

CHAPTER 1

A Brief History: The Role of the Nurse in Caring for the Mentally Ill in Australia and New Zealand (Aotearoa)

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Acknowledgment

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KEY OUTCOMES

AFTER READING THIS CHAPTER, YOU SHOULD BE ABLE TO:

- understand that mental health nursing has always been fundamental to the care provided for people living with a mental illness in Australia and New Zealand (Aotearoa)
- examine more clearly the importance of mental health nursing history and how these understandings have shaped the public perceptions of mental illness
- identify some of the changes and challenges to the caring role of mental health nurses, especially those driven by the anti-psychiatry movement, along with deinstitutionalisation, mainstreaming and nurse training moving into the tertiary sector
- identify some of the major historical milestones in the treatment and care of people living with mental illness
- recognise how stigma is linked with mental illness and the role of the media
- understand the development of mental health nursing as a discipline and the caring role of mental health nurses.

KEY TERMS

- asylum
- case management
- deinstitutionalisation
- Dreaming (or Dreamtime)
- mainstreaming
- medical model
- mental health nursing
- psychiatry
- stigma
- Te Tiriti O Waitangi
- therapeutic alliance/relationship

Introduction

This chapter examines some of the complex issues of **mental health** as a topic, and more importantly the history of **mental health nursing** and the care provided to people who were mentally unwell in Australia and New Zealand (Aotearoa). First, the chapter examines aspects of the initial history of care for those deemed mentally unwell. This foundational history provides a context that will act as an introductory base to the care provided in more recent times, with a specific focus on mental health nursing care since

the 1960s. Note that the terms ‘psychiatric nurse’ and ‘mental health nurse’, and the words ‘psychiatric’ and ‘mental health’ are terms that have historical perspectives, having been used at varying times across the history of the profession, depending on when and where staff were trained and the accepted terminology of the day. The terms used in this chapter endeavour to bridge these different historical perspectives. For example, the term ‘patient’ became accepted in the 1970s, while the term ‘client’ or ‘consumer’ is now being more readily used in contemporary mental health care.

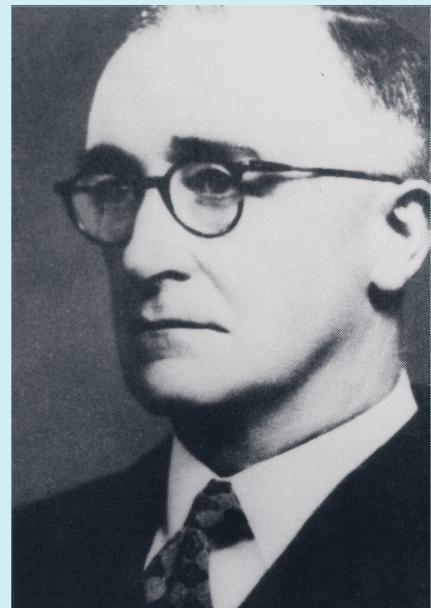
Education and training have also fundamentally changed over the past 50 years. In recent years, educational preparation for nurses has moved away from an apprenticeship style of training to a tertiary education setting, with speciality degree programs or units for mental health nursing. Today, Australian and New Zealand nurses complete comprehensive degree programs, and on graduation are recorded on a single register, with no separate register for mental health nurses. Nurses interested in working in mental health are expected to undertake post-graduate studies in mental health nursing.

Though mental health nursing is now practised in a different way, with a shift from the institutionalised asylum care model into more community-based and recovery-oriented options, stigma regarding **mental illness** is still very much alive, and nurses choosing this speciality of nursing are often influenced by it. In fact, mental health nursing numbers are in serious decline (Holmes, 2006; Grant, 2006; Sabella & Fay-Hillier, 2014; Stuhlmiller, 2005) and the advent of this in Australia and New Zealand appears to coincide with the arrival of the comprehensive degree programs and the single nursing register. The movement of nursing education into the tertiary sector has meant the slow whittling down of mental health nursing courses/units into comprehensive degrees. This philosophy is built upon a misguided idea that the skills and expertise of mental health nursing can be easily incorporated into acute medical surgical pedagogical structures. The arguments that suggest that anxiety is the same illness in a person pre-surgery and someone who is constantly fearful and hyper-vigilant is misleading, fanciful and useful only to those who hold the purse strings. The nuances of any illness and the therapeutic relationship that nurses build and use towards recovery are significant to consumer care and philosophically important to mental health nursing’s professional identity. These are matters that others will touch on or address in following chapters of this text.

History of care in Australia and New Zealand

The history of mental health nursing, and the care of those who are mentally ill in Australia and New Zealand, has not been well recorded or in any great depth. **Psychiatry** by its very nature, and by the picture it may conjure up to the general public, has remained a rather elusive, problematical, mythical and a consistently fascinating topic (Bostock, 1968). Those considered mentally ill were often institutionalised, with this care (as containment) taking place in large **asylums** that were often placed on the edges of larger towns, driven by an ‘out of sight out of mind’ philosophy. Nolan (1993) talks of the removal of the pauper insane from the community into institutions in England as having a practical utility in freeing others in their families from caring for them and thus allowing them to work. Nolan (1993) suggests that this arrangement was almost a win/win situation as it underlined the values of a bourgeois society where rationality came to be identified with work and irrationality with idleness

Figure 1.1 John Bostock



and poverty. The subsequent lack of information about the early years of mental health nursing has resulted in an absence of founding fathers and mothers, and a lack of historical role models; hence, this type of nursing has been left in a state of almost professional obscurity (Nolan, 1993). Mental health nurses are distinctive professional people and much of the care provided to those deemed mentally ill has been provided by this dedicated group. Digby (1985) adds to this point, calling asylum keepers and attendants the hidden dimension of the asylum system. Russell (1983) adds to this, saying that attendants were the backbone of the system exercising considerable influence over the lives of patients.

Few authors have chosen to examine mental health nursing beyond that of a cursory glance. Many refer to a history of psychiatry rather than examine a history of psychiatric nursing, with Shorter (1997, p. ix) describing the history of psychiatry as being like an ‘uncharted minefield’ with both literary and anecdotal evidence, suggesting that the richness and rather abstract nature of the sources make it possible to demonstrate almost anything through the use of selective quotations. The lack of any clear defining (and often rather elastic) diagnostic boundaries tends to keep psychiatry and its linkage to mental health nursing shrouded in mystery and not really topics for any in-depth critique.

