Feature article: Can mental health nursing survive the zombie apocalypse?

Talk at the (Covid-disrupted) 2021 MHNS Forum, by Teresa O'Connor

Tēnā koutou katoa. Thank you for inviting me to give a presentation at your forum on capacity and duty of care. I have to say I feel a little fraudulent as I am neither a specialist mental health nurse, or any kind of nurse for that matter who has practised recently.
I recently retired as a co-editor of *Kai Tiaki Nursing New Zealand* after 29 years. And I suppose if anything gives me a shred of credibility to be speaking at your forum, it is that. I have observed, reported on, commented on, ruminated about, marveled at, been astounded by, infuriated by, very frustrated at and profoundly grateful for nurses and the nursing profession over that time.

So . . . to introduce myself. Ko Teresa O'Connor ahau. I am a mother, daughter, sister, wife, friend, colleague. I was raised on a dairy farm – which was a far cry from the industrialised dairying of today – outside Nelson. I trained as a journalist on leaving school and after one and a half years at university, I realised lawyering was not for me. I then got a job as a psychiatric assistant at the sprawling Ngawhatu institution in Nelson and saved money to venture overseas in 1977. It was at Ngawhatu that the seed of pursuing nursing as a career was sown. I admired the chutzpa of many of my colleagues, I enjoyed their humour, their perspectives on life and, for the most part, how they cared for patients. But I was ignorant of the history of such institutions and of many of the practices that were

carried out within them.

After six years overseas, for the most part working as a journalist in Ireland, I returned to Aotearoa, broke and in need of work. So I returned to what I knew – newspaper journalism in Whangarei, Nelson and Wellington. But the idea of nursing had never left me so in 1986 I took the plunge and embarked on the three-year comprehensive nursing diploma at Nelson Polytechnic. I had wanted to do my psychiatric nursing training but the only training available then was at Seaview in Hokitika. All those I spoke to told me I would be foolish to do psychiatric training when comprehensive training was available and the way of the future. I made my decision based on that prevailing wisdom.

Once I completed the diploma, I returned to journalism to save money to travel overseas again. A year later I began looking for a nursing job in Auckland – none were available at Carrington and I didn't get one at Kingseat.

Disappointed, I took a job in a surgical ward at Middlemore Hospital. While I loved the privileged intimacy of nursing, I found the health system, structures and processes, particularly the hierarchies, quite crushing of my spirit. And I found the apathy and at times ignorance of nursing colleagues about wider societal issues, particularly given we were nursing in South Auckland, pretty depressing. I admire all of you who have stayed in the profession in the face of mounting and sometimes seemingly insurmountable, pressures. I really do.

I decided to leave and return to journalism, absolutely knowing that nursing was the nobler path. And I still believe that. On my last day on that surgical ward, the co-editor role was advertised. I applied and was appointed and so began my many years at *Kai Tiaki* and as an employee of NZNO.

Which brings me here today. My presentation is not an academic one, nor is it developed from direct practice experience. Rather, it is an entirely personal opinion, based on the plethora of factors that go into developing one's own opinions: observations, conversations, reading, class and gender, and how these shape your personal values and beliefs, yours and others' experiences, both personal and professional, the cultural/religious/familial mores you were brought up with, political beliefs. . . the list goes on. So, I make no claim that this presentation is anything more or less than my opinion, backed up by some reading I have done around the subject. But I hope that it may have resonance for some of you and may prompt some bigger picture thinking when it comes to considering the future of your chosen area of practice.

My basic premise is that mental health nursing has been colonised by general nursing and that unless practitioners reclaim/demand a separate registration and educational preparation, and develop nursing leaders courageous enough to challenge the current structures, processes and paradigms, then mental health nursing is destined to remain just another nursing speciality. When, patently, it is far more than that.

I can put it no better than Australian-based academics Richard Lakeman and Luke Molloy who, in their 2018 paper, 'Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category', published in the *International Journal of Mental Health Nursing* state: "Over the course of the 20th century, mental health nursing in Australia has endured changes to factors that were integral to its professional identity The wind down of the standalone psychiatric hospital system, adjustments to its educational preparation, and the loss of the nursing profession's recognition of its

difference through specialist registration have all contributed to an increasingly ambiguous role for mental health nursing in the changed world of 21st century mental health care."

While referring to the Australian situation, their contention, I believe holds true for New Zealand too.

