

Addressing mental health nursing workforce shortages

If a crisis in the recruitment of mental health nurses is to be averted, a review of the mental health component of the undergraduate nursing programme is urgently needed.

By Sharon Logan

Along with many other countries, New Zealand is facing a shortage of mental health nurses.^{1,2} The mental health nursing specialty does not seem to be attracting sufficient numbers and will not meet the growing demand for services.^{1,3}

Stigma towards those who use mental health (MH) services is still very evident in our society. This stigma also affects students as they are considering which area of nursing to pursue as a career. Until this stigma is addressed, nurse recruitment will continue to be affected.

The number of MH nurses per 100,000 population in New Zealand is expected to fall by 2026.⁴ This is due to the bulk of the MH nurse workforce retiring over the next 20 years, and a considerably smaller number of recruits entering the sector.

In 2015, there were 22 MH nurses in the under-25 age bracket working in the community, as opposed to 453 in the 50 to 54-year bracket.⁵ This raises serious issues of future sustainability. Unaddressed, this will affect service users, especially as nurses are seen as uniquely placed to meet their mental and physical health needs.⁴

The current undergraduate nursing programme may be one of the factors negatively influencing graduate numbers.^{3,6,7} Is the MH component of the programme fit for purpose? Bachelor of nursing programmes, provided by Nursing



Sharon Logan

Council-accredited tertiary organisations, are developed with local stakeholders. They must meet the council's education standards,⁸ and are benchmarked with other providers to ensure standardisation.⁹ However, the education standards do not specify any explicit details for the MH curricula – there is no minimum content or expectations. In some cases, this has led to some academic staff seeing MH as a low priority. There have also been concerns over consistency,^{10,11} and perceived inadequacy.^{1,2} Furthermore, MH is an area of nursing that is not well understood,⁷ with recruitment falling.³

Minimal mental health content

The comprehensive/generic nurse education programme, introduced in 1974, is attributed with improving nurse education standards. However, there are

concerns this change in nursing education has led to less MH content and a loss of the MH nursing specialty.^{3,12} With insufficient MH content in the curricula, students often feel ill-prepared for clinical placements. The clinical placements themselves can be inadequate in terms of time and quality, and can even discourage interest in MH.^{3,7,13}

To ensure graduates develop the requisite skills for MH, additional (funded) postgraduate education is required – the nurse education to speciality practice programmes (NESP).¹⁴ Additionally, increasing demand and reconfiguration of service delivery require general nurses working in areas such as primary care to provide MH assessments and interventions. Research suggests these nurses also require additional training.¹⁵ How effective is the undergraduate programme in ensuring every nurse has generalist MH skills? Not particularly, as what is developing is resource-intensive postgraduate education.

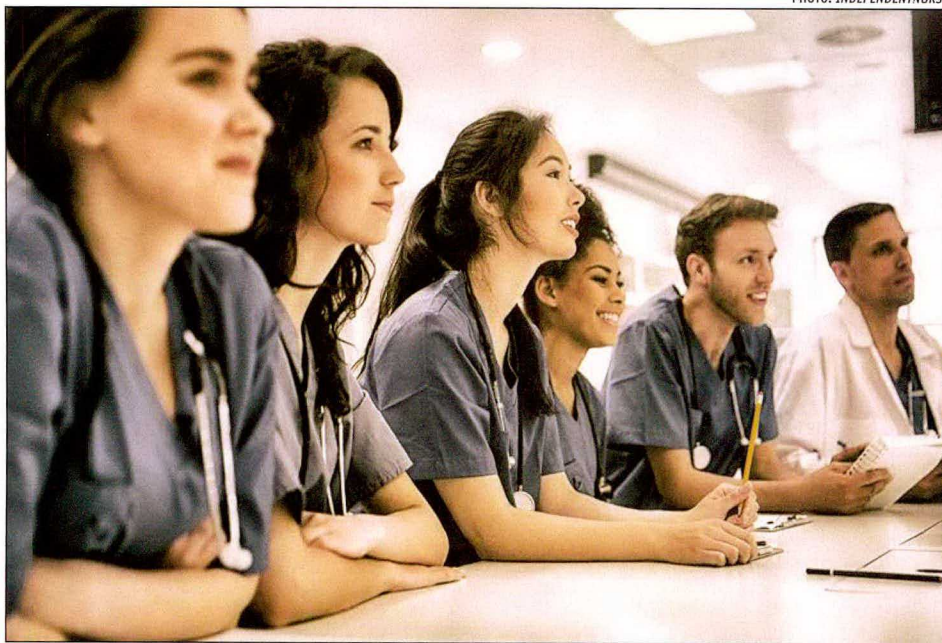
Prejudices and anxieties

In addition to the perceived lack of undergraduate preparation, there are wider issues, such as prejudices and anxieties about MH nursing, which affect recruitment.¹⁶ An adequate undergraduate programme could address these prejudices and reduce these variables.