Over time, the number of people deemed mentally ill continued to increase and concern was raised about these growing numbers. Nolan (1993, p. 33) suggested that in 1890 there were 86,067 officially certified cases in England and Wales. Nolan (1993) also argued that history tends to confirm the legitimacy of the service one provides; yet mere inclusion in the history of another group implies one-down subordination. Under this benchmark, mental health nursing is seen as an integral yet subordinate part of psychiatry, having its contribution mostly painted and organised by another professional discipline (mostly medical), which tends to marginalise (and in many ways disenfranchise) nursing. Clearly, both the historical and contemporary roles played by mental health nursing in the care and recovery of those who are mentally ill are both substantial and significant and there are concerns that the current educational structure is not adequate to provide the future care that is required.

Given the relatively recent European settlement of Australia and New Zealand, the history of psychiatric and mental health nursing is not as extensive as its overseas counterparts. It is apparent that many of the foundational origins related to the care provided for ‘the insane’ in Australia and New Zealand had their beginnings in English and similar overseas institutions. Carpenter (1986, p. 15) described this English heritage by saying that the Victorian image of the asylum was still prevalent in the mid 1980s, with ‘asylums likened to public sewers designed to cleanse cities of moral filth, unobtrusively removing it to a distant place where its threat to decent society could be contained’. Because of these views, asylums were seen by the general public as punishment-centred bureaucracies (Nolan, 1986) where ‘mad’ was often equated with ‘bad’ in the eyes of the community and treated in a similar fashion.

An ignorant general public

Unless directly involved in some aspect of psychiatry, the general public in countries around the world during this period tended to ignore mental illness or casually attach it to other more benevolent or charitable activities. Many chose to make fun of those who were mentally ill in the hope of hiding both its seriousness and the impact it may have on themselves, the sufferer and the sufferer’s family. This, in

many ways, is still done today despite how stigmatising this strategy is to those who are unwell. Along this same theme, ‘madness’ was often viewed in the nineteenth century as ‘possession’, usually by the Devil, but sometimes as the person being in some way touched by God.

People were often spoken of as being insane or as lunatics, thought of as idiots, invariably scorned and often tried by the courts or punished as witches or warlocks (Jones, 1972, pp. 4–9). This was probably the genesis of **stigma** and forms the basis of the stereotypical view in mental illness, whereby if we make fun of those who are mentally ill then it allows us to separate ‘us from them’ and this safeguard acts as a defence mechanism—labelling them rather than ourselves. Historians tended to record insanity based on these archetypal symbols and ideas, and were not especially interested in those who delivered the care nor the quality of care received by people with mental illness.

Understanding mental illness

Much of the literature depicts the history of psychiatry in Australia and New Zealand through the common view of the time, which tended to link mental illness to suspect metaphysical beliefs (Lewis, 1988). Insanity was often subsumed within larger disenfranchised groups, such as vagrants, petty criminals, the physically disabled and paupers: mentally ill people were often not recognised as a separate group that required special accommodation and care. As Lewis (1988) noted, the varieties of insanity from which they suffered were more easily defined as medical conditions, the preserve of a new type of medical specialist. These ‘mad-doctors’ (as they were called) not only provided specialist care but usually also administered the asylums that housed their patients (Scull, 1979). The adoption of the **medical model** in psychiatry across the world for the treatment of the insane was to remain dominant for the next hundred years (probably longer), and still sets the scene at varying levels today (Lewis, 1988). The mentally ill were physically isolated from the rest of the community in the belief that a combination of medicine and geographical distance and asylum could help to restore sanity and balance. Furthermore, insanity itself was conceptualised in a new way: moving from being thought of as being attached to metaphysical beliefs to a disease category or an entity with an underlying pathology, which would be better understood, and more accepted (it was assumed) with the advancement of medical science and when supported by nursing care (Lewis, 1988). Using a medical model to label illnesses also allowed the pathology of the problem to be more easily understood, and therefore the treatment and management of illnesses became possible with a range of pharmacological preparations. Today, the medical model is being harnessed to other theoretical inputs where models of care are tailored to the illness, and consumers are encouraged to take an active part and become more invested in their own treatment and recovery. Many of the more contemporary treatment strategies that are tailored to recovery have merit, although strategies such as consumer-centred therapy, solution-focused therapy, motivational interviewing, mindfulness, **mentalisation**, music therapy, **drama therapy**, aromatherapy and the **strengths model** need to be carefully selected and used by practitioners based on the contextual circumstances and needs of the individual person, rather than their catchy names or by cost constraints.

Nolan (1990, p. 3) suggests that in more recent years there has been a plethora of new ideas, fads and fashions about care in general, and provision for the mentally ill in particular. He rightly points out that ‘it is easy to fall into the simplistic trap of adopting a condescending attitude towards the past as we view it from the enlightened theories of the present’. Hunter and McAlpine (1974, 1992) extend this point by

arguing that to consider the past as wholly primitive and barbaric would be, and should be, considered erroneous, and that the history of the care of the insane has revealed many examples of good consumer care that were delivered on the back of profound and intelligent humanity. Anecdotal evidence from the 1960s and 1970s supports this view:

Those old arrangements were so much better than how we practice psychiatric nursing today.
At times it was a bit rough and ready, but we cared about our patients treating them as people
rather than as the illness they suffered from.

An experienced nurse trained in the 1970s (Ward, 2001)

Clearly, not all the care provided by nursing staff was of the textbook variety (and arguably still isn't), with variations of some of the day-to-day micro-skills required for good consumer care built on the accumulated wisdom and experience gained over the life of the profession and modified for more contemporary practice settings. Many practitioners used a more eclectic model of care that incorporated many of the more recent strategies mentioned above. In addition, these interventions were built on the foundational wisdom learnt across generations of nurses who imparted their skills across the apprenticeship model of training and often followed on from one generation to another, as children often followed their parents into asylum work (Nolan, 1993).