The seeds for the colonisation of mental health nursing were, I believe, sown in 1972 when control of psychiatric hospitals moved from the Department of Health to hospital board control. That move set in motion a cascade of events which have over the succeeding decades gradually eroded the strength, vitality, standing, esteem, unity, voice – and humour – of the psychiatric/mental health nursing profession. It laid the groundwork for the for the loss of united union membership and it laid the groundwork for absorption of mental health nursing into general nursing.

A situation which occurred not too far from here in the early '80s is a microcosm of the impact of that change a decade earlier. Orokonui was a psycho-geriatric facility at Waitati and the Otago Hospital Board, in its infinite wisdom, decided to close Orokonui Hospital and replace it with a day-stay facility at Wakari Hospital, with those patients needing full-time residential care to be cared for at Cherry Farm or non-governmental organisations. Psychiatric nurses were then employed under DG3001 and general nurses were employed under DG21.

A month-long picket outside the hospital, supported by staff from Cherry Farm, did not stop the closure but did result in some "concessions". The PSA won a concession for the psychiatric nurses to work in the day-stay unit for a period of five years. They could also maintain PSA membership for that time. After that, they had to have bridged to comprehensive registration, and if working in the day stay unit, become NZNO members. The picket also resulted in funding for psychiatric registered nurses to "bridge" to comprehensive registration.

That event was succeeded by the establishment of acute mental health units within Dunedin Public Hospital – and other general hospitals around the country; and with that, the burgeoning of NZNA membership among psychiatric nurses. Changes to legislation governing union coverage also contributed.

The loss of psychiatric nurse training was not far behind and mental health nursing education was absorbed into comprehensive registration. How successful has that been in producing nurses grounded in mental health nursing theory, confident in the complex demands of mental health care, and empowered to advocate strongly and persistently for the resources needed for those in their care?

Certainly, the plague of chronic anxiety and depression and New Zealand's alarming suicide rates, would indicate that whatever has happened within the wider mental health care arena, it is not working. As one Australian commentator has stated, the vast investment in mental health drugs and the expanding mental health industry has not demonstrably improved the mental health of nations.

Current Professor of Sociology, at Cardiff University School of Social Sciences Joanna Latimer asks why nurses do not, as promised, seem to have been empowered, or had their status elevated, by the shift of nurse training into the academy. And I quote: "Moving nurse education into the academy was of course promoted and driven by the group whose interests it best served: nurse educators. But this move has not been entirely successful."

She says the reasons for this are complex but include the fact it divided education from clinical practice in ways that undermined practice.

Secondly, nurses' status and position is underpinned by “an archaeology of problematic relations, including the asymmetrical relation between medicine and nursing.” One of the results of this asymmetrical relationship is “the difficulties of making nursing visible as grounded in scientific evidence where notions of evidence are dominated by the medical model of a profession, including that knowledge needs to conform to the scientific method, with ever increasing pressure to get nursing research and practice to follow very narrow notions of what constitutes scientific research.

And thirdly, according to Latimer, nurse education has only partially shifted into the academy. They are not brought into the heart of universities/institutes of technology, nor integrated into the hospitals and clinical settings in which they undertake clinical placement: they find themselves betwixt and between, belonging to neither culture. Lakeman and Molloy state that: ”Nurses, including those who are identified as mental health nurses, are in a large part a product of their education. While some academics in Australia might claim the mantle of mental health nurse (or might even be credentialed), by and large full-time academics in Australia are conspicuous by their lack of recent, meaningful experience in the craft they are supposed to teach.

And don’t get me started on the utter absurdity of performance-based research funding and how that demeans, discourages and disillusions any nurse intent on research that nurtures, nourishes and expands the body of worthwhile knowledge.

Thus, I believe, the impact of the assimilation of mental health nursing education into comprehensive education has been profound and long lasting. No amount of education and support within a nurse entry to specialist practice programme, no amount of preceptorship and mentoring, can make up for the loss of a dedicated, stand-alone, robust education programme.

And I don’t think the fragmentation of union coverage can be underestimated as a contributing factor in the loss of mental health nurses’ voice, identity and influence. It’s worth remembering that when psychiatric hospitals were still under the control of the then Department of Health, the PSA and the department could not agree on rosters, so PSA members made a unilateral decision to begin working the four-on/two-off roster on a particular date. They did so and that is how the roster was won. It was subsequently “agreed” with the department. That’s power and influence. Now, the voice of mental health nurses is fragmented between NZNO, the PSA, the College, Te Pou and thus is diluted and much more easily ignored.

