MENTAL HEALTH SUPPORT IN GENERAL CARE SETTINGS:
AN EXPLORATORY STUDY INTO FACTORS THAT
INFLUENCE NURSES IN MEETING PATIENT’S NEEDS.

A thesis presented in partial fulfilment of the requirements for the degree of

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Declaration

I declare that the work presented in this Thesis is, to the best of my knowledge and belief, original and my own work, except as acknowledged in the text.

Signed:       Date:
Abstract

It is estimated that thirty to sixty five percent of patients within general care settings have specific mental health needs that do not always get addressed. These may be related to minor mental health problems, pre-existing mental disorder or illnesses that may develop during the course of inpatient care. Nurses are the largest professional healthcare group to provide direct and indirect care, and are in a unique position to be able to assess and assist a person who may be suffering from a minor mental health problem. However, literature suggests the assessment, understanding and management of patients with mental health needs is limited. Investigation into specific factors that influence nurses from meeting the mental health needs of patients in general care settings is important in not only enhancing the provision of patient care, but also in identifying what support may be required. This may assist in ensuring appropriate interventions are made and holistic care that best meets patients individual recovery needs is provided.

A mixed quantitative and qualitative design was used to investigate the hypothesis that New Zealand results will be the same as found in international studies. The research question “what factors influence nurses in meeting the mental health needs of patients in general care settings?” was explored using a self administered questionnaire. The questionnaire was forwarded to nurses (n = 90) working in acute, medical, surgical, and rehabilitation wards in a regional hospital and comprised questions relating to nurse’s views and experience in caring for people with mental health needs and problems. Participation was voluntary and anonymous. The aims of this research project were to: identify factors that influence nurse’s meeting patient’s mental health needs; determine any factors that prevent needs from being met; assess if there is a need for educational support; and compare results to international literature.

Participants (n = 29) indicated that factors such as workload, task oriented care, environment, severity of condition, and education, influenced them from meeting patient’s mental health needs. Participants further indicated an even split regarding having sufficient knowledge and confidence to care for people with mental health problems and also feeling vulnerable. This may indicate a need for additional training for some nurses and possible targeted mentoring. Fifty two percent of participants indicated they did not have enough support to care for people with mental health problems. Forty eight percent believed that more support from mental health services was also needed, which would increase confidence. Fifty six percent of participants indicated they did not have enough time to care for people with mental health needs and 71% wanted further training in order to expand their knowledge in mental health. This may suggest that ‘protected time’ may be useful. Results were similar to international studies completed in the United Kingdom and Australia in the past seven years.
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CHAPTER 1

Introduction

Background to the thesis

The researcher believes that all patients, regardless of the area in which they are receiving care, need to have their holistic needs met to the best of the carer’s abilities. Many people are admitted to hospital with either a pre-existing mental disorder or for a variety of reasons, may have mental health problems that develop into mental illness. Early identification of these problems along with appropriate intervention can make a vast difference to the patient’s overall hospital experience and recovery. Recent information suggests that nearly one in two New Zealanders will have some kind of mental disorder in their lifetime (Ministry of Health, 2004a). Therefore, to assist in reducing the impact of any developing mental health problem in general hospital care, it is essential that early assessment is made.

In my role as the Mental Health Consultation Liaison, referrals are received with the requests for advice, guidance, education and/or assessment and intervention for people with various mental health needs. Many referrals are made by nurses on behalf of the medical staff and others are due to ‘a feeling that things are not quite right with the patient’. On many occasions a formal assessment of the patient has not been made. When enquiries are made with nurses to assess whether a referral is required to go ahead or not, many nurse’s reports not having completed even a basic assessment due to not having the knowledge, skill or time to discuss mental health needs with patients. Although it is highlighted by the Nursing Council of New Zealand (2005) that all nurses should be competent in the provision of holistic care, personal experience and research from Australia by Gillette, Bucknell and Meegan, (1996, as cited in Sharrock & Happell, 2002) suggests some nurses also report assessment of mental health needs does not relate to their scope of practice within a general area. The literature was reviewed to see if this was similar in other hospitals that had consultation liaison services. Many similar concerns were identified internationally with various studies in the United Kingdom (UK) and recently in Australia. The extent of this issue needs to be explored in the local area.

Overseas studies highlight patients with mental health problems are also frequently seen in general settings, with the prevalence of mental disorders being high (Arlot, Driessen, Bangert-Verleger, Neubauer, Schurmann et al., 1997). Twenty five per cent of patients have adjustment and mood disorders (Mulley, 2001, as cited in Harrison, 2001). Ten per cent of patients admitted to general care settings also have delirium, while twenty five per cent of older patients in medical areas have dementia with associated behavioural problems (Bowler, Boyle, Branford, Cooper, Harper & Lindsay, 1994, as cited in Harrison, 2001). In New Zealand “the prevalence
of delirium is estimated to be from five percent to eighty percent in ill older adults” (Neville & Gilmour, 2007, p.22). Thirty to sixty five percent of patients have psychiatric symptoms that do not always get addressed (Callaghan, Eales, Coates & Bowers, 2003). This can cause longer hospital stays which are reported to be associated with greater psychological co-morbidity, particularly depression and anxiety (Regal & Roberts, 2002).

“Mental health and wellbeing means more than the absence of mental illness”, and can be influenced by many factors (Edwards, 1999, as cited in Ministry of Health, 2002, p.18). Specific mental health problems within general care settings include needs related to the impact of illness. This is due to many physical illnesses provoking physical and psychological reactions such as anxiety, fear and even hopelessness (Eysenck, 1995). Although a mood disorder may be a normal response to the hospital environment or medical problem in some cases, it is not always a consequence of illness (Harrison, 2001). Careful assessment of the severity and duration of symptoms of an altered mood is required in order to initiate appropriate intervention and care (Regal & Roberts, 2002). An individual also needs to have special time to express their thoughts and feelings whilst receiving care in hospital. This may make a difference in the progression of psychological symptoms, which can potentially worsen the physical condition (Regal & Roberts, 2002). Nurse’s are in a unique position to assess and assist a person who may be suffering from a minor mental health problem or a mental disorder whilst in general care. However, recent research from Australia and the UK shows that at times the assessment, understanding and management of patients with mental health needs are limited (Happell & Platania-Phung, 2005; Harrison & Zohhadi, 2005).

The nursing profession strongly advocates holism to be the basis of care within its philosophy (Regal & Roberts, 2002). However, as Harrison and Zohhadi (2005) found in their UK study at times the care provided is not always so. As well as ensuring the best outcome for their patients, nurse’s also need to guarantee the provision of holistic care in order to meet their expectations of practice outlined within the four domains of competence for the registered nurse scope of practice (Nursing Council of New Zealand, 2005). In order to provide appropriate holistic care, a thorough assessment first needs to be undertaken. Unfortunately, as research from overseas suggests, many nurses working in general hospital settings do not consider themselves as being adequately prepared, skilled or experienced enough to both assess and care for people with mental health problems (Happell & Platania-Phung, 2005). Brinn (2000) suggests some of the reasons for this in the UK include fear, lack of time and support, the environment including work-load, individual attitudes, knowledge, experience, abilities and the medical model within healthcare. In Australia however, Gillette, Bucknell and Meegan, (1996,
as cited in Sharrock & Happell, 2002, p.39) found that this issue was not due to skill and knowledge alone but also where nurses saw their scope of practice. In their study nurses also “questioned their role in the care of patients with mental health problems, and did not see it as part of their ‘real’ work”. Due to this and giving priority to patients with physical needs, they often actively avoided patients with mental health problems. Nurse’s also had a perception of inadequacy in meeting the mental health needs of patients, which was compounded by a lack of resources and much difficulty accessing mental health services. According to Peterson, Pere, Sheehan and Surgenor (2006) avoidance of patients with mental health problems is also a problem in New Zealand healthcare settings, which often leads to inadequate provision of clinical services and therefore poorer outcomes.

**Hypothesis**
Many factors influence the ability of nurses to meet the mental health needs of people in general care settings. The hypothesis of this study was that New Zealand results will be the same as found in international studies. This hypothesis was grounded in the assumption that all nurses perceive themselves as being competent in the provision of holistic nursing care in practice.

**Research question**
The question for this research project was;

“What factors influence nurses in meeting the mental health needs of patients in general care settings?”

**Aims of the research**
The aims of this research project were:

i. to identify factors that influence nurses meeting patient’s mental health needs;

ii. to determine any factors that prevent needs from being met;

iii. to assess if there is a need for specific educational support; and

iv. to compare results to national and international literature.

**Purpose of the research**
Current literature from overseas suggests that nurses working in general hospital settings do not believe they are adequately prepared, skilled and able to meet all of the mental health needs of patients in their wards. Therefore, patient’s mental health needs are not able to be fully met (Brinn, 2000; Harrison, 2001; Regal & Roberts, 2002; Sharrock & Happell, 2000). This study aims to determine if this was the case within a regional hospital, therefore providing a New Zealand perspective. Suggestions for further education, practice and research were also
envisaged to be highlighted. This will assist in the promotion of quality improvement initiatives and ongoing nursing development. Enhancement of the provision of mental health care in the general care setting would also be of benefit to nursing in general, potentially leading to more positive outcomes for patients with mental health needs in general hospital care.

**Thesis direction**

This chapter has provided a brief background to the thesis including the research hypothesis, question and aims. In Chapter Two, a comprehensive literature review highlights international and New Zealand evidence relating to mental health, mental health and related nursing care in general care settings, and factors that influence mental health nursing care and psychiatric symptoms in general care. Chapter Three describes the methodology used within the study. Ethical and cultural considerations within the study are also discussed. Chapter Four presents the findings of the study, discusses the data and compares it to international literature. Chapter Five provides a discussion of the findings and Chapter Six provides conclusions and recommendations for practice and further research. The questionnaire and study approval letters can be found in the appendices.

**Definitions**

**Mental health**

As previously cited, mental health involves more than the absence of mental illness (Edwards, 1999, as cited in Ministry of Health, 2002). Mental health can be influenced by many factors including a person’s cultural values, beliefs and concepts of psychological, and social functioning. It is evident in ‘psychological clarity, moods, feelings, and our ability to cope with day to day issues and relationships’ (Mental Health Foundation, 1995, as cited in Disley, 1997, p.3). Durie (1998) outlines mental health in New Zealand as that which nurtures spirituality, psychological wellbeing, physiology, family/whanau and self. Mental health is also “an inseparable component of total wellbeing” (Ministry of Health, 2002, p.6). Mental health “is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with daily challenges” (Edwards, 1999, as cited in Ministry of Health, 2002, p.18). Protection and promotion of mental health is essential (Ministry of Health, 2002).

**Mental health problem**

Although there is no widely accepted definition, Disley (1997, p.4) states that mental health problems “are those psychological and emotional reactions or behaviours outside of the usual range that may cause distress to themselves or others”. Such problems are relatively common, and either transient or not so severe that a person is not able to carry out usual day to day
activities (Disley, 1997). In some settings “the presence of a diagnosed psychiatric disorder can be considered a defining characteristic of a mental health problem” (Sharrock & Happell, 2000, p.35). Although as suggested by Mayou and Sharpe (1991, as cited in Sharrock & Happell, 2000), some people may present with psychological problems and may benefit from some form of intervention, however may not necessarily meet the diagnostic criteria for a psychiatric disorder. Clinical examples that demonstrate a mental health problem can include “sub clinical depression or severe anxiety in response to physical illness, behavioural disturbance such as aggression, and treatment difficulties such as poor compliance” (Sharrock & Happell, 2000, p.35). Further examples include a person who may have a tendency to become argumentative after drinking alcohol, normal grief reactions from either a death in the family or a change in personal physical state, and marked anxiety whilst awaiting results of an examination. Any mental health problem that becomes more severe and disabling can become a mental disorder (Disley, 1997).

Mental illness
Mental illness and mental disorder cover a broad range of clinically diagnosed conditions and as defined by the American Psychiatric Association (2000, p.xxi) are “a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability”. Examples of major mental illness include depression, bipolar affective disorder and schizophrenia (Stuart & Laraia, 1998).

Mental disorder
In New Zealand mental disorder is legally defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992 as “an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition; of such a degree that it -

(a) Poses a serious danger to the health or safety of that person or of others; or
(b) Seriously diminishes the capacity of that person to take care of himself or herself”.

The terms mental illness and mental disorder are often synonymous in literature, however for the purpose of this thesis the term mental disorder will be used.
CHAPTER 2

Literature review

Introduction
The following Chapter presents a review of national and international literature relating to factors that influence mental health needs being met in the general care setting. Prevalence of mental disorder, mental health, nursing and provision of mental health nursing in general care settings, will be presented along with factors that influence mental health nursing care and psychiatric symptoms in general care settings. Also presented will be literature discussing holism, mental health consultation liaison, competencies for practice, professional needs, dualism, education, fear, stigma and discrimination, avoidance, expanded contact with people with mental health problems, assessment, physical and organic causes for psychiatric symptoms, mood disturbances, depression and suicide, self harm and suicide attempts and risk assessment.

Search strategy
A search was undertaken using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed using a variety of search terms such as; physical and mental health; mental health needs, mental health in general care settings, consultation liaison, liaison nursing, holistic care, mental disorder in New Zealand, nursing competencies in New Zealand, avoidance, attitudes, stigma, discrimination, psychiatric symptoms in general hospital, and risk assessment. The search was limited to research studies undertaken within general hospital care as well as articles related to terms previously noted. The timeframe was limited to 1990-2007. While the search within CINAHL provided relevant publications, PubMed was more successful whereby 50 articles were found including several research studies. There were subsequently used within this thesis due to being relevant to the thesis topic. Articles such as nursing care in psychiatric hospitals were excluded whereas articles such as mental health nursing care in general hospital were used.

Prevalence of mental disorder
A recent survey by the Ministry of Health (2004b) found that nearly one in two New Zealanders will have some kind of mental disorder in their lifetime, and twelve percent of people who access general hospital care were found to have an existing mental disorder. The survey also reported twenty percent having a mental disorder in the last twelve months. Also identified was that Maori are less likely to visit their General Practitioner for minor physical health problems, which may mean they would enter secondary care sooner if their health concerns were not addressed during the early stages. This highlights the need for health professionals working in
tertiary care to also assess for mental health problems where appropriate, as a hospital may be
the single place care may be received (Oakley Browne, Wells & Scott, 2006).

Mental disorders account for nearly eleven percent of the total disease burden globally (Murray
& Lopez, 1997). In a report by the Ministry of Health (2001), it was highlighted that many
psychiatric conditions impact on the total disability burden in New Zealand. The report further
noted that many mental disorders affect both the disability adjusted life years (DALY) and the
DALY burden of disease. Recent data for the top twenty DALY burden of disease for Maori
and European men and women showed that anxiety rated higher than self harm and suicide, as
did mood disorders. However, self harm and suicide rated higher in both Maori and European
men compared to Maori and European women (Ministry of Health, 2004a).

*Mental health in general care settings*

The experience of hospitalisation, whether for medical or surgical reasons, can provoke both
physiological and psychological reactions. This can be due to the stress of the actual
environment, or the reason why hospitalisation is needed (Black & Matassarin-Jacobs, 1997).
Specific mental health problems within general care settings include needs related to the impact
of illness. Psychological problems secondary to illness are also relatively common (Maguire
& Haddad, 1996) and are often difficult for nurses to separate when attempting to meet patients
needs (Harrison, 2001). Anxiety, fear and hopelessness are all potential disturbances that may
occur with illness. It is important for the nurse to recognise specific cues and respond
appropriately (Eysenck, 1995). Feelings of being overwhelmed with the hospital experience can
lead to further stress, anxiety, sleep problems, low mood and decreased motivation and energy
to continue in recovery programmes (Bridges, 2001). Psychological symptoms can include
depression, anxiety and sometimes psychosis. Psychosis is defined as “a gross impairment of
reality testing” (Goff, Freudenreich & Henderson, 2004, p.155) and can result from a wide
range of psychiatric and medical disturbances Stuart & Laraia, 1998).

Many debates have occurred throughout history, relating to the relationship between the mind
(*psyche*) and body (*soma*) (Stuart & Laraia, 1998). Although some believe that *all* illness has a
psychophysiological component, in practice there are many differing opinions (Regal &
Roberts, 2002). This may in part be due to historically physical illness being more acceptable to
have than psychological problems (Slevin & Sines, 1996). Although, with the recent mental
health promotion campaigns in New Zealand, mental health problems are now more openly
discussed and accepted amongst the general population (Ministry of Health, 2006). The idea of
patients in general settings having psychological needs, and nurses having a significant role in
caring for these needs, are not new. However, when a patient is being treated for a physical illness, according to findings from their UK study, Wells, Rogers, Burnam and Camp (1993), often patient’s psychological needs are missed. Harrison and Zohhadi (2005) suggest this continues to occur, despite increasing recognition of how psychological process influence mortality and morbidity rates.

There is increasing evidence that illnesses with biophysical origins often have psychosocial consequences (Regal & Roberts, 2002). In their UK study, Callaghan et al., (2003) found that thirty and sixty five percent of medical patients in the UK have psychiatric symptoms which are not always addressed. They further state that patients may also have their clinical symptoms of physical concerns wrongly diagnosed, as many physical illnesses can present as psychiatric disorders. In a New Zealand study Peterson et al., (2006) found that physical health symptoms are also often treated as mental health symptoms such as possible breathing difficulties that are sometimes thought of as due to anxiety, which according to Happell and Platania-Phung (2005) has the potential of compromising patient’s individual wellbeing.

