their initial nursing qualifications through hospital-based nursing programs. Of the five participants, three also have tertiary qualifications. Three males and two females participated in the study. Four participants had in excess of ten years mental health nursing experience. The remaining participant's experience in mental health was three years; however, she had more than ten years experience in forensic nursing.

Data Collection and Instrumentation

A focused self-report technique using face-to-face interviews of 1-3 hours duration was used for this study. This allowed participants to tell their own stories in a narrative fashion, and allowed the use of a topic guide to stimulate ongoing dialogue. The use of open-ended questions minimized closed responses. Data was recorded on an audiotape, allowing the researcher to feel a sense of involvement and participation.

FINDINGS

Data Analysis and Interpretation

Themes were identified using thematic analysis, which involved listing patterns of experience identified from the transcribed interviews; identifying data that related to the classified patterns and cataloguing these patterns into sub-themes. Coding and thematic analysis revealed five essential themes common to all participants. These were:

1. Holistic care of clients;
2. Isolation, autonomy and advanced practice;
3. Professional development and status recognition;
4. Educational support;
5. Caseload numbers and caseload composition.

Holistic Client Care. Participants related their experiences and identified the responsibilities they had for managing client care. Participants viewed the role of the nurse as complex and involving many facets. This included an awareness of, and responsibility to, the community. Participant statements included: “As a Community Mental Health Nurse I am part-time social worker, friend, counselor, nurse”; “you need to be aware of things like surfing conditions”; “I see my role as a Community Mental Health Nurse rather than a Mental Health Nurse. I put the emphasis on the community rather than just on the patient.”

Therapeutic use of self, client assessment, ongoing monitoring, planning, implementing and evaluating care, crisis intervention, psychoeducation, caregiver support, advocacy, liaison with other agencies and assisting clients with their social needs were responsibilities mentioned by most participants. “We do what is necessary to ensure a patient’s wellbeing, which can include ringing Centrelink and liaising on their behalf, advocating on their behalf, organizing their tablets, organizing their scripts or just dropping in and having a cup of tea and bit of a chat. So it’s a range of things you do while monitoring and assessing their mental state.”

The model of care used by participants varied. One participant cited sharing responsibility for care with the GPs. Other participants spoke of working as members of a team. Of these, only one participant viewed the team as a “partnership” and discussed working closely with other health care workers. The need to be aware of what was happening in the community and knowing clients’ networks of family and friends was crucial to the delivery of holistic care. The lack of resources and facilities in many of the areas meant the nurse became the resource, a “jack of all trades,” prepared and willing to undertake many different tasks.

Isolation, Autonomy and Advanced Practice. The interplay between the themes of isolation, autonomy and advanced practice was evident in narrated experiences with participants speaking of the independence and interdependence of their roles. Independence and autonomy were closely aligned and were discussed as significant factors supporting the need for experienced nurses. There was a perceived devaluing by metropolitan nurses of the rural role, and a lack of understanding about the isolation and how that relates to clinical issues and clinical decision making.

Participants cited geographical isolation as a part of everyday experience. In practical terms, this meant that nurses visited remote farmhouses, saw patients alone in areas where mobile phones did not work and had limited access to immediate collegial support.

All participants cited maintenance of personal safety as being a concern. One participant described the experience of being a community mental health nurse as “10% terror” due to concerns for personal safety related to changes in patients’ mental states. Although ensuring all safety protocols were followed, taking another nurse on a visit, and

organising clinical supervision helped diminish these feelings, the stress and perceived lack of support in the community have challenged her clinical confidence and self esteem.

Isolation and the lack of available services appeared to have a direct impact on nursing practice. Participants described their experiences of decision making and autonomy as an integral component of their job. Limited medical coverage necessitated autonomy for rural community mental health nurses to make decisions regarding client care. The nurses were also used as a resource within their local areas, assisting staff at local hospitals and GPs with management of patients.

All participants in the study shared this experience. All participants believed that they were working at an advanced level that was not acknowledged through status or remuneration.

Professional Development, Status Recognition and Supervision. Three of the five participants mentioned the lack of professional training opportunities. The inability to attend training due to the tyranny of distance coupled with a lack of relief was discussed by all participants as being a major obstacle to training. This is discussed at length in the literature as a major issue for all rural nurses in Australia (Bell et al. 1997b; Borland, 2000a; Brown, 1998). Experiences related to orientation and training in community mental health were limited.

