

COMPETENCE IN PROVIDING MENTAL HEALTH CARE: A GROUNDED THEORY ANALYSIS OF NURSES' EXPERIENCES

Ms Julie Sharrock, RN, General Nurs Cert, Crit Care Cert, Psych Nurs Cert, B Ed, MHSc (Psych Nurs), Dip Gestalt Therapy, Psychiatric Consultation-Liaison Nurse, St. Vincent's Mental Health Service, Fitzroy, Victoria, Australia.

julie.sharrock@svhm.org.au

Professor Brenda Happell, RN, Cert Psych Nurs, B.A. (Hons), Dip Ed, B Ed., M Ed, Ph.D, Professor of Contemporary Nursing, School of Nursing and Health Studies, Central Queensland University, Rockhampton, Queensland, Australia.

Accepted for publication December 2005

ACKNOWLEDGEMENTS

Thanks to Professor Andrew Retsas and Ms Meredith Bucknell for their supervision and support during the completion of the thesis. Many thanks also to the feedback provided by interested colleagues in relation to this study. Finally, eternal gratitude to the four nurses who shared their experiences.

Key words: Mental health, psychiatric nursing, psychiatric co-morbidity, nursing education, general health care

ABSTRACT

Objective:

In view of the evidence that general nurses have difficulty in caring for patients experiencing mental health problems, the aim of this study was to explore and describe the subjective experience of nurses in providing care for this client group.

Design:

A grounded theory approach was used. The data were collected via semi-structured individual interviews and analysed using the constant comparative method.

Setting:

The study was conducted with nurses from general health care settings that provide medical and surgical care and treatment.

Subjects:

Four nurses who were completing their second year post graduation participated in the study.

Main outcome measure:

The experiences of providing care for people experiencing a mental illness as described by participants.

Results:

The findings indicated the nurses were striving for competence in the provision of mental health care. They acknowledged the mental health needs of patients and their right to quality care.

Conclusions:

This study supports the notion that general nurses lack confidence when caring for patients with mental health problems in medical and surgical settings. It also highlights a discrepancy between the holistic

framework encouraged at undergraduate level and what is experienced in practice.

INTRODUCTION

During the 1970s the Australian nursing profession began the shift from an apprenticeship model to a university-based system of nursing education, a direction consistent with international trends in nursing education (Commonwealth of Australia 2002). By the end of 1993, undergraduate university programs with a minimum entry standard of Year 12 equivalent had replaced pre-registration nursing courses based in hospitals (Commonwealth of Australia 2001). During the 1990s, a comprehensive approach to undergraduate programs was advocated. Comprehensive nursing curricula adopt a holistic and culturally sensitive approach as the basis for integrating theory and practice drawn from general, psychiatric and community nursing as they occur in institutional and non-institutional settings. The broad expectation of these curricula is to prepare graduates who leave university with a comprehensive grounding in nursing theory and practice (Reid 1994) and who will be able to function as first level, multi-skilled practitioners in any area of nursing practice (Mental Health Branch 1998). Graduates then have the option of undertaking postgraduate study in specialist and advanced areas of nursing (Commonwealth of Australia 2002).

Within a similar time frame, the de-institutionalisation of mental health care and the implementation of the National Mental Health Policy (Australian Health Ministers 1992) was occurring. This was a coordinated policy direction to replace traditional stand alone psychiatric hospitals with a mix of general hospital, residential and community services integrated into and co-located with the mainstream health system. It was hoped that by reducing the isolation of psychiatric services, clients would have increased access to general health care; stigmatisation and neglect would be reduced

(Australian Health Ministers 1992); and continuity and quality of care would be improved (RCNA 1995).

However, the effectiveness of comprehensive nursing curricula in the preparation of nurses to care for clients with mental illness has been questioned in Australia (Clinton 2001; Commonwealth of Australia 2001; Nurse Recruitment and Retention Committee 2001; Wynaden et al 2000; Henderson 1990) and New Zealand (Prebble 2001). Further to this, significant inconsistencies in the amount of time allocated to the theory and practice of mental health nursing in undergraduate programs within Australian universities have been identified (Nurses Board of Victoria 2002; Happell 1998; Farrell and Carr 1996).