*Nursing in general care settings*

Nurses have a unique position within the general scheme of healthcare provision due to several reasons. They are the largest professional group in the hospital sector and they generally understand the challenges of the health care system. They are also in a perfect position in which to promote health and prevent illness, including mental health and/or mental health problems or disorders (Happell & Platania-Phung, 2005). Despite this, however, as suggested in the UK studies by Brinn (2000) and Harrison and Zohhadi (2005) and Australian studies by Sharrock and Happell (2006) and Reed and Fitzgerald (2005), care that addresses all aspects of the person is always not being provided. Furthermore, the nursing profession has always suggested that it maintains holistic care in practice (Dossey & Dossey, 1998). However, the UK study by Brinn (2000) suggests that some nurses believe they do not have the confidence or competence to always deliver holistic care. In order to provide high quality nursing care, the focus of holistic care must be kept central to provision. Nurses must also be both willing and able to provide this (Happell & Platania-Phung, 2005).

*Holism*

According to holism “the person is greater than the sum of their parts”, and it is a challenging concept within the two specialties of medicine and nursing (Regal & Roberts, 2002, p.32). Holism is often used as “shorthand for patient-centered care or attempts to integrate physical, psychological, social or spiritual aspects of care” (Regal & Roberts, 2002, p.25). As holism is
considered separately within dominant health care systems, integrationist or integrative would be a more accurate definition when describing care (Regal & Roberts, 2002). Although there has been much literature about the holistic nature of nursing assessment and intervention (Jenkins, 2006), according to Barker (1997) in practice the reductionist view is still seen. Chummun (2006) suggests the two contrasting philosophies of reductionism and holism however, are important approaches in the general management of patients with coronary heart disease for example. Furthermore, Hawley, Young and Pasco (2000) also suggest that reductionism is not incongruent with nursing core values and argue for reductionism in nursing science. Hawley, Young and Pasco (2000) further suggest that despite these arguments, the reductionist view has historically not been very popular in nursing. Most nurses profess to be in favor of holistic care for patients in general care although Regal and Roberts (2002) suggest holistic care in the ‘true sense’ may not always be provided. Various factors affect the way in which nurses conceptualise the psychosocial components of their work, in order to provide this ‘holistic care’. This can include the amount of time spent with patients, and also the degree of closeness (Harrison, 2001). Furthermore, McKinlay, Couston and Cowan (2001) suggest what nurses in the UK believe about the attitudes of their colleagues can also be a factor and can determine the type of caring behaviour.

Provision of mental health nursing care in general care settings

It is likely that nurses working in general care settings will come across people experiencing psychological or mental health problems. It is common to see mental health problems among those with illnesses such as Parkinson’s disease, multiple sclerosis and epilepsy (Harrison, 2001). Salkovskis, Storer, Athac and Warwick (1990) found that patients in the UK with illnesses such as diabetes, cancer and cardiac problems have a higher incidence of mental health problems. This was also found by Arlot et al., (1997) in their study of the prevalence of psychiatric disorders in German medical and surgical inpatients.

In order to evaluate how many patients presenting at UK accident and emergency (A&E) departments show signs of psychiatric disturbance, Salkovskis et al., (1990) evaluated 140 consecutive medical presentations to an A&E department using a range of simple self-report and rating measures. They then repeated the evaluation on the same participants a month later. High levels of psychological problems were detected at screening, and these persisted at follow-up. Correlation of psychological disturbances and repeated attendance at accident and emergency departments were investigated, indicating the relevance and feasibility of mental health intervention related to simple predictors.
In their UK study, Wells et al., (1993) examined the course of depression over two years for outpatients with and without a history of hypertension, a history of myocardial infarction, or current insulin-dependent diabetes. Among outpatient visitors to the practices of 523 general medical clinicians and mental health specialists, depressed patients (n = 626) were followed for one or two years with a telephone-administered interview. Depressed patients with and without medical illness were noted to have had high rates of persistent depressive symptoms. Furthermore, a relatively high percentage of all depressed patients in this study had persistent depression regardless of the extent of medical co-morbidity.

The main focus of care in general wards is for medical or surgical needs. However, nurses frequently care for people who have a mental disorder (Regal & Roberts, 2002). This was highlighted in the study by Arlot et al., (1997), where prevalence rates of psychiatric disorders assessed with 400 patients in a general care setting in Germany. The results of their study showed that more than 46 percent of patients had a psychiatric diagnosis, with the most common being organic brain syndromes, depression and alcoholism. According to Brinn (2000) comprehensive nursing skills are therefore imperative. Recognising how an individual's role and relationships can change is also important, as this can affect recovery (Mental Health Commission, 2001). An individual also needs to have special time to express their thoughts and feelings whilst receiving care in hospital. This may make the difference in the progression of psychological symptoms potentially worsening the physical condition (Regal & Roberts, 2002).

Mental Health Consultation Liaison
Consultation and liaison mental health services are an important service within general settings (Sharrock & Happell, 2000). Consultation liaison nursing originated in North America in the 1960’s (Sharrock & Happell, 2000), and New Zealand in the 1980’s (T. O’Brien, personal communication, September 13, 2007). Mental health consultation liaison (MHCL) nurses provide advice and support to general hospital nurses, education about specific care for patients experiencing mental health problems, psychological care to patients and families, and liaise with other disciplines (Roberts, 1997; Sharrock & Happell, 2002). Examples of problems referred to MHCL include depression, acute situational distress, functional psychosis, aggression and/or disturbed behaviour, and deliberate self harm (Callaghan et al., 2003). When MHCL services are not available for any reason general nurses may have to manage people who present with presentations such as the above. McCann, Clark, McConnachie and Harvey (2006) found nurses who had attended in-service education on managing patients who deliberately self harmed for example, were more are able to manage patients’ needs.
A number of international studies have commented that nurses based in non-mental health settings are not able or qualified to care for patients who may have mental health problems (Brinn, 2000; Harrison & Zohhadi, 2005; Sharrock & Happell, 2006). In New Zealand there is an expectation that all nurses display competencies for the registered nurses scope of practice. The competencies are designed to be applied in a variety of clinical contexts (Nursing Council of New Zealand, 2005). Although MHCL services provide assessment, care and support to clients experiencing mental health problems, it is also important for general nurses to have the knowledge and skills to be able to provide basic and competent care when required (Regal & Roberts, 2002; Sharrock & Happell, 2006). This is not only so they can be assured their patient is receiving the best possible care, but also to confirm they are meeting their professional requirements in nursing (Harrison & Zohhadi, 2005).

Competencies for practice
Brinn (2000) suggests all nurses, whether in general or mental health settings, like to view themselves as being competent in caring. Competencies that nurses use to demonstrate they are competent to practice in New Zealand are based on four domains. These domains include; 'Professional Responsibility; Management of Nursing Care; Interpersonal Relationships and Interpersonal Health Care and Quality Improvement. Under these competencies, specific indicators highlight how nurses can display they have met the criteria in practice (Nursing Council of New Zealand, 2005). Competencies and indicators for practice display that caring for someone with specific psychological needs is not limited to mental health settings. As highlighted within the Nursing Council of New Zealand (2005) competencies, nurses are expected to be competent in undertaking a comprehensive and accurate nursing assessment, and use assessment tools and methods to assist in their collection of data. Nurses are also expected to maintain therapeutic interpersonal relationships and use the therapeutic use of self as the basis for providing nursing care for clients with mental health needs. Furthermore, they are expected to utilise effective interviewing and counselling skills (Nursing Council of New Zealand, 2005).

Establishment of rapport and trust is an essential part in the provision of nursing care (Taylor, Lillis & LeMone, 2004). Nurses are expected to provide this whilst implementing nursing care in a manner that facilitates the independence, self-esteem and safety of the client. There must also be an understanding of therapeutic and partnership principles (Stuart & Laraia, 1998). It is important that nurses recognise and support the personal resourcefulness of people with mental and/or physical illness. Appropriate communication skills are also extremely essential. Using a variety of communication techniques, they must be able to communicate effectively with clients and members of the health care team (Nursing Council of New Zealand, 2005).
Factors that influence mental health nursing care

Many factors may influence the ability of nurses to attend to a person’s specific holistic needs (Regal & Roberts, 2002). Examples suggested within the literature include lack of time, individual attitudes, confidence, competence, knowledge, experience and abilities (Brinn, 2000), the environment including work load and task oriented care, disruption cause by patients, professional support (Harrison & Zohhadi, 2005) and the medical model within healthcare (Harrison, 2001). The patient with physical care needs is also more likely to meet care plans, and engage in behaviour that is more in keeping with the ‘sick role’ (Trexler, 1996, as cited in Sharrock & Happell, 2000). Furthermore, they are more likely to meet the set expected time frame of recovery, whereas psychological needs often do not have a set care-plan (Brinn, 2000). This may result in the focus being primarily on the person’s physical problems only (Harrison, 2001).

Professional needs

Harrison and Zohhadi (2005) found that only by addressing the professional needs of nurses, can effective patient care can be assured. Using a focus group (n = 9) as the first part of an action research project, their study explored some of the factors that influenced the delivery of care by nurses to people with mental health problems. These UK nurse’s primary professional focus was providing physical care to patients in an older adult unit. The themes that emerged included disruption, role conflict, professional resources and professional distress. Patients with mental health problems were viewed as a significant source of disruption on the ward to staff, other patients and their visitors. Nurses stated this impacted in the way they were able to do their job, especially when inappropriate behaviour was displayed. Some nurses also believed the patients were in the wrong place as the acute medical setting was not equipped to manage them. Role conflict occurred due to nurses not feeling as though they were professionally able to meet needs. Nurses described the impact that lack of resources had on the provision of care in the ward. This was lack of skills, knowledge, time, access to appropriate training, and lack of support and understanding from management. Finally, nurses felt inadequate due to not knowing how to help their patients with specific mental health problems which caused a great deal of professional distress. Some nurses even questioned their ability to continue in their role within the ward due to this. Other nurses however, gave examples of feeling confident and capable of being able to care for patients following a stroke and did not perceive themselves as providing mental health care. This is despite much literature suggesting that stroke is an illness that has numerous emotional and psychological consequences requiring highly skilled staff to meet needs (Bennett, 1996; Warner, 2000). Although this study was important in exploring factors that delivery care by nurses to people with mental health problems, a further study with a larger sample size may provide more reliability.
Bennett (1996) studied nurses (n = 14) working in a stroke unit in the UK to ascertain their understanding of post-stroke depression and what they would do to help someone who was becoming depressed. Nurses were able to describe characteristics of depression and recognise the effect it had on rehabilitation. They were also able to identify patients who were becoming depressed and helped to the best of their ability. However, some of them described feeling constrained due to lack of time, limited skills and lack of appropriate training. They wanted to be able to meet the needs of patients who were depressed and thought this could be achieved through better staff education and access to staff more experienced in providing psychological care. Recommendations from this study include nurses having access to expert staff as a source of referral and resource for support and guidance. Furthermore, an educational programme that combined theoretical and practical aspects of psychological care was suggested.

Sharrock and Happell (2006) used a grounded theory approach in their small study (n = 4) to explore and describe the subjective experiences of nurses in their second post graduate year providing care for people with mental health needs in medical and surgical wards in an Australian hospital. Nurses described feeling constrained at times when providing care for patients with mental health needs due to lack of support within the hospital environment, workload, high patient turnover and the high focus being on physical needs being the priority of care. Time and resources were also focused in a more reductionist and task-oriented way. Nurses felt that support was readily available however, and had an influence on the delivery of care. Emotional, practical and educational support was also valued although nurses had minimal access to resources on mental health related topics. They concluded that nurses not specifically educated in mental health face difficulties in caring for patients with mental health problems in general wards. This study highlighted important data although a larger sample size may have established better reliability. This was noted by the authors however as a limitation of the study.

The link between physical and emotional health is receiving increased recognition. However, as noted in international studies, many clinicians are still failing to address these areas (Brinn, 2000; Harrison & Zohhadi, 2005; Sharrock & Happell, 2006; Teasdale & Mulraney, 2000). Although an awareness of psychological problems experienced by patients in general wards is held, many nurses report feeling unable to address them (Harrison & Zohhadi, 2005; Warner, 2000). Nurses may also focus on aspects of their work they feel they are accountable for and may not see psychosocial care as a priority. This may be due to the nurse not feeling competent to make a psychological assessment (Happell & Platania-Phung, 2005), or nervous to be around those with these special needs (Harrison & Zohhadi, 2005; Regal & Roberts, 2002).
Dualism
The emotional and psychological effects of physical illness have long been recognised (Regal & Roberts, 2002). With the wide range of emotional responses resulting from physical illnesses, separating the physical and emotional can be very difficult (Harrison, 2001). Further complicating attention to these specific needs is the theory of dualism, or the mind-body split. Within the theory of dualism, illness is thought of as a problem of the mind or a problem of the body. The biomedical model reinforces this theory (Harrison, 2001; Regal & Roberts, 2002). The current health care culture, with its segmented approach, also reinforces this thinking of the mind-body split, (Lupton, 1994, as cited in Harrison, 2001). Unfortunately for those with needs other than physical, the dualistic notion of biomedicine has continued to dominate within healthcare services, despite strong evidence of its limitations (Eysenck, 1995).

Education
Education and training is another possible reason why mental health needs may not be attended to in practice as well as they may be. According to Sharrock and Happell (2006), there is a strong need to increase the holistic component within nurse education in Australia. This may lead to increased sense of self-efficacy in providing care for those with both physical and mental health needs (Stuart & Laraia, 1998) and, promote a more holistic approach in all areas where nursing care is required (Brinn, 2000). Richardson, Vernon and Jacobs (2005) comment that undergraduate nurses in New Zealand are taught to view patients from a holistic perspective. However, once out in practice, knowledge about patient’s spiritual needs, for example, is not put into practice. Benner (1984, as cited in Sharrock & Happell, 2006) suggests with the mind and body –the psychosocial and physical being separated for the purpose of study, nurses find it difficult to re-combine these components in order to achieve a holistic approach and therefore provide holistic care. Sharrock and Happell (2006) also highlighted a discrepancy between the holistic framework encouraged in undergraduate education and what is actually experienced in practice. Nurses did not feel prepared from their undergraduate studies, doubted their knowledge and had limited confidence in their expertise. One participant did report feeling confident in caring for people with mental health problems however. Although it was mentioned that this was due to completing a separate undergraduate course that had a significant time allocation to mental health.

Fear
In Wales, Brinn (2000) found that nurses in general settings were often fearful of patients who required intervention for their mental health needs. Brinn’s study investigated the attitudes of nurses (n = 64) in general wards towards those with mental illness, with the view of highlighting specific training needs. The specific aims included comparing the effect of caring for people
with two different psychological disorders, with both qualified and non-qualified staff. The final aim of this project included investigating the perceptions held by nurses on the level of competence that they felt their training gave them in order to care for these patients. A small-scale questionnaire survey using a ‘within groups’ design was used to measure the reactions and expectation of nurse, to vignettes describing patients with unstable diabetes and a co-morbid psychiatric diagnosis. The results from their study suggested that the nurses in the sample were fearful of people with a mental health problem. This was in part due to being wary of possible unpredictable behaviour. Qualified staff generally felt more equipped to cope with such patients, depending on their psychiatric experience. The conclusion reached was that general nurses who have had more exposure to patients with mental health problems during their initial training, are more likely to feel adequately prepared for managing people with mental health problems.

**Stigma & discrimination**

Stigma is “the perception that an individual or group possesses a discrediting, exaggerated flaw” (Halter, 2004, p.44). There is much evidence relating to the stigma of having a mental health problem (Mental Health Commission, 2001). The basis for stigma is a fear of what is not understood, which indicates a lack of knowledge or misperceptions (Halter, 2004). In a USA study, Halter (2004) found that stigmatising attitudes could seriously compromise the diagnosis and treatment of patients with depression and negatively affect help seeking behaviours. As identified by the Mental Health Commission (1998), discrimination results in poorer outcomes for people with experience in mental illness, stunts all aspects of recovery and erodes people’s life chances. According to Regal and Roberts (2002) a person with a history of mental illness receiving care in a physical care setting, is likely to experience some form of stigma or discrimination, similar to those living in the community. A recent New Zealand survey by Peterson et al., (2006) looking at discrimination faced by people with experience of mental illness accessing care within general settings, highlighted that much is needed to be done within the service providers of general settings. Evidence was found that health professionals can and do discriminate, which can lead to poor outcomes for people. Twenty three percent of people said they had been discriminated against, with almost 25 percent often having all symptoms being seen as related to mental illness. This survey supports a report by Handiside (2004) which stated that some of the reason why people with experience of mental illness were sicker and dying earlier was due to discrimination by healthcare providers.

Despite being taught to care for the range of needs patients may have, Peterson et al., (2006) found that many nurses have a negative response to those who need extra care for their mental
health needs. Hunt (1993) suggests this occurs due to the worker being able to rationalise the avoidance of a patient who is different. Regal and Roberts (2002) supports this, stating by avoiding those who may have mental illness the nurse may concentrate their efforts more on patients who will reassure them of their competence as they meet their physical needs. Sharrock and Happell (2006) found that nurses wanted to be able to care for patients with mental health needs and did not discriminate against them. However, the nurses did report finding their work setting difficult to incorporate mental health care into. In their Australian study of emergency nurses McCann, Clark, McConnachie and Harvey (2007) also found that overall nurses did not discriminate in their triage and care decisions of patients who had deliberately self harmed.

Many people choose not to disclose pre-existing diagnoses of mental disorder when they access general healthcare. According to the Ministry of Health (2003a) this is due to fear of discrimination and of not receiving the appropriate care. It is also suggested by Peterson et al., (2006) that there is a concern that health complaints may be dismissed as symptoms of mental disorder. Ensuring that care is appropriate and equal is the individual nurse’s responsibility (Nursing Council of New Zealand, 2005). People in general care settings also need to be able to trust those caring for them, as this can have a significant impact on ongoing recovery (Ministry of Health, 2003b). Having the assurance that respect, appropriate time and care will be given if a pre-existing mental disorder is disclosed, will assist in the overall hospital experience (Hunt, 1993; Peterson et al., 2006).