English principles and practice in the Australian and New Zealand context

English principles and practice in the late eighteenth century and across the nineteenth century continued to be influential in the Australian and New Zealand context. However, the law, administration and systems of care were gradually shaped by the colonial experience—first, by the penal character and autocratic government of the early settlement, and later by the values of a more confident bourgeois society (Lewis, 1988). Lewis suggests that the 'principles and practice' and the 'law, administration and systems of care' were less intimately linked than one might have expected, arguing that the shaping of the approach, which was essentially English, was templated on the context of the colonial experience. However, the limited depiction in the literature regarding this shaping (Bostock, 1968) suggests that it could almost be the other way round. It appears that British laws and administration systems were quickly modified to suit the Australian and New Zealand situations, taking into consideration location, size, geography, environmental issues, climate and the local inhabitants. These changes were accepted in the absence of any suitable alternatives because there were no government officials to carry out the laws, or arbitrate their suitability in any way. There were limited physical facilities in which to detain prisoners or deal with the insane (criminals and the mentally ill were often housed in the same sites, promulgating the 'bad equals mad' maxim) and with no judiciary in rural areas, a country policeman was often the law and the mentally ill were at the mercy of local officials. On this basis, any care was dispensed on the premise that anything is better than nothing. Under these parameters there was also often a custodial basis or nature to this care.

Bostock (1968, p. 9) states that 'Australia began its life beset with some of the problems of the older world'. By implication, 'New Zealand fared under the same arrangements' (Elder, 2009, p. 47). According to records from the Porirua Hospital Museum (n.d.), the beginning of mental health services in New Zealand occurred in 1844 when an advertisement appeared in the *New Zealand Gazette* and *Wellington*

Spectator calling for tenders to construct temporary wooden buildings for the insane in Wellington. This signalled the building of a pauper lunatic asylum attached to the Wellington jail. However, there was a growing awareness that the mentally ill were a group needing special attention and that their care was not appropriate for a penal institution, and there developed a public demand that they be housed separately in an asylum, as a place of refuge, separate from jails and ordinary hospitals. The first legislation concerned with the mentally ill in New Zealand was the Lunatics Ordinance of 1846, which, among other considerations, provided that after certification a mentally ill person could be sent to a jail, house of correction or public hospital; or alternatively to a public colonial asylum, although no such institution existed at that time. This represented a step forward in the development of special services for the mentally ill in that it envisaged state provision of services and was available to every person in the community (Porirua Hospital Museum, n.d.).

Building different provisions for criminals and the mentally ill was also part of the development of care in both Australia and New Zealand, as evidenced by the design of Sydney's Tarban Creek Asylum (Gladesville Mental Hospital; see Figure 1.4) by William Lewis (1834–37), which was adapted from contemporary British plans. These British designs were significant across Australia, with the Yarra Bend

Figure 1.2 Porirua Psychiatric Hospital (1910)



POTIRUA ASYLUM

Figure 1.3 Tarban Creek Asylum (Gladesville Mental Hospital)



Figure 1.4 Yarra Bend Lunatic Asylum



Lunatic Asylum in Victoria (see Figure 1.5) exemplifying this point. The illustrations demonstrate how similar the structures of asylums in Australia and England actually were. Yarra Bend, Melbourne (Figure 1.5) and St Georges Hospital (Figure 1.6) in Stafford clearly have a similar design.

Another consideration is indigenous cultural issues; these are significant in both Australia and New Zealand, and are based on different understandings that fall outside the culture shaped by Anglo-centric colonisation. The approach to culturally sensitive practice in both Australia and New Zealand has evolved separately, reflecting different historical backgrounds to the relationships between indigenous peoples and settlers (Bradley & De Souza, 2013). Māori are the indigenous people of Aotearoa/New Zealand, whose relationship with Pakeha

(non-Māori) is defined in Te Tiriti O Waitangi (the Treaty of Waitangi)—a document signed in 1840 by the British Crown and Māori chiefs. Te Tiriti forms the basis for biculturalism: an equal partnership between the two groups in which the Māori are acknowledged as tāngata whenua (people of the land/Earth) and the Māori translation of Te Tiriti O Waitangi is acknowledged as the founding document of Aotearoa/New Zealand (Wood, Bradley & De Souza, 2009). Indigenous populations in both Australia and New Zealand go about their daily lives in a range of ways different from non-indigenous groups; because of this, and a host of other considerations, care delivered by mental health providers needs to consider these different beliefs and perspectives. Tāngata whenua for the Māori and the **Dreaming (or Dreamtime)** for Australian Aborigines need to be considered within any nursing care and/or medical treatment package provided (Awty, 2013). To avoid these considerations would be counter-productive and therapeutically unwise.

Figure 1.5 St Georges Hospital, Stafford



<https://aturnoftheky.com>

Psychiatry as a topic is often represented from an English perspective by examining the care delivered at the facility popularly known as 'Bedlam'—St Mary's of Bethlehem in London. Built in 1247, Bethlehem had a controversial history, but its practices and approaches were used as the blueprint for much of the Australian and New Zealand mental health systems. Bethlehem has always had its defenders and attackers. Since some of the early records of the hospital have now been destroyed, records are largely dependent on partisan accounts of the treatment at this time. *The Story of Bethlehem Hospital* (O'Donoghue, 1913) was written by the hospital chaplain, who outlined a range of disturbing issues related to hospital life. These issues included using Bethlehem inmates as a source of amusement for the general public, who paid for this entertainment. This payment probably went to the attendants. A poem, which was said to describe life at Bethlehem (Jones, 1972, p. 14), was written by J. Clark in 1744 and sold to visitors:

... to our Governors, due praise be giv'n Who, by just care, have changed our Hell to Heav'n.

A Hell on earth no truer can we find than a disturbed and distracted mind.

... our learned Doctor gives his aid, and for his Care with Blessings ever paid, This all those happy Objects will not spare who are discharged by his Skill and Care.

Our Meat is good, the Bread and Cheese the same, our Butter, ... Beer and Spoon Meat none can blame. The Physic's mild, the Vomits are not such, But, thanks be prais'd, of these we have not much. Bleeding is wholesome, and as for the Cold Bath. All are agreed it many Virtues hath. The beds and bedding are both warm and clean, ... Which to each comer may be plainly seen, Except those rooms where the most Wild do lie.

Excerpts such as these perhaps summarise how the general public felt about insanity, but did little except to deter them from being involved or to change their understandings of what it would be like to be ill in such a facility—they served only to make people wary of what insanity may mean or entail. Manning (1880) makes similar reference to conditions across the care offered in New South Wales in Australia, while Digby (1985, p. 4) takes up the issue of insanity having a marketable value:

From the mid seventeenth century onwards, certain individuals began to make a living from insanity through the development of private madhouses. But it was not until the middle of the eighteenth century, when there was an appreciation that the mad could be managed, rather than brutalised, that different kinds of provision for the insane could develop.

