ABSTRACT: Mainstreaming of mental health care and the prevalence of mental illness have increased the requirement for care by nurses in the general hospital setting. In rural Australia, mental health services are limited and nurses have less access to support and education. Little is known about how these factors influence attitudes and the care of people with mental illness in rural hospitals. A qualitative descriptive study was used to investigate nurses’ attitudes to caring for people with mental illness, the issues that impact on their ability to provide care, and the effect of education, experience, and support. In 2003, 10 nurses from two wards in a rural hospital were interviewed. Participants from one ward had education and support from mental health nurses. Attitudes were found to be inextricably linked to issues that influence nurses’ ability to provide care. Dislike was apparent from nurses who suggested it was not their role. Others identified fear, causing avoidance. Conversely, those receiving support and education described increased comfort, with some nurses expressing enthusiasm for mental health care, seeing it as integral to nursing. The priority of physical care, time constraints, environmental unsuitability, rurality, and the lack of skill, knowledge, and mental health services reduced safety and effective care. A limited ability to help was reported, despite support for Mental Health Strategy goals. Positive experience promoted through education and support was required for nurses to improve care and attitudes. Notably, collaboration with mental health nurses was identified as helping nurses overcome fear and increase competence in caring for people with mental illness.

KEY WORDS: attitude, education nursing, mental health, nursing, rural hospitals.

INTRODUCTION

The need for care of people with mental health problems in general hospitals has increased. Nurses are the major providers of hospital care and have become an important resource in the delivery of mental health care. However, the attitudes and ability of many nurses in providing this care have been shown to be poor (Sharrock & Happell 2002), and this may have a negative impact on care. No research has been conducted that specifically explores nurses’ attitudes and the issues they believe affect their caring for people with mental health problems in rural hospitals, where demand for care is high, and support and education from mental health specialists is low. The purpose of this study was to explore rural nurses’ attitudes and how they affect care, the problems they associate with providing care, and the impact of education, support, and experience.

BACKGROUND

The last half century has seen major change in mental health service policy and delivery in Australia in line with Mental Health Strategy goals (National Mental Health Strategy 2000). The trend towards care and treatment within the general health system and the community due
to the increased emphasis on the rights of people with mental illness has led to the closure of many psychiatric institutions. This process, combined with financial restraints on mental health services and the high prevalence of mental health disorders (Australian Institute of Health and Welfare 1999a), has increased demands for care from the general health field. More than ever before people with mental health problems are cared for in Emergency Departments and general hospital wards (Hundertmark 2002; Sharrock & Happell 2000). In addition, comorbid physical and mental disorders are common in people being treated in general hospitals (Clark et al. 1991). Rural areas are affected more by the demand for mental health care because of limited mental health resources (Auditor General Victoria 2002). This has resulted in rural general hospitals having higher rates of admissions of people with mental health problems (Australian Institute of Health and Welfare 2002).

Research conducted in urban areas has found that many nurses responsible for care feel unprepared to support mental health needs, and have negative attitudes to caring for people with mental health problems (Brady 1976; Brinn 2000; Roberts 1998). The need to explore how attitudes affect nursing care has been identified from findings that negative attitudes lead to social distancing that reduces the ability to provide effective care (Corrigan et al. 2001). In addition, the provision of mental health care may be more difficult in rural areas where many hospitals have limited or no psychiatric facilities or personnel, and mental health services are generally less available (Auditor General Victoria 2002). Rural studies on mental health care in general hospitals (King et al. 2001; Muirhead & Tilley 1995) have found that general health professionals report poor knowledge and skill, lack of assistance, and the need for ongoing support and education to provide effective care. Olade (1983) and Rohde (1996) have also found that education, support, and experience may improve nurses’ attitudes towards mental health care. However, nursing education has only recently sharpened the focus on mental health, with the amount still considered inadequate (Wynaden et al. 2000). In addition, the majority of rural nurses are in an older age group (Australian Institute of Health and Welfare 1999b) and, thus, many have not had the benefit of educational preparation in mental health.

Research on rural nurses indicates that they are committed to the health and well-being of their communities, but because of scare resources and gaps in service delivery, support is limited, yet expectations are high (Keyzer 1998; McPhee & Scott 2002). Although support and education for staff in some urban hospitals is provided by consultation-liaison services that include psychiatric nurses, this service is not generally available to nurses working in rural areas (King et al. 2001). Roberts and Priest (1997) report that collaboration between mental and general health services can provide similar benefits, and it is a feature of the hospital where this research study was conducted. Mental health nurses have provided in-service education, advice, and support to the nurses on one ward of the hospital, which has facilitated increased admission. This has bearing on the study by increasing support, education, and experience for some of the nurses involved.