Attitudes
Negative attitudes towards a person’s psychological needs can have a detrimental effect on their recovery (Bridges, 2001; Mental Health Commission, 2001). Awareness of individual attitudes and reactions having a positive or negative effect is important regardless of what area a nurse may work in (Arnold & Bogg, 1999). The patient is in a vulnerable position when in hospital. Therefore, awareness of self and the impact we can have on others is essential (Black & Matassarin-Jacobs, 1997; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005). The perception of patient’s needs may also be somewhat different between both the patient and nurse (Black & Matassarin-Jacobs, 1997), which is noticeable in the nurse’s attitude (Farrell, 1991).

International studies have highlighted that some nurses have negative attitudes towards people with mental health problems (Brinn, 2000; Reed & Fitzgerald, 2005). In Australia, Bailey (1994) found that some nurses had negative attitudes towards patients who had self harmed. However, this was highlighted to be due to concern of saying the wrong thing to patients. From this same study, Bailey (1998) suggested some of the factors that influenced negative attitudes
were lack of knowledge and positive support. Also in Australia, Fleming and Szmukler (1992) found that nurses had poor attitudes towards patients with eating disorders, although McCann et al., (2007) found that overall, nurses had sympathetic attitudes towards patients who had deliberately self harmed. Sharrock and Happell (2006) also found that nurses had a strong sense of commitment and concern, and wanted to provide high quality care to patients with mental health needs. They did find that some nurses reported older and more experienced colleagues had negative attitudes which led to avoidance of patients with mental health problems.

In Australia, Reed and Fitzgerald (2005) found that attitudes were linked to issues that influence the nurse’s ability to provide care. Their qualitative study investigated the attitudes of nurses ($n = 10$) from two different medical and surgical wards in a rural hospital, to caring for people with mental health problems. They also looked at issues that impacted on the nurse’s ability to provide care and the effect of mental health education, experience and support. They found that nurses that had had previous education and support from mental health services had increased comfort and enthusiasm to provide mental health care and saw it as integral to nursing. This was due to the gaining of assessment skills and greater knowledge and understanding of mental disorder. They also felt they were able to help maintain patient rights better due to their ability to help reduce stigma. Conversely, nurses who did not have as much education and support reported a dislike for such patients and often avoided them because of fear to themselves, the person in their care as they were concerned of providing the wrong type of care and others on the ward. They also felt both professionally legally and ethnically vulnerable. Some nurses also did not feel qualified or see it as part of their role to care for patients with mental health problems but did indicate a strong desire to care for people with mental health problems despite this. The unsuitable environment, inability to predict patient’s behaviour, priority of physical care, time constraints, lack of skill, support and knowledge, previous negative experiences, and high patient ratios were all highlighted in this study as being linked to issues that influenced nurse’s attitudes. Education and support were identified as a means of assisting nurses overcome fear and increase competence.

McKinlay et al., (2001) used a questionnaire and two vignettes to look at how UK nurse’s attitudes and social pressures from colleagues affected the way in which they were able to care for those who self-poisoned. They found that the nurse’s attitudes and what they believed about the attitudes of others predicted their behavioural intentions. In South Africa, Mavundla (2000) explored the perception of nurses ($n = 12$) in caring for those with mental illness in a tertiary hospital. The results of their study highlighted a negative perception, which affected the intellectual and affective component of the nurses psychological functioning. A
The recommendation from this study was a need to increase knowledge and skills in mental health care. Mental health training and support was also a recommendation from Haddad, Plummer, Taverner, Gray, Lee and Payne et al., (2005) cross-sectional study in the UK, of district nurses (n = 331). Keshavan, Sriram, Kaliaperumal and Subramanya (1991) had similar findings within their study of nurses (n = 46) working in a general hospital in India. This was also found by McCann et al., (2006) in the Australian study of emergency nurses (n = 43) caring for people, who had deliberately self harmed, and by Wilstrand, Lindgren, Gilje and Olofsson (2007) in their recent study in Sweden of emergency nurses.

Avoidance

Violence against nurses is high (Poster & Ryan, 1993), especially from people who may have dementia. This is also common in Alzheimer’s disease with up to 20 percent of patients displaying aggressive behaviour (Freyne & Wrigley, 1995, as cited in Brinn, 2000). Gillette, Bucknell and Meegan (1996, as cited in Sharrock & Happell, 2000) found that nurses had a perception that patients with mental health problems took more time to nurse. This would lead to avoidance. Menzies (1960, as cited in Harrison & Zohhadi, 2005) found that avoidance was common with nurses whose patients had either chronic or acute mental health needs. They also hypothesised that the emotional demands of nursing resulted in some nurses becoming emotionally disconnected and detached from patients when they felt they were unable to meet mental health needs effectively. Furthermore, some patients may evoke feelings of anxiety and uncertainty and the most common way for nurses to deal with this was the defense mechanism of avoidance. This was believed to lead to further distress for the nurse as well as mental health patients being further viewed as being a separate and challenging group. Harrison and Zohhadi (2005) also found this to be the case in their study as did Reed and Fitzgerald (2005). Fear of aggression has been noted to be one of the many reasons for avoiding patients with mental health problems (Reed & Fitzgerald, 2005).

Problems many nurses in general settings have in meeting psychological needs, has been suggested by Hunt (1993) to be due to the focus being more on physical needs as these needs are seen as ‘more real’. Sharp (1990) also suggests that mental health problems may also be less likely to be viewed as genuine by some nurses as they are not as ‘visual ‘or apparent. Repper (1997) suggests addressing psychological needs may seem less appealing because of the anxiety and fear that may be generated in nurses. Cotter (1998) states that unconsciously avoiding contact with patients with psychological needs is common, and may be due to a means of minimising personal emotional distress. Furthermore, Hunt suggests that general nurses also see patients with mental health needs as ‘special’ and believe they require distinct knowledge
and skills in order to be able to meet needs. Hunt (1993) further states that the label of being ‘special’ can result in minimised contact, with fear and anxiety sometimes being used as a reason for further avoidance. Harrison (2001) suggests other factors may promote avoidance including a lack of knowledge regarding psychological problems; limited skills to be able to respond to psychological distress; lack of objectivity in reasons why psychological care is required; lack of confidence in attending to psychological needs. Nurses may also avoid patients with mental disorder due to the perception they take more time to nurse. However, Armstrong (2000, as cited in Happell & Platania-Phung, 2005) suggests there is no evidence that a person recognised to have a mental disorder, will require a greater level of care simply because they have a mental disorder. It is further suggested that if this perception is held, it may be in some way due to a lack of understanding of the extent to which a mental disorder may contribute or prolong a physical illness (Happell & Platania-Phung, 2005).

Expanded contact with people with mental health problems
Slevin and Sines (1996) found that nurse’s in the Northern Ireland who had expanded knowledge and experience in caring for those with challenging behaviour, verbalised a more positive attitude toward them. This was also the finding in Rohde’s (1996) pilot study in the USA, where 22 psychiatric nursing students who spent more time with those who were mentally unwell stopped seeing them as different. The students consequently felt less anxious and fearful when caring for those with mental health needs. Surgenor, Dunn and Horn (2005) also studied 164 New Zealand nursing students and found the need for specifically focused training. Weller and Grunes (1988, as cited in Brinn, 2000) found that nurses who had more contact with those with a mental disorder had more positive attitudes toward the patients. Reed and Fitzgerald (2005) also noted that nurses in their study that had had more interaction with people accessing mental health services felt more confident and had less fear and anxiety than their colleagues who had not had the same experience.

Assessment
Brinn (2000) and Harrison (2001) suggest that failure to adequately recognise and assess psychological needs is a common problem in the general nursing setting. Fuller and Schaller-Ayres (2000) state it is important these needs are given equal priority within the nursing assessment. It is also important that nurses check with the patient on their perception of needs (Farrell, 1991). In the UK, Farrell (1991) examined the extent nurse’s perception of patient’s needs corresponded with the patient’s view of their own needs. A questionnaire assessing emotional and physical needs was developed and given to 30 patients in general care and 30 patients in inpatient psychiatric care. The results indicated a strong variance between the nurse
and patient of perceived needs. According to Fuller and Schaller-Ayres (2000) communication and observation skills are also vital in ensuring accurate history taking. Description of a person’s mental state, including behaviour, mood, speech, perception, and cognitive functioning is important to include in admission documentation (Harrison, 2001). Harrison (2001) further suggests that nurses need to look at several factors within the patient’s presentation. This includes whether they have; a fearful or depressed appearance, social withdrawal or decreased talkativeness, psychomotor retardation or agitation, mood that is non-reactive to environmental events, marked diminished interest or pleasure in most activities, brooding, self-pity or pessimism, feelings of worthlessness or excessive or inappropriate guilt and recurrent thoughts of death or suicide. Having a baseline of a person’s mental state can assist in measuring any deterioration (Stuart & Laraia, 1998).

For a variety of reasons mental disorder is often not recognised or detected in general care settings, which could be related to lack of skills or expertise in assessment (Happell & Platania-Phung, 2005). In their North American study, Rincon (2001, as cited in Happell & Platania-Phung, 2005) found that critical care nurses did not have the skills or expertise to assess for anxiety, depression or delirium. Booth, Blow and Loveland (1998, as cited in Happell & Platania-Phung, 2005) suggested this detection of mental disorder could be helped through the use of brief screening instruments during patient admission which nurses could easily be taught to use. This is supported in the study by Silverstone (1996, as cited in Happell & Platania-Phung, 2005, p.45) where nurses were found to be “more proficient than medical staff at identifying patients who had received a DSM-IV diagnosis”. Their findings support the potential value nurses can have in the detection and assessment of mental disorder. This is providing they receive appropriate training and support (Happell & Platania-Phung, 2005).

There are many tools used to assist in assessing a person’s mental state and or mood in physical care settings. These include the Hospital Anxiety and Depression Scale, the Geriatric Depression Scale and the General Health Questionnaire (Tunmore, 1997). Harrison (2001) suggests assessment of several other factors is critical in the provision of psychological care. For example, assessing for the risk of self harm, and for a patient’s general concerns or anxieties. Alteration in usual mood is also important to monitor. Specific psychological interventions can then be made, for example protected time, relaxation techniques, stress management, active involvement of relatives/carers/significant others, and links with other professionals (Regal & Roberts, 2002). Specific factors are critical in the assessment and management of psychological needs. For example, Harrison (2001) states that in order for holistic care to be provided in the ‘true sense’, a person’s psychological needs need to be
acknowledged as a ‘legitimate’ area of concern. Furthermore, Regal and Roberts (2002) suggest that in order to address these needs, ‘protected time’ needs to be set aside in a private area, to enable the nurse to explore the person’s feelings, perceptions, fears and anxieties with them. Having this time set aside also validates these needs as worthy of separate attention. It can also reinforce the normalising process within the adjustment phase of illness (Nichols, 1994). Nurses that report having the ability and time to perform assessments for patients with mental health needs also have more enthusiasm to provide care to patients with mental health problems (Reed & Fitzgerald, 2005).

Psychiatric symptoms in general care settings

Physical and organic causes for psychiatric symptoms

According to Wyszynski and Wyszynski (2005) there are many physical or organic causes for psychiatric symptoms often seen in general settings. Many drug treatments for physical illnesses have the potential to cause psychological or psychiatric presentations. For example, central nervous system depressants may all potentially cause delirium or confusion (Harrison, 2001), which is essential to address as incorrect or delayed diagnosis can cause intentional and or unintentional injury (Neville & Gilmour, 2007). Beta-blockers and corticosteroids may cause acute psychotic symptoms and antihypertensive medication, oral contraceptives, neuroleptics, anticonvulsants or corticosteroids may cause depression (Harrison, 2001). Antidepressants, corticosteroids, or anticholinergics may cause an elevated mood and benzodiazepines, neuroleptics and lithium may alter behaviour significantly (Wyszynski & Wyszynski, 2005).

Mood disturbances

As found in the USA study by Roache, Connors, Dawson, Wenger, Wu, Tsevat et al., (1998), disturbances of mood, particularly depression may be seen as part of a person’s adjustment to acute or chronic illness. Tunmore (1997) notes however, this can be difficult to distinguish from pathological mood disorders. Assessment of the severity and duration of specific symptoms is essential in determining whether a mood disorder is apparent or, whether the person is displaying a ‘normal’ adaptive response to illness (Regal & Roberts, 2002). Happell and Platania-Phung, (2005) also stress the importance of appropriate assessment so that symptoms such as reactive anxiety are addressed early. Harrison (2001) suggests it is also important for nurses not to ‘expect’ psychological problems as a response to illness, as when faced with certain stressors many people may be able to adapt and cope. Papalia, Olds and Feldman (2003) further suggest that it is difficult to predict how a person may react to the stress of illness, due to abilities of adapting and adjusting to illness being individual. Psychological responses to sudden illness according to Papalia, Olds and Feldman (2003) are also likened to
the grieving process, which nurses need to have some understanding of in order to provide the most appropriate intervention.

Depression is “an abnormal extension or over elaboration of sadness and grief” (Stuart & Laraia, 1998, p.856). The word depression can be used in a variety of ways and can refer to a sign, symptom, syndrome, emotional state, reaction or disease (Stuart & Laraia, 1998). Depression often increases the risk of morbidity and mortality, and according to Maguire and Haddad (1996) is a common psychological problem with illnesses such as cancer, diabetes and neurological conditions. Wells, et al., (1993) found there is also much evidence relating to the link of increased mortality rates in those with co-existing depression and cardiac disease.

Harrison (2001) suggests it is important for nurses to be aware that although depression is a common consequence, it is not an inevitable reactive response to primary illness. Bridges (2001) also states that many problems associated with physical illness and depression can cause delayed recovery and rehabilitation. As found by Roache et al., (1998) increased morbidity is also a major concern, due to depression worsening the prognosis in pre-existing physical illness. Furthermore, a person may also have reduced physical activity, as well as difficulty in understanding and complying with treatment plans, particularly drug regimens (Regal & Roberts, 2002). According to Bridges (2001) and Harrison (2001) depression may also be a factor in increased length of hospital stay and in those physically recovering from illness, may increase the likelihood of failed community care, as well as increased need for residential care.

In their recent Swiss study Rentsch, Dumont, Borgacci, Carballeira, de Tonnac and Archinard et al., (2007) found the detection of depression in those with physical illnesses can be difficult and is a major health problem. Examples of the effects of depression can include poor appetite and sleep patterns, loss of energy and fatigue (Stuart & Laraia, 1998). When looked at in isolation, these symptoms are more likely to be due to an underlying physical problem. Additionally, depressive symptoms are more pronounced when stresses from events occur at the same time (Harrison, 2001). According to Harrison (2001) whatever the cause of depression, it is appropriate to utilise antidepressants in general settings. However, appropriate assessment is the first step and it is essential that nurses are able to assess for even mild symptoms of depression. In findings from their Italian study, it is suggested by Martucci, Balestrieri, Bisoffi, Bonizzato, Covre and Cunico et al., (1999) that failing to assess for depression may result in postoperative complications. This may also lead to the opportunity to detect a significant mental disorder being missed, leading to delays in referrals to specialist care. In their UK study, Roache et al., (1998) found that depression was found to be higher in people with severe
physical health problems. Furthermore, according to the Ministry of Health (2003b) older people also have an increased risk of suicide when physical recovery is delayed.

Depression and suicide
The World Health Organisation (WHO) predicts that by 2020 depression will be the second highest cause of death and disability in the world. It is also predicted to be second only to cardiovascular disease in contributing to the global burden of disease (Ministry of Health, 2005a). There is also a strong link between depression and suicidal attempts, with half of the New Zealand suicide cases in 2002 associated with depression (Ministry of Health, 2005b). In 2002, of the 460 people who took their own lives in New Zealand, ninety percent were suffering from depression (Ministry of Health, 2004a). Five thousand people were also hospitalised in 2002 after attempting suicide (Ministry of Health, 2005b).

Self harm and suicide attempts
According to Sidley and Renton (1996) another presentation that may result in negative attitudes from nurses, are self-harm or suicide attempts. Hemmings (1999) suggests overdose is the most common form of self-harm that is likely to be seen in general care. Approximately 500 New Zealanders die by suicide each year. Although the rate of suicide has decreased in recent years, New Zealand has one of the highest youth suicide rates in the Organisation for Economic Cooperation and Development (OECD) areas (Ministry of Health, 2003a). Stuart and Laraia (1998) state the risk of suicide is also higher among people with co-morbid depression and feelings of hopelessness. Regal and Roberts (2002) also suggest suicidal thoughts may be a sign of mental illness such as depression or anxiety. However, not all people experiencing acute ‘crisis’ difficulties and subsequently self-harm, have a mental illness. According to their UK study, Hackman, Goldberg, Brown, Fang, Dickerson and Wohlheiter et al., (2006) found that self-harm may also be triggered by chronic physical or, social and interpersonal problems.

Emergency departments are often used for the assessment of people with mental health problems (Thompson, 2006). This has been more so since the move towards deinstitutionalised care in New Zealand (Ministry of Health, 2003b). However, despite much contact with those who regularly self harm, as suggested by McLaughlin (1995) nursing and medical staff within emergency departments often do not have the knowledge or confidence to assess and meet specific needs. McAllister, Creedy, Moyle and Farrugia (2002) also found this in their Australian study although nurses reported wanting to develop their knowledge. Arnold and Bogg (1999) suggest it is important for staff to use effective interpersonal skills and view each
patient individually. Furthermore, any verbalisation of suicidal ideation must be taken seriously, with appropriate assessment undertaken (Melville & House, 1999; Ministry of Health, 2003b; Roberts, 1996). According to Cleary, Jordan, Horsfall, Mazoudier and Delaney (1999) nurses providing ‘special’ one to one care also need to be skilled in observation in order to assess level of suicidal risk and provide the most appropriate intervention.