The lack of courageous nursing leadership has also contributed to the erosion of mental health nurses’ influence and voice. While many nursing leaders do their best in difficult circumstances, we must always remember whether they are working for district health boards, educational institutes or any other organisation, their primary loyalty lies with their employer. Continued employment status or tenure depend on adherence to the prevailing orthodoxies. And that is a pretty effective muzzle.

While operating in the very different US nursing landscape, nursing commentator Anita Nitzky, writes that gender norms have contributed to nurses’ weak leadership skills. “We shortchange ourselves by deference to authority, by not insisting on representation, and by self-deprecation, a strategy that devalues us, erodes our self-esteem and belief in

ourselves," she writes.

Lakeman and Molloy, when referring to the corporatisation of health and education state: "True to nursing's humble and servile beginnings and traditional deference to authority, nursing has been conspicuously quiet with respect to any of these changes. Arguably, it has demonstrated little resistance, and appears on the face of it to be mostly acquiescent, and conformist in satisfying the demands of the organization."

Joanna Latimer argues that there has been a switch in the alignment of nurses from patients to managers, and an annulment of any prospects of promotion as clinical nurses with a few specialist exceptions, such as nurse practitioners and consultants. "In respect of this last point we need to ask how can a profession prosper when advancement means a career change from nursing to management?", she asks.

And in discussing factors that have contributed to mental health nurses' loss of voice, influence and identity, one cannot underestimate the corroding influence of close to 40 years of neoliberalism on the health and education systems. The neoliberal consensus on taxation, economic growth and monetary policy – all of which have been an abject failure in delivering equity or social justice in any form – is so deeply embedded as to be taken for granted as the only way of viewing the world.

And that consensus has reduced the health and education systems to "markets" where productivity and efficiency – however they are achieved – are lauded as primary values; where managerialism reigns supreme, where the aridity of auditing and measuring is seen as some authentic gauge of success; and where genuine, conscientious critical thought is anathema. Joanna Latimer has suggested that, over the last three decades or so, nurses have been driven to prioritise efficiency as a moral demand. And that, my friends, is the path to professional bankruptcy.

Sadly, my observations, readings and reporting over the last three decades, has led me to agree with Lakeman's and Molloy's contention in the same paper, that, in recent decades, powerful forces "have contributed to the zombification of the mental health nursing workforce and the academy."

As an aside, I am proud to say *Kai Tiaki Nursing New Zealand* published some of Richard's early work – both when he was a student and a neophyte academic.
They argue that an increase in medical hegemony, the ascendancy of allied health in mental health service provision, the need for uncritical and servile workers, protocol-driven work practices, and a failure of leadership to mobilize any substantial resistance to these trends have enabled the infection (zombification) to spread. This is a harsh, uncompromising view of mental health nursing which I believe has relevance and resonance here as well as in Australia.

While it is easy, if not welcome, to point out how mental health nursing's voice, influence and identity has been eroded, it is a far more difficult to come up with ways of reversing that erosion and rebuilding a profession that can fulfill its essential remit as a transformative force for good. I can only offer a few suggestions.

If I could wave a magic wand to bring about a transformation in nursing, I would ask for nursing to be rid of its obsession with, its adoration of, its belief in and its respect for hierarchies, be they nursing, medical or bureaucratic. It is no surprise that a profession with its roots in the church and the military should worship hierarchies. But I firmly believe

that it is this obsession with hierarchies – HCA, EN, RN, CNS, NP, ACN, CN, ADON, DON, EDON – the list goes on and on – that bedevils nursing, sets nurse against nurse, embeds notions of superiority (and thus inferiority), nullifies the essence of feminism, encourages patch protection, undermines equity and mirrors the worst aspects of medicine. Enough said about that particular obsession of mine but I firmly believe if we could eliminate hierarchies, nursing would be a far stronger and more united profession.

And I know this will win me no friends, but I believe that nurses only fighting for across the board percentage pay increases, rather than more for those on the lower rungs of the nursing profession's sacred ladder, promotes the values of elitism rather than equity.

I believe political activism is essential to the restoration of the voice, influence and identity of mental health nursing. But, of course, it is over to mental health nurses to firstly agree their voice, influence and identity needs to be strengthened. You may strongly disagree with my contention that that is what is required and a distinct registration and a separate education system is the best way of restoring your voice, influence and identity. Whatever is agreed – and agreement is essential to unity and action – then the road to achieving that goal would be long and arduous.

And nurses generally have not been well versed in the ways of political activism. Psychiatric nursing traditionally was a far more political, working-class and male-driven profession than general nursing, with its more middle class, good girl values. But contemporary nursing undergraduate education pays scant attention to the value and the necessity of political action by nurses. The drive for health equity and the importance of public health values, particularly in a Covid-19 world, will hopefully play an important role in ensuring undergraduate education pays far more attention to the importance of political action and advocacy by nurses.

