

Challenges in mental health nursing: current opinion

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Abstract: The current mental health care system in the US continues to struggle with providing adequate care and services to all that require it due to limited resources, biases from both other professions and the public, and the complexities of treatment of many of those individuals or populations that suffer from mental illness. Mental health nurses, also referred to as psychiatric nurses, are impacted by those same biases, limited resources, and complexities in their role. This paper provides a brief history of mental health nursing and a discussion of the current challenges faced within the profession. It will also include how the public's perception of both those who have mental illness and those who treat it is based on the sensationalism of those who are violent, and misunderstanding of current treatments. It is imperative that mental health nurses continue to define and educate other health care professionals as well as the general public of the role of the mental health nurse and those who suffer from mental illness. Unfortunately, some of the same bias that was present in the 1930s remains today, but perhaps with perseverance and education it will not continue into the future.

Keywords: mental health, psychiatric nursing, pre- licensure, post-licensure challenges, professional obstacles, public perception

Introduction

Health care in the US currently faces a number of obstacles, perhaps chief among them is having been declared a broken system years ago.¹ Aside from system-related problems, we face numerous health and social problems which include: an aging population; increased numbers of Americans who are obese and have problems with diabetes, high cholesterol, and hypertension; citizens who are uninsured and in some cases underinsured; a high percentage of children living in poverty,² and cutbacks on numerous services to people, including programs and treatment for those in need of mental health care. It is no secret that in spite of the enactment of The Mental Health Parity and Addiction Equity Act of 2008, which requires that financial requirements and limitations on the cost of mental health treatment be on par with medical or surgical financial requirements and reimbursements,³ mental health care and treatment, for the most part, leaves much to be desired. The health care professionals providing a large portion of the care to those who are fortunate enough to access and receive mental health care are nurses. To be more specific, they are mental health nurses, also referred to as psychiatric or psychiatric/mental health nurses. Yet, just as the mental health field is not without obstacles and challenges, mental health nursing faces a number of obstacles and challenges as well. Some obstacles and challenges have a longer history than others, but they all have the capacity to render mental health care

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less affordable, accessible, and efficient, and in doing so, to negatively impact this area of specialized nursing. This paper begins with a brief history of mental health nursing followed by a discussion of a number of current challenges faced by mental health nursing, including pre- and post-licensure problems, and challenges that arise directly from the profession itself as well as from public perception.

History and practice of mental health nursing

Historically, mental health nursing grew out of the need to have nurses work in hospitals and asylums and tend to the large numbers of patients contained within before the introduction of psychotropic medications and the eventual closing of such facilities. During the 1940s, for example, it was estimated that there was roughly one nurse for every 135 psychiatric patients in hospital.⁴ Their role was primarily to help doctors care for this population, and in many instances, the asylum or hospital itself trained the nurses.⁵ Mental health nursing was one of the last areas of specialization to come to the profession of nursing and one of the last experiences required in the training of nurses.⁶ In 1882, McLean Hospital in Massachusetts implemented the first nursing program that trained its students how to work with and care for those with a mental illness.⁷ Years later, in 1913, Johns Hopkins offered a course on psychiatric nursing to its students, making the course, which is said to have served as a prototype for other nursing programs, part of its curriculum.⁸ Several decades later, in 1950, the National League for Nursing mandated that nursing programs provide students with experiences in mental health nursing in order to be accredited.⁷ From the 1960s onwards, a number of publications devoted to mental health and psychiatric nursing, such as *Journal of Psychiatric Nursing and Mental Health Services*, *Issues in Mental Health Nursing*, *Journal of Child and Adolescent Psychiatric Nursing*, and *Journal of Psychosocial Nursing* became available. In addition, the American Nurses Association has offered several revisions of scope and standards related to various mental health nursing practices.

The practice of mental health nursing has undergone numerous changes during its evolution, including the role and function of the mental health nurse and it being considered a specialized area of nursing which requires specific knowledge, skill, and experience in working with those experiencing mental health issues. Building on the functions of psychiatric nurses defined by Hays,⁹ among which was helping patients to explore their thoughts and feelings and supporting them in times of crisis and emergencies, Hildegard

Peplau, considered by many as the mother of psychiatric nursing, viewed the essence of mental health nursing to be one of counselor or therapist. Her view about mental health nursing focused heavily on the interpersonal connection between nurse and patient, which she viewed as the heart of psychiatric nursing, with the nurse taking on such subroles as counselor, teacher, leader, and a resource for and to the patient.^{10,11} Presently, the foundation of interpersonal connections remains the focus in development of mental health nursing courses. Over the course of time, the process used in the development of those connections is refined and reframed as health care providers incorporate evidence-based practices, as well as addressing diversity in their practice. However, the path has not been easily navigated, well defined, or clearly articulated for this specialization.

