MAKING QUEENSLAND HISTORY

2010 NOTEWORTHY PEOPLE & ACHIEVEMENTS IN MENTAL HEALTH NURSING
ACKNOWLEDGEMENTS

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INTRODUCTION

Coleborne and Mackinnon’s (2003) collection of essays on the history of madness and asylums in Australia emphasises and analyses the important place that mental health services have in Australia’s historical landscape. Yet, the editors acknowledge the absence of the nurse from this collection and express the view that it is an important theme in Australian psychiatric history that needs to be pursued. Such work has potential to preserve the heritage and increase awareness of the social and intellectual origins of mental health nursing, its struggles and advances (Keeling & Ramos 1995). Perhaps by exploring and then disseminating the insights gained through examination of the past, students and practicing mental health nurses may have their professional connections and commitment to mental health nursing clarified and reconfirmed. With some notable exceptions (Happell 2007; Maude 2002; Bradshaw & Madsen 2007; Monk 2001; 2008), the history of mental health nursing within Australia is largely unchartered territory and particularly in Queensland, there is a dearth of literature.

Mental health nursing has a long history in Queensland. The Park, (Previously known as Woogaroo Lunatic Asylum, Goodna and Wolston Park Hospital), established in 1865, is the oldest mental asylum in Queensland. This organisation produced thousands of mental health nurses through its nursing training which commenced formally in 1910. Similarly Mosman Hall in Charters Towers, Baillie Henderson Hospital in Toowoomba, Lowson House in Bowen Hills and Winston Noble Unit in Chermside, provided training for thousands of mental health nurses. Moreover, these institutions along with mental health units in Townsville, Cairns, Rockhampton, Bundaberg and Brisbane each have their own nursing histories with unique stories of tragedy and transformation (Clifford & Kaspari 2003; Lawrence 2002; Patrick 1987; Swendson et al. 1991).

Other historical glimpses can be obtained from small museums and exhibits. Baillie Henderson, The Princess Alexandra Hospital and The Park have all created displays of interesting artefacts that illuminate past mental health and nursing practices. For those who take the time to visit these displays stimulate reflection about the aspects of mental health that have changed and those that have not (Davis 1995).

More recently the retrospective of Wolston Park, ‘Remembering Goodna’ (Museum of Brisbane 2007) moved beyond the traditional museum style of simply displaying objects and produced instead an interactive, emotional experience that included the voices of former nurses and patients of the hospital. Whilst evocative and moving, the exhibition provided a relatively macroscopic view on Queensland mental health nursing, and did not provide detail about particular nurses, nursing work and achievements (Finnane 2006).

Such detail would provide a much needed source of information to the public and health professionals, including nurses, because evidence suggests that the role of nurses in the history of mental health is not clearly visible and nurses themselves are often unaware of nursing’s contribution to mental health (Keeling & Ramos 1995). Nolan (1993) argued that mental health nursing history has not been given its rightful place and allowed to fully tell its story because it had either been an appendage to general nursing or medicine or not seen worthy of mention in the history of care. Another major reason for this ignorance rests in the fact that not many psychiatric/mental health nurses have a developed interest or expert knowledge in historical research methods. Indeed, as a profession nursing has tended to rely primarily on oral forms of communication (Heartfield 1996; Hardey et al. 2000; Martin & Street 2003). Consequently documental accounts of nursing knowledge and history are less common than for many other professions (Happell 2005; Mee 2003; Mulhall 1996; Stepnaski 2002) and nursing education continues to pay scant attention to historical studies (McAllister et al. in press).
A significant gap exists in appreciating the history of mental health nursing – that of understanding and preserving our heritage. Heritage provides us with aspects of the past that are valued and meaningful, which can be passed down from preceding generations to promote identity and belonging (National Trust 2009). Heritage is our stories about us. As critical and feminist theorists argue, when nurses find and use their own voices collectively or individually, they can achieve positive change and empowerment (Abma 1999; Belenky et al. 1997).

Inquiries into nursing’s past, using diverse methods are vital to the understanding and advancement of mental health nursing and for recording and preserving experiences of the past (D’Antonio 2006). One way to examine values worthy of conveying to future generations of mental health nurses is to survey current nurses about particular nurses they have valued over their nursing career. Once these nurses are identified, their attributes and achievements can be analysed and the resultant wisdom shared through the literature and in teaching and learning strategies. The results from this process of inquiry will make a worthy contribution to the mental health nursing profession. They will be of historical interest to Queensland and have practical significance for future generations of nurses. The aim of this study was to identify important or noteworthy Queensland nurses from the perspective of contemporary nurses and is an important beginning in understanding the heritage of Queensland mental health nursing.

THE STUDY

The study aims were to identify through opinion the mental health nurses who contributed to Queensland mental health nursing in recent history and then to explore the aspects of their contributions and their relevance to the broader profession. Thus the study was designed in two stages. The first stage involved the development and administration of a questionnaire to identify mental health nurses who were regarded by others as noteworthy. The second stage, which is still underway, will proceed to interview the identified persons and produce oral histories.

STAGE 1

Aims

The aims of the first stage were to:
1. Explore perceptions of Queensland members of the ACMHN about noteworthy mental health nurses
2. Examine the aspects of these nurses’ contributions and their relevance to the broader profession.

Design

An underpinning assumption was that knowledge of one’s heritage can engender a source of collective pride, and this process would be all the stronger if members of the broader professional community of mental health nurses in Queensland were able to influence the decision making regarding the nurses selected for oral history interview. Therefore a method was designed that would aim to achieve systematic identification of noteworthy mental health nurses. The design was deliberately inclusive, seeking advice from all mental health nurses listed on the Queensland Branch of the Australian College of Mental Health Nursing (ACMHN) email list, regarding their views about who they considered to be significant mental health nurses.
Sample

Queensland members of the ACMHN comprised the population to be sampled. Potential participants were accessed via the email based membership list of the Australian College of Mental Health Nurses living in Queensland. An email was sent to list members by an official of the Queensland list inviting members to complete an online questionnaire developed by the researchers. In order to increase the participation rate, a reminder email was sent three weeks following the initial contact. Thirty eight questionnaires were received. The researchers were not privy to information about the number of members, or how many received and/or opened the invitation email. Therefore it is not possible to provide a response rate. It is important to emphasise that it was not the intention of this study to suggest the sample is representative of mental health nurses in Queensland, but rather to provide an opportunity for interested members to identify people they believe have made a noteworthy contribution to this profession.

Instrument

A questionnaire was developed by the research team. It consisted of three primary questions:

1. Who do you believe is or has been a significant mental health nurse who you consider a leader or positive role model for nurses in Queensland mental health nursing? (you may include more than one name)
2. Please explain a little of the context around which you knew him or her? E.g. was it an education, management or practice area? The time? The place?
3. Please explain why you think this person is of historical interest. Did he or she make significant contributions, achievements, overcome barriers or stand out in other ways?

Ethical Issues

Ethical approval was obtained from the Human Research Ethics Committees at the relevant Universities. Participants were provided with a plain language information sheet, which explained the purpose of the research and what participation would involve. Information included the statement that participation was voluntary. Consent was implied by the submission of a completed form.
Data analysis

An independent data management company managed the online survey data by aggregating and transferring it into an excel spreadsheet ready for data analysis. The data collected from the questionnaires was analysed quantitatively and qualitatively. Quantitative analysis involved calculating frequencies for a) the number of nurses nominated; b) number of times each nurse was nominated; c) a brief descriptor of the background of the nurse's primary area of contribution, i.e. education, administration or practice and d) the nurse's current geographic location. While the number of common responses was considered by the researchers, the primary concern was with the rationales that underpinned the nurses who were nominated.

Qualitative data analysis involved the three researchers independently reading through each questionnaire and identifying the common themes underpinning the reasons for the participants’ nominations, (Creswell 1998). The researchers each generated a list of themes reflecting the information emerging from participant responses. The chief investigator then aggregated the lists and the team analysed the themes collectively looking for commonalities and differences.

FINDINGS

Twenty nurses (one deceased) were identified as significant key figures in Queensland Mental Health recent nursing history. Some of these nurses were identified by more than one participant. Qualitative analysis of why these nurses were suggested by the participants resulted in the data being distilled into two themes: achievements and qualities. The participants’ nominations and the reasons for their nominations provided an interesting insight into the meaning of ‘cultural heritage’ in mental health nursing. Three sub-themes related to what the participant perceived as achievements in mental health nursing: practice pioneer; career longevity; and far reach of influence (See Table 1). Related to qualities of the nurse were two further sub-themes: inspirational role model; and passion dedication and commitment.

Table 1: Themes

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Qualities</th>
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<tr>
<td>• Practice pioneer</td>
<td>• Inspirational role model</td>
</tr>
<tr>
<td>• Career longevity</td>
<td>• Passion, dedication, commitment</td>
</tr>
<tr>
<td>• Far reach of influence</td>
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Achievements

The theme identified as “Achievements” produced the greatest quantity of information from participants, and included the three themes of: practice pioneer; career longevity and far reach of influence.

Practice Pioneer

The theme of practice pioneer produced the most number of nominations and the most detailed commentaries. This theme was related to the contribution the person made to service development or to the mental health nursing clinical role. One nurse was noted for ‘leading the reform of Wolston Park
Hospital including the decentralisation of services’. Similarly, another was nominated because of ‘effective guidance during challenging times’ when a new mental service was established in 1999.

Three nurses, were nominated for ‘starting up new and innovative services’, for emphasising a ‘primary mental health focus’, and for being visionary about the mental health nursing services by ‘working closely with NGOs.’ Another nurse was seen as significant in the part that he played in ‘developing the specialty role of clinical liaison’. He was described as ‘an instigator’ who has fostered consultation liaison nurses, who work in specialised and isolated roles allowing them to ‘find support in each other and a united voice.’

One nurse was nominated for ‘her passion for the MHNIP [Mental Health Nurse Incentive Program] and for forging an alternative career pathway in mental health nursing.’ The nurse was noted for ‘breaking down barriers for those many nurses who have relatives with mental illness.’

Career Longevity

Career longevity in mental health nursing included the length of time working as a mental health nurse. For example, one nurse was noted as having ‘been a nurse more than 50 years’. The sense that the nurse had worked in mental health settings involved in now redundant treatments was seen as noteworthy by one participant because she ‘ worked in old institutions in the days of insulin shock and bromide’. Longevity was also acknowledged in relation to the capacity to still contribute as a professional even though they were aged. One participant thought to nominate a particular nurse because ‘at age 80 she has a full-time position in a community mental health service’.

Far reach of influence

Far reach of influence related to the nominated nurse’s impact on those he or she had taught. One nurse appears to have assisted learners to extend their potential as humans: ‘her articles and teaching style have inspired and challenged many mental health nurses to become better practitioners and human beings’. Another nurse was identified by several participants for his educational impact across many years. According to one participant he conveyed ‘insights into the human condition that have shaped my practice for the better.’

Another participant described three nurse educators as ‘highly educated people who passed knowledge on to the next generation’ and that ‘a huge number of mental health nurses have been trained by these three people.’

Two nurses were acknowledged as having made ‘a huge contribution by providing a pathway for nurses and mainly graduate nurses wanting a career in mental health nursing’.

Qualities

We have identified the second theme as “qualities” to identify the various positive professional or personal qualities valued by participants. This theme included the sub-themes: inspirational role model; and passion, dedication and commitment. An overview of these two themes will now be provided.

Inspirational role model

This theme related to the qualities in nominees that were reported to have inspired others. One nurse was nominated because the participant ‘saw the effects of her passionate and inspiring case management and
nursing first-hand'. As a result this participant described being ‘inspired to improve my own practice’. Another participant similarly nominated this nurse because ‘she has lead from within - showing by example how to work collaboratively with patients’.

Additionally, one nurse was nominated for being ‘a positive professional role model not only for nurses but for all mental health professionals’. Finally, another nurse was seen as a role model in another way: ‘he was a great leader – quite supportive, allowed us to practice to the limits of our knowledge and skills without interference’.

**Passion, dedication and commitment**

This sub-theme encapsulated many of the qualities admired by the participants in the nurses they nominated. Such qualities were evident in the following descriptions:

‘Instils passion and enthusiasm through his style and charisma’

‘Always held a positive belief striving for better outcomes for consumers with mental illness and their families/carers’

has ‘A passion for other nurses to learn and grow’

had ‘a passion for psychodynamic theories’

**DISCUSSION**

This study identified two major themes that recur in the literature about heritage and histories of professions: by identifying and sharing how significant people embodied positive values a group can build pride and identity; and by exploring what these people achieved over time a collective history is grown (Sandbrook 2009; Wineburg 2001). Some of the people identified by participants are contemporary practising nurses. Thus, heritage and history in nursing doesn’t necessarily just refer to the distant past, as they are constantly evolving (Davies 2007).

Long term commitment, to patients and to nursing, was valued. So too was being a leader, a pioneer, an instigator, a teacher, a mentor, and an inspiration. These contributions and values are based on what nurses have done, as well as how they have conducted themselves. They are important to acknowledge and to investigate further.

Iconic figures also make for interesting participants in historical research and this study appears to have identified one particular person who presents as a ‘larger than life’ figure (Chapman & Facey 2004). This nurse, now deceased, was nominated several times. He had a far reach of influence, an ability to convey knowledge and a passion for knowledge that he willingly shared with others. The significance of this person to the history of Queensland Mental Health Nursing would seem important to preserve and thus it is recommended that oral history and secondary source inquiry be undertaken to provide this knowledge. Another nurse with iconic qualities who at 80 is still practicing was also nominated a number of times. Her qualities as a mental health nurse generally inspired others but her tireless capacity to continue to nurse despite her age gave her an iconic status.

In contrast, Borsay (2009) has argued that overlooking ordinary lives can prevent a more comprehensive analysis. Thus, the other nurses identified, even though they may not have had such a far reach, their
influence has been noted as significant, perhaps because of both what they achieved, and how they practiced as a nurse, and importantly, the impact that they had on the careers and practice of other mental health nurses. These everyday practices will be important to explore and indeed may well be critical in detailing the nuanced, hidden, perhaps unnoticed attributes that more accurately define the art of mental health nursing.

The role that particular nurses played during times of significant change seemed important to participants because the pioneer theme was discussed most often. This finding could mean that little was known about mental health nursing history amongst those sampled. Perhaps some people were mentioned as important to Queensland history because of their close association with, and contribution to significant reforms and not because of what they themselves achieved, or who they were. Further inquiry into these people is needed in order to analyse their significance (Thompson 2000).

The study also revealed an insight about times of change. Participants valued the people involved in change not just because of their presence, but for providing safe stewardship during challenging times and for producing unity when a new role for mental health nurses developed. In subsequent oral history interviews, details about these change processes and the nurse’s perceptions about what they felt was needed will be interesting to explore.

The notion of change facilitation connects to the next important aspect to discuss – this study has provided interesting information about what is valued by mental health nurses in terms of effective leadership in their profession. Participants described the pioneers; and how some were able to achieve change despite resistance and in the face of unforeseen resource challenges. Others were able to remove stigma from a doubly marginalised sub-section of the profession. Still others were able to achieve unity and strong professional identity in an emerging sub-specialty.

These findings will be taken into consideration when planning the second stage of the study, which involves oral history. According to Sandelowski (2007) this is an appropriate sampling procedure that will provide a defensible rationale for the selection of cases for analysis in the second stage. Interviews with these nurses may reveal important knowledge for reclaiming and developing the know-how of mental health nursing leadership, an important aspect of the profession that has lamentably been eroded because of our preoccupation with technical aspects (Roy 2005).

In the second theme there was less about what was achieved and more about the attributes or qualities of the individual that had a positive impact on others and which also seem to inform effective leadership. Qualities such as passion, quiet support, ability to convey information and dedication were all noted. These insights are interesting because they highlight some of the fundamental practices that Kouzes and Posner (1995) have said characterise exemplary leaders; Inspiring a Shared Vision; Enabling Others to Act; Modelling the Way and Encouraging the Heart. The only characteristic missing from the data is the practice of challenging the process. When the oral histories are conducted it will be important to explore these qualities with the subjects in order that deeper investigation is achieved. Their histories can be analysed for whether in fact Kouzes and Posner’s (1995) elements about leadership are relevant or whether new aspects are revealed.

Nurses who had performed educational roles were also nominated by the participants. Inspirational teachers were mentioned as having an effect on others’ future practice. These effective teachers had a willingness and capacity to share and ignite in others a passion for mental health nursing, and for particular theories and aspects of study in mental health. Clearly teaching and learning, and by association excellent teachers, were seen as valuable in advancing the mental health nursing profession. Perhaps when reflecting on where resources need to be allocated to preserve or develop professions such as ours, we should consider strategies to build capacity and grow numbers in mental health
educators and academics. As Sally Thorne (2006) forecasted, the core business for nursing education is in producing a knowledgeable nursing workforce with a professional voice. Effectiveness in mental health nursing, according to this study, is noted by others for not just what you (can) do, but how you go about doing things.

STAGE 2

Aims
The aims of stage two were to
1. Articulate the contribution of mental health nurses to contemporary mental health services
2. Appreciate the importance of mental health nursing to the broader nursing profession.

Design

Oral history, the recording of memories of people’s unique life experiences, is a powerful research methodology (Robertson, 2006). Its resurgence after World War II demonstrated clearly that transmission of memories, such as from holocaust survivors, can ensure that injustices are not forgotten (Green & Troup, 1999). Further, its use by women’s history, black history and the working class shows that it is an effective means of struggling against the silencing of one group by another (Perks & Thomson, 2006). Like other methodologies oral history has undergone paradigm shifts. It has moved from a concern to establish empirical legitimacy through objectivity, and thus reveal detailed facts about events, towards a concern to achieve understanding about the meaning of events through an appreciation of the subjectivity of memory, shaped by things like culture, race, class and gender (Gluck & Patai, 1991; Grele, 1985).

In the seminal text on the subject, “The Voice of the Past”, Paul Thompson (1988) explains that oral history has a potential to be transformative in the way it can bring recognition to substantial groups of people who had been ignored. He argues that it can be used to change the focus of history itself, to open up new areas of inquiry. It can break down barriers between teachers and students, between generations, between educational institutions and the world outside, and in the writing of history. By introducing new evidence from ‘the underside’, by challenging some of the assumptions and accepted judgments about an event, Thomson argues that oral history is democratic and can “give back to the people who made and experienced history, through their own words, a central place” (Thompson, 1988, cited in Perks & Thomson, 2006, p. 26). Table 2 explains the assumptions that underpin this interpretive approach to oral history.
Table 2 Assumptions underpinning the Interpretive Oral History Method

- Source material is personal recollections and memories
- These memories are not just factual statements, but an expression and representation of culture – the things we think are important to our identity
- Events that we experience with intensity become memories and this ensures that we recall what is most important to us. What is important will vary from individual to individual
- Since memories have a cultural, psychological and subconscious dimension, they include the unsaid, the implicit and the imaginary (including traditions, myths, values and ideals)
- Transmission of these memories is facilitated not only through literal narrations, but also through interpretation
- The responsibility of the interpreter is not merely to give voice, but to provide a challenge, and understanding which helps towards change. That is, the task must be not simply to celebrate mental health nursing, but to raise its consciousness
- In this way there can be tension between the oral account and its interpretation. For example, a subject may recall their life by adjusting sequences of events to fit an overall narrative, or a ‘usable past’. The researcher, however, may analyse this recollection using a range of cultural theories or tropes. (Tropes are devices and conventions that a writer can reasonably rely on as being present in the audience members’ minds and expectations)
- It is also important to attend to issues of ethics and rigour, in order to protect the rights of the subject and to enhance the credibility of the interpretation. Guidelines from the Oral History Association of Australia recommend that the researcher should clarify meanings with the subject, provide an audit trail of how meaning is made, and be accountable for his/her own interpretations
- One approach to analyse oral histories is by searching for myths and metaphors, which are the relationship between the imaginary and the real (Samuel & Thompson, 1990).

Population and Sampling

The approach taken to selecting participants for interview conformed to the process of theoretical sampling, most commonly seen in grounded theory research (Glaser & Strauss, 1967). That is, the goal was not to seek the representative capture of all possible variations of leadership or achievement, but to gain a deeper understanding of each case and then to facilitate the development of analytic concepts for future research about professional success in mental health nursing.

Ethical considerations

The guidelines for ethical conduct provided by the Oral History Association of Australia were adhered to, and include: full explanation provided to participants about the interview’s purpose, process, storage and planned publications and future archiving of the material; signed release of copyright where the participants assigned copyright to the researchers, an option to remain anonymous, signed consent, interviews conducted with objectivity, honesty and integrity, awareness of defamation laws and implications of publishing defamatory material, participants given the opportunity to review, correct and/or withdraw material.
Data collection
Twenty nurses were interviewed from those identified as potential participants in Stage 1. Letters of invitation were sent to the nurses selected for interviews. In the letter participants were informed that a member of the research team would phone them on or after a specific date to discuss the project further. They were provided with a phone number and email address to contact the team if they do not want to be approached by telephone.

The one to two hour interviews were conducted by a member of the research team. Interviews were audio-taped with permission. It was explained that the aim of the research was to be thorough, impartial and will not cause harm – to either the participant, or individuals identified in the interview. It was appropriate in this study to use purposive sampling because we aimed to specifically select key informants for interview. We did not use an anonymous process. All those who participated in the study granted permission for us to use their real names. We did offer to protect identity, if requested. Participants were given the opportunity to read the transcript of their interview and discuss information they did not want included.

Data Analysis
In the data analysis, the researchers individually read each interview transcript and then analysed and interpreted the participants’ stories, looking for how they perceived mental health nursing. Individually, researchers compared the transcripts with each other to understand the commonalities and differences in the experiences and reflections of the nurses. Close attention was paid to how their stories of nursing reflect broader social, health and professional changes. That is, “how the narrator experienced, remembered and retold his/her life story and what light this may throw on the consciousness of the wider society” (Thompson, 2000, p.270).

Finally, the transcripts were subject to a process of critical interpretation, which refers to a concerted effort to examine the texts for issues of power and empowerment, silence and voice (Grundy, 1982; Kincheloe & McLaren, 2000). Critical interpretation may also uncover tensions and paradoxes and therefore may challenge conventional views and traditional boundaries and contribute to new knowledge (Cohen, Manion & Morrison, 2000). This dual analysis enabled the team to produce a defensible historical record that also has educative potential.

FINDINGS
There are many nurses who have worked in Queensland and through their efforts have contributed to a better quality of care for individuals experiencing mental health problems. Not all of them have been acknowledged in this research process because the aim was not to identify them all, but to come to understand why it was that others had singled out particular nurses as influential. This interpretive process is revealing, therefore, not just about the qualities each case embodied, but what peers valued in inspirational colleagues.

Table 3 provides a list and brief biography of the 20 people interviewed.

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<tr>
<th>Kathy Arandt</th>
<th>Barbara Hayes</th>
<th>Syd Roberts</th>
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<tr>
<td>Judy Boyd</td>
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<td>Chris Dawber</td>
<td>Christine Palmer</td>
<td>Roianne West</td>
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</tbody>
</table>

Table 3
Table 4 lists names that were mentioned by the participants during the interview of process of other influential nurses, not necessarily from Queensland, who should be interviewed in the future.

<table>
<thead>
<tr>
<th>Kerryn Fenton</th>
<th>Fran Gallagher</th>
<th>Deb Nizette</th>
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<tbody>
<tr>
<td>Kim Foster</td>
<td>Greg Holland</td>
<td>Jim ??? (Baillie He)</td>
</tr>
<tr>
<td>Andy Froggett</td>
<td>Richard Lakeman</td>
<td>Mick Blair</td>
</tr>
<tr>
<td>Claire Lees</td>
<td>Beth Matarasso</td>
<td></td>
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<tr>
<td></td>
<td>Tom Ryan</td>
<td></td>
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<td></td>
<td>Ken Walsh</td>
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The next section is lengthy. It was felt that the best way for these peoples’ stories and ways of being to be represented in this study was to provide the interview transcripts, in their entirety and un-analysed. The ‘voice’ of the interviewer is only included when it is considered meaningful to the flow of the person’s oral history. The histories are presented alphabetically.

Oral history is a method of gathering and preserving historical information through recorded interviews of people about past events and ways of life (Thompson, 2000). Queensland mental health nursing history is unresearched and oral histories will provide the basic information or narrative and the context of the nursing role. However, this method will also uncover the many meanings ascribed to ‘certain events, institutions and processes’ (Prebble 2007, p. 20). This is important in the area of psychiatry, where so often history is shrouded in silences and hidden meanings.

Seldon (1988) suggests that oral history can provide unique information that cannot be accessed elsewhere and Boschma et al. (2008) argue that this method provides opportunities to understand occurrences and perspectives from those who experienced them. It allows participants to express thoughts ideas and share experiences in a way that may not be preserved in written documents (Boschma et al. 2008).

Kathy Arandt
Current position: Retired

On being nominated: [Practice pioneer, Career longevity]

I suspect that it was because I’ve worked in mental health for a long time and maybe because I’ve been in the role of service manager for the past 10 years.
I started at Prince Charles after coming back from Victoria in 1979. I had two children to care for and felt I needed to get back to my family of origin so I returned to Brisbane. I secured a job at Prince Charles in the geriatric area. The Psychiatric Unit there, which was called the Winston Noble Unit advertised for Registered Nurses so I put my hand up and said I was interested. I was given a position, loved it and then went and did my Psychiatric training at Wolston Park as they called it then, and then came back to Prince Charles after I finished the eighteen month course. I returned there partly because it was comfortable there, it was near to where I lived, I had the children to consider and I was able to work in a position that didn’t have shift work for the first couple of years so that was attractive. So basically, I settled in there. It was through choice but I probably would have looked at other options had my circumstances been different. I liked working there, and there was flexibility with my working hours. I worked in a variety of roles during my time there so there was always something different and stimulating happening. This culminated in my being successful in being appointed as Service Manager in 1999.

On Wolston Park

Well it was the most fascinating experience I’ve had. I’d been a General Nurse and to go out there was a great eye opener. I thought General Nursing was rigid and strict [laugh] but it had nothing on Wolston Park. At the same time it was like a paradox at Wolston Park because there was a lot of tolerance demonstrated at the same time as the rigidity was practised. It’s a difficult thing to explain.

You could work a shift and work with someone who didn’t speak English particularly well, someone who was doing their Masters, a real mixture of cultures and skills thrown together. It was just the way they managed the roster, people appeared to be slotted in to fill gaps and it didn’t seem to take into consideration the continuity of care for patients, it just blew me away. Being a student on night duty I felt that I had too much responsibility given my level of experience as the rostered nurse in charge absented himself for long periods. But this was the type of attitude held by some of the staff. On the other hand, there were many fabulous people that worked there; really committed, devoted, talented people who did wonderful work. If you upset the party line you could be marginalised by the diehards and some staff had negative things happen if they rocked the boat. So it was a great educational experience for me really. Seeing those really disturbed people, and a group of people trying really hard to look after them well and another group of people who seemed to have a different agenda, I guess an agenda of self interest. But you always get a mixture in a work group, I appreciate that. The school was great out there, the teachers were fabulous. (Judy Boyd and Denny Cowell were outstanding teachers. I was so lucky to be able to work with Denny later on when he came to Prince Charles. He was wonderfully learned and wise and he generously shared his knowledge with everyone. He was a shining light for nurses in mental health and is much missed).

I did the 18 month course that followed for nurses who had completed their general training, which is no longer available. Things have changed dramatically since then. I saw there was so much work to be done for people with mental illness, and doing the course made me realise just how much there was to do and I wanted to be part of it. The course gave me enthusiasm to learn and do more. I learned that seniority does not mean professional behaviour and that was an important lesson. As a Psychiatric Nurse I wanted to be seen as a true professional and make a difference.

Characteristics of a good role model

Listening to the patient is the most important thing. I think a lot of people don’t listen to the patient enough. They have this view of what is wrong immediately. Nurses are very quick to jump in and come to a conclusion and have an action ready. But actually, if someone could sit down and listen to the person or observe or read the chart and see what’s been happening, knowing the history makes a huge difference. But we don’t always do enough of that. The experienced clinicians do and ask the question...
why is this person behaving like this, what’s happened in the last few days, what do they know about them, look at the history, and try to work it out if some time is given to it. Another issue of importance is listening to the family and that does not always happen as much as it could. There can be a very different perspective to be gained from the family.

One of our great teachers, Denny Cowell, was a great one to espouse the “rule out organicity first” mantra and sometimes that can be forgotten in the heat of the moment. Maybe there’s something wrong with them medically, we need to look at them, do the observations if possible. Listening to the patient, observing the patient and taking cautious action with safety as a priority consistent with the information that is available. It can be tempting to jump in, particularly with people who have a history and jump on the band wagon of previous presentations. The previous history is important and part of the picture but not all. I guess it’s putting it into the current context that has to happen.

Wolston Park had extremely difficult people to care for. Some staff worked there for years in the long term wards for years and still managed to care for the long term chronic patients people with great respect. I really admire this because the work was hard and grinding and rewards in terms of improvement for the patients were rare. Maintaining them and making them as comfortable as possible had to be fulfilling enough for them and I really admire that characteristic in a nurse. I believe that we need our most skilled and professional nursing staff in some of the more chronic and less visible environments and not necessarily the highly visible pointy end treatment areas.

One of the important aspects of role modelling seems simple but it’s not always achieved. How individual staff members speak to each other in work related conversations. If a staff member speaks about a patient in a professional and articulate matter, it has a lot more impact than someone who’s not clear or precise about what is said. Nurses have not done this so well in the past but it’s getting better.

Training and preparation for your role as a nurse

I think the 18 months course was good, because I think I learned from a whole lot of people and learned what not to do, and I also learned what to do. And learning the basic grounding in treatment approaches was excellent. I don’t think you can ever have enough learning, really. We have to just keep on learning forever.

Probably if the course had been a bit longer it would have been good [laugh] but you’re sort of ready to finish after 18 months I guess. I think just being with disturbed people every day was good. I think that taught me more than anything, and listening to what they said, listening to what their families said; that probably is the best learning experience. I mean, you can read all the textbooks in the world and you need to do that, I’m not saying you don’t, but it doesn’t prepare you for some of the behaviours you have to manage; the aggression which can be very upsetting. One thing that bothered me was the behaviour spiral or cycle that seemed to happen repeatedly when a patient’s behaviour was escalating and you just knew what the end result would be and that would be seclusion. How to break that inevitable cycle was important in order to avoid seclusion. There is another way for some of these patients to be managed, it doesn’t have to always mean seclusion. (We are still working on that and making a little progress at last.)

The significance and importance of the cohesive team was an important part of my training as I could see when the team was not united and the outcomes for the patient were not as good.

Giving a person some space and room to move was an important learning, as frequently they feel crowded out crowd and lack personal space. The physical environments that we work in don’t help our patients, particularly when someone is highly disturbed and forced to be in a restricted environment. This
can trigger a primitive response. The way that physical environments have been constructed severely limit our options in treatment in particular situations. It's as if our practice is dictated by our physical environments.

First impressions

There was a completely different atmosphere in psychiatry from what I had experienced in the general area. There was more discussion about the care of an individual and what was being done with regard to treatment, and this discussion didn’t make a lot of sense to me at first, but that was my naiveté at the time. That's how I saw it then because I'd come from a General area and it was very medical, write out the script, do the dressing or whatever it was, but you never sat around and talked about how we’re going to look after this person. Whereas when I went to the Psych Unit at Prince Charles as a General Nurse, all these were people sitting around talking and I'm thinking, “What are they talking about?” It seemed like there wasn't anything to talk about, it seemed like on the face of it the patients were okay, they seemed okay. [laughter] . I was green. At this early stage I didn’t actually have the subtlety of working out what the symptoms were. I knew there was more to it but I didn’t understand what it was. Then I realised, when I saw a few people who more unwell and I thought, “Yeah now that makes sense.” This was a time when there were no acute patients in the open wards at Winston Noble Unit and patients would stay in hospital for sometimes months at a time. I didn’t think that was necessarily a good thing because a lot of them didn’t need to be in hospital in my view. We seemed to be making them more ailing or unwell. That changed with more acute patients being brought into the system.

I knew I needed to learn more about this Psychiatry stuff if I was going to function effectively. So I read more and then I did my training.

I did question for a time whether I’d made the right decision to work in Psychiatry but going to Wolston Park confirmed that I certainly had made the right decision.

I gradually had more understanding when I was exposed to a group of patients who were much more disturbed with more complex disorders than I had previously experienced. This was when I became hooked and developed a passion for Mental Health. There was nothing quite like it, when it was working well I think the camaraderie in a team looking after someone and seeing them improve, I just thought that was the best buzz, and particularly when everyone was on board, there was nothing more satisfying.

The vital role of the nurse in the team was highlighted when I first became involved in Psychiatry. In the general area it was very much that the Doctor was the boss at that time. The strength that a competent nurse adds to the team is just so significant and this was so encouraging to me and enhanced the appeal of working in a mental health team

Highlights

When I returned from Wolston Park I worked in the ECT Suite. I negotiated this so I could have more time with my children rather than any special desire to do the job. I threw myself into it as I always wanted to improve the existing situation and to do better, I guess. In retrospect this seems like a small thing but having just graduated as a psychiatric nurse I was keen to make a difference. The patients used to come for ECT and then they’d go back to the ward and it was like they were disconnected from the suite. I thought it would be better to follow them up after each treatment. This would involve visiting each ward and checking that their recovery was satisfactory. You sometimes see the family that way and they know you’re looking after their loved one when they’re in the ECT room and that was obviously better for them.
It was a little thing but it was a more personal, better service for people and I could write a little note in the chart to say that I’d followed them up and if there were any complications post ECT. So I liked that, but again it was connection with the patient.

Then in 1984, I’m not sure if I was ready for this, I was appointed to the position of Charge Nurse in the Intensive Care, 22 bed locked ward. That was a real challenge. The person who had been in the role previously had struggled, and I guess I was a bit naive, I just thought, “Oh yes it’s a challenge,” it’s regular hours Monday to Friday; it was a promotion. I found it very difficult but I learned so much. I learned heaps about managing people in an Acute Psychotic State. I don’t know that I can think of a specific highlight, but I think the learning that I went through during that time was indeed the highlight. Just the everyday management which was a nightmare initially, as I hadn’t done that before. The staff, [laughs] were well and truly trying me out because I was new. We ended up making a few changes there and things got better and that was a good experience in the end, but it was tough. It was really tough. When I went home in the afternoon I would say to my kids “Please don’t talk to me for half an hour or ask me for anything” and I’d make a cup of tea and recover from the day. The constant psychosis and all that raw emotion all around you all day, and that feeling of responsibility for all those people just used to drain me. But it was great, I learned heaps and saw some people get well, and some people didn’t get so well, but that’s what severe mental illness can be about. It opened my eyes to the tragedy for families when their family member becomes acutely ill just when their life is opening up before them. This highlighted how hard it was to treat someone successfully when assessment doesn’t happen until the illness is well and truly developed.

The acute environment I got to really like it even though it’s taxing on you all the time, you know that potential for aggression is ever present and the struggle to ensure that everyone is safe and being managed well. This is where I learned that while the majority of staff members are great there are always a few that required a lot more time and energy.

[Then I became a Nursing supervisor] and I really liked that. The kids were older by then and I could work evening shifts. I would be the phone contact if any patients at home were having difficulties, this is before we had the Acute Care Teams and all that sort of thing. I would also manage any presentations via Police, and Ambulance etc. So managing all that was great. The job also involved the management of staff.

Having an overall view of the unit was good, knowing who were the sickest patients and negotiating space if we needed to admit was challenging and interesting.

I was encouraged to do the supervisory role, it was a promotion. A lot of these things happen because they haven’t got anyone else [laugh] or you are silly enough to do it, to be quite frank, I think I probably had had enough of ward seven by then. It was getting to the point where I was acknowledging that. A lot of it again was managing rosters and covering shifts which is less interesting but it’s all part of the overall management role. I liked it because families would come in with someone, you could sit down and talk to them and listen to what had happened and try and help them as well. That contact, and contact with the Police was an important part of the role. One of my colleagues used to say of the role, ‘it’s a little bit like flying a plane [laughs] you take off and you hope you’ll be able to land safely’; I liked that analogy. Every shift was different and patients would go AWOL and occasionally there would be a suicide or a serious incident, and these situations are always traumatic and dramatic for everyone involved. Then there were medical emergencies, and all the issues that can crop up in an acute unit. But I liked it because it was always changing and you never know what’s around the corner. So that was fun.

Then you moved on to Assistant Director of Nursing?
That was managing the nursing for the service, and that was great. I quite liked that period though it was challenging. We had a system of administration that meant a lot of tasks landed on my desk, so I learned how to run the show [laugh] by default. But it was really invigorating pulling the nurses together because we had a great nursing team with a number of bright enthusiastic people and I think we did some really good stuff. We worked on improving the quality of assessments and there were a number of projects in which a number of staff participated. We talk about a team, frequently though there’s a different hierarchy in a team, and encouraging the nurses to be vocal about things when they really felt that they needed to be was important. The situation was rather mixed at the time, some staff members were quite visible in their participation and assertive, others were less so. One of the key areas was the ward round, as it was called then and trying to make sure that nurses had input when all the team members were present.

We had no trouble recruiting at this time as good staff seemed to be plentiful and we would be turning people away as we didn’t have positions for them. We had good numbers applying to us, so we were able to be more selective. We had a bit of an influx from the U.K. of really good people. A number of Scots, they’re still there, 20 years later, but they came and they were a good bunch. There were about half a dozen and they were good clinicians, and they came with us and grew with us and have been great models for others. It was a rich creative time for us and I encouraged the role of the Artist in Residence as we had a talented artistic nurse who managed to do wonderful projects with patients and this included staff members. During this time I could see more clearly how nurses were the ‘doers’ and had a lot of good ideas that they were prepared to run with. This was more noticeable in the nursing group than in the other disciplines.

The service was very much focused on inpatient care (with something like 150 beds) and during this time there was a lot of talk about an ‘integrated service’. There was a community clinic at Aspley and the communication between inpatient and community was not efficient and effective.

We had some meetings to try to plan how an integrated service might look for us. It was painstaking and with all of us having our other responsibilities there was little progress made. The whole idea seemed daunting. Anyway the Director came to me one day and said, “How would I like to draw up a plan for our service to have an integrated model of care?” God where would you start?

But I thought, “Well I’ll have a go at that” so I was seconded to do that for 12 months. This was in 1996 and at that time we had a District Manager who was keen to change things in mental health so that support was helpful.

There was a new inpatient unit planned for 1998 with 60 beds. We had at that time 150 beds and no community teams. The idea of managing with the reduced beds was daunting. I visited some services in the south and tried to get my head around how an integrated service would best work for our particular service. We had to set this up and of course make it a cost neutral exercise.

I did a lot of consultation with all staff groups and we talked about how it would happen, carving out teams with the existing staff and establishing community clinics. We knew that we were getting the new unit in 1998, this was 1996 and we had to cut the beds to 120 and then we had to cut them by half. There was considerable pressure from other services not to reduce our beds at that time which was another complicating factor. So how were we going to do reduce those beds? We obviously had to reduce the demand on beds so first up we looked at the group of patients that had been admitted twice in the last 12 month period. There were some other criteria developed along with the admission rate and we targeted that group specifically. We established a Mobile Intensive Support Team in 1997 to care for these patients so that they would not need admission to hospital. It was a great success, it’s been fabulous. It is still a great team that does fantastic work. So we were off the mark! We had a great
Making Queensland history

team leader at the time, we had a great group of people that were skilled and committed and they set a high standard. There was a lot of unrest during this period as change is never comfortable for most people and this was a significant change to how we were doing business so quite threatening. There were industrial issues also that accompanied the change in practice. The Older Persons Team and then the Acute Care team were established and the other teams followed in time. So we were able to cut the beds down sufficiently and then we moved into the new acute unit. This integration project was probably the hardest thing that I had confronted when I first tackled it.