METHOD

This research used a qualitative descriptive research method to provide a ‘comprehensive summary’ of the data presented in an understandable and usable manner (Sandelowski 2000; p. 334). It was chosen due to the limited research in the area and the possibility of promoting understanding of attitudes and perceptions of the issues that impact on nurses’ ability to provide care.

The target population was nurses working in two wards of a rural hospital of approximately 300 beds that provide a wide variety of health services to the community. Hospital ethical approval was obtained from both the hospital and university, research and ethics committees. A stratified random sample gave Associate Charge Nurses, Division 1 and Division 2 Nurses the same chance of being selected, and removed the risk of bias from researcher familiarity with participants (Beanland et al. 1999). Nurses not in direct care of clients or with specialist mental health education or experience were excluded.

Ten nurses gave informed consent and participated in semi-structured audio-taped interviews. Questions focused on perceptions and experiences in caring for people with mental health problems. The recordings were transcribed and analysed to identify themes and relationships within the data, using a method of qualitative content analysis for interview transcripts (Burnard 1991).

Trustworthiness was established through the application of dependability, credibility, confirmability, and transferability. Dependability was ensured through the maintenance of a clear audit trail, by a thorough check of the work by research supervisors, and actions taken to enhance the credibility of the study (Holloway & Wheeler 1996). These actions included prolonged engagement through a working acquaintance; tape recording of interviews for accurate and detailed recording of responses; peer consultation with supervisors and experts in the field; checking identification of key points and
interpretations with participants; data triangulation through the use of subjects working in different areas; person triangulation by accessing subjects with different levels of training, experience, and responsibility; and the careful examination of contradictory data to modify interpretation and explain negative cases. Confirmability is assured by a detailed description of the research process with the inclusion of data that support conclusions (Holloway & Wheeler 1996). The provision of a description of the study group, location, research process, and interpretation allows the reader to evaluate the transferability of the study results to other settings and populations (Polit & Hungler 1999).

RESULTS

Nurses’ attitudes to caring for people with mental health problems were found to be highly varied and were inextricably linked to the issues that influence nurses’ ability to provide care. In spite of negative attitudes expressed by 50% of participants, the majority indicated a strong desire to be able to provide care for people with mental health problems in their own community hospital. While participants accept the current model of care, they believed they possessed a limited ability to help these people and required education and support to achieve this goal.

Attitudes

Analysis of the data revealed the following four recurring attitudinal themes: ‘not our role’, ‘fear’, ‘comfort from education and support’, and ‘mental health care as integral to nursing’.

‘Not our role’

Some participants stated they disliked caring for people with mental health problems and would not do so if they had a choice. They saw it as a role they had not been trained to undertake. However, dislike was not only based on the problematic behaviour they associated with this care, but also on the lack of personal appeal they felt towards these people.

... there’s always lots of negative emotions ... it’s always very hard ... It’s not only peoples’ behaviour, it’s whether you like them or not, you know. As much as you try to deny it, it’s always there.

Negative experiences revealed that the nurses felt that people with mental health problems did not appreciate their care and were likely to be uncooperative and resistive, reacting in a manner that caused management problems. No positive feedback was received from care, so dislike and negative impressions were reinforced. Participants irrevocably associated mental health problems with difficult behaviour. They indicated that it is not part of their accepted role to avert or control such behaviour.

... they can be really agitated ... and they can be aggressive ... they don’t realise that you’re trying to help them, they see you as the bad guy.

... we’re trained to be carers ... not trained to hold people down and use things against their will.

Dislike and poor understanding of individual mental health needs concentrated attention on the work the nurses felt competent to carry out. For example, hygiene standards of the nurse were prioritized over psychological well-being, and medical restraint was used to control behaviour.

... if you’re trying to change a bed or trying to change their ...attire ... things like that, they can be very resistive.

... you can usually give them a sedation order of some sort if they’re a bit agitated.