One participant, when employed in the United Kingdom, had received formal training, paid by his employer, in the area of community mental health and viewed this as important. However, he felt that this opportunity was lacking within the current Western Australian system. He explained that in the United Kingdom training was linked to career structure and salary, validating and professionalizing practice. One participant noted the need for a more defined philosophy and goals and more structure within the working environment. She felt that there was minimal direction given to new staff and that a defined philosophy and goals would provide a framework for practice.

Two participants identified a lack of regular clinical supervision as being problematic. Clinical supervision lacked a formal structure and was reliant upon the practitioner seeking supervision when he/she felt it was needed. Concern was voiced by one participant that supervision was “after the event” rather than at the time of an event.

Educational Support. Three participants mentioned the clinical supervision and support provided by them to local hospitals. This supervision and support was varied and included direct patient care, such as performing a mental state examination or risk assessment, development of clinical management plans for patients and education of staff on a wide range of topics relating to mental health. A collegial relationship between the participants and the agencies allowed participants to work in a consultancy-type role.

Two participants identified student supervision and facilitation of student learning as having an impact on their workloads. Both participants supported student education; however, they felt the tertiary institutions should provide more support to the students than was evident. The need to provide students with positive experiences, and encourage them to see mental health nursing as a viable option, was discussed by both participants, who felt they had a professional responsibility to preceptor students. Participants said that although they were supportive of student nurses, providing learning experiences for a student involved more work. These clinicians felt unable to provide the students with the experiences and support required due to their increased workloads. This had resulted in them having no nursing students gaining clinical experience, in their area, in recent months.

Caseload Numbers and Caseload Composition. All participants cited increased acuity, excessive caseload numbers and complexity of cases as being problematic. Nurses performed the same tasks, irrespective of their experience. There was a sense of being overburdened with high caseloads, and having no validated method of determining case complexity. There was consensus that individual case numbers in urban areas were fewer and that in urban areas cases were assigned according to complexity and the nurse's experience. Participants argued that their high caseload numbers, coupled with case complexity and geographical isolation, meant that they should be employed as advanced practitioners.

Limitations

Essentially this study met its objectives, although its limitations must be acknowledged. The sample size was small and taken from one rural region, placing limitations on the extent to which results can be generalized. Although hermeneutic phenomenology will not aid in the prediction of roles undertaken by rural community mental health nurses, it provides an understanding of the issues and concerns faced by these nurses. Due to a shortage of information on the roles and responsibilities of Registered Mental Health Nurses working in rural areas, extensive meaningful comparison of findings in related literature was difficult.

RECOMMENDATIONS AND CONCLUSIONS

This study has reinforced the literature findings regarding issues faced by rural nurses in Australia (Alcorn & Hegney, 2000; Bell, Daly, & Chang, 1997a; Borland, 2000b). Unifying themes that were woven through all narratives were those of isolation, autonomy and advanced practice. Findings indicate that the role of these nurses is complex, involving local knowledge, awareness of community resources, therapeutic interventions and support to other clinicians. These findings support prior studies regarding the enhanced role of generalist nurses in rural and remote Australia (National Rural Health Alliance, 2002b).

The development of skills and knowledge necessary for undertaking a rural community mental health nursing role was described as experiential. This is consistent with findings on generalist nurses in rural areas (Alcorn & Hegney, 2000; National Rural Health Alliance, 2002b). Accessible, formal education programs are needed to validate the role and provide a framework for practice. This study highlights the need for formal recognition of advanced practice and structured clinical supervision for rural community mental health nurses.

Furthermore, it was identified that community mental health nurses were often the sole providers of care for the client and were responsible for coordinating all aspects of the clients' care. This multifaceted, advanced role of rural community nurses is supported by current literature (Bell et al. 1997b; Hegney, 1998; National Rural Health Alliance, 2002a).

Furthermore, there is a need to address specific issues such as formal recognition of established rural and remote nursing roles, the role of the nurse practitioner, recognition of the nurse practitioner role by GPs, prescribing rights, advanced emergency clinical skills, and ongoing competency training if nurses are going to be encouraged to work in rural areas (Bradley & McLean, 2000) Action on these issues will be required if the mental

health needs of rural Australians are to continue to be met by Community Mental Health Nurses.

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