Nolan (1993, p. 45) argues that the emergence of the asylum system in England was in response to threats posed by problems of the lower class, which involved both moral and paternalistic attitudes, and that there was an 'increasing power of the State over the lives of individuals in the mid-19th century. Although asylums wrapped their aims in medical rhetoric, as state-funded institutions their purpose was essentially social and lay in welfare administration'. Nolan (1993, p. 45) also stated

Figure 1.6 St Mary's of Bethlehem



Drawn by Thos H. Shepherd.

Engraved by J. Tingle.

NEW BETHLEHEM HOSPITAL, ST. GEORGE'S FIELDS.

that the 'idealists who had hoped that the newly built institutions would be hospitals where mentally ill patients could be protected from the hostility of society, were rapidly disillusioned'. This idealist view went to the provision of care to those who were mentally ill in the 1800s and early 1900s in England. Scull (1979) proposes that social class may well have contributed to this issue, suggesting that humanitarian attitudes held by nineteenth-century upper-class Evangelicals and Benthamites were really the views that the dominant class had towards those lower down the social structure. Since the establishment of the asylums and the introduction of carers to work within them, attendant care (or nursing) has always found itself sandwiched between those in pursuit of scientific certainty in the diagnosis and treatment of mental disorder and those whose pragmatic approach to psychiatric institutions has seen them 'merely as centres for the dispensation of welfare [calling them workhouses]' (Nolan, 1993, p. 5) and the instigators of social control. These foundational benchmarks, whereby all institutions were locked and overseen by what were then called 'turnkeys' under the medical model regime, have probably set the scene for how mental health nursing is thought about and practised today in the UK, USA, Australia and New Zealand.

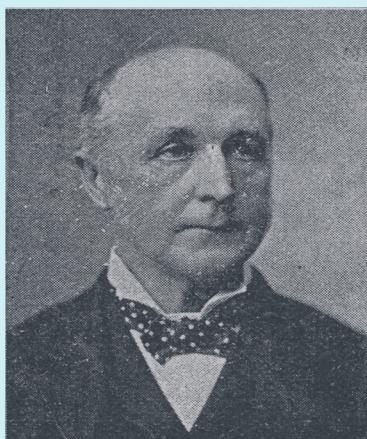
The role of the attendant from the start of the asylum system was determined initially by the medical profession who assumed responsibility for the selection, supervision and termination of employment of attendants, but also realised that the success of the asylum system was dependent on these attendants. In 1841, Dr Kirkbride from Pennsylvania Hospital for the Insane prepared a manual for attendants in which he spelt out the requirements for a good attendant. He spoke of a high moral character, a good education, strict temperance, kind and respectful manners, a cheerful and forbearing temper, with calmness under irritation, industry, zeal and watchfulness in the discharge of duty and above all sympathy that springs from the heart. Dr Kirkbride was forced to acknowledge that finding such upright individuals to work in asylums would not be easy. Further to these qualities for a good attendant came an interpretation of the role of attendant, which incorporated the attendant as a rule keeper, an enforcer, a servant to the patients, a spiritual guide and an intermediary between doctor and consumer.

Australian psychiatry was originally overseen by Frederic Norton Manning and written about by Tucker (1887). Manning sought advice from clinical practice overseas with the view of introducing to

Australia what was thought to be good psychiatric practice. Good practice at that time was benchmarked on the medical control of asylums for the insane and was viewed by Lewis (1988, p. 27) as being instrumental in the setting up of 'specific training requirements of nursing staff'. Norton Manning, who was appointed as medical Superintendent of Tarban Creek Asylum in 1868, toured a range of asylums in Australia and internationally to see what was considered standard practice in psychiatric care in counterparts elsewhere.

Manning was particularly critical about the condition of the Parramatta asylum, suggesting that 'the buildings at Parramatta were utterly and completely unfit for the purpose for which they are at presently employed' (Manning, 1868, in Smith, 1999, p. 15). Manning argued further that no amount of money would render them adequate, and that the asylum should be abandoned and a new asylum be erected. Manning also suggested that many new asylums should be constructed in country areas and they should resemble what was on offer in England under the guidance of William Tuke at the York Retreat: a pioneering, more open, different, more recovery-based option that had the beginnings of a facility based on humanitarian principles.

Figure 1.7 Frederic Norton Manning



 CRITICAL THINKING OPPORTUNITY

- 1 How do you think psychiatry or mental illness as topics are represented in the media?
- 2 How do you think the past has contributed to the emergence of stigma experienced by people who are mentally ill?
- 3 What keeps that stigma alive and well today?
- 4 Did locked mental health facilities keep patients safe or were they designed to keep the general public safe?

By the end of the Second World War a range of pharmacological treatments had emerged, including a range of antipsychotics and antidepressants. The introduction of new pharmacological measures began gathering momentum in the 1950s and 1960s, and saw radical changes in the care and treatment of people with a mental illness. Pharmaceutical management meant that there was less reliance on physical restraint and increased opportunities for mental health nurses to engage with consumers therapeutically. The concept of the psychiatric hospital as a therapeutic community, where nurses took 'a personal interest in and formed a healthy relationship' with consumers (Sainsbury, 1968, p. 20), was incorporated into the education and training of mental health nurses. Education programs included the topics of psychology, psychiatric/mental health nursing, sociology and rehabilitation, as well as anatomy and physiology, medical and surgical nursing, and pharmacology. These programs moved away from what Sainsbury (1968) viewed as the previous authoritarian approach to the care of the mentally ill. The usage of medications allowed mental health care to emerge and complemented a range of skills given to mental health nurses through their specialist training. These centred on the therapeutic relationship and the development of working alliances with consumers, which assessed consumers along recovery-based principles that had improvement of overall functioning as its cornerstone. These new therapeutic strategies brought to the fore the theoretical approaches constructed by key mental health pioneers such as Hildegard Peplau and Joyce Travelbee, where mental health-care professionals began to see the merits of rapport building, empathy, understanding, keeping consumers safe, improving self-esteem, insight and milieu, plus employment-related activities as all foundational to recovery and moving consumers forward.