‘Fear’

Some participants did not feel comfortable caring for people with mental health problems, despite expressing ideas of advocacy and a desire to help. They related this attitude to feeling threatened due to their lack of control versus their sense of responsibility to maintain the health and safety of the people in their care. Not only did participants fear harm to themselves, the person in their care, and others on the ward, they also felt vulnerable professionally, legally, and ethically for their action or inaction to avoid harm. Furthermore, caring for people with mental health problems was felt to compromise work safety because participants did not feel able to predict behaviour or control the situation for which they are potentially responsible. This threatened their physical and emotional well-being, creating anxiety.

You do feel frightened. I mean any human would ... and some of these people are violent too ... You got to think of yourself, too.

... somebody might just do it, and you feel responsible ... you become vigilant about checking and all that sort of thing.

The participants suggested many factors that contributed to this feeling of fear and vulnerability. These were as follows.
Fear: Lack of support from environmental resources  The building and fittings were designed to suit medical care not mental health needs. Most rooms in the wards were isolated from the nurses' station, limiting observation and access to assistance. Unsecured exits and stairs and the availability of implements that could be used to inflict harm were of concern. The lack of time to give appropriate care due to physical demands and high patient ratios was also felt to reduce safety.

... it would be very easy for them to get scissors and things like that because you have to have them in a hospital and you can't lock them away.

... they're not getting that attention, ... you've got other things to do. You're running around doing all these other things and you're not there with that person.

Fear: Lack of workplace security and support  Complaints were made that fears were not taken seriously by other staff and management, and of being unable to access appropriate help when needed. They felt particularly vulnerable working after hours when few staff were available and the only form of security was the local police force.

... there's no back up if there is an issue with violence, especially after hours. There's no actual um security on the premises as such.

Fear: Lack of education causing inadequate skills and knowledge of mental health care  Concern was expressed about lack of knowledge and skill to care for people with mental health problems, and the need for ongoing education to help them overcome this fear.

Not knowing what you are doing often makes you uncomfortable. You've got no way of really assessing what is going on and you tend to find that extremely, I mean it's quite horrible.

Fear: Lack of mental health services  Participants indicated that the limited access to people with knowledge and skill in mental health care increased the risk of harm. Also, the lack of acute psychiatric beds in specialist units increased risk because individuals assessed as in need of acute psychiatric care were admitted or were continued to be cared for at the hospital because there was nowhere more suitable for them to wait.

Sometimes we have them here a little bit longer than we would like to ... we've had one incident where the police were called because we had a fellow that had to go to (acute psychiatric unit) ... he had to wait a couple of extra days before the bed was available.

Fear: Rurality  Rurality was reported to lead to long delays in accessing assistance, leaving nurses to contend with situations that were frightening or they were not sure how to manage. This contributed to the sense of vulnerability and an unsafe workplace.

They blow up when every thing is delayed. In this sort of country atmosphere ... there's always a delay.

Fear: Negative personal and/or nursing experiences  Negative past experiences confirmed participants’ perceptions that the risk of harm is increased when caring for people with mental health problems.

One of the nurses was attacked and ... physically beaten really badly ... but that was enough to realise that these people can be really, really dangerous.

These factors combined to create the attitude of fear that impacted on the ability to carry out nursing care. The vulnerability the nurses felt led to coping tactics, such as avoidance and detachment.

Mmm, keep your distance. Yeah, probably not the best treatment for them, but ... well it's my way of coping. It's an avoidance issue.

‘Comfort from education and support’  Some participants expressed more positive attitudes towards caring for people with mental health problems, describing this in terms of ‘increasing comfort’. They related this to positive experiences in caring for people with mental health problems resulting from education and interaction with the local mental health team and supportive nurses on the ward. While some participants reported a lack of ability to provide effective care, they generally felt more confident in the system that supported them and thus expressed a greater sense of control over their responsibility. The provision of increased support and access to assistance from familiarity with the mental health team, and gaining assessment skills through greater knowledge and understanding of mental illness, reduced fear and anxiety.

I wasn't as comfortable initially ... but the more information we've got about that it makes you feel a lot better, ... realizing that they're not putting anyone here that's going to endanger you.

We've been getting in service education ... what to look for in clients, and how to write notes, so you sort of feel a bit more confident in assessing them.

Importantly, comfort and the feeling of being in control enabled the nurses to make more attempts at therapeutic care for people with mental health problems. They
spent time talking and interacting, thus meeting their responsibility to provide adequate care.

Once I would have gone ‘Oh my God! I’m not going to, you know, ask them what their voices are saying’ . . . but I think that you just have to learn to relax, and that’s part of what their going through. For them the voices are real.