In the presence of a mainstreamed health care system all nurses need to be adequately educated and equipped with expertise to care for people with mental health problems. This is particularly relevant for medical and surgical nurses because it has been estimated that between 30% and 50% of general hospital patients have a psychiatric co-morbidity (RCP and RCP 1995; Clarke et al 1991). Physical illness is known to increase the risk of psychiatric disorder (Clarke et al 1991; Feldman et al 1987; Mayou and Hawton 1986). In addition, people who have a psychiatric disorder are more likely to have physical problems and are now more likely to access general hospitals to meet their health needs (Lawrence et al 2001; Koranyi and Potoczny 1992).

There is evidence that nurses working in general health care settings have difficulty in meeting the needs of this group of patients. A number of studies found that general nurses perceived themselves as lacking knowledge, skills and confidence in the assessment and management of mental health problems (Sharrock and Happell 2002; Wand and Happell 2001; Brinn 2000; Bailey 1998; Roberts 1998; Gillette et al 1996; Muirhead and Tilley 1995; Fleming and Szmukler 1992).

Bailey (1998) identified feelings of fear and inadequacy and a lack of understanding among critical care nurses caring for patients post self-harm. In other studies nurses have been found to describe reduced work satisfaction; to question their role; and to give priority to physical needs and task completion in caring for patients with mental health problems (Gillette et al 1996; Bailey 1994; Fleming and Szmukler 1992). Some evidence suggests that nurses find it particularly difficult when patient behaviour is perceived as difficult, threatening or disruptive (Happell and Sharrock 2002; Heslop et al 2000; Pollard and Hazelton 1999).

Compounding these difficulties is a lack of resources, expert assistance and workplace policy in relation to people with mental health problems (Wand and Happell 2001; Bailey 1998; Gillette et al 1996). In addition, staff attitude is an important factor when considering the delivery of mental health nursing to patients and both negative (Brinn 2000; Bailey 1998; Mavundla and Uys 1997; Gillette et al 1996; Fleming and Szmukler 1992) and positive attitudes have been reported among nurses

(Rogers and Kashima 1998; Anderson 1997; Sidley and Renton 1996; McLaughlin 1994).

The limited published research relating to general nurses and the care of patients with mental health problems has examined nurses' responses to particular psychiatric symptoms or disorders and in specific clinical settings. There are no studies that have examined the subjective experience of nurses caring for people with mental health problems in the general health setting and consequently a rich description of the nursing experience has not been articulated in the literature.

The purpose of this study was to explore this experience from the perspective of comprehensively educated nurses working in the medical and surgical settings.

METHOD

In order to access the subjective and descriptive experience of nurses, a qualitative approach was selected for this study. In particular, grounded theory (Strauss and Corbin 1990; Glaser and Strauss 1967) was favoured as it provides for the generation of emergent theory when there is little known about a particular phenomenon. That is, grounded theory applies a systematic, concurrent data collection and analysis process throughout the inquiry that allows salient features of the phenomenon under investigation to emerge from the data. These features are conceptualised, categorised and verified, leading the researcher to generate a conceptual framework that assists in understanding or explaining that phenomenon. The conceptual framework forms a theory that is grounded in the data.

Ethical approval was obtained from the University Human Research Ethics Committee prior to commencement of the study.

Participants

Participants in the study were selected from nurses introduced through collegial networks, who fitted the inclusion criteria and who indicated an interest and consented to participate in the study. Theoretical sampling guided participant selection. Concepts that arose from the data directed the researcher to additional participants who could provide further data that had relevance to evolving concepts. Participant selection, data collection and data analysis continued until theoretical saturation was reached and rich description of experience had been obtained. Data collection was ceased after the fourth interview, as it was clear that no new themes had emerged.

The authors acknowledge it is unusual for data saturation to occur after so few interviews. However, in this case the four participants raised essentially the same issues. The data derived (as will be demonstrated in the findings section) supports the available literature thus suggesting that while the participant responses cannot be generalised, they are consistent with what is known about nurses' attitudes toward people experiencing mental health problems.

Procedure

Data were collected through in-depth semi-structured individual interviews using an interview guide (Minichiello et al 1995). At interview, participants were asked to describe their experience of caring for at least one patient within the previous two months who experienced a mental health problem during their medical or surgical admission. Interviews lasted from 45 to 60 minutes, were audiotaped and transcribed. The transcribed document formed the basis for data analysis.