Risk assessment
Ambrose (1996) and Hemmings (1999) suggest the ability to perform a risk assessment is not specific to mental health and is a skill that all nurses need to develop. Folse, Eich, Hall and Ruppman (2006) also emphasise the importance of the development of this skill from their USA study detecting suicide risk in adolescents and adults seeking treatment in an emergency department. They also suggest that nurses in all health settings need to initiate screening for suicide risk and implement nursing interventions directed toward suicide prevention. Recent guidelines from the New Zealand Guidelines Group have outlined a triage tool specific to the emergency department for the purpose of suicide risk assessment. However, this tool can also be used as a guide for other healthcare areas (Ministry of Health, 2003a).

Summary
As suggested by Harrison (2001), there is likely to be both a physical and psychological effect for any person who may be physically unwell. This may be due to the illness, environment or is the response of the carer towards specific needs (Black & Matassarin-Jacobs, 1997). Psychological needs may be overlooked and Regal and Roberts (2002) suggest nurses need to develop their awareness of these needs and their ability to assess them. Appropriate interventions to try and minimise the negative psychological impact of illness need to be provided. Jenkins (2006) states that unless nurses take the time to listen carefully to patients, holistic care is not being provided and important information may get missed. Furthermore, ensuring the mental health needs of patients is crucial in the provision of high quality care in nursing (Happell & Platania-Phung, 2005).

The literature review has shown there is a great deal of information on factors that influence nurses meeting the mental health needs of patients in general care settings. However, there is limited information relating to New Zealand. The following chapter discusses the method used by the researcher in the attempt at gaining data relevant to New Zealand, and meeting the aims and purpose of the study as identified on page 3.
CHAPTER 3

Methodology

Introduction

This chapter discusses the research design and the processes used to gather data in order to answer the research question. Due to the design being both quantitative and qualitative, each design will be discussed in relation to its appropriateness in this study. The setting, sample and date collection tool and data analysis will also be discussed, along with ethical and cultural issues of undertaking such a study.

Research design and method

The purpose of the research approach and design is to “provide the plan for answering research problems, which then becomes the vehicle for answering research problems” (Beanland, Schneider, LoBiondo, Wood & Haber, 1999, p.176). It is the research question that determines the approach and the design must be able to answer the question posed (Beanland et al., 1999). An exploratory design was used in this study which according to Beanland et al., (1999), may use either qualitative or qualitative designs. The design used for this study was a mixed quantitative and qualitative design. Quantitative research is objective and systematic and refers to the investigation of phenomena that lend themselves to precise measurement and quantification (LoBiondo-Wood & Haber, 2002). In quantitative designs the researcher attempts to use a design that maximises the degree of control over variables tested. Consistency in data collection procedures is also essential (Beanland et al., 1999).

“Nursing is both a science and an art. Qualitative research combines the scientific and artistic natures of nursing, to enhance understanding of the human health experiences” (Beanland et al., 1999, p.238). It assists researchers to study things in their natural setting and attempts to make sense of the meanings people bring to them (Denzin & Lincoln, 1994, as cited in Beanland et al., 1999). Quantitative designs select representations of the population and use specific questions to measure the variables of interest. This is called deductive analysis. Whereas qualitative research selects participants who are experiencing a phenomenon. This type of research uses interviews and inductive analysis, which is narrative summary describing the persons experience. This type of design provides a deeper insight to the phenomenon and is popular in nursing (Beanland et al., 1999).

Non experimental research designs are used in studies where the researcher wants to construct a picture of a phenomenon or, specific events, people or situations are required to be explored as they naturally occur. When this design is used there is no manipulation. The independent
variables have already occurred, so the investigator cannot directly control them by manipulation. The aim of a non-experimental design is to explore relationships or differences between variables. This design also works from a clear, concise problem statement based on a theoretical framework (Beanland et al., 1999). The broadest category of non-experimental designs is the survey study. These can be further classified as descriptive or exploratory research designs. Descriptive or exploratory surveys collect detailed descriptions of existing variables and use the data to justify and access current conditions and practices. They can also be used to make changes appropriate to the area studied. Investigators use this design to search for accurate information about the characteristics of particular subjects or groups. This design is also useful when wanting to know about the frequency of a phenomenon occurring particularly when little is known about it. Most studies will collect factual data, which includes basic demographic data. These studies are also used to determine differences between variables, for example assessment needs for future studies (Beanland et al., 1999).

In descriptive or exploratory studies, investigators attempt only to relate one variable to another. They do not attempt to determine causation. There are both advantages and disadvantages of survey research. Two major advantages are that a great deal of information can be obtained from a large population in a fairly economical manner and, that survey research information can be surprisingly accurate. If a sample is representative of the population, a relatively small number of subjects can provide an accurate picture of the population. There are several disadvantages of these studies however. Information can tend to be superficial. The breadth rather than the depth of information is emphasised. Conducting a survey also requires a great deal of expertise in a variety of research areas (Beanland et al., 1999).

Data in survey research can be collected by either a questionnaire or an interview (Beanland et al., 1999). An exploratory survey was used within this study. The survey was a semi-structured, self-administered questionnaire. A questionnaire is highlighted within the literature to fall into the quantitative paradigm (Beanland et al., 1999). The questionnaire had several sections including one in which respondents could make comment. This is why the survey was considered as being both quantitative and qualitative. An advantage of the questionnaire is that it is most useful due to having a finite set of questions which the researcher can be assured of having clarity and specificity of items. Interviews and questionnaires are the most commonly used data collection method in nursing research (Beanland et al., 1999). They have a purpose of asking subjects to report data about themselves and can be used to get to a larger number of the population and can be anonymous. However, if the questionnaire is too long it may not be completed. The respondent can also answer the questions in any order, which may affect their
response more than if they had an interview. Furthermore, if an appropriate survey cannot be located a new one is required to be developed which can be time consuming (Beanland et al., 1999).

Development of the questionnaire

Interviews or questionnaires require subjects to report data about their knowledge, attitudes, beliefs and feelings on particular topics (McGibbon, 1997a). General thematic areas for the 23 questions were developed from general themes reported in the literature. Themes presented included time, workload, task oriented care, environment, and severity of condition, knowledge and education, support from mental health services, attitude from colleagues, and avoidance of people with mental health problems. The questions must ask only one question, be grammatically correct, free of jargon, not open to interpretation, and written in a language understandable to respondents (Beanland et al., 1999). A definition of mental health, mental health needs and problems was also provided on the information sheet.

There were five different sections within the questionnaire developed for this study. Part A included demographic questions. Within this section nurses were also asked to identify what level of nursing they were as in the regional hospital chosen for this study, nurses have the opportunity to be part of the Nursing Professional Development Recognition Programme (NPDRP). Using a professional portfolio, nurses are asked to display evidence of nursing competence from a series of clinical indicators ranging from level one to four. The competencies and indicators are based on the competencies for the registered nurse scope of practice outlined by the Nursing Council of New Zealand (2005). The ‘level’ process is based on the Dreyfus model of skill acquisition from ‘novice to expert’ as described by Patricia Benner (1984, as cited in Dracup & Bryan-Brown, 2004), where level one is for the novice nurse, level two is competent, level three is proficient and level four is expert.

Part B and C had fixed responses. Part B had closed ended questions that focused on the nurse’s views about providing care for people with mental health needs and problems. Part C also had closed ended questions about nurse’s experience when providing care for a person with mental health needs and problems. Part D had both open and closed ended questions around training, and finally Part E provided an area for nurses to make their own additional comments. A five point Likert scale was used in this study in Parts B and C. On the left were strongly agree, agree; the intermediate point was neither agree nor disagree, and on the right were disagree and strongly disagree. The five point scale is regarded as optimal as most people can not discern beyond five positions (Davidson & Tolich, 1999). Many instruments, especially
Likert-type scales, contain both positively and negatively worded items within the same scale (Beanland et al., 1999). This was so in the questionnaire used by the researcher. In computing total scores with scales that contain oppositely worded items, negative items are reversed scored so that strong disagreement is given the same number as strong agreement with positive items. Therefore, the scoring of disagreement with the first item type will be equivalent to agreement with the second. The assumption underlying such a scoring method is that individuals who disagree strongly with an item on one side of the range will usually agree with the other side. This should result in a similar degree of correlations between oppositely and similarly worded items. Although it may be assumed that reverse scoring oppositely worded items makes the scores equivalent, this is not necessarily the case (Beanland et al., 1999). It is also suggested by Davidson and Tolich (1999) that this method can affect the reliability of the tool used within a survey due to possible confusion of what the question may actually mean.

Although at times difficult to design, questionnaires are a popular and useful method of data collection due to a lot of data being able to be gathered quickly and efficiently (Jack, 1998). It also takes a relatively short time to complete (McGibbon, 1997b). Advantages of use of this tool within the collection process are that they can reach large numbers quickly (Gillis & Jackson, 2002). When questionnaires are self-completed, it also helps to avoid researcher bias. Further advantages include anonymity which is likely to ensure honest responses (McGibbon, 1997a). Reliability and validity of the questionnaire can also be tested more easily using pre-developed statistical tests (Beanland et al., 1999).

Disadvantages of self-completion questionnaires however, are that they can result in response bias from inappropriate responses or non-responses. This is because there is no opportunity for the respondent to clarify a question (Dunning & Martin, 1996). Furthermore, although questionnaires also have the ability to obtain certain kinds of information such as attitudes and beliefs, there is a concern with accuracy. This is due to no way of knowing what the respondent has identified is true. For example; people are known to respond to a question in a way that makes a favorable impression. This is termed social desirability, as there is no way to tell if the person has told the truth (Beanland et al., 1999). The researcher is forced to accept that the respondent is telling the truth however. The return rate is also often low which may reflect on how well the sample represents the population. It is generally accepted that a response rate of twenty five percent is acceptable. Response rates of less than ten percent are of dubious value (Gillis & Jackson, 2002; McGibbon, 1997b). To address the disadvantages of the questionnaire, as much care as possible needs to be taken in designing the questions. This is to avoid ambiguity. Questionnaires also need to be scrutinized by others through use of a pilot test. This
helps to confirm reliability and validity and elicit any faults in the design (McGibbon, 1997b; Minichiello, Sullivan, Greenwood & Asford, 1999).

Reliability can be defined as “the consistency or constancy of a measuring instrument” (Beanland et al., 1999, p.586). The reliability of a questionnaire is the major way of determining its quality (Dunning & Martin, 1996). Validity is the extent to which the questionnaire measures what it is supposed to measure (Beanland et al., 1999). Bailey (1991) and Dunning and Martin (1996), suggest that proving reliability and validity can be difficult when using questionnaires. For the purpose of this study however, a questionnaire was considered the most effective and appropriate approach to use. To ensure the reliability of the study, it was essential to confirm that participants understood the questions. This was achieved through use of a pilot study, to clarify aspects within the questionnaire and to ensure whether what the researcher was asking was interpreted the way in which the researcher intended. The researcher also needed to check if the questionnaire needed to be rephrased, deleted/added. The value of a pilot lies in the fact that it provides an opportunity for the researcher to review all aspects of the study, identifying strengths and weaknesses and assess whether the design is appropriate (Dunning & Martin, 1996). Reliability may also be affected by participants making comment regarding the role of the researcher. Although the intention is not to have the focus being on the role of the researcher, it is acknowledged that some participants may feel the need to make comment which needs to be highlighted as a threat to reliability.

The questionnaire was believed to have face validity and was piloted amongst a group of ten experienced nurses to ascertain if the questions were appropriate and Understandable. Apart from some minor spelling changes there were few changes required in the questionnaire. Explanation of the survey was provided via letter first to the Clinical Charge Nurse on the ward. This was to ensure they were aware of the pending research and gave their approval. Posters were also strategically placed around the wards after permission was gained. The date the questionnaires were to be collected was provided to the Clinical Charge Nurses. The questionnaires were then taken by the researcher to the acute, medical, surgical, and rehabilitation wards of the hospital. A covering letter explaining the aims and objectives of the research was provided on the information sheet along with an explanation that participation was voluntary. Nurses also had the opportunity to make comments on the questionnaire. To ensure the researcher was not aware of the specific ward the completed questionnaires came from, at the end of the two weeks a mental health colleague offered to assist in the collection.
Setting
The study was undertaken in ten different wards of the hospital. The areas included the acute (emergency, acute assessment, intensive care), and medical, surgical and rehabilitative wards. The rehabilitation ward is also known as assessment treatment & rehabilitation (AT&R). The reason for the specific areas chosen was due to these areas all having Registered Nurses caring for people with mental health needs.

Sample
Sampling is the process of selecting units of a population for a study in a research investigation (Beanland et al., 1999). Convenience sampling was used in this study, where the respondents were chosen by non-random methods. This strategy is often used in non-experimental designs (Beanland et al., 1999). There is however, a risk of bias in convenience sampling, due to self-selection to participate and the researcher not being aware if the respondents have any other motivation that is their primary focus (Beanland et al., 1999; Gillis & Jackson, 2002). The sample group for this study was Registered Nurses since they all have the same expectations from the New Zealand Nursing Council (2005) within the competencies for the registered nurse scope of practice. Participants were recruited via poster. Three hundred questionnaires were distributed with thirty questionnaires being placed in each of the ten areas. It was anticipated that over one hundred nurses would reply.

Data analysis
Raw quantitative data from questionnaires was analysed statistically. Statistics are the most common way to convey the results of a quantitative study using a questionnaire (Jack, 1998). Data from the questionnaire were analysed using Microsoft Excel and the Statistical Package for Social Sciences (SPSS). Responses were converted to numerical values in order to be analysed for distributions, modes and medians. The purpose and advantages of turning responses into a summarised statistical form is to aid in analysing information, as well as communicating the findings in a form that represents shared understanding between the researcher and reader (Beanland et al., 1999; Gillis & Jackson, 2002). Consideration for responses with negatively worded questions was made for reasons previously discussed on page 28.

A numerical average was also calculated for each Likert-scale question, where each category was assigned a value (as below). The number of responses in each category was multiplied by the score for that category. These products were then summed and divided by the total number of responses.
<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>5</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

Thematic analysis is a method of qualitative analysis based on participant conceptions of communication (Gillis & Jackson, 2002). This method was used for the qualitative sections of the questionnaire. Written comments, read and categorised based on recurrence and repetition, were examined for emergent themes. Themes were identified by specific words that were mentioned by participants. This provided the most effective way in formulating the qualitative data by participants.

Ethical considerations
As highlighted by Beanland et al., (1999) in relation to research being conducted legally and ethically, research participants consider not only the ‘rules and regulations’ involved in research but also the conduct of the researcher. Researchers must always be fully committed to the provision of informed consent and ensure the persons rights are maintained. The thinking of the end justifying the means must never come into account. Every precaution to promote people from any form of harm must be taken. Appropriate language and avoidance of technical language should also be used when explaining the consent process. This way informed consent can be guaranteed. Furthermore, no vulnerable population should be singled out for a study because they are available and convenient (Beanland et al., 1999).

Participants were given clear information of the purpose of the study. No coercion or incentives was used. As the researcher visits the wards involved in the research regularly as part of the role held within the hospital, during the two weeks the questionnaires were on the wards the researcher refrained from discussion about the research to the nurses. Furthermore, the completed questionnaires were collected by a colleague of the researcher. This was to ensure the specific ward the questionnaires came from was not known to the researcher, only the area. Participants were also informed of what will happen with the completed questionnaires and data. Participation was on a voluntary basis and anonymous and no potential harm to participants was anticipated. As completion and return of the questionnaire was on a voluntary and anonymous basis, a consent form was not included with the information sheet. Respondents consent to be involved in the survey, was assumed by their completion of the
questionnaire. The statement “By filling in and returning this questionnaire, it is assumed that you give consent to participate in this research” was included on the information sheet and questionnaire. The information sheet included clear information regarding the purpose of the study, along with the expected time for completion, what will happen to information gathered, where data will be stored and, who would have access to the data. All completed questionnaires are kept in a locked filing cabinet, accessible only to the researcher. Computer files are also password protected. The thesis has no identifiable information. All raw data will continue to be kept in a secure place by the researcher and held for a period of up to five years. At the conclusion of this time all data will be destroyed.

**Ethical and research approvals**

As with all research involving human participants, ethical approval was required to be gained (Beanland et al, 1999). Prior to commencing the research applications for ethical approval were made to the Central Regional Ethics Committee, Eastern Institute of Technology Research Committee, the Maori Health Unit and Research Coordination Committee of the hospital. Declaration of the day to day role on the wards held by the researcher was made to the Central Regional Ethics Committee. This ensured that possible suggestion of any coercion was addressed. The application to the Central Regional Ethics Committee was accepted, however approval was not required. The committee did however, provided ethical advice. Approval was given for all other applications.

**Cultural considerations**

There were no concerns regarding cultural issues anticipated by the researcher. Identification of how many respondents were Maori was specifically requested by the Maori Health Unit in their response to request for approval. This was done by a question within Part A of the questionnaire whereby participants were asked to identify whether they were Maori or non-Maori. The researcher also ensured the Principles of the Treaty of Waitangi (Participation, Protection and Partnership) were maintained by doing this in partnership with Maori, by ensuring those that identified themselves as Maori had the opportunity of participation and, had ethical and cultural protection of their rights.
CHAPTER 4

Results/findings

Introduction

Chapter Three outlines methods of data collection and analysis that were used in the study. Data were analysed using Microsoft Excel and SPSS. A numerical average was also calculated for each Likert-scale question, where each category was assigned a value—as discussed in Chapter Three. Thematic analysis was used for the qualitative sections of the questionnaire. Potential errors were minimised by double checking data input and coding. This chapter will present data from completed questionnaires. Part A includes demographic information, Parts B and C focused on the nurse’s views about providing care and their experiences when providing care for a person with mental health needs and problems. Part D had questions around training, and Part E provided an area for nurses to make additional comments.

Out of the 300 questionnaires forwarded to the 10 areas, 90 completed questionnaires were returned which was a 30% response rate. On return their return questionnaires were numbered and kept in numerical order, in order to refer to individual respondents when analysing the qualitative data, especially the comments.