We planned a service so that there was as much continuity as possible for patients so that if they were admitted to hospital they were cared for by the same team as when they were in the community. We divided the catchment area up geographically paying attention to numbers of active patients in certain suburbs and the population projections for the area. Accommodation had to be found for the teams and the clinics had to be fitted out. This process highlighted what “can do” people many nurses were. Nurses pick up the ball and run with it sometimes [laughs], it’s good as long as they run in the right direction. [laughs] You give them something, they’re, “How can we do this” and they’ll do it, and there is an enormous amount of creativity and a lot of great work done by nurses. There were some Allied Health people that were really good, but fewer, as their numbers were fewer. I wanted to lift the Allied Health component to make a more balanced multidisciplinary team across the service. As we received funding over time we built on the allied health numbers. Some of the nurses didn’t like that so much as they would have preferred to have more nurses.

Establishing the integrated service model in the time frame was very gratifying to me and a tribute to a great team.

The next year, 1999 was when the position for the Service Director was advertised, and I was encouraged to apply. I was ambivalent about it and then I thought, “Oh no” anyway, I did apply. There were a number of applicants, I was interviewed and I was successful. The College of Psychiatrists was not happy about the fact that the position was not given to a medico. They recorded their disapproval in writing to the District Manager and I believe the Chief Health Officer. Then that following year we had a number of visits from the College of Psychiatrists to check our Registrar Training Program. As if appointing me was going to change the Registrar training program. Nothing happened as a result of the inspection visits but it was very uncomfortable for me and I felt quite vulnerable at times. One of the Psychiatrists resigned on the basis of my appointment and he made the reason for his resignation well known.

The thing that bothered me most was the de-valuing of my nursing background and the fact that I’d worked in Mental Health for 20 years, and was passionate about it. I’d done lots of the hard yards in the service and it was as if that didn’t count for anything. I just found that astounding. I had the experience of driving the service change with much of the work being done very effectively by non medical staff and this did not seem to have any value in some medical quarters. That was a very difficult time for me so I decided to give it a year and see how things were. It’s important to say that I did have support from a number of people and in particular a senior medical person who was a great ally. He helped me keep my feet on the ground and encouraged me to keep going.

Then we had the Building Program that included the Community Care Unit at Pine Rivers and then the Medium Secure Unit both completed in 2000. These were 2 big projects for the service at a time when we were just trying to consolidate the new integrated service. Those units were badly needed to serve the demand in the patient population. I did a lot of that work, we didn't have a special commissioning person [laughs] we missed out on that somehow.
Then we had the new Mental Health Act in 2002, and that was an educational program for everybody; which was significant but was an important progressive step for consumers’ rights. Setting up a consumer liaison role was a small but important step as there is much more to tackle in working with Consumers and Carers. The review of the Model of Care in the Intensive Care Unit was an important project as needed to improve the throughput. This was driven by nurses and led ultimately to our having a designated Psychiatrist and Registrar for the unit. This has meant that our sickest people ‘in fact’ have intensive care and stay in that environment for the least time possible. This had not always happened unfortunately.

Building liaisons with other agencies like Drug and Alcohol, Housing, Police, Community Corrections, DSQ and Child Safety to assist patients with complex needs. These people now are living in the community and are no longer in hospital so case managers need to have support in order to manage them with more understanding. Building relationships with the people in other agencies improves the chances that the services for the patient will be better. There are great areas of need in the areas of Indigenous Mental Health and Forensic Mental Health and the area of Intellectual Disability when the patients become involved in the Mental Health Service. We have done some work in an attempt to address these deficits but there is a lot more to do.

Quality and Safety is an area that I have been keen to improve on in the service and an area where nurses are pivotal in maintaining quality care. In 1998 we had an incident in the old Winston Noble Unit, and I was keen to have a close look at all the facts so we decided we’d have a Critical Incident Review. We did this and found there was a lot to be learned and it was a valuable experience. This practice has become mandatory state wide more recently over the last few years. We’ve been having these critical incident reviews ever since 1998 and this has helped people to see that this practice is a non blaming learning exercise. This led to the “lessons learned” which is a very simply written one pager with some relevant points to think about if the particular situation arises again to assist in every day practice. The “lessons learned” is to ensure that the learning is shared and not lost.

We grew to include others if appropriate, in the incident review we’d include Police, Security Officers, GPs if possible, and get everybody’s perspective because frequently we found we were doing our own little thing but you have to take a broader view. We found that was really useful.

Another thing that we introduced out of the incident review process was the suicide follow up letter. The letter to the family, it’s a hard one isn’t it, the family has lost someone they love and they probably blame the service for it. We found that if we phoned them about 6 weeks later and said, “Did you want to have any contact or do you need support or help with anything?”. That wasn’t the best way to communicate with the families. So we got the idea of writing a letter to them, an open letter just saying, “That you don’t have to answer this letter, a very carefully worded letter to suggest that if anyone close to the person who had died felt the need for support or assistance or information they could just ring the number provided and also to send them the ‘bereavement by suicide’ group information. Interestingly enough, people would ring up and thank us for the letter, hardly anyone ought assistance but that’s okay as the offer was made. There may be a feeling of discomfort between the service and the family and sometimes we don’t know how to break that. But if we invite them to contact us, then it’s easier for them rather than them having to do it without the prompt. That as a small but important sensitive communication we introduced.

The incident reviews bring up the issue of clinical supervision for nurses as they are both about safe practice.

It was glaringly obvious that clinical supervision was not happening and it needed to. We struggled with this because we had to get someone in the role to drive it or we couldn’t make much progress. We didn’t have any money but with some financial creativity we bit the bullet and started with a fantastic person in a part time position and then built it up to full time, and it was only long after this that the work was
acknowledged and we secured specific funding for the role. This program has now been adopted across many services in Queensland. This issue is so important for practising nurses.

The information systems, would have been introduced to have an honourable goal but eat up staff time and have changed the practice. I think you see this in a lot of areas not just health. I think we run the risk of losing focus on the patient. The information system holds too much kudos, rather than the tool that it’s designed to be. Staff run the risk of worshipping [the system] as they feel the pressure to put the data down and that’s great, but it becomes the goal and not the tool. While they’re doing that they’re not talking to people, and this is what the patients are saying that the staff are not actually talking to them they’re looking at the computer and they can’t understand that. This is a resource issue obviously. We need to find a better way. I think the patients just feel they are being neglected while the staff are pressured enormously from all sides.

**Do you consider yourself as a pioneer?**

In a way I suppose I do. In other States non medicos were in those service manager roles about that time, for Queensland probably yes. When I got the Service Director job some nurses said to me, “It’s changed my view of my career path, that I could now think of doing that, I never thought that would happen” kind of thing. So I suppose in that sense yes. I was glad that my getting that role it gave some nurses the thought that there was another option.

I’m more of a quiet achiever; I’m not a showcase person. I have been criticised for this. I’m interested in getting the job done on the ground with a strong team, that’s my focus. I like to get the job done and make progress. I guess one of the other things I’ve always been keen to do is to be available to staff. I’ve always wanted to keep in touch with what’s going on the ground to hear it straight from the horse’s mouth so to speak. I dealt with the complaints as this kept me in touch with what the patient’s and families’ perceptions were. This can be useful. Obviously other staff managed complaints as well but sometimes themes come through that are useful in monitoring the practice in the service. The contact with the patients and families was probably a bit vicarious but that part of it gave me some satisfaction.

**On Humour**

There are so many funny incidents that happened over the years. Mental health is ironically full of humour if you care to look for it. We used to have an annual dinner dance and awards were given for certain achievements, they were always funny. I was reminded recently that I was awarded the “head bangers award” one year. That was a very appropriate award as I often felt as though I was banging my head against the wall. I probably could have received it for a number of consecutive years.

It’s absolutely crucial in my mind to maintain a sense of humour whatever you do, it’s been a life saver for me. The thing about working in a team is that frequently humour is part of the glue that holds the members together. I don’t think you could go on without a sense of humour. Funnily enough our patients seem to have well developed senses of humour, sometimes better developed than some of the staff members.

**Worst times?**

- Frustration when trying to make progress and feeling as though your hands are tied behind your back being confounded by bureaucracy at every turn. There seemed always a reason not to progress good ideas that have been submitted. We risk losing creativity with the risk-averse approach taken by current governments.
• When despite the best efforts of the service an adverse incident occurs.
• Frequent confrontation with a system that invariably endorses medical power over all other disciplines
• Struggling initially in the role as Service Manager, I felt as though the pressure on me was significant and that the support of a group of staff was not behind me.

There were many more good times than bad overall.

**Judy Boyd**

![Judy Boyd](image)

**Current role:** Community mental health nurse

**On being nominated:** [Career longevity]

Well because I’ve lived longer than others obviously [laughter].

And because I’m known even today as a rogue nurse so I’ve always been known as a rebel nurse right from word go. So I was prepared to buck the system all the way along the line and the people who do that stand out. They don’t have a very comfortable life but they stand out and they’re the ones that people remember. Simple as that.

And... I’m a nice person I think that’s another reason [laughter].

**On your nursing career**

I went into nursing to escape, to have somewhere to live away from home (in South Australia).

So I could leave home decently by becoming a nurse. I lived in the Nurses Quarters in 1949 when I was 16 and I decided I wanted to do psychiatric nursing and because everybody said, “You’ll never do it, you know you can’t do it” because I was a spoilt young thing, I was very bright so they didn’t think that was a place for bright people and so of course the more opposition I got the more I dug my toes in. So that’s how it all, that’s how it all started. And I went to what was Parkside Mental Hospital in those days there to do my training. It was an interesting time because it was the end of the war and the servicemen, males particularly, were drifting in to psychiatric nursing and there was a large contingent of central Europeans I suppose, Balks we used to call them who also came as part of their entry to Australia to work in the less appealing jobs around the place and the madhouses were seen to be you know such a job. So it was that kind of scenario that I walked into. I’d come from University where I’d failed dismally in my first year, because I thought it was like school, you didn’t have to do any work. Failed all my subjects, had a fear of failure all my life [laughter], so that was a propellant in itself. Because I was bright, I was the Matron’s favourite for a while until I kicked over the traces and offended all the norms of the day by selecting to take up with the wrong kind of men and so on. So that all proceeded. And they were indeed interesting times. They were the traditional asylums of yesteryear and I spent a deal of time...
supporting those concepts, the concepts there and later on when I came to Queensland which was about where South Australia was when I left 20 years before, there was a spirit it was before the antipsychotic drugs came on the scene so people were very, very mad but they were very happy and they tended the vegetable gardens and they polished the knobs on the doors and all this and they went to woodwork they did all of these things. And there were some very, very sensitive attendants you know as they were known at that time, nurses whose first language was not English but who intuitively knew and treated the patients as people indeed. Mind you, we had to because in reality it was the patients who ran the show. Very short of staff of course.

It wasn't so very different when I came to Queensland. But anyhow, I did my 3 years training there. The first year was anatomy and physiology, second year was medical nursing and only in the third year did we get introduced to psychiatric nursing. It was doctor dominated and doctor driven and then matrons of yesteryear made sure the nurses were obeying all the conventional rules, etcetera, etcetera. So it was that kind of time I suppose. At the end of my training there because I wasn't interested in bodies, I thought, “I'm only interested in people's mind” etcetera, I didn't go and do my general training after that. I left nursing for oh half a dozen years I suppose. Worked in long range weapons and associated at Woomera [laughs]. Married had children so I was away from it for a few years and then when the last of the children were at school I went back to nursing and nothing much had changed in this 15 years and so I decided then, “Well I must go and do my general training.” So then I was a marginal man and seen as being a bit odd because those were the days when married women didn't work and mothers didn't work and then I went to the Royal Adelaide and the first day said to me, “The Florence Nightingale Service will be held at such and such a time and you will be there.” I said, “I haven't been to Church for 25 years, I'm not going to start now.” But I enjoyed my general nurse training because I went into it and I was keen to learn. I wasn't a threat to the sisters who were waiting to race off one of the doctors, etcetera, etcetera and if you are you know show that you're keen and you're interested people respond accordingly. So I had a good time doing the general nurse training. But then came crunch time. What was I going to do then? So they offered me a job setting up a unit at the Royal Adelaide Hospital and I didn't, I wanted to get out of hospitals. I had drug and alcohol was another service that was being set up so I went into that for a short time and but that wasn't very, for about a year, I suppose, setting up a service there, but then we decided to come to Queensland. It had been the weather attracted us here. We didn't know anyone in Queensland, I had four children, they were at a stage where they could change schools and we landed in Queensland in 1970 and that was interesting itself. I hung around for the school holidays and then thought, “What am I going to do? I know I hate night duty; I'll teach. Where will I start? Well I'll start with the Psych Hospitals.” So I look up the phone book etcetera and I get onto Gordon Erckhart who was the Director at that time and said, “I'm here this is what I've done, I'd like to teach. If you have any openings I'm happy if not I'll go to the PA.” They were very short of Tutor Sisters as they were called then.

I had no teaching experience but because I was good at learning, I figured I'd be able to teach alright. Anyhow, he sent me out to Wolston Park. What he didn't tell me and what I didn't think to ask of course, he didn't tell me that the woman who had pre, who had been there before me had gone crazy or something so she'd just left, but there were staff there that were sitting their finals for the tenth and eleventh time, they had no English see (Polish nurses). They couldn't pass the exams. They were lovely people, good people.

“Go out and try it,” said he. So I did and even then, I didn't because I'd come from Adelaide and I thought, “Now there'll be other educators…”

It was only when I went out to Wolston Park that I realised there were 2000 patients at that time. There were no other staff. I was it, that I was given a little old Queenslander and that was the school of nursing. That's where I had to teach. I had to teach anatomy and physiology which I hadn't done for 25
year etcetera and the curriculum in fact was established in 1928 and I was given care of lanterns, candles and matches to teach [laughs] insanities. Which always attracted me the insanias and melancholias was another favourite one.

So anyhow I then realised if you wanted to influence, I saw this as being 50 years behind you know South Australia etcetera, such wasn't the case but that's as I saw it then. So I said, “I've got to be in a position of power to be able to influence” so that’s when I started. So the first thing I had to do was learn to be a teacher. So I applied to go to the College of Nursing. There I made my first series of blunders because I got all the power people offside because I used Joan Godfrey’s toilet and that was bad, it was very structured, very hierarchical, wearing hat and gloves when you went out to practice-teach and this kind of stuff. And so they didn’t care for me at all and I took a delight in antagonising and challenging and all that kind of stuff. But I did at the end of the day become a Nurse Educator, a teacher.

Then when I had gone to, so I had some kind of qualification to offer, I was not seen as a good teacher by any means, but I was adequate. And then I went back to Wolston Park and thought, “No I've got to get some more experience, I'll apply for a Churchill Fellowship, that's what I'll do. I'll go overseas and see what's happening” and then I had to front up to all these powerful nurses that I'd offended all along and of course, they didn’t give me the time of day. They told me I was more of, like a psychologist than a nurse and so, so I was you know very soundly rejected from the Churchill Fellowship for Nursing and that was probably fair enough.

So I thought, “Well if I can’t do that, I’ll go to the University. Okay so what will I do in the University?” People were starting to rumble then about nursing education going to the University and it was a really hot topic and the culture of Wolston Park of course was such that they wouldn’t consider it, wouldn't even entertain the idea that that’s where education, nursing education should go. Got to have hands on, tra, la, la.

So having decided then that I would go to University, what was I going to do? Nursing wasn't there yet. I was a teacher. Right I’ll go to education. Who do you start applying? That’s right. I put in a formal application which was knocked back because they said my matriculation was too old. I had a feeling that that wasn’t the case. So I said, “No I’ll go and find out why they really won't have me.” So I made an appointment to see Professor Basset at that time and said this was a case that I didn’t feel that he was telling me the truth. And he said, oh that’s right, they had said, “Go and do arts and if at the end of 1 year then you can come back and do, come over and do education.” “I don’t want to do arts I want to do education.” So he admitted then that indeed that wasn’t the real reason. I was knocked back because I was in the eyes of the University I was neither a professional nor a teacher. Now I didn’t mind them criticising my teacher training because it wasn't very good, but I was very professional in those days. I did take umbrage at not being a professional so I threw a temper tantrum and said, “How do you expect nursing to get…” because he was a friend of Joan Godfrey etcetera, etcetera so anyhow he was somewhat taken aback by that about that but agreed that I could enter the holy Faculty of Education but he would be keeping an eye on me. And that was the best motivator in the world. No way, I wasn’t going to succeed having been told that. So I found myself with the in the Graduate Program. I don’t have a great memory of that but certainly in the Masters Program I was with the Deputy Headmasters and Headmistresses at that level of teaching and I was appalled that the teachers knew absolutely nothing about mental illness whereas schizophrenia, where would you see it first if not in the classroom. So I very rapidly became the marginal man. The hospital said, “Well you’re crazy you’re not going to get any more money for going to University, why do it?” University it was all “One Flew Over the Cuckoo’s Nest”, all evil places so here am I trying to peddle Freud in the Sociology Department [laughs] oh I made some horrible mistakes there. But I learnt how to learn and that was the important thing. And I did I got a great deal from my University training. And then came back into the system with a much broader oh yeah understanding I suppose of the various other disciplines. And I’d been washed along
with nurses versus psychologists versus OT’s versus social workers. All these interdisciplinary wars that went on for years but when the first lot of restructuring took place we all had the disciplines had to work together and so we worked together in demeaning the doctor’s first of all. You had to do get the God doctors down off their pedestals. And I came, then went from, by then because I was good at writing submissions I had eight educators working for me and we became the professional educators at Wolly Park.

Ended up with eight educators there and a number of programs and then we became the Professional Development Centre so it became more interested in coordinating education for all of the disciplines you know learning along the way that’s what everyone else was thinking. And it was then that I realised the truism that one famous writer has said that, “the discipline is much less important than the personality of the individual in working with people in mental illness” and I saw that time and time again. So I slotted in fairly easily to that. I was, I let go of baiting the doctors very late in the piece but I could relate that to my childhood experience, no father and you know all this kind of stuff. So you know I was there for 23, 24, 25 years and Rosemary Gray was the yes, Director of Nursing at that stage, Matron and Director of Nursing and she gave me my head which was amazing. It was an amazing thing for her to do for a start because you know I was, I disturbed everyone along the way but she had enough faith in me. She had a lot of faith in education, too much faith in fact. That she saw that as the answer to you know the future of nursing was going to lie in education. So as she did, and because I worked hard, I think that was another thing, if you seem to be a hard worker people like you. I didn’t slack around in the system. I was always doing something even if it was slightly unethical or whatever, there was always something in the planning stage. Twenty-three years later nursing went into the colleges, we made a stand but didn’t get anywhere with it of course so then changed our focus to looking at the practical experience that people in the colleges were given and gradually it all settled down, we discovered that the colleges were quite capable of educating nurses so.

Then came time to retire. And I said, “Well this is ridiculous I don’t want to retire.” They said, “You have to because you’re 60 whatever.” And I said, “I tell you what if you make me retire I’ll take you to the Age Discrimination Board” so they took two steps back and said, “Alright so you don’t have to retire.” So I stayed for another 6 months just to prove the point and then I retired. But guess what? I failed retirement [laughter]. I was absolutely no good at retirement.

Came to Bribie Island. I explored every group in them, I knew my community like the back of my hand and at the end of 6 months I said, “Well what do I do now?” So at that stage I was doing a bit of work with the Environmental Association and they said, “Will you be our representative on the at Council’s big committee that they’re setting up for an integrated health policy for Caboolture.” I said, “Right I’ll go and do that.” I get into this enormous committee and listen attentively to what all these bearing people were saying. But it was all broad street pump stuff, mosquitoes and dogs and all that kind of stuff and I’m constantly saying and needling, “What about mental health, what about mental health?” and to this day mental health doesn’t get a mention in the aims of the Caboolture Council. So I didn’t get, but anyhow so they said to me because they got sick of hearing me, “There’s a guy down the street he’s setting up a community mental health centre, go and talk to him if you’re so keen on mental health.” So it was there I met Karli and he made a big impact on my life Doctor Karli and he had taken up the challenge of setting up a community mental health service in an area where there was no big mental hospital and a culture that you had to undo before you could start again. So we had you know 5 or 6 glorious years where we set up our protocols and we had visions and dreams and we could see how that could work. You know these were really genuine partnerships and so on. And as I say, they were very heady days and we were trying out all our new models. We had, Karli was good at getting people from overseas, we had all the best people in the world would come and talk with us where they had done amazing things in the community. But of course, the service got bigger, the bureaucracy grew [chuckles] and we lost those dreams one by one. But now we’re an alright service but we’re not an
extraordinary service that we had seen ourselves as being and maybe you can’t do it with large numbers I don’t know. But it was certainly good to have that experience and we were encouraged to try out different therapies. Very keen on narrative therapy for quite a few years and that was exciting too and you could see we were getting results from that. And there were people like Denny Cowell who was one of the Nurse Educators and he had a profound effect on mental health nursing over the years before his untimely death and in the school, it was Denny who was, this is at Wolston Park, who was an avowed Freudian, I was more a social scientist if you like and the other fellow, Ian Hay was the hardnosed psychologist and you know we had some amazing discussions and stuff about how to you know what the diseases meant and how to manage them and so on. They were beautiful intellectual days. So moved on from there and now I suppose my running battles are with the rhetoric versus the reality. You know we have, we talk about recovery.

Recovery that’s the thing but no way clinicians and clients and carers mean the same thing; use the words in the same way. And so that, that’s been quite difficult to point out and as I listen to the language that people use it’s not the language of recovery and but by the same token I can’t offer you know research based evidential you know truth that recovery the concepts of recovery and the strategies that go with recovery are producing or what they’re producing. I just know they work. But that’s not what the people who have the money want; they want to have measured outcomes. Measured outcome and you know qualitative stuff is hard to measure. So right now, I go about my business. I have a caseload of about 40 people. I work hard and I do everything wrong in the eyes of the establishment, I visit people in their own homes by myself.

I don’t check the drugs on; have another nurse with me to check the injections I’m going to give. I give injections of people on my way to work. I even let the clients use our toilet here. Very much a no no. You know how you can catch schizophrenia using toilets and so on.

I expect to see people putting sheets on the chairs before they sit on them or something so a lot of that stuff still remains just below the surface there but by and large I do, oh that’s right. Then I became, my focus became what at that stage was called community integration which is now called social inclusion and I think that’s a better phrase come to think about it. And that had been one of the things that I had been interested in doing. How to get the public to accept people who are different and that was a very hard thing to do. So I started off traditionally. I rounded up all the Church groups I thought they’d be a good place to start. I took my personal conventional person with schizophrenia, person with bipolar, person with anxiety or depression with me. I let them talk when I talked to these groups of mainly woman, not totally, and letting them know what it was like for them. How they would like to be treated. But of course they hated it because it made them feel so guilty and it didn’t produce any change at all. So I thought you know this is going to be a waste of time, we’re not going to do this anymore. Because I have a very simple philosophy if something doesn’t work, you do something different.

And then of course the pennies dropped, I go to play tennis, this is my friend Andrew he plays a good game of tennis, 20 people in the tennis club know that Andrew, it’s obvious he must be strange or he wouldn’t be with Judy, but he plays a good game of tennis, that’s all they’re interested in. And even my own complex that I moved into when my husband died had amongst its rules people of unsound mind were not allowed to live here.

Or drunkards, unsound mind or drunkards. Well when I arrived there and started examining the rules I said, “This is incredible.” So I got myself on the committee and pointed out the number of empty bottles that were around in the morning that suggest some drunkards might have snuck in here. But they stood firm on that on it an amazingly conservative state in the Petersen era and the people on this, and this is a complex of 50, you know 50 units and very, very, very, very conservative. They so, “No we won’t, we can’t, to change the rules it’s going to cost $900.” I said, “I don’t care if it costs $9,000 if you don’t do it
I will take you to the Discrimination Board.” So they did. They did have to change because they didn’t have a leg to stand on. And then I went one step further and I’d been seeing a young man with chronic schizophrenia, got to know his mother well, he had five older sisters, all professional women and Mum was dying of cancer, a very invasive cancer, she didn’t have long to live and what was going to happen to Peter? I said, “Alice why don’t you buy him a unit at the (27.38) and then let the girls manage it or be trustees or whatever” and so she did just that and along came Peter who was of unsound mind in their definition to actually live amongst them. Now Peter is as harmless as the day is long, he’s interested in birds. I said to him, “Peter why don’t you have a little bird walk every Saturday. Advertise in the paper, take people down around Buckley’s Hole, look at all the birds.” Which he did, which he does 10 years later, he’s still doing that and people can see that there must be something strange about him because Judy knows him [laughter]. And I have another very, very chronically schizophrenic young man who was tattooed with random numbers so he was quite strange to look at, tattooed and even lately he’s had some tattoo on the back of his head which is strange to me but he’s got a good brain. And I said, “Paul why don’t you learn to play bridge, you’ve got a good brain.” And he’s a bit obsessive compulsive, “Bridge would be great for you.” So having taught Paul some skills of keeping his weird ideas under wraps and they were the flight of ideas he had the lot. He agreed to go along for lessons and now plays bridge. He plays a passable game of bridge and if it’s in the afternoon, he’s not so good in the morning, in the afternoon and there’s 100 people in the bridge club and he says, well he doesn’t look at you when he speaks to you there’s something odd about it, but he plays a good game of bridge.

So maybe people with you know have a mental illness aren’t all axe murderers which is you know some of the, so it’s only going down that kind of path that I can see that can make any dent in community attitudes because, and even at the Alliance Conference that I went to lately and was quite impressed by the research showed that whilst mental health, mental illness literacy was increasing, improving greatly, stigma and discrimination was increasing, it was somewhat worse now than it has been. Because people are saying, “Not in my backyard, not in my backyard, too close” and so on. So we haven’t cracked that boundary of dealing with people who you know who are different and I don’t know what the answer to that is but hopefully you know we’ll get better as time gets on as people speak up more, as the Alliance would certainly have them do because I think the future, that’s where the future’s going to lie in consumer run facilities, mental health systems and carers for that matter. Carers are not, I do a lot of work with the .... and those people blow me away. Yeah absolutely amazing.

So that’s my potted history.

Going back, when you first started in your first few weeks at Wolston Park.

Oh, I can tell you exactly because it’s very vivid in my memory. At that stage, Matron Egan ran Wolly Park. Now Matron Egan was left over from the war. She was an Army Matron. I would go and we wore the white uniform the flowing veil and all the rest of it and she treated me with grave suspicion right from the start because I was a Mexican. I’d come from south of the border and, “That Boyd I never know what, I don’t know what she’s up to up there” that kind of stuff. I used to regularly present to her every Monday morning and you know talk with her about difficulties as I saw them and so on. She would listen politely and look me up and down and I’d think, “Have I shone my shoes?” and that. And then one day I thought, “Now I’m sitting in this little house in the middle of this big asylum, I don’t go out of here, I don’t go to the wards at all, what on earth am I wearing a veil and a white uniform?” So I thought, “I’ll do this gradually.” So the next week I turned up at Molly Egan’s office without my veil. And that was the most fearsome to me thing I had ever done. I was quaking in my shoes. I could not get over that. Anyhow, I went in there and she looked me up and down, looked me up and there was the pregnant silence but she didn’t say a word and it was still, “That Boyd who knows what she’s up to there [laughter].” And at that stage Gordon Erckhart was spearheading change anyway so you know I would say to him, given the language difficulties, these people are never going to pass those exams so he made then that level of
assistant nurses and they became assistant nurses and kind of settled down a bit after that. Then of course, we had to get control of the curriculum which was controlled by the doctors. At that stage, they decided what we should know and what we shouldn’t know and then the Board of Nursing Studies came along. And there’s another whole drama unfolding there as everyone jockeyed for positions. Everyone was very, very professional and so on. We were at odds with Bayley Hendersen that was the only other teaching hospital and we, it was all confrontational. We had to show we got better passes in exams than they did and so on. So a lot of stuff went on there for quite a few years till we settled down and got used to the, used to that. So the feeling then was I’m in a, alternated between, “I’m in a strange land, I don’t know what I’m doing here, there’s no one around that understands or even knows me” but the students liked me and they were the only people who did. So that was, that was okay and they were eager to learn, they were keen to learn and they would suggest things. I took on the Unions first. Unions were very strong and there was always, “Out on the grass if you don’t do this, this” and always having strikes, lightning strikes and I got a bit tired of this and said, “Well if you put the, if you have the students go out in my lecture time, I won't nominate them for exams and you know they’ll never pass their exams.” So the union body got together and said they exempted the students. But that really wasn’t enough because shortly after that a group of students came along who were politically minded and they got into positions of power within the union itself. So we had a reasonable relationship with the union. So then, we had to tackle the administration itself head office that was a different kettle of fish. Because they were very high, highly you know motivated people and you couldn’t. They had set up their own little circles of influence and, “We know what’s best for you.” Who to keep under the thumb and so on. Gordon Erckhart had cause to call me up one day and say, “You know Judy you can teach what you like how you like but don’t rock the industrial boat.” That’s what he saw me as doing. So I toed the party line you know pretty much up there because I had quite a respect for him, he had a very onerous job with Petersen breathing down his neck and all the other stuff that was going on at that level, the Parliamentary breakfasts they used to go to and so on. And they were trying to keep the lid on Wolston Park because it was at the point of exploding and that would have been politically very dangerous so they didn’t want that to happen. You know we have to keep the natives quiet at all costs. And Rosemary Bray for her part was had come very much from the Labour Union movement kind of background before she came nursing and we used to fantasise, you know because we could have sparked a Royal Commission, it wouldn’t have been any problem to do that. Would we do it? This is how we’d do it and we’d plan it but we were never game to and it would have been a disaster anyway. A good thing that we weren’t going to because that is not the way to get change although at that time we saw it as they’d blow the whole thing up and then start again building from the bottom. But you wouldn’t because you’d have the same people, the same people there.

The yeah big, no there were no big startling insights or changes for me personally except when I got to meet Karli and when I retired I thought, “Now I know all there is to know or I know how to find out or where to find out, you know my work here is done.” But when I became involved in his planning, I suddenly realised I knew nothing and I was going to do a Patricia Benner, you know from novice to expert and then I had to re-write my book from expert to novice [laughter] because I’d never really talked to patients as they were then and clients and appreciated them for what they were. So busy using my superior language, professional language and all that crap with trainee nurses that I didn’t get to you know to looking at the person behind the illness. Although Whitehead, Alison Whitehead came into, she headed up ARAFMI and she came across my path and asked if she could talk to the student nurses and that was one of the things too that started me thinking that maybe I didn’t have all the answers. And she talked when the carers talked of their experiences and they were just allowed a guest to you know be guest speakers in the curriculum once in a while. They should have been centre stage but the crib cycle was more important than that.

On student days
It was frightening because I’d gone in with all the stigma all the beliefs that everybody else had. I saw danger at every turn. But I also saw a lot of handsome men that were there. We were doing lectures with and they’d just come back from the war and they were men of the world and they didn’t, they would give cheek to the Matron and just left us open mouthed we would never have dared to speak to her like that. So the student body sort of allied itself and we had a feeling that things were going to be different. The thing, you know the war was over now and there were straws in the wind that suggested that maybe it won’t always be as hierarchical as it was then. And what and also when, after I first graduated when I had well and truly fallen out with the Matron she gave me the most difficult ward of female, it was a female ward of dangerous patients, who you had to get onside because they ran the ward virtually. You hung onto the keys but they said who would do what around here and all the rest of it. And they did it quite well I might add.

But if you wanted to exert your authority (and we were giving ECT for punishment in those days), because we had a lot of borderline personality young women there, but one of the things that struck me, I had a sneaking admiration for these women. Although they were very crazy, they held themselves well, they looked alright about themselves because it was before [medications] and when I came back later and saw these same women, okay so it’s 15 years later, but they you know they’ve got the blank look...

And we gave enormous quantities of drugs. We did insulin therapy, we did malaria therapy and people were some people were even working on ecstasy, that drug to discover the secrets of schizophrenia. But insulin therapy got a bit hairy at times, because you know you get people in and out of comas and it was pretty horrendous and ECT was the best behaviour control mechanism we ever had. So and in the hospital itself there were a number of, a lot of what they called cockatoos, so if the Medical Superintendent or Matron were doing a round, the phones would ring, so they’d before they got there, so you could and all the illegal things would disappear behind things and so on and they’d come through and they’d go on their way and so that provided us with the safety net that we needed I think.

When I look back now at some of the people that worked in those old fashioned ways the sheer magic, they would never be able to say why they did what they did, but it worked because they could connect in a human, human to human fashion and you know I would never have them denigrated as institutionalised nurses because they were, they were such good people.

So, where will it go from here? Ah anybody’s guess but I suspect it will come from the consumer and caring group. That’s where the next big changes will come from. And that’s going to be rugged for professionals because we’re so used to believing that we have the answers and we know what’s best for you and we’re going to be challenged on that many times I suspect and I’m not sure how we’re going to handle that.

On anecdotes
There’s a million of them. Oh, no look I can’t bring any to mind which is ridiculous because I know they’re all out there.

My most significant moment probably, no I’ve seen a few sparking moments but I suppose because of recently I would think realising how ignorant I was and ...discovering humility. Yes that’s right discovered you know to be humble, how to be humble and that Karli taught me. I learnt from him he didn’t sit down and teach it but when I saw this man who worked like Mahatma Ghandi I thought, “Ah this really blows me away.” And he was so wise. And that was the beginning of wisdom for me. To realise that I knew nothing and I needed to listen and when I started listening, active listening to these women and women particularly and asking the right questions. I hadn’t been asking the, I’d been asking the things that I knew had to be written in charts, but that wasn’t things that were important to these women. Their family relationship, what’s it like to have night terrors and ghosts and things watching you and being terrified
out of your mind and yet being able to carry on in some way. You know it’s just, nothing short of amazing in my book just as it is with carers living with this 24 hours a day.

Best times?

The best times have been these times because I can do what I like, how I like and people know that I get the job done, that clients like me. I rarely have anybody in hospital. I bend over backwards to keep them out of hospital and all of those things are seen as positives and they don’t dig too deeply into how I do these things. Occasionally I get the disgruntled young psychologist, “That Judy Boyd she gets away with murder” you know etcetera, etcetera. And so there’s you know there’s bit’s of envy fly up from, oh no not really envy because no one envies an old person. Not if you’re professionally upwardly mobile. Age is the last thing you envy. But I suppose feeling confident you know about what you’re doing and I guess having psychiatrists say when they’re moving on, the Registrars particularly, “It really has been a pleasure working with someone with experience.” So it, it shows through yeah down the at all levels I think and because all of the Clinical Directors we have are young enough to be my sons anyway if not quite my grandsons then and you know that’s how I treat them as you know nice young men who don’t necessarily have all the answers and I you know I’ll challenge them as much as anybody else. But I have learnt to do it in a much more subtle way than when I was doctor bashing. I’m not particularly proud of all that stuff now but I think it was part of everyone’s life at that time yeah. Okay. I guess the other yeah and there is something to be said for recognition. When they gave me an AOM last year or something the year before whenever it was. It was nice to get that recognition and I used that to milk that for all it was worth for a long time to further the cause of nursing but then got very irritated by this group of us and there were about 50 men and about three women in this group to get recognition from Quentin Bryce and this gentleman insisted on helping me up the stairs as if I’m old. I might be an old lady but I don’t need help to go up the stairs [laughter] so those bits and pieces. But no and I guess the things that I still feel sad about because one of my roles is that of a peer supporter and that’s very important to me and we look after the difficulties, problems that our peers are having that doesn’t go anywhere near the system. It’s all you know completely confidential and all the rest of it but there’s some quite nasty stuff that goes on and I’m disappointed that that’s still happening.

People backstabbing and all that kind of stuff and trying to smooth that over when people are fired up to, “Aint it awful look what she’s done to me now” you know that kind of stuff and I’m sorry that’s still there. But I can see why and I can see a bit of myself in it a lot of the time too and hopefully there’s again experience or something or whatever it is that gets you over these hurdles.

Worst times?

The worse times it’s certainly not in the community. It wasn’t in the worst, because I look back and because my glass is always half full, I can’t think of any. Oh no I guess it would have been when you know I was caught out in my perfidies you know early in my training and people, and the Matron had said, “I’ll see you never graduate” you know this kind of stuff and I felt very alone then not having any support. But I knuckled down and I worked hard and I got my two gold medals then. One then, one from the Royal Adelaide you know just to show them [laughter] which is ridiculous, ridiculous but there were some not so good times there and I think that was a lot of guilt because I was behaving disgracefully. They had every right to be chastising me and all the rest of it but at the time I didn’t see it, I dug my toes in instead of being a little bit more diplomatic or polite about it. And so there were a few years but then I when I left and went away from it, I missed it, I really did and I was very glad to come back to it and I had resolved a whole lot of my stuff then so it was easy going after that. Okay. So…

When we leave here I will pack up my four lots of injections, illegally put them in my car, illegally go out and see my guy that nobody will visit because everyone knows he’s a murderer and my other fellow who
can’t see any reason to leave his house for any reason at all etcetera so I’ll go and have a yarn with him and my other fellow who’s following the trail of Buddha or some Taoist or something and he has no reason to eat or drink because that doesn’t fit with his philosophy and who’s the other one? Oh my other lady which is very, very sad. She is the mother of four children, she has a chronic schizophrenia herself and her husband did as well and all four children are chronic schizophrenic and she’s just been diagnosed with CA breast cancer and has had a mastectomy.

And she’s battling this with all these other very “bad” illnesses that the, because all of these children are all the new long stay chronic people. And it’s been so sad to watch. We thought the youngest child might get away with it. She was bright at school and all that but then 3 years after leaving school, now she’s a big, fat, bloated, glass ceiling, expressionless from this vital young woman that I knew 5 years ago so you know that’s a sad story but a very courageous story and her spirituality will pull her, you know will pull her through.

Well you’ve been wonderful to talk to.

I do all the talking.

The legend, Judy Boyd.

I can always talk.

Anneke Bull

Current role: Clinical Nurse, Older Person Mental Health, Ipswich Hospital

On being nominated: [Career longevity, Inspirational role model]
I have no idea. [Laughter] I know I’ve been blessed over the years to be able to do many things and many opportunities come my way and wear many hats, to be involved and setting up of projects and pilot schemes, and to be able to share the information learnt from the projects and pilot schemes at conferences and things like that. To be quite honest, I couldn’t think of anything specific I suppose. But then I am, from the historical perspective, I’ve seen a lot of changes over the years too; I’ve been around a long time in Mental Health, [Laughter] Like many of us, many moons. So I think we’ve all seen many changes happening, which I think they’ve all been quite good but yeah, my area of passion I seem to be following through a lot more. So I couldn’t say anything specific unless a certain project or pilot schemes that I’ve been involved in that I’m quite happy to talk about.

There’s about three different lines that I know really, that I quite noticed changes in, let’s put it that way. One was quite a few years ago, it was a short term project and that was just do a review as to how to minimise the re-admissions into, it’s now called the Older Person’s Mental Health Unit, used to be called Aged Care. With recently, changing things. At the time, it was found, people came back in was more related to loneliness and as soon as they came back in the Unit, was no change made to their regime but they certainly flourished and blossomed, so we felt that needed to be curtailed somehow. So we looked
at some sort of enabling education process that we could do. Originally, we looked at, and looked at it from outside sort of as community, using volunteers and get some community education and that sort of thing. But like everything else, it’s the mighty dollar, a great-laced plan, the mighty dollar sort of stop it. However, the one thing I have learned, although it might be a great plan, it’s good to keep it on the shelf for when the dollar does come. Sure enough, something had occurred, we eventually got sufficient funding for an O/T, who was very much into the enabling process and read the research I had done at the time, and she modified it to the impatient unit. So actually now it’s getting people from outside, agencies come in and talk about various things. So it was demystifying a lot of things, a lot of time was fear factor. And also, to encourage the folks to be more involved in some of the things they could do for themselves, so get them to be a bit more assertive and pro-active, and that was really good to see the changes within the population we had. They did become a bit more pro-active and a bit more assertive, able to say, “I want to do this and I want that” whereas before, they were more subservient. From that, it changed also, the side effect from it, was the change in the nursing staff, seeing the pleasantry of the patients, patients within the Unit, clientele outside, but being more assertive and having their say and then allowing it, it actually made the workload easier ‘cause they ended up doing a lot more things for themselves. So that was one thing.