Pre-licensure challenges

Challenges to mental health nursing occur in a number of arenas, including the classroom where nursing students are first introduced to the various areas of nursing. However, by no means a common practice in all schools, it is certainly not uncommon to see some of the content taught by faculty and instructors with limited experience or academic preparation in a given area. One of the practices in nursing programs that does not serve mental health nursing well is the use of non-mental health nurses to teach mental health nursing. Although it can be beneficial and enriching to supplement content by inviting non-mental health guest speakers into the classroom, it is recommended that experienced mental health faculty be the basis for teaching the necessary mental health curriculum.

Given that we all have emotions and at some point in our lives have experienced some level of depression or anxiety, many feel that it is acceptable to give a non-mental health nurse the mental health textbook. The belief seems to be that because this is such an easy topic and one that most if not all have personal experience with, anyone can teach it. It is akin to having a native English speaker teach English classes or a woman who has given birth teach obstetrics. Unfortunately, what is communicated to the students is a lecture with little depth by someone with little to no insight or experience to share with the students, to breathe life into what mental health nursing is all about. One of the authors is reminded of co-teaching a mental health nursing course with another instructor who was not a mental health nurse but who had a family member with bipolar disorder. On that instructor's night to teach, it became movie time to hide the fact that this was not her area of expertise. While that was

bad enough, what was worse was that before the students had even started their clinical experiences, she showed them “One Flew Over the Cuckoo’s Nest”, thus setting the stage for them to expect a horrible and “Nurse Ratched”-type experience. While this might have been a better choice toward the end of the semester, when students had some clinical experience under their belts to demonstrate how things have changed since then, it served to give the class, who did not know any better, an unrealistic and unpleasant picture of how things are today. Since mental health nursing is seen as a soft form of nursing, the door is open to allowing in people to teach it who should not do so.

Another challenge to mental health nursing at the pre-licensure level has to do with how the students conceptualize nursing. Typically nursing is associated with doing and administering. Nurses are trained to deliver treatments, pass medications, take vital signs, and monitor laboratory values and patient status. Emphasis is placed on technical and mechanical skills, and on completing all the demands of that shift on time. One is always busy as a nurse. That is the introduction to nursing that students receive in the beginning years of their programs. As has been noted decades ago, at this point the “student’s pattern is pretty much set”.¹² As mental health nursing courses are often positioned later in the curriculum of some nursing programs, now as it was the case then, students have been acclimated to such an approach and may find it difficult to make the transition of being in the moment with the patient. Weiss’s argument then is just as valid today as she notes that the student now feels that there is nothing to do, and that the patient, who can walk, has no tangible signs of medical illness, and does not require a treatment or dressing change, represents a challenge to the student as she is now called on to keep busy in a totally different way.¹² And now, just as was the case years ago, students may see working with mental health patients as depressing, taking too long to see improvement, putting them at risk of being exposed to violence, or requiring more of an interpersonal connection with the patient than they would like or feel they would be good at.¹³ Unfortunately, what students often see is the mental health nurses on the unit devoting much of their time to charting, pills, and paperwork. It would serve us well to offer students exposure to as many sites and contexts as possible which utilize the skills and services of mental health nurses in addition to relying solely on clinical experience in hospital settings.

An added complication in attempting to coordinate diverse clinical experiences is that there are limited sites, as well as competent clinical mental health faculty. The limited

sites and increase in enrollment of students have led many programs to utilize simulation experiences.^{14,15} Simulation experiences can be beneficial in providing students with an opportunity to practice new skills in a setting where they feel safe to make mistakes without the risk of causing a true sentinel event.^{14,16–18} Although simulation can be a valuable educational experience, it does not replace the importance for students to have structured and interactive contact with the mental health care system (which includes with the patients, staff, and environment).

Post-licensure challenges

Sometimes miracles do happen, and the student who swore she would go into an area of nursing post-graduation other than mental health undergoes a change of heart and now reports she would like to work in mental health. One of the authors has seen this happen with several of the students she has precepted in clinical work. With a good and supportive clinical experience, students can be divested of the negative stereotypes and images they may have, and while that is a worthy outcome in and of itself, it can open the door to wanting to work in the field. One of the challenges at this point is that, in some locations, the numbers of services and beds are limited, owing to various cutbacks and downsizing as well as problems with the economy. The county where one of the authors lives, a wealthy county in Pennsylvania which boasts some expensive horse country, saw one of the mainline hospitals close its mental health unit in the hospital, leaving the county at the time with only one small unit in another hospital. With fewer beds and services, there is less opportunity for applicants to find positions in mental health nursing. Positions and opportunities in the field have become more limited as compared with years ago, and many places want applicants to have mental health experience in addition to a Bachelor of Science in Nursing. And when thinking about graduate school, those who would like to become mental health nurses find they can no longer get a master’s degree in mental health nursing to take on the role of clinical nurse specialist because that option has been replaced by the nurse practitioner master’s degree, which does not appeal to everyone because not everyone wants to be a nurse practitioner. Such a state of affairs has the potential to direct those who might be interested in working in mental health to other areas of nursing.