Aside from having a complementary relationship with the pharmacological regimes prescribed by the psychiatrist, these activities also added to the treatment options contained within the different Mental Health Acts (in both Australia and New Zealand), which included involuntary options for consumers that incorporated seclusion, or treatment strategies such as electro-convulsive therapy.

Peplau (1962) viewed mental health nursing as a therapeutic and interpersonal process, believing that the nurse–consumer relationship was the crux of mental health nursing. Through this relationship, the nurses use themselves as the therapeutic instrument or as travelling companions to consumers. That is, the nurse engages with

Figure 1.8 Hildegard Peplau



Figure 1.9 Joyce Travelbee



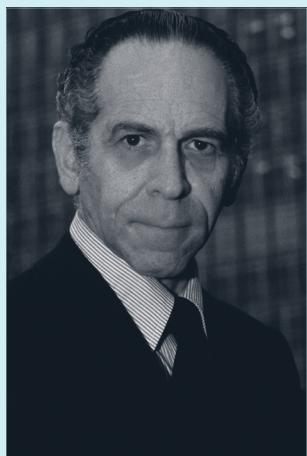
consumers through a variety of psychosocial interventions to facilitate personal growth on the part of the consumer. This concept moved the idea of nursing practice to one of 'being with' a consumer rather than 'doing things' to them. This last point implied a much more active and interactive dialogue between nurse and consumer (Barkway, 2009). Peplau (1962) also proposed the therapeutic relationship passed through a number of phases that evolved from the initial contact through to discharge. Peplau identified these phases as the orientation, working and resolution phases, and saw each stage as a building block to the consumer's recovery. In order to maximise their work with consumers, Peplau (1962) proposed that nurses assume a variety of roles at different times, in response to the emerging needs of the individual. The collective activities were arranged to produce the best possible outcome for the consumer despite, of course, not many consumers or their relatives enjoying some aspects of this treatment.

The anti-psychiatry movement came to the fore in the 1960s and was really a movement that questioned and challenged the fundamental claims and practice of mainstream psychiatry. This movement was promulgated on the basis that mental health treatments were thought to be ultimately more damaging than helpful to patients. Rather than being compassionate medical practice, it was seen as a coercive instrument of oppression and social control involving an unequal power relationship between doctor and consumer, and a highly subjective diagnostic process, leaving too much room for opinion and interpretation. R D Laing, Thomas Szasz and Michel Foucault all challenged the very basis of psychiatric practice and cast it as repressive and controlling. This movement incorporated a range of views promulgated via professional bodies, the mass media and myriad activist organisations. Laing, Szasz, Theodore Lidz and Franco Basaglia in varying ways argued that mental illness was best described as an inherently incoherent combination of medical and psychological concepts. These arguments opposed the use of psychiatry to detain and treat, or excuse what they saw as mere deviance from societal norms or moral conduct. Many other notable authors made contributions to this debate, including Erving Goffman, Gilles Deleuze and Félix Guattari, and Thomas Scheff, with these authors suggesting that

psychiatry was variously stigmatising, an instrument of social control and an option that afforded the consignment of a label that people then often self-fulfilled, and was (because of these) morally wrong. The media influenced this movement and this influence was bolstered by the novel and film *One Flew Over the Cuckoo's Nest* (Kesey, 1962; Forman, 1975) where involuntary admission, involuntary treatment, lobotomy and shock therapy, plus the acerbic nature of Nurse Ratched, added weight to the arguments put forward by the anti-psychiatry movement. The image of Nurse Ratched (see Figure 1.13) as a jailor remains indelibly printed in the minds of many members of the public when they think about the role of mental health nurses.

Running concurrently with these issues was the increasing emphasis on the social rights of the individual, with statements regarding changes to health-care delivery generally—and mental health care in particular—being considered with an emphasis on every person suffering from a mental illness having their civil, political, economic, cultural and social rights recognised (as in the UN Universal Declaration of Human Rights) and protected by the various state and territory Mental Health Acts (*Mental Health Coordinating Council*, 2011). A range of authors alerted the mental health profession that change in mental health care was coming, with Holland (1978),

Figure 1.10 Thomas Szasz



 CRITICAL
THINKING
OPPORTUNITY

- 1 Is psychiatry an instrument of social control? Give two reasons to support your answer—agreeing or disagreeing.
- 2 When considering movies about mental illness, what role do you think this has in such things as stigma of, and discrimination towards mental illness and the mentally ill?

Figure 1.11 *Nurse Ratched, One Flew Over the Cuckoo's Nest*



Habibis and colleagues (2003) and many others suggesting that mental health-care services outside hospitals was the future. The primary focus for mental health nurses at that time was perceived as containment and being focused on the behaviour of consumers as a response to the emotional and personality changes resulting from mental illness. Alchin and Weatherhead (1976) developed their text on mental health nursing with the premise that ‘psychiatric nurses in training needed to know/have a range of skills about what to do in specific situations which they would be confronted with in the ward environment and similarly, in the community’ (Shea, 1976, p. i). The caring role of the mental health nurse was grounded in helping consumers deal with their reactions to the symptomatology of their illness (Alchin & Weatherhead, 1976).

The approach to care and the roles of mental health nurses continued to develop through **deinstitutionalisation**, the advent of nurse-independent practitioner roles, the prescribing options afforded some practitioners and the modifications made to the various Mental Health Acts (Australia and New Zealand), which endorsed a more community and recovery orientation to care. **Case management** and **mainstreaming** were both policy initiatives of the 1980s and 1990s, while a range of mental health strategies and the Burdekin and Richmond reports in Australia shifted the practice of mental health nursing care away from the traditional institutions. The promise of the Burdekin report was that the

dollars would follow the consumer from institution to the community. Those in clinical practice at the time know that this wasn't the case and many patients moved from the asylum to unsupported bedsits or makeshift shelters. This shift for some did provide what might be described as reasonable acute care in medically oriented services within a few hospital settings as part of their deinstitutionalisation, and embodied the rhetoric of what Burdekin called improved community oriented and supported service provision. However, this was not the trajectory for far too many who tried to fend for themselves once this health reform came into place. Many nurses also found these changes difficult, which slowed the acceptance of these policy changes across the health-care sector; indeed, it is arguable that they still have some way to go before being totally accepted by current practitioners (Sharrock & Happell, 2000) as this push by public mental health services to 'mainstream' the care of individuals experiencing mental illness has had its problems. This health reform means the provision of services for people who are mentally ill are treated within the current general health system rather than in a specialist mental health, publicly funded hospital. In consideration of this, many comprehensively trained nurses who provide care to these individuals tend not to have a wide-ranging understanding of the problems and needs of people experiencing mental health problems (Sharrock & Happell, 2000; Fleming & Szmukler, 1992). Consequently, many nurses tend to avoid in-depth contact with people/patients experiencing mental health problems because of fear and a sense of powerlessness due to a knowledge gap. This feeling of powerlessness goes to preparation of skills (Happell & Platania-Phung, 2004; Gillette, Bucknell & Meegan, 1996). This is obviously an area for improvement in the current health-care system and not what the architects of deinstitutionalisation and mainstreaming had in mind when these schemes were introduced.