The other thing was a big 3-year project I had a blessing of being involved in. That was actually setting up a Consultation Liaison Service within the community that was taking on a CL role for the elder person within the whole of the district, and Queensland Health and their wisdom, likes to grow the districts, so my area to cover grew. [Laughter] Yes, right. It was a 3-year funding through DOHA and the briefing was to interface and have an interlayer in between the Primary Health and the actual Mental Health Service. So trying to stop people coming into Mental Health Service, but at the same time, give them Mental Health support to people out in the community or residential facilities. The only drawback was, because it was through DOHA, they had to have ACAT approval. Now, if they’re in residential facility, it was fine ‘cause they would have ACAT approval. The community made it a bit hard, and one time I did have a case, that she was too good to have an ACAT approval even for a pilot scheme. So, I had to tell this poor lady, “Look I’m sorry, I can’t accept you because of” but she was so happy with that, and she felt ‘Oh I’m too good for this’ and [laughter] that really lifted up her spirits. As a lady for depression and then coming up humbly and say ‘look, I’m sorry I can’t do anything,’ just sort of really made her day. And things picked up from there ...

So you don’t always think of it at the time. But from that was trying to empower the nursing staff at the residential facilities, because most of them are unskilled labour or they have the Certificate III, as well as doing mental health assessments and helping with management plans, and really work alongside with them. So it took away a bit more of the traditional case management role, and I had a short-term case management, I could only keep them for about a month, that was one of the stipulations. Which made it a little bit more challenging, because you forever had the exit strategy in mind and you always had to tell your clientele how that “I do have to close you in a month; could only have a month with you.” It was sort of really straight away setting the limits and the boundaries, but over time it really actually worked out quite well, it’s one of those new territories, because with traditional case management, you keep on people probably longer than we should. We’re not too quick in closing in case that come back, when someone’s a bit too longer. And because I didn’t have that luxury of keeping longer than I should; I had to think of some effective ways of discharging them off the books, of closure, that they’d still moved on because we didn’t want a return rate either. So what happened there is, I spent a lot of time in the assessment but I actually end up talking with GP’s direct and most of them just over the phone. When I talk about medications or testings that need to be done, we found that something a bit more physical because with older persons you know it’s definitely physical as well as mental but I’m also very much into spirituality, so I took that component on board as well. So quite often, I would simply ask if the residents’ Chaplain could have a few chats with them because quite often that’s all they need is a Pastoral visit. Especially if it’s a new location, readjustment related to relocation, that you knew a bit of Pastoral visits
would quite often do the trick rather than get onto medications. That was part of teaching the staff as well, not to look at the pill trolley first, we look at alternatives first and find out why this person's behaving, go beyond the behaviour. Being untrained, they see the behaviour and react to it, and it was forever my role to remind them though, there is something else under it, there is something else under it, look at that first. And of course, the delirium factor too, look at the UTI's look at the (8.52) that sort of thing. So what happened in the end, it actually noticed with the stats we were keeping, it actually reduced the number of presentations to ED, it reduced significantly the numbers of referrals to the mainstream service, it took a while for people to get used to the idea, what my role was in the mainstream, but that's like anything. And when you work with private organisations that have double-digit staff turnover, things are repetitive. I had a very good cooperation with GP's, that even GP's referred people direct to me rather than just a mainstream service, and facilities referred them direct to me because that was one of the other beliefs - anyone could refer, but GP's were more than happy with it. I ended up working indirectly closely with them, and in some ways like I said to my line managers, that I ended up prescribing by proxy, that whatever I suggested, GP's just went along with it. I had the good fortune that they all got well. [Laughter] Occasionally though one lady, the GP was a bit enthusiastic and prescribed a bit too much, well her blood pressure dropped down below the boots, but that was alright, that was a lesson learnt. But we learned from that, it's something, and the GP learned. But it also allowed for case conferencing which doesn’t happen quite often with main stream, that you can actually have a case conference and a facility, have the GP, the family there, and the staff there, and really to sit down and do a full case conference on that particular person which really was beneficial, which I don’t see that happening with mainstream services. They’re too busy with themselves; it’s usually the busyness that slows it down.

The other component was also an education component and I developed a course for just the basic Mental Health Nursing course for the untrained staff, just to get an idea about Mental Health itself, and some on disorders, personalities; I did it over a 6-week period, and I gave them homework to do. So it was more reflective, I made it reflective but a lot of the feedback was that they found their own practices were changing by doing that. They also found it was easier to manage their residents because they sort of looked at it differently. Another side effect from it was that a number of them also had family members with mental illness and they came back and they said, “I now know why my son or my nephew does this.” So obviously, I knew I was connecting and they were learning, ‘cause to me was more important to learn. So we had done that. The bigger Districts, I did a lot of phone conferencing because I couldn’t always travel down there, went to Kingaroy two times but it was hard to justify. While I was in that role I did stage an Older Persons Health Conference for the whole of the District, for all NGO’s ...

... as well as Government things, and that was inviting various people in to talk specifically about Older Person Mental Health, and at all disciplines. We had Chaplains, we had Nursing, we had O/T’s but they all came from various NGO organisations, so I did that. And that really turned out well and I was blessed that again, a lot of the drug companies were happy to, including the Council, the local Council was happy to support that. It came at cost neutral, that was the aim, the Executors said, "Well as long as there was no cost involved" they were happy for me to do that. So I thought, “Yeah that’d be right.” [Laughter] can’t spend the money; you can do it but don’t spend the money. So I was blessed, and it actually ended up being cost neutral so I didn’t have to charge anyone, it was free of charge. We had a big turnout, we had about 60 odd people that actually turned out, and some people from Kingaroy even and various players, I was really stunned; I thought 30 would be nice, particularly first time round the Hospital, wow, I thought that’s just amazing. I did duplicate that for them at Kingaroy, we did promise that for two half day ones and that worked well. Then on top of that within that role, ‘cause it was a liaison role so there were a lot of connective work out in the community, I was involved in the inter-agency disability meetings and so on, it was at the Council and would arrange their AGO’s. I did some talks as well through the carer’s support and Commonwealth Care link, to carers about Mental Health that sort of thing, so I worked with that. I even was blessed to be able to talk about dementia to a Japanese
delegation through an interpreter, ’cause they have their problems but it was good, I learned about their problems as they sort of learnt with that. I then was involved with Ageing Disability Expo as well locally, and set up with that as well. So I was quite busy those years. [Laughter]

Then top of that, I actually was given some grant funding through the Aged Care Improvement Granting to do the multi-sensory therapy ...at the bedside. But I managed that project, and then I had a project officer, so I did my own project and then I managed that project. But one did fit in with the other because the multi-sensory therapy we did was at the bedside in the medical unit (15.04) and we then covered the three D’s. Whether it was depression, delirium, or dementia, but they had to be identified as a difficult patient by the staff, and then we would do then do that, it was a 6 month project, so we would do that. We and that was good, because we did a lot of research into multi-sensory therapy, we did a lot of site visits, to have a look at various rooms and that, and we wanted to stay away from the room. We wanted something that was fairly easy, fairly flexible and that would just utilise the principles of multi-sensory therapy, but also that they could take back home and do it at home, so there’s that further follow on. It of course had to be cost effective for the person, because we had to think about people who could rub 2 cents together, to still be able to do that, which created an extra challenge on top of that.

But we actually found, as a by-product or a side effect, but the staff of the ward quite actually enjoyed it themselves ’cause they noticed the patient was settling. And they did, they just melted in front of us, the most difficult ones and 20 minutes later, they would just melt; it was lovely to see that. Again we looked at the stats, and we looked at stats through the prime reports that we used, ’cause we’re trying to work out how to measure the effectiveness of it. One way we did was look at the actual prime report that is that electronic patient incident reporting that they have in Queensland Health. And I took two snippets prior to that or 3 months, 3 months prior to us starting, 3 months at the same time the year before that we did the project, and then the 3 months while we actively did on the floor, and that filtered us what we needed, (17.07) the Health and Safety mob were able to filter it. I actually found a 75% reduction in that, but it was a pilot study, so it’s a rough figure but still nonetheless, we knew it worked and that demonstrated it. Then we did biological markers before and afterwards, we took a pulse rate before, and we noticed significant drop in the pulse rate, as our biological marker ’cause we’re seeing something visually but how you do a demonstrate that. We just had a basket, as we looked at what we do is mobile, so we had a basket and we were in civvies, and because the basket was covered we already broke the barriers because the person’s own curiosity of wanting to know what’s in the basket broke the barriers; so it took away all that clinical focus. Although it was a clinical intervention, it took away the clinical focus, and that really got us, and we didn’t have a ‘no’ once....... not once. Sometimes we’d get, “What are you doing here” and we’d start talking about it and then they got more curious and wanted to see what was going on. And that’s how we slowly stimulated more than one sense. For that talk yesterday, the reduction of what they did in, I knew what they were talking about because, yes it does work ’cause I’ve seen it; it’s a great tool. I have learned since then that they have to tried and introduce it in various places. One of them was one of the nursing homes, their dementia unit, they wanted to do something mobile, and they found the staff enjoyed coming to work because they’re coming to play. They still do their care but they’re coming to play. And I’ve been in that dementia unit many times, and it really is now humming quietly, it’s buzzing quietly, humming quietly. They’re some of the things that I’ve done. Unfortunately they (19.05) the project ’cause of no funding and I was able to clearly demonstrate the reduction of the pressure of the services and the person staying longer, our return rate of return of re-referrals was quite significant, like 2% - 3% out of that 3 years, which is quite low.

And the liaison I had was fairly steady, although I had lots of people in the end; facilities in the end simply rang and ran things past me. They were so well, ’cause some of the staff had told me they were so well trained that they knew what they had to do before, so when they rang me, they said, “We’ve
done this, this, that” listed it all off, and quite often all they wanted was affirmation that they did the right thing, and I said, “Sounds great, wonderful, I'll pop around in a few days time.” I always had that post 48 hour policy, I always liked it 48 hours before I see them because I learned that if you see them within the 48 hours, there’s still a lot of dust gathering. It’s after the 48 hours, the dust has settled and you get a far more objective viewpoint from the staff, the emotions have finally settled. If you go in with a heap of emotion, you lose the plot ... so I’ve learned that I've got to come later. I had a rule for myself that I had a week turnaround for each referral, and I did have a referral a week for myself was pretty good ’cause I had everything else happening. I actually ended up having more referrals than that. [Laughter] The stats are phenomenally high, but I did make contact within the week, and they found it was a pretty quick turnaround. But unfortunately, I had to close it; I had to wind it up because there was no funding. Looking for funding in various places to try and keep it going. But with the economic downturn. And I have been made aware that the line management executive have been looking at funding too ’cause they could see too that the value of having somebody out there to take the pressure off, just simply wasn't there; so unfortunately I had to close. And since then, I’ve noticed that they are getting snowballed again with all these residents. [Laughter] I like to laugh because we all know, but I feel sorry for it at the same time, but it just proves that there is a necessity. I did try to, also, the other things I wanted to try, and implement, I had been negotiating with the Divisional GP, is the Mental Health Incentive Program.

I did a bit of time backfilling, and I am still now, still under contract, with the Division to backfill any of the nurses at the GP clinic, so I’m familiar with the processes. I said to them, I also knew at West Moreton, they have got two big clinics at the facilities, so why can’t we set it up at the facilities, and I’ll be then the Mental Health Nurse, I will present a program at the facilities. It leads to three facilities, half a day, a week or something or a day a fortnight, I think we worked out a day a fortnight to start with to make it viable. But it’s the viability and the turnaround that’s really stopped it. It’s a Medicare thing that, that really stopped it, which is a shame. That’s about all I can think of in a nutshell what I’ve done over the past so many years, I was doing lots of education stuff as well as clinical stuff, various roles that we do.

**Coming into Mental Health Nursing?**

Many years ago, many moons ago as a wee girl, as we all do, I had this calling for Nursing. I actually applied to various Hospitals to do Nursing. But being a migrant I missed out on my markings of my English, ’cause I'm of non-English speaking background, and I had to go back to night school to re-do my English and get my Junior English up to date, up to scratch. Wolston Park was basically the first Hospital, they said, “Yes start” so I figured I’d start Mental Health; my mother was working at Wolston Park, so it wasn’t too unfamiliar. So I thought I’ll with start with Wolston Park and then I’ll do my General after, by the time I’d finished at Wolston Park, they just changed, you couldn’t do the General after. That was fine, I didn't miss out much ’cause I did ECT and I learned a lot there. While I was in ECT, we also set up cardiac emergency procedures, so that if anything happened. As an ECT Nurse, I was taught by the Anaesthetist to defibrillate and ’cause that meant up-skilling standby ECT people for backfilling for me; so there was all this succession. This was moons ago, it's embarrassing today (25.05) and you had your Medical Centres, I picked up on a lot of medical stuff and general stuff anyway, so it didn’t really, didn’t miss out on anything. As a consequence I've always stayed in Mental Health ...

Yeah, yeah and my area of passion has always been Psycho-Geris, it has always been my ambition, but I did Acute, did various other sorts, of course I'd done Community, as well as Adult Mental Health Community, and now older person, I've done Assessments and Acute Care; yeah quite a variety.

[When I started] I thought I came to heaven work-wise, because I came straight out of a nursing home where it was head down and bum up, never stopped working. Then suddenly getting told by these old Polish Assistant Nurses [at Wolston Park], “No sit down Dearie,” ’cause I couldn’t sit still, I was used to
having the old Matron chasing me. [Laughter] To suddenly to sit down, oh my goodness gracious! Didn’t
take long to learn to sit down and sit still. The big bins were an eye opener, and these big dormitories,
’cause I worked in the nursing home and we only had two wings that had a dormitory of four beds; that’s
as big as it went. Most of it was private because it was a Private Sector. There were the concessional
beds that were in the dormitory but the rest was all private. So coming to big dormitories of having 20
odd people in a dormitory with a little locker beside them, that was a bit daunting, and then the big solid
doors of the rooms with the brick stark walls, it was all stark; that was quite daunting. As old wards, they
were very hollow they are not acoustically friendly. The one thing that I really found most, great big
pool tables set up, big pool tables. [Laughter] But it was a pleasure because it was from the patients
then that I learnt to play pool, learnt to play cards, and they really did teach us a lot of things, ‘cause the
staff itself, they didn’t teach you very much. It was the keys were thrown at you and then this patient
would, entrust a patient, they’re the ones who had to show you around and show you where to go and
what to do, and that was very different. It didn’t frighten me, I just thought it was quite novel, to me was
normal at the time. But I did learn a lot from them, and it also allowed me to learn too at the time,
having them thrust upon me, to learn from them, is to let down the barriers too, that myth of a mental
health patient, you saw them for the person that they were, you saw them in a different light; so that was
good. The yard duty, I found absolutely boring, sit down and watch the fence [laughter] ...

I was more than happy to roll up cigarettes and sort out the bag of odd socks. [Laughter] Do something
with them, or go into the linen room. They were just menial tasks, they really were, they were menial
tasks, and talking to patients then, although you did some of it, it wasn’t really the expectation; your
expectation was to make sure that no one would jump over, and they’d be no fights in the yard, that was
it. So it was very hard to engage and you really weren’t taught to engage either. It was sort of later in
your training when you learn some of the counselling skills that you then learn a little bit of engaging with
your patients. Reflecting back now, I think it is a skill that you pick up over time, it’s hard to learn, but
probably experience teaches more. You can give the basic framework but doing it, it’s probably a little
bit foreign.

And of course the meals, they were interesting because at first, they were the big dining rooms so we had
to go into trails of trains of people going into the dining rooms, where the patients would line up for their
meals and the cooks would give it and then the staff would hang around this brick walls and watch
everything go by. I think the best thing though was the movie night ‘cause you were allowed to take them
out to the movies, the old thing. They had the big rec hall, what they called the recreation hall, set up like
a cinema and you took them out for the evening. So that at least allowed me to pass the time away
because, otherwise you’d sit down and do nothing. [Laughter] It wasn’t as engaging then as it is now.
So, they were good, but they did try at times, if you had the right staff mix, tried to make it nice. They’d
have a theme night and try and do something nice, but occasionally you came across some of the older
staff that were a little bit shorter tempered, and a little bit heavy handed. For me, that was a bit poor
role modelling on their part, and then times I thought that was sort of what you expected to do. And it
wasn’t until later there, I thought no, it’s not we’re expected to do, that was really hard. In short, it sort of
fell in its own trap or being firm and tough and didn’t think twice about secluding them if it needed, you
didn’t think about it then. But I think that was how the culture was at the time, it was a real heavy handed
culture, but then it was in context of a background of a culture of older stock that didn’t have much
handle on medicating their clientele then. That was of the old stock that it was fairly normal for a patient
to really go off, ‘cause there wasn’t much around to medicate them. It was normal to have fights, it was
sort of normal for them, and this was sort of a transition because when I came on, there was a few more
medications, although we know they have got horrendous side effects but that’s all you had. Whereas
now, things are a little bit different. I could see the progression of the older stock as they were talking
about, the walk-in historians that we had then, as they were talking about their days and what happened
in their time, it was fairly normal to have someone throw a bedpan at you at 30 paces or something
[laughter] when they get mad. People picking up things and just eating whatever it might be, either
cigarettes and whatever what lying. Whereas to when I started, the medication’s picking up, and they were talking about seeing those changes, so for them it was a transition. However, the transition in the care I’ve seen is getting a lot faster, but a lot more funding has been put in too, in allowing that to happen. Whereas before, it was very much the poor cousins of Health Care. You really relied on a lot of hand-me-downs and scrapings off the floor and you could see it too in the patients themselves. You could see them being really unwell, and it always reminds me of when I first learned, and I did my Masters, when I first learned about the older terminology and then when they talked about Praecoax dementia. It really has got merit for an old term in the time, where they couldn’t do the scanning, that they already could see some dementia process is happening, and when you look at the old burned out ones then, that’s gotta lessen in our time as we go ahead because we’re getting a bit more proactove. But in those days, it wasn’t. And you could see them literally deteriorating, you could see it in front of your eyes. The only difference I see today with mental illness, it’s being tainted with the drugs and alcohol, it’s a dirty milk mental illness. Whereas when I first started, it was clean and they were just, drug and alcohol is not really as prevalent as it is today. So, now today when you get a clean mental illness, it’s a treat [laughter] you call everybody in, “Look at this one!” It’s a real learning treat. They’re the things that you see different, in cultural changes and the effects that it has on that.

On studying

Actually, I quite enjoyed it. Yeah I quite enjoyed it. I thought it was good, although the classic term of, “You’ve learnt this in school dear, this is what we do on the ward” but I’ve got a quirky sense of humour so [laughter] always saw the funny side, “Oh well!” it’s handy now to be doing the ward but, it’s good to know what I learnt at school too ‘cause it prepares you. But I found that it gave good grounding because as you were going into block time, and did the learning and did the intense lectures in block, then when you went back out in the wards, you were still able then to put some bits into practice, or certainly look at things a little bit more differently. So each time you had a chance to re-look at things, not re-evaluate but re-look at things from a different set of eyes ‘cause you learn a little bit more. And of course, you’re keen as mustard, you want to put it into practice, and the older dogs would occasionally pull you back, some of them let you go and didn’t worry about us, it depends on what you had. But the old ward rapport system really was, in some ways it was good, yes it could create nepotism and it could create problems, but sometimes it’s good. Because I find now, with some of the transition nurses as they come through, I think “Gee I wish we had an old ward rapport system because there is some real problems. You wonder how on earth they get registered ‘cause there are real problems and real liabilities there, and you’re trying to work with it but they’re so short termed, where for us, we’re in the long term. Your drop off rate was big after first year, but that’s normal with any course, and whatever was left you graduated together, and you did form a good close bond too, working bond, you’re a good support for each other at the ward and you didn’t have the culture shock; the culture shock was gone. By the time we’d finished, you just slipped into role. Whereas today, I see some of them having that difficulty slipping into role, ‘cause when we did our training, when you were third year or pre-finalist nurse, it was being in charge of a ward. Often we were put in charge of the ward, so you really learnt fairly quickly how to delegate and how to organise things and plan and prepare. That sort of things. You did some HRM stuff as well because you had to deal with some staff, especially the older assistants of those days that came across on contract, they were set in their ways and you still had to make things happen somehow. So I think, from that perspective, it was a good learning thing and I found it sort of gave me good grounding.

A passion for Older Person’s Mental Health

you get your students that like to go into ED and save lives and that sort of thing, and I remind them that “You will get an older person with a mental health problem in ED. I can guarantee you that,” and I said “You will also get one in medical ward and the cardiac ward and certainly in the orthopaedic ward,
where you’ve got delirium and dementia on top. I can guarantee you those things.” It then sort of makes them re-think that they are no matter where they are, no matter where you are, they are there. But it is true; it’s not a sexy area, Older Person Mental Health, definitely not. Any older person care is not a sexy area. People see straight away the physical side of it, where I remind people that, because I like it, at least it’s a population’s a low smoking population, and a low swearing population; they still say please and thank you [laughter] when you’re a lovely dear, and still good in the ego stroking. [Laughter] I think I let people know I’ve done my fair share in Adult, I’ve done my fair share of take downs, and I don’t want it any more. I don’t want that anymore, I just like to sort of slow it down myself and I enjoy, and they’ve got lived lives, so they are more than happy to share their lives, so it makes it a little bit different.

Highlights?

I think some of the best things, although I’ve worked in Mental Health and I’ve worked for, what’s now West Moreton, but for the same employer for a couple of decades now, I haven’t done the same job perse for the period, I’ve had a variety, I’ve still been able to move around. So the blessings I’ve had and the opportunities that have come my way, to be able to move around and wear the many hats, I think that’s good. That has been certainly the highlights for me ‘cause I get a bit bored after a while, a couple of years I’ve had enough, I feel the territorialism set in, so I know it’s time to get out. And then when I come back, I’m always happy to come back, but I did something different. But the one success story I really had was really what I enjoyed, I enjoyed talking to Drug Reps, ‘cause I also try to once a month, organise a Drug Rep in-service, just to keep up to date, just to get the skills up to date, especially when you’re in a full front area, people rely on you and rely on your knowledge. It’s good for me to keep it up to date. We had one lady in a facility, she had on organic disorder, it was alcohol related, and she wasn’t over 65, she was my 45 year old baby because in term of older person, 45 year old’s a baby. [Laughter] and she was also very dysarthric as related to her alcohol abuse, very loud, very restless and they medicated her. But over time, I noticed she was getting more stressed and more restless, and I asked her about it. So I queried, I looked and I queried and thought well maybe she might have that motor restlessness related to her medication. Then I asked her if she had noticed changes within herself, and through her dysarthric manner, she was able to say that she had found it more difficult to relax and sit still. So I figured it’s obviously got to be a motor restlessness happening here. So I liaised with the GP, we changed her med’s to another type of drug, another type of antipsychotic, and then it actually got better, it settled to point that she did so well that she, her dysarthria started to settle. She was still explosive in her expression but she was much better to articulate things and that she wanted to do a lot more for herself, and the facility facilitated that and then allowed her to go on leave. They were very happy, just to see that transformation of her, blubbering mess to a person who started to express interest in things and started to want to do more. And because facilities are patient focused, centred focused which fits lovely with the recovery model that we’ve got to be in anyway, so to me suited fine, that they noticed that transition. I think that gave them faith as well to look back into, review things rather than just medicate, let’s just look at something else or let’s look at the whole picture again. As much as I’ve had a fellow who was referred for, this is years gone by but it’s the same sort of thing, he was referred for being very teary at a certain time of the day, a post CBA fellow, and through talking we learned that history wise, his own history, he was very much involved in the Church. He was a Church Elder, he was a Sexton at the local cemetery ‘cause he was from a country town, and they noticed whenever they had any sort of praise and worship music on, he’d come to life but when it was off he’d be teary. I said, “Well I think the man’s feeling spiritually deprived rather than mental illness.” So I said, “How about you set it up with the local church or Pastoral visitor, or the Chaplin organise (44.50), for a regular Pastoral visit and also to have Communion because he missed that, he missed having Communion, and set that up. I checked a month or so later and they did as suggested, he was fine. So again, they learned to look at it from different domains, and I said, “That’s why it’s important to find out what the person’s own passions are and what they feel is comforting for them. Whatever’s comforting for them, tap into it.” As much as I taught a lot of people in dementia units, to tap into the world that the person’s at. I said, “This person
loses time, they go back in their own world, not much point bringing them back because it’s not gonna help.” It’s not gonna work, ‘cause you try and you know it’s not working, tap into their world, do what the world is. There was one particular Nurse, who shared that she tried it and had success with it. She found this lady used to be, after lunch at the table, used to be quite dominant. Then they learnt that she used to chair a lot of meetings, she was involved in CWA. So she set up these other cohort, who didn’t say much or a bit deaf, happily sat at the table, gave them pen and paper, and then let this person go. This person conducted this meeting with the other cohorts happy to sit there, and she said they had no problem, it was a good afternoon. I said, “Well that’s the whole idea, tap into it; find out if they talked to a plant, let them talk to a plant.” That’s the other thing, they were always concerned they were talking to walls and things, and I said, “Yeah hallucination can happen, that’s part of the organic process, but then what is the hallucinations doing to them? Is it distressing them, is it stopping them from eating or sleeping?” They go, “No, no.” I said, “So is there a problem there?” Get them to review it, why do you want to medicate someone, run a risk of increasing a falls risk, ‘cause that’s what you’re effectively doing. Then they’d have to think of something else to keep them occupied, when they’re happily being occupied in their own world. As long as they’re not distressing anyone, they’re not distressed by it and they’re happy in it, they’re eating, they’re drinking, they’re sleeping, and then they were happy to let them sit down and talk or play with dolls or stuffed cats. They started to see the value of allowing that to happen, rather than thinking clinical sterility.

So I said to them, “We gotta step out of this sanitised world and be a world of allowances and look at the basics first. As long as there is not distress, it’s not impeding on anybody else, they’re eating, their drinking, their sleeping, it’s fine. If they’re mobilising, talking up and down with their imaginary friend, well they’re getting good physio in.”

I said, “Look at it from a different perspective.” I found when they started doing that, it actually dropped the number of concerns. They had a fellow who was always difficult and then one day they really observed ‘cause you must observe behaviours, ‘cause telling me someone’s difficult means nothing, you got to tell me explicit.

And through observing this person, in preparation (48.31) they actually noticed some lady, another old lady co-ward, was whispering something in this fellow’s ear, and that set him off. So originally, the focus was on his behaviour, but while they were observing, they’ve gone, “Hang on a minute! It’s not him, it’s her!” So you couldn’t really say one highlight, but you see the changes and the effects that it had.

I think it’s my laziness that’s probably allowed me to think outside the square. [Laughter] I always figured if it works, finding out what works for them and what gives them comfort, it allows them to take the ownership, and by allowing them to take the ownership, they actually go out finding their own resolution to the situation, and they’d be happier with it and it saves me work. [Laughter]

A lady out at community for depression and she said to me at the end, “You’ve changed my thoughts around.” I’m thinking “How the hell did I do that?” “Did I, that’s nice to know but how did I do that?” so she told me, and she said “because you re-affirmed, every time I put a suggestion forward that I want to do this and that, you let me know it was fine and it was a good idea and that allowed me to think more positive.” I didn’t tell her, but to me it was, the only reason I thought it was a good idea is I knew she was taking ownership, she wanted to do something and I knew she’d be motivated to do it if I validated it. If I said, not look just see your other clinician, this is what I want you to do, and I knew I wouldn’t get motivation. So in order for them to get motivated is get them to take ownership and bring the ideas to me, and say, “Okay well let’s do it.” That was one of the things I learned when I did my Grad Dip was my sift model. I always liked that sift model that said: self initiated, facilitated, teamwork. And it fits in the recovery model, and people talk to me about the recovery model coming out, I throw my arms up in the air and I thought, “No I liked that ‘cause that’s how it always worked.” That probably then allowed
me then to think outside the box and allowed me to do things differently. One time we had a lady brought into the unit who couldn't do without her dogs, we said, “Okay you can have her but this is the proviso, and she adhered to it. But she didn't have to stay long in the end 'cause it was therapeutically beneficial for her, although it took us to let the Hospital know, “Look sorry we go to bring in some animals here, tough luck this is what's happening.” But because she had to take on responsibility and with that responsibility, she took on that ownership, and then got better from it a lot quicker.

On conflict

It was usually my peers that always wanted, but I think they got used to me and see me as the mad one that just does mad things. [Laughter] I had found over the years, I frequently had, when I did the Clinical Nurse or the Deputy Charge at the time, you know 'cause it all changed names, that had staff assigned to me that was so-called difficult. They would always challenged me on things, but I didn't mind because as I was debating with them, we developed an alliance ...Through these verbal challenges we then developed this alliance that, they didn't challenge me anymore, they just simply went on and did the thing, and I didn't have to worry about them, they would go off and do the work. So it became then the challenges, I used it as promoting team cohesiveness, I was never felt challenged about the challenges. I found it a challenge for me to think on my feet and to give them the rebuttals.

So it was more a bring it on challenge, rather than I don't want this challenge. I think I developed a reputation after a while, don't bother her, 'cause it's not gonna get anywhere. [Laughter] You never know what people tell behind your back. But I certainly got a bit notorious there for a while, yeah.

Worst things?

I think what is still bad and I still see it, is, it's a very difficult thing, and I still currently see it at the moment. Not so much in the older person unit because as peers we tend to be of a similar calibre. But I do see it in other areas, it seems to be more pressure, and more strain on the expectations of outcomes and performance of staff that as a consequence, it makes it difficult for them to be a little bit more creative and it makes it more difficult to, for them to think things through. And it's because of this burden, and it is my campaign at the moment, I never stop with campaigns, it's my campaign (55.29) at the moment it's the duplication. Although we've gone to the simmer system, which is that fully computerised system, there's still paperwork happening, and it's duplication and there's no need for it. When I did the CL work, 'cause that was just my own, everything I had, I did fully e-charting, I had no chart at all, I just e-charted everything and anything that had to be hard copied of, I sent it off to Health Information for filing. I will not have a chart, that's the whole idea. And I found it saved me time. And because I, in nursing homes, a lot of them are fully electronic charting now, and I've seen the positive effect of that. It was clumsy at first for them to get rid of all the paperwork, but they did it, they got rid of all the paperwork, and it's all electronic now, and they got a much friendlier system I must admit than Queensland Health has. [Laughter] Queensland Health system, the principle was good but the system is so cumbersome and it's so pedantic, but it's typical Queensland Health. I was able then to log in at the facilities, they all gave me a password to log in, and I was able to print off my notes and all I had to do was then. So they had an electronic version, all I then was took it back, signed it, scanned it, put it in my Simmer that was my notes done for Simmer, and then sent it off to Health Information for filing; that was it. So it saved me a lot of time. I was able to shave a lot of time off that way. The staff now, in the system, they've got to do paper charting, still got do electronic, a lot of them in community are doing a lot more electronic, they're starting to get the hang of it now and starting to realise that yes it does save time, and if you're stuck somewhere else, you don't have to worry about your chart 'cause you can just
log on. ‘Cause sometime I have to sit in a ward, when they’re picking up a patient to take back to home and the get delayed, so instead of twiddling the thumbs thinking I could do some charting, they can do that now ‘cause they can just hop on the computer, log in and do their charting on their way. But in the wards, they’re still very fixed on paper charts, which as a consequence, you get these gaps from your electronic chart to the paper chart and they’re not talking to each other. Now it’s not too much a drama on the older person cause the turnover is slower but in the Acute, it’s a faster turnover, never mind all the paperwork you got to do when they come in. And it’s that deluge of paperwork that’s been put in when a person comes in, even for one night, I can see why it’s stressful and annoying for the staff. I honestly believe if most submissions, you get an idea of whether it’s long or short term and if you only have someone that only needs to come in for an overniteer because they’re in a crisis, it only needs to have one form to say they’re in, why they’re in and what their current meds is but that’s it. There shouldn’t be anything else. But they expect you to do all these other things, and yeah I can see why the staff get annoyed because all this paperwork, and they’re out again the next morning, we need again to do all this paperwork. This is where that bureaucracy comes in, that’s why I think people might end up in mental health celebrate, they don’t have this I know that. So I think for us we really need, I’d like to see more of a push to get rid of the paper charts, just get rid of it and go fully electronic. Increase your terminals and make it fully electronic, that we’re all forced to go on it. Sure it will have its teething problems, sure it will be difficult at first, but like anything else, after a couple of months ...People will just do it, and then they come to realise how much time it saves. So that, it’s the changes processes that Queensland Health doesn’t do well. I still also see some of the older nurses have been in one area for a long time and the sadness is, they do stagnate and they do dig their heels in because change for them becomes far more challenging. I don’t think they don’t want the change, I think they’ll feel so challenged about the change, and that it’s more difficult for them to do. That can be very labour intensive for the change agent, very labour intensive. Historically, some of the bad things were the physical abuse that I’ve seen, that is certainly, I can’t say that it’s eliminated, but it’s significantly gone down. The ABM training that they do, the de-escalation, because in Queensland we have the 5 day for de-escalation, and the idea is that you prevent the actual physical side, you get in there early. So, it’s getting a little bit more proactive in nip it in the bud early thing, spend time with your patient, but that’s in conflict with expectation of documentation. If even in the community for the posit, it’s the expectation of the posit. I know a lot of people haven’t done it, and why haven’t they done it? Because they haven’t got the time, because the caseloads are so humungous. We’ve got to give them credit; they see clinically the priority first as a first priority, whereas admin is a low priority. To change the shift in focus and say, I’m sorry you’re gonna have to snip a bit off your clinical fund, to give you that. Okay so more time for admin focus, that in itself is going to be difficult ‘cause again, it’s a cultural shift. I know some case managers have clientele that I feel they are a little bit too over servicing, they find it difficult. And this is part of our Health Care role, that we can fall in that maternal/paternalistic trap. And some of them have fallen in that trap, and I think that’s where the blessing has been for me, having so many roles that I’ve learnt not to fall in that trap. To be able to say, “No you will find your own way. If you can find your way to Greasy Joe for a meal then you can find your way to come to the help class for your meal. Even if it’s on foot, you just get up a bit earlier and do it a bit earlier.” “I’m happy to give you a ring, a wakeup call and say time to get up and do it, but that’s as far as it goes.” Whereas other drive around and do all sorts of things. However, there is merit to the driving around, because it’s a captive audience and they can talk to them. [Laughter] So there are pros and cons. I don’t know if I answered all your questions.

On humour

Oh I think it’s lovely. I have no problem, because I think it personalises. I remember reading one time an article written by a consumer, that gave a little bit of insight into personalising ‘cause she was talking about case management and all they do is give that clinical focus you know. Come for a clinical visit, have you done this, have you done that, just like doing the old patient rounds on the wards. And she said, “But I’m a person too.” She was trying to say that in her little story, I can’t remember it all but I
remember it well. She said, “Although I make mistakes, I’m still a person, and why don’t you just simply come and talk with me.” So I think it has value in that, and it is valuing the person as a person. It allows us to shift the focus away from them as a patient and brings into focus a person, and it re-valuates them, it helps them with the valuing process as a person that I can be (1.04.45) to. And I’ve done it myself, and I’m even now back in the unit. At the dining room because it’s a small unit, I quite often try and get them to engage with each other, and then occasionally we’ll throw a crack at each other as staff, but then patients get involved too. Some do get involved from the table, come up with some real pearlers, and it gets to be light. I’ve been known to get up and dance and do all sorts of funny strange things, but just seeing the smiles on the faces, you can see them think, “Oh look at that mad thing.” But it lightens the load, and I find I lightens the shift, takes away that seriousness that doom feeling, it lightens the shift. And I find the patients are far more receptive and you get a bit more of a human value to them. So there’s room for that, and I think it’s huge part of our holistic approach, we got to look at all the little snippets and bit and pieces.

Why do you stay in Mental Health?

Because I enjoy it. [Laughter] I enjoy it; I don’t think I would have it any other way. I’m not a desk jockey and I think it’s the variety, and although you have a wonderful day planned whether in the community or in the ward, all it takes is one phone call and your whole day changes. So you got be on your toes, it promotes that ability to be flexible, to be able to change, to keep your smarts, not smarts, your sharp, on your toes. And it’s so grey, it’s not just black and white, there is not right or wrong, it gives flexibility. Probably why I’ve been in it for so long you know. [Laughs] It’s very diverse. I’ve had when I facilitated, some Under Grads when they do their 2 weeks of tourist duty, as I call it, ’cause that’s what they are, bug-eyed tourists, poor fellas. I’ve always taken on the approach to assign them to an area for the 2 weeks, but then pluck them out for a field trip here and there, so they have got some continuity of an area. But as the same time, give them exposure of different areas, so they get the feel of it. “If I’m gonna have to evaluate you, I can’t’ do it if I give you a day here and a day there, you’ve got to have some continuity to work with.” I found their feedback is they quite enjoyed it, but also, the feedback was they didn’t realise how big Mental Health really was. Most of them thought it was just a ward like an orthopaedic ward. No, this is quite diverse. I think it’s probably one the most diverse areas of Mental Health and it’s still a growing area. Even at the conference, learning about the synaptic activity and actually giving it a bit more of a structural focus to it rather than a mystical focus. It’s just wonderful to see so many changes made, and we’ve still got room for pioneering...I love to dabble into something new and different, put something together and then pass the baton on and go elsewhere, no trouble with that.

Denny Cowell (as remembered by Tania Yegdich)

Position: Nurse Educator (Deceased)

On being nominated [far reach of influence]
Oh, I can tell you. Well, I think he knew he was a brilliant teacher. He knew he was the most un-neurotic man alive, and I think he was actually. He was very humble. He wasn’t arrogant but he knew he was good. I think he helped a lot of people and he’d been around a very long time of course. And it’s not so much that he wrote or published or there’s not an artefact that you could pick up of Denny’s, but you’d never forget him. And I think really he was just this package that once you met him and if you were a student of his, well there probably might have been some students that didn’t think much of him but that’s all right. On the whole, most people who’d been taught by him would probably carry a bit of Denny Cowell in their heads, “Now, what would Denny do here?” and I don’t think it was ever anything that he’d ever published, ‘cause there wasn’t much. But really, what he gave was so much more of greater depth that people took a piece of him and I think that made people feel good about themselves, good about the profession and confident in whatever it is they were doing in mental health nursing and I think that’s remarkable on his part.

**On becoming a mental health nurse**

He was from the working classes and I think he’d like to have been in medicine. He was very interested in that but he couldn’t get in or whatever and he came into nursing later in his life and he went into general nursing in Concorde in Sydney and while he was there, I don’t know how, but he got interested in psychiatry and he went over to England and he would have been one of the, he went over in 1959. I was two and he did his psych training at the Maudsley which, back then, would have been really something. I’ve got his old vellum certificate, you know. It’s beautifully done with water colours and everything, gorgeous thing and he probably was one of the very first people to ever have done that because people didn’t travel in the 50’s and he went over by boat. It took him three months and somewhere along the line, I can’t remember if it was in Concorde or at the Maudsley, somebody asked him to do a lecture and he did and he just said, “Wow.” [Laughter] I remember him telling me this and he just came away from that thinking, “Wow, this is for me,” and he decided to be an educator and I think he did his Dip Ed or whatever it would have been back then. And he was a painfully shy man for all of it, a very private man and he used to tell me stories of how he forced himself to face crowds, because he hated that, but he’d practice in front of a mirror to get the lecture right [laugh].

He shied away from any publicity. He’d have been amused by all of this but he’d have done it. “Oh yes, of course, I must go along.” But he just had that sort of superb mix, I suppose, of shyness and humility and yet, having something to say and wanting to say it and he could present it across quite, I think, with a lot of presence. So people found him rather memorable and they are the same people that would get this voice, Denny’s voice, and, “What would Denny do here? Oh, I know.” I still hear it today, six years down the track, people say to me, “Don’t you remember when Denny used to say blah, blah and blah, blah,” and sometimes I do, sometimes I don’t, but yeah. When he found mental health, he just fell in love and when he, it was just serendipity again, somebody said, “Give a lecture,” and despite that crippling shyness, he just loved it and, “This is me. This is what I want to do for the rest of my life,” and he did [laugh].