Professional obstacles

Heyman¹⁹ points out that mental health nursing recruitment proves difficult and that appreciation of the skills and roles

of mental health nurses is low. While the public's perception of mental health nurses is not always favorable, the nursing profession also views mental health nurses in less than a favorable light. Many of our peers in other specialties view us as inferior and not real nurses, and have at times been overheard by one of the authors telling non-mental health nurses that mental health nurses are crazy. According to one study,²⁰ the nursing profession views mental health nursing as a less desirable career choice when compared with other areas of nursing and as a specialty area that lacks an advanced knowledge base and advanced skill set. Students are not unaware of how both mental health nursing and mental health nurses are viewed, not just by the public, but by those in the nursing profession as well. Undoubtedly, that leads some students who want to be "real" nurses into other specializations. This is supported by some schools having non-mental health faculty teach the course.

Another area that perhaps muddies the water revolves around what it is that mental health nurses do. While Peplau²¹ characterized mental health nursing as "difficult intellectual work", which indeed it is, she also noted years ago that many of the mental health nurse's duties centered on giving medications. With the passing of medications, recording them having been given in the patients' charts and taking off orders, she lamented that there was little time for nurses to interact with patients to take on the role of counselor and therapist, which is the essence of mental health nursing. The nurse's day, as Peplau²¹ noted, was spent in large measure doing paperwork and handing out medications. Unfortunately, even today, in many settings, that continues to be the primary role of mental health nurses. Even in an advanced practice role, psychiatric nurse practitioners more often than not are utilized as prescribers and not counselors or therapists. Students on clinical rotations see this, as do potential psychiatric nurse practitioners. Those who want to spend time with patients and who view treatment as more than handing out pills can be discouraged from joining the ranks by the prospect of pill pushing being their main function. And since the profession no longer offers the psychiatric/mental health nursing clinical nurse specialist master's degree, anyone wanting a master's degree in mental health nursing is forced into a psychiatric nurse practitioner program. The bio medicalization of psychiatry, and along with it, by association, in no small measure, the bio medicalization of mental health nursing, has definitely served as an obstacle to affording mental health nurses the opportunity to be and to do all that they could be and do.

The elimination of the mental health clinical nurse specialist has also further supported the lack of value of nurse

therapists, and specialty staff educators, as a valued resource in working with complex mental health patients in the inpatient and outpatient settings. Although in the medical field both a doctor in osteopathy and a medical doctor use a different lens when they work with the patient, both have been found to be valuable to the overall medical care of patients.²² Unfortunately, such respect was not supported in the nursing profession or health care systems when the role and certification of the clinical nurse specialist was eliminated. One author's thought is that, as nurses struggle to work with the complexities of health care, population-based care, developing skills in the outpatient setting that focus on stabilization, maintenance, and relapse prevention, the role of the clinical nurse specialist will emerge once again.

In addition, even when we in the field are asked what mental health nursing is and what it is we do, we are often hard pressed to answer that question. Perhaps a bit extreme for most, some adhere to the belief that mental health nursing is a myth, and a discipline with "no obvious purpose".²³ The authors ask what is it that mental health nurses do that is not already done in part by those in other disciplines, such as social workers, psychiatrists, psychologists, or untrained helpers. They argue the fact that historically mental or psychiatric nursing was created by physicians to help them serve the needs of the many patients inhabiting the various asylums and state hospitals before the introduction of psychotropics in the 1950s and the closing of those institutions. Once there was no need for massive numbers of mental health nurses in their original role as hand maidens of doctors and psychiatrists, Barker and Buchanan-Barker²³ suggest that mental health nurses have had to create other roles to justify their existence, and suggest that perhaps in doing so, we have borrowed some duties and roles from other disciplines. However, to borrow does not mean that we own the whole. It often seems that mental health nursing is assigned the understudy role in relation to those professions with which we share or there exists overlap in various roles and functions. At the advanced level, mental health nurses are required to take courses in treatment modalities and be educated across a great number of areas, including psychopharmacology, pathophysiology, and development across the lifespan, yet we and our skills are often ignored and underutilized by members of those other professions. Is it that they are threatened by what we can do and act to limit our offerings out of fear in order to maintain their territory? It is no secret that the medical profession has issues with nurses rising too far above the bar they have created for us, and that this struggle for practice rights is not limited to mental health nursing. Nonetheless, it represents

a challenge for psychiatric mental health nurse practitioners who, in many instances, depending in part on what state they practice in, have limitations on their scope of practice. As Peplau wondered in the 1990s, are we in this decade still facing limitations imposed on us by physicians as well as other professions?²¹