A review of the literature indicates that increased interest, confidence and recruitment in MH nursing can be achieved by adapting, and/or increasing the content of the MH curriculum, or by using innovative teaching such as simulation and actors.^{3,16,17,18} Interventions that increase perceived skill-preparedness for clinical placement, and that reduce fear and anxiety, are key ways of engaging students in clinical learning and developing an interest in MH nursing. Targeted MH education and learning within the existing programmes can increase confidence, reduce fear and anxiety, and increase the number of graduates choosing his specialty.

Effective clinical placements are an essential component of nurse education. However, problems with them are often threefold. Firstly, students do not feel well-prepared, which limits engagement.^{11,19} Secondly, clinical placements

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'Student nurses' personal stigmas can lead to anxiety, preventing them from exploring career options in mental health.'

can have a negative affect on students' interest in MH nursing due to the workplace culture and patient acuity.^{1,7} Thirdly, an ongoing shortage of MH nurses can limit the availability and quality of clinical placements. This can become cyclical, affecting the development of MH nursing/generalist MH skills.

In light of the current and predicted MH nurse workforce shortages, and concerns about the quality and quantity of the MH component of the undergraduate programme, a review seems essential. Researchers have suggested there needs to be increased collaboration between academics and those leading MH services.¹ This is imperative, as education relies on theory and practice. Research and frameworks already exist which could be used to adapt the comprehensive programme, eg the Ministry of Health's (MoH) Let's Get Real framework²⁰ and recovery-focused education, which is more in line with what service users want.^{10,21}

United Kingdom model

A more radical option is to develop a specialist MH stream within undergraduate nurse education, which is the model used in the United Kingdom (UK).^{1,13} It has been said the UK system protects MH nurse numbers, as well as ensuring nurses have the right skills and atti-

tudes.⁶ In fact, the New Zealand system has been seen as a good reason *not* to adopt a comprehensive undergraduate system.⁶

I am also aware that some universities delivering nursing degrees in New Zealand are now increasing the MH component of their undergraduate programmes.

Protracted programme

The NESP programmes and the MoH's voluntary bonding scheme²² both report success at attracting more graduates into MH. However, these interventions come at the end of the undergraduate programme and could be considered too late. They miss the opportunity of prompting interest in MH when students are yet to decide on a career pathway. Also, the current system is a protracted and resource-intensive method of training MH nurses, taking at least four years.

As a clinical nurse leader who supports and supervises new graduates, I see high-calibre graduates who are recovery-orientated. However, they often lack core psychological skills to support service users with therapeutic interventions. They also describe a lack of identity in terms of what it means to be a MH nurse, with concerns of "skill loss" when working in the MH sector.

The mental health and addiction work-

force strategy⁴ offers some hope of a "top-to-bottom" approach to address the MH nurse workforce shortage. The key action points are collaboration between academic, MoH and the health sector to address education issues and workforce shortages. Marketing strategies to promote careers in MH (reducing stigma and discrimination) and schemes that promote MH nursing as a valuable career could make a real difference. Targeted interventions to attract more Māori and Pacific nurses are also needed, as Māori are over-represented in MH services.⁴

However, the strategy's overall aims appear to favour the comprehensive programme, the expectation being that all nurses should be able to provide appropriate MH assessment and

interventions in their practice area.⁴ The strategy hints at new ways of training, with an emphasis on meeting service users' needs – people-centred care and strengths-based practice – but these issues are already covered in existing documents.²⁰ This strategy is a missed opportunity to directly tackle the shortcomings of the current education system.

Disparities in the health and social outcomes for MH users originate from stigma. Stigma is about labelling, devaluing and discriminating. It exists in multiple layers, such as self-stigma (devaluing self), interpersonal stigma (devalued in relationships) and structural stigma (discriminatory policy, laws, institutions).²³ For service users, stigma means being reluctant to seek out physical and MH health care, due to experiences of being treated differently and not taken seriously when seeking health care.