Demographic results

A. INDIVIDUAL DETAILS

Question 1

Are you male or female?

The majority \( n = 83, 92\% \) of participants were female. One person chose not to answer.

Figure 1: Gender

![Gender Chart](image-url)
Question 2
What is your age?
Nurses were given the opportunity to identify their age. The median age was 38.8 years and the highest frequency was in the group between 35-44 years with 34% ($n = 30$). The largest group of participants in this age group ($n = 14$) were from the acute area. Two nurses chose not to answer this question.

![Age](image)

Figure 2: Age

Question 3
What is your ethnicity?
The majority of participants identified themselves as non-Maori ($n = 81$, 90%). Two nurses chose not to answer this question.

![Ethnicity](image)

Figure 3: Ethnicity
Question 4
What are your nursing qualifications? (please identify as many that apply)

Nurses were asked to identify their nursing qualification from a list of nursing diploma; nursing degree; post graduate certificate; post graduate diploma; master’s degree and other. One nurse chose not to answer this question. There were no nurses who participated in this study that identified as having a masters degree. Sixty three nurses (65%) however identified as having a nursing degree, and 18 a nursing diploma. Ten nurses highlighted other, 10 nurses had a post graduate certificate and seven had a post graduate diploma. Many nurses ($n = 11$) indicated they had a nursing degree as well as other qualifications. One nurse reported having a nursing degree and diploma, a post graduate certificate, and a post graduate diploma. Two nurses reported having a nursing degree, post graduate certificate and post graduate diploma. Four nurses reported having a nursing degree and diploma. Three reported having a nursing degree and post graduate certificate, and one nurse reported having a nursing degree, diploma and post graduate certificate. One nurse identified they had a hospital based certificate and post graduate diploma. Another nurse identified themselves as a senior registered nurse (SRN), and another was a registered general nurse (RGN). Neither of these last two nurses identified they had other qualifications.

Question 5
How many years of nursing experience do you have since qualifying?

Nurses were asked to identify how many years of nursing experience they had since qualifying. The years from initial qualification ranged from between four months to forty years. The most common group of years of experience was five to ten years ($n = 18$, 20%) but the median was between 10-15 years. One nurse chose to not answer.

Figure 4: Years of experience
Question 6

In what area are you based?

Nurses were asked to identify which area they worked in from the choices of acute (emergency, acute assessment, intensive care), and medical, surgical, and rehabilitative – Assessment, Treatment & Rehabilitation (AT&R) wards. One nurse chose not to answer this question. More participants (\(n = 34, 37\%\)) identified as being from the acute area.

Figure 5: Area of work

<table>
<thead>
<tr>
<th>Area of work</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>No answer</td>
<td>1%</td>
</tr>
<tr>
<td>Acute</td>
<td>37%</td>
</tr>
<tr>
<td>AT&amp;R</td>
<td>10%</td>
</tr>
<tr>
<td>Medical</td>
<td>24%</td>
</tr>
<tr>
<td>Surgical</td>
<td>28%</td>
</tr>
</tbody>
</table>

Question 7

If you have been leveled under this hospital’s Nursing Professional and Development Recognition Programme, what is your present Nursing level?

Participants were asked to identify what level they had been assessed at. Most participants were level three (\(n = 35, 39\%\)). In relation to identified work areas, (\(n = 12\)) participants were level 3 and (\(n = 5\)) were level 4 in the acute area; (\(n = 9\)) were level 3 in medical with (\(n = 11\)) in surgical; (\(n = 3\)) were level 3 in AT&R and (\(n = 2\)) level 4. Nineteen nurses did not to answer. It is unknown however, whether they chose not to answer or had not been assessed under the NPDRP.
Views

B. YOUR VIEWS ABOUT PROVIDING CARE FOR PEOPLE WITH MENTAL HEALTH NEEDS/PROBLEMS

Nurses were asked to rate their response to the following questions;

Question 8

Regardless of the area a nurse works in, I believe it is part of a nurse’s job to care for people requiring psychological support.

Table 1: Question 8

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td>Agree</td>
<td>52</td>
<td>58</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The average for this question was 4.4 which indicates that all the nurses surveyed believe it was part of their job to care for people requiring psychological support. There were insufficient numbers to undertake a comparison between males and females regarding age and qualifications.
Question 9:

I believe that people with mental health problems should be cared for in mental health inpatient units (MHIPU).

Table 2: Question 9

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>10</td>
</tr>
<tr>
<td>Agree</td>
<td>28</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>32</td>
</tr>
<tr>
<td>Disagree</td>
<td>16</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>2</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
</tr>
</tbody>
</table>

The average for this question was 3.3, indicating that more nurses agreed than disagreed with this statement and believe that people with mental health problems need to be cared for in a MHIPU. This may stem from an assumption that these patients are in hospital for other than mental health reasons and thus should be cared for in the appropriate medical or surgical ward. This answer might also be considered biased through interpretation of ‘mental health problems’ being considered as only the severe end of the continuum.

Out of participants that indicated agree and strongly agree ($n = 15$) participants were from the acute area and ($n = 12$) medical, ($n = 8$) surgical and ($n = 3$) participants were from the AT&R area. In the researchers experience during practice, the acute and medical areas tend to have more patients with acute mental health needs as well as their physical. For example, these areas have patients admitted following deliberate self harm requiring medical attention more so than the surgical and AT&R areas. However, this is only an assumption from the researcher. There were no major differences between males and females with qualifications or between age groups up to age 55 years. However, the 55 years and over ($n = 6$) were more likely to indicate agreement with the question. It is also to be noted that many nurses ($n = 32$) neither agreed not disagreed to the statement that people with mental health problems should be cared for in an MHIPU.
Question 10

*I believe that mental health nurses only, are able to nurse people with mental health problems.*

Table 3: Question 10

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Agree</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>52</td>
<td>58</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

The average for this question was 2.5 which indicates that in general participants do not believe that mental health nurses only are able to care for people with mental health problems. This suggests most nurses feel capable in dealing with mental health issues on the ward. Those that indicated they agreed or strongly agreed with this statement were evenly spread amongst the four work areas.

Question 11

*I believe that I have sufficient knowledge to care for people with mental health needs.*

Table 4: Question 11

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Disagree</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

The average for this question was 3.0 indicating an even split of participants suggesting that some participants do and some do not believe they have sufficient knowledge to care for people with mental health needs. This indicates some need for additional training, but also that some nurses are comfortable with their existing knowledge. Those who agreed and strongly agreed with this statement were from areas such as acute \( n = 9 \), medical \( n = 11 \), surgical \( n = 9 \), and AT&R \( n = 3 \). Those nurses who indicated they either disagreed or strongly disagreed with this statement were from acute \( n = 19 \), medical \( n = 5 \), surgical \( n =10 \) and AT&R \( n =1 \).
Males were slightly more likely to indicate they had sufficient knowledge with an average score of 3.6 compared to 2.9 for females. Only the 55 years and over age group indicated concern over their knowledge level with an average score of 2.3 ($n = 2$ disagree). Sixty one percent of females and 71% of males felt they had sufficient knowledge to care for people with mental health needs. In terms of age bands, 67% of those under 25 years of age, 100% of those 25-44 and 77% of those 45-54 indicated they were happy with their knowledge level. The only age group where the majority of nurses felt they did not have sufficient knowledge was the 55 years and over group, with only 33% indicating this. There were no large differences between nurses with respect to qualifications and satisfaction with knowledge level (degree 62%; diploma 55%; other 64%; postgraduate 75%). With respect to levelling, again the majority of nurses indicated satisfaction with their knowledge level (not levelled 63%; Level 1 62%; level 2 71%; level 3 100%; level 4 57%).

**Question 12**

*I feel confident to care for people with mental health problems.*

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Agree</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Disagree</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The average for this question was 3.1 which suggests some participants do not feel confident to care for people with mental health needs. This may indicate a need for targeted mentoring. Although there was a large group of participants who indicated they feel confident. Areas where participants indicated they feel confident were from acute ($n = 14$), medical ($n = 10$), surgical ($n = 7$) and AT&R ($n = 3$). Areas in which participants indicated they did not feel confident were from acute ($n = 17$), medical ($n = 5$), surgical ($n = 7$), and AT&R ($n = 1$). Males were also slightly more likely to indicate they felt confident with an average score of 3.6 compared to 2.9 for females. Only the 55 years and over age group indicated concern over their confidence with an average score of 2.2. All of the nurses within this age group had been nursing for over 30 years. Nurses in this group were from the acute ($n = 2$), surgical ($n = 2$) and medical ($n = 1$) areas.
Question 13

I feel vulnerable when nursing people with mental health problems.

Table 6: Question 13

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Agree</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Disagree</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

The average for this question was 3.0, which indicates that some nurse’s do and some do not feel vulnerable when nursing people with mental health problems. Those who indicated they feel vulnerable were from acute \((n = 16)\), medical \((n = 7)\), surgical \((n = 9)\), and AT&R \((n = 1)\). Those who indicated they disagreed or strongly disagreed with this statement were from acute \((n = 10)\), medical \((n = 7)\), surgical \((n = 10)\), and AT&R \((n = 5)\). Those in the 55 years and over group \((n = 5)\) indicated an average score of 3.7 which suggests those in this group feel more vulnerable than those in the younger age groups. Nurses in this group had been nursing for over 30 years. Participants \((n = 17)\) agreeing with this statement disagreed to questions 11 and 12.

Experience

C. YOUR EXPERIENCE IN PROVIDING CARE FOR PEOPLE WITH MENTAL HEALTH NEEDS/PROBLEMS

Question 14

I believe that people with mental health problems impact on the overall provision of care in the ward.

Table 7: Question 14

<table>
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<th>Number</th>
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<tbody>
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<tr>
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</table>
The average for this question was 3.4, which indicates that some nurses believe that people with mental health problems impact on the overall provision of care in their ward. It may be suggested that this is to be expected given that it is another job a nurse is required to do, which may influence the time and energy for other tasks. Those participants who agreed with this statement were from acute \((n = 22)\), medical \((n = 12)\), surgical \((n = 14)\), and AT&R \((n = 2)\). Those who disagreed were from acute \((n = 7)\), medical \((n = 4)\), surgical \((n = 5)\) and AT&R \((n = 3)\).

**Question 15**

*I believe that care for patients with mental health problems could be improved in my area.*

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
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<td>Agree</td>
<td>48</td>
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<tr>
<td>Neither agree nor disagree</td>
<td>17</td>
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<td>Disagree</td>
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<td>Strongly disagree</td>
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The average for this question was 3.9, which indicates that many nurses believe that care could be improved in their area of work. There was a strong belief that care could be improved for mental health patients in their area. Participants \((n = 16)\) that indicated they agreed with this statement were from the acute area; \((n = 14)\) were from surgical, \((n = 12)\) from medical and \((n = 6)\) from the AT&R area. Participants \((n = 11)\) indicated that indicated they strongly agreed with this statement were also from the acute area with \((n = 5)\) from the medical area, and \((n = 1)\) both in surgical and AT&R areas. Those that disagreed with this statement were from medical \((n = 3)\), surgical \((n = 2)\) and AT&R \((n = 1)\). This supports comments about mental health problems impacting care on the ward, but it is not clear why they have this opinion. It is also unclear why some participants believe care does not need to improve in their area.
**Question 16**

I believe that more support is needed from Mental Health Services in order to care for people with mental health problems.

Table 9: Question 16

<table>
<thead>
<tr>
<th>Number</th>
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<td>Agree</td>
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<td>15</td>
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<td>Disagree</td>
<td>2</td>
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<td>0</td>
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</table>

The average for this question was 4.1 which indicates nurses believe more support is required in order to care for people with mental health problems. Very strong agreement for increased support from mental health services. However, given that we know nurses are under strong time pressures (as pointed out in question 19), it is entirely natural to want additional support, this will free them up for what they may see as their primary job. Those that indicated they disagreed with this statement were from medical \( n = 1 \) and AT&R \( n = 1 \) areas.

**Question 17**

I believe that more support from Mental Health Services would increase my confidence in caring for people with mental health needs.

Table 10: Question 17

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<td>1</td>
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</tbody>
</table>

The average for this question was 3.8, suggesting more support from mental health services would increase nurse’s confidence in caring for people with mental health needs. It is interesting to note that \( n = 8 \) participants that indicated they disagreed with this statement, \( n = 4 \) of these same participants also indicated they did not have enough confidence (question 12).
This may suggest that for these participants, it is believed that more support from mental health would not be enough to increase their confidence. These same participants agreed and strongly agreed with the statement in question 16.

**Question 18**

*I believe that I have enough support to care for people with mental health problems.*

Table 11: Question 18

<table>
<thead>
<tr>
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<tbody>
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<td>1</td>
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<tr>
<td>Agree</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
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<td>23</td>
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<tr>
<td>Strongly disagree</td>
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<td>7</td>
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</table>

The average for this question was 2.5 which suggests a great deal of participants do not believe they have enough support to care for people with mental health problems. Those who indicated they feel they have enough support were from areas such as acute, \((n = 3)\), medical \((n = 3)\), surgical \((n = 7)\), and AT&R \((n = 4)\). Participants \((n = 5)\) between the age of 55 years and over indicated they disagreed with this statement.

**Question 19**

*I believe that I have enough time to care for people with mental health needs.*

Table 12: Question 19

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Agree</td>
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<td>Disagree</td>
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<td>56</td>
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<tr>
<td>Strongly disagree</td>
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<td>22</td>
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</tbody>
</table>

The average for this question was 2.1 which indicates nurses do not believe they have enough time to care for people with mental health needs. However, this question may be answered in a similar way if nurses were asked if they felt they had enough time to care for patients with any...
type of specific needs. Those who indicated they have enough time were from acute \((n = 2)\), medical \((n = 2)\), surgical \((n = 4)\) and AT&R \((n = 1)\).

Overall there were few differences from the total average response with questions 8 to 19, and in almost every case the differences are from small groups, which means the results have no generalisability.

Training
D. TRAINING

Question 20

*Would you be interested in undertaking further training in order to expand your knowledge in mental health?*

Table 13: Question 20

<table>
<thead>
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<th></th>
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<td>28</td>
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<tr>
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<td>1</td>
</tr>
</tbody>
</table>

Participants that indicated they would not be interested in undertaking further training were from acute \((n = 10)\), medical \((n = 5)\), surgical \((n = 7)\) and AT&R \((n = 3)\). Participants \((n = 13)\) that indicated they did not have enough knowledge (question 11) also indicated answered no to this question. It is unclear whether those that indicated they would not be interested was due to actual disinterest or the themes noted below.

Question 21

*If your answer to above was yes, is there anything that would prevent you pursuing further training?*

Table 14: Question 21

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
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</thead>
<tbody>
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<tr>
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</table>
Question 22

If your answer to above was yes, please specify what would prevent you most from undertaking further training.

Themes identified include time, family, finances, education and lack of appropriate courses, shift work and support from management.

Time

Fourteen participants identified that time would prevent them from undertaking further training. One participant further mentioned “time, funding and work pressures” whilst another suggested “time as I have a wide area of commitment to my young family and aged care impaired parents”. Also noted was “in our ward situation, even if we knew lots more it would be difficult to find adequate time to actually carry out better care”.

Family

Eleven participants mentioned that family and related responsibilities would prevent them from undertaking further training. Two participants noted “time and family commitments” as a reason whilst another mentioned they had “family commitments and responsibilities”. Other comments noted by participants included; “busy at home with the kids”; “time away from family”; “family and already working full time”; childcare; “not looking to take on any further training at this stage in my career (financial, family reasons); and “incorporating further training and working full time with family to provide for”. One participant further stated “time, family commitments so more short in-services”.

Finances

Another theme identified by nine participants as preventing further training from being undertaken was financial and resource constraints to pay for courses. It was not mentioned whether the same staff had accessed any scholarship or professional development funds for funding for specific courses however. “Not getting paid for it”; was reported as was “being asked to give up even more of my own time to do training, eg no paid study time”; “money”; “financial/resource constraints”; “if money was required by s/n doing course”; “costs”; “financial”; “need for income”; “budget”.

Education and lack of appropriate courses

“Lack of education” and “lack of available courses” was identified as reasons preventing two participants from undertaking further training. Another participant stated they “would like to have study days and short courses, but would not do post grad as not desired field of nursing”.

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“Programmes based around ED presentations” was also highlighted. Regarding the issue of time and training, one person also suggested one reason included “length of study courses”.

Shift work and support from management

“Shift work hours”, “being able to attend” and “support from management” was highlighted by two participants as reasons preventing further training from being undertaken. “Short sessions prior to pm (afternoon duty) shifts or after an am (morning duty)” was highlighted by two participants as a means of assisting.

Question 23

*If your answer to question 20 was yes, what would motivate you most to undertake further training?*

Nurses were asked to select either; a certificate (recognised qualification), salary enhancement, career progression, knowing that as a result of training you were better able to meet the needs of patients, other. Many nurses highlighted a combination of answers. Thirty eight nurses highlighted that a certificate (recognised qualification) would motivate them most, 27 identified salary enhancement, 19 career progression, and 53 participants identified that knowing that as a result of training you were better able to meet the needs of patients. Seven nurses also ticked other and highlighted that the following would motivate them to undertake further training:

“I would be able to give other staff guidance and confidence in these issues”.

“Professional recognition, ie in the area of work”.

“But in small modules. I don’t wish to take time out from my current post to undertake yet another qualification”.

“Study days on various types of mental health issues and how best to handle situations and provide necessary and proper support for patients”.

Comments

E. ANY OTHER COMMENTS?

*If you would like to add further information, please use the space provided below.*

Nurses were invited to add any further comments. Themes presented included time, workload, task oriented care, environment, and severity of condition, knowledge and education, support
from mental health services, attitude from colleagues, and avoidance toward patients with mental health problems.