Data analysis

Each transcript was analysed using the constant comparative method. This method employs coding techniques through which data are broken down, conceptualised and put back together in new ways (Strauss and Corbin 1990). This type of analysis uncovers the common elements in the subjective experiences of participants (Fossey et al 2002). Analysis is a constant and dynamic process where questions are asked about data and comparisons are made between emerging concepts. Consideration was given to what words, phrases or paragraphs represented and a label was applied. This generated an extensive list of labels that were sorted and categorised into groups of concepts with similar meaning which were subsequently named. The categories were further developed through identification of relationships between the categories. As the categories were developed, the researcher returned to the transcripts to validate their consistency with the data. In addition, a descriptive narrative was conceptualised into a *story line* and this also assisted the researcher to identify the categories and to make links between the categories. The story line became more integrated through the use of questions and comparisons and the application of the *paradigm model* (fig. 1). This further assisted in organising the concepts as they emerged into a theory that was grounded in the data.

Rigour

Methodological rigour (Fossey et al 2002) was enhanced through the systematic application of grounded theory methodology and techniques. Member checking (Lincoln and Guba 1985) was used to strengthen the credibility of the study, that is, ensuring the descriptions and interpretations of the experiences were faithfully reflected so they could be recognised not only by the participants in the experience but by others who have had similar experience (Sandelowski 1986).

Each participant was given the opportunity to review, clarify and correct any points within their transcript. Three participants were available to review and comment on the emergent theory. General and psychiatric nurse colleagues were also asked to comment on the emergent theory and indicate its applicability to the experiences of nurses outside the study. The subjectivity of the researcher in qualitative research is acknowledged (Minichiello et al 1995) and it is essential that the researcher is sensitive to the phenomenon. However, Strauss and Corbin (1990) warn that it is important to balance sensitivity and bias. The opportunity to debrief with peers and supervisors (Lincoln and Guba 1985) assisted in maintaining this balance as it provided space in which to review and seek alternative views regarding the emerging concepts.

FINDINGS

Context

Participants included in this study were registered nurses (RN Division 1 in Victoria), who had completed a comprehensive undergraduate nursing course, who had not completed specialist psychiatric nursing education and who were in their second year of experience in a health care setting that provided general or specialist medical or surgical care as its primary focus. Participants were assigned a pseudonym as follows (table 1):

Participants considered that their comprehensive undergraduate education gave them general and psychiatric nursing qualifications yet they perceived themselves primarily as general nurses:

To be honest I classify myself only as a general nurse because I don't know anything about psych ... I have heard some people say, 'well you know, you are psych trained as well'. I'm not really. (Helen)

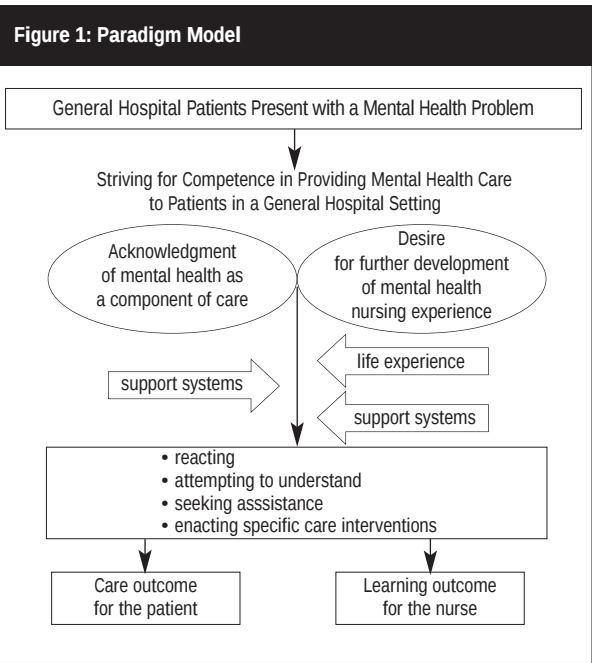


Table 1: Participants				
Psuedonym	Sue	Sarah	Helen	Karen
Undergraduate Education	Rural university	Metropolitan university	Metropolitan university	Rural university
Employment	Rural public hospital	Metropolitan public hospital	Metropolitan public hospital	Metropolitan private hospital
Age	24	23	23	23
Experience Since Registration	15 months	15 months	16 months	18 months

The participants perceived they had increased exposure to the theory and practice of psychiatric nursing and considered themselves as better equipped than nurses educated outside the comprehensive course.