I think he was there a couple of years. He couldn’t afford to live there, nobody could at that time. He found his first wife there, Kay, married her, brought her back and started a family. He went down to Sydney, because he was originally from Sydney, and I think when he was around 40 he decided, he worked in Parramatta, I think and I think he was, like what would they call it, like the manager of the education. I don’t think he enjoyed doing that at all but he was probably the most senior person and around in his 40’s, very early 40’s, he decided to come here to Brisbane because he said to me, he looked around at his colleagues and he said the pace of Sydney was so horrible that people were dropping dead around and he thought, “Bugger it, I don’t need this.” So he came up to Brisbane and he started his life again in his 40’s here and he came here to the Park and he was here until he was 60. Then he retired and his wife died at that time and after he retired, he was bored after three weeks
[laugh] and he got a job in the prisons just up the road working as an RN. He didn’t care for that much but he really didn’t know what to do and eventually we got together and he went into education again because he could never really stay away. And he spent the remainder of his career at the Prince Charles Hospital. I think he was there 10 years and I think he was probably the most happy there, much more happy than he was here where there were a lot of local politics at the Park. Whereas at the Prince Charles Hospital he was surrounded by women [laugh] and I think he rather enjoyed that and ‘cause they just doted on him and thought the world of him. They valued him very highly.

Anecdotes

Oh, gosh. I’d really have to think about this.

Most significant moments

What would he say? Well, he wouldn’t say what you’d expect, which would be stuff like the awards he got.

I think, secretly, he enjoyed that but publicly he would sort of say, “Who cares,” and I think what really would thrill him when he’d get a free dinner out of something. Like, he was made a member of the Royal College of Psychiatrists and all he could think of was the free dinner in Adelaide [laughter]. He didn’t really much care about the rest but I think secretly he was quite pleased but whether, if he didn’t get them, he wouldn’t have cared either. So it’s stuff like that. Look, you know what I think? I think he would say is… remember when we had Brian Austin here as the health minister and Denny was always fighting for mental health nursing, always trying to get politicians, I suppose, when you could talk to them, this was in the 80’s, talk to them about what needed to be done and that and I don’t know how it was but he’d sort of be one of the people that would talk with Brian Austin, and he disliked him intensely, I might add. But I think, if he could ever get a point across and sort of win the day, I think that made him extraordinarily happy and I don’t think it was anything to do with winning or being better but just getting the point across, “Well look, nursing needs this,” or “Mental health needs that,” and I think he felt very, very happy about those things. Probably, off the record, when Brian Austin was in prison and Denny nursed him there, he was extraordinarily happy over that. I think he probably got his own back there because Brian was very difficult. But I think it was that and the college work he did and he was one of the founding pioneers, I suppose, and he’d organise the conferences and he’d be part of that team and I think that really made him extraordinarily happy and I think he believed in the college in terms of this is the voice for mental health nursing. He liked that whole idea that there was this organised assembled bunch of mental health nurses. I think, for him, his best moments would have been having knowing he did a really good lecture and walking away thinking, [laugh] “Shit, that was great,” and not with any sense of entitlement or arrogance. Just, “Gee, that was good.” I think it would have been that sort of stuff.

Worst moments

[Laugh] his moments with Brian Austin [laughter]. Well, I think fighting with bosses too. See, he didn’t have that at Prince Charles. That’s why I think he was so happy there although it was a much more modern world, too. But when he was here he constantly, I mean you would know, educators always have to fight with their directors and managers to get people released for education and all that and I think that really pissed him off. Anything that he saw that was unjust would have made him cross. Seeing people promoted that should never have been promoted, things like that. He was a very easy going man, very forgiving. I suppose he was forgiving. Is that the right word? He’d just work through things.

He stayed in mental health nursing, really to the end of his life, didn’t he?
Oh, yes.

**Why do you think he stayed?**

He loved it. He loved it.

I think he loved teaching. I really think it was that; it was first and foremost. He just loved teaching. He had one of those photographic memories, although it was waning as he got older. But he could just remember things and absorb things and he could sort of analyse things and make them his own and I think it gave him great pleasure to be able to tell students, or whoever came, the sorts of things that he knew about, the insights that he’d had. And I think it just really, it just made him happy. It just really made him happy. The people contact, I guess, look, he could have taken or left that. I think it was just the whole fact that he could take something that was complex and put it into everyday language and he could see the lights come on in people’s faces. I think that just absolutely made his day and of course for himself, the stimulation. I mean, he never stopped reading. He had favourite things he read. He read everything but there were favourite things he liked to read, like schizophrenia and suicide. And I guess he was on a mission too to solve the mysteries and I think he was just absolutely driven by pleasure and curiosity. I think it was just the curiosity. He knew he was dying and he obviously had choices. We didn’t know how long he had.

**How did he die?**

He died of cirrhosis, although I hasten to add, as did he, that he didn’t drink. So one of life’s unfairnesses, I suppose. But he didn’t even know he was sick, actually but anyway. No, we didn’t know how long he had but he did have choices. He could have left and travelled or what have you. I knew he just wanted to do what he was doing and before we knew about that, he always used to joke that I’d go before him [laugh]. It was a bit of competition for him [laugh] and I never argued and he said he wanted to die with his boots on and I think that’s exactly what he did do. He just kept teaching right up until the last moment and three weeks before he died, he went into hospital and he never came out and I don’t think he expected that. He was still planning and plotting for the next year’s intake; that was in September, but it was pretty clear that that wasn’t going to happen.

**It sounds like you’re very proud to have been so close to him?**

Yeah.

I think it was one of the most ... [Tearful] I was very, very lucky. Very lucky that he came into my life; that he was in it for so long. That’s just incredible, really and he was just a really great person and no, there won’t ever be anyone like him, that’s for sure. And I can’t talk about him without crying, so don’t worry.

I just can’t.

I just feel enormously grateful, just enormously grateful and when he died, it was just horrific and I think the worst part was just, I couldn’t imagine a world without him. It was just unthinkable in a sense because, for all of my adult life, he was always around. I wasn’t married to him earlier on, obviously, but I could just always call him, always talk to him. We often had contact and he was just there for so long [laugh] and I think a lot of people felt that way, people like Judy and lan who had worked with him here. It was hard for all of us just to think of life, just the world goes on without him in it. It’s just so hard, yeah. But yes, I just feel grateful. Yeah.

I still can’t do it. I still can’t talk about him without this [tears] but that’s how it is.
What would he think of mental health nursing and where it's going?

I think he had been worried about it for some time, actually. I think with all these changes and the national registration, I don't think he'd be against that. But I think the death knell of the endorsement and all of that, I don't think he'd have approved of that at all, because I think it was largely due to Denny that we kept endorsement in Queensland because he was at the forefront. See, he was a fighter in those days and I remember him telling me how he was virtually treated like he had the plague by the general nurse, our general nursing colleagues, “Who do you think you are?” But he was one of the few people, actually who argued against going into academe because he always predicted, if you did that, we'd lose the profession. And not only that, we'd have enormous recruitment retention issues and all this. And of course, everything he said turned out to be the case. I think he would have been just absolutely appalled. I mean, if we lose endorsement, then we're finished as a profession. He'd have been appalled by that because his whole life work was about being recognised as a profession, as an independent. That was his whole life work and that's what drove him, so yeah, I don't think he'd be real happy [laugh]. I don't know whether he'd do anything about it, you know. He was 73 when he died so I think he'd sort of say, “It's for the young ones now.” Where is it going with the recovery models there? Well, I wouldn't mind saying he'd still say, “We still haven't got it right. We've just never got this thing about nurses talking with patients and being with them. Really, we just haven't got that, we just never really. We say we do, but we really haven't done it. We really haven't got that right”.

What do you think?

I would agree. I don't think we've ever got it right. I really do, and I don't know what it is. I've spent years thinking about it and I don't know what it is. Obviously, there's defensive behaviour there. But we talk about the recovery model, so the therapeutic paradigm again is overshadowed. And I've got nothing against recovery, but recovery can't take the place of therapies. It doesn't do that. You need more than just recovery. Yeah, somehow we just, I don't know. I don't know what it is. Whether it's an organisational system thing. Whether it's, we just don't want to get too close to that because we know it's an emotional burden, we know that, whether it's that. I was looking at something the other day, the newer more contemporary mental health courses and I was just absolutely appalled because it had all this stuff. It was all organisational. How to take a patient to the canteen [laugh]. Well, it wasn't quite like that but it may as well have been. And I'm looking at it and I'm thinking, “This is all great if you're grade one,” and yes, there was assessment and there was sort of recovery and there was sort of interventions. But again, there wasn't this sort of long distance thing with patients and talking with them and just getting to know them and going on that journey with them. It was, “Let's get you to the bus station. Let's get you on recovery. Let's get you sorted out here and sorted out there,” and I'm not against any of those things. But if those things take central stage, well you've lost everything again. And I think that kind of alarms [laugh] me, in a sense, because I don't know if it's me being old fashioned or gee, I'm just not contemporary enough or whether we are moving. Although, we're sort of articulating our tasks better, they still are just tasks and it's all this process kind of, not even process. Look, it's just that organisational stuff, rather than the being with the person.

It just doesn't make sense to me and I don't know if I'm losing it and dementing slowly. But it's possible [laughter]. But to me it just looks like gobbledygook and I went, “This can't be contemporary. Excuse me?” So, yeah, I don't know, I don't know. The loss of the profession is not something to scoff at, obviously, and I don't really know what to make of that, quite frankly. I think, “Gees, have we all just been that complacent, we didn't give a shit,” you know? “Why didn't we fight this,” and I'm as guilty as everybody. I don't know.
I don’t know what the solutions are. I really don’t but it just seems to me, although the paradigms are irrefutable, you can’t argue against recovery; you can’t argue against integration with the community, all that shit. You can’t, but somehow, I don’t know but I think we’re less friendly to patients [laugh], you know. We’ve got patient rights now but we’re less friendly and I don’t know what that is. I just don’t know [laugh]. Yeah, no it's interesting, it’s interesting. It will be interesting to see what happens with national registration and whether we do get to keep some sort of register or not, I don’t know.

I’d like to think we would. But we have been a bit complacent, I think and I’m not sure why we were either. We were all so exhausted we never got around to...[laugh], but it’s interesting.

Chris Dawber
Current Role: Consultation Liaison Nurse, Sunshine Coast and Wide Bay District, Nambour Hospital

On being nominated [ inspirational role model]

Maybe they were good friends that nominated me [laughing] but I would like to think that it’s to do with the humanistic, holistic perspective that I have on mental health care, and in regards to nursing in general. I recognise that the concept of 'caring', not just in mental health nursing but nursing as a discipline, has in some ways been undervalued. Some of the things that make us good nurses are not necessarily those things that make us specialised in our particular clinical area. There are key personal factors in nursing that I can compare best, I think, to psychotherapy: where the non-specific factors like alliance building and instillation of hope, and the way that you work with people, are some of the best predictors of outcome. I’m a great believer in that and I try to promote the importance of those things: compassion and hope and communication: in my work and with my colleagues as well. I aim to support them and have compassion with them as well. So it’s not just clients, it’s not about us and them. We’re all human beings. One of my great heroes is Irvin Yalom, who says “We’re all just fellow travellers on the journey of life” and that’s the way I like to see it too.

A group of us - myself and two others, Barb Bowler (a Mental Health Nurse Educator) and Kylie Garrick (who is a Psychologist), started up a peer support network in the Redcliffe Caboolture District. We are trying to do something positive for our colleagues. I would like to think I have always tried to help my colleagues; offering debriefing or supporting them at times when there’ve been critical incidents. I’d like to think that maybe I’d been nominated for this project because of that side of things. I’m not necessarily a great academic or an especially skilled clinician, not necessarily more so than other people, but I think that I have a really strong focus on the human side of mental health nursing. Plus I’m a little bit quirky, a bit sort of different and a bit of left of centre, and I have a very non-medical approach. So I think that can be something that's helpful in making you stand out a little bit when you're working in a workplace which is predominately driven by the medical model... and I think psychiatry, unfortunately, is becoming more and more medically oriented. So those are some ideas I have about why I might have been nominated [laughs].
What made you go into nursing and how did you do all that?

I fell into mental health nursing by accident. I was 18 at the time. I’d sort of taken off from home and I was living in Melbourne in a one bedroom townhouse with about five other kids. One of the girls I was living with took me with her and her parents, when they went to see her Great Auntie, because I wasn’t doing anything. Her Great Auntie was in her nineties at that time. She said, "What are you doing for a job?" and I said "I work in a pinball parlour". "Oh for Goodness sake, why don’t you do something useful with your life?" she said, then added "Now my husband, he worked as a mental health nurse and he worked two on, two off. They pay you to train and you get 6 weeks holiday a year". I thought that sounded pretty good so I actually went in and put in an application. A few months later I had an IQ and aptitude test and, because it was a while before the next nursing intake I was asked to come and work as a ward assistant. So I really did kind of fall into it by accident, not unlike many others I’ve since found out. That was in the early 1980’s, in Victoria. I did my training at Royal Park Hospital which was the first accredited psychiatric hospital in Australia and there were some people, working there at the time, who were very influential on my professional development. One in particular was John Watkins; he had a tremendous influence on me. He had some very interesting alternative views of schizophrenia that really grabbed my attention. He has now become an extremely positive influence on the understanding and management of Schizophrenia of from a holistic framework.

We did quite a lot of alternative stuff back then, you know, in a number of areas of psychiatry: working with psychotherapeutic modalities as well as some cutting edge biochemical treatment regimes. There was a considerable amount of tension and reflection prompted by these different approaches to treatment. I worked in the John Cade unit, most people know John Cade for developing lithium treatment. It was probably the first of the modern mental health admissions units in Australia. After my training I went and worked in a private psychiatric hospital, the Melbourne clinic, in the psychotherapy unit. I worked under Dr. Brian Muir, a psychodynamic psychiatrist who was a leading expert in developing therapeutic communities in the UK and Australia.

Then I left nursing for a little while, probably about a year or so, and went to New Zealand where I’m originally from. When I came back to Australia I returned to mental health nursing and had the opportunity to work in a range of different clinical areas. I found I was particularly drawn to acute psychiatry. I worked in a rural mental health facility in Victoria and I continued to see that there was a lot that could be done outside of the medication that was being given to people. I started doing more and more group activities with patients; taking them on outings or even just going out into the hospital grounds and doing treasure hunts, anything that was kind of different or stimulating. I used to involve the staff in these activities as well and they started to get excited, they found it really stimulating too. It’s more fun coming to work if you can do things that are uplifting and rewarding, and know there is a therapeutic benefit as well.

So after about a year, I started developing a group activities program. We did a lot of relaxation therapy, stress management activities and interpersonal communication skills training. We did art therapy and music therapy. I developed psychotherapy group, in conjunction with a psychologist who did sessional work for the Group Program, which looked at the impact of illness and hospitalisation. I had a great team working with me. It was a highlight of my career. I’ve since found out that other people were doing similar things at around the same time, but kind of in isolation - not realising what was happening elsewhere. It was synchronicity, of a sort, on a nationwide level; a phenomenon I’ve noticed a number of times since.

After the group program we had carefully constructed was abruptly scrapped, a victim of Victoria’s economic rationalism during the Kennett era, I went to work in child and adolescent psychiatry. I completed post graduate studies in Developmental Psychiatry through Monash and Melbourne
Universities, and helped set up the Gippsland CHYMHS service. There had never been a locally based child and adolescent service in Gippsland up until that time, so this was another challenging and stimulating chapter of my professional life. I did that for a few years and then went to work in a small, integrated rural mental health service in East Gippsland. I worked as a senior clinician and developed my interest in critical incident stress management and disaster recovery work. In smaller, rural communities you need to form close links with a range of other professionals and agencies. You need to be able to put your hand to anything for anybody. I did a lot of police liaison and training. I went out into the field with them a lot and ended up in quite a few fairly traumatic situations myself; bad luck or bad management in some cases [laughs]. This personal experience further developed my interest in support structures for nurses and their mental health colleagues. If we feel supported during times of crisis and stress, and cared for and valued, then I think that helps us to be much better clinicians for our patients. I think that should be a much higher priority for health services. So I remained in that job for quite a long time, just over 6 years. By the end I was in a sort of shared the team leadership role - clinical leadership.

I moved to Queensland in 1999, so about 10 years ago. I worked in an acute care team for the first 6 or 7 years. Once again, I developed a police liaison role and was involved in mental health education for first year constables, and also in the training that accompanied the role out of the new mental health act. I moved into consultation liaison psychiatry about 5 years ago, and so that is sort of ‘my latest thing’ at the minute. I went back to Uni. and did post graduate studies in psychotherapy at UQ; I’ve got 12 months to go to finish my masters. I also completed my masters in mental health nursing at USC. I’ve become an accredited trainer with the Critical Incident Stress Management Foundation of Australia and am heavily involved with Clinical Supervision. So that sort of brings you up to date with my career.

Yeah, I’ve been lucky really to have the opportunity to do the things I’ve done, and I think they’ve all really gelled together and helped to keep me enthusiastic and motivated. It’s kept the skill levels up too, because they’re transferable skills that keep developing and getting added to. The stuff I did in child and adolescent has really helped me, I think, in my work with adults. I like the idea of coming up with formulations and putting a bit of thought into the grey areas. I think there’s a lot of pressure on us as mental health practitioners now to provide a diagnosis immediately. It’s just so easy to say, “Oh they’ve got depression” or “They’ve got a personality Disorder”, but there’s always so much more. It tells you about that person, and that person’s experience of what they’re going through. It’s just so easy to say, “Oh they’ve got depression” or “They’ve got a personality Disorder”, but there’s always so much more.

What was it like when you first started?

Well, I’d always been a little bit unconventional in my dress sense and one of the first things I remember, during my initial week of work, was turning up one day dressed in camouflage pants and a t-shirt, and one of the other staff members refusing to let me out of the locked ward. I don’t know whether that incident helped me to identify more with the patients [laughs] or not, but I kind of always had the sense, even in those days, that, there but for the grace of God go I, or any of us. But at the same time it is kind of reassuring to think that, if that is the case, well I know from my own life experience that a person can do something about this, you can help yourself, or someone else, work through it. There is reason to be hopeful, genuinely hopeful for anyone - even if they’ve got a really debilitating form of schizophrenic illness. There are things that can be done to improve quality of life and to help personal growth. And so even in those early years as a young person and quite naive and immature, working in the mental health area taught me that everyone’s different but we’re all fundamentally the same.

Back then, like many of us, I used to hear other people going on about the old days and I used to think, "Yeah, yeah whatever." But I think there were some really good things about that particular era in
Psychiatry, the late 1970's early 1980's, because there was a lot going on that was new, and there was
great debate between biochemical and functional models for understanding mental illness, and the anti-
psychiatry movement was quite vocal. We considered and explored and experienced different types of
therapies during my training; even Reikian Therapy, Gestalt and Primal therapy. They all had something
to offer and the different frameworks for understanding personality and psychopathology encouraged
lateral thinking and reflection. In the end, not all approaches may have been able to establish a
convincing evidence base, but I think having an understanding of a range of different models and
approaches, and being able to apply them in response to the individual client's needs, is a really helpful
thing. Well it’s been good for me. I've gone through stages of feeling a little jaded or cynical about
things but I hope that now we might going into an exciting new era. It would be great if things were to
become more progressive again. I think that mental health nursing is a profession that has been
undervalued in the past, but I can see that there is now a change, driven from within the profession.
People are starting to realise how important our role is and how it kind of holds everything else together
in the clinical environment, well that's my explanation anyway.

So you know because of that belief I still feel really useful and positive about the job now, the same as I
did back then. Although a lot has changed over the years, in a way nothing’s changed for me. I mean
there are times I've been in danger of burning out, but I’ve always had the conviction that there’s so much
that we can do as nurses, and we're really in a privileged position, that's how I see it. Thousands of
people have told me personal things about their lives and their intimate secrets. They have trusted me
enough to do that and I should, I have to, respect that and honour that. I’d just like to see that all of us, as
nurses, maintain that level of respect. In fact, I think upholding a caring, holistic nursing philosophy is now
more important than it ever was.

On early student days

When I did the basic mental health nurse training, it was 3 years, although I had to do an extra half year
because I mucked up too much [laughs]. But I remember my training being very much focused on building
interpersonal skills. Sure, we did all our A&P and other subjects we needed to know in order to become
a nurse; medication competency, enemas, taking obs. etc., but we also did a lot of stuff around
interviewing skills, listening skills, basic counselling using the Egan model, and dabbling in different types
of therapies. We used to do a lot of experiential learning. For example, we would actually participate
in therapy with therapists from Gestalt or Psychodrama backgrounds, we went away on residential
weekends where we joined in group work, or we would go to see an interesting movie on mental health
and then discuss it. During our placements we would be supervised, but we were also given a lot of
responsibility and autonomy I think. The downside of that I guess was that maybe sometimes you ran the
risk of getting into situations where perhaps you could potentially be out of your depth. But I found that
way of learning very stimulating. At Royal Park, many, not all but many, of the staff seemed quite
progressive, very interested. It wasn't just our facilitators or the Charge Nurse. Other staff would say,
"How you going with this situation" or "You seem to have spent a lot of time with that particular patient,
what are you doing with that time?", or "What is it you are achieving through this intervention?" I need
to be a little bit careful about seeming to paint an idealised picture. Of course students were also
exposed to bad practices there, the same as anywhere else. But on the whole I looked up to many of the
people that worked there. Maybe part of this was because when training, many of them had also gone
through the therapeutic community, through the unit for newly diagnosed psychosis (which was the
precursor to the EPPIC early psychosis program developed by Pat McGorry). The newly graduated
nurses who stayed on at the Hospital had also had all these different experiences too, and this helped
them to be good role models I think. There were still the old cynical, burnt out "bin nurses" there as well,
although some of them were good at their jobs, in their own way too. There were ones that were
malicious at times; treating patients punitively or with excessive force... and at times that needed to be
confronted. I remember a couple of instances where I actually got up and said something, or tried to stop
it. I might get support from a deputy charge nurse who’d say, "All right, well if that’s the case, we need to do something about it" but there were other times where they’d say "Shhh, you’d better not say anything or you’ll get into trouble. It could affect your career”.

So my training was really an apprenticeship, very much so, and I personally think that was a good model. I guess the risk relates to who you’ve got providing input for you. I was lucky, I had a lot of input from really progressive, interesting people whilst at Royal Park; Dr. Nicholas Keks, Dr. Pat McGorry, Dr. Bill McLeod, John Watkins amongst others, and Lee Hunt who was another good educator and who’s door was open. My educators gave me a bit of slack when I mucked up, I guess they saw something in me that they believed in. We had a good group of students in our group. I don’t know what they’re all doing now but we all supported each other at times, we had some challenging, but also interesting and stimulating times. I think I was lucky.

Any anecdotes?

I remember there was this one incident in a locked unit, that might seem quite comical now but wasn’t at the time. This woman was being kept in a seclusion room. When she was manic, she could be irritable and aggressive at times. She was knocking and slamming on the seclusion room door, "I need go the toilet, I need to go the toilet." So I’ve opened the door and no sooner had I got it open when this hand came out full of faeces and wiped it straight through my beard. Of course, I was taken completely by surprise. Part of me was thinking "What the heck am I going to say?" I didn’t get the chance to say anything much because she commented, "Come on, what’s a bit of shit amongst friends." [Laughing]. My colleague wasn’t much help, he just burst into laughter - that was all the support I got from him. I headed off to the showers quickly.

On reflection, this story raises a number of issues. Despite what happened to me in this incident, I admired this woman. People react in a way that is relative to the way they are treated. She remained defiant. The use of seclusion has thankfully changed over the years.

It also illustrates the different traumas that nurses might be exposed to in the line of duty. I have been in a number of life threatening traumatic incidents, but for some reason that incident always comes to the fore. I guess we all have to expect shit sometimes in life but nurses are often required to deal with someone else’s shit

There have also been some very poignant times, times where I learnt a lot about human suffering. I remember one young chap during the early 90’s who could become quite psychotic. He was being charged for holding up a corner store with a table fork, or something ridiculous like that. He was going to jail because it was deemed that he wasn’t psychotic at the time of the offence. He was talking to me about jail one day, very distressed. "I don’t want to go because I know what’s going to happen to me if I go there." He starting crying and he grabbed me and he just kept holding me and said, "I just don’t know what I’m going to do". I stood with him for ages. His despair was overwhelming. I couldn’t help crying as well at times. I felt powerless to stop what was happening to him. All I could do was witness his despair, maybe be a container for it. I let him vent. When I think back on that, I imagine people say, "Well that’s wrong, you were losing your boundaries" or whatever. It’s something that always sticks in my mind. It made me realise that I couldn’t solve everyone’s problems, but it also made me realise that every little bit I give might help in some way. Sadly he eventually shot himself some months later. We did what we could to try and help him deal with having to go to jail. I guess he had just made a decision that he didn’t want to face things anymore, you know.

All psych nurses could tell you of many similar intense emotional experiences they’ve had, about amazing people that they’ve met. I guess some of us might become a bit blasé and complacent about these, but
each of us could write a book. Because you’re faced with life and death and human suffering, you share
a range of intimacies with people; times like these ones that still live with me over twenty years
later. You need to find ways to deal with this. Despite the apparent grimness of incidents like these, I
don’t find my job depressing. It is a privilege.

And there have been many uplifting times as well. Yeah, other times spent taking patients on outings;	absailing, white water rafting, times when we’ve just sort of got people to experience life and living.
Seeing people who are quite severely disabled just really coming out of their shells: Sharing these kinds
of experiences, connecting, or just playing music, telling jokes, singing songs. Establishing a connection
and then sustaining that and really feeling that there had some kind of personal growth experience for
each of us that was involved. And the growth was not because of mental health issues and not regardless
of mental health issues, but a combination of both. We were there in that place, at that time for that
reason, because they were clients and we were staff, but in the end it was the human sharing that might
have been the most important thing. I’ve had some great times like that.

Best times?

Some of my best times have been the work I’ve done with groups; I really enjoy working with groups. I
think groups are a very powerful medium for therapy but also very complex and you need to have a
good understanding and grounding in principles of group dynamics and facilitation to make the most of
that power... because it can also become a destructive power if it’s not handled properly. Some of my
most rewarding group experiences have been during the transition groups that I used to run for clients
moving out of case management. The groups aimed to help them assume responsibility for their own
care; they were becoming their own case manager. We sort of put it to participants as that, learning
how to case manage themselves. It ended with a graduation ceremony. That was really powerful. I’ve
had some other great experiences with groups like that. Reflective practice groups for nurses,
particularly the work I’ve been doing over the last few years with midwives and nurses in palliative care
and critical care settings. Sharing in the wealth of wisdom those nurses possess, and exploring that
unacknowledged experience, that knowledge that people have that can’t be learned out of books. It’s
not from university; it’s through experiences like those we’ve been talking about, life experiences and
experiences as a nurse. Trying to separate our professional and personal selves is artificial and
unachievable, but that’s what we’re encouraged to do - in the end they both inform each other. We just
need to remain aware of their relationship to each other. So that’s really been a highlight for me. So
has been my time working with groups of people in disaster recovery areas, like with the sea spray
floods in 1991, more recently with the storms here in southeast Queensland, and during a number of
other disaster situations. You see this tremendous resilience in human beings which, if you are able to tap
into it and enhance it, is tremendously uplifting for everyone involved, including yourself. Groups can also
be very effective in what might be seen as quite oppressive, non-conducive settings like inpatient mental
health units. They actually allow us to facilitate the formation of cohesive relationships between people;
sometimes patients, but also staff members. People start to work together, they form alliances. That is
tremendously rewarding for a facilitator, and it’s been great experience for me. I’ve also really enjoyed
running relaxation and stress management groups.

I also think that working in consultation liaison has allowed me to redefine my focus on the mental health
issues that human beings experience and that are often overlooked, when people are physically unwell in
general medical facilities. I’ve done some work with people who have been recovering from neurological
conditions: Guillain Barre Syndrome and Stroke for example, or other quite debilitating physical
conditions. They’d be receiving their medical treatment, rehabilitation, physiotherapy, occupational
therapy; but in parallel with that I was able to do work with them on their mental health issues - a captive
audience so to speak. Over 6 months later, it has been possible for them to reflect on their own
emotional and psychological recovery, and acknowledge its role in their physical recovery - and that’s been tremendously rewarding. Also some of the work I did when I was a case manager, with people who, once again, had been seen as being fairly unworkable, people with borderline personality disorders or antisocial personality disorders, you know. There’s some people I worked with for 5 or 6 years and I (and they) could see tremendous change. Some of them have gone on to do great things some have become fantastic artists, that’s also been tremendously rewarding.

**On worst times**

I think that what’ve really been the best times for me too, have been, and have actually come from what have been some of the worse times.

Getting through some of those really hard, difficult clinical situations; when you go “what the am I going to do here? Shit this is a terrible situation”, you know "How am I going to make something positive out this?” and often in the end it’s not about you making something positive, it’s about you being there and being aware and being able to work with whoever you’re with to help them find the positive. You know you don’t have to go in there with a preconceived idea; you need to be able to go in there feeling a receptive and hopeful. That’s it! You don’t have to have the answer; you have to have hope that the answer is there somewhere. I think that’s the most important thing, helping someone find their solution. I think that’s the same in community disaster recovery work, or when working with people who have been through strings of personal disasters throughout their life. There is always that potential for a solution, there can always be a goal. What matters who defines it and how it can be achieved.

To be honest, some of the worse times for me, probably, were the times when I was that person, lost in that situation; where I was the one struggling with my own depression. This was the case particularly during my twenties. We have a family history of mood disorder and I suffered with depression quite severely in those years. I had already completed my mental health nurse training at that point, and I had to practice what I preached. I needed to say to myself, "Okay, how genuine am I about all this? How much do I really believe it all? Have I been bullshitting to them (my patients) the whole time? No! Well now I’m going to have to do something about it". So my own personal growth work paralleled, reflected, was involved with, and informed that of my clients. In a way I think that it’s important, in saying that, to recognise that personal mental health issues are really only useful to your clients when you are aware of them, address them, and have grown through the experience. I should clarify that when I talk about our professional and our personal selves being linked, I mean that they do inform each other but they do, in some ways, need to be separate and different. Whenever you’re with a client, you’re there for their needs, that’s the contract you have. It’s often an unwritten, unsigned contract, but your roles are prescribed. The worst times for me were probably during that period, when I had to be honest with myself and say, "Am I able to be there for them (my client) or do I need to withdraw and attend to my own needs and tend to them first?" And certainly a couple of decades ago there were times when I had to do that. I overextended myself, and nearly paid the price, but I have learnt from those experiences.

What I did in the end was look at the things I needed to do to help myself stay resilient. I did leave nursing at one stage, but was more because of an opportunity to do something that I found exciting and interesting at the times. What I have done, in the past when I’ve been through bad times like those in my twenties, is I have sought help. I’ve been in psychotherapy myself a number of times. I found that really helpful. After careful consideration, I opted not to use medications. I developed my own; I guess what I’d now call CBT techniques and strategies; for dealing with these things. I’m a very great believer in a full and balanced life; with adventure and activity, sport, music (I play a lot of music) and a good social life. I have a small group of like minded people, professional colleagues, who I discuss issues with. We share an affinity in the way we look at life and our work. I talk to them about situations, and they do likewise. I get a lot from them and they from me. All those things help, it’s hard to pin it down to one particular
Actually, other bad times for me (and look one of the things that I can still find quite distressing) are not so much related to clinical issues, but to situations when personal and organisational politics create disharmony in the work place. You know, work place politics distract us from the other more important things we need to do. So probably, for me, a lot has been about managing that effectively; learning to establish and maintain my boundaries and develop strategies in relation to those issues - similar to those you employ with your clients. I can be honest and open, I can deal with issues as they come up. I might be able to help or support others, but I have to be careful not to take things on personally, I need to deal with my personal reactions in a constructive way. I think that's really important. Sometimes I remind myself, "Okay, this is your shit, not mine." And the other thing that can sometimes still get to me is the amount of administrative and non-clinical work that nurses are now forced to do - especially as we get more and more senior in our clinical area. I find that difficult to deal with. One of the worse times for me, currently, is when I'm stuck there knowing that I've got 3 hours of paper work ahead of me (laughs). At the moment that's probably my worst time.

Significant achievements

Well these are not to do with my qualifications or awards, nor with the services I've been involved in setting up. I recall one day having an argument with a Registrar in an Acute Care Team I was working on; it was getting a bit heated. I remember talking about what makes a good clinician. He said, "You might be a good human being, but that doesn't make you a good clinician. I can see right through a person's bullshit. I am astute and I can find what person's problem is (yes, this was how he talked). I can prescribe the right medication and handle things and then get it contained and that's it. Some people might think I'm a bastard, but I'd rather be a good clinician than a good human being any day." My response to him was "You can stop being a clinician when you go home, but you're always a human being. If you're a good human being, you can develop your clinical skills." It's much harder to suddenly recognise yourself as a good human being if all you want to do is be a clinician. I don't know if I explained that properly but I guess what I was trying to say is that I think the two need not be mutually exclusive as he was saying, and why is the distinction even necessary? It's really important to look at the human side of being a clinician, especially for a nurse. I would like to be remembered as someone who was a humanist, maybe what my friend calls an existentialist phenomenologist [laughing]. I don't know, I guess they're all just more categories and labels, but being recognised as that is my greatest achievement - do you know what I mean?

Another thing I'd like to add is, just as I was saying about clients that I have had the privilege of working with, that none of them I've seen as being bad people. Well I feel the same way about the nurses I've worked with. Even those burnt out "bin nurses" I described in our discussions about the early days. Even though some of them that may have had some very undesirable practices, there were also situations where I'd see them being extremely compassionate and kind to patients, unexpectedly so. I generally have respect and admiration for all those people who choose to work in mental health nursing, they all deserve recognition and appreciation for doing such a difficult job, often with little recognition. We also need to give recognition to those enlightened managers and senior clinical nurses who have been responsible for the development of mental health nursing. We need to give them credit for their work. That's why I'm really pleased that this project has focussed on developing a more formal history of mental health nursing in Queensland. I'm happy that I got interviewed, but you know it's great to hear that there's 20 other people who have also been interviewed, and more people later, hopefully. You know the sort of questions you're asking will hopefully draw out some of that wisdom I referred to earlier, and give something important back to the field of mental health nursing and to all mental health nurses. I would like to recognise all those nurses I have worked with; all of whom have been through those sorts of things that I have described in this interview; you know the funny things, the sad things, the tragic things.
In the early years of my training, I was still 18, I remember working in what was then called the receiving unit. In those days we used to accept anyone and everyone with behaviour issues; whether these were caused by acute schizophrenia, personality disorder, acquired brain injury, dementia, intellectual disability, or anything else for that matter. There was a guy in his early 60’s who had really bad Korsakov’s. He was a significant risk to himself and others. He was very combative, would attack others without provocation. He was also extremely ataxic, and was always falling over and hurting himself.

Of course as a young male nursing assistant, I landed the job of specialising this guy for the twelve hour shift, with relief for meal breaks thankfully. So towards the end of the shift, I was sitting there and he was almost out on his feet, pumped full of paraldehyde and all the other old goodies, like chloral hydrate and stuff, but he sort of still managed to run, or lurch, around. What am I going to do, I thought? I didn’t have any skills and everyone else was busy, so I said to him "Sit down here on the sofa and I’ll sing you a song". So here I am with this guy in his mid sixties and I’m an 18 year old kid sitting there singing him lullabies and songs in Maori [sings] and this guy and all of a sudden he stopped being aggro and agitated, and he looked at me with a tear rolling down his face and said, "You must have a beautiful mother." And then he just lay there and went to sleep. And everyone’s going, "Gees what you do?" and I said, "I sang him a lullaby and he went to sleep." [Laughing] Even this guy who was so knocked off and so distressed was capable of empathy and rapport. I just try to be with people and interact with them on a human level. He had just enough of a spark of insight to know that I didn’t want to hurt him, that I was trying to help him in some way and you know that was probably the nicest thing he could say. It was a very powerful moment. That’s nearly 30 years ago ....

I think our interactions with colleagues should be just as thoughtful and constructive. You know sometimes, the kind of organisational system that we work within promotes compartmentalisation and dis-integration. We stop looking at how we might help each other and how we can work together for the good of our clients and we become protectionist. Instead, we look at how can we avoid having to take that patient because they should be the other department’s responsibility. Similarly, when we see a colleague who’s stressed and under pressure at work, we could think, "Oh, thank god that’s not me, I’d better get out quickly before I get involved" or we can say "Look are you okay, can I help you out with something". Compassion, I think that’s the important thing for me. I try to find compassion for everyone. I admit, there are some people that it is hard to like but I reckon it’s possible to develop rapport and empathy on many different levels; even if it is, "Well we’re both human beings" or "One day we’re both going to die". Sounds morbid, but it’s true, we’re all going to face that particular event on our own and, peculiarly, I see that as uniting us, we’re all in it together alone". So sometimes it’s as way deep down as that (laughs), but more often there’s some point of connection with everybody, there’s no one that I’ve ever come across that I’ve thought, "You’re totally evil, I can’t have empathy for you". I think that’s what it is what I’d like to be remembered for. Maintaining compassion in my practice is my greatest achievement and that’s the legacy I’d like to leave for those I work with.
Kevin Fjeldsoe
Current role: Director - Mental Health Plan Implementation, Mental Health Branch, Qld Health

On being nominated [far reach of influence]

Because I’ve been around so long I guess. With the exception of a few locums interstate and in other Departments in Queensland I’ve spent my whole career working for Queensland Health and mental health pretty much and I guess you come into contact with a lot of people and I probably know as much about the services in Queensland as anybody. I think my most significant work is the sort of work I’ve been doing lately. I believe it will make a big difference in the way we deliver Mental Health Services in Queensland in the next decade.

On whether you’re more interested in the work that you do as a nurse. My view has always been that it doesn’t matter what role you take, if you have a professional background as a nurse it shapes your judgement in a particular way, so that you come with a history and a set of values and beliefs which guide your behaviour and the way you think about the world.

I’ve always promoted myself as a nurse no matter what position I’m in. I see myself as a nurse who is working in a particular position with a particular job. Having said that when you are working in a senior nursing position you do have a more defined stream of work. I seem to have been involved with a lot of change from the time I started working as a nurse (most people who have worked in mental health over an extended period have) at Baillie Henderson Hospital in 1973.

Baillie Henderson was a very different place back in the 1970’s and 1980’s. It saw itself as a leader in change and very actively promoted alternative models. For example, it set up one of the first and most comprehensive models for delivering mental health services to rural and remote communities. It set up some interesting models for delivering services in the community, including things that people are talking about now as innovation. I can remember for example being involved in establishing a cooperative housing project where we had a group of young people with schizophrenia that we supported to take responsibility for leasing a managing a large house and then operating it independently ( A consumer operated service).

They employed their own cleaners and support from a cook. That was back in the early 1980’s. Today it would still be promoted as an innovative model.

Baillie Henderson was interesting. We had the first day hospital for old people in the country, we had the first and it was said the most sophisticated community mental health service for old people around in those times. When I worked at the Gold Coast I think I was if not the first mental health nurses to work in the general hospital setting, at the Gold Coast. At that time, there were practically no mental health services there at all. There was a psychiatrist who ran an outpatient clinic, there were no inpatient services and practically no community mental health services.

I did my general nurse training there.

I’m very proud of the work I did at the Park. It was a very difficult, complicated task. The hospital had reached the point where it became unbelievably neglected and was in a terrible state. Conditions for patients and staff were terrible. I was recruited with a couple of other people to try and fix it. I was recruited as director of nursing. At that time it was very large. It had about 700 nurses and it was a very complex organisation by any standards. I think I became completely obsessed with trying to help. When I started the Hospital had just had a major review and been described as the worst psychiatric hospital in the country. I think it was probably true. The conditions there for patients and staff were just abysmal in most areas. I think I had a significant impact on nursing there and the health care system.
generally. I certainly seemed to upset a lot of people during the process but I think people understood the need for change in their hearts.

The resistance to change made you constantly question whether what you were doing was right but I’m sure it was right. I’m sure a lot more people get access to better services because of the work we did there. Throughout that period I became aware of how important it was to think and plan carefully before you launched into a task as complex as this one. In the first six months, we were just trying to fix things that were immediately and obviously in need of repair, be they human resource issues or clinical practice issues or very practical things like the infrastructure. We tried to fix them but without a clear strategy and a properly thought through plan we found we were getting nowhere and I think that work was a stimulus for the first state plan in Queensland. We basically said, “We can’t do this on our own, we need a coherent strategy for the State which incorporates the change required at this place.”