While these policies initially promulgated the role of the general practitioner in providing treatment, and also had some benefit in reducing stigma and curtailing the excesses of some treatment practices in the older, more isolated, stand-alone mental health facilities, more broadly they have been a failure. 'Mainstreaming' as a term is full of rhetorical promise, but the reality produces a range of what might be described as unintended consequences. The mainstreaming of mental health service reform in the 1990s tends to miss the unique needs of individuals suffering mental illness and does not fully appreciate and provide for these people with regard to access to services. This last point has led to a secondary marginalisation of mentally ill people in general health services.

CRITICAL
THINKING
OPPORTUNITY

- 1 What do you think nursing care contributes to reducing discrimination against people with mental illness?
- 2 What are the factors to consider in your assessment of this question?

Caring and the mental health nurse

As Happell (2007) points out, the history of mental health nursing differs significantly from that of other branches of nursing. For example, there is the clear influence of iconic figures such as Florence Nightingale and Lucy Osborne on the development of nursing services in the colonies (Bessant, 1999). Historically, the care of people with mental illness has been a completely different matter. Caring attitudes and actions

cannot be specifically defined or prescribed—they depend on the unique circumstances surrounding each event because caring is always/should always be understood within a context (Warelow, 1996). For example, if technical expertise is needed, then knowledgeable technical care is experienced as caring. Similarly, curative methods of practice can and should be harnessed under a more caring framework, because before caring behaviours can be displayed there must be a combination of the personal values, ideas and beliefs to which the carer is committed, as well as his/her cognitive and technical competencies (Shiber & Larson, 1991). For mental health nursing, this means that personal qualities must be fused with nursing skills.

Benner (1984) emphasises the ability of the expert nurse to be able to combine these components in daily practice. Her premise is that experience allows nurses to move through stages from novice to expert based on developing experience (using an intuitive base), rather than relying on formal theoretical models. Benner advocates that a mental health nurse should be able to notice problems, suggest solutions and implement strategies, with each case cared for on the merits and contextual circumstances at play. Some might call this intuition, but others say it is a learnt or constructed skill (Peck, 2013).

The mental health nurse must then, as part of nursing care, evaluate the effectiveness of the strategies used; that is, the nurse's 'commitments to the client as a person could/should take precedence over the nurse's commitment to the client's treatment goals' (Morse et al., 1990, p. 10). Another difficulty for the mental health nurse in forming an interpersonal relationship with consumers is the call by peers to avoid personal involvement. For many health-care professionals, personal involvement conflicts with the traditional view of remaining objective and is therefore considered unprofessional in some quarters. Health professionals share the concept that failure of objectivity decreases the accuracy of diagnosis, the correctness of treatment decisions and the success rate of procedures (Curzer, 1993). Looking at the concept from the consumer's perspective, a transpersonal or interpersonal relationship could still present problems, such as in a situation where the consumer dislikes the nurse, as this must be preclusive to developing rapport and moving into successful nurse–consumer relationships. Some consumers are embarrassed by the intrusive invasion of privacy often necessary in nursing treatments, and for their own self-esteem prefer the mental health nurse to focus on the task rather than themselves. These consumers may resent the need to become an object of significant emotional attachment in order to receive care (Curzer, 1993).

When a person is asked what they do for a living, it is common to hear them refer to their position title; for example, 'I am a nurse'. Explaining what a nurse does is usually described in terms of their place of employment, specific tasks or functions, who they work with and perhaps examples of their work. What people are actually describing is their role (Hercelinskyj, 2010). Caring is argued to be an activity that is central to the role of nurses generally (Henderson et al., 2007; Watson, 1988) and the term 'caring' could almost be said to be interchangeable with the term 'nursing'. The caring role of nurses in mental health has also been explored, with Warelow and Edward (2007) suggesting that the demands of mental health nursing today extend well beyond the more traditional skills of care and caring; and that in order to meet mental health needs in the twenty-first century, caring should be extended to encompass the additional expertise of emotional intelligence, praxis and resilience. Emotional intelligence, praxis and resilience have the potential to assist individuals to transcend negative experiences and transform these experiences into positive self-enhancing ones. This has implications for improved consumer outcomes through role-modelling and educational processes, but also may hold implications in supporting a strong workforce in mental health nursing into the future.

Generally speaking, caring in nursing is in itself not that hard to do. However, with changes to the nurse role, educational preparation and the effects of community-based care—which means dealing with more acutely mentally ill consumers and having a quicker turnover of consumer numbers—the caring role is becoming more complicated and confounded by myriad day-to-day circumstances that come into play related to the context of the care required. Some argue that the ability to care is inherited and then often built on via parents and other close loved ones; others suggest consistency in caring; while still others suggest caring can be taught (Dunlop, 1986). I suggest here that caring is not simply a set of identifiable attitudes or rules such as sympathy or support; nor does it comprise all that nurses do. Instead, as Morse and colleagues (1990) suggest, caring combines both attitudes with action in the carer's commitment to maintaining a person's dignity and integrity. Nursing care is determined by the way a nurse is able to use knowledge and skills to appreciate the uniqueness of the consumer, and physically and emotionally assist and apply this knowledge and skill to the individual merits and intricacies of the particular circumstances. For example, if someone is unconscious we physically care for and about the consumer and/or their family and friends. Similarly, if our consumer is anxious we care for them and their family in a more emotionally supportive way to overcome their anxiety. In this sense, caring will always be fundamentally variable across a range of differing yet similar themes.