Time
The issue of not having time to care for patients with mental health needs and problems was highlighted by four participants. One participant stated “in my area (AAU) time is a problem. I often face difficulties in caring for 'demanding' mental health patients due to time factor. There are also times when I feel like 'listening'. Would help someone but I was not able to give them the time. I do feel it is an area we shy away from due to time factor mainly”. Another participant noted “time is a big factor in how much a patients mental health issues are dealt with in ED. Mainly medically oriented cares are given”. A further comment by a participant mentioned about care being provided. “In the acute setting mental health patients are at risk at receiving insufficient care from RN’s due to lack of time”. It was also noted about the effect lack of time has on patients. “One of the biggest problems is we don't have enough time to nurse those patients with basic surg/ortho needs, let alone patients that may have their stay compounded by a mental health problem, however minor”.

Workload
Another barrier highlighted by two participants was their existing high workload and not being able to address mental health needs because of this. It was commented that “they can dominate an RN's workload to the detriment of other patients”. Workload and high turnover of patients was also noted by a participant. “The main barrier to helping and understanding those patients in our ward, is the lack of time due to pressure of workload and high turnover of patients due to bed demand”.

Task oriented care
Two participants made statements regarding task oriented care. One participant mentioned that “mainly medically oriented cares given” in the emergency department. A surgical nurse also wrote “surgical/ortho nursing is for the most part task oriented... "fix em up...shunt em out”.

Environment
Four participants identified the general hospital environment as a difficult area to provide proper and adequate care needed for some people with mental health problems. One participant wrote “sometimes depending on the severity of a patient's mental health condition, a ward environment is not a safe and ideal environment to provide the proper and adequate care needed for the patient”. The emergency department was highlighted by one participant as “a
terrible place for people with any mental health issues. It is too frantic, too busy and too stressed. Need to concentrate on moving people on to a more appropriate area to receive help etc. Far too often people are cleared medically and then wait hours in a stressful environment to see someone from mental health. Ultimately, the ED is an inappropriate environment”. Another continued by saying the “ward environment is not always suitable for mental health patients. One other participant noted “It is exceptionally difficult to nurse both mental health consumers and medical patients together. I feel confident caring for both but the environment is inappropriate for some mental health patients”. One further comment by a participant mentioned caring for patients depended on how the ward was set up. “I believe that as we are comprehensively trained we should be able to care for persons with mental health needs - depending on safety to staff and whether the ward is set up to deal with them”.

Severity of condition
One participant highlighted that being able to care for patients with mental health problems depended on the severity of their condition. “It is difficult to answer some of these questions as the degree of the mental health problem/need is what impacts on their care in the area in which I work”.

Knowledge and education
Three participants highlighted the need for extra education relating to mental health. One participant related this to care received. “In the acute setting mental health patients are at risk at receiving insufficient care from RN’s due to and lack of knowledge”. Another participant noted that extra support and knowledge in managing patients would be valuable. “More information like a fact sheet of mental illness history, more readily available on any inpatient admission”. One participant further stated “staff education is ongoing including aspects of mental health needs”. As previously mentioned, one participant stated “I believe that as we are comprehensively trained we should be able to care for persons with mental health needs - depending on safety to staff and whether the ward is set up to deal with them”. One participant who graduated eight years ago highlighted choosing to complete the third year mental health option paper during nursing training due to not feeling prepared through the under graduate year two course. This led to increased confidence. “As a comprehensive RN I believe my degree (1999) prepared me for the role. I completed the mental health as an option paper as I have always believed year 2 mental health paper did not properly prepare me. The 300 level option paper gave me much more confidence”. Another participant took the advice of a mental health worker and specifically gained experience on the general side, despite their desire to work in mental health first. “Mental health has always been a passion of mine which I would like to
pursue in the future, but on advice from experienced mental health workers endeavored to gain mainstream nursing knowledge first”.

Support and response time from mental health services
Six participants identified wanting more support and a faster response from mental health services. One participant mentioned “great having mental health liaison nurse to review patients such as OD's. Very approachable. However, they also stated the “CATT Team not that approachable, always such a hassle to come and review patient. Difficult on weekends”. Another participant stated “extra support and knowledge in managing such patients would be valuable”. Further comments included “in general, I feel in our area more staff are needed and a faster response time from mental health is required, as staff and resources are pushed to the limit in busy times. This is when a difficult/challenging patient comes in. Other patients suffer due to staff being tied up with this patient”. Also added by another participant was “it would be great to have more support in ICU at times. Usually we get prompt response to calls, but often the mental health team is very busy”, and “why do we struggle to get support from mental health staff? Any referral I have ever made is met with a reason. Why can’t they come and assess or be involved in collaborative nursing approach for patient”. Finally it was mentioned that “not enough support for mental health nurses and other staff in other specialties are well aware of it, so one will want to go into a specialty that is ill equipped”. One participant did note however “in my work area, access to advice or staff from the mental health service is readily available for any patient who requires their services”.

Attitude from colleagues
Two participants commented on the attitudes of their other general nursing colleagues. It was noted by one participant that “staff attitude toward these patients can also be a hindrance and has made me feel unsupported at times”. Another participant highlighted that some nurses do not have a positive attitude towards patients with mental health problems. “I feel that some nurses still do not always have a positive attitude to patients with mental health issues, although this is not revealed to the patients. I think this needs to be addressed and mental illnesses treated with the same compassion and understanding as physically ill patients”.

Avoidance
Avoidance towards patients with mental health problems was highlighted by one participant as being due to personal experience. “Personal experience with a parent with severe depression and agoraphobia has tainted my view of mental health patients and I tend to avoid because of this”.

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Several participants added comments specifically relating to questions 9, 10, 11, 13, 14, 15 and 20.

**Question 9**
Six participants added comments regarding this question. *(I believe that people with mental health problems should be cared for in mental health inpatient units).*

“Depends how unwell they are”.
“Depends on degree of problem, patient safety should come first”.
“Unless they have a critical/acute medical/surgical illness”.
“Depending on admission”.
“If mental health is primary issue -definitely, but if medical/surgical issues outweigh mental health, they should be in appropriate ward to receive appropriate nursing care”.
“Depends on the reason for admission. If surgical reason then... ‘If this is their primary reason for hospitalisation, otherwise they can be nursed on the ward’.”

**Question 10**
Two participants added comments regarding this question. *(I believe that mental health nurses only, are able to nurse people with mental health problems).*

“Acute mental health problems take a lot more nursing input than someone more stable with mental health problems. Ie: patients that need specialing, sectioned patient”.
“Again depends on severity of problem. In acute psychosis, yes”.

**Question 11**
Three participants added comments relating to this question. *(I believe that I have sufficient knowledge to care for people with mental health needs).*

“Not for real acute problem”.
“With the right support and knowledge I would feel better equipped but I feel I have the basics”.
“But would like to learn more. Not enough support for mental health nurses and other staff in other specialties are well aware of it, so no one will want to go into a specialty that is ill equipped”.

**Question 13**
One participant added a comment regarding this question. *(I feel vulnerable when nursing people with mental health problems).*

“Not personally, but would not have knowledge to make safe decision for that person”.
Question 14
Two participants noted comments regarding this question. *(I believe that people with mental health problems impact on the overall provision of care in the ward).*

“Due to stigma of mental health”.

“Due to attitudes towards them”.

Question 15
One participant added a comment regarding this question. *(I believe that care for patients with mental health problems could be improved in my area).*

“have not had patients with mental health issues since being on ward”.

Conclusion
Results of the study indicated that 58 percent of participants believed it was part of a nurse’s job to care for people requiring psychological support (Table 1 page 37), and 36 percent believed people with mental health problems should be cared for in mental health inpatient units (Table 2 page 27). Fifty eight percent also disagreed that mental health nurses were the only nurses able to nurse people with mental health problems (Table 3 page 38). Participants were spilt evenly regarding whether they believed they had sufficient knowledge to care for people with mental health needs (Table 4 page 38) and whether or they felt vulnerable (Table 6 page 40). It is difficult to correlate participants mental health knowledge to their knowledge and confidence when meeting the needs of people with mental health needs due to participants not specifically asked the level of mental health training during their initial or subsequent training. Thirty two percent of nurses also indicated they did not feel confident (Table 5 page 39) and 47% agreed that people with mental health needs impacted on the overall provision of care in the ward (Table 7 page 40). Fifty three percent of participants also agreed that care could be improved in their area (Table 8 page 41), with 48 percent agreeing that more support from mental health services was needed, which would increase confidence (Table 10 page 42). Fifty six percent of participants disagreed that they had enough time to care for people with mental health needs (Table 12 page 43) and 71 percent wanted further training in order to expand their knowledge in mental health (Table 13 page 43). However, a total of 43 participants commented that themes such as time, family commitments, finances, lack of courses, shift work and support from management affected this. Short in-service training was highlighted as a means of assisting this. Further factors reported by 29 participants affecting mental health needs of patients from being met included time, workload, task oriented care, environment, severity of condition, knowledge, education and support from mental health services, attitudes from colleagues and individual experiences affecting contact with people. Results were similar to international studies completed in the United Kingdom and Australia in the past seven years.
CHAPTER 5

Discussion

Introduction

Many of the factors that influence nurses in meeting the mental health needs of patients in general care settings reported in this study support those of international studies (Bennett, 1996; Brinn, 2000; Harrison & Zohjadi, 2005; Reed & Fitzgerald, 2005; Sharrock & Happell, 2002; Sharrock & Happell, 2006). For example in this research study 58 percent of participants agreed and 42 percent strongly agreed that it was part of a nurse’s job to care for people requiring psychological support. Thirty one percent of participants also agreed that patients with mental health problems should be cared for in mental health inpatient units. Those in the over 55 year’s age group were more likely to agree with this. Thirty six percent however identified they neither agreed nor disagreed and 18% disagreed. It was also indicated by 47 percent of participants that people with mental health problems impacted on the overall provision of care in the ward although 20% disagreed and 21% neither agreed nor disagreed. It may be suggested that this is to be expected given that it is another job a nurse is required to do, which may influence the time and energy for other tasks.

Fifty three percent agreed and 20% strongly agreed that care for those patients in order of meeting needs could be improved in their area. This supports comments about mental health problems impacting care on the ward, but it is not clear why participants have this opinion. It may be due to a belief that the mental health problem is a secondary issue and that because they are in a medical/surgical ward where the priority is whatever the patient’s physical issue is. Fifty eight percent of participants also disagreed that mental health nurses only are able to nurse people with mental health problems. Although 14 percent agreed and 20 percent neither agreed nor disagreed. As discussed further within this chapter factors such as lack of time, knowledge, support, confidence, vulnerabilities, attitudes, education and training, workload, task oriented cares, and work environment have been highlighted by some participants as influencing them from meeting patients mental health needs This chapter will present a discussion of the findings from this study and studies previously undertaken internationally, in relation to the factors that influence nurses in meeting the mental health needs of patients in general care settings.

Significance of the research

The study presented in this thesis is important in highlighting factors that may influence nurses in meeting the mental health needs of patients. This may assist in ensuring appropriate interventions are made and holistic care that best meets patients individual recovery needs is provided. The need for further support and resources may also be highlighted to enhance
nursing knowledge, which will ultimately strengthen quality in practice. Knowledge gained from this research will further increase the body of knowledge in nursing relating to holistic care needed in general care settings. Nurses may also have highlighted whether they believe they are providing full holistic care and meeting their competencies of practice. Evidence from this study may identify whether care is provided according to the New Zealand Government’s strategies for mental health services in New Zealand, which includes the promotion of mental health and wellbeing.

Factors that influence nurses in meeting the mental health needs of patients

Time
Fifty six percent of participants disagreed and 22 percent strongly disagreed that they had enough time to care for people with mental health needs. One participant reported patients with mental health problems took more nursing input, taking more time. However, this question may be answered in a similar way if nurses were asked if they felt they had enough time to care for patients with any type of specific needs. This was also a finding in studies by Brinn (2000), Harrison and Zohhadi (2005), Reed and Fitzgerald (2005), and Sharrock and Happell (2006). Regal and Roberts (2002) further stated there needs to be ‘protected time’ in a private area to enable nurses to explore a person’s feelings, perceptions, fears and anxieties. In the research study presented in this thesis, one nurse in the emergency department also indicated difficulty having time with patients to explore their mental health needs, due to the challenges of the environment and a focus on medically oriented cares. In Bennett’s (1996) study it was reported that nurses felt constrained to provide care, even though they knew how to assess and wanted to meet mental health needs. Reed and Fitzgerald (2005) suggested time constraints were also linked to negative attitudes, and that having the ability to have the time to perform assessments increased nurse’s enthusiasm.

As previously presented, 53 percent of participants in this study agreed and 20 percent strongly agreed that care could be improved in their area. Three participants further commented that lack of time made this difficult. It was reported by one participant that at times patients with mental health needs impacted on how much time they had to provide cares to patients they were responsible for. One other participant further commented that other patient’s were sometimes at risk of receiving insufficient care, due to lack of time. One participant queried whether the lack of time was due to caring for people with actual mental health needs and/or problems whilst on the ward, or whether they perceived patients that had a mental health diagnosis to potentially impact on nurse’s time. Armstrong (2000, as cited in Happell & Platania-Phung, 2005) suggests there is no evidence that a person recognised to have a mental disorder, will require a greater
level of care simply because they have a mental disorder. If this perception is held it could be due to a lack of understanding of the extent to which a mental disorder may contribute or prolong a physical illness.

Knowledge
Thirty six percent of participants believed they did not have sufficient knowledge to care for people with mental health needs. This was also the finding in studies by Brinn (2000), Harrison and Zohhadi (2005) and Sharrock and Happell (2006), where nurses felt they did not have the knowledge, experience or ability to care for people with mental health problems on their wards. There was also a perception of inadequacy in these studies due to the lack of knowledge. They further found that nurses did not feel prepared, skilled, qualified or experienced enough to assess people with mental health problems. Thirty one percent of participants in the research study in this thesis however did note they believed they had sufficient knowledge and 26% indicated they neither agreed nor disagreed. This may suggest a need for some additional training, although some nurses are comfortable with their existing knowledge. Male participants also indicated they had sufficient knowledge and those age 55 years and over indicated a concern regarding their knowledge level.

Nurses in Reed and Fitzgerald’s (2005) study felt that due to the lack of knowledge they did not feel it was in their scope of practice to care for people with mental health problems. However, they did still have a desire to care for people with such needs. There were no large differences between nurses in the study presented in this thesis with respect to qualifications or specific level for those in the NPDRP programme. One participant in the study reported they felt that meeting the mental health needs of patients was definitely in their scope of nursing practice, which is in line with the expectations of nursing practice by Nursing Council of New Zealand (2005). Bennett (1996) found that nurses felt they had enough knowledge to assess but lacked the time to do so. Reed and Fitzgerald (2005) reported lack of knowledge and skill was linked to negative attitudes, and Brinn (2000) noted a lack of knowledge and understanding towards patients with mental health problems led to avoidance. One participant in this study reported the behaviour of some patients was difficult to manage due to a lack of knowledge. In their study, Reed and Fitzgerald (2005) suggested the inability to predict patient’s behaviour due to lack of knowledge, can also be linked to negative attitudes.

It is interesting to note in this research study that 18 participants had extensive nursing experience of between five to ten years, with the median between ten to fifteen years indicated by 11 participants. However, participants (n = 36) suggested not having sufficient knowledge to
care for people with mental health needs, which one participant reported they felt at times put patients at risk. One participant also reported wanting to care for patients, but sometimes did not feel able to due to their perception of not having the skills and experience. These findings were also noted in the study by Reed and Fitzgerald (2005), where nurses reported a lack of knowledge which unfortunately led to sometimes nurses disliking the patients with mental health problems and avoiding them. However, at times this was due to being concerned at doing and saying the wrong thing or providing the wrong type of care.

Support
Fifty two percent of participants in this study indicated they disagreed that they had enough support to care for people with mental health problems. Seventeen percent however agreed they did have enough support and 23% neither agreed nor disagreed. One participant reported they did not have enough support from management to care for patients with mental health problems, and another commented they had difficulties being able to have the time to leave the ward to attend training. This was also the finding in the studies by Brinn (2000) and Harrison & Zohhadi (2005) where nurses reported a lack of professional support and understanding in the day to day caring of people with mental health problems, as well as support to gain further knowledge and skills. These authors found that those who had support from management were able to provide more effective patient care. This may suggest that in order to provide better patient focused care, professional support is essential. One participant in this research study further reported feeling constrained and having a perceived inadequacy in meeting the mental health needs of patients, and another participant stated this was compounded by a lack of resources and much difficulty accessing practical and prompt support from mental health services. This was also the findings in studies by Bennett (1996), Gillette, Bucknell and Meegan, (1996, as cited in Sharrock & Happell, 2002), Harrison and Zohhadi (2005), Sharrock and Happell (2006) where access to resources on mental health related topics and support from mental health services was valued and highlighted as resulting in general nurses having better attitudes, increased comfort and enthusiasm when caring for people with mental health problems. In the study presented in this thesis, 50% of participants agreed and 31% strongly agreed that more support from mental health services was needed, which indicates very strong agreement for increased support from mental health services. This may suggest that stronger collaboration between services is required in order of assisting general nurses in caring for people with mental health problems.
Confidence
Thirty two percent of participants in this study disagreed they felt confident to care for people with mental health problems. Thirty percent however agreed they felt confident and 29% neither agreed nor disagreed. More male participants also indicated they felt confident when compared to female. Those in the 55 years and over age group also indicated a concern. This may indicate a need for targeted mentoring. Fourty eight percent of participants also agreed and 22% strongly agreed that more support and knowledge from mental health services would help to increase confidence. It also needs to be acknowledged that participants were not asked the level of mental health education received in their initial or subsequent training. Therefore it is difficult to fully correlate participant’s mental health knowledge to their knowledge and confidence. In the study by Harrison and Zohhadi (2005), nurses noted they were nervous to be around patients with mental health needs and also felt inadequate which decrease confidence and caused professional distress. Brinn (2000) noted a lack of confidence led to a perceived lack of competence. However, nurses in general hospital areas care for people with a variety of psychological needs, at times without even realising it. Harrison and Zohhadi (2005) found that nurse’s reported having much confidence and competence when caring for people recovering from a stroke, although they did not perceive this as providing mental health care. This was despite this condition having numerous emotional and psychological consequences requiring many skills as noted in the study by Bennett (1996). Results from Harrison and Zohhadi (2005) study may therefore suggest that nurses may not be giving themselves enough credit for the highly skilled care they provide. This is also the opinion of the researcher. As noted in this research study 30% did have the confidence, however as noted by four participants the environment made caring for patients with mental health needs more difficult. Although small in number the researcher believes this data is relevant to note.