The experiences of caring for a patient experiencing a mental health problem described by the participants occurred on cardiac, neurology, orthopaedic, paediatric and rehabilitation units. One participant cited experience in a private general hospital, the remainder in public metropolitan and country general hospitals. The work environments were usually busy with a dominant focus of attention on physical aspects of care. However, the participants recognised that it is impossible to separate the mind from the body. The work setting made it difficult to incorporate mental health care into their practice and many of the experiences described highlighted this conflict, for example:

If they've got a stroke ... How do you work it out? ... What do you look after first, their mental health or their physical health? I don't know what comes first. (Sue)

The patients described had mental health problems that were either pre-existing or developed during hospitalisation. Most had multiple, complex problems of an enduring nature and displayed a range of disturbances in mental functioning. The participants had some information on the psychiatric diagnoses of the patients but generally used descriptions to depict patients' behaviours, emotions, thoughts and perceptions, as the following quote suggests:

She was fine pre-op but post-op ... with the anaesthetic and that, it sent her a bit funny and then she got worse for days and days. And then we found out that she had a psych background ... There was one morning when I looked after her and it was around 3 o'clock and she started going all funny, yelling out and holding onto the bed as if it was upside down. She was saying 'the bed's upside down, I'm falling, I'm going to fall' and she was just shaking and bright red all over. (Sarah)

Striving for competence in providing mental health care

Central to the nurses' stories was a strong sense of commitment, a genuine deep concern for patients and a desire to provide high quality care. In terms of mental health nursing, the participants recognised that their expertise was limited and they wanted to move from a reactive to a more considered approach to care. This was exemplified by Sarah who expressed disappointment at her management of an incident:

Because I had done some psych it made it a bit easier for me...but not enough to actually know what to do at the time. Take control of it I suppose...I should have known more having done the psych and general double degree ...

Acknowledgment was the term chosen to encompass the recognition and acceptance by the participants that patients in their care could have mental health problems, that these patients had a right to quality care and that as

nurses, they had a role in providing that care. Given this, participants considered patients with physical and mental health problems had a right to be cared for in a general hospital setting:

At the time I said 'why don't they just take him to [a psychiatric unit]?' Then I said, 'Don't be so stupid, he's got to be here. This is a stroke ward, he's had a stroke for God's sake!' I said it about 3 times. I was angry ... but there's no way I wanted him to go ... (Sue)

Participants' attitudes toward people with mental illness were overwhelmingly positive. They referred to their patients in a respectful and non-judgmental manner and they embraced the concept of holistic care, for example:

You can't take the (psychological) component away from someone if they've got a physical problem, and nor should you have to. I mean it's holistic care. Just because someone's got a broken leg doesn't mean that they're not going to be sitting there paranoid. (Karen)

Participants recognised their need for further exposure to psychiatric nursing, as stated:

We did psych at uni but nothing prepares you for it when it's face-to-face like that. We didn't cover enough ... You've got to have the experience as well. (Sarah)

Undergraduate education

The role that undergraduate education had in the development of expertise was echoed throughout the participants' comments. The quantity and quality of exposure to the theory and practice of mental health nursing represented the most significant factor affecting the participants' confidence in their expertise. Three of the participants were critical of their undergraduate education and believed that the mental health nursing content was inadequate to equip them to care for patients with mental health problems in any setting. Sarah described her undergraduate education as:

... mainly focussed on general. We just had little compartments of psych in it and there were a few clinical placements.

Consequently they doubted their knowledge and had limited confidence in their expertise:

I think you turn a bit of a blind eye though. You don't really address that side of it in the acute scene ... I think you are probably scared to. You don't feel as if you've got the knowledge. You sort of tend to avoid it. (Helen)

In contrast, one participant had completed an undergraduate program with a significant time allocation to mental health. She demonstrated a higher level of confidence and spoke very positively of her undergraduate program:

Fifty percent of the time was psych involved and the other 50% was general involved ... Honestly the awareness that raises is great. (Karen)

Participants considered their clinical placements as extremely valuable because they provided the opportunity to practise skills through direct contact with people experiencing mental health problems. The placements increased awareness and understanding of mental illness and the life context in which it exists and assisted the participants to connect theory with practice:

You learn more on your placements ... with your first hand experience ... And you see it right there ... like if someone's got delusions ... They [lecturers] can tell you all about that but when you get to your psych placement in an acute ward, you actually get to see the patients displaying those certain things. (Helen)