Florence Nightingale advanced the view that nurses needed to assist patients and put them in the best place to allow nature to work and heal (Nightingale, 1863). Orem (1991) also encouraged nurses to promote self-care and to help people to help themselves—working with patients instead of for them. This shift is significant from the traditional approaches. Barker and Buchanan-Barker (2006) likewise suggest that we should begin recovery from day one of treatment and that consumers need to be instrumental in their own care; and thus nursing care along these lines is more 'doing with' than 'doing to'. This type of care invests in the consumer and this investment empowers the consumer throughout the illness–health continuum. This would mean that the many different theories attached to the formats in which care takes place actually change how care is delivered—with care also being modified on multiple perspectives outside of the practitioners who deliver it (Stockdale & Warelow, 2000). McCormack and colleagues (2002) suggest that we all should blend these types of care options and base the delivery of care within the context of the circumstances in which people and their nurses find themselves.

By not responding to the relationship, will consumers compromise the care they receive or deny themselves good-quality care? The concern here is that if a relationship is not built, or seen as important by the consumer, the nurse or the educational sector, then surely this has implications for therapeutic potential in consumer outcomes. Caring for another involves a level of emotional labour on the part of the carer—in this case, the mental health nurse. A study undertaken by Sourdif (2004) suggests that satisfaction at work and satisfaction with administration are the best predictors of intent to stay at a particular nursing job. Use of self, including the emotional self, is important in establishing a therapeutic nurse–consumer relationship, but carries the risk of burnout or vicarious trauma if prolonged or intense (Sabin-Farrell & Turpin, 2003). Caring in mental health nursing is complex and requires clear boundaries while forging an alliance with consumers to facilitate an intimate dialogue of often extremely sensitive personal information.

The modern mental health nurse uses the self and their history in therapeutic interactions. We call this using emotional intelligence, which in many ways is what we encourage our consumers to adopt in relation to their mental health issues (Warelow, 2005; Sánchez-Álvarez et al., 2016). The therapeutic use of self involves using aspects of yourself—such as your personality, experience, knowledge of mental

illness, and life skills—as a way of developing and sustaining the therapeutic relationship with consumers. A consumer needs to feel trust and safety in order to disclose sensitive information about himself or herself to another person; importantly, the consumer may not have spoken about this sensitive material to another person before. Therefore, the beginnings of the **therapeutic alliance/relationship** are critical to the establishment and maintenance of the caring relationship. This therapeutic alliance between the mental health nurse and the consumer is one that can be emotionally charged and often challenging for the mental health nurse. The modern demands of mental health nursing requires nurses to draw on the skills of resilience to meet the needs of direct consumer care within the framework of a therapeutic alliance (Edward & Warelow, 2005; McQueen, 2004; Cleary, Jackson & Hungerford, 2014).

The research literature also demonstrates that consumers value the therapeutic potential of the nurse–consumer partnership. Key elements are identified as clear communication, empathy, trust and cultural sensitivity. Concerns are also raised with regard to consumer autonomy; notably, that there be an absence of any coercion (Gilbert, Rose & Slade, 2008; Langley & Klopper, 2005; Williams & Irurita, 2004). While it appears that consumers share a similar view as to the importance of the mental health nurse's caring role, Norman and Ryrie (2009) believe that the caring role and identity of the mental health nurse has been shaped by two distinct and at times conflicting traditions in relation to their caring role. These arguments centre on the 'artistic interpersonal relations tradition' of mental health nursing—in which the therapeutic relationship assumes the central position in relation to how mental health nurses enact their role—and the 'scientific tradition with the delivery of evidence-based interventions that can be applied with good effect' (Norman & Ryrie, 2009, p. 1537). Within mental health nursing, Gournay (1995, 1996) dismissed psychoanalytic understandings and nursing knowledge, such as Peplau's ideas (1962), as outdated relics, presumably because they were not supported by empirical evidence. Gournay argued that community mental health nurses needed to embrace specific knowledge, such as information processing theory, neuropsychology and attribution theory, to meet local context needs, and simultaneously be 'sensitive and responsive to the needs of individual users and their carers and families' (Gournay, 1995, p. 14). However, he appeared to qualify his remarks regarding the biological model when he stated that the biological approach is one approach to the care and treatment of people living with mental illness and cannot be divorced from other models, but that 'a humane approach to all patients, regardless of the problem, must be paramount' (Gournay, 2006, p. 345).

There are also a number of other factors that create or perpetuate tensions in relation to the caring role of mental health nurses. These factors relate to the stigma attached to mental illness and the association of nurses with such an area of health, the perceived image of mental health nurses and the overreliance on the medical model at the expense of broader psychosocial responses (Hazelton et al., 2011). Another factor is role conflict created by the tension between legislative requirements related to the treatment of people experiencing mental ill health and the expectations of mental health nurses based on their professional socialisation and education.

Authors such as Halter (2002) and Humble and Cross (2010) suggest that the role and identity of mental health nursing is inextricably linked to psychiatry and public perceptions of mental illness, which remain largely stigmatised (Adewuya & Oguntade, 2007; Halter, 2002; Overton & Medina, 2008). Additionally, health professionals are no less likely to share stigmatising views than the general population towards people living with mental illnesses (Björkman, Angelman & Jonnson, 2008; Rao et al., 2009). The public does hold perceptions about who nurses are and what they do. Some researchers have hypothesised that these social perceptions, together with media representations and professional

attitudes, converge and stigmatise mental health nurses through a negative association with mental illness (Aber & Hawkins, 1992; Bridges, 1990; Brodie et al., 2004; Fiedler, 1998; Gordon, 2001; Kalisch, Kalisch & McHugh, 1980; Takase, Maude & Manias, 2006).

Morrall (1998) and Morrall and Muir-Cochrane (2002) have drawn attention to what they describe as the fundamental issue that impacts on the caring role of mental health nurses. This is the constant tension between the therapeutic intent of the mental health nurse's role and interaction with consumers, and the legislative demands that govern involuntary admission and enforced treatment of the seriously unwell. Continuous changes to the economic policy and legislative mandates of varying governments and, increasingly, better-informed health-care consumers (Hardy & Hardy, 1988) can create role conflict for the nurse because there is a dissonance between the professional nursing role and competing organisational requirements, fiscal considerations and legislative demands (with one often getting in the way of the others).