In a 2005 article in the *Journal of Professional Nursing*, 'Nurses' political involvement: responsibility versus privilege', three US nursing academics, Carol Boswell, Sharon Cannon, Joyce Miller, say nursing apathy toward participation in the political process is pandemic. They write that political involvement encompasses being knowledgeable about issues, laws, and health policy.

They state that the implementation of a political role for a nurse is based on three levels of commitment including survival, success, and significance. Survival includes individual involvement within communities. Success accepts challenges in addressing injustices especially within the health-care arena. Significant involvement uses visionary nurses toward the betterment of the nurse profession. And they say nurses can no longer be spectators in the political arena.

Ways of involving nurses include raising their political awareness, incorporating the importance and relevance of political action in undergraduate and graduate education, and teamwork.

Back to US nursing commentator Anita Nitzky, who says political activity takes the work of nurses from being a discreet event in one setting, and raises it to a societal level.
But that fear has traditionally held nurses back. And certainly my experience when wanting to speak with nurses about what short staffing means for patient care, about their working conditions, about what impact a particular policy might have on their work, or whatever, was that fear keeps far too many nurses quiet. She urges nurses to lose their fear, to band together, to find safety in numbers, to support those seeking change and those brave

enough to speak out, to speak out themselves. And she urges nurses not to downplay the achievement of their colleagues.

She, too, stresses the importance of nursing education preparing nurses with skills of political advocacy, negotiation, and articulating the value of our profession to the public – that health care is not all about medicine and physicians. And Nitzky says that the most important reason to be politically active is because politics is a means for nurses to advocate for their patients.

Another US nursing commentator, Karen Des Jardin, in an article in the *AORN* Journal 20 years ago, said the public would not recognize nurses as patient advocates until they begin to champion public health and social issues at the institutional, community, and national levels.

A group of nursing academics, writing in the journal of the New York State Nurses Association in 2009, stated that political activism was a crucial complement to clinical practice. Nurses were in a unique position to not only provide bedside care but also to advocate for change within the political arena and the community at large, they wrote. The concepts of service, community, collaboration, empowerment, and political activism were essential foundations in preparing nurses to meet the healthcare needs of individuals and communities.

Back to academics closer to home, Lakeman and Molloy say the challenge for mental health nursing in Australia, is where the collective voice of practitioners can be gathered. And, as mentioned earlier, having New Zealand's mental health nurses' voices dissipated through four different organisations, undermines any sense of unity or common purpose.

Lakeman and Molloy are harsh about the organisations that should be the advocates for mental health nurses. They write that both the Australian College of Mental Health Nursing and the Australian Nursing and Midwifery Federation seem natural vehicles for dissent, and both advocate for conditions that, if realized, could strengthen mental health nursing in its fight against zombification. "However, these organizations, being themselves conservative to the point of obsequiousness, have failed to stir significant action from those who might have power to effectively intervene."

It is worth pondering whether the organisations which represent mental health nurses in New Zealand could be described thus.

In a paper published last year, 'Positioning Psychiatric and Mental Health Nursing as a Transformative Force in Health Care', four Swedish nursing academics state that psychiatric and mental health nurses, whether clinicians, researchers, educators, or managers must contribute to achieving good health and well-being and reducing inequalities for all. They state that for this to happen, "psychiatric and mental health nurses need to overcome challenges posed by a dominant medical paradigm, the devaluation of caring, and the questioning of their professional expertise. This requires a renewed belief in the therapeutic potential of psychiatric and mental health nursing and the courage and perseverance of mental health nurses to shape their own future."

While Lakeman and Molloy seem pessimistic about the current state of mental health nursing in Australia, they believe that the recognition of zombification, active resistance against the forces that conspire to cause it, and the cultivation of genuine conscientious critical thought and debate offer the only hope of survival of mental health nursing as a

thriving specialty.

They conclude their paper by stating that “recognition and resistance might offer some hope, and the Australian experience might provide salutary lessons for the survival of mental health nursing in other parts of the world”.

And I can only hope that you, who work under such difficult conditions, caring for some of the most emotionally vulnerable of people, can see some way towards recognising and resisting what is going on within mental health care and shaping your own future in a way that is consistent with the values of your profession. And which ensures the unique voice, influence and identity of mental health nurses takes its rightful place at the centre of political activism, policy making and practice.