Support systems

The participants made repeated reference to the provision (or lack) of support within the busy general hospital environment. Work load, patient throughput, work organisation and the focus on physical care were factors that impacted on the participants' abilities to attend to the mental health needs of their patients. Time and resources were limited in a hospital environment that tended toward reductionism with a priority on throughput, physical care and task completion:

A lot of people on a general setting find they don't have ... the time that it takes to work with someone who's got a mental illness ... Do the quick in 'Hi how are you?' Walk out the door because they've got so many other tasks. In general settings we seem to be very task orientated. (Karen)

The availability, accessibility, quality and timeliness of support within the work system had a significant influence on the delivery of care and whether the experience described was positive or negative for the participant. Emotional, practical and educational support was valued. The sense of being able to share the load with colleagues and having somewhere to turn for advice, direction, help, validation and information were all considered important. Whilst support was sought from a range of team members, the main source was other nurses:

All support came from the nursing staff ... The thing is they're my peers, without that support it would be awful. No one to turn to for advice. (Sue)

In addition, the attitude of other staff was sometimes inconsistent with the participants' attitudes. Some colleagues shared a positive approach while others demonstrated limited commitment to attending to the needs of this group of patients. Participants gave examples of marginalisation and avoidance of patients with mental health problems with a perception that older, more experienced nurses were less likely to be committed to mental health care than younger, less experienced nurses were.

The participants described minimal access to educational resources on mental health related topics in their work areas. They were unaware of the availability of

mental health specialists to help them care for patients. The nurses in this study were junior and relied on senior staff to access expert guidance and education.

DISCUSSION

Participant responses clearly indicate that these four nurses had positive attitudes toward people with mental health problems and acknowledged mental health care as part of their nursing work. However, their stories highlight a discrepancy between the holistic philosophy encouraged at undergraduate level and what is often experienced in practice. The need to care for the mind and the body in an integrated manner was important to the participants, but they faced a work environment that focussed on the physical, and organised nursing work into tasks. In addition, their undergraduate education was fragmented with mental health and general nursing theoretically and clinically separated, for all but one.

Lawler (1991) is critical of a reductionist organisation of knowledge that separates the mind and the body because, in doing so, the person is neglected as an integrated being. Benner concurs by stating: 'We analytically separate mind and body - the psychosocial and the physical - for study and then find it difficult to recombine these components to achieve a holistic or total approach to the patient' (1984, p.48). The participants appeared to have difficulty reintegrating the fragments of their education to care for patients with multiple needs.

Three participants described low levels of confidence in their mental health nursing practice. This is concerning, as anxiety can impede further skill development. While a low level of anxiety provides motivation for individuals to learn, high anxiety can prohibit taking on new information or adopting alternative frameworks for viewing a situation (Peplau 1988). If low confidence persists, the participants may become less open to learning, more rigid in their views and less able to assist patients through hospital experiences. Lack of success in establishing and maintaining relationships with patients with mental health problems may further compound their feelings of uncertainty.

The clinical situations described were in relation to patients with multiple and complex problems. In many instances, the care demands of the patients were beyond the expertise of the participants. Other nurses were accessed for clinical support and guidance, but the nurses who the participants in this study accessed, shared similar limitations. This raises questions about the quality of mental health nursing expertise that beginning practitioners might develop if nurses with limited skills were the main resource available for guidance.

The development of psychiatric/mental health nurse consultants in general hospitals has arisen in response to recognition of the challenges faced by nurses caring for patients with psychiatric and physical co-morbidity in the medical and surgical setting. There is growing evidence

that these services can promote staff confidence, positive attitudes and improve the quality of care through the provision of advice, guidance, assistance and education to generalist nurses in relation to the care of patients with mental health problems (Sharrock et al 2006; Sharrock and Happell 2001; Gillette et al 1996; Newton and Wilson 1990; Davis and Nelson 1980). The development of these services is worthy of further research.

LIMITATIONS

This study used a very small self-selecting convenience sample and therefore cannot be generalised to other groups. It is possible that the nurses that accepted the invitation to participate in this study had a degree of commitment and some affinity toward mental health issues. Further to this, it cannot be determined whether the participants' practice was congruent with the positive attitude presented to the researcher or if their skills were as limited as they perceived.

CONCLUSION

This study adds depth to understanding the experience and challenges for beginning nurses and factors that can influence the development of mental health nursing expertise. It also supports the notion that nurses not specifically educated in mental health face difficulties when expected to care for patients with psychiatric and physical co-morbidity in a busy general hospital setting. While the findings of this study cannot be generalised, the experiences described are likely to be recognised and related to by other nurses working in medical and surgical settings.