Vulnerability
Thirty three percent of participants indicated feeling vulnerable when caring for people with mental health problems. Although 28% neither agreed nor disagreed and 28% disagreed. Those in the 55 years and over age group indicated feeling more vulnerable than those in other age groups. The nurses in this age group had worked in nursing for over 30 years, with only one having a nursing Degree. Due to their initial training being hospital based, it may be suggested that vulnerability could be due to less training in mental health. Reed and Fitzgerald (2005) suggested that feeling vulnerable was due to fear. Fear was noted by Harrison and Zohhadi (2005) to have caused feelings of vulnerability and therefore avoidance. Fear of patients and feeling vulnerable when around patients with mental health needs and/or problems was not highlighted as an issue in this study. However, a concern was highlighted of not having the knowledge to make safe decisions which resulted in feelings of vulnerability. Professional,
legal and ethical vulnerability was also noted by Reed and Fitzgerald (2005). Fear was suggested to cause feelings of vulnerability leading to avoidance. Although this was not highlighted by participants in this study, it was a suggestion by one participant that avoidance by them was due to personal reasons not professional.

Attitudes
One participant in this study reported that attitudes from colleagues influenced how supported they felt in their ward area, and the kind of care they were able to provide patients. McKinlay et al., (2001) found that attitudes of colleagues can determine the type of caring behaviour, and that nurses own attitudes and the attitudes of others predict behaviour intentions. Mavundla (2000) suggests negative perception affects the intellectual and affective component of nurses psychological functioning, of which knowledge and skills are recommended to improve responses. Brinn (2000) also found that individual attitudes impacted both on patients and nurses. One participant in this study further reported patients with mental health problems impacted on the ward, due to the stigma and negative attitudes directed towards them by some nurses. Brinn, (2000) and Reed and Fitzgerald (2005) suggest the more contact and interaction nurses have with patients with mental health problems, the more confidence and positive attitudes are displayed. One participant in this study also reported wanting to care for people with mental health problems and treat them with the same compassion as any other patient. This was the finding in the study by Sharrock and Happell (2006) where nurses felt much commitment and concern and wanted to provide care. As previously noted, poor attitudes and avoidance can be due to feeling concerned at providing the wrong type of care. Furthermore, unsuitable environments, inability to predict patient’s behaviour, priority of physical care, time constraints and lack of knowledge, skills and support, high patient ratios can all influence nurses attitudes (Reed and Fitzgerald, 2005).

Education and training
Sixty four participants in this research study indicated their interest in undertaking further education and training and two participants stated that this would add great value to their practice. The participants stated they believed this would increase their knowledge base and therefore confidence, resulting in feeling better equipped to care for patients with mental health problems especially when challenging behaviours are displayed. Studies by Slevin and Sines (1996), and Rohde (1996) found that expanded knowledge and experience in caring for those with challenging behaviour resulted in less anxiety and fear and more positive attitudes. Mavundla (2000) also found that knowledge and skills help reduce negative perceptions. These ideas are also supported in the studies by Brinn (2000) and Reed and Fitzgerald (2005). Further
indicated by one participant in this research study was the benefit of extra mental health education in the undergraduate course (third year option paper), was also the finding in the study by Sharrock and Happell (2006). Brinn (2000) found that the more exposure nurses had to people with mental health problems in their nursing education, the more they felt adequately prepared. Studies by Keshavan et al., (1991), Brinn (2000), Haddad et al., (2005), Reed and Fitzgerald (2005), McCann et al., (2006) and Wilstrand et al., (2007) found that more education relating to mental health and support from mental health services led to less fear and anxiety, and better attitudes towards patients with mental health problems. More education to increase knowledge and skills was also reported by Harrison and Zohhadi (2005) to also reduce the role conflict some nurses had.

Sharrock and Happell (2006) reported that nurses not specifically educated in mental health could expect to face more difficulty when caring for patients with mental health problems. Bennett (1996) suggested that there was a definite need to have better nursing education that combined the theoretical and practical aspects of psychological care. Two participants in this research study indicated a lack of appropriate and available education and training sessions in mental health. Harrison and Zohhadi (2005) also found this in their study. In the study by Bennett (1996) it was suggested that lack of appropriate training led to nurses feeling constrained. Two participants in this research study reported wanting short in-service education in between shifts as a practical means of being able to expand their knowledge of mental health and mental disorders. In the study by McLaughlin (1995) nurses reported they did not have the knowledge and confidence to assess people who had deliberately self harmed, and did not feel they could meet those patients needs. McAllister et al., (2002) also found this, although nurses did report wanting to develop their knowledge in order to assess better. McCann et al., (2007) found that nurses who had attended in-service education on how to manage patients that had deliberately self harmed had a more positive attitude and were able to meet patients needs better.

High workload and patient turn over
Two participants reported they felt constrained in providing mental health care due to high workload, a high patient turn over and bed demands. Another participant suggested that it was difficult at times to meet patient’s psychological needs let alone their physical. This was also found in the studies by Brinn’s (2000), Harrison and Zohhadi (2005), Sharrock and Happell (2006). Reed and Fitzgerald (2005) found that high patient ratio was also linked to negative attitudes towards patients with mental health problems. Although results are from few participants, the researcher felt these were worth noting.
Task oriented care

Task oriented care was also indicated by two participants as a factor influencing them at times in providing appropriate care to people with mental health needs and/or problems. This was also found in the study by Sharrock and Happell (2006) where some nurses felt constrained to provide holistic care due to a high focus on physical needs, even when a mental health problem was affecting physical recovery. Time and resources were all focused in a task oriented way. Harrison (2001) suggested it is the strong focus of the medical model which is still the driving force of task oriented care. In this research study one participant in the emergency department noted that cares were mainly medically oriented. Harrison and Zohhadi (2005) also found that nurses reported looking after mental health needs as not being part of their role. This caused conflict and professional distress to some nurses as they wanted to provide care but felt unable as the priority for their area was physical care.

Work environment

Four participants in this research study identified the general hospital environment as not an appropriate environment to care for patients with mental health problems. One participant mentioned this however depended on the severity of the mental health problem. One participant of this group identified that the ward environment is not always suitable and another identified that the emergency department was especially inappropriate due to being frantic at times. Another participant in this study indicated that although they felt confident caring for both, it was hard to nurse patients with both physical and mental health needs. One other participant further reported concern for the safety of staff and patients due to the ward set up. Harrison and Zohhadi (2005) noted this, with reports of patients being in the wrong place as the ward was not set up to manage. Participants in the study by Sharrock and Happell (2006) also felt constrained to care for patients with mental health needs due to the ward environment, stating it does not promote the ability to have time to assess and care for matters of a non-physical nature. Reed and Fitzgerald (2005) found unsuitable environments were also linked to negative attitudes. Two participants in the study presented in this thesis also suggested that when patients with mental health problems displayed inappropriate behaviour, it impacted on patients and staff. This was also the findings in the study by Harrison and Zohhadi (2005) study where disruption was noted to also cause emotional distress.

One participant in this study indicated their ability to provide mental health care in the general hospital area depended on the nature and severity of the patient’s condition. One further participant also report patients requiring ‘specialising’ or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 required more input. One participant indicated in these circumstances the mental health inpatient unit would be the most appropriate environment to
care for the patient. However, this may compromise a person’s physical state as well as not providing care in the least restrictive environment as outlined within the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health, 2000). It may therefore be helpful for mental health nurses to assist general nurses in extending their knowledge on managing patient’s behaviour and the legal requirements of care for patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. This may help in ensuring the specific goals of care are being met.

**Conclusion**

Participants in this study perceive themselves as being competent in the provision of nursing care. However, many factors can influence the ability for nurses to meet patient’s specific needs. The findings of this study have been discussed in this chapter, with specific focus on how factors such as lack of time, knowledge, support, confidence, vulnerabilities, attitudes, education and training, workload, task oriented cares and work environment can limit the ability for nurses to interact and assess patients with mental health needs and problems. Although the mixed method design used in this study may differ from other methods used in studies undertaken elsewhere, these findings support the hypothesis of this study that New Zealand results would be the same as found in international studies.
CHAPTER 6

Conclusions and recommendations

Introduction
Mental disorder is recognised as a major health issue in New Zealand (Ministry of Health, 2006), and can influence the course and outcome of physical illness. By broadening their scope of care nurses can assist in the detection of mental disorder and help reduce the prevalence, thereby aiding in improving patients physical wellbeing (Happell & Platania-Phung, 2005). This chapter will discuss the conclusions and limitations of the study and provide recommendations for nursing education, practice and research.

Conclusions
Nurses are the largest professional healthcare group to provide direct and indirect care, and are in a unique position to be able to assist a person who may be suffering from a mental health problem (Sharrock & Happell, 2000). However, although nurses have a strong desire to help as identified in this study some nurses believe they do not have the knowledge, confidence or support to do so. Findings of the study indicate an even split of participants feeling vulnerable when caring for people with mental health problems, with those in the 55 years and over age group also indicating feeling more vulnerable. There was also an even split amongst participants regarding whether they felt they had sufficient knowledge and confidence. This may indicate a need for additional training for some nurses and possible targeted mentoring. Those in the 55 year age group again indicated a concern regarding lack of knowledge and confidence when caring for people with mental health problems. More support from mental health services was highlighted by 48% of participants would help to increase confidence. Fifty two percent of participants disagreed they had enough support to care for people with mental health problems although 17% agreed they had enough support. 50% of participants agreed and 31% strongly agreed that more support from mental health services was needed, indicating very strong agreement for increased support from mental health services. Fifty six percent of participants disagreed and 22% strongly disagreed that they had enough time to care for people with mental health problems. This may suggest that identified ‘protected time’ where nurses can spend time with their patients to specifically assess and provide psychological interventions may be useful. This may assist nurses in exploring the person’s feelings, perceptions, fears and anxieties as suggested by Regal and Roberts (2002).

Fifty eight percent of participants agreed and 42% strongly agreed that it was part of a nurse’s job to care for people requiring psychological support and 31% of participants agreed that
patients with mental health problems should be cared for in mental health inpatient units. Thirty six percent however identified they neither agreed nor disagreed and 18% disagreed. It was also indicated by 47% of participants that people with mental health problems impacted on the overall provision of care in the ward although 20% disagreed and 21% neither agreed nor disagreed. Fifty three percent however agreed and 20% strongly agreed that care for those patients to meet their needs could be improved in their area. Fifty eight percent of participants also disagreed that mental health nurses only are able to nurse people with mental health problems. This study helps to understand some of the challenges faced by nurses in the general setting in caring for people with mental health problems. It also supports the idea that factors such as lack of time, knowledge, support, confidence, vulnerabilities, attitudes, education and training, workload, task oriented cares, and work environment have been highlighted as being an influence in meeting patients mental health needs.

Some of the findings in this study may possibly be interpreted as critical of general ward nurses. However, it was the intention of the researcher to explore previously unaddressed issues and bring them to the forefront of nursing and academic debate. It seems there also may need to be a plan developed to help reduce a possible gap between the philosophical position and the realities of nursing practice in the general hospital. Harrison and Zohjadi (2005) also suggested similar in their study. While the findings of this study cannot be generalised to be the experiences of all nurses working in other hospitals, just as in the study by Sharrock and Happell (2006), the factors highlighted are likely to be recognised and related to by other nurses working in the general care setting.

**Research limitations**

Although consistent with international studies, the findings of this study can in no way be generalised due to being undertaken in one single regional hospital. Also, some issues highlighted regarding lack of mental health support may be specific to the hospital the study was undertaken, as other areas in New Zealand have MHCL teams and stronger connection with the mental health crisis service. There were also differences of opinion highlighted relating to the severity of the mental health need and/or problem throughout written comments within the questionnaire. This may be seen as a limitation due to different interpretations. There were also comments regarding the role of MHCL which may be interpreted by some as a threat to reliability. The purpose of the research however was not on the role of MHCL. Finally, participants were not asked for the level of their initial training or subsequent qualifications since graduating. A RN may have completed hospital based training and or subsequent Bachelor of Nursing education which was not focused on mental health. Therefore without this
information it is difficult for the researcher to ascertain all participant’s mental health knowledge to their knowledge and confidence when meeting the mental health needs of people with mental health problems. One further limitation was the small sample size of each group area, including male respondents. This made some expanded statistical analysis more difficult and therefore not undertaken as it may have been with more participants. The two week timeframe is also considered as a limitation in this study and further studies if undertaken may need to be for a longer period to perhaps enable other staff to participate.

Recommendations for nursing education
Although 61% of females and 71% of males indicated they felt they had sufficient knowledge to care for people with mental health problems, the findings of this study indicate that nurses working in general wards want further education in the area of mental health. There were no large differences between nurses with respect to qualifications, however participants in the acute areas indicated they felt they wanted further knowledge. Sixty four participants in this research study indicated they were interested in undertaking further education around mental health. It may be helpful therefore for education and training opportunities focussed in the area of mental health to be targeted and accessible to increase nurse’s knowledge on how to manage issues and situations that may arise for those who feel unable to manage due to knowledge deficits. One participant in this study also stated that currently the mental health component within nursing education is not comprehensive enough to ensure nurses are equipped and feel prepared once their undergraduate studies are completed. This may suggest some benefit from nursing educators placing an increased focus on factors that affect mental health. Happell and Platania-Phung (2005) suggest a comprehensive focus within nursing training programmes is important in ensuring that nurses are equipped to care for those with many complex needs. Also identified by Brinn (2000), a greater level of understanding would be valuable in helping nurses manage the mental health needs of patients. Furthermore, this would enable nurses to provide stronger mental health care, as they attend to the physical care needs (Harrison, 2001). This will not only enhance the knowledge base of nurses but also give more satisfaction in practice. Furthermore, the new graduate nurse may feel more prepared to care for patients with mental health needs in non-mental health settings (Brinn, 2000).

Adequate mental health education is an achievable goal, but first it needs to be confirmed by those in academic institutions that it needs improving (Happell & Platania-Phung, 2005). The researcher believes better integration of mental health knowledge would be of benefit. This would help to avoid the difficulties some face of re-combining knowledge in order to provide
holistic care, as identified by Benner (1984, as cited in Sharrock & Happell, 2006). Increased learning of psychological responses to illness would be of benefit along with learning possible interventions, including ‘use of self’ (Stuart & Laraia, 1998). As mentioned by two participants, initiation of regular short in-service education sessions on mental disorders and nursing interventions would be beneficial, along with stronger collaboration with staff from mental health services.

As mentioned, support from mental health services was also strongly highlighted by participants as needed to assist in enhancing nursing knowledge and provision of better patient care. The researcher believes sessions learning how to detect mental health problems, and the use of screening tools would also be extremely beneficial. As highlighted by Sharrock and Happell (2000), nurses have more contact with patients, and with appropriate support and training, they could potentially play a central role in the detection and early intervention of mental health problems. With support in learning how to use screening tools, important information could be gathered and appropriate plans initiated. Nurses may also help to balance the scales between biomedical and mental health support towards the goal of high quality care (Happell & Platania-Phung, 2005).

Recommendations for nursing practice

As mentioned the findings of this study suggest that some nurses do not believe they have the knowledge or confidence to be able to appropriately care for people with mental health problems. Caring for patients with specific mental health needs can be challenging for nurses in general settings. Nurses need to therefore draw on many different skills in order to assess and provide the most appropriate interventions (Harrison, 2001). Effective interpersonal skills, specifically active listening is essential. This can assist in open communication and in gaining vital clinical information (Jenkins, 2006). Furthermore, having protected time for ‘one to one’ communication is very important. As identified in this study, nurses need support to assist in providing the most appropriate care. This support needs to come from ward management as well as mental health services. As suggested by Harrison (2001), there is likely to be both a physical and psychological effect for any person who may be physically unwell. Nurses need to have support in order to develop their awareness of these needs and their ability to assess. Appropriate interventions to try and minimise the negative psychological impact of illness are only then able to be provided (Harrison, 2001; Sharrock & Happell, 2000).

Ensuring the mental health needs of patients is crucial in the provision of high quality care in nursing (Happell & Platania-Phung, 2005). It is important for nurses to include mental health
care as part of day to day care, recognise specific cues and respond appropriately (Eysenck, 1995). This is a priority for improved care (Happell & Platania-Phung, 2005). Duty of care is not the only reason why nurses need to attend to the mental health needs of patients. There are practical implications as well. As noted previously, early detection and intervention is important in assisting better physical health outcomes (Happell & Platania-Phung, 2005). Appropriate intervention can make a vast difference to patients overall hospital experience and recovery. When considering the current mental health campaigns, promotion of mental health should be in all areas of the community including the general hospital setting (Happell & Platania-Phung, 2005; Ministry of Health, 2006).