I recall myself and a colleague were summoned before a panel of senior managers including a couple of deputy director generals and director of mental health who basically said to us, “What the hell do you think you’re doing?” We said, “We’re trying to fix up that bloody mess out there,”. They said, “You’re upsetting everybody and if you keep doing it we’ll sack you,”. So that’s when we formed a view that we couldn’t do this on our own but we needed to be part of a properly thought through Statewide plan, we couldn’t just plan it ourselves in isolation.

It was a very challenging time. I mean it’s the most challenging thing I ever did in my career. A lot of people around the State had an idea about how bad things were with the Park and how important it was to fix it but by the same token when you actually talked to them about what needed to be done to fix it and what their role in that might be, for example in terms of taking patients back and you started talking to them about the patients and about transfer there over the last 15 or 20 years and they started remembering how complicated their needs were and how demanding they had been and they became rather anxious about the whole prospect of change.

When you started talking to nurses and doctors and other staff about how they needed to change their practice and how they would need to go somewhere else to work and that they wouldn’t have a future in this organisation, it became very challenging for them personally and professionally. People suffered a lot because of that. People would get very anxious and some became quite depressed and angry. So that was very difficult for a lot of people and I think for the patients too. I think if the staff are disconcerted and uncertain it impairs their capacity to support people who are in need as well. So I think it was a difficult time for patients as well, some of whom had spent many years there. I think it was challenging for everybody.

I think that’s where I learnt how important it is to have a clearly articulated, well researched and thought through vision for the future and a clear plan about how you’re going to get there because if you ask people to take risk and change, you must be clear with them about why, when and what you want to them to change to and how the part that they play fits into the grand scheme of things. I think uncertainty for people is very demoralising and I think that’s one of the reasons why the Park, for example had suffered so badly. It had, for a very long time had a very uncertain future. We provided a very clear vision of the future regardless of how painful it was for people.

I can remember talking to a nurse one day. I hadn’t been working there that long and this guy was a young recent graduate who was leaving, he had made a decision to leave and I was told me that he was a bright young student and it was a shame to lose him. He said, “Look I enjoyed training here,” he said “It was fantastic and I learnt a lot and I want to be a nurse and I want to have a career in nursing,” but he said, “I can’t do it here,” and I said, “Well what do you think our problem is?” and he said, “First of all,” he said, “Every time I pick up a professional journal or I talk to some of my peers who don’t work...
here they tell me what a hopeless place this is and how institutions are terrible, have to be shut down and then I read all these horror stories about what’s happening here and it doesn’t make me feel proud to be part of this organisation …. everybody I talk to says it has to be closed. So that doesn’t make me feel good. When I talk to people here, they can’t tell me what the future of this place is, people seem disconcerted, they seem unhappy and they don’t know what the future holds. There’s no plans for future development, when I come to work I’m surrounded by staff who haven’t had any post graduate training for 20 years, who haven’t been to a conference, who get no support from the organisation or haven’t been supported by the organisation to do anything. Sometimes I’m in charge of a ward and the only staff I had to work with are assistant nurses who have no training. I come to work in buildings that are falling down and the roofs leak,” and he said, “it’s too difficult to stay,” and I think he was right. I thought a lot about that.

I think the solutions were about building an organisation that knew where it was going and what its core business was. I think people need to know that the organisation will support them and expect they will engage in professional development and that it has an interest in making sure that all staff have the skills and capabilities they need. I believe strongly that staff need to be able to be proud of the work they do. I think that sort of conversation was a pretty powerful one for me. It just reminded me how important it was for people to have reasonable environments to work in where they felt appreciated when they came to work.

During that period I had the opportunity to work in corporate office for periods of a year or two to help out on service planning in the main. This work initially, in about 1995, exposed me to a lot of the services in the state and interstate as well, I did a lot of travelling around talking to people about service models and doing a lot of thinking about the details of planning it and what an effective system looked like, how you resourced it and the sorts of leadership that needed to be put in place. This work was part of the development of the new state plan for mental health for Queensland. For me this was an important piece of work and I went back to the Park and was clear the plan for the park was an integral part of this state plan. The Park was now seen as part of the solution not part of the problem at the state level.

**On becoming a mental health nurse**

Just by accident. There was no calling or anything, I was about 17 or 18 at the time and I was studying at the University of Southern Queensland and I used to work part time with racehorses, ran out of money basically. Somebody told me you could get a job at the local psychiatric hospital so I got a job and started off delivering food on the food trolleys and cleaning and polishing floors. That was our system back then before you started nurse training.

I think my intake was one of the first, of what they called phase intakes. I can’t remember the number of hours involved but it was the start of a serious attempt to provide a professional level undergraduate program. A lot more hours, a lot more dedicated lecture time and I remember a lot went into student supervision and practical evaluation in the wards. This was a huge change at the time.

**First impressions**

I think I was just horrified. I think this was because I had never had any exposure to mental health or people who had problems. I think it was challenging at two levels. One is you saw people who were in incredible states of distress and who were being cared for in conditions which seemed pretty difficult. On the other hand I can remember one of the first wards I worked in was a ward called, I think it was E ward and I don’t think too many people there were mentally ill, I think it was like a gentleman’s club. All these guys used to work around the hospital on the roads and bits and pieces with the electricians and the plumbers and in the kitchen. They all had jobs during the day in the hospital and a lot of them were
probably people who had histories with alcohol and had been at the hospital for a long time. There were about 50 people on this ward and I still remember, they used to all be upstairs in a dormitory at night and they’d be all naked. They’d come downstairs for showers naked. I still remember, I got told to go and open the gate and there was like 50 naked men came charging down this great big staircase and I remember thinking “Holy shit’. 50 human beings all got herded into a large bathroom!

In those days the wards were separated, males and females, I think these sort of experiences shape your attitudes and values more than we realise. It was an interesting place in those days, it had its problems but there was a core group of professional, hard working people in leadership positions, charge nurses mainly who provided excellent role models for young staff. I can remember being struck by how professional these people were and how caring they were and how, despite what was around them, they still maintained clear standards and expectations. They were very powerful and I think they set the scene for a lot of behaviour and a sort of organisational success that occurred at BHH over that period. When I looked at other psychiatric hospitals or mental health services around the country and try to identify why they are successful and why some seem to struggle with the issues of culture and performance and effectiveness leadership invariably is the issue. They weren’t all like that. At Wolston Park there were some great people, but there wasn’t a strong sense of organisational spirit or a culture of pride and respect for leadership.

**On training and preparation for the role**

Look, I think it was fantastic. We learnt so much. And I think the messages were important. I talked before about how some of the things we talk about today are not new really and I think the recovery model is a good example. I can remember when I was a nurse training in the first year, that we were given very strong messages about how important it was that we considered patients as individuals, as partners and that we considered needs not just in our terms but on the basis what was important for them. We talked a lot about how critical issues of dependence and independence were. About how do we define success for them in their own terms? So how do we work with people to help them identify what’s important to them and what gains they could make as individuals? We learnt about how important social inclusion was and how the traditional model which provided everything for the individual wasn’t necessarily the best way to think about organising services for somebody, that there was a hard social circumstance that people needed to be engaged in if they were going to be successful in the community. There was no point discharging somebody unless they had somewhere decent to live and something useful to do during the day which wasn’t a sheltered workshop but was an active engagement in the community in a way which was meaningful for them. The nursing models and philosophies we worked with in those days are just as relevant today.

I think I was lucky. I trained in a time where we spent a lot of time questioning the values of psychiatry. I think that questioning helps you consolidate your thinking around the relative merits of some of the things you do and the positives and negatives associated with some of the traditional models.

I thought this was a very good educational model. I that we should have replicated that model in a partnership with the Universities. I argued strongly against the current nurse education models to no avail. I think we lost a huge amount of resources devoted to supporting ungraduated students and lost a lot of the good things about the traditional practice based model that we didn’t need to.

I mean my view always was that there were problems with the way that we prepared nurses that could be overcome if we just changed some of the ways we thought about things. The apprentice model had its problems but it also had its strengths. There was no reason why we couldn’t have had partnership with the universities which the universities provide the training on the campus. I couldn’t see why we couldn’t
pinch the medical model for mental nursing. They would say, “It’s too expensive,” and I would say, “It’s too expensive not to.” I think I was right because I don’t think today that nurses get the right sort of preparation they need. I think it’s a miserable failure and for mental health nurses I think the constant challenge is to get the academic sector to invest enough in mental health education and training.

When I was at the Park I tried to replicate that model, so we developed a partnership with UQ to offer the course on campus. My proposition was that if we could demonstrate it worked there in the context of huge recruitment problems it could be replicated elsewhere if.. We delivered the postgraduate program on campus administered it and it was delivered by UQ. We gave people time off to attend lectures and a supported work environment where they could establish a cohort, be part of a student cohort and get supervision on site from senior lecturers or senior clinicians. So we got UQ to do the program on campus and we had no trouble filling that, people completed it, people were happy with the products of the program. They wanted to keep them, they were encouraged to stay and we didn’t have a recruitment problem anymore. So we tried to promote that as a model across the State here but I couldn’t get anybody interested, still can’t. Don’t really understand why..

The Program was a test and was never going to last because Wolston Park was getting smaller and smaller and its range of services are becoming narrower and narrower. I tried to convince people to deliver it across the southern area and to have one or two universities involved in delivering and have rotation of placements for staff but nurses can be a conservative bunch. I couldn’t get people to commit to it. To commit to it they would have to create training places and people just wouldn’t create training places. You know I’d say to them, “Why can’t you create 8 or 10 training places out of 120 nurses?” “Oh we need experienced staff, we can’t have inexperienced staff in here.” I said, “Where do you think the experienced staff are going to come from if you don’t and we don’t take responsibility for development.” “Oh, it’s not my problem, it’s the university’s job.” So I’m still struggling with that and still promoting it. I’ve got another plan now!

So anyway the work at the Park was pretty interesting.

I did a lot of secondments, some to corporate office, I did a secondment to Tasmania as state manager for example for 6 months. I went and worked for the police force for 6 months.

It was a fantastic experience. Yeah, learnt a lot, an incredible amount. The Chief Superintendence was seconded to help set up the Department of Child Safety and I was offered the opportunity to replace him for this period. He was responsible for professional development, recruitment and the academies. I’d been there about a week and the monthly Queensland police union journal came out and asking, “What the hell is a psychiatric nurse doing in charge of the professional development for the police force.” Good question.

It went well after all. I felt like a fish out of water but look after a month or two I got on really well with them and I think I contributed something to them and they appreciated that, I was only there for 6 months and I was there to try to help and learn and I learnt a lot, it was a good experience I think and the sort of thing you need to do to broaden your perspective.

So I did quite a few of those sorts of secondments here and there. I think it’s important, otherwise, particularly working at the Park at that time, you can lose your perspective and enthusiasm. You know it was a really tough job and you could easily find a reason to compromise or leave. The job at the police force turned out really well because one part of the job was responsibility for the police academy and the police academy’s were in a terrible state and they just kept throwing money at them but the infrastructure was so poor, getting old, no space and had all sorts of problems so I said, “Why don’t you build a new one?” and they said, “What are you talking about, it’s too expensive.” At that time we were
Making Queensland history

trying to work out what we were going to do with the old Wolston Park buildings and land so I had an idea that the old hospital would make a great academy. They liked the idea and I think that work has now commenced on a fantastic new police academy out there.

I’d been lobbying hard to convince mental health branch of the corporate office for some time that we needed a new mental health plan, the old mental health plan had been abandoned, neglected, you know they’d dropped the ball with it. We needed a new plan and so when Aaron arrived here he had the same idea so that’s when I started this current contract 2006. I helped develop the plan and then have responsibility for funds acquisition. I took responsibility for the submission to acquire funds for implementation and then was given responsibility for spending it. A good job. I did that for the last 2 or 3 years and just more recently I’ve been given responsibility for workforce as well.

I feel anxious about the future of mental health nursing and in a lot of ways I feel disappointed that I and a lot of others haven’t been able to do something more useful about promoting the profession and consolidating its expertise and dealing more effectively with the undergraduate, post graduate educational challenges.

I thought a lot about why we haven’t been able to do more, it just seems to be very difficult to get people to take risks really and invest. I think the other problem in Queensland is our population’s grown. The investment required just to keep up is enormous. Recruitment is a continuing challenge and we’ve had a lot of nurses come from interstate and overseas who have different views of the world. It should be a strength but I don’t think it necessarily has been. I can remember when I started work at the Park and I went to this meeting this day with this group of nurses who were union reps and I thought I can’t understand what these people are talking about, I don’t understand the language the values and it only struck me after about, after this meeting, but everyone of those people was from Victoria or somewhere else. Each had their own views of Queensland based on their personal histories. A lot of them were forensic nurses.

I finish next year. I’m going to retire. Thirty seven years is probably enough. I’ve got a great team now, it’s only half a dozen of us or so but we’re going to spend the next 12 months developing a funding submission of a plan for stage two of the state plan. Hopefully we can get that in place by the end of next year and I’ll be happy to retire then. I mean I’ll still do some work in mental health, I do quite a bit of consultancy work, interstate or overseas. So I’ll still do a bit of that maybe, go to the races a lot more often.

Career highlights

I think managing the change at the Park. Yeah I think that has had a profound effect on services in Queensland. I think the work I’ve done in the two State plans in Queensland, has been significant and rewarding. I think they’re the main things.

I’ve always had this idea and I think it comes from your training to some degree, about the value of questioning, what we do and how useful it is. I can’t understand how you can convince yourself that we just can’t do better for somebody with such a debilitating illness or debilitating set of problems associated with serious mental illness than we currently do. The evidence is so clear. I’ve always had this idea that we’ve got to be able to be better than this and if you’ve got that in your head somewhere it means that you are constantly nagged or driven to want to change things and improve things. So yeah, I just keep thinking that we have to be able to do better than this.

And I’m not sure that a lot of things we’ve done have made a huge difference but I think at least there were attempts to try and do something and have a more positive impact than they have in the past. So
they’re changes, I think changes are critical. I’ve seen a lot of changes handled badly and I think if you’re not going to manage change properly, don’t do it at all, you’re going to cause so much damage that you shouldn’t do it. So I think you have to change but it has to be managed properly. I think that’s the other problem you have with mental health is that we don’t, it’s not because of mental health, it has a bit to do with health as well, we don’t invest enough in thinking about leadership and leaders. You know a lot of the leadership positions that we have are taken up by people who don’t really want them, who are there because nobody else wants them or they get talked into it. We don’t get vast arrays of great candidates for senior positions. I think that’s a problem for us. That’s particularly a problem in mental health nursing; we just don’t have enough people who are prepared to take up leadership positions.

I think leadership is always challenging when things are changing and so I think they’re tough jobs. I don’t know if it’s part of our history or what it is but I don’t think the profession values leadership the way perhaps in which it has in the past and that’s possibly because leaders have let it down in the past. I don’t think the profession values leadership basically. I don’t think it promotes it. It’s never seen as attractive. It’s almost seen as the clinicians are the good guys and the leaders and the managers are the bad guys. Very destructive dynamic.

I actually remember being completely overwhelmed by the change in people’s attitudes when I moved into a leadership position and then I was just naive enough to think that we were all in it together and we’d all be working together now to make things better. As soon as you move into a leadership position that’s completely different, yeah and I still don’t understand it, never have understood it really. So I think that’s simply the problem for us. They are tough choices, and a lot of people don’t last. I think this system is difficult to work at as well you don’t get the level of support you need as leaders. Unions, I think our nursing unions, I think their attitude to leaders and service delivery is abysmal and I think purports to be professional body, interested for nursing but at the end of the day it’s the industrial organisation that’s interested in protecting its members and it basically tells leaders indirectly that they’re not welcome as members. I’m not sure about the numbers these days but a few years ago a lot of Directors of nursing left the union.

**Career lowlights**

I always thought as director of nursing at the Park, Wolston Park at the time, was the most senior nursing position in the State and I thought I had a responsibility to try to provide some State wide leadership but I found it almost impossible to get people to talk about the issues at a statewide level. I think that was because, and I’m not sure if I rationalise it but I think it was because at that time most people had seen the Park as a terrible place, to be avoided at all costs and anybody who came from there couldn’t have anything useful to say.

I would have liked to help develop the profession by more effectively consolidating some sort of proper academic preparation for mental health nurses, with effective post graduate preparation.

**What’s made you stay?**

I think the challenge makes you stay. I mean, as I said before, you just know you’ve got to be able to do it better than this and I’ve been in a position a couple of times where I could have left and done something different but I would have felt like a coward. I would have just felt like I was walking away and not doing what had to be done. So I think you do get to a position where it’s difficult to leave because you know there’s so much to be done. You wouldn’t feel good about yourself if you just deserted so to speak. I know that sounds a bit corny but I think that’s what has kept me there. I know at the Park, I think my attitude changed, I think when I was working at Baillie I was enthusiastic about the future and I was fairly naive in some respects, you know I just thought everybody was nice, do you know
what I mean? We were all sort of trying to make things better and it was easier then, but when I started working at Wilston Park the whole thing became much more complicated. I realised it was a lot more challenging than I thought it would be and I just became completely obsessed with fixing it up and I couldn’t have left until I was comfortable that I’d done what I thought had to be done otherwise it would have felt like I had let a lot of good people down.

It sounds a bit dramatic but it’s true. I just wasn’t going to give up and while I think the place still has its problems it’s a lot more civilised it has a clear understanding of its future, its role and its value. A lot of resources from there have supported new services across the state.

**Coping with challenges**

We had a pretty good team I guess. I talked about that before. Never underestimate the critical value of a cohesive team. Unless you’ve got a team of people it’s very difficult to and you couldn’t manage it on your own. Having said that, the teams change over the years and became weaker and need to be rebuilt but you must be manage to keep a sense of a leadership team in place as you move forward. I think because there was a lot of change going on there at the time it attracted some interesting people who wanted to be involved. So we got some smart people. You need smart people around you. Always try to recruit people who are smarter than you is a good rule.

I think in the early years, having a strong relationship with and corporate support was important to us. Knowing that the organisation was behind you was really important. We got a lot of support from our director general and others at the time. I can remember we had a particular disaster with one of our forensic patients and it was terrible.

It’s a tragic story. His family were very wealthy they were from Melbourne and their son was very ill. They sent him on a holiday to the Gold Coast. When he was at the Gold Coast he murdered a young girl, it was a tragic circumstance and he was in hospital here for a couple of years and responded really well to treatment. His parents decided that Victoria was the best place for him and, if you know the interstate agreements about transfers and forensic patients, they’re very complicated. So they decided that they would take him back without approval. It was a terrible outcome for their son, the mentally ill generally and for the staff of the service. The behaviour of the press was incredibly bad. I could not then and still now find their attitudes and values to be very disappointing. The Director General was fantastic, it was an interesting time, a lot of support from a lot of our peers and we certainly got a lot of corporate support. Reassurance and support from your peers in times of crisis is critical.

**On humour**

Mental Health is a very imperfect science. If you take yourself too seriously, you can tend to very disappointed. It keeps you very humble. I think you’ve got to be somewhat irreverent and I think most mental health nurses have a healthy degree of irreverence and are prepared to laugh at themselves. I think there’s lots of examples where mental health nurses act in odd ways [laugh]. So I think it’s an important part of the game. We used to, at the Park, just because we had to celebrate the change and celebrate what was happening and try and help people feel good about what was happening, we used to put on shows so we got 300 or 400 staff come to a Friday night and we’d put on shows which involved people making fools of themselves, dressing up in a tutu and all that sort of stuff and that was just taking the Mickey out of each other and setting each other up. It didn’t matter if you were the gardener or the electrician or the nurse or the doctor, everybody was making complete fools of themselves [laugh] singing or dancing or something stupid. Yeah and that was what it was all about was everybody getting on stage and looking stupid, the sillier the better [laugh].
I think you develop a different sort of relationship with the patients too of course where the level of interpersonal engagement means that you can take some more personal risks in terms of humour and having fun with each other than perhaps you do in a more formal health setting. It’s a delicate balance but I think nurses and patients often have a lot of fun [laugh] and people see the value of that. So I don’t think you see it as much in other parts of health as you do in mental health. Maybe that should be our new slogan, mental health nurses have the most fun.

**On values**

Of course Mental Health Nurses having a particular set of values which we all understand in different ways but there are common themes, I think if you work in mental health nursing for a while you also have a healthy appreciation of our history and how bad it can get. I also think we have a better appreciation than most of how difficult it is to support somebody with a serious mental health problem year after year after year than perhaps some of our colleagues do so I think we value the persistence, consistency and resilience... we value the relationship and understand the power of empathy.

As clinicians and managers we understand the complexities of change. I still remember somebody said to me once, that he never ceased to be amazed how effectively mental health nurses were able to get people to do things they don’t want to do without them knowing that it was happening and I’m not talking just about patients [laugh]. So I think you do get a set of skills which help you manage systems. So I think there are a very particular set of values and skills and attitudes and they are founded on our history and experience of it.

**Philippa Harris**

Current Role: Education & Training Manager, Mental Illness Fellowship NQ Inc., Townsville

**On being nominated: [passion, dedication, commitment]**

I’ve got no idea [Laughs] which I’m sure is what most people would say. I don’t know really. I think I’ve been incredibly fortunate to, to have found a niche, somewhat outside the basic mental health system but still within mental health and it’s suited me and I think I was fortunate to be doing that at a time when there were opportunities that maybe hadn’t been around before and certainly, I was, I was privileged to, to be able to do things that were outside straightforward mental health nursing and I think, it was just some, I’d assume, it’s just some of those opportunities. I don’t think that I would’ve been nominated for the stuff that I did as a, as a person working on the wards, yeah.

...I just had opportunities once I came to Townsville and the context around that was that I arrived here, but my husband was transferred, just after the Carter Inquiry into 10B which was a very disruptive time for people and certainly a time of great angst around the mental health services themselves and a time of re-adjustment and re-evaluation and coming from the outside and looking in, I, I, to be truthful, I
thought, "Is this an area I really want to go straight into, the hospital setting?" There wasn't much of a community mental health area at that time. There was, but it was very small. "Do I really want to go into that setting?" And I, when I reflected on it, I thought it's going to be really hard to do the things that I'm comfortable doing in that setting because everybody's going to be watching and everybody's going to be very stressed. And so I thought that maybe there are some other opportunities and I was able to, to get some work just relieving with the Mental Illness Fellowship which was then the Schizophrenia Fellowship and that started the, the relationship going back in 1991 and I've been with the Fellowship ever since but in multiple roles and having lots and lots of different opportunities within that organisation. Really. So I, sort of, opted out in many ways but kept within the circle of mental health. Mmm, so it was for very selfish reasons, perhaps [Laughs].

When I started with the Fellowship; I started with counselling and information provision and providing support to individuals and families in, in that sort of community setting. It was non-clinical stuff but it was, very much, whatever was required, trying to, sort of, work with those individuals and families and trying to liaise with the mental health services that were there to get some good outcomes. But then in 1995 we got an opportunity to apply for some funding to actually take education out into rural and remote areas and that was something that we had never done and neither had anybody else that we could really find out about, but we had been fielding phone calls from people in those areas of North Queensland, since, really, since we started. So we were aware of some of the difficulties that families and individuals had with lack of services, lack of appropriate responses within the community and a great deal of stigma and misunderstanding about mental illnesses. And so I developed a program which we applied for funding for and we were able to get which enabled me to travel to places, along the Flinders Highway, so that was from Townsville and out to Mt Isa, and because we wanted to maximise the opportunity, it takes a while to get there, we didn't want to just do one or two things when we got to the small towns there. We wanted to maximise those opportunities so that the program that we developed was focussing, mainly, on carers and providing them with the information and some skill development around caring for somebody with a mental illness but also looking at opportunities to up-skill local service providers and doing some mental health awareness in the high schools as a prevention and early intervention strategy as well. And so we ran separate workshops in those areas, and we also did one-on-one counselling with the individuals and with their family members as well, to get a link together and then the, sort of, second part of the program was around providing telephone support counselling from here in Townsville to people along that route. So once we developed the links and the relationships, they could be maintained on the phone.

there wasn't anybody else doing it [telephone counselling] at the time. I mean, there are lots of different ways for service providers to get information, advice and support now. There are ways for consumers and there are a number of support services for families as well, but at the time, I mean we're going back 15 years, there was really nothing, and so it was quite innovative at the time and it certainly made a huge difference to those people. We were able to expand the program to take in some areas, sort of, in a circle around down to Mt Isa, to Mackay and then up to and across the Tablelands around Cairns and up to Mosman. So I think we went to about 31 different centres, all up, over the period of six months, and then revisited again over the following four years.

And how many people delivering this program?

Me. [Laughs] Me and a consumer. And, I think, again that was another unique thing that we were doing is that we felt that in order to, to really challenge people's assumptions, we needed to have role models and so having a consumer, somebody who'd experienced a significant mental health issue, come along as a co-facilitator to the workshops as somebody who could talk about the lived experience and show that recovery was, possible, but that would, but that would have a, quite a considerable impact and it did. And I went, I travelled probably with half a dozen people over the three years or four years that we ran the program. And each one was very different but each one was, just had an amazing impact because
they could tell their stories. Because they were there as living proof that we could get, people, recover from mental illness that you could manage it, control it and you could, develop a life for yourself afterwards.

What were some of the examples of the impact?

I think, we went into High Schools and talked, we used the Mental Health Education Australia program which had been developed a few years before and we entered into a partnership with MIE Queensland to deliver their program and, I think, some of the, some of the most important impacts that that had was going into High Schools, talking to High School students, having them ask questions of me and of the person I was travelling with and going back the next year and finding out that, the kids had come into school and other classes and talked about what they learnt, what they were aware of, but making some decisions that perhaps might’ve been different had they not had the talks that we were able to give, particularly around things like substance abuse and looking after themselves and recognising that, things do have an impact in the longer term, so yeah. So that sort of preventative and early intervention stuff was very, was very much an emphasis on the High School education programs and still is because I did one this morning and it’s still really, really a strong part of what we do. It’s about raising awareness of mental illness and risk factors and giving young people some tools to deal with whatever comes along, including the onset of mental illness.

[So that road show program] went for four years, yes. I delivered it for the first three and another worker took over in the final year. We had, heard many stories from people who were family members who had been caring for somebody with severe schizophrenia for a long time who were just burnt out, tired, worn out. After attending workshops they became motivated to change by finding that, actually, people didn’t have to be like that all the time, that there were opportunities to grow and to develop and there were things they could do to look after themselves. And so those things gave people just a different perspective on life, a few new skills and some ongoing counselling and support from people who actually understood their situation and that was really good. Yeah, yeah. Lots, there were lots of little things, people who didn’t know anything about mental illnesses that, "Wow; now I understand something and I’ve been dealing with this for a long time. I didn’t realise, that I actually had a condition that could be treated. I just thought this was how it was." Just lots of little things that, that people would come and tell us afterwards about the impact that the program had made. We were letting people know they’re not alone and that was a big thing, yeah, particularly for families.

A wonderful thing that happened as a result of a trip out west, was that a family in Hughenden that I had met, held a fundraising night at the local pub with a live music, country and western naturally, raffles and donations with the profits going to the rural program. It was a great opportunity to raise awareness of mental illness in the bush and a fantastic local initiative – that’s what community development is about, sowing seeds and nurturing local responses.

On your daily work

I’ve had a lot of different roles within the Fellowship. In (I think) 1996 or 1998 I attended the first Early Psychosis Conference in Melbourne and came back determined to start something to help families cope with their first experiences of psychosis. I was able to work with local mental health services (an OT) and we developed a 6 week family psycho-education program. It is still running, though it has been updated a number of times to keep it current and has had a few name changes, but the feedback has been very positive throughout the years and has been a great partnership with the mental health service. We run housing programs and I helped developed a long-term housing project here which, again, was one of those early things that we recognised it’s very hard for people to recover from mental illness if they don’t have safe, secure and affordable housing. And a lot of what I’ve done, I think, is just being in the right place at the right time. Seeing an opportunity and going for it, taking risks (in our projected capacity to
Making Queensland history

achieve program outcomes) in many ways but we were able to develop a long-term community housing program which we have grown over the years. We now have 18 properties that we’re able to lease out to people with mental illnesses. When selecting properties for purchase, I was very aware that the property had to be well presented, easily maintained, in a ‘good’ safe area, close to transport and other facilities and somewhere that the eventual tenants would be proud to live. We had a number of consumers on the property selection panel and everyone volunteered their time to go ‘house hunting’. It was often exhausting, giving up weekends etc, but the outcomes have made it worthwhile. All our properties are at least two bedroomed, allowing tenants flexibility to live alone or with others, including family members or friends. We also ensured that at least one room is air-conditioned, to take account of the climate in the tropics and the difficulty many people with mental illness have in handling the heat and humidity, due to their illness and the effects of their medication. We have also been able to provide non-clinical support to tenants, so if there are concerns they have had established links to the Fellowship services.

Moving has been life changing for the people who’ve been able to go into the properties. We’ve had people who have been in and out of hospital who, because we could provide accommodation and some support, who have managed to cut down or cut out their hospitalisations and, in fact, return to work. Some full-time but mostly part time, that’s, that’s tremendous to be able to offer them that opportunity and it’s not one that is easy to find anywhere else. The housing, housing wait lists are enormous, so are ours, well; ours would be if we had them. We actually, we are able to offer housing in a slightly different way from Public Housing. We offer housing to people who, we believe, will be able to take advantage of the opportunity and cope successfully in the housing. So it’s not about people housing those with the most disadvantage, they’re the ones that get the public housing. Whilst you’d like to house everybody, for us it’s about who is the most likely to be able to, to continue their recovery journey and maximise the opportunities once they know they’ve got somewhere safe and so we’ve had some really amazing outcomes from the people who’ve gone into our housing. Many of them stay there for quite some time, some of them choose to move on into private housing when they’ve got better incomes and things. So that’s been, that’s been wonderful to see the growth that people can have in that area

Other projects

As the organisation grew, I became the co-ordinator, manager and eventually became the CEO of the organisation and we’ve, well, we’ve done lots and lots of things in that area. We certainly were able to get funding to establish a day-to-day living program downstairs which has been going for just a couple of years now, and that’s providing opportunities for people who have long-term chronic illnesses to be able to start to re-develop some of their skills and to find social opportunities and to re-develop some of their work skills as well, and they’re developing their own life enhancing opportunities as well. So I developed the model for that program. I’ve done lots of things, lots of things. I think I’ve been quite challenging around some of the things that I’ve done, like the conference papers. I presented for a number of years, every year, at mental health nursing conferences because I wanted nurses to understand the family’s perspective families. I felt that for some there was a need to move beyond our own experiences of families sometimes. That sometimes our own experiences particularly if they are negative, can get in the way. Nurses we’re not reflective in their practice and, I think, that’s one of the areas where mental health because it was one thing that just didn’t seem to be coming through, but families have an incredibly important role to play but often there was very little dialogue between families and the professionals, mental health professionals and nurses in particular, and so I, I suppose I set about trying to change that by, just by growing the awareness of mental health nurses on the impact that mental illness has on nursing has come a long way. That reflective practice is now seen as best practice whereas a few years ago maybe it wasn’t seen as being so important. Challenging people and providing alternative perspectives has been, has been one of the things that, that I certainly set out to do. I don’t take any credit for the fact that things have changed. I think there’s been lots of factors that have
influenced that but certainly I felt that it was important that we did provide better links between families and mental health nurses, in particular, because they have such a lot of influence on what happens and they have that involvement with the individual and potentially can have a lot of involvement and influence with the family, to everybody’s benefit.

Are you still the CEO?

Nope. No, I stepped down last year in June of last year intentionally. I suppose there are number of factors in that. I’m not a big organisation person. I think I discovered that as, as the organisation grew. My interest and probably my skills as well, is not in managing larger organisations. My interest and skills is in doing the hands-on stuff. When I started we had a budget of $300,000 pa. and we now have about four million. It’s certainly not all due to me, but I’ve been around over that period of growth and, probably, the most significant areas of growth I was around then as the CEO. But ultimately that’s what the organisation needed to do, but not what I wanted to do and so when an opportunity came for me to be able to pass the reins over to somebody else who I was very confident in, I did it. [Laughs] And, I’ve, I’ve been fortunate that I’ve been able to juggle family commitments with my work throughout most of my career and when I was working in hospitals was when my children were younger and when I came up here they were a bit older and bit more independent and when I was, sort of, going out on the road and travelling a great deal, they were, they were pretty grown-up by then and now I’m I’m working part-time and going back into the caring role for my father, so I don’t like to go away quite so much and I don’t like to be tied up with work quite so much, too. So I’ve been able to through luck rather than judgement, juggle many of those things as well. So it’s worked out quite nicely for me. In 2008 I had a year where I took six months’ long service and then came back doing some outreach work again, just part-time and then from July this year, then I just took on the role of manager of the community education service side of the programs that we run now.

On becoming a mental health nurse

My first contact with mental health nursing was actually when I was about 15 and I was, I grew up in England and there was a large psychiatric hospital in our area called Barming Woods in Kent. The names are wonderful, aren’t they? And as part of our, I suppose you’d call it work experience, we went on a tour of, of the hospital and it was one of those huge Victorian institutions that you can see the world over. It would’ve had many thousands of people there. But anyway, we went on a tour and I found it quite fascinating in a macabre sort of way, Our visit was probably considered appropriate at the time, so it, sort of, ignited some interest in that this might be something I wanted to do but fortunately my parents were far too sensible and banned me from thinking about such a career at 15 (the hospital ran ‘cadetships’ for young people who were then able to undertake their training for Registration once they reached 18 years ol. So that meant that I, I went off and did lots of other rather pleasant things and I actually came back into, into the notion of mental health nursing when I was 22, so quite some years later. I had actually been working in a nursing home. The story behind that was that I was homeless and I needed somewhere to live and at that time if you were nursing, they gave you a roof over your head. So I did. When I say I was homeless, it wasn’t quite as dramatic as that but I had an altercation with the boss where I was working as a receptionist in a hotel. I think I had a strong sense of social justice, as well, and there were things that were happening there that were inappropriate and wrong and so I challenged him and he sacked me. [Laughs] Sacking someone was easy, in the 1970s and, yeah, 1970s. So yeah, so I thought, “Oh, dear, where am I going. I can’t stay with my friends all the time.” So there was an aged care service in what had been, I was Wales in the UK at the time, and there was an aged care service which had previously, previously been the Poor House and up on the hill in Brecon in Wales and I went there and got a job as a nursing assistant and I actually really enjoyed working there. I was working with a lot of elderly people and it was really, really good fun and I enjoyed it and I got on well with them and then I thought, “Well, I’m 23, if I want to do this, I probably shouldn’t just be a nursing
assistant. I should try and do and something a bit more with a career structure to it." So that’s when I applied to do my mental health nursing. And I went in, went to Buckinghamshire, Aylesbury in Buckinghamshire to do mental health nursing I had family near there so that made it a good move.

It was in another institution. They had downsized quite a bit by then. I think we had about 3000 people in the hospital. It was St John's Hospital in Stone, a little village near Aylesbury. And it had that same wonderful Victorian country house façade with all wards behind it. But it also had a number of new buildings and a very smart, modern, acute inpatient unit as well. So it was, it was stepping over the divide between the old fully institutional care and going into that more, more progressive recovery focused model.

This would’ve been in 1973. I qualified in 1976. It was the three-year training in the hospital and so you, you did blocks in the School of Nursing and then you did three months on the ward and back into block and then back onto the wards again and, mmm, a very different sort of training to what, student nurses get now.

The high points

Apart from the social life [Laughs]. The old institutions all had social clubs. Every hospital had a social club and there was lots of, lots of drinking and partying, yes, yes. But I think, as far as the nursing side of things was concerned, I think, I think it was at a really, again, just a very opportune moment. It was the development of community mental health nursing in the UK and we had some really progressive people there who were, who were establishing the first community mental health nursing services in Buckinghamshire. Probably other ones in other counties but there were a couple of ladies there who were, who were doing that and that was, and it was, it was just a time of change and challenge and it was nice to see the closing down of some of the old wards and people actually going out into the community and it didn’t happen in a hurry but the changes were there and the opportunities were there to, to be part of that process. And I, I qualified in '76 and I was, I was a Staff Nurse on the acute ward for a couple of years then I got to Charge Nurse’s position but that was in psycho-geriatrics and that was lovely. I enjoyed that. Again, it was about bringing about change because they were still tying people into chairs at the time and doing all those things and, and I had the opportunity to create a much more family oriented, home-like environment on the ward even though it was still within an institution and give the patients opportunities to do things that, that were much more dignified, I suppose. So that was, that was good. I got married around that time too, had a baby and then we came out to Australia.

and I had a couple of years where I wasn’t working, I had a second child and then when we moved to, to Brisbane I started working at the Royal Brisbane Hospital in the early '80s, maybe '82, '83.

Comparing UK and Australia

Oh, certainly from my own experiences, I mean, the Royal Brisbane Hospital was nothing like St John's out in the middle of countryside with the farms still around it and although the farms didn’t work at the time. So it was very different. It (RBH) was a big hospital; the mental health unit was part of a general hospital with the old Lowson house at the time, just back on the hill there. That was very different. I started running the evening clinic, so the first job I had there for a couple of years was just going in, in the evenings and providing support, therapy and treatment for people who were working during the day, who had been, hospitalised most of them, had recovered well enough to go out to get back into work but still needed some ongoing support. So that was, that was really, sort of, quite progressive. And I don’t know many places that do that now, provide that sort of social and therapeutic support for people who are working. Mmm, so that was, that was really interesting and really good. Then I took up an opportunity to do some night work there. Again, the kids were getting that little bit older, they could be
left at home with my husband overnight, so I started doing night shift as well, yes. Juggled, the children, juggled the work as women do. So I did that for a few years as well. During this time I divorced and eventually remarried and came to Townsville with my new husband.

The best times?

I think they’ve all been good. I make the point of trying to enjoy whatever I’m doing because you don’t get another chance to do it so you might as well enjoy it, yeah and find the good things out about it. There’s always plenty of bad things around if you look. I like to look at the better things. So it’s all been good, it’s all been challenging, it’s all been an opportunity, I suppose, doing something special has been working in the community and within the non-government sector that’s given me the most pleasure. It’s given me the opportunity to really get to know the families and to get to know individuals and I’ve made some, some wonderful friends out of it as well as, we don’t use the term client. You get to see them as real people. You get to share with some of the triumphs and many of the dramas but you’re able to be there to witness the recovery. I think one of the great things about the NGO sector that I found is that there tends to be a lot more stability in it as far as staffing is concerned. I’m still in contact with people I’ve been supporting for, for years, 10, 15 years and that support’s obviously varied over those years. It would be terrible if I was providing the same level and type of support For many it is just the chance encounter in the street or they send me Christmas cards or I’ll pop in and see them if I happen to visit Mackay or whatever and it’s just lovely to have that longitudinal contact with people, rather than it being short term and purely clinically related. I think that’s been good. I think one of the nice things is being able to use my clinical knowledge and skills and understandings to break down some of the misunderstandings because I think that’s what, not just mental health nurses but what the mental health services in general hadn’t done well - explain why they do things the way they do, what it is that they’re trying to achieve and why common sense is not always the best response to an issue.

Could you give me an example of that?

Discharge from hospital. Where a family, perhaps, is seeing that somebody is not well but they are being discharged anyway. When nobody explains that, well, ‘they’ve already been in hospital for three months and we’re really quite concerned that they are losing a lot of their skills and a lot of their capacities by being here. If we can get them home and provide them alternative support to them in the home setting then they’ll actually get better quicker’. When nobody explains that or didn’t, haven’t always explained that sort of situation the families are left frightened about how they will cope and if they can keep their loved one safe. So, so families are there saying, "No, no, don’t discharge them, don’t discharge them. We can’t cope." And they have been very upset and angry with the services for still going ahead and discharging people. And sometimes the support services and follow-up don’t materialise and the family’s nightmare becomes a reality. So it’s that, miscommunication that used to occur and still does occur at times as well. So it’s been nice to have an opportunity to try and break some of that miscommunication down. And, and it’s about knowing the inside as well as the outside of mental health. I think that’s been, that’s been really good and enabling people to develop shared understandings of mental health issues, the family’s perspective, from the individuals and from the professional’s perspective so that they all get on the same page and work together. That’s been, that’s been really good.