REFERENCES

- Anderson, M. 1997. Nurses' attitudes towards suicidal behaviour-a comparative study of community mental health nurses and nurses working in an accidents and emergency department. *Journal of Advanced Nursing*. 25(6):1283-1291.
- Australian Health Ministers. 1992. *National mental health policy*. Canberra: Australian Government Publishing Service.
- Bailey, S.R. 1994. Critical care nurses' and doctors' attitudes to parasuicide patients. *The Australian Journal of Advanced Nursing*. 11(3):11-17.
- Bailey, S.R. 1998. An exploration of critical care nurses' and doctors' attitudes towards psychiatric patients. *Australian Journal of Advanced Nursing*. 15(3):8-14.
- Benner, P. 1984. *From novice to expert: excellence and power in clinical nursing practice*. Menlo Park: California: Addison-Wesley Publishing Company.
- Brinn, F. 2000. Patients with mental illness: general nurses attitudes and expectations. *Nursing Standard*. 14(27):32-36.
- Clarke, D.M., Minas, H. and Stuart, G.W. 1991. The prevalence of psychiatric morbidity in general hospital inpatients. *Australian and New Zealand Journal of Psychiatry*. 25(3):322-329.
- Clinton, M. 2001. *Scoping study of the Australian mental health nursing workforce 1999*. Canberra: Commonwealth Department of Health and Aged Care.
- Commonwealth of Australia. 2001. *National review of nursing education discussion paper*. Canberra: Australian Government Publishing Service.
- Commonwealth of Australia. 2002. *National review of nursing education 2002: our duty of care*. Canberra: Australian Government Publishing Service.
- Davis, D.S. and Nelson, J.K.N. 1980. Referrals to psychiatric liaison nurses: changes in characteristics over a limited time period. *General Hospital Psychiatry*. 2(1):41-45.

- Farrell, G.A. and Carr, J.M. 1996. Who cares for the mentally ill? theory and practice hours with a 'mental illness' focus in nursing curricula in Australian universities. *Australian and New Zealand Journal of Mental Health Nursing*. 5(2):77-83.
- Feldman, E., Mayou, R., Hawton, K., Arden, M. and Smith, E.B. 1987. Psychiatric disorder in medical in-patients. *Quarterly Journal of Medicine*. 63(241):405-412.
- Fleming, J. and Szmukler, G.I. 1992. Attitudes of medical professionals towards patients with eating disorders. *Australian and New Zealand Journal of Psychiatry*. 26(3):436-443.
- Fossey, E., Harvey, C., McDermott, F. and Davidson, L. 2002. Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*. 36(6):717-732.
- Gillette, J., Bucknell, M. and Meegan, E. 1996. *Evaluation of psychiatric nurse clinical consultancy in emergency departments project*. Faculty of Nursing RMIT, Bundoora, Melbourne.
- Glaser, B.G. and Strauss, A.L. 1967. *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine Publishing Co.
- Happell, B. 1998. The implications of legislative change on the future of psychiatric nursing in Victoria. *Australian and New Zealand Journal of Psychiatry*. 32(3):229-234.
- Happell, B. and Sharrock, J. 2002. Evaluating the role of a psychiatric consultation-liaison nurse in the Australian general hospital. *Issues in Mental Health Nursing*. 23(1):43-60.
- Henderson, A.R. 1990. Nurse education in Australia-comprehensive nursing challenged. *Australian Journal of Mental Health Nursing*. 1(1):7-11.
- Heslop, L., Elsom, S. and Parker, N. 2000. Improving continuity of care across psychiatric and emergency services: combining patient data within a participatory action research framework. *Journal of Advanced Nursing*. 31(1):135-143.
- Koranyi, E.K. and Potoczny, W.M. 1992. Physical illnesses underlying psychiatric symptoms. *Psychotherapy and Psychosomatics*. 58(3-4):155-160.
- Lawler, J. 1991. *Behind the screens: nursing, somology and the problem of the body*. Edinburgh: Churchill Livingstone.
- Lawrence, D., Holman, C.D.J. and Jablensky, A.V. 2001. *Preventable physical illness in people with mental illness*. Perth: The University of Western Australia.
- Lincoln, Y. and Guba, E.G. 1985. *Naturalistic inquiry*. Beverly Hills: Sage.
- Mavundla, T.R. and Uys, L.R. 1997. The attitudes of nurses towards mentally ill people in a general hospital setting in Durban. *Curationis: South African Journal of Nursing*. 20(2):3-7.
- Mayou, R. and Hawton, K. 1986. Psychiatric disorder in the general hospital. *British Journal of Psychiatry*. 149:172-190.
- McLaughlin, C. 1994. Casualty nurses' attitudes to attempted suicide. *Journal of Advanced Nursing*. 20(6):1111-1118.
- Mental Health Branch, Victorian Government Department of Human Services 1998. *Undergraduate nursing education in Victoria: psychiatric knowledge, attitudes and skill requirements for beginning level Division 1 nurses*. Melbourne: Aged, Community and Mental Health Division, Victorian Government Department of Human Services.
- Minichiello, V., Aroni, R., Timewell, E. and Alexander, L. 1995. *In-depth interviewing: researching people* (2nd edn). Melbourne: Longman Cheshire.
- Muirhead, J. and Tilley, J. 1995. Scratching the surface: mental health training for rural health workers. *Australian and New Zealand Journal of Mental Health Nursing*. 4(2):95-98.
- Newton, L. and Wilson, K.G. 1990. Consultee satisfaction with a psychiatric consultation-liaison nursing service. *Archives of Psychiatric Nursing*. 4(4):264-270.
- Nurses Board of Victoria. 2002. *Review of mental health/psychiatric nursing component of the undergraduate nursing program: discussion paper*. Melbourne: Nurses Board of Victoria.
- Nurse Recruitment and Retention Committee. 2001. *Nurse recruitment and retention committee: final report*. Melbourne: Policy and Strategic Projects Division, Victorian Government Department of Human Services.
- Peplau, H.E. 1988. *Interpersonal relations in nursing*. The MacMillan Press: Basingstoke.
- Pollard, C. and Hazelton, M. 1999. The 'good' and the 'bad': nurses and patients who are 'troublesome'. *Looking forward, looking back; Australian and New Zealand College of Mental Health Nurses 25th Annual Conference Proceedings*. September 1999. Launceston: Australian and New Zealand College of Mental Health Nurses Inc. pp.319-325.
- Prebble, K. 2001. On the brink of change? Implications of the review of undergraduate education in New Zealand for mental health nursing. *Australian and New Zealand Journal of Mental Health Nursing*. 10(3):136-144.