Recent public campaigns promoting mental health along with significant changes within the delivery of hospital care in New Zealand, has enhanced the way in which healthcare is provided (Ministry of Health, 2006). However, there still appears to be a gap between the philosophy and reality of ‘patient focused care’ in the hospital the study was undertaken. The researcher suggests that this should not be considered as a reflection on nursing practice, but the wider systems that need to support and develop implementation of care that meets the identified philosophy. In order to provide a patient focused care service, it is essential that care is holistic and focused on identified needs (Happell & Platania-Phung, 2005). This is to ensure care that is in the patients best interests is being provided. Nurses also need to be supported in order for the philosophy to be a reality (Sharrock & Happell, 2000). Mental health promotion is also an important area for nurses to be supported in providing within general areas, rather than it being thought of as only undertaken by those who specialise in mental health (Calloway, 2007).

**Recommendations for further research**

Potential research approaches

Although rich data was able to be gained by using a mixed quantitative and qualitative design, further studies using qualitative designs or action research may be of benefit. A grounded theory approach could be used to explore the subjective and descriptive experience of nurses towards people with mental health problems. This approach would be beneficial as there is little known about this particular phenomenon. Action research would be beneficial in the attempt to try and understand the experience of providing mental health care from the perspective of nurses in a general care setting. This could then be used a mechanism for developing lines of inquiry and generating a theoretical perspective for further research (Beanland et al., 1999). A longer period for the questionnaire to go out to participants may be an advantage, in order to assist with gaining higher numbers. The researcher was informed by
six nurses after the questionnaire collection date that they were on leave. Although there will always be some nurses on leave, a longer period may in fact enable more to answer. The sample size could be increased in any future research so that findings can be tested for statistical significance and that such can be given a degree of further validity (Beanland et al., 1999).

Potential research topics
Research into investigating factors that influence nurses in meeting the mental health needs of patients in general care settings within other areas in New Zealand would be of benefit. Further research looking at the relationship between reported emotions and the nurse’s expectations of patient behaviour would also be of benefit. It may be useful to contrast the feelings of both general and mental health nurses. Future research may also determine why nurses have specific expectations and, hold negative emotions of people with mental health needs, and how this is reflected in the care provided. Research into this area could further determine the level to which nurses feel capable of meeting the psychological needs of patients. Training needs could then be looked at in order of ensuring the nurse feels capable. Further investigation is also required to continue identifying the impact that current models of care and service provision have on the ability of nurses to meet patient mental health needs. Literature about New Zealand nurses meeting the psychological needs of patients in general settings is somewhat scarce. One may question if this is because it is not seen as important or, if it is because research has not been undertaken as yet. One further aspect for New Zealand nursing practice and research that needs to be taken into account is whether the mental health needs specific to Maori are being met. This is questioned by the researcher due to the ‘whare tapa wha’ model used by Maori in describing the four part dimensions of health similar to the description of holism (Durie, 1998).

Final comments
The physical, mental, social, spiritual and cultural domains of a person are equally important areas to be addressed by nurses. This is ‘true holistic care’ which the nursing profession advocates for (Happell & Platania-Phung, 2005). Addressing the mental health needs of patients is crucial to the holistic philosophy in nursing, especially if nursing is to uphold this philosophy as more than rhetoric (Happell & Platania-Phung, 2005). Holistic care also acknowledges the “interdependence of the mind, body and spirit” (Sharrock & Happell, 2000, p.36), which Florence Nightingale suggested was an equally essential need when caring for a person’s physical health and wellbeing (Dossey & Dossey, 1998). Jean Watson (1985, as cited in Fuller & Schaller-Ayers, 2000, p.124), also states that “health refers to unity and harmony within the mind, body and soul” and nurses need to do what they can in any setting to ensure this unity occurs. Mental health needs are essential areas for nurses to ensure are focused on, as
whilst these needs are not being met the goals within the government strategies are not able to be fully addressed (Ministry of Health, 2006). There does need to be an acknowledgment however, of how nurses in general care settings use both their interpersonal competence, and intuitive skills within their work (Regal & Roberts, 2002). Additionally, many nurses face difficult challenges with limited support from specialised areas. More support and recognition of the day to day difficulties often faced by nurses in practice needs to be provided (Alderman, 1995; Harrison, 2001). Furthermore, according to the World Health Organisation (2001, as cited in Happell & Platania-Phung, 2005, p.45), “the general goal in the global effort to provide a more responsive mental health care system is to create a greater synchronicity between mental and physical care”. The researcher believes it is the responsibility of all healthcare professionals to do what they can to work toward this.
REFERENCES


Bridges, J. (2001). Meeting the needs of older people in rehabilitation care. *Nursing Times, 97*(3), 33-34


Appendices
Are you a Registered Nurse working in Medical, Surgical, ED, AAU, ICU, & AT&R?

Your opinion is highly valued

A research study looking at what factors influence nurses in meeting the mental health needs of patients in general care settings, is to be undertaken. Your participation is needed.

If you would like to volunteer for this worthwhile project, please complete a questionnaire and return in the bright purple box in your area titled ‘Mental Health Survey’.

Many, many thanks

Justine Pack
Master of Nursing student with Eastern Institute of Technology
Dear Colleague

As part of the completion of a Masters Degree in Nursing with the Eastern Institute of Technology, I will be undertaking a research project looking at the factors that influence nurses from meeting the mental health needs of patients in general care settings. It would be great to have involvement from the nurses within this hospital.

I have had acceptance to undertake this study from the DHB Research Committee. Ethical approval was sought from the Central Regional Ethics Committee, however was not required. The general focus of this letter is to inform you of the project, and to request your support in encouraging as many nurses in your area to volunteer and participate. A questionnaire will be provided to those interested in volunteering. It will take approximately 20 minutes to complete. Completed questionnaires will need to be placed in the purple coloured boxes with the title ‘Mental Health Survey’ which I will collect two weeks from initiation of the study. I appreciate your support in this worthwhile project.

Many, many thanks

Justine Pack
Master of Nursing student with Eastern Institute of Technology
Mental health in general care settings:
An exploratory study into factors that influence nurses in meeting needs

My name is Justine Pack. This research forms the Thesis component of my Masters Degree in Nursing, and is being undertaken in conjunction with the Eastern Institute of Technology. The purpose of this research is to “investigate what factors influence nurses in meeting the mental health needs of patients in general care settings”.

Mental health is considered as more than the mere absence of mental illness. Mental health needs are that which nurture spirituality, psychological wellbeing. Mental health problems can include psychological and emotional reactions or behaviours outside the usual range. Nurses are in a unique position to be able to assess and assist a person who may be suffering from a minor mental health problem. However, for many reasons this may be difficult. Investigation into the specific factors that influence nurses from meeting the mental health needs of patients in general care settings is important in identifying what support may be required.

The attached questionnaire is to be sent to Registered Nurses working in the areas of medical, surgical wards, ED, AAU, ICU and AT & R. In order to participate, you are invited to fill in and return the attached anonymous questionnaire. The questionnaire takes approximately 20 minutes to complete. It comprises of questions relating to your views and experiences of caring for patients with mental health needs in your area. I invite you to also add additional comments in the space provided within the questionnaire if you so wish. Participation is on a voluntary basis.

The information gained will be used for the study outlined and will remain confidential. Data will be used within the final report, and any publications arising from the project. At the end of the study the questionnaires will be kept in a locked cabinet, to which the researcher will have access. All questionnaires will be destroyed after a period of five years. Ethical approval was sought from the Central Regional Ethics Committee, however was not required. Ethical advice was given. It is assumed that by filling in and returning this questionnaire consent is given. Please contact the Employee Assistance Programme if you have any queries or concerns.

Please place your questionnaire in the purple box titled ‘Mental Health Survey’.

Many, many thanks for your support
The Mental Health Needs Of People In General Care Settings

This questionnaire is focused on identifying factors that influence nurses in caring for people with mental health needs. Participation is voluntary and all answers will be treated in the strictest confidence. Please identify your answer in the boxes provided. In questions requiring further information, please provide where specified.

NB: By filling in and returning this questionnaire, it is assumed that you consent to participate in this research.

A. INDIVIDUAL DETAILS

1. Are you male or female?
   - [ ] Male
   - [ ] Female

2. What is your age?
   - [ ] Under 25
   - [ ] 25 – 34
   - [ ] 35 – 44
   - [ ] 45 – 54
   - [ ] 55 or over

3. What is your ethnicity?
   - [ ] Maori
   - [ ] Non-Maori

4. What are your nursing qualifications? (please identify as many that apply)
   - [ ] Nursing Diploma
   - [ ] Nursing Degree
   - [ ] Post Grad Cert
   - [ ] Post Grad Diploma
   - [ ] Masters
   - [ ] Other

5. How many years of nursing experience do you have since qualifying?
   - Years [ ] .................................................................

6. In what area are you based?
   - Acute (ED/AAU/ICU) [ ]
   - Medical [ ]
   - Surgical [ ]
   - AT&R [ ]

7. If you have been leveled under this hospital’s Nursing Professional and Development Recognition Programme, what is your present Nursing level?
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
B. YOUR VIEWS ABOUT PROVIDING CARE FOR PEOPLE WITH MENTAL
HEALTH NEEDS/PROBLEMS

8 Regardless of the area a nurse works in, I believe it is part of a nurse’s job to care for
people requiring psychological support.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
<th>Nor disagree</th>
<th>Disagree</th>
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9 I believe that people with mental health problems should be cared for in mental health
inpatient units.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
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10 I believe that mental health nurses only, are able to nurse people with mental health
problems.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
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<th>Disagree</th>
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11 I believe that I have sufficient knowledge to care for people with mental health
needs.

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<th>Strongly Agree</th>
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12 I feel confident to care for people with mental health problems.

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<th>Strongly Agree</th>
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<th>Neither agree</th>
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13 I feel vulnerable when nursing people with mental health problems.

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<th>Strongly Agree</th>
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<th>Neither agree</th>
<th>Nor disagree</th>
<th>Disagree</th>
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C. YOUR EXPERIENCE IN PROVIDING CARE FOR PEOPLE WITH MENTAL HEALTH NEEDS/PROBLEMS

14 I believe that people with mental health problems impact on the overall provision of care in the ward.

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<tr>
<th>Strongly Agree</th>
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<th>Neither agree</th>
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<th>Disagree</th>
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15 I believe that care for patients with mental health problems could be improved in my area.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
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16 I believe that more support is needed from Mental Health Services in order to care for people with mental health problems.

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<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
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<th>Disagree</th>
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17 I believe that more support from Mental Health Services would increase my confidence in caring for people with mental health needs.

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<thead>
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<th>Strongly Agree</th>
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<th>Neither agree</th>
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18 I believe that I have enough support to care for people with mental health problems.

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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
<th>Nor disagree</th>
<th>Disagree</th>
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19 I believe that I have enough time to care for people with mental health needs.

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<th>Strongly Agree</th>
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<th>Neither agree</th>
<th>Nor disagree</th>
<th>Disagree</th>
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D.  TRAINING

20  Would you be interested in undertaking further training in order to expand your knowledge in mental health?

   Yes  No

21  If your answer to above was yes, is there anything that would prevent you pursuing further training?

   No  Yes

22  If your answer to above was yes, please specify what would prevent you most from undertaking further training

   ……………………………………………………………………………………………

23  If your answer to question 20 was yes, what would motivate you most to undertake further training?

   a certificate (recognised qualification)  salary enhancement  career progression

   knowing that as a result of training you were better able to meet the needs of patients  other (please specify)

   ……………………………………………………………………………………………

E.  ANY OTHER COMMENTS?

If you would like to add further information, please use the space provided below.

   ……………………………………………………………………………………………

   ……………………………………………………………………………………………

   ……………………………………………………………………………………………

THANK YOU FOR YOUR ASSISTANCE IN THIS RESEARCH PROJECT

PLEASE RETURN THE QUESTIONNAIRE IN THE PURPLE BOX TITLED MENTAL HEALTH SURVEY
Full written responses (to questions 22, 23 and Section E)

Question 22
If your answer to above was yes, please specify what would prevent you most from undertaking further training

Time.
Not getting paid for it.
Time.
Time.
Lack of education.
Time; perhaps short sessions prior to pm shifts or after an am.
Programmes based around ED presentations.
Time, funding, work pressures.
Time away from family.
Shift works hours.
Being asked to give up even more of my own time to do training; e no paid study time.
Support from management, money.
Going on maternity leave, lack of available courses.
Financial/resource constraints.
If money was required by s/n doing course.
Time; as I have a wide area of commitment to my young teenage family and aged health impaired parents.
Being able to attend.
Family, time, costs.
Family, and already working full time.
Financial.
Time and family commitment.
Not looking to take on any further training at this stage in my career (financial, family reasons).
In our ward situation, even if we knew lots more it would be difficult to find adequate time to actually carry out better care.
Time.
Childcare.
Time family commitment, so more short in-services.
Time and need for income. Length of study courses.
Incorporating further training and working full time with family to provide for.
Would like to have study days and short courses, but would not do post grad as not desired field of nursing.
Currently on graduate programme with set study days.
Budget.
Family commitments and responsibilities.
Busy at home with kids.
Don’t want to work in mental health.
Time.

**Question 23**

*If your answer to question 20 was yes, what would motivate you most to undertake further training?*

Other

Able to give other staff guidance and confidence in these issues.

Professional recognition. Ie in the area of work.

But in small modules. I don’t wish to take time out from my current post to undertake yet another qualification.

Study days on various types of mental health issues and how best to handle situations and provide necessary and proper support for patients.

E. **ANY OTHER COMMENTS?**

*If you would like to add further information, please use the space provided below.*

Sometimes depending on the severity of a patient's mental health condition, a ward environment is not a safe and ideal environment to provide the proper and adequate care needed for the patient.

Re Q 9, 10 -depends how unwell they are. Acute mental health problems take a lot more nursing input then someone more stable with mental health problems. Ie: patients that need specialing, sectioned patient.
Great having mental health liaison nurse (Justine) to review patients such as OD's. Very approachable. CATT Team not that approachable, always such a hassle to come and review patient. Difficult on weekends.

In my area (AAU) time is a problem. I often face difficulties in caring for 'demanding' mental health patients due to time factor. There are also times when I feel like 'listening'. Would help someone but I was not able to give them the time. I do feel it is an area we shy away from due to time factor mainly.

Time is a big factor in how much a patients mental health issues are dealt with in ED. Mainly medically oriented cares are given.

In the acute setting mental health patients are at risk at receiving insufficient care from RN's due to lack of time and lack of knowledge or, they can dominate an RN's workload to the detriment of other patients. Extra support and knowledge in managing such patients would be valuable.

Q 9 -Depends on degree of problem, patient safety should come first; Q10 -Again depends on severity of problem. In acute psychosis, yes; Q11 Not for real acute problem; Q13 Not personally, but would not have knowledge to make safe decision for that person.

Personal experience with a parent with severe depression and agoraphobia has tainted my view of mental health patients and I tend to avoid because of this.

The ED is a terrible place for people with any mental health issues. It is too frantic, too busy and too stressed. Need to concentrate on moving people on to a more appropriate area to receive help etc. Far too often people are cleared medically and then wait hours in a stressful environment to see someone from mental health. Ultimately, the ED is an inappropriate environment.

In general, I feel in our area more staff are needed and a faster response time from mental health is required, as staff and resources are pushed to the limit in busy times. This is when a difficult/challenging patient comes in. Other patients suffer due to staff being tied up with this patient.

It would be great to have more support in ICU at times. Usually we get prompt response to calls, but often the mental health team is very busy.
Good luck.

Ward environment is not always suitable for mental health patients. Staff attitude toward these patients can also be a hindrance and has made me feel unsupported at times.

It is exceptionally difficult to nurse both mental health consumers and medical patients together. I feel confident caring for both but the environment is inappropriate for some mental health patients.

Questions & answers can vary depending on patient. I believe that as we are comprehensively trained we should be able to care for persons with mental health needs -depending on safety to staff and whether the ward is set up to deal with them.

As a comprehensive RN I believe my degree (1999) prepared me for the role. I completed the mental health as an option paper as I have always believed year 2 mental health paper did not properly prepare me. The 300 level option paper gave me much more confidence.

Mental health has always been a passion of mine which I would like to pursue in the future, but on advice from experienced mental health workers endeavored to gain mainstream nursing knowledge first.

Q9 -unless they have a critical/acute medical/surgical illness.

It is difficult to answer some of these questions as the degree of the mental health problem/need is what impacts on their care in the area in which I work.

One of the biggest problems is we don't have enough time to nurse those patients with basic surg/ortho needs, let alone patients that may have their stay compounded by a mental health problem, however minor. Surgical/ortho nursing is for the most part task oriented... "fix em up...shunt em out".

More information like a fact sheet of mental illness history, more readily available on any inpatient admission. Good luck with your masters.

I feel that some nurses still do not always have a positive attitude to patients with mental health issues, although this is not revealed to the patients. I think this needs to be addressed and
mental illnesses treated with the same compassion and understanding as physically ill patients. The main barrier to helping and understanding those patients in our ward, is the lack of time due to pressure of workload and high turnover of patients due to bed demand.

Q9 depending on admission. Q11 with the right support and knowledge I would feel better equipped but I feel I have the basics.

Why do we struggle to get support from mental health staff? Any referral I have ever made is met with a reason. Why they can’t they come and assess or be involved in collaborative nursing approach for patient.

Q14 - due to stigma of mental health. Q15 - have not had patients with mental health issues since being on ward. Q9 - If mental health is primary issue - definitely, but if medical/surgical issues outweigh mental health, they should be in appropriate ward to receive appropriate nursing care.

Q9 - Depends on the reason for admission. If surgical reason then… Q14 - Due to attitudes towards them.

Q20 - but that doesn't mean admit to surgical ward.

Q11 - but would like to learn more. Not enough support for mental health nurses and other staff in other specialties are well aware of it, so no one will want to go into a specialty that is ill equipped.

Not enough support for mental health nurses and other staff in other specialties are well aware of it, so one will want to go into a specialty that is ill equipped.

Q9 - If this is their primary reason for hospitalisation, otherwise they can be nursed on the ward.

In my work area, access to advice or staff from the mental health service is readily available for any patient who requires their services. Staff education is ongoing including aspects of mental health needs.