Anecdotes

I think some of the ones, where we’ve been travelling have been great fun. I think the notion of going out and spending two weeks travelling alone with a person (a client) with a mental illness back in the mid-1990s was quite revolutionary, people, even nurses and other mental health professionals, would say, "What? You’re going to spend [Laughs] two weeks, with him or two weeks with her? Is that all right?"
And it’s this notion that somehow it wasn’t OK, I don’t know what it was but, that was great fun to, to challenge people, to do that and then to come back and share some of the amazing stories of travelling great distances with people, of sharing laughs and tears as well along the way and of meeting some amazing people in rural communities. I think, one of the, one of the things that, perhaps, touched me most was the isolation that people often experienced, even in, in fairly substantial towns, where there is a such a stigma around mental illness and I think of a family in particular who had a son with very severe schizophrenia who had tried to commit suicide by jumping off a building and had broken both his legs and ankles and was permanently confined to a wheelchair. And I rang his mother up, doing the support thing on the phone sometime afterwards, to see how they were getting on and she was from a CALD [culturally and linguistically diverse] family so there were some language barriers there as well. And so I rang her up and I said who it was and she burst into tears. She said, "You’re the first person that has asked how my son is since his accident." And he’d been back six months and it was, like, to everybody else he was dead because nobody, none of, nobody in her care, none of her friends, none of her family, no workers, nobody had actually said to her, "How is your son getting on?" And that was stunning. I found that really, really stunning and it makes you realise how important the follow-up stuff is. How important it is to ask the questions and so often we don’t ask because we actually don’t want to know the answer cause we’re frightened of what the answer might be and whilst that, in some ways, is understandable. I think as professionals, that’s one of the things we need to do. We need to ask those questions and be willing to accept the answers and we may not want them, we may not like them, but I think we have to accept the challenge.

There were lots and lots of laughs along the way. There were many times when our accommodation was, perhaps not quite what we had expected and I remember at Julia Creek, I think it was, being there with a female consumer and going into this motel room, and it was just revolting. It was absolutely awful. This was many years ago now. And the two of us just, we just looked at each other ‘cause we were saving money and sharing a room, well, you couldn’t do that now but anyway, we were at the time [Laughs]. It was okay to save money so you could go out twice instead of only once and so we shared a room. It was, it smelt of urine and beer and oh God, it was just a disgusting room. We couldn’t do that, we just couldn’t. [Laughs] So we walked in and walked out and then had to find somewhere else. That was terrible. And in another, another town that I was with, with another lady, again sharing the, sharing the motel room, and it was in a mining town and obviously they had fly-in fly-out miners who used the motel. So I was up and getting breakfast and my friend, my colleague was still in bed and suddenly the door burst open and in walked this burly miner with his bag, ready to start work the [Laughs]. He’d still got his key because he was there every week, during the week, but we happened to be there on the weekend and, yes, yes. So I don’t know who was more shocked, him or us. But certainly it was, it was quite stunning, yeah. [Laughs]

Achievements

I recently returned from a trip out West with a couple of friends – we developed the Learners Permits program together and our friendship grew from there. We each have different professional backgrounds; one holds a Doctorate in Women’s Studies, the other is a Psychologist. Anyway, we decided that we would like to work together on another project and came up with the idea of taking a workshop out to remote areas that usually wouldn’t get access to workshops. Places where it was difficult to gain funding to visit. We decided we would fund it ourselves and provide a workshop just for women that would tackle the isolation and loneliness, provide opportunities to laugh and have fun and provide some basic health messages in the process. We came up with the ‘Superwoman’ Workshop – acknowledging the amazing lives these women lead. It consisted of three parts – one each- Laughter yoga; Taking care of yourself, which included Belly Dancing, and Coping with the Wild Child. We visited Winton, Aramac, Barcaldine, Alpha and Clermont. In Alpha, we held the workshop at the hospital and the elderly ladies from the extended care facility came along, they were having such a good time, sitting in
their chairs, dancing with their jingling sashes hands and it was just such a lot of fun to do this and, look, you never get funding for this. You never could because, I mean, what was the point of it. The point was to have fun, in weird and wonderful places it was just the best thing I've done for a long, long time and it was certainly outside my nursing but it was, at the same time about getting some basic health messages there about balancing life and welfare and looking after yourself. There were just some lovely, things came out of that. We had a lovely comment from one lady who was all dressed up in the belly dancing belts, she explained that she lived on a property, worked all day fencing, handling cattle and generally was considered 'one of the boys'. “This is the first time in years that I have felt like a woman” she said. When we were in Claremont we had about 30 people came from all over the place and everybody joined in the laughter. It was very challenging because laughter, laughter workshops are quite challenging because it's about dropping all your guards and your facades. And that was the only place we had one person who just couldn't do it. Just could not do it. She just, she just had to walk away from it because it was just far too challenging for her, which was, which was in itself a huge insight into, into her life and the strictures around her life and what she was dealing. Everybody else they had a wonderful time and really enjoyed the workshop. We had four generations of one family all there at the same time and all doing belly dancing. [Laughs] It was, it was fabulous. Absolutely fabulous and we got, lots of great photos of the four generations all in their costumes all just looking, gorgeous there. They were mostly CWA ladies. It was just lovely. Yeah. We were very, very privileged to, to be able to do that and to get those people along. It was just gorgeous.

I was fortunate to be made ‘Citizen of the Year’ for Thuringowa (now Townsville) in 2007 in recognition of my work in mental health in North Queensland.

On low points?

I think if we try to identify low points, they’re probably around feeling of inadequacy to the tasks that sometimes you’re presented with. And, I think, perhaps some of those were round feeling like you were a lone voice at times, particularly around getting people to listen to families and to involve families. And I certainly know that there were times when I'd go home quite distraught that something had happened and nobody had explained and, and you spent probably two hours with a really distressed, disturbed and often terrified family, terrified of what was going to happen or what was happening to their loved one or what might happen. The frustration was getting others to see the benefit of open communication, of talking with families, of involving them, and the notion that you don’t have to agree in order to get positive outcomes; that it is possible to negotiate with families. I think, I think that’s part of our maturity as adults but also, perhaps, as a profession to recognise we can hold different opinions and still work together and that often we can get the best outcomes by, by doing that. I think, mmm, the idea that nurses have to control things is very outdated and, I think, we do much better working together. But, I think those have been some of the hardest times when I felt frustrated and inadequate to the task, of not being able to, to facilitate better communication, better relationships between the mental health services and the families, in particular.

I think some of the times have also been when progress has been made with an individual, family and service and then staff have changed and the forward momentum stops or even regresses because the new staff member either doesn’t have the background knowledge or holds contradictory opinions. The burden falls most heavily on the individual and their family, and it is then not surprising when they become angry and lack the inclination to start again.

Are there any particular stories that exemplify that?

I suppose, they would be stories around families who have had concerns about somebody becoming really acutely unwell. Who have, who have raised the issue with mental health services, who have made phone calls and done all the things that we often tell them to do around early recognition,
intervention, early responses. They’ve done all those things and then have been told that, well we actually don’t think that they’re, they’re sick enough to require hospitalisation and the person has then turned on the family as being the ones who are ‘trying to lock them up’, who are the bad guys who are trying to create problems for the individual who, really, doesn’t have the capacity at that time to make informed decisions. And I suppose that’s one of the complex and difficult areas where, perhaps, nurses have started to ‘get it’, if you like. Of recognising that when somebody is acutely unwell, we do have to take account of, do they have the capacity to make informed decisions? I think, there’ve been times when people have been prepared to go along with whatever seems, is going to make their life easier, rather than really challenging, ‘does this person understand? And often that resulted in things like families being excluded because the person said, "Oh, my Mum’s awful. I don’t like her anymore and I don’t want you to talk to her.” Whereas Mum was the only one that actually kept them going. Mum was the only one who, who was there for them and whilst Mum might’ve made mistakes, she didn’t have three or five years training to put her on the right path and somebody should’ve been talking to her about, about what she was doing or how she could, perhaps, be more of assistance. Mum’s do what Mum’s need to do and it comes back to that what you do instinctively or what you believe is common sense isn’t always the right thing to do. If the communication and education is not there, how do you know? That’s where family education’s so important.

It’s about having, taking time to see that a person, nobody lives in isolation. Not people with mental illnesses, not nurses, we all live within a context, within an environment and we need to really understand the environment in which a person lives. Not just when they are unwell, but when they are well and functioning. In those sorts of situations it is about making an opportunity to talk to members of the family in private. Not to share confidences with the families but listening to them, listening to their stories so that when, when you’re doing an assessment it’s not just on how the person is going to present to you at that particular time, and we know that we can all present differently given certain circumstances and certain benefits, we will, we will behave differently and a person with a mental illness is no different. But, by getting a more holistic understanding of the person and their environment then you can make better assessment of that person. You can put up better, better support plans, better involvement and you actually get to know the person a lot better more quickly too because you understand more about, about where they come from and how they got to be where they are at that particular point. Mmm. So it’s about communication and investigation; it’s about, even when the person doesn’t want the family involved, that the family aren’t totally excluded. That they can be involved but in a way that doesn’t compromise the relationship between the nurse and the patient. Families can still be informed and still be included so that they, they aren’t lost, they aren’t cut adrift in, with worry and things. I mean, you see so many family members who themselves end up suffering from depression and anxiety and post-traumatic stress disorders and a whole range of mental illnesses themselves through taking on a caring role for their person and whilst you can’t prevent all these things from happening, maybe we should take all the opportunities to minimise that sort of trauma.

If you take the time to gather that information privately, that doesn’t interfere with the relationships that exist in that context, then there’ll be benefits that flow?

Absolutely. Yeah, for everybody. One of the projects I started here in Townsville was to set up some standards, some protocols around involvement of family, particularly in admission and treatment. We took a community development approach and we’ve done a lot of work around that. It’s an area that I, I find particularly rewarding. The process takes a long time, but it’s rewarding and we were able to bring together consumers, people with mental illnesses, family members, non-government organisations, mental health service providers to sit down and to nut out some protocols around when families should be spoken to, timeframes how it’s recorded by the hospital, what do you do if the person says that they, don’t want the family involved, and noting whether the assessment is that they have capacity to make that decision. If they do have capacity, then what processes and protocols should be followed to not exclude the family.
totally but just to keep them informed with the things that need to know. If the person is deemed not have capacity, how do you proceed. A flowchart plotted the involvement with that family from admission to discharge within the hospital setting but also in the community. The development was a very lengthy process but one that was instigated by me challenging, the status quo and saying, "This really isn't good enough." And it was good having an opportunity to link up with other like-minded professionals across the board, particular Dr John Allen, and mental health nurses, like Richard Lakeman, Andy Froggett, who also came on board to help us work through those issues to, to develop something that was going to be useful and to set some standards around the involvement of families. It was a three-year program, probably, all up and it worked really quite well and Richard developed some interesting research around the outcomes but like so many things, if it's not continuously monitored and reinforced, it can fall off radars very quickly, which is what it did. The project did not continue long enough for the Family Involvement Standards to become routine practice within the Townsville mental health service. I think, the contact that nurse have with families is not always routinely recorded, in the same, sort of, streamlined way. It's hard to audit those processes now. But I think, I think also there's been a turning of the tide where families are more likely to be involved now. There are always exceptions to that but, I think, there is, a greater understanding of the role families can take. One of the interesting things is referrals by mental health staff to the family education programs. We run 'Wellways,' which is family to family mental health education program and the referrals come mostly through word-of-mouth and other NGO staff. We should get referrals from all nurses, all mental health staff, every time they come across a new family that has had little contact with mental illnesses, they should be referred to somewhere where they can receive the information and support that they need. It would make their job so much easier. And there are changes but it's slow it's almost a generational change, I think. It just takes a long time to keep informing people and, I think, because there is such a turnover in mental health nurses within the hospital and community setting, in particular, you've got to constantly let them know that these programs are there and what they can do for the families, what the benefits are for the individual and how when families are better educated and supported it can help them with their work, as well. If you leave the promotion of the education programs for more than 12 months, half the staff have changed and that's always, it has been a bit of an issue. But over time people are coming from other areas where they've also had contact with family support services, so it's improving but it's a slow process. Yeah. Yeah.

**On being a nurse in Queensland**

I think one of the great things that I've had the opportunity to do is actually to, sort of, to do some unusual things and one of the things that I was involved in was actually writing a parenting program for parents who have mental illnesses and that came about through some work I was doing with a young woman who had bipolar disorder and had a family. She had been sent to do a number of parenting courses which had left her severely traumatised because she felt that they didn’t meet her needs. Particularly if she was becoming unwell, she couldn’t put into practice the protocols that they were saying were important, particularly around consistency in parenting. When you've got bipolar disorder, consistency is probably one of the things that's very hard to find. And, so after some conversations with her, she and I presented a paper at an international women's conference here in Townsville. It was very fortuitous as there were other people presenting with similar concerns around issues of parenting and so we, again, taking a community development approach, got together some educationalists from Queensland Education and psychologists and some people working in mental health, people working with families and the families themselves, a number of families with mental illnesses in their family and we developed the Learner’s Permits for Parents Program.

This [showing the manual] is just the black and white one which is not nearly so interesting. But, anyway, it dealt, basically, with parents who had mental illness and also parents who had children with ADD, ADHD
because one of my observations had been that those two things often went together. Parents who are raising children whilst they are themselves trying to cope with mental illness, seem to have quite a high proportion of children with, not necessarily just ADD, but conduct disorder, oppositional disorders, a range of disorders and, obviously, it makes their parenting ever harder. And so we wanted something that was actually going to meet those two needs at the same time, because you could do one on mental illness and you could do one on ADD, but it’s really hard to integrate the two sorts of information and skills development at the same time when they’re delivered separately. And so myself and the community group met many, many times and employed a psychologist, an educational psychologist to help us to write the program around these particular needs. And, that was wonderful to get that opportunity to be able to run the program and it’s, sort of, taken on many different forms since then. It’s been adapted for foster families, for blended families, for families that are just that little bit different where there are issues for them in their parenting and so that’s been a really great experience to be able to be part of this. The program uses lots of humour because everybody learns better when they can relax and have fun. And so the colour version of the manual, is very bright, very cheery and very practical and it’s been lovely to get the feedback from families who’ve been able to access the course.

We were able to seek funding from the Office for Women, and we got a little bit from a number of other sources. So it the funding was, pooled and everyone put in just lots and lots of voluntary hours. And that’s been, I mean, that’s the nature of NGOs. Perhaps now as much as ever, if there’s something you’re passionate about, you just do it. That’s the nature of women I think, and nurses, probably, as well. We just do it if it’s there and needs to be done.. If it’s something that you really think is important, you can’t wait around for somebody else to think it’s important enough to do something. There are heaps of families falling apart today, why would you just sit around? I don’t know that it’s a good model [Laughs] there are I’m sure down sides to it. I think one of the nice things was when we did our two Learners Permit pilot programs, my hypothesis that there was a high correlation between being a parent with a mental illness and having kids with difficult behaviours, ADD etcetera was true, 75 per cent of the families that came to do the program had children with ADD and ADHD and conduct disorders and oppositional defiant disorders and those sorts of things. It probably wasn’t a large enough sample to be extrapolated across the general community but it was nice to think that there was an issue there that I’d been able to identify and that it actually had proven to be probably reasonably accurate.

I think we got all together about $25000 or something. Not much really, which is what happens, isn’t it? But, it was enough to employ somebody to help us with the writing and we got someone with considerable experience in writing these types of programs before.

And has it helped you in terms of the next project?

Always. Yes. I think one of the things that you learn particularly in the non-government sector is around being able to do a bit of a sell and if you want more funding then you’ve got to sell what you’ve already done and some of the projects and programs and things that we’ve done. I have been fortunate to receive an international award for our rural program where we were travelling around delivering all those different aspects of support and education. And that was very nice but the best thing was it offered opportunities for us to gain support for other programs.

Where did you get that international recognition?

It was from the Commonwealth Secretariat which is based in London and that was back in 1998 It was pleasing to be recognised as developing a model of best practice for mental health services for women carers, because we had a particular focus on women as they’re are the majority of carers and service providers too in health areas in general. So, so that was nice.
We deliver it in partnership with Centacare here in Townsville. We do a lot of partnership work because we’re still a small organisation in many ways. We are still underfunded in many ways and so partnerships are the way to go and the benefit of partnerships is that you pool, not just resources but knowledge and understanding and people. And that’s, that’s really good. So we deliver range of educational programs, Learner’s Permits is one that we deliver that as the need arises. I run the Adult Mental Health First Aid courses and the Youth Mental Health First Aid courses for adults working with young people. I do the High School Education program, the Well Ways Family Education program and today, I’m actually starting a new program which is a Dual Diagnosis program for families, where we look at mental illness and substance abuse which is such a complex area and it’s so hard for families because they’re dealing with two, almost separate issues but that complicate each other incredibly.

This program has been developed in Victoria by Mental Illness Fellowship as was the Well Ways family to family course. So I haven’t written them, I deliver them and train families as facilitators for our services in Townsville, Mackay and Cairns. But the way the duo program works is somewhat different to the straight Well Ways program in that it starts off looking at a scenario which is quite typical to a family situation, where a person, usually a young person, has a mental illness and a substance use disorder. And it asks the families to identify what the key issues are from that little vignette, so the program is actually based on developing problem solving skills and so once they’ve identified what the issues are and why the issues are important, then the vignette is expanded a bit more, it goes on in time, maybe six months down the track or whatever, now this is what happening, what do you think the issues are now? And all the time you’re building on people’s knowledge, understandings and learning’s, filling in the gaps but they’re doing it themselves. So it’s very much based on adult learning principles. Tonight’s the first session and we’re looking at schizophrenia.

We also have the opportunity to bring in the bi-psycho social model understanding the causes of mental illness, treatments and outcomes. It gives us an opportunity to look at the models of change as well. It gives us an opportunity to look at stress vulnerability models. So all those things come into the program as we go through each of the vignettes and each, it’s a six-week course each week we have a different vignette and we just keep building on it and building on it and the end is looking for some solutions and allowing people to be really creative. The vignettes are very much the sorts of things you would expect in a family that’s trying to deal with dual diagnosis so it’s about helping them to fit the new understanding and knowledge into their own context. Whereas our other Well Ways program, for example, it’s very much providing information to families and building the knowledge that way. This is a very different, sort of approach. Certainly from the research that’s been done around the the duo program, it would seem that this has the best outcome for families as far as developing their knowledge and their skill development it’s so real.

What would you say are the qualities and skills that you bring to teaching?

I think, from the feedback that I get, I bring knowledge but I also bring humour and I bring some, well, it’s been described as a gentleness. I don’t know how that comes across but that’s how people have described it. I think families respond well to a little nurturing and care. It’s a very gentle approach to the teaching but also to the listening for what other people have to say because there’s are always people who have great knowledge and understanding of things, and there’s always opportunities to learn. I think it’s about making education it real and I love stories, and I like turning the theory into something that people can relate to so that it has meaning for them and it has relevance to them. I think, that’s one of the key things about getting the positive feedback that I get from the education programs that I run. People like the illustrations I use to explain the information being shared. They like normalness of it and they like the fact that I try not to use language that’s the professional language, that I try to use ordinary language in describing things that we’re talking about and, I think, that makes it a lot easier for people to understand. And I use lots of cartoons. Lots of humour. Lots of funny things and, and I’m very happy
to poke fun at myself and, I think, when you’re a teacher it’s a bit about being an actor as well. There is a certain persona that you put on, it’s not a false one, but it’s one that’s particularly useful in the teaching area, particularly if you are a bit shy like me.

More dramatic probably?

More dramatic, that’s right, and expressive. Facially expressive and people relate to that and they like to have a little giggle and, they like to feel that you’re sharing something personal with them and like everybody else I’ve got my own experiences within my family of mental health issues and with the greatest respect, being able to share some of those personal insights and personal understandings. It brings a lot of connection.

Lessons to be shared?

[Laughs] I think, one of the things that is very different when you’re working in an NGO to working, say, within a clinical setting is, is about the boundaries. That you don’t have the same boundaries and, I think, often within a clinical setting, they’re quite well defined and well understood by most people and often well enforced. In the non-government sector, those boundaries are grey and, I think the cautionary note is to make sure that you are always questioning your boundaries, both from having them too large but also having them too small.

I think where the boundaries are too restrictive would be thinking it’s not okay to, say, accept a small gift from somebody. When you’ve been working with somebody or it’s coming up to Christmas and you’ve, you’ve spent a lot of time with somebody and they really appreciate what you have been doing and the work that you have done with them and they want to give you a small gift. Now, that can be seen as not appropriate, and, well, maybe it’s not. But to refuse a small gift is a bit of a slap in the face for the person and so I think it’s perfectly fine to do that, but I think you need to be open about it and let people particularly your supervisor know that that’s what’s happened and this is what you have done because things can be misinterpreted. I also think it is OK to reciprocate with a small gift, in just the same way as you might when you are not involved in an hierarchical relationship. I think, as long as you reflect on why you’re accepting a gift and why it’s being given then, I think, those sorts of things are absolutely fine. I think where they get too broad is where, when you’re working with somebody that you actually do start to become actively involved in their personal life outside of the context for your working relationship and that’s a pitfall for anybody working in the sector. It’s about finding the balance and the recognising that the balance may changes. It is not a straight line and it will vary from person to person and it’s about constantly evaluating and checking and having good supervision and support around your boundaries. I think that’s one of the beauties of working in the NGO sector is that the boundaries tend to be blurry and you can develop some amazing relationships with people that are very therapeutic, very helpful to them and very rewarding to you too. Because there isn’t those same restrictions but you always have to be checking, you can’t just assume. And you have to be checking out how other people might perceive the relationship as well. Boundaries are always a big issue in any sector where you’re working closely with people. But, I mentioned earlier that having developed great friendships with people and they have developed over times and they are very personal friendships now, but they’ve also been very cautious friendships and have, I have reflected on them and, and discussed them with, with people over the time. And even when they are very personal friendships, I think I’ve managed, mostly anyway, to maintain the capacity to step back if the person needed some more intensive professional support rather than friendship support and, I think, that’s been, that’s been the lesson that has, at times, been hard. Whilst you can counsel friends, it is not useful to ‘become their counsellor’. You don’t always get it right but I think one of the big things is to acknowledge when you get it wrong because most people are really willing to forgive you for getting things wrong. People with mental illnesses and families are just amazing at how much they can forgive because we’re not perfect. I’ve had to go and explain this is what I did and I
realise now it might not’ve been an appropriate thing or I probably should’ve done that differently. Sometimes that has been the catalyst for some amazing growth, not just for me but for them too. So it’s nice to be human and to be able to acknowledge that you don’t always get things right.

I think the NGO sector is just an amazing sector to work in because you have such a lot flexibility and because there are always challenges and new opportunities there, that for anybody who likes a challenge it’s a great area to work in. I’ve done things that I couldn’t have done had I remained within the straight clinical sector and I think that clinical background has enabled me to develop other things that have been non-clinical but I couldn’t have done it without the clinical background and so it’s that ability to slip from one to the other that has created lots and lots of great opportunities and also to gain entry to some areas. I think. If I didn’t have a nursing background and I didn’t have experience in the field, that then many of the things that I have, well, probably I wouldn’t have been able to do. It has given me a lot of credibility to say the things that I’ve been able to say and to challenge the things that I see have perhaps not been the best or needed to change.. And I think NGO sector doesn’t pay particularly well [Laughs] which is unfortunate but look, there’s a lot more to life than money and I think that the rewards that I’ve gained have far outweighed any financial loss that I might’ve incurred because I’ve had such a, a fabulous time in doing the things that I’ve been doing for the last 20-odd years. It has been lovely. I’ve been really blessed to have those opportunities and look, they’re still going on which is great.

PS

I have just returned from a weekend presenting Mental Health First Aid to folk in Georgetown - about 6 hours drive north west of Townsville. Many had driven more than an hour from cattle properties and other small towns to attend, staying overnight to avoid the drive back in the dark with the likelihood of 'close encounters' with kangaroos and cattle! Their open interest in learning about mental health/illness was very evident, with a number acknowledging various personal MH experiences and genuine concern for others they knew. Their unique issues in coping when there are literally no services - even emergency services can take several hours to respond - is very challenging for them, but they are very practical and eager to learn. These workshops always generate a real buzz and lots of wonderful social networking - which is, I think what keeps them all going.

Barbara Hayes
Current Role: Emeritus Professor of Nursing, James Cook University, Townsville.

On being nominated: [Practice pioneer, career longevity]

It’s a real pleasure to be part of, well, capturing the history, means capturing the harvest too, so that we can hand it on to the next generation who’ll be doing things we’ve never thought of, or, and I have every confidence in the next generation that they’ll be right for their time. We were right for ours, the previous
generation were right for theirs, that’s when the colleges were set up, the colleges of nursing and then followed by the, our own college. That whole sophistication of nursing education came post Second World War by the nurses who returned because they were doing it as a living memorial to the nurses who did not come back. The girls who did not come home as they said. So when we say it about in Queensland because a lot of my experience has been in Victoria and in the United States in mental health, but in Queensland I would say, I think, that because Elizabeth Beattie and I were, and we had a very small staff at that stage, six, four academics and two admin people. We wrote that curriculum which, if you remember, we were, when we moved in Queensland into universities, which was 1990, I know people have had post graduate courses, CQU and QUT but actually the bachelor, bachelor courses. We were still trying to get the four-year degree and so they really didn’t make up their minds till we actually had taken the students in, but anyway. So we got the three-year degree. But, so we wrote the curriculum for that and it was definitely a bias towards mental health because both Elizabeth and I believed that if you understood the mental health aspects it would make a lot of, give you a rationale for understanding the behaviour of people who are stressed with physical illness. I just don’t buy the dichotomy at all. See I think, we talked about holism, you know but I think that, I suppose if you ask me what is my moral imperative and that would be that of Christian humanism. So to see people as a value in themselves, whatever it is and a holistic value but understanding that, at times, various aspects of their lives become in disarray and that’s when we can walk the journey with them or go into the tunnel, as we say, with people in delusions and accompany them that way. So I think it was the curriculum which was truly a strong curriculum. It was strong in mental health nursing; it was strong in science because, again, we believed that if you could understand the body from the cell up, you could make intelligent interventions about what was needed in nursing. And we also had a strong request from practitioners to start a mental health nursing, post graduate mental health nursing but we were, we couldn’t run before we could walk so we needed to get the bachelors up but it gave them a great grounding and we recruited a lot of mental health nurses in those, in those years when we had that basis.

The second thing was my own research. I find schizophrenia so engaging because it is one of the most elusive of the mental health ill, disorders and one of the least, the least easy to understand, really. I’ve tried to put myself in that position but I really haven’t been able to. You can think about people who’ve got depression, ‘cause we all have some sort of depression. Whether it’s, often said that unless you’ve had a good bout of depression, you’re not being an adult because you haven’t loved someone or something enough to feel the loss but, so that’s where I did my doctoral work in is in schizophrenia and the relation of family effective climate in negative symptoms.

Then later on we developed those scales. If there’s one thing that, it’s like a lot of scales, it’s been misnamed, it’s the positive and negative symptoms of schizophrenia. We should never have named them that because people feel labelled. We’ve got, present your negative symptoms and also negative symptoms were so hard for people to understand, because people, because quite often mental health nurses and others felt it was, it was personality related or motivationally related and the patients themselves called themselves lazy. "I'm lazy; I can't get out of bed." I said, "You're not lazy at all, you have symptoms." And so I think, I think they’re the two things in, research I would dearly have loved, like to have gone on the schizophrenia area and I still am passionate about it. I go to every, visiting lecture I can about it and try, try and keep up but I, because research is quite often, well, the opportunities for research come together when people of like-minds come together so there was Brent Bradley who's now the professor of psychology at Charles Sturt and a biostatistician, Denny (? Coomans) who was still over here in mathematics and stats. We arrived about the same time and so we started to research together and so my first research project was at the Women’s Hospital which was then at Kirwan, it’s now relocated back to the Townsville Hospital Main Campus, but there was so little research going on anyway by anyone that nursing research was so welcomed by the practitioners. They were, they were enormously helpful. They’d put aside the patient histories on, [they’re Barbara’s] but they could come and get them so the women didn’t lose their place in the queue. All these things we had such access to that.
And I had no research assistants; I needed to train my own. There was no pool of graduate students or anything and, I have to say, my research assistants have all risen to the top of, of, senior directors of nursing and, and a couple have moved into IT in the health field. Because I said to them, what you pay a research assistant is next to nothing on any grant, I said, “I would teach them research as I went along not just data gathering.” I think they were the two reasons, really. The, and it wasn’t till later that I realised that, how much it meant to the practicing nurses that there would be nursing research. When I went to do the Beyond Blue one, well, I had an NHMRC in between that, still at Kirwan, and then the Beyond Blue later at, when they were on Main Campus and one of the practicing midwives on the floor, I heard her coming down the corridor, we were meeting in the tearoom, so I briefed them about that and she had a stammer, she says, "If it’s, if it’s Barbara’s, it’s all right. It’ll be, be all right." [Laughs]

So you established a trust and openness to research?

Yes. And a valuing of it and, I suppose, one of the things you earn your spurs, don’t you? It’s interesting. We had one woman who was very high on our scales, we use the SADs and the, we use some of the Blue Blood scales; I’m never one for developing my own. I was weaned off that at, when I was at the University of California, San Francisco and these were based on the, the criteria that DSM3 were based on. They’d been, it’s the sort of Blue Blood stuff, reliable and valid. And anyway, she was very high on them so we had a pathway of care, of course, that she went into the consultant, she didn’t see the registrars. And she delivered this little daughter, Madison, multiple, multiple birth abnormalities and incompatible with life so she lived a week. Now, they didn’t pick it up on scans or anything and what they felt was that because of the research, she got the best care they could’ve given her anyway cause, so it just formed a bond that was, we, when we went to see her, she said, "I suppose I can’t be in the study anymore?” And I said, "Of course you can be in the study. We can have a subset of (10.27) of one." [Laughs.] I didn’t say that to her, but anyway but she conceived again. She was, her husband was in the army as many of the women here are and, of course, he was out on the field because they didn’t expect a problem with the birth. So, so, I suppose it’s interesting about that bond with practising nurses and midwives and, never take it for granted, always respectful, always, always open up a place myself. We had nine sites for the Beyond Blue research and I opened up every one myself. We’re a thousand kilometres from Mt Isa. Most of them were well over 500 kilometres from here.

On the Beyond Blue project

Yes, well, the reason, I was invited to be on it was that I had, when I applied for the NHMRC, excuse me, grant which, sorry backtracking here but I got an internal grant for the first thing and NHMRC always wants you to have some basic data so I got the second one. One of the, I rang someone, one of the professors, (? Cardrie) I knew at Royal Park. He was a lowly clinical professor then and then he was [laughs] he was at the top of it. And I said to him, "Should I have a consultant psychiatrist on that?" I said, he said, I’m not sure how I did it. I didn’t sort of, I said, "Would it help if I had a consultant psychiatrist?" He said, “It would help a lot.” I said, "Can you give me some names?" So he did. Anyway, I got Brianne Barnett who was, she’s the guru, really, for peri natal mental health in this country. She’s, she’s just given the first, lecture from the Marseilles Society, the distinguished lecturer and she’s, she’s taught us all, really. She’s, psychiatrists and nurses, mental health nurses, people across the board. She’s a charming clipped woman. So she, she was my consultant and I had another one, John Condon, in Adelaide and out of that, you see, and through the Marseilles Society, they had, the Marseilles Society is spelt out quite nicely there in that, that sheet that the College of Nursing did. I was invited to be part of the Beyond Blue. It was called the Beyond Blue National Postnatal Depression Program. Even though we knew at that stage and my two, my studies ahead of it had contributed to the fact that there probably, that anti natal or pre natal depression, was probably as prevalent as postnatal depression. Now, that only happened in the ’90s. And the other thing that happened in the ’90s which came out of psychology was that the, the infants of depressed mothers have a cognitive deficit. Excuse me, let me rephrase that.
A cognitive slowness and they develop slowly as well the social and emotional and that's because the brain is so plastic. So we go back to the neuro plasticity of the brain and the, that, intuitive, almost, cueing in that the mother does or the carer, it can be. We have to realise that the aristocracy have always had carers for their children but whoever is that. But it's that cueing in of the brain all the time. There's the bird, here it is, that, and without that they don't, they fall behind in their milestones and then they go to the playgroup and they bite the child next to them and then they're not welcome and then they, drift behind. So it really is, you've got two people involved here, as well. So anyway, we had, this was a very exciting project and we had a State, we had a national director who was Professor Anne (??) University of Melbourne and then we had state directors. Brian was in New South Wales, John Condon in South Australia, Jeanette Milgrim, Victoria; I was in Queensland and Sheryl Pope as in West Australia. So what was interesting for me was, two things: Beyond Blue got us together before they gave the grant to see whether we'd work together. That's an interesting and so I had that plane ticket and I paid for another one cause I was determined and I thought it was timely, I said, "We can't do this in the 21st Century, without Aboriginal and Torres Strait Islander women involved so I took Lenore Guy down who then worked with me on the project and is now doing her PHD in looking at the strengths of birthing and child bearing on Palm Island from the perspective of four generations. So these things, sort of, move on but from that we developed, we were part of the mainstream screening and, the, for anyone who wants to look, they're all on, that's on the Beyond Blue site the results of that and we've written two articles about the three sites we had for the Aboriginal Torres Strait Island women where we actually translated, if you, the Edinburgh Depression Scale as well as their information sheet and their informed consent and, and when I say translated, we sent them over to John Cox, who was the lead on the Cox Sergovsky and Holden, 1987, and he's, we called them modified, he said, "These aren't modifications, they're real translations," because they were obviously, the language is meaningful to those women, to those who it was given. So we were pleased about that. I suppose I have then and still have a real criticism about informed consent sheets. I think they cover the backs of the researchers. I don’t think they're at all clear to the people you give them to. They trust you because they like you. So we wanted to make it as clear as we could be for, for these women because and we also wanted to give them something back. No, it, let me rephrase that. Part of forming the partnerships with them is that they have a clear benefit and the clear benefit was their own translations of the Edinburgh and then the booklet which was distributed for emotional care in pregnancy and early parenthood, which was, that's also available on the Beyond Blue website and is available free from, from Beyond Blue and that's now in its third edition. But they translated their own. We did it with, of course, a reference group. That was, that was what took a lot of time. It took me two years to set up all of that on those sites so that we could do it in a way that was respectful and that they had ownership.

You had a long history before you joined us in Queensland

I think practically all of us, or family, my family of origin, have gone into the serving professions. It was very strong. Both my parents had university degrees. My father had a BABM and my mother had a BA which was, sort of, unusual at that stage. If you have an education, you ought to give back. If you have certain gifts, you should give back so sort of, that's, and, you should work as well and as hard. And it wasn’t a sense of achievement for achievement’s sake, it was achievement for service. So that, and my, my mother’s father, my grandfather, operated on the beach at Gallipoli and he, and he was a New Zealander and he and my uncle, Uncle (??) both worked at, at times, worked at St Vincent's in Sydney so when I decided to, that, I would go down that nursing road I went to St Vincent’s in Sydney. Although our family was in Brisbane. I went to St Rita’s school in Clayfield, Brisbane and to the great Presentation Nuns, fantastic teachers, absolutely fantastic.

I went to university for a year and then I, I joined nursing because I wanted to help people. Well, now you'd call it altruism or something, something else but that's what I, I wanted to do. So, and, I went to St Vincent’s and did the usual thing, midwifery, infant welfare but, I think, meanwhile I, I was always
interested in new developments and Margaret McKinnon, I don’t think you know Margaret McKinnon, but she was head of ACU, well she was head at the College of Nursing Australia when I joined the staff there and, but she was at ACU.

Anyway, when I was going overseas for the Kellogg [scholarship], Lois Wakefield, who was the director of nursing at Royal Park had a lunch and she said, "Instead of me saying something on Barbara, for Barbara. I think I'll invite all of you, to say something." Well, you could see the spouses of the people that came pale, and it was, but Margaret McKinnon said, "I've always seen Barbara on the cutting edge of change." And I found that quite an insight for me because she was absolutely right as far as my career went. I'm very conservative about some other things, but that was, so I think there was some sort of thirst for knowledge or whatever

And serendipity perhaps because when you came to Queensland you found yourself on the cutting edge of change in Townsville (with the Ward 10 B Inquiry)

Yes, yes.

And, you see, I think that's why I, that also I am a pioneer. I really enjoy that challenge and I found when I came here and they were truly not ready for health science in one way but Pat Slater who was one of my mentors and she was on the selection committee. She wrote to me and said, "They know nothing about nursing but they're teachable." [Laughs] And so I found 80 per cent of it was easy and 20 per cent stretched me, so for that setting up the school and the foundation and that. But I was determined to do the research as well. So, and it was a stretch to do that but I, I just knew we wouldn’t have any credibility without that. The other thing is, I felt, again, I had been given that opportunity and that I needed to use it, develop it.

Becoming a mental health nurse

I came in as a post basic student after I'd done my major in psych at the University of Melbourne and so I, I came in, in my early 30s so I'd done quite a lot of things before that and mental health nurses at that time, I'm not quite sure how they are now, but they felt anything physical was out of their realm. So they used to say, "Get Barbara." [Laughs] "Blood to be taken, get Barbara." I said, "I'll teach you how to take blood." [Laughs] But one of the, one of my most memorable things that happened when I was there, and I, I enjoyed that and also there we had a couple of bipolar women who had become deeply, really psychotic and they came in and, and, I was very happy to be their, the nurse, well, the person in charge, the person working with them. That was quite cutting edge stuff cause we had Queen Vic for the postnatal depression women but these women were psychotic, floridly, beautifully psychotic. Shredding perineal pads all over the place [laughs] in the, in the way that, enjoying themselves. Anyway, so but, but the pivotal thing was how long can they be with their baby and that so we, but one of the things that happened there which we had, which was memorable, I found most of my experiences when I read the question you asked about humour, I found most of them were poignant rather than humorous.

And we had this 16-year-old; we had a couple of very young, classic dementia-praecox. One young woman that, I think she was about 15, 14, 15 that way. Plaits down here and writing and writing and writing and they just and another one she was Malaysian I think, anyway and she was so ill, so ill and, of course, she was so, she wouldn’t, she was so dehydrated it really, when our consumers became, had some physical symptoms we’d send them off to the Royal Melbourne and that so offended me, it so, you’ve got someone who has one of the most severe mental illnesses you’ve got, she's in a most acute phase and you're going to send her off to the Royal Melbourne for people who can't even spell schizophrenia.
I thought it really deskilled mental health nurses so I'd said to the consultant, "Look, we can look after her. We can do the mouth washes...because she would've died if she didn't have some, some real intense, physical care. So one day, I, we were in the same unit as the ECT was given and so I slid in and slid to the anaesthetist, "Would you come and put an IV in this young woman?" Everything has to be plastic, the cannula and everything. And, boy, did I, I knew I only had a short time before the afternoon shift came on and they, so, we certainly ran a whole lot of IV fluids. She was just dehydrated and I had learnt this before because of psychology but I'd had a great mentor in the closed unit when I was a student, post basic student called Sue Hanbury. I'll never forget Sue, and she understood when the consumers were brought in, they'd been, if they were bipolar they'd been deteriorating for, they're escalating for at least, about 24, 48 hours before someone realised they were in an acute phase. Schizophrenia, they'd been just neglecting themselves. They were dehydrated and that's, we've got a brain already under deep distress and then, the dehydration on top of it. So, so, she made sure we gave the fluids and she, she taught me a lot, Sue, about real respect for psychotic patients. Tall, lean, gay woman who had very little respect for the male staff [laughs] and I said, "I'm going to stick this, stick with you Sue." She said, "Don't expect me to teach you anything," she said. But, of course, she did. And it was, she's always been so and I admired her. I haven't kept in touch with her but I've kept in touch with some of the other really outstanding mental health nurses and I was smart enough at that stage and had enough chutzpah to put, make sure I went with the good practitioners, so that I really got some good, good experiences. But I remember that young woman but, at least, we, gradually she got better but she should've had, I mean, that's what we should've done for her before.