Reid, J.C. 1994. *Nursing education in Australian universities: report of the national review of nurse education in the higher degree sector-1994 and beyond*. Canberra: Australian Government Publishing Service.

Royal College of Physicians and the Royal College of Psychiatrists. 1995. *The psychological care of medical patients: recognition of need and service provision*. Salisbury: Royal College of Physicians Publications Unit.

Roberts, D. 1998. Nurses' perceptions of the role of liaison mental health nurse. *Nursing Times*. 94(43):56-57.

Rogers, T.M. and Kashima, Y. 1998. Nurses' responses to people with schizophrenia. *Journal of Advanced Nursing*. 27(1):195-203.

Royal College of Nursing Australia. 1995. *Mainstreaming: mental health services*. Discussion Paper No. 3. Canberra: Royal College of Nursing Australia.

Sandelowski, M. 1986. The problem of rigor in qualitative research. *Advances in Nursing Science*. 8(3):27-37.

Sharrock, J., Grigg, M., Happell, B., Keeble-Devlin, B. and Jennings, S. 2006. The mental health nurse: a valuable addition to the consultation-liaison psychiatry team. *International Journal of Mental Health Nursing*. 15(35):35-43.

Sharrock, J. and Happell, B. 2001. The role of the psychiatric consultation-liaison nurse in the improved care of patients experiencing mental health problems receiving care within a general hospital environment. *Contemporary Nurse*. 11(2-3):260-270.

Sharrock, J. and Happell, B. 2002. The psychiatric consultation-liaison nurse: thriving in a general hospital setting. *International Journal of Mental Health Nursing*. 11(1):24-33.

Sidley, G. and Renton, J. 1996. General nurses' attitudes to patients who self-harm. *Nursing Standard*. 10(30):32-36.

Strauss, A. and Corbin, J. 1990. *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park: Sage Publications.

Wand, T. and Happell, B. 2001. The mental health nurse: contributing to improved outcomes for patients in the emergency department. *Accident and Emergency Nursing*. 9(1):166-176.

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