Aside from how other professions may define and perceive us, we seem to have problems defining what we do and who we are. Barker and Buchanan-Barker²⁴ cite their study in which they asked 200 mental health nurses to briefly define what is psychiatric and mental health nursing and how do nurses practice this. They reported that many found answering the questions difficult and the descriptions that were offered were often “jargon-ridden summaries of eminent theorists”.²⁴ In addition, most respondents did not distinguish between “psychiatric” and “mental health” nursing. Such a finding begged the question of how can we expect to recruit professionals into the field if we cannot define what it is that we do and who we are. How can we consider ourselves a distinct specialty if we cannot define what that specialty is? Even in our title there is confusion.²⁵ Is one a psychiatric nurse, a mental health nurse, or a psychiatric/mental health nurse? And does one practice psychiatric nursing, mental health nursing, or psychiatric/mental health nursing? Thus, we still have many questions with no easy or clear answers.

Finally, within the profession, things can and do frequently change. Once offered as a degree, the Doctor of Nursing Science was gone almost as soon as it appeared. Programs and degrees come and go, and while this experience is not unique to mental health nursing, it does impact it. Now the route to a master's in mental health nursing is at the nurse practitioner level, like it or not, as the option of clinical nurse specialist was removed. And those certified in adult mental health nursing will soon find themselves facing obsolescence because that is being replaced by family mental health. It seems at times that we keep reinventing ourselves, perhaps in part to find an identity that works.

Public perception

Much of the public perception of mental illness has been and continues to be, to say the least, negative. Historically those even suspected of having a mental illness were shunned, feared, ridiculed, locked up, and, at times, even burned to death.⁶ While treatment has improved and patients are no longer subjected to strait jackets, lobotomies, insulin therapy, hydrotherapy, and unnecessary restraints and isolation, applied mostly to settle the “wild beast”, the public continues to fear this population. It is common knowledge

that various forms of “treatment” years ago, such as locking people away in asylums and providing them with lobotomies, were, in part, motivated by the desire to keep the public safely separated from the mentally insane and render them harmless for the good of the general public.²⁶ Individuals exhibiting symptoms were believed to be dangerous, unpredictable, and possessed by the devil, and were often treated like outcasts or criminals. Many believed that working in a mental health setting was to put oneself in danger and at great risk of being subjected to violence. Some also believed that working with those experiencing mental illness would increase the chances of that person becoming mentally ill herself, a question asked of psychiatric nurses as far back as the 1930s.²⁷ Stigma has long been a companion to mental illness, and as Goffman²⁸ informs us, there is guilt by association, such that those involved with a stigmatized or marginalized group of individuals, themselves become guilty by association in the public eye. Nurses are first and foremost human beings and are not immune to the portrait created by the social discourse centered on this population, including, as some researchers found,²⁰ that the public views mental health nurses as evil, corrupt, and mentally unbalanced; surely not the most enticing image for someone deciding on what area of nursing she wishes to work in. Such a bleak and worrisome picture of working conditions, patients, and mental health nurses undoubtedly serves to frighten off even the most intrepid of nurses from working in mental health. And not only do nurses not want to go into mental health nursing because of the misconception that it is dangerous, but there is also the issue that not only the public, but nurses as well, are not sure about what mental health nurses do and wonder if this really counts as “real” nursing.

Conclusion

In 1994, Peplau noted the following: “the definition of the contents and scope of psychiatric mental health nursing is still incomplete.”²¹ Almost two decades later, her observation still rings true. The challenge lies not so much in how the external world, including other professions and even our colleagues within nursing, defines us, but more so in how we view and define ourselves, our roles, our function, and our territory. While we are no longer the accomplices and handmaidens of paternalistic physicians and psychiatrists who manned the asylums of yesteryear and who needed someone to do their bidding, we have yet to find solid ground on which we can build a sound ideology. This is not a task we should leave to others. As Kalkman²⁹ advised over five decades ago but which still rings true today, other ancillary psychiatric groups

are doing much better than mental health nursing. We need to do a much better job of defining ourselves and demonstrating to others the importance of what it is that we do lest we become overshadowed by other professionals in the field.

One method to further define and disseminate the achievements of our specialty is for mental health faculty to collaborate with mental health staff nurses in sharing their clinical experiences in journals and other nursing publications. Unfortunately, many nurses who work in hospital settings may not be comfortable with the publishing process. Even in the academic setting, writing for publications can be a reluctant undertaking that is an intimidating and time-consuming process for mental health faculty. Addressing and conquering the hurdles of publishing the role of the mental health nurse through collaboration of academic and practicing mental health nurses would be an essential and invaluable contribution to highlighting the importance of mental health nursing.

Disclosure

The authors report no conflicts of interest in this work.

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