Appreciating the importance of history: A brief historical overview of mental health, mental health nursing and education in Australia.

by

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Abstract:

History is consistently acknowledged as crucial to the identity of a profession. In the case of mental health nursing this is perhaps more so, as published accounts of the history of nursing rarely pays attention to the specialty of mental health. The aim of this paper is to provide a brief overview of the history of mental health nursing in Australia. It is concluded that an understanding of history is essential in understanding and interpreting contemporary mental health service delivery and seeking to overcome the professional distance between mental health and other branches of nursing.

KEYWORDS: De-institutionalisation – History – Mainstreaming - Mental Health Nursing

Introduction:

Understanding the history of mental health nursing promotes increased awareness of the social and intellectual origins of the discipline (Keeling & Ramos, 1995), and provides a better basis from which both students and practicing mental health nurses can meet the mental health needs of the community, not just in the present, but in anticipation of the changes that are likely to occur in the short and longer term future.

Nursing is generally acknowledged as a highly complex and diverse profession, providing care to people across the life span, who are experiencing a variety of health care problems. However, interestingly this is not often reflected by historical accounts. Histories of the nursing profession tend to focus on the care of people experiencing physically illness or injury. Mental health nursing is either totally absent from or receives only superficial mention within these historical texts (Maude, 2002).

This situation may be partially explained by the fact madness was historically viewed as the result of factors such as possession, ‘bad blood’ or inherent character flaws rather than as an illness (Singh, Benson, Weir, Rosen & Ash, 2001). Furthermore there was a greater emphasis on the custodial rather than the caring role in the treatment of people experiencing a mental illness, an approach which is not often considered to be characteristic of nursing. However, if we are to provide education for nurses that is genuinely comprehensive, greater attention must be devoted to the history of all branches of nursing. To exclude mental health nursing may be interpreted as reflecting the view that this area of specialty is not as important or not of equal status to other areas of nursing practice. This runs the risk of further stigmatizing people who experience mental health related problems.

The history of mental health nursing in Australia differs significantly from the history of other
branches of nursing. The history reflects a primarily custodial approach to the treatment of people experiencing a mental illness. The first Australian Lunatic Asylum was opened at Castle Hill (in what was later known as New South Wales) in 1811. The institution was staffed by untrained mental attendants. Large numbers of disturbed people were primarily restrained as a means to keep control. There was virtually no emphasis on treatment (Keane, 1987).

In response to overcrowding of the Castle Hill Asylum, a new asylum was erected at Tarban Creek (also later known as New South Wales) in 1837. This continued to be the place where people experiencing a mental illness were housed until the opening of Yarra Bend Asylum in 1948. The Yarra Bend Asylum was opened at Kew in the Port Phillip district (later to be known as Melbourne). Immediately 10 mental patients were transferred there from goal. A lay superintendent administered Yarra Bend, his wife occupied the position of matron, for which she received approximately half of his salary (McCoppin & Gardiner, 1994). Asylums were subsequently opened in other colonies of Australia.

The early approach to the treatment of people experiencing a mental illness followed the British model, and tended to reflect the views of medical superintendents who migrated to the colonies to oversee the asylums. The philosophy was one of humane care. However the considerable overcrowding of the asylums frequently led to a more custodial approach. A number of Royal Commissions during the 19th century did not substantially address the problems identified (Singh et al, 2001). In 1867 an Act of Parliament was passed which made it mandatory that persons showing signs of mental impairment must be sent to a lunatic asylum rather than a prison (Keane, 1987). By 1900 people experiencing a mental illness were separated from the ‘mentally retarded’. The ‘nursing’ in the mental asylums continued to be predominately delivered by male attendants. The care continued to be custodial, delivered by untrained staff until the medical staff of the institutions commenced providing lecturers to the attendants. The idea of employing female attendants then began to receive serious consideration (Keane, 1987).

The period from the 1950s to the 1980s saw rapid changes within the health care industry which dramatically altered the practice of nursing. The knowledge base required for nursing expanded enormously. The knowledge required for practice could no longer be included in nursing curricula, hence the commencement of specialization and the development of nursing specialties (Bessant, 1999). The practice of psychiatric/mental health nursing was similarly affected by advances in medical science. Mental impairment increasingly became considered as an illness, and considerable attention was devoted to finding a cure for specific illnesses (Cade, 1979). The 1950s were particularly famous for the first use of major tranquillizers. The heavy reliance on the strait jacket and other forms of physical restraint was no longer necessary. Psychiatric nurses were able to establish therapeutic relationships with clients, involving both group and individual therapy (Cade, 1979).

Further changes to psychiatric/mental health nursing occurred during the 1970s and 80s when large psychiatric institutions (previously known as asylums) were scaled down and later closed and were replaced by smaller units within general hospitals and an increase in community based care. This movement, known as ‘deinstitutionalisation’, has seen huge reductions in the length of stay in psychiatric hospitals, and a significant number of people experiencing a mental illness are now never admitted to hospital.

Criticisms of deinstitutionalisation tend to reflect the view that not enough funding has been provided to ensure that adequate supports are available for people experiencing a mental illness and their families in the community and that community services are not sufficiently well resourced to ensure an optimum level of care.
The strongest critics suggest that deinstitutionalization has meant relocating the institutions from hospitals to boarding houses or special accommodation facilities. No doubt this is true in some cases and community services require further development and additional funding in order to realise their full potential. Despite the different views regarding the extent to which the deinstitutionalisation movement has been successful however, there is wide agreement for the idea behind caring for the mentally ill with, while restricting their freedom as little as possible.