I mean, she was so much more settled when she was hydrated. Otherwise she was wandering around with a nurse specialising her wandering around after her, you know what I mean. I'm not, I mean Royal Park was an excellent hospital but we just, we just didn't understand that you have to do both, you have to. And, and I said, "She'll take jelly, she'll take..." You know we had to therefore order, it's a major public hospital so, I felt like going running out and buying the jelly myself and making it. [Laughs]

How long later was it that you went on that Kelloggs scholarship?

Well, a few years later. Fairly soon after I had graduated and I worked in the acute unit. I did, because I wanted to do my honours year, I'd done my BA but I wanted to do the honours year, I worked for nine months night duty in the acute unit. Because you couldn't tell either side what you were doing. The university said, "No, you've got to give up all your part-time jobs. This is a very select group and..." and I don't know that Royal Park would've been thrilled about my doing studying during the daytime and working at night. Ah, but anyway, it was the only way to do it and one of the lovely experiences I had was, with people who have major mental illness they don't, their sleep pattern's disrupted. And the last thing I felt, I couldn't, just, I suppose, I felt it was dehumanising to have them sitting in front of a television in the dayroom at 2 am in the morning, but that was where they came. So I read Shakespeare to them, the plays and you see, they just drifted in and out. It didn't demand anything of them and that language is so beautiful and rhythmic and it's human voice. So, and I [laughs] enjoyed it and was with the patients in an humanising environment. I mean being read to is very humanising and nurturing, isn't it, that's to, and I'd do the same with, in, with patients in the dayroom in the daytime, just read out, I said, "What are you most interested in? The newspaper?" And I'd read aloud, cause, I can remember my parents doing that. My father saying, "Oh, Helen, you must..." and read this out. My mother could perfectly well read the paper for herself [laughs] but it's, it was a sharing moment. And when we think back, I mean, we do it for children, we do it for lovers do it, reading poems to each other. It's a very humanising sort of thing. But so I, I think those experiences were very strong for me and then I had the opportunity to go to the United States. I was, really, if it hadn't been for Bernadette Keene, I don't think, and Pat Slater, I was, I don't know that I would've applied. I was quite happy being where I was, but anyway I sent it off.
it was suggested I apply for this scholarship] Bernadette had had a short-term one and just knew, sort of, what a rich resource, especially UCSF was very, Anne Davis, Holly Wilson, just in little offices, not even as nice as mine, actually. [Laughs] Linda Chavetz, it's a lot of people there. And so Bernadette knew that and Pat Slater just felt that this was all very well me going off to do mental health but, she, she, she could see that I had leadership qualities... I didn’t see them, I didn’t see them, I think, till I went there and what Margaret McKinnon said made me very thoughtful and then when I went over there, I thought, "Oh, I know. “I've got, I know quite a lot."

What do you think your leadership qualities were then and are now?

I lead from the front but I also bring people with me. So I mean, so I hope that’s not a contradiction in terms. The respect for the skill mix, that people realise that other people can do things much better than I in some areas. I think I’m pretty good at curriculum but Liz Beattie was far better than I.

How long did you spend in SF?

Five years. I went over to do my masters...I was single. And the thing is, I went over to do my masters and when I got over there I realised that what I needed was to be (35.50) prepared. So I, when I left, the Dean said to me, "You persuaded us to do something we weren't ready to do but you did." So I said, "Look, I’ve got, I'm willing to work for the whole year, the summer," and my Masters was two years and the doctorate was normally five but I said I’m willing to work through all the Summers and, and Kellogg let me have two years’ funding. They weren’t going to but they said, "Oh, if you do your masters in one that's what you've come for, you go back,” and my heart sank. Anyway, because I, well, in 1984 was Bob Hawke made that statement of moving nursing education into universities and 1985, January 1985, New South Wales went cold turkey cause they were worried that the State government would renege and then the rest of the States took them time and Queensland was the last to move. Queensland sits on the fence a lot and waits to see what mistakes and things that everyone else makes but, but, but I went over to that. That was a marvellous five years. I became an international citizen of the international world of nursing.

I learnt an amazing amount and also I just wanted to come back, very much wanted to come back. I had no question that I wanted to stay in the United States. I’d come for that and to come back. And then this opportunity to come up here, really attracted me and I, I did have other offers, Margaret, in that time [laughs] in Australia and I, I always went down and visited if the people asked me to apply for them. And, but the thing that kept me here was, a couple of things: One was the Aboriginal and Torres Strait Islander opportunities cause we, actively recruited people from those backgrounds from the start and we had a bridging course and then we, and James Cook University had always been good like that. They’d had, started in education, they went into community welfare, then we were the third, what they call, Enclave Programs and, I said, with our staff, I said, "This is, this is not a choice, it's our destiny. you can't live here, you know." And that's still a passion of mine. In fact, that's what I've narrowed down. When I sit on a committee like the Beyond Blue plan committee and the expert group, I said, "I'm very happy to participate in anything but you have to know that's why I'm here." And it’s good conscious raising for people and, and not that I think I represent people at all, I'm just keeping a place at the table till somebody else can take it. People, someone from their own people and, so, in all of that, so I've stayed with mental health in, in my research and I also think that that early work, I'm very pleased about that early work that and the projects before I went into Beyond Blue and I was very, always been pleased about my practice. That I've been, I'm, very proud of the years I was in practice. And I'd hate to lose those skills. I say, “That’s why I won't wear my nails long, I like to have my fingers, tips of my fingers as some of the most..."

To get back out there at a moment’s notice?
[Laughs] well, well, they’re the most, one of the most sensitive things you do. And, and in mental health and I think we’re better at it now with the physical care, the aromatherapy, the, warm baths, what I mean it’s not saying to someone go in and shower, you shower them. Just that connection, sitting with them, even if you’re sitting in silence. That’s...

On the notion of presencing

It comes from the Heidegger notion of, to present oneself to the other, and, and, it was something that every post grad mental health group recognised somehow, so that’s what we do. We, we, you, we think it’s the mind but it’s the embodied person who has the experience of mental illness and you sit beside them as a human-to-human. You can, talking is sometimes helpful. Sharing a cup of tea but a lot of sitting in silence is, is comforting too. But, it’s the total body, total person experience, the total, the real Peplau. That, the interaction, the nurse, the nurse patient interaction as she called it, is in and of itself therapeutic. Long before we had medications so that’s and I still believe in that and, I mentioned to you about the rehab. I think that’s the same in rehab, the way you take people down to the bank to get their money out, you walk in, you walk the absolute journey with them when they’re at that, that stage. So, I didn’t do a lot of community mental health. Oh, that’s not true, I did when I was in the States, I did a whole summer in a shopfront clinic in the Tenderloin.

It was just, it was a fantastic experience. These people, some of them were homeless. It was an old shop. [laughs] Old store, so it wasn’t purpose built or anything. The, so all you had was, it was mixed, multidisciplinary. So everyone just had desks and chairs. It was like, sort of, the Japanese, you pretended there was a wall [laughs] and then you had, that was upstairs and then downstairs was a big, biggish room where you had the activities, yeah.

[people who were homeless] were referred, they were referred out of, they had the psychiatric emergency service, just like you have the physical emergency service at the San Francisco General, known by those who had got connected with it "The General." "I’m going to The General" so, and see a lot of people don’t realise that in the United States the poor are looked after by the County Hospitals. It’s the people who are middle income who take out insurance and then [the working poor] and also, middle class people. But there were a quarter million illegal refugees from Central America, El Salvador and things at the time. They were treated at the General with no questions asked. And our, our people, that’s, that was where they had the clinic but they were referred out through the community mental health service cause they were at that, at that stage. Very, just a very interesting mix of therapists and, clients as I think we called them then. Very, what’s the word? A bit like the therapeutic communities, you really had to be straight, no bullshit because they pick up on it.

The high points of that time?

Working with a wonderful mentor, the Head Nurse, Laurie Barkin and she was, cause this was part of my experiences, the Master’s experience, and we’re still friends, so. That and a very good psychiatrist who I always remember him saying about anti depressants and he had them written down on a wall chart or a board or something and he said to the clients and to the rest of us, "If one doesn’t work, there are 14 more." Now, there’s many more now but he said there are 15, remember if one doesn’t work, there’s another. I thought that was very insightful thing to say because often people say, "Oh, I went on anti depressants and it didn’t work." Again we come back to the neuro plasticity of the brain; it works for some brains it doesn’t work for others.

And, I guess, in that way he’s hope giving as well?
Yes, that's what he's saying. He's saying, "Hey, just because this one hasn't worked," and it's the same thing with therapists. They were very, amazingly open, well, we were, at the soup kitchen next door we had something else, we were in the poorest part of San Francisco. They, if one, they were very honest with their, in their meetings. They said, "Look, I just don't think I'm the right person here, we've got a clash round that," and someone else would say, "Well, I'll take the lot." I thought that was so, what's the word? Sophisticated professionalism. It's not my ego and my, thing, but it's, it's, this is not the right mix for this person. So, I just, I learnt, I suppose, I could see despite those surroundings, I mean because they were primitive, but the high level of care, high level of care those people got and that was, again appeals to my sense of that those who are sickest ought to get this care. I think that's what nursing does, nursing across the board in mental health, we've always been very good at, what I call, distributive, well, I don't call it distributive justice, it's John Rawles, but, we've always seen that the people who are sickest get the best, whether they, whatever category they might be in, or get the extras or and I've seen that right across all the phases of nursing I've been in, that, it's really something I find very, sustaining and inspiring about them. They do it by stealth a lot of the time. You know when that poor bugger over there hasn't got any flowers, we pinch some from someone's whose got a lot. [Laughs] and sometimes they ask sometimes they didn't, and, or, or, or something else. But mainly the care that was given and, and that's, I've done a lot of post grad teaching here and the reflective practice, that's not always the experience people have had. They, there was one experience someone wrote about, an Aboriginal person in, somewhere in the North, I won't say where but was ordered this, was in renal failure, was ordered this medication and the English registrar said, wouldn't give it. Said it's too expensive for him and this is, this, see, it's, and he died soon afterwards but she was so outraged, that it had happened. It didn't happen yesterday when she wrote about it, but that's what I feel about reflective practice. If you can get, it's, you start to shape, put words into meaning, sorry, dignify the experiences that you've had with words so that then you can, engage with them yourself and move on and also change your practice. She said, next time I wouldn't. I would've run the consultant and said it's not being given.

Best times

I remember when I was Royal Park, and I'd finished a shift and I'd come out and I would have to sit in the car for at least 15 minutes or half an hour because I just felt that the clients had a right to it, it was my psychic energy. So, what those people have, the suicidal, acutely suicidal people just take every bit of energy you've got. I'd sit there and I'd just, I found that enormously affirming. I felt I have given them what they want, when their psychic energy is low I've said mine's available and I've just sat there, I couldn't have driven out into the traffic 'till I'd, till I'd had some reflection and meditation and just, and then sort of went on.

So I, I think it was similarly, when I was a fairly new grad I went into, cancer nursing and I would find that a lot of similar situations there with pain management and it was a fabulous place, it was the Peter McKellam Clinic in Melbourne and, boy, did they know about pain management. Even now, all these years later, decades later, people aren't doing it as well. We did it very well. And I, I think that being part of that sort of level of sophistication was very satisfying.

It's like that young woman whom I got the IV into, it's like this woman on a hot, hot Saturday, February, a day in February in Melbourne, no air conditioning and the North wind blowing and she was, 30 with two children, CA breast with cerebral metastases and she, and she had a lisp and we were in secular hospitals we were called Sister, "Oh," she said, "Sister Hayes, I feel so ill" and I just, went into this, got to tell the students it was a sort of, managed to wash her, even with the curtains, I was careful not to rattle them. Did the whole thing and, first of all, got her some pain control and by the time I'd finished she was asleep and I thought, now those sort of experiences, that young girl, they keep me alive.
Paediatrics was the same. I was in the haematology, childhood leukaemia and thalassemia and there’s, I often say to the students, the two groups of people who’ve taught me most about communication are children with life limiting illnesses, whose career is illness and whose expertise is pain and people who have acute psychotic episodes. They’re the two who’ve taught me most about communication, because all that overlay falls away and they can, they can pick up whether your, the clear communication. Amazing. They’re just children often who couldn’t tell you what was wrong with them but you could pick it up and the same thing with people who are acutely psychotic. They can’t actually tell you what’s wrong but they can sense that you’re there for them. That’s right, I come back to that. Being available, the presencing, the psychic energy, "I’m here for you," whatever it might be.

So I think they’re still along with the research and the other things, but as far as a, as far as a nurse, my nursing goes, they’re the things that, and the same thing as being a midwife when you’ve been able to, support people through tragedies like little Madison who was born with all those, about seven or eight major birth defects and, that, being, being with people without any demands. Being available without making any demands on them or, so how you convey that I’m sure in one way, one of the things I used to say when I was teaching RA’s about the Beyond Blue, I had mainly midwives so I needed to teach them a lot about mental health and I said, "But there are two things you need to do when you’re interviewing people." I said, "You have to absolutely concentrate. Even if you sit outside in the car for five minutes to get clear away the shopping list and what the kids are doing. As much concentration as you can and then you believe what they say." You don’t say, "Oh, you mean X and Y, you believe what they say." You see, the mother of Madison, she had these thoughts that she was going to harm the child when she was born so there was, she was picking up on something that had gone wrong with this pregnancy and nobody else had picked up on it till it was born, so, except there, we’d picked up that she was anxious and, and, and more highly anxious, I think, than depressed. I can’t remember exactly but whatever it was we got her into the, the care. So, it’s, it’s wonderful, I suppose, having the opportunity to talk about it but it’s also, that’s what I’ve taught students, is that especially about mental health, I said, "It’s not us and them," I said, "We’re all on the one continuum and we can change places any time. Any time at all." Got a bit of reservations when you get over 40 you’re probably not going to get schizophrenia, but, but I said, "It’s that, it’s not, it’s that distance and you don’t have two groups of people." And I think that I’ve been able to hand on some of that to students. And it’s, it’s like the neuro plasticity and the things they’d get them somewhere else if I hadn’t taught them but what it is, it’s the, the values and the commitment and they’re always caught not taught. So, I think that’s, and so I’ve had a, I think, I’ve had such a privileged life.

You said the values and commitment are caught not taught?

I think partly, demanding respect for each other in tutorials. Demanding respect in lectures. When I say demanding, I don’t say I’m demanding but I’m very skilled at lectures. If everyone’s chatting, I put on a mobile mic and walk up the stairs and talk from the back with an overhead or a thing there. I, it’s saying, I suppose, conveying to them and the same thing with tutorials when they sometimes lapse into the vernacular with each other, I said, "Excuse me. Is that how you talk with patients, like that?" "Oh," I said, "This is a formal forum of the university. What you say to each other in the under croft is your own business but not here. Oh, goodness, me." So what I think is, I do use a lot of the theatrical because it’s natural to me, I like the theatre. But also I have, I think, learning has to be memorable, you have to, and those sorts of attitudes is that, and some, sometimes they’re very, got very cross with each other and, so it was sorted out that this is, this is professional language. I said, "You don’t have to like people to work with them." I said, "That’s a bonus." I said, "Don’t look for that. But you’re in this class together etcetera," and sometimes classes get clicky and, and things but anyway, I think, that was that, when I say demanded there is, we weren’t having feet on chairs and a few other behaviours that, I think, are disrespectful. You wouldn’t allow in a morning meeting a consumer to put feet on chairs. So why are we allowing university students? "Well, my feet are tired." And I said, "Well, they’ll be far better rested, your body is a really
a mechanism. Of course I thought, "So if you sit up straight and put your feet on the floor, you'll feel much more rested." And I said, "Trust me, I'm a nurse." [Laughs] So it's partly, it's partly that, I suppose, lightness of tone in some ways but very, it's very, sort of, I was saying that what we are doing is serious without being solemn. And it's serious because we have a commitment to consumers out there and you need to get the best education possible. I said, "This is a moral responsibility."

The worst times?

For my own mental health I sort those out at the time. I made a commitment to myself when I was in the psycho geriatric ward at Royal Park, that I would do my own personal work as I went along no matter what it took. So there were, some people I found difficult to work with but I thought, I promised myself I'd find something, one attribute they were good at. Do your own personal work, find something good.

Remember that you need to spend time, focus on your own growth as well your personal growth, because you can't give them water if the well's run dry. So I think that's a very important part. It's what I say to all, all students is you have to take care of yourselves. I mean, in taking care of yourselves, you know how to take care of other people and in taking care of yourselves you find out where your energy comes from. So, you need to do those sort of things. Whatever it is, whether it's music or running or, my, mine is, poetry and the arts and that renews my energy. It's a very aesthetic energy and I do meditation and I say whatever it is, do it. There's no one size fits all around that.

The other thing is to, to question. I was confident enough when I was a mental health student and I think I was pretty confident earlier than that, to question and I think people encourage you to question. But you just have to time the questions. Just before you go, "Why are we treating that person this way and this person this way? I don't quite understand that," because without that clarity, I think we are not able always to exercise our duty of care, which is implicit in, obviously, in consumers who've come in for our care but it's implicit in research, participants and researchers. That's what I found with the Beyond Blue, is I, particularly the Aboriginal and Torres Strait Island women who are health workers. I've worked with the health workers, 'cause that's what they wanted me to do, not directly with the women but to skill the health workers but then they were asking these women questions about, and they hadn't resolved a lot of their own about their, their own birthing, their own things. So I, manage but I thought any other, research grant I'd asked for I'd bill that in. I said, "You have to have supervision of, if you're going to put people out on that frontline, you have to make sure there's safety nets under them." And as I said, I managed to do it, and one young woman I spent hours on the phone at Mt Isa, in Mt Isa but finally got Centre Care. See she couldn't go to the public hospital. It's a small place. Anyway, I got someone in Centre Care to see her and doing it just to be a supervisor while she was doing it but it's scary stuff, when you start to do that. So there's a duty of care implicit in every, research, every time you take informed, consent. I also believe and I'm on a bit of a roll about this at the moment, there's a duty of care to publish. Now, I know one ought to publish because you've been given money and career and all those things are secondary to me. We had, usually say in informed consent, we're asking you to do this. You may not get direct benefit but others will. Now, others won't if it sits on the shelf and gathers dust, so I feel quite strongly about that. That you have to get out and I know it's not easy and that's when I'm, we're still trying, what I'm still doing now, out of the Beyond Blue and others, particularly about the Aboriginal ones is, is to, we've given a lot of conference presentations and things but also to get out the publications. So it's, without clarity to the extent that one can, I think, about the treatment, I'm not sure that we should really give the treatment. We're treatment brokers, after all, we, someone writes us the order and we give it. So unless we understand that, I think that's, that's something that came out of when I was at Royal Park. It was huge at the time. One, we were in shifts you always went with the same group of people. (1.06.28) And we had this young woman in and a lot of the nurses on the shift I was on, I was in charge of but didn't believe she had schizophrenia and we were treating her for schizophrenia. Well, we finally had to have a full meeting with the psychiatrist and everybody and everyone and I, I agreed with them. I said,
"If they don’t believe she has schizophrenia, they can’t give an order," that’s treating her, and she was atypical, it was complicated. So and I think that’s the same with, that’s what I would say to the young practitioners. Even if people get cross with you, I said, "If you get cross, just say, “Before you go, could you just answer this question?”"

So I suppose that’s a sense, I think it’s not just ethics, I think it’s morality too. It’s where ethics and moral, it moves in to morality. And, and I think in that way, we can then say to, to the consumer, "This is why we’re giving you this. This is what we hope it’ll do," and also, one of the things I said about the mentors and I had some fantastic mentors. John Cox, John Cox, tall, lean, male nurse said, gentle, compassionate man. Done a lot of forensic mental health and, I had the opportunity to, he was senior when I was a student and a couple of things that came up and he’d lean back, cause he wouldn’t perch on anything, he was too tall, he’d lean back against the filing cabinets and he said, "The question I always ask myself is what would the coroner say?" And I thought, that’s been a piece of wisdom for me cause I say to myself, "What would the, say it’s about a student, "What would the review panel say?" "What would the thing,” "Have we really sort of made sure the student wasn’t bullied or whatever.” So it’s, it’s just a wonderful thing that he was looking and I suppose he’d been to more, coronial inquests than I had been but what would the coroner say? What’ve you done? And I thought, it’s a nice piece of practical wisdom, isn’t it?

It helps us check our accountability

So students need to develop their own benchmark, their own ethical standards and sometimes you can’t always exercise them but you can have them and say, "I don’t agree with this," but if it’s an order and everyone else agrees, but keeping that sort of conversation going.

I think one of the things is I’ve always so enjoyed my colleagues. I’ve enjoyed the, well, look, those colleges I belong to. I enjoy crossing disciplinary boundaries, professional boundaries. I do that with great ease. I do that with great ease cause, and this was the thing about the. Beyond Blue, I was the only nurse midwife as a State director. The, the others were psychology psychiatry etcetera but I was there because I was authoritative about what I, what it was that I wanted. Like, to a change of practice for midwives and mental health nurses and it’s coming. Perinatal mental health is now being picked up my mental health nurses who wouldn’t touch something that didn’t have an ICD or DSM on it. Now, it’s, you can see how it changes practice. But I’ve always enjoyed my colleagues. As I’ve said, I’ve had really splendid mentors and I consciously mentor other people. Formally and informally and that, so I, because I think that’s, I suppose it’s because I, I enjoy it. I enjoy articulating what we do. I enjoy the language and I love the way nurses subvert language. I can’t think of an example from mental health at the moment but there’s a lot of them (1.11.52) themselves but there was this one at, from St Vincent’s Private Hospital in Sydney and, Sue Ronaldson is Professor of Nursing there, heard the late Frank Packer who was, not Frank, that was his father, Kerry Packer came in and he was patron saint, of course, of St Vincent’s. He’d given a lot of money, they’d saved his life. Anyway, he came in, there were two defibrillaters outside these two rooms and he said, "What are they?" And they said what it was and he said, "Well, every room’s got to have one. Every room’s got to have one." So anyway, she heard them doing the inventory one day and they were doing, in the storeroom something, "Eight so many cathereters, ten so many this and ten so many this, eight packer whackers, eight packer whackers.” [Laughs] I think, I think nurses subvert the language like that in a way that does no harm but that’s what I think where you get the humour from too. They’re sort of, they’re just great. So you, you have another interview to do, I know.
Margaret McAllister
Current Role: Professor of Nursing, University of the Sunshine Coast

On being nominated: [Inspirational role model; passion, dedication, commitment]

It’s probably because I’ve taught in the post graduate mental health nursing area for quite some time. And when nurses come back to graduate studies they come back through choice, they want to investigate the topic further, and when they do, I’m usually very passionate and supportive about change in the mental health system and they usually find me, I suppose, accepting and encouraging of them exploring things deeper. And I think they possibly find that in their working life, it’s hard to have that opportunity to investigate things further. So they probably see me as someone with an enquiring mind who doesn’t conform to the system. But you see, I think being an academic who is distanced from the system of healthcare you’re at a distinct advantage, you can keep hold of your ideals and you don’t have to sort of suffer the shock of reality sometimes of practices that continue despite the need for change, clients who maybe don’t get well and you continuing to see them, all of those things that can deplete you, that’s not part of my every day. And so I guess I keep an eye on the big picture a bit better and I’ve maintained my idealism and my enthusiasm.

I’ve also made a concerted effort to maintain my idealism and I think in nursing you get told frequently to “Open up your eyes to the real world,” and, “Stop being a dreamer,” “isn’t this naive” and all of those things and I’ve always seen the value in idealism.

I would say it goes back to my childhood and my schooling years. I grew up in a working class family, didn’t have much money, I was one of five kids, and we were Catholic, poor Catholics living in a bay side area of Brisbane. I went to the same school for 12 years, I had the same friends, and there were lots of nuns teaching us and these nuns were really into social justice. For a while there I wanted to be just like those nuns and I wanted to be a nun myself, but then I changed, and I could see the difference between religion and making change for justice. And so I didn’t lose my inspiration to want to see social justice done and I had my eyes opened to people who were from areas of need and disadvantage and wanted to make a difference there. At first I thought it was going to be through religion but it wasn’t. So my whole area of being idealistic comes from, if you want to make change you’ve got to keep the fire burning, you’ve got to be passionate about it or otherwise you kind of just slip into just working, and 9-5, and not having much enthusiasm and that doesn’t interest me.

The other thing that I think keeps my idealism going is that I’m creative and I like to go from project to project. You could probably track that in my nursing career ‘cause I didn’t stay in one place for very long and just kept moving ‘cause I wanted something to do, I wanted to have a small project, see the beginning, and the middle, and the end of it and then move on and in academia I can do that. I go from maybe publication, or research project, or course, or whatever, and continually moving so that’s good. And also travel the world, going to conferences; I don’t tire of that because there’s so much you can get out of every place you go to. So I sound a bit “Polly-Anna-ish.”
I’m not “Polly-Anna” and I can get very upset about things not changing and the continual injustice, for example, the marginalisation of mental health nursing in nursing programmes here in this University or anywhere. You think you’re making a difference but you’ve got to be vigilant, you’ve got to keep a watch for how the status-quo and conservatism continues and it re-emerges. So that can be depleting, but I suppose if you’ve got the energy you try to keep going.

I suppose when you think back on your schooling and you see teachers who had a drive or enthusiasm, people either love you or hate you in that regard don’t they I think, and probably some of them would have quite easily taken me off the nomination [laughing] I don’t know. But three of them bothered to nominate me so that was good. So I think that’s probably why, they felt my enthusiasm and they were inspired by that.

**How did you start nursing?**

Well I stumbled into nursing. If you look back again at my history, my mother was a nurse and a midwife, my sister, my older sister started nursing and didn’t finish it, my younger sister is an endorsed enrolled nurse and works in a doctor’s surgery. When I left school I didn’t have a clue what I wanted to do. Our school was not about career, it was about having an intellectual time or being challenged.

It was a small Catholic school where the teachers did not talk about careers they talked about knowledge. So we were doing things like studying economics and being interested in why some economics works in some cultures and why not. And I had no interest in jobs; I didn’t have a job when I was going to school. And then suddenly I left school and realised we had to make a choice about where we wanted to go, so I just picked Uni, Queensland Uni, and picked an Arts degree ‘cause I thought, “Oh well that’s pretty general I’ll just do that for a while.” I had no clue. I went out there and was overwhelmed with how big it was and felt immediately disengaged and felt so small when my schooling and my life had made me feel so big I think. Mum thought I was smart, teachers thought I was smart and then I went to Uni and felt very insignificant and so I dropped out and I joined the public service and it was boring in about 2 months. My sister had become a nurse at the P.A. Hospital and a job came up, you know how they used to advertise? I think they had two intakes a year or something like that. So I thought, “I might do that.” And also because they’d just changed the rules at the P.A. Hospital and you didn’t have to live in anymore and so I liked the idea of not being so institutionalised. So I put my hand up and I got accepted.

Still I had no desire to be a nurse, I was just following my sister I guess. And I was there and it was a culture shock. I’d never worked so hard in all my life, I’d never...I think in my life it takes me a while to see the big picture of things and I used to be engaged in small activity like doing someone’s dressing and not realise what sort of ward I was in or what the point of the dressing was for, I just used to do little things and I used to find it incredibly boring and distressing.

I used to find a lot of it distressing ‘cause I couldn’t see the point and I couldn’t see what the point of my role was. So I lasted 9 months, my boyfriend went away and I dropped my bundle, I think I was maybe only 19 or 20 and I rang up my work and I quit. And the next day, it only took me a day and I regretted what I’d done, so I rang back again, I said, “Could I please speak to the nursing supervisor because I’ve made an awful mistake,” and they wouldn’t let me come back. [Laughing] I’d bet they’d let you come back these days wouldn’t they? But she wouldn’t let me come back. So I was unemployed for about 3 months or so, had a great time, because I was 19 and I just ran around going to parties and having fun. I went on the dole and then got a job because they got you jobs in those days and I got a job as a clerk. I worked as an accounts payable clerk for 2 years and I loved that job, because you
Making Queensland history

could get everything neat and ordered and finished and I really enjoyed it but it wasn’t intellectually challenging after a while.

Then I saw that nursing was being taught at University and I thought, “Well I really liked the theory of health,” didn’t particularly like the prac of it [laughing]. And I applied to go to QIT and I was successful. So it was really just an extension of my living a free life and I went to Uni and I really enjoyed it.

I found the prac safer, somebody was looking after me, there was a point to it, that was really important to me, that we had a chance to reflect on what we were doing and if I didn’t understand anything it was their job to help me, whereas in the other position I never found anyone to help me. Often they’d yell at me or they’d diminish me by saying, “Why don’t you already know this?” And I think I was a slow learner then anyway and I probably was frustrating to them. But anyway, I did enjoy the way I learnt at QIT it was then. So that was a fulfilling experience and I succeeded at it and I did well and then I had to get a job. So I got a job at Greenslopes hospital which was where I was living close by. Worked there for a little while in a respiratory medical ward and then I worked at the Mater Private ‘cause I moved house and as soon you moved house, if the place wasn’t 5k’s away, I got a job close to my life. So I worked at the Mater Private for a while

and then I think I saw that mental health nursing was being advertised, there was a short course starting at Prince Charles Hospital. So I eagerly applied for that and I got it. And so that began my, what I thought was a career, ‘cause I suddenly thought, “I love this.” I really loved it. I knew I loved it when I was in prac at Uni and I was at Winston Noble Unit in my prac and on prac the Doctors would ask my opinion, I could sit and talk to patients and

You could sit on beds [laughing]! Yep. And you could use your creativity. If you thought that you’d like to organise a game of football, then you could, and if there was a reason for it then it was welcomed. And I really liked the way that you extend yourself and that it wasn’t just about routines, and functions, and techniques. So I think I was attracted to that but I didn’t quite know why at the time, I couldn’t articulate it, I just knew that I liked it. And so mental health nursing began for me and again it was pretty safe, in terms of psychologically safe. There were people who said, “You’re a student, right, well this is what students do,” and they limited my practice and that was good. So I worked, I did my 18 month course there and then I stayed there for something like 6 years.

I became a clinical teacher, and was working part time for them as a nurse, and part time for the different Unis, and was second in charge of a ward there, worked in a closed ward, worked in open wards and then I worked for a year in London in acute psychiatric hospital in the east end of London which was a huge eye opener and fantastic experience. Then I came back and I worked part time as a nurse, part time as a facilitator, and part time in the mental health association doing promotion of mental health in the community which also was a great job and really exposed me to, it broadened my outlook. So I wasn’t just a nurse and looking at things from a nurse/patient relationship, I was looking at people and what people needed to promote their mental health and well-being and what the community needed. So it really broadened my outlook I think.

One other thing I’ll say is that, “Why nursing?” It wasn’t really, “Why nursing?” I picked an issue that I felt needed to improve and I just stuck with one issue which was that we need good nurses in our community. For a civil, caring, society we need high quality nursing care and I’ve just known that I’d better stick with one idea and focus on one idea and so it’s nursing. I guess it could’ve been medicine, it could’ve been art, it could’ve been teaching, it could’ve been being a journalist, but I just decided, “Okay I’ll have one career and this is what it’ll be.” Every now and then I think, “I’m sick of this. How bout I do another career?” But then I think, “I couldn’t be bothered starting all over again.” It’s also interesting because, although it’s not a female profession, it is gendered in that there is a lot of gender role behaviour going
on, that we have a history that involves women’s oppression, we have people doing what was seen as unworthy work and dirty work and to me that’s intellectually interesting and as a woman it’s interesting that that caring behaviour is diminished. I find all of that needs to be reclaimed and needs to be articulated and spoken about so that we can see that that caring work is really important work, and we need to find a way to speak about it to value it.

*How did you move into academia?*

I have always enjoyed listening to students and responding to students. When I was a student myself, doing the shortened psychiatric course, I would empathise with the students doing that were in an earlier year than I was and I’d support them and they said to me, “We value your support.” And I found that validating. I found that we need to protect and support each other and that it doesn’t happen all that often or well. As soon as the opportunity arose I wrote to all the Universities and volunteered myself as a clinical facilitator. I found myself working in a whole range of services but particularly I also worked in the service that I also worked in, which was Prince Charles Hospital. That was great because the staff knew me and trusted me and I was confident to follow the students through and to facilitate their learning for them. I find teaching a really creative thing to do. I love finding a new and engaging way to say something to make schizophrenia interesting, to open people’s eyes to issues that need improvement and need to be rethought and I find that a challenge. I like new media, I like working with all the technology because I’m constantly learning and I think I’m pretty good at making complicated things meaningful for students. So I think that is the art of a good teacher is to make complicated things accessible to others and I guess that’s my challenge is to continually try to make it accessible to people. So here I am and 16 years later working in academia, I’ve worked in every single position from clinical facilitator, associate lecturer and now I’m an associate professor and one day I’ll probably be a professor I hope, if I haven’t jinxed myself.

*Have you got any stories about using humour or anecdotes?*

A fantastic experience that I had at the Prince Charles Hospital was when we had an artist in residence and that was his job. He was a nurse as well, Neil Price. And Neil was a lovely bloke, is a lovely bloke, and it was his job to engage patients in meaningful activities and he worked shifts. We would do things like ordinary art work, we’d do crafts, we’d do murals, he’s done some lovely murals with patients. But one particular occasion we decided to make a Chinese dragon and we were also having a fete at the same time. I can’t remember why we were doing this; it was just a one off thing. But we spent about 6 months planning for it so all the patients were involved with various activities to support this fete. Some of it was cooking, some of it was craft work, some of it was constructing this dragon, and there was one particular woman who was a really good guitar player and singer, opera singer, who was also very sick with schizophrenia. Over the weeks we just used to ask her to write some songs for us. So the idea was that there’d be people under the dragon and we’d carry this dragon all through the hospital and there’d be little band singing songs alongside this dragon. It was the 1980s. And she wrote the most amazing little songs that we all learned to sing and it was lovely and she played beautiful guitar, but she couldn’t handle being in large crowds and so we would just write these songs together and put them away and she’d go off in her...she was quite disorganised and quite distressed, she used to hear voices and have delusions and she’d get very distressed often there were times when she had to be quite heavily medicated and so on. I just remember one day, ‘cause it’s not very humorous it’s very sad actually. I came off lunch and there she was sitting at the end of the corridor where people were allowed to smoke, and she was just wailing, and rocking, and she was sad and I said to her, “What’s the matter?” and she said to me, “It’s not my fault. Is it my fault? They keep telling me that I caused World War 3. Is it my fault?” So this was the kind of distress that she experienced and I could see then, that it must have been a torment for her, to feel like she was responsible for world events and world events that hadn’t happened. But that’s the kind of life she was living and yet she was so talented in this other area and
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that was an eye opener. But anyway, getting back to the...on the day, I requested an Early so that I
could spend my time with her, and nurture her, and support her whilst we were doing this thing. Anyway,
she de-compensated. When we got the dragon out it looked spectacular. Actually we called the day,
“Spekka” and I think one of the patients gave it that name; it was going to be a spectacular day so they
called it, “Spekka.” I went to her and I said, “Are you ready to come now?” And we couldn’t contain her
so she actually had to go into seclusion. We weren’t around the rest of the day, and of course I had
responsibilities with other patients, there wasn’t much time to consider this issue. We took the dragon all
around and then when we were heading back to the ward, we all decided that we’d all go past her
room and we’re outside her room giving her a special show. So that wasn’t humorous, but it was special,
and I hope she understood that. What was I going to say? Often with people who are very disturbed
like that you wonder about how much emotional significance they place on that. Like, I could see that she
was extremely distressed I wonder if she ever gave that a moment’s thought afterwards or not. I don’t
know whatever happened to her. So that was one thing.

And as a teacher?

A lot of students come back years later and say, “Do you remember this day?” And often I don’t
remember the days [laughs] but they do. But I do recall this event and it only took place a few months
ago. I was working at Griffith for 10 years, and when I first started there I’d just had my son. I used to
actually bring my son into the clinical labs, because I was a single parent, and that age he was actually
too young to go into day care. So he used to be beside me and the students loved him and he was no
trouble and quiet. When I started teaching there a student started part time, and it took her 6 years to
do her nursing degree, and then she got a job at a private hospital, and after a couple of years she
came back and did her master of mental health nursing. So I had her for that whole 6 years and then I
had her as the teacher in the masters. She grew from being a tentative, shy person in those 6 years and
really unsure of her practice and wanting to know everything, wanting to be a sponge and absorb
everything. Until now, when I saw her as a nurse educator, where she is handling the most complex unit
as a nurse educator. Dealing with that issue over there, going over to that nurse, remembering that client’s
name, managing an emergency, walking into a closed ward and dealing with these nurses, and that issue.
She can just keep complexity in her head, she’s got focus, she’s humane, compassionate, thoughtful and I
just think, “My God, I’ve really cooked that cake well.” It seems like she’s turned out well. The message
with that is being engaging, being open and giving people time to answer the questions and the concerns
they have, hopefully they’ll flourish in the end and that’s... yeah. And she’s going to come back,
hopefully, when her life settles a bit at the moment. She’s going to do her PhD in kindness in mental
health nursing. So I hope that...and with me. So I hope that I’ve played a part in keeping her compassion
for human beings alive, and that now she’s got her own way of saying this and her own language and
she’ll make a contribution.

Best moments as a mental health nurse?

When I was a clinician, the best moments were when, as a team, we bounced off each other well, and we
supported each other well, and there’s nothing better than being in a team that makes you feel strong
and makes you feel supported. And so there were lots of...particularly in evening shifts, where you’d
have a chance to have a chat with your colleagues and then you’d say, “Let’s go and do something
interesting,” or, “We may have to respond to this emergency is everyone okay with it?” We’d come
together as a team. That made me feel like I was doing a good job, made me feel like I was part of
something bigger than just my own ideas. So there were plenty of events like that as a clinician where it
all worked out well. When I look back on my clinical career there were hardly any times when the team
didn’t work well, that it was dysfunctional, I don’t recall that, however, I do hear it from current students
that there are teams that are quite dysfunctional. But maybe it was because I was working in a very
contained... ‘cause it was in-patient care, and it was quite contained and predictable therefore.
Whereas in the community I think it might be very different and maybe scarier. And plus there’s multiple players now. When I was a clinician there was nurses, doctors, and there were psychologists, and social workers, but they very much had a consultancy role, they weren’t there all the time. And so it was the doctors and the nurses who came together as a strong team. My most memorable teaching experiences are often with just interesting students, where we might be just having interesting discussions, that you can tell that their eyes are getting opened, they’re feeling enthused and motivated. I’d go home walking on air then, because they’ve energised me and I know I’ve energised them.

**Worst moments?**

The worst moments clinically are when things don’t work out and when people’s distress doesn’t get contained, and there’s been quite a few of those. The people’s suicides, people being in a state of agitation and it not being addressed for a long time, I find that really distressing, to see people in pain for a long period of time, that’s awful.

There was a patient who was floridly psychotic and he was sort of dancing around in a circle, and he was hyper-agitated, and it would’ve been for hours. It seemed to go on maybe even two shifts and it wasn’t being... nobody was attending to him, they were just letting him do it, and I think they might not have been able to think how he might be feeling, I think they just sort of saw him as a bit of a spectacle. That was distressing to know that, when you actually talked to him he didn’t want to be doing that, he wanted help, he couldn’t signal it. That’s been a constant thing, is that with people with mental illnesses it’s often that you can’t presume you know what’s going on in their head; you actually have to ask them. So even when they seem like they’re being funny, or seem like they’re being happy, you actually have to ask to find out what’s deep down inside.