Stigma isolates people from friends and families, and leads to a cycle of disempowerment due to barriers to education, employment and housing. This, in turn, leads to poorer life quality and health disparities.^{24,25} The impacts of stigma on an individual can be viewed through the Te Whare Tapa Whā model.²⁶ Stigma can undermine essential well-being (taha hinengaro), including family

and connections (taha whānau), physical and socio-economic well-being (taha tinana) and spiritual well-being (taha wairau). Stigma is one of the biggest barriers to recovery.²⁷

In 2004, 84 per cent of service users reported discrimination.²⁸ For our health strategy to be realised,²⁹ and to address the disparities in health and social well-being affecting service users,³⁰ stigma in our communities, the media and the health workforce must be tackled. Unaddressed, it will continue to negatively affect clients. By association, it will negatively influence MH nursing as a worthwhile career.^{25,31}

Student anxiety

Stigma is a contributing factor affecting MH nurse recruitment.^{1,11} Structural stigma in undergraduate programmes can discourage students from choosing MH as a career.⁷ They can also be discouraged by the minimal MH component of programmes. Correspondingly, personal and societal stigmas held by student nurses, often include ideas of dangerousness, blame, and fear.⁷ Student nurses' personal stigmas can lead to anxiety, preventing them from exploring career options in MH, and preventing full engagement with MH clinical placements.¹¹ This stigma restricts learning, affects care, and leads to ongoing cycles of stigmatising attitudes in nursing. Combatting stigma would not only boost numbers entering the workforce, but also improve care for service users in all health-care settings, wherever barriers exist.^{15,23}

Education institutes are ideal envi-

ronments to tackle nurses' stigmatising attitudes.

Addressing stigmatising attitudes demands more MH content in the classroom, as well as in clinical placements. Some researchers have noted the MH practicum had half the hours allotted to a critical care practicum.³¹ A central theme regarding stigma is the exposure students have to service users. Opportunities that support this, whether from personal experience (outside nurse education), service user involvement in education or effective clinical placements, can reduce stigmatising attitudes.³²

Time spent with service users tends to reduce stigmatising attitudes in terms of pity, danger and fear, but does not seem to lessen attitudes of blame, ie that the service user is responsible for their illness.¹¹ Other researchers found no significant change to prejudice post-placement, although students' perceptions of client dangerousness and the possibility of recovery decreased.¹⁸ However, a five-week practicum may not be long enough to address deep-rooted stigmas. Research is also unclear whether the acuity of service users increases or decreases stigma.^{11,25} Therefore, although clinical placements have a crucial role in reducing stigma, there are different types of stigmatising beliefs, which may be addressed, preserved or even increased during clinical placements.

Educational strategies that challenge stigma can be seen as an essential precursor to the clinical placement. Concepts of blame and stigmas in mental illness (or any illness) can be unpicked through supported group and self-reflec-

issues can also create barriers.

Nurses need to feel "skilled" – this is essential to reducing stigma, as anxiety is reduced.²³ Virtual reality, voice hearing stimulators, use of actors and role play enable realistic, safe learning experiences, which all help reduce stigma. Unfortunately, many of these innovative techniques are limited due to resource availability.¹⁷

More classroom education to learn skills, address stigma (reducing anxiety and building confidence), followed by supportive clinical placements, are key ingredients for reducing stigmatising attitudes.^{3,11,18} Broader educational approaches to address stigma would also be helpful, as student nurses' beliefs likely reflect deeper societal beliefs.

Conclusion

The undergraduate nursing programme is one of the factors negatively influencing the recruitment of nurses into the MH field. Stigmatising attitudes depreciate the value of MH nursing, negatively affect recruitment and the care, treatment and well-being of service users.

Reform of the MH component of the programme is needed, including allocating more time, resources and a revised curriculum to support and celebrate the MH nursing specialty. Such a curriculum should include targeted learning to address student nurses' fear and stigma.

The ability to establish meaningful relationships is the basis of nurse competency and is essential for the successful delivery of MH services, wherever care is provided. Student nurses should feel well prepared and confident to engage with MH consumers in all levels of care, through the acquisition of core skills, training, compassion and self-awareness. Specific MH educational standards, collaboration between MoH, academia and industry, and increased peer and service user involvement are all structural necessities to support this vision. •

* *References for this article are on p44.*

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For our health strategy to be realised,²⁹ and to address the disparities in health and social well-being affecting service users,³⁰ stigma in our communities, the media and the health workforce must be tackled.

ronment to tackle nurses' stigmatising attitudes. Researchers have noted that MH clinical placements in the first year of undergraduate study have led to changes in stigmatising attitudes.⁷ Undergraduate students should be educated about stigma, so they understand how it affects service users and their clinical

tive exercises.¹⁸ Consumer involvement in nurse education can help normalise mental illness, dispel myths and reduce fear.³³ There is significant research supporting the value of user-led education.⁷ However, stigmatising attitudes can prevent full integration of their involvement in academic programmes.³⁴ Resource

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