Positive experiences had arisen from this care, and those who had lived and worked in the same rural community for some time reported seeing the beneficial results of nursing care after client discharge. It was suggested this was an added motivation to further develop skills to provide care for people with mental health problems.

I’ve got one lady that comes in and has a black witch on her shoulder . . . I’ve seen that same lady when she’s good . . . and you would never know she’d had a problem . . .

‘Mental health care as integral to nursing’

A small number of participants revealed very positive attitudes to caring for people with mental illness, regardless of current influences. They attributed this to their life experience and the recognition of mental health being an integral part of holistic nursing care. They did not associate mental illness with increased risk of personal harm, because their interpretation of behaviour that others saw as potentially dangerous was different.

I like that kind of nursing . . . I think that’s one of the areas I’m good at . . . Behaviour that could be called aggressive or threatening . . . wouldn’t worry me . . . I can see that they’re expressing fear rather that personal attack.

These participants reported carrying out mental health care as part of their nursing with good results and positive experiences. They explained how they developed the nurse–patient relationship, receiving positive feedback and information that assisted them to care more effectively for people with mental health problems.

. . . I just like to interact with them, and just give them a little break throughout the day . . . they seem to enjoy it, they love it, you know.

Two other major themes were identified.

Acceptance of Mental Health Strategy goals

The data revealed a high level of acceptance of Mental Health Strategy goals for the mainstreaming of mental health care into general hospitals to reduce stigma and improve access. Although collaboration with mental health nurses may have helped, some participants not involved also expressed the ideal of advocacy for these people by revealing an interest in supporting their rights to be cared for in their own community and be free of discrimination. The participants reported that care in the community hospital is the right thing to do because it makes mental illness more acceptable to the person experiencing the problem, their family, and the general public. It was also suggested that it helps maintain the rights of people with mental health problems.

I believe that what we are doing is right, trying to keep people in their own environment, close to the community where they feel safer and I think sometimes they have a bit more control rather than if they get sent to a psychiatric centre.

An added benefit of improving knowledge and skill and gaining experience with caring for people with mental health problems was the nurses’ perception that it improved their ability to help reduce stigma. This ability extended beyond the hospital to their family, friends, and community members, enabling them to encourage help-seeking behaviour.

Limited ability to help

The majority of participants expressed a desire to help the mental health of their community but reported a very limited ability. Participants were all frequently required to care for people with mental health problems and most relied heavily on previous personal and nursing experience to identify problems and guide care, rather than using knowledge from education and evidence-based practice specific to mental health.

Basically you use your experience . . . you don’t have the knowledge as such, the formal knowledge . . . You have your own set of ideas built up over the last few years, and people that fit into what you’ve seen in the past you just assume . . . It’s possibly not a good idea . . . the assumption may be wrong.

Lack of understanding led to mental health needs being viewed as more complex and difficult to comprehend, and the feedback received from their care indicated that it was often ineffective. This heightened feelings of dislike and resulted in anxiety.

. . . it’s like working in ICU looking after someone on a ventilator. I think ‘oh dear I don’t know what to do’, and it makes you feel uncomfortable and unsure and you lose confidence. You feel inadequate to provide the best care, and I don’t like the feeling of being inadequate.

The participants were also concerned that they may actually cause harm to people with mental health
problems in their care, and increase the risk of danger to themselves or others by merely saying the wrong thing. Many reported avoiding in-depth conversation about the mental health issues of the people in their care through fear that it might have the wrong effect if done inexpertly. However, by avoiding the care that they perceived might cause harm, they neglected the care that may have been beneficial.

I don’t try and delve too much . . . you would get your self into a bit of trouble . . . they could perhaps twist what you say, misconstrue, get it out of context . . . its not my place to discuss certain things because I feel that I’m not qualified in that aspect to make comments or agree.

I probably don’t go into things in-depthly enough . . . I’m frightened of what I’ll find and that I won’t be able to deal with it.

The need for further education to gain skill and knowledge to improve their provision of care was highlighted by the participants. However, it was pointed out that such education was impractical and difficult to access.