Hazelton and colleagues (2011) also argue that the medical model remains the dominant focus of health-care policy. This dominance on curing and concomitant reliance on pharmaceutical treatments relegates broader approaches to working with consumers to a more marginal or adjunct status (Hazelton et al., 2011). This view is reinforced by an experienced mental health nurse who argues that mental health nurses are all working with a narrower skill and knowledge base, fewer role models and more of a focus on the medical model that is the predominant paradigm in the world of mental health; further, there's been a huge shift away from anything that's psychotherapeutic (Hercelinskyj, 2010).

Clearly, mental health nurses need to learn from history or in some ways be cognisant of what it means and entails. In this, history needs to inform what we do now, where mental health nursing learns by its mistakes. Further, those who hold the purse strings and those who make uninformed policy decisions that have no relevance to contemporary practice need to recognise errors made and move this profession in a new direction. This new direction needs to learn from history and provide quality care for those it is there to help.

**CRITICAL
THINKING
OPPORTUNITY**

- 1 Why is it important to learn about the history of caring in mental health nursing's development as a discipline?
- 2 Is care the same for an anxious consumer as someone anxious about a fractured neck or femur?
- 3 How does this knowledge assist you in developing an understanding of the mental health nurse's caring role and any tensions within this role?

Some commentators have argued that mental health nursing has been experiencing an identity crisis (Holmes, 2006). This crisis has been brought about by a whole series of factors, including biomedicalisation and education issues, and these have led to a steady decline in graduate numbers of those showing interest in mental health nursing and the subsequent recruitment and retention of staff. History clearly demonstrates that the significant decline in numbers of graduates coming into this speciality area of nursing practice, with 6434 females in clinical practice and 6058 males in Victoria in 2002 (Nurses Board of Victoria, 2002). These figures, which have not improved over the intervening years,

clearly highlight that in Australian and New Zealand there have been significant and poorly thought-out changes to the ways in which mental health nurses are recruited and educated. The trajectory of these changes was sealed over 25 years ago, when professional nursing organisations expressed support for a change to ‘comprehensive’ courses located in the tertiary education sector. With the benefit of hindsight, these decisions have been instrumental in the deleterious position of mental health nursing today.

The future for mental health nursing is to clearly define and take ownership of nursing’s contribution to the treatment and recovery of people who are mentally ill. This should be done by demonstrating this contribution through professional, empathic and informed in-depth practice and research to provide evidence for practice (Beaton, Mann & Grigg, 2011). Also important is to harness assessment and care practice to an obligation and responsibility for each nurse to improve both the quality of the person-to-person care that is such a hallmark of nursing, as well as to positively influence the system that delivers it. History allows us to look back at what has gone before with the hope that we collectively learn from past experience and grow in this process. We suggest that changes need to be made to how we recruit, educate, promote and retain mental health nurses, and to acknowledge that their skills are vital in the care offered to those who are ill. Change can be difficult, but inputs from consumer movements in both Australia and New Zealand are offering new conceptualisations of what is mental illness and, because of this, different ideas about how to treat those who are mentally ill. History itself may be used to the overall advantage of nursing in mental health care. Using the words of Churchill: the further backward you can look, the further forward you can see.

SUMMARY

The history of care for people diagnosed with mental illness is poorly recorded and therefore poorly understood. The contribution that nurses have made, and continue to make, to the care of people with mental illnesses in Australia and New Zealand has largely been ignored. The literature that does exist primarily relates to the history of psychiatric services, with nursing only considered in a subsidiary capacity. Historical notions of madness were associated with deviance and punishment. These views had a significant impact on the attitudes towards the mentally ill, their treatment and their recovery.

Contemporary public perceptions of the role of the mental health nurse have been shaped by media representations, together with prevailing social attitudes towards mental illness. These views can stigmatise those who are mentally ill and those who nurse the mentally ill through their association with mental ill health.

Regardless of clinical context, caring in nursing is both an attitude and an active interpersonal process between the nurse and consumer. Tensions between the therapeutic intent of mental health nursing practice and factors such as legislative demands, government policy and fiscal imperatives continue to challenge the way in which mental health nurses practise. Changes to mental health nursing education, recruitment and retention are required to improve the deleterious position of mental health nursing today. Nolan (1993, 4) suggests the biggest issue of all for mental health nursing is whether it can survive.


**DISCUSSION
QUESTIONS**

- 1 Traditionally, 'out of sight and out of mind' appears to have been a major consideration in the containment and treatment of people who were deemed to be mentally ill. Why was this?
- 2 Australian and New Zealand institutions were carbon copies of treatment sites from other countries, particularly Great Britain. Was this a good strategy for these colonies?
- 3 If mental illness can be effectively treated, shouldn't this mean that stigma should also disappear in line with successful treatment options? Think about the role of stigma—does it serve more than one purpose?
- 4 What progress in regard to mental health care have we made in the last two hundred years? Reflect on your insights.
- 5 What progress in regard to mental health care have we made in the last ten years? Reflect on your insights.

TEST YOURSELF



- 1 What skills do you feel best reflect the role of a nurse in treating someone presenting at an emergency department with a mental illness?
 - a Cool, calm and collected
 - b Inquisitive, insistent and detached
 - c Friendly and warm
 - d Understanding, reassuring and knowledgeable
- 2 Who initially oversaw building up of Australian psychiatry?
 - a Frederic Norton Manning
 - b William Tuke
 - c Henry Maudsley
 - d Thomas Szasz
- 3 In what year was St Mary's of Bethlehem built in London?
 - a 1434
 - b 1247
 - c 1286
 - d 1178
- 4 In what year were the documents known as Te Tiriti O Waitangi signed by the British Crown and the Māori Chiefs?
 - a 1852
 - b 1799
 - c 1865
 - d 1840

USEFUL WEBSITES

20/20 Hindsight—A history of the Mental Health Legal Centre: www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/20_20_Hindsight_Final.pdf

ABC Adelaide—Inside Glenside: A history of mental health in Adelaide: www.abc.net.au/local/photos/2011/05/11/3213910.htm

The Porirua Hospital Museum—History: <http://www.porirualibrary.org.nz/Heritage/History-of-Porirua-City-Centre--Elsdon-and-Takapuwahia/History-of-health-care-in-Porirua>

The Time Chamber—The history of the asylum: <http://thetimechamber.co.uk/beta/sites/asylums/asylum-history/the-history-of-the-asylum>

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