Mental Health Services in Australia - The Current Perspective:

Changing views about mental illness gradually led to the view that the isolation of people experiencing a mental illness within institutions was not a satisfactory arrangement. Major changes to the structure of mental health services represents the outcome of this movement. While there is variation between the states and territories of Australia, there has been a trend towards the scaling down, and in some cases the closure of large institutions, and an increase in community based services. This reflected the belief that people experiencing a mental illness should where possible receive care within their own family and community settings (Singh et al, 2001).

The development of community-based services was celebrated as a significant advance. However, the separation of mental health services from the broader health care system continued to be an issue of concern. The release of the National Mental Health Policy (Australian Health Ministers, 1992) signaled one of the major reforms to mental health services in Australian History. The focus of official policy following the trend towards primary prevention by promoting the maintenance of mental health as opposed to a primary focus on the treatment of what was frequently termed: “serious mental illness”. The National Inquiry into Human Rights and Mental Illness (1993), commonly known as the Burdekin Report, also highlighted problems which affected consumers, their carers, and members of the public and detailed the incidence, effects and treatments available for them.

One of the most significant outcomes of this new policy direction was the introduction of a process known as mainstreaming. Mainstreaming refers to the integration of mental health services within the general health care system. In most instances this has meant that units providing inpatient care for people experiencing a mental illness are now located within a general hospital. The desire to produce a responsive health care system, capable of responding to a broad range of health care issues, and to reduce the stigma frequently associated with accessing mental health services, were the primary reasons for the introduction of mainstreamed services (Whiteford, 1998).

These reforms to mental health services have not developed uniformly throughout Australia. In Victoria, for example, all of the large institutions have now been closed and all in-patient facilities are located within general hospitals, with the exception of Thomas Embling Hospital, which provides inpatient beds as part of the Victorian Institute for Forensic Mental Health. A number of other states, such as New South Wales, Queensland and Western Australia, currently have both units located within general hospitals and separate institutions specifically for the provision of mental health care, although these are now considerably smaller in terms of bed numbers, than they were historically (Singh et al, 2001).

Mental Health Nursing Education in Australia - An Historical Perspective:

Historically mental health nursing was viewed as a separate branch of nursing. In order to become registered as a mental health (or psychiatric) nurse, a student undertook a three-year hospital-based course. Some variation in the structure of courses was apparent between the states of Australia,
however, generally students were required to take clinical experience in a broad variety of settings including acute admissions, long term wards, child and adolescent, aged care, drug and alcohol and community settings. The theoretical component was generally delivered via study blocks (periods of full time study of up to several weeks duration) and individual study days. The student was employed by the hospital and undertook clinical experience as a paid staff member of the organization. At the conclusion of the course the student sat State based examinations. On successful completion of the examinations, the required amount of clinical experience and demonstration of competence through the satisfactory completion of clinical objectives and practical examinations, the student was able to register as a nurse within the state in which the course was undertaken. People registered as mental health or psychiatric nurses were only able to practice within their specialty area. They were not able to practice as general nurses without undertaking additional studies in this area.

The change to this model of nursing education resulted from the transfer of nursing education from hospitals to the higher education sector. The first tertiary based nursing program was established in Melbourne by the Royal College of Nursing Australia in 1974. (Bessant, 1999). This provided impetus for other parts of Australia to follow suit and led to the release of a report which reflected collaboration between the College of Nursing Australia, the Australian Nursing Federation and the Florence Nightingale Committee. This report articulated a vision for the future of nursing education in Victoria. It included the recommendation that nursing education be transferred to Colleges of Advanced Education as a matter of priority. It was further recommended that such courses be comprehensive in nature, that is, that they would educate nurses for practice at a beginning level in all areas of nursing care except midwifery (College of Nursing Australia, the Australian Nursing Federation & the Florence Nightingale Committee, 1975).

In 1984 the federal government announced full support for the transfer of nursing education in the tertiary sector. This process ensued over the subsequent decade. The battle for comprehensive education was won in all states but Victoria. The education of psychiatric and mental retardation nurses was transferred into the tertiary sector in 1989. The graduates of these programs became eligible for registration as a psychiatric or a mental retardation nurse by the Victorian Nursing Council under the Nurses Act of 1958. In 1993 the introduction of a new Nurses Act resulted in the immediate cessation of direct entry psychiatric nursing programs. Undergraduate nursing education throughout Australia was to be comprehensive in focus.

Comprehensive Nursing Education: the Current State of Play:

Rather than specializing in a specific area of nursing, comprehensive education is designed to prepare a generic nurse with sufficient skills to practice at a beginning level in a variety of health care settings including the mental health area. For you this means that after completing this course you are legally able to seek employment as a mental health nurse. It is also expected that you are competent to meet the basic mental health needs of the patient across a variety of health care settings.

The extent to which existing courses are truly comprehensive has been the subject of much debate. Australian research suggests that the vision has not been realized in reality. Undergraduate nursing curricula remains highly focused on hospital based medical-surgical care, with significantly less attention devoted to areas such as mental health and care of the elderly (Farrell & Carr, 1996; Happell, 1998, Stevens & Crouch, 1995).
In order to further develop the skills and expertise required for specialization in the mental health field, postgraduate courses in mental health nursing have been developed throughout Australia. The structure of these courses varies considerably both between, and within, the states and territories. Current courses are offered at the post-graduate certificate, postgraduate diploma and masters level, and vary in duration from the equivalent of six months to two years full time. Some courses are offered on campus and delivered primarily through face to face teaching, while others are offered through distance or internet based education models, or through a combination of face to face and distance. These courses may be offered entirely by the university or through a partnership between the university and health care services.

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