DISCUSSION

Nurses’ attitudes to caring for people with mental health problems

The varied attitudes of the rural nurses to caring for people with mental health problems reported in this study support that of urban studies (Bailey 1998; Brady 1976; Brinn 2000). In this research, 50% of the participants expressed a clear dislike of caring for people with mental health problems, although some indicated that their beliefs were more positive than their prevailing attitude. The other 50% of participants were positive towards caring for people with mental health problems. A number of factors appeared to have influenced these attitudes, such as disparity in the provision of specialist mental health services, the high perception of danger due to the unsafe environment, and the lack of time, support, and education, and also the stigma of mental illness. Negative perceptions may have influenced the nurses’ belief that it is a difficult, unrewarding area of care, and that there is a high risk of danger in caring for people with mental health problems in the general hospital setting.

Participants indicated that the nature of their experiences, whether positive or negative, had been the most significant influence on their attitudes. However, Olade (1983) claims that attitudes to mental illness may be based not only on experience, but also on values and beliefs shaped by environmental and social influences. It is possible that experiences related in this research, and their interpretation, relied on existing attitudes and the behaviour they evoked, which reinforced perceptions. Corrigan et al. (2001) state that negative attitudes can increase discriminatory practices. For nurses in this study, negative attitudes led to avoidance that discriminated against people with mental health problems, resulting in negative responses and bad experiences. Herrick et al. (1997) point out that avoidance compromises nursing care by reducing the amount and quality of care the patient receives. Conversely, it was also apparent in this study that repeated positive experiences could alter attitudes, making nurses feel comfortable about care provision and quality. This supports Brinn’s (2000) finding that nurses with experience were more positive about caring for people with mental health problems relative to the extent of their experience. Nevertheless, the nurses in this study had already had extensive contact with these people, highlighting the need for nurses to feel more competent, safe, and supported to improve their attitudes to caring for people with mental health problems as Rohde (1996) has found.

The issues that affect nurses’ ability to provide care for people with mental health problems

Environmental influences: Safety and time

The nurses felt that their physical safety and psychological well-being and that of others were at risk because of the unsuitable ward environment compromising both the nurses’ and the hospital’s duty of care to provide a safe workplace. King et al. (2001) also found that health professionals in a rural regional study suggested that the hospital environment created many functional difficulties in caring for people with mental health problems. In addition, unsuitable environments have resulted in greater use of physical and chemical restraints, which undermine human rights (Hundertmark 2002). Some participants indicated that nurses used restraints of this nature to maintain safety and control.

It was also evident that nurses caring for people with high physical and medical needs and people with primarily mental health needs in a limited time frame felt forced to prioritize. Whitehead and Mayou (1989) found essential physical needs demand priority when levels of staffing are low, and that nurses feel they need more time to talk, to aid mental health care. When demands are high, mental health care may often be left till last, only carried out if there is still time, and only by those who feel able.
The high perception of danger

Many participants expressed concern based on the perception that people with mental health problems may be unpredictable and potentially dangerous. Media portrayals often promote this perception (Pilgrim & Rogers 1999). Other studies (Grigg & Sharrock 2002; King et al. 2001) have also found the fear of violence from these people among health professionals. King et al. (2001) suggest that this may not be based on reality, but rather on expectations created by negative portrayals. However, it is apparent that violence against nurses is high overall, with two-thirds of nurses reporting verbal or physical abuse in a recent survey (Australian Nurses Federation 2003). Hinson and Shapiro (2003) suggest high rates of violence can be partly attributed to people with mental illness being treated in general hospitals, particularly those who provide nursing home care and social services. Love and Morrison (2003) also believe there is an increased risk of violence from people with mental illness being treated in Emergency Departments. Rural hospitals cater for all these areas of care.

Nurses in this research were also concerned for their responsibility for the safety of the people in their care. There is no doubt that some mental illness may increase the risk of deliberate self-harming behaviour (Whitehead & Royles 2002) or of accidental injury that may occur when the environment is not suited to people with cognitive impairment. It appears that the nurses’ concerns for personal and client safety when asked to care for people with mental health problems in a rural general hospital setting may be well founded.

The effect of education, experience, and professional support on nurses’ perceived ability to care for people with a mental illness

Education

Participants believed that their lack of knowledge and fear of saying the wrong thing result in people in rural communities receiving limited mental health care from nurses working in the general hospital. Some of the participants indicated they would like to be able to provide the appropriate care but were afraid to do so. In contrast, participants who had received some education had attitudes that were more congruent with their beliefs. Rogers and Kashima (1998) suggest stereotypical responses are automatically triggered towards people in marginalized groups. They also found that nurses’ responses to people with mental illness could be more negative than their personal beliefs indicated, whereas nurses who were educated in mental health were more able to inhibit automatic responses, and behave in a manner more in line with their actual beliefs. In this research, education about mental illness was suggested as a solution to these problems.

Education in mental health has only recently been considered an essential part of nurse education (Wynaden et al. 2000), and the nurses in the study reported that they had received no or minimal tuition in this aspect of health during their training. However, it was apparent that the education provided by the mental health team had proved beneficial. Attendees reported greater understanding, confidence, and control and a reduced perception of danger. Olade’s (1983) study has previously shown that positive change occurs in attitudes towards people with mental health problems with education. This research shows that the provision of a relatively small amount of education can be effective when delivered appropriately in the workplace in an ongoing manner.

Experience

The participants had extensive general nursing experience but confessed to a limited knowledge of mental illness and heavy reliance on personal and nursing experience to guide care. It is to be expected that many nurses will experience mental illness themselves or within their immediate circle of family and friends. Personal experience was found to have a profound effect on beliefs and attitudes. It appears that these experiences, although not necessarily good experiences, developed understanding and a realization of how nurses could help by providing care, but did not always allay fears.

As Mayou and Hawton (1986) point out, reliance on experience appears to hinder the understanding and treatment of mental health problems. Bailey (1998) found that nurses’ experience of caring for psychiatric patients in general wards was predominantly negative because it lacked positive feedback. These findings confirm Rohde’s (1996) belief that safe supported clinical experience in mental health encourages relating to people with mental health problems and thinking about their individual needs, resulting in better care and positive experiences. Some participants in this research indicated that seeing the good results and positive feedback of their care was very motivating. Rural nurses who live and work in the same small community are more likely to encounter people they have cared for in their day-to-day life and, thus, receive more positive feedback. This factor is unique to rural nursing and may be of significant benefit in improving attitudes.
Support

It was indicated that nurses need more practical and emotional support in caring for people with mental health problems due to the stressful and complex nature of this work. They relied on their peers for support but many felt that this was inadequate due to poor attitudes or lack of expertise. Lack of knowledgeable support and delay in access increased the perception of danger. Other studies (Bailey 1998; Roberts 1998; Sharrock & Happell 2002) also indicate that general nurses need support to provide mental health care, and that this is often unavailable. Bailey (1998) believes that poor institutional support in this area results in coping tactics, such as tea room humour as stress release, at the expense of patients. Venting feelings in this manner could also perpetuate the stereotypical negative responses suggested by Roger and Kashina (1998) contributing to the stigma of mental illness.

Shortage of mental health services and distance due to rurality also reduced the availability of support for rural nurses in this study. Judd and Humphrey (2001) believe insufficient resources create serious problems in providing support for people with mental health problems and limit access. This appears to be true also for the nurses in this research who identified long delays in assistance arriving due to large areas of coverage and high demands on local mental health workers.

King et al.’s (2001) study indicated an interest from rural hospital and mental health service staff to strengthen existing relationships in the area where this study took place. The results of this desire were reflected in this research, with collaboration between services demonstrating higher levels of support to the nurses involved. However, this was restricted within the hospital by being confined to only one ward.

CONCLUSION

Despite the fact that this research was limited to a small sample of nurses in one rural hospital, it appears that the increased need for care for people with mental health problems in general hospitals has impacted doubly on rural nurses. These nurses report similar difficulties as urban nurses; however, the already expanded role of the rural nurse requires them to provide this care faced with larger client loads that have more diverse and often complex and acute health-care needs. To compound the problem, support and education is less available due to rurality and sparse mental health resources. Fear and poor attitudes are understandable under these circumstances. The consequences are that nurses feel inadequate and suffer anxiety, and people with mental health problems are avoided, have their rights to equitable care ignored, and their mental health needs largely unmet.

Many of the participants in this research demonstrated a strong desire to help with mental health needs and protect the rights of their community members, but identified the need for more education and support to assist this role. Experience played an important part in confirming or reformulating nurses’ attitudes to caring for people with mental health problems. Providing care in a supportive and informed environment improved attitudes by reducing fear and uncertainty and increasing competence through good experiences. Some participants were able to provide greater access to care for people with mental health problems, reduce stigma, and enable early intervention both in the hospital and in the local community. Furthermore, positive reinforcement was gained from witnessing the good results of care within the hospital and community. In this research, collaboration with mental health services increased support and education for nurses, improving comfort levels and confidence to provide care. Such collaboration may assist nurses to facilitate the inclusion of appropriate care for people with mental health problems into mainstream rural hospitals.

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