But the thing that has...on reflection, the thing that has most moved me in my career, the bad news story, was when my partner had a compound fracture of his leg, and this is 2 years ago. It’s not a mental health story it’s just a story that shook me to my foundations. So he had this compound fracture of his leg, and he was first taken to a country hospital where the management in the emergency department was really terrible. He had an IV canula in, and the medical registrar was trying to get pain control, and they were giving him fentanyl, and it wasn’t working. In retrospect I wonder whether the IV was positioned properly. But whilst the doctor was at his head trying to ventilate and medicate, the Orthopaedic doctors were down at his leg and they started pouring normal saline onto his wound before he had pain control, and I was at the head of the bed with him. And first of all they started touching him, and he was screaming, and then when they poured the water he screamed so much that he fell unconscious. It was devastating for me, but obviously terrible for him, but now as I recall it, it was like what it must have been like for soldiers on a battle field, that was the kind of agony he was in. That they didn’t notice, that they were more concerned about his leg than they were about him, was very distressing. But the doctor, the medical registrar, said to me, he saw me and he said, “Sit down.” He was caring for me, and I could see that, in these moments, there are some who don’t see the human being and who just see the technique in front of them or the issue in front of them. But there are others, and they might be rare and few and far between, but sometimes when they reach out to you that human connection is very, very, powerful and I think it makes you go on. But anyway, we got transferred down to another major hospital where he had a series of procedures done which was one botched thing after another. Again, there were times when I remember standing in front of him and just crying and saying, “I’m so ashamed to be a nurse.” I rang a professor friend of mine who I knew worked in the hospital, and I said, “Can you come and help me because I’m going crazy here; I can’t get anyone to listen to him.” She told me what to do, and she gave me good advice, but at the time then I just said to her, “I don’t want to go on as a nurse. I have no...I am so ashamed, I feel as though I’ve made no difference and I’ve been a teacher of nurses for nearly 20 years, and I feel like I’ve made not a lot of difference.” And so I had my own existential crisis. And for a moment maybe, it was even a few days, I really felt like my
purpose in life had been to no avail. That really, what I did didn’t make a difference in the scheme of things.

But I quickly regained my purpose because I thought, “If I haven’t made a difference [phone ringing] yet, I’m gonna keep trying until I do. And actually what happened after that was he and I made a film together which is, I’ll show it to you [moves away]. So he’s in that film. So I’ve written this book on, “Solution Focus Nursing,” and I wanted to show an example of, how do you be solution focussed with patients? And it came from mental health, “Solution Focus Counselling,” but I deliberately tried to make it about general nursing because my view is that mental health is every nurses business and you can bring mental health nursing skills into nursing, and one should, because nursing is about human interaction, and all the skills we have as a mental health nurse should be shared with nurses. So anyway, “Solution Focus Nursing,” is all about that and I thought, “I won’t have a client that is a typical mental health problem I’ll pick a medical patient.” So he had an external fixation on his leg, he was a good prop, so I used him as my example in there. I basically just show how you can be engaging of the individual, spend time acknowledging what their concerns are, work with them to set goals, facilitate supports so that they feel as though they’re on the road to recovery. That’s all that is, and I just demonstrate it. So I kind of turned what was a trauma for me into something that could be used for positive gain I guess. I suppose that’s what I’d done in my whole career is, if you find a problem, well then it’s something to talk about, it’s something to generate solutions in. So that’s sort of how come I go from project to project ‘cause there’s so much work to be done.

**Significant moments in your career?**

Being a mental health nurse, finding my place as a mental health nurse, that was fantastic, because I went from being someone who went from job to job to suddenly having a career and being passionate about a career.

I was eager to get up to go to work. Before that I used to find any excuse not to go to work. I found that my work became my life, not in a bad way, but I used to find it stimulating, enriching, my friends were there, the challenges were there, the interesting things that were gonna take place were there, instead of just in my private life. So I found it fantastic because before then I thought work was just...you just went to work to get money, and suddenly I discovered actually your work can be a fulfilling part of your life. And that was when I was still a student doing the shortened psychiatric course, but I felt like I had something valuable to offer and it was also interesting. So that was one pivotal moment. The other was, I suppose, getting a full time job as an academic because I think I’ve always been a writer and good at speaking, and so I again found a niche, and I found another way to be challenged. Because the other thing about being a teacher is you learn as you teach. And so in teaching I got the privilege of keeping on learning and I was learning for free, I didn’t have to pay for it. Plus being an academic I got my master of education for free, and I got my doctor of education for free, so that’s a pretty good perk. Not that you get very well paid now compared to others, but money isn’t a great motivator, I mean, I think academics deserve to be well paid because it is a hard job, but money isn’t why I stay. Why I stay is because it’s intellectually stimulating and it’s such a creative job.

So the next pivotal moment in my career was publishing and I had my first publication in 1996. The reason I did was because there was a guy in religion who was very creative too, and I think I said to him, “You’re a really creative teacher, tell me why are you doing that?” And he said, “Well I’m always trying to think of different ways of engaging the students.” And so we started talking and I said, “I think I’ve got a few ideas that I could talk about to engage mental health nurses,” and he said, “Well I’ll help you write a paper.” And I thought, “Oh God I’ve never thought about writing a paper, on my practices? My teaching practices? Why would anyone think that was interesting?” And he helped me shatter that fear that I had, and the mythology that you have to be somebody completely brilliant to write. And then,
when I had my first publication, I was so happy to see my name in black and white and I just thought, “I like this idea of being a writer.” So ever since then I’ve been trying to find things to write about.

Hopefully one day I might even write a novel, though I haven’t got a single idea in my head about that. But I do like the challenge of turning maybe an amorphous thing like, maybe a research project, into a succinct 5,000 word paper. I like that challenge and I like to show that nursing practices are important. So that was another pivotal thing, publishing.

I think I was pretty proud when I got promoted to associate professor. That was quite good. Because that was a long haul too and there was a real glass ceiling to get through, especially if you’re doing it and you’re staying at your own University, because it’s much easier to get promoted if you move outside, you know the old, people like the outsider; they don’t like the people in the inside. So that was quite good to get that and I felt a sense of accomplishment. You know I always...like today I launched this DVD it’s a resource [returning] that the Federal Government funded. So we made a series of what we call, “New Media Resources,” which are a set of nine vignettes that are acted by actors and they have accompanying teaching and learning material to go with it. The idea is to bring mental health out of the margins and into the centre of nursing practice, to say that all nurses need mental health skills, because when they face patients you can bet your bottom dollar that patient will be in some kind of psychological distress, be it anxiety, anger, depression, substance misuse, or whatever. So that’s the outcome of our one year project that we did, where we consulted with the community to find regionally relevant things, then we did a film production, then we did an educational production. So that’s another sort of pivotal moment, is producing something that you hope will be useful to improve education and hopefully nursing practice.

But I also get...there’s doubt a lot of the time, like I think, “Oh maybe it’s a product that won’t have any value or it’ll be just another thing that sits on people’s shelves.” And so that self doubt is both my Achilles heel ... I shouldn’t be so critical, but it’s also the driver, it’s that thing that makes me want to pursue excellence. And if I didn’t care, that would probably be my last one that I make, but it probably won’t be, I’ll probably make another one and this time I’ll hit the jackpot and make a good one. There are things in it that are quite good so I hope that it makes a contribution.

What is it about mental health nursing that just keeps you there?

Well I care about the human spirit, and I like to find ways to awaken and nurture that human spirit. I care about people who are in distress and that distress may be because of physical reasons, but it has psychological and social effects. And so I’m really interested in helping those people find safety, security, comfort, and meaning in their lives and I’m attracted to that in all aspects of my life. So if there was a movie and it was about that or there was a movie about, I don’t know, car chases or something, I’d go and see the human interest story, the one that has something meaningful to say. I think it takes us closer to who we are as human beings; it takes us to the kind of bone marrow of what community can be. I hope I’m kind of etching out just a little about how to be a better human being in being a nurse and so mental health nursing is in the centre of all of that. But I see myself as a nurse and a mental health nurse, and maybe my nursing is made better by my mental health background and vice versa. But I think it’s about helping understand the human condition and then appreciate the human condition in all its diversity. People with schizophrenia aren’t always suffering from schizophrenia. They might be people with schizophrenia, we don’t have to assume that they’re always suffering, and to me that’s the joy and complexity of humanity, and not being afraid of that and being actually attracted to it. We can learn something from that. I’ve learned from a lot of people with schizophrenia, their humanity, their openness, their honesty, plus their distress. How they can be so courageous and how they can be so grounded and say, “Yeah I’m over that now and moving onto another thing.” They’re so resilient. It’s generalising I know, but that’s what I’ve learned in seeing people in these situations that, boy, the power of the human
And plus I’m not very technical either so I don’t think I would’ve been very good at taking blood, or orthopaedic nursing, or something like that, I think, “Err yuck.”

I can’t fix a thing at home, I’m hopeless at fixing. I’m not very practical. Mental health nursing is very good for people who aren’t that practical.

Paul McNamara
Current role: Consultation Liaison Nurse, Cairns Base Hospital

On being nominated: [Inspirational role model]

I would imagine that it’s since I’ve moved into the consultation liaison role. Early on in the piece there I didn’t really know much about it, as is often the way when you start a new job. So I went looking around the country and found some other consultation liaison nurses. As a mechanism to stay in touch with them I helped establish an email network, and help promote that. Then that email network morphed into becoming a special interest group in consultation liaison nursing as part of the college (ACMHN). So I’d imagine it’d be that work, but really it was just that I fell in with a good crowd. There are a lot of really motivated and really smart people who are working as CL nurses, and I found them really inspirational. I felt like I rode on their coat tails a bit, and picked up on that level of commitment and enthusiasm and just went with them.

On the CL role

I started off as a general nurse and really enjoyed that role. Sometimes as a general nurse you get more of that quick fix feedback than you do as a mental health nurse. Like, you can be looking after somebody who’s really quite crook or has an arrest or something, and you go off and you do something which is half heroic and part of your job and that was really self gratifying. With mental health, as most mental health nurses know, you don’t have those spectacular quick fixes. You work away at problems and you still get that reward but it doesn’t happen so instantly. In consultation liaison nursing, because you’re applying your trade in the general hospital, you’ve got like a foot in both camps. So you get, oh for me anyway, for my self-satisfaction, I get a get a bit of both of those things. Those long term outcomes and those long term engagements plus some of that, yeah “quick fix” is the wrong way to say it, but being around people in really important parts of their lives. For instance, you don’t get admitted to this hospital after self harm without having a chat with one of us. That’s an amazingly important part in somebody’s life and it’s a really privileged time to be speaking to somebody. That is, for me, a little bit reminiscent of caring for somebody’s who’s just slipped into atrial fibrillation or ventricular fibrillation or something; you’re intervening at a really important time.

I guess there’s a little adrenalin rush, in that you’re not really sure which way that turning point’s going to go at that time. Things could turn really bad or things could be quite positive, and yeah... So there’s that
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part of it which I really enjoy. I guess the other part of it is that we see ourselves as having two sets of customers really. One is the character in pyjamas: the person who’s in the hospital bed, and then the other ones are the people wearing the name tags who are at the bedside helping them. Quite often they feel way out of their comfort zone dealing with people with mental health problems or suicidality or any of those sorts of things. Or even behavioural problems, somebody just says “fuck” a lot. Often that’s out of people’s comfort zone and we, I think, can often help supporting those staff members and a bit of well, it’s really quite informal education. A lot of it os actually modelling behaviour and showing people how to go about stuff rather than lecturing from on high. Again, I find that really gratifying.

So when you’re modelling Paul, are you saying, “Watch what I do” or are you saying, “Here’s what I would do” or do you actually talk with the client there and then and the others are watching you? How does it unfold?

Well, often in general hospitals those ideals of privacy are really compromised. A curtain in a four bed bay doesn’t give you a hell of a lot of privacy Our patients aren’t always mobile enough to get out of there and follow us down the corridor to go to another room. So there’s those opportunities that it is really easy to model behaviour because the nurse will be in the bay with you. We try to, tackle those clinical challenges that you get where the team often gets split. So often I will ask the general nurse to come along with me and we will interview the patient together because that dampens down how many mixed messages people get, and how much the team’s split. And again I think that’s a really good opportunity to, not just talk the talk, but walk a walk and take somebody with you on that stroll [Laughs].

I think something that mental health nurses do better than most is engage. It’s not just that superficial engagement, but actually really engage. I don’t really know how to actually describe that process, but I think I know how to do it. I certainly know when I don’t get it right. I think that’s what I try to do. I feel really self conscious talking about this, but I think if you’re authentic with people (and most people have a reasonably good bull shit radar), and if they know that you’re playing it for real, they reciprocate and you can get that engagement. I think that the danger of any of us working in the health system is that we can just play a role ‘cause you can. Like, you can just put on a uniform or put on a badge and act as if you’re it for the remainder of the day. But I think if you come along and if you work on a human relationship first, and then take that human relationship into a therapeutic relationship. I think that might be the only real clinical skill I’ve got.

On therapeutic engagement

A lot of it’s about education. Except for those people who’ve been around the traps, I’m thinking here about our consumers now: the patients in the hospital. A lot of them actually know more about their mental health problems than I’m ever going to know, because they’ve lived it. That can still be educative because they can educate me about their experience.

But probably more often we come across people whose first experience of a mental health crisis is when we meet them. So it’s about letting them know how we understand how stuff works. Same with the people who know them and love them, getting them worded up too about how we understand that this stuff works. I guess it’s the other part of consultation liaison. It’s not always those big ticket items that you see in the remainder of psychiatry: schizophrenia and bipolar are actually a fairly small part of our core business. There was another CL nurse who coined the phrase, “the four D’s of CL nursing”: delirium, dementia, deliberate self harm and depression. They are what make up consultation liaison. So a lot of our education and support is that this 75 year old man: your husband or your patient, hasn’t suddenly developed a psychotic illness, he’s got a delirium. a I wonder if we find a reason for this temperature, if we get rid of that temperature (which is probably an infection), whether all those behaviours will go
away: which invariably they do. So yeah, so it spills over into the general stuff a bit. I can’t believe how much I ramble on [Laughing].

No that’s really interesting though and so it’s about accurate diagnosis …

Yeah.

… and ruling out conditions?

Yeah.

And understanding the connection between health and mental health …

Yeah.

… that there’s that two way thing that mental health can be a result of the physical illness but it can also exacerbate other …

Yeah that’s right - you’re right. Because it is a two way street. We know the people with depression have their experience of pain amplified compared to somebody who hasn’t got depression. So yeah, it is a two way street, mind and body. The neck does more than just hold the head up, it serves as a connective tissue as well [Laughs].

On becoming a mental health nurse

A bit accidentally. I kept on having jobs and saving up a bit of money, going on holidays, spending all the money and coming back and getting another job and I couldn’t help but notice the pattern that I was getting worse jobs every time [Laughing]. I came back and I thought in my mid 20s I probably should really get myself a qualification in something. Then around that same time I was reading a John Irving novel called “The Cider House Rules”. It’s got a lot of controversial stuff ‘cause it deals with illegal abortions and drug use and all of that sort of really cool stuff. But in there, and it’s almost like a refrain, is the bit that really resonated with me as with Homer: the primary character. He was always being urged by the nurses at the orphanage where he grew up to “be useful” or to “be helpful”. That pops up over and over again through the book, ‘cause he left and was going to try and forge his own life, but in the end he succumbed to these urgings to “be useful”. Anyway, at the time I was driving forklifts in a warehouse and I thought, “Maybe it would be nice to be useful”. Nursing crossed my mind for a couple of reasons. I knew a few nurses, I’ve got a sister and a cousin and I shared a house with a few nurses and spoke to them about it. They all tried to talk me out of it. But in the end it just seemed like a good idea for me to be useful. At the time it was still hospital training, so it was down to the Royal Adelaide. I earned a grand $12 an hour as a student nurse rather than having to throw myself into university life and get no dollars an hour. So that was the choice that I took and it feels a little bit accidental, the way it all happened. But it turned out to be a really good accident.

On the high points?

Oh probably it’s a bit mushy… but probably the high point for me has got nothing to do with the job as such, or the clinical work of the job anyway. I met my partner, Stella, at the Royal Adelaide = she was in the same intake. So that was a happy accident. I like to tell everybody that our eyes met over a steaming bed pan [Laughing] and that’s not far short of the truth. We met there and got to know each other quite well, as you do when you’re a shift working student nurse. You never get a weekend off so we were essentially cut off from our old social networks. Because we always had Tuesdays and Wednesdays off and we had nobody else to play with, we got to know each other quite well as friends.
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On having a good day

It probably happens the most when we run our outpatient clinic alongside the antenatal clinic. That was something that was quite accidental again - this accidental career I’m having [Laughs]. The midwives, who are a staunch bunch those midwives, they demanded that we provide an early intervention/prevention style of service for their patients. Actually, their “women”, don’t call them “patients” in front of a midwife. That was a little bit different to the way mental health services usually position themselves. Mental health services tend to deal with people in crisis, or case managers try to prevent those crisis’s from arriving, but they’re always at that acute, exciting spectrum. The midwives “bullied” me and my team towards that early intervention prevention stuff. They often refer people who, right here right now haven’t actually got any psychopathology. Referrals will be, “She had this depression three years ago” or, “With my last baby I had really profound postnatal depression and I don’t want to go through that again”. I think the reason I feel most useful when we’re engaging with those patients, is because we engage over the course of the pregnancy. You get to know them, and to a lesser extent their fellas, and I guess sometimes their babies and toddlers. You get to actually really engage with the whole family. We’re trying to “head stuff off at the pass”, and if we can’t do that well we pounce on it early and act early. I think we’ve stopped lots of people having a real miserable time of parenthood, because we’ve been able to offer a bit of that assertive, preventative/early-intervention kind of support. So that’s probably been over time the most gratifying, consistently gratifying part, yeah.

On therapeutic engagement

Yeah, you really notice it there in the general health setting. I’m going to borrow from The Onion; some people use journals to guide their practice, but I’m using that spoof news thing called ‘The Onion’/ One of the headlines that I saw them release recently was, “Studies reveal that yelling out ‘CALM DOWN!’ is mostly ineffective.” [Laughter]. That was another thing that really resonated with me because often people respond yelling back to the yelling person, “Calm down, calm down”. If you can just cut through all of that, and actually engage them and not their behaviour, they’ll calm down by themselves.

More on becoming a mental health nurse

So, at the Royal Adelaide I had a bit of a taste of everything. I ended up working in a mixed high dependency - ICU unit, and it was full-on. Again, there were some really inspiring characters around: these other nurses that you’re working with. With them you’re thinking, “Oh one day I wouldn’t mind being a bit like that”, and so I hung around there for a while. That was really good work and I really enjoyed it there. The other place that I work was a neurology/neurosurgery ward as an RN. Again, there was this really dynamic core of experienced RNs on R5, but I wound up on S4 and being in an intensive...
care/high dependency unit. The staffing levels at night were pretty much the same as they were during the day, which meant that night duty came around about, oh. every 10 minutes. I wasn’t all that good at sleeping during the day, so I was almost always a little bit sleep deprived. Sometimes I thought I was flirting with psychosis ‘cause I was so sleep deprived. I was going to do the ICU course but as I was about to sign up on the dotted line, I saw an ad for the mental health course come out. This was going to be an 18 months long hospital based thing blah, blah, blah but no night duty. I thought, “Oh that’ll do” [laughing]. When you’re at the end of the bed in ICU, and there’ll be the 30 year old bloke who’s been in a car accident and has got a head injury/ And he’s got the wife and the 6, 7 and 8 year old kids there at the bedside., I always thought it’d be actually nice to have some counselling skills to be confident about situation, aboit what I’m doing with those people anyway. But really the main motivator was to get away from nights for 18 months, with the intention of picking up those counselling skills and going back to intensive care. But I’ve never worked a night duty since.

It was at, it was called SAMHS at the time: the South Australia Mental Health Service. It was conducted across both Glenside and Hillcrest Hospitals. It’s one of those churns in government departments that it happens where they merge facilities; not long after I finished SAMHS dissolved and those hospitals became campuses of the nearest general hospital. So SAMHS was a short lived thing. Anyway, sl did the mental health nursing course, and it was across two hospitals and it was really good. One of the things that they did (and this is how I wound up working in Cairns), is that for your 8 week community placement they said, “Oh you can go wherever you want but you’ve got to sort it out yourself”. The placement period was falling in a August/September which are kind of cold and rainy months in Adelaide, and I thought, “Cairns would be nice.” So it took a few phone calls and what have you, but the community mental health team up here (via a bloke called Greg Holland, who I really admire), was good enough to allow that to happen, which took a bit of flexibility on their behalf. While I was up there (again, it’s just another accident in my career), I thought, “Oh well I’ll escape a bit of winter and that’ll be that, go back down”. But while I was up here Greg and the team were all saying, “Well this is a growing service and funding is really improving and there’s going to be job opportunities coming along so keep us in mind.” So when I finished up the course I moved straight from there into a job with one of the pilot MITT (Mobile Intensive Treatment Teams) at the time. So I went from being a student mental health nurse to a case manager on the MITT team which was, ahh - I feel like I took a bit of a short cut in my career getting that. So I was really fortunate, and Stella and I were both ready for a change of scene so it’s worked out really well.

I had a really small case load and we engaged with clients in a really intensive fashion. One of the things that we soon found out with a bit of reflection on practice and chatting amongst the team, is that our file entries quickly moved away from being mental state assessments and da, da, da, to becoming a journal of the therapeutic relationship. That’s because there was a focus on that engagement that we wanted with these people who were often the most difficult to engage. People with really unstable and poorly controlled schizophrenia, I think almost entirely made up our case load. So these people were really kind of struggling with life a bit, and often spent long periods in hospital, and their quality of life when they came out was pretty dodgy anyway. So with them, they got a chance to get to know us really well and vice versa. In hindsight one of the downsides to that is that we built in a dependency for those patients, and I know that they’ve revisited that model since to try to filter some of that dependency out. Kerry Counihan who was the team leader was really sharp about collecting information so we could then go back and see whether or not we’re making a difference. Kerry picked up tools like the life skills tool and all those quality of life measurements, and then I guess a more rigid measurement about how many bed days those outpatients took up. It was really clear that within months of us getting going that we were making a big difference on all of those fronts. We were improving people’s quality of life, improving their level of functioning and decreasing how much time they were stuck in hospital for. So that was really, really good work A little bit exhausting because those human relationships were so intensive. There
was always a threat from both our point of view and the patient’s point of view of being swamped in the therapeutic relationship. It was that the level of engagement was so intense. But that was good.

At the time there wasn’t much in the way of other services about. So one of the things that we managed to do, and I was lucky enough to be part of the management committee, was get some of the funding that disability services had but wasn’t really making much use of in regards to helping people with psychiatric disabilities to get back in the workplace. So we set up an NGO in its own right called “Worklink”, and there was a lady from the Chamber of Commerce and a lawyer and blah, blah, blah and I was the only fluffy one with a clinical background on the management committee. These other people knew how to get things done really quite ruthlessly and efficiently. So we got hold of that funding and incorporated the thing and employed a couple of really dynamic people at Worklink, and then we had a service available for our patients to help them back in the workforce. We recognised that as mental health nurses and social workers and psychologists and such we probably didn’t really have that skill set. So we found people who did have those skills, and at the time when this was going on (back in ’95), in Cairns there were certainly some services around but not the level of stuff that’s available now. I haven’t had much to do with Worklink since they got on their feet, but one of the real gratifying things is that that organisation has just grown and grown and grown in strength. That’s going really well.

**On rewarding work**

Yeah it was too and I shy away from taking too much personal credit for that. It wasn’t really me who identified the gaps but when those gaps were identified and then somebody said, “Do you want to be part of the management committee?” I said, “Oh yeah I’ll give that a go,” and the strengths on that management committee which came from way outside of the health sector really helped that get going and that partnership with those other people, it’s really good to see that up close in person.

Yeah and I guess like talking like this it’s not necessarily just your personal contribution but what other nurses in the future could see in the role and the potential in the role, so hopefully other nurses read this.

Oh yeah.

**But they might identify, “Oh okay that’s the potential that I could make of the role.”**

Yeah, yeah, yeah look and I think ’cause for the last 12 months in particular I’ve had a fair bit to do with student nurses, that I know that you’ve got to walk before you run. But I always tried to let people know if I could that there is more to nursing than managing medications and there is more to it than those basic nursing procedures. There’s a lot of scope for creativity. You’ve got to have the advantages of having people around you who help that to happen. I think for me, anyway, I need to be around people who would push me along; my default thing might to be a bit lazy I think. But there’s plenty of really inspiring and really smart characters out there and you need to find them and hook on to them.

**Inspirations**

Greg Holland up here in Cairns would probably be one I’d put up the top of the list. His ability to engage with those people who everybody else found impossible to engage with, so often those people with all the negative symptoms of schizophrenia, and whether or not they have antisocial personality features or not I don’t know, but until Greg engaged them. That was all about that therapeutic use of self. He put himself out there as this authentic, charming, funny sort of bloke who people would relate to and then once he had them relating to him, then he would start the therapeutic stuff. But he would always go out there and get that level of engagement first. When I came up here as a student I spent a lot of
time with Greg as a student nurse. What a luxury watching somebody who had that skill! I’ve just stolen probably about three quarters of his repertoire and tried to use that skill set. So he’s one.

I think just about every CN and CNC down at the Royal Adelaide that I worked with as a student nurse down there inspired me. They were really sharp, and it was the first time I saw anybody trot out in conversation referring to “the evidence”. You know. people would say something and then one of the CNs in handover would say, “Oh actually I was reading about that yesterday,” and da, da, da. It was making this real practical use of what research was coming out, and until I actually saw that in action the research and the clinical practice just seemed worlds apart. I know you’ve got your name on more than a couple of general articles, but often the language of academia makes it seem a little bit impenetrable. When you’ve got clinicians interpreting it and bringing it to the ward, that’s where it was really good to have that modelled and that happened a lot at the Royal Adelaide.

Then in consultation liaison nursing, people like Julie Sharrock and Tim Wand. Julie’s down in Melbourne and Tim in Sydney and those two in particular are real standout sort of characters. Really bright, really committed. I guess they, oh and Scott Brunero too, he’s probably turned into the most published of the CL nurses in recent years. So there’s these people that are just pumping stuff out there in the literature. Around those people, although probably not as prodigious in the literature, but there’s all these other people on that same wavelength, who are examining their own practice and being really thoughtful about not just what they do with their patients, but what they do with the other clinicians who are caring for their patients. So there’s this cohort of really inspiring sort of characters in CL.

**Insights on the CL role**

I think that the ideal consultation liaison service will be the one that doesn’t need to exist anymore because they’ve done such a great job supporting all of the general health clinicians that they’ll be able to take on most of that stuff. That’s the ideal which I think, as far as job security goes, is probably something I don’t have to worry about happening in the next month or two. Having said that, and I’m pretty sure if we went through the doors and asked the nurses on the medical, surgical and women’s health units they’d probably agree, is that they do feel somewhat more comfortable and somewhat more skilled engaging with the patients now. I think that’s probably what we should be doing. There is an area of concern that I have at the moment with the consultation liaison thing. Actually, it’s not really about us, it’s about people who are admitted following deliberate self harm or have got great big behavioural problems going on. Often, for reasons of safety it’s thought that a really good idea would be to put a special nurse on them. But unfortunately the special nurses are usually ill-equipped. They haven’t got the qualifications or skills to do a good job with that task, and I’m really concerned that we, we the health system, although being very well meaning, are actually re-traumatising some people by giving them inadequate up close and personal support.

**So that’s an area for development?**

Yeah it is, and I haven’t really got an answer. The knee jerk answer would be, “Oh well why don’t we have skilled mental health nurses doing specials,” like if the specials were RNs of some years experience and blah, blah, blah they’d probably do a good job. I think that’s probably true, but nobody’s going to find the money for that in the near future. So that’s not going to happen. So something I think we, as a system, need to look at is how we’re going to keep those people safe. Keep the assistants in nursing and/or security guards who wind-up performing that one-on-one role, keep them safe too because they are way out of their depth. It must be a little bit frightening for them. How do we stop those people harming one another?, ’cause I think that’s happening a little bit at the moment and I haven’t really got an answer for that. That’s something for mulling over and talking about, I think.
If you were being assigned to special a patient who was out of control maybe, what are some of the things that you’d think about?

I’d probably fall back on trying to engage them.

Sometimes you’re meeting people at a time in their life where that’s not going to happen, at least help contain them and so that they might not actually feel all that happy but at least they feel safe. I guess maybe the skill mental health nurses have that some of these special nurses might not have, is that I would resist the temptation to give advice or words of wisdom. I think that’s a difficult thing to resist unless you’ve had a bit of practice at it.

And I guess the other thing that you are doing in that process of containing that patient for them is containing your own feelings of fear or whatever. You might be able to do that in the knowledge that it’ll probably be contagious, your own fear.

Yeah. The Infection Control Department might disagree, but I actually think the most contagious thing in general hospitals is anxiety. I gave that example before of walking into a ward where somebody’s yelling out “fuck” a lot and there’s dozens of people around who are all yelling out, “Calm down!” If you can go in there and just make that source of anxiety go away, all the rest of it goes away as well.

On worst times?

Our trade -is mental health nursing in the general hospital setting with consultation liaison. Our patients die sometimes. Sometimes that’s a direct or indirect result of their mental health problems. I know it’s grief and I know it’s an understandable reaction, but I find it really sad.

That it’s like a waste that you weren’t able to help?

Yeah, yeah there’s that and [Pause] yeah I guess there’s a bit of that but it’s not really about, at that stage it’s not really about us [Becomes tearful].

Do you want me to stop it?

What I’m trying to say is although it’s sad and disappointing for us, it’s not really our feelings that count then. It’s the family and friends. We see their grief and it’s hard.

Paul one of the things that I notice about you is that you have maintained your sensitivity in what can be, you know it’s often characterised in films and stuff like that but nurses are like insensitive …

Yeah.

… and that’s part of what you learn to be like?

Yeah I remember being told that stuff and I always thought it was bullshit. It was going out as I was coming into nursing. I think that idea of not acting like a human, that was being less emphasised as I was starting. It was still held by some in some quarters, I think. The overall thing that I was exposed to, or what I heard anyway, was that we, as nurses do use ourselves therapeutically. That’s not the exclusive domain of mental health nurses. Midwives and general nurses do that too, and that therapeutic use of self runs through nursing. I’m really not sure if I was told or just kind of made it up as I went along, but I thought part of that therapeutic use of self, of being useful, was to be authentic.
We talk about holding and containing other people’s emotions, and our own. I got a little bit teary then even though boys don’t cry. Got a little bit teary when talking about the consequences of patients dying and everything. But if I came to work every day and got weepy I’d probably be looking for a different job. It’s only every now and again that one goes through to the keeper, and if I lost that I’d be a bit worried about myself, that I’d lost some of who I am. I think often the people who touch me the most or the people’s stories who touch me the most are when they’ve got the least in common with me. And so it’ll be an indigenous lady from up the Cape or something, and I’ll let my defences drop because I don’t think her story’s going to affect me personally. But if she happens to have the ability to jump all those cultural, language and gender hurdles that stand between her and I, and actually tells me her story, quite often I’m really, really affected by those stories because I didn’t expect to have to defend myself.

So I guess what you’re saying to me that you find the shared humanity in spaces where you weren’t expecting to?

Yeah, yeah and, and when I find it where I wasn’t expecting to; often I arrive at that point without have my defences up, so that’s when they are often the stories that touch me emotionally the most because I’m ...  

And so these stories they touch you and they move you and you said the best, I’m not trying to be psychotherapeutic here but I was asking you about the worst times…

Oh yeah.

... and you’ve identified things that were emotionally touching and they wound you but I think from what you’re saying they are also enlightening for you ‘cause they show you, they reveal humanity I guess and they make you feel purposeful?

Yeah.

So they’re bad times but they’re also good times.

Yeah, yeah and I’m not really sure where I stand morally [Laughing]. You know, I’m being paid to do a job and I’m taking people’s stories and letting them inform my life. I’m not sure if that’s quite the right thing to do it but they do, nevertheless they do.

How do they inform your life?

Being around people who are dying, you never hear them say, “Oh gee I wish I spent a bit more time at work or a bit more time at the office or I wish I spent a bit more time painting the house” or da, da da. I think people who are dying give you great windows on what is important, and those things that are important are family and friends and enjoyable experiences. Actually, not even enjoyable experiences but a range of experiences. That’s what people talk about. When they do die the people who care about them, that’s what they value as well. If you don’t hear that I reckon you’re missing out on some really important information.

And so hearing and being with people at times when perhaps they die, they’ve helped you have a better life ...

Yeah, yeah.

... because you were able to value the people you love and ...
Yeah which I try, a real big part of me feels really squirmy around that. I’m not sure about the morality of that but …that’s the way it works out and I guess and it doesn’t always have to be death. Like, as a student mental health nurse at Glenside Hospital I realised that so many people’s stories involved a really difficult childhood, often really traumatic childhoods. So it gave me an opportunity then to thank my mum and dad for keeping me safe. I was able to have those insights and tell mum and dad without waiting for them to die, while they’re quite healthy and happy, just to sit down with them and tell them how much I’ve valued all of that, ‘cause otherwise I probably never would have had that insight.

Any more lessons?

I’d say if I’ve got one trick to share that would be keep an eye out on the good nurses around you. Watch what they do, and if you’re lacking original ideas (as I am a bit), borrow some of their ideas and try them out for yourself. Because there’s enough of those really clever inspirational people out there to, yeah just hook on to them. So that’s my only advice I think.

On being a school based youth health nurse

In the late ‘90s that was rolled out as a pilot project. There was a fair mob of us who started first up. I think 80 or 90 of us started up at the same time. We went down to Brisbane and had a week’s worth of induction kind of stuff and that’s all really cool. I couldn’t fly back home at the designated time ‘cause cyclone Steve came through and the airport was shut and blah, blah, blah. But anyway, That was a nice job. I think two of us who took it on had a background in mental health nursing. That was a bit of a mixed blessing. I’m not really sure if that was a good thing to have or a bad thing to have. Well no, look actually I’ll take that back. I do think it was a good thing to have, but personally it wasn’t always to my advantage to ask that next question. I think as a mental health nurse you’re more comfortable with intruding on people’s lives a little bit more and asking follow-up questions rather than letting things brush by. So as a mental health nurse I engaged with a lot of the students who disclosed certain things about self harm or suicidal thoughts and sometimes sexual abuse. Those really heavy issues. They’d disclose them where otherwise they might not have if they didn’t have somebody that they felt comfortable with

So amongst the really big things that really stuck in my mind happened at one school. It was in my first week. I’d only just started and this year 10 boy turned up, knocked on the door and introduced himself and said, “Look I just want to introduce myself my name’s” … you know whatever it was blah, blah, blah. He said, “I thought I should let you know I have been getting treatment for depression for a while. I think I’m going okay at the moment and I probably don’t need to speak with you but if I do, it’s good that we’ve met each other.” This kid was a year 10 kid, so aged 14, 15 or something. When he walked out I was thinking, “God I’d like to be mature as that one day.” So these kids were often really worldly and impressive.

One of the things that I worked really hard to do was engage with some of the indigenous students who were at one of the schools. A lot of them weren’t excelling all that well academically, and things like attendance and behaviours were sometimes a bit problematic. I felt that my job, using those skills of a mental health nurse, should be to try to engage with a few of these students. So what I wound up doing and I stole this idea, yet another stolen idea, from Ernest Hunter who’s a psychiatrist who’s had a fair bit to do with remote mental health up this way. I remember him speaking once about using genograms as a tool to engage indigenous people, particularly indigenous young people. That’s got an advantage of that you don’t have to meet their eye ‘cause you’re both turned to the paper. You ask them to tell their story and you draw it for them as they go. In a lot ways it’s putting yourself in the position of being the humble, naïve learner: “Tell me about your family. You’re the expert, I know nothing.” And all I’d say is that I’m really good at drawing family trees. Often there you’d get some really extraordinary stories which took some complex genogram drawing. I’d leave it with them. I didn’t need to have it for my file,
not with those jobs. So we’d draw the family tree and I would retain the stories that I thought were the standout stories from that family tree, but I would leave them a thing and so they got something out of it too. Sometimes those kids would come back and sometimes with a piece of paper, more often without but would say, “Oh do you remember blah, blah, blah?” “Yeah well what he or she’s doing isn’t so hot.” That would act as a vehicle where these students were able to tell me about what was going in their own life. Sometimes that included things like quite serious abuse which they hadn’t been able to sort out themselves, so took that really brave step of coming to see the white baldy fellow and telling me to see if there’s something that we could do to help.

Intervening in abuse always had really big fall out and for me, the school and the students themselves. The consequences of acting are such that you can see why people don’t act. Because the consequences of acting are also really severe. So actually I’ve got some empathy for those people who are often portrayed as monsters ’cause they haven’t acted to prevent things that have happened. You can see there are some real incentives not to. So we acted and that didn’t always go well. I guess it’s easier when you are in a paid role: the choice of acting is taken out. I guess I was really mindful that those students had jumped a lot of barriers. Often they had to jump not just a culture barrier, but sometimes the language and the gender barrier to speak to me about that. I always thought that I was probably an option of last resort almost for these kids so …

The high and low points of the role?

High point is that it taught me more about health promotion than I knew before. Like in the classroom doing a lot of stuff there, Teachers often don’t feel comfortable talking about things like sex and drugs and all those groovy things, so that was really nice to be able to engage with students at that level. Again steal some ideas off the teachers on how they do business. The teachers I remember the most in my own school were the ones who were the sternest disciplinarians. But in the school base youth health nurse role I learnt a couple of teaching tricks off the school teachers. The good ones have this trick of going quietly The noisier the classroom gets the quieter you get; it’s a really good way to engage with a classroom full of people. At one school I was really impressed to see that the teachers often, in their staff meetings, would talk about rather than catching the kids being naughty, catch them being good. That was something that I hadn’t really thought of or heard about before. I’ve been able to bring that back into clinical practice, like particularly around somebody’s behaviour is a little bit atrocious, let’s find what they’re doing well.

And so you can cross pollinate some of those ideas between teaching and clinical practice. So that’s a high point.

I think some of those low points for me is often I felt a little bit isolated sometimes. When you’re the Queensland Health guy working in the education department, well we’ve got different ideas about how confidentiality works. So often I was holding people’s stories and holding them by myself. It took me a long time to recognise, I’m just showing you how dopey I am, that I really needed to be engaged in clinical supervision in that role. Because it was a non mental health role, I didn’t think I needed to at first, and by the time I got around getting clinical supervision underway I had probably been a bit damaged. Well, I definitely would have been a bit damaged by the process. I was a little bit frightened that I was going to become overwhelmed or burnt out by it. With the benefit of hindsight, I think if I had supervision in place when I started it might have been a role I would have stuck with longer than 18 months.

Am I right in thinking that the burnout that you are at risk of developing was because you were holding the stories inside?
Yeah. I guess before we spoke about holding and containing and here we’re holding and containing some really difficult parts of teenager’s lives, and without really having a structured way to get through that. I think every other role I’ve worked in with nursing has been within a team, and that team offers a lot of support. Then in mental health I’ve always been a little bit mindful of making sure I’ve got some sort of clinical supervision going on too. I think that’s really important. I guess for me that clinical supervision is all about nurturing the nurturer. I think when we don’t have that we do put ourselves at risk and secondary to that, probably put our customers at risk, yeah our patients at risk.

Jim O’Dempsey

Current role: CEO Australian Health Practitioner Regulation Agency, Queensland

On being nominated [far reach of influence]

I’ve held a number of reasonably high profile jobs. I was the inaugural CEO of the Queensland Nursing Council from its inception and established it as a Greenfield site. I had a high profile within the medical profession, with the Patel issues.

About the QNC

Queensland Nursing Council was a great opportunity, regulation up until that time, well nursing regulation tended to be very reactive, no standard setting, and fairly, if I can put it, in a sense it was a cottage industry.

[as nurses ] we all had our State exams through the Board of Nursing Studies and the Nurses Registration Board but we learn about, so we can answer the questions in the exam at the State finals, and no-one really knew about the Board, its regulation, and it didn’t have much influence over the profession. Establishing the Queensland Nursing Council was the opportunity to make regulation count and for the first time regulation in Queensland and probably nationally and internationally took on a focus of how to develop the profession in the public interest, rather than just act as a policeman for naughty nurses.

So for the first time a regulatory authority took a business approach to regulation and developed a strategic and corporate plans to achieve their outcome so we’re very business focussed in achieving strategic outcomes and we engaged with the profession so that we didn’t act as a maternal or a parental figure, but developed tools that the individual registrant could use to regulate themselves, so I’m quite pleased with how the Queensland Nursing Council developed and delivered.

And it got both a national and international recognition for such things as the scope of practice framework, their approach to professional standards and competence and one of the first jurisdictions to actually do things like business services, like online renewals, so it was interesting looking back at the retrospective that was done in this last Queensland Nursing Forum and they did a timeline and against each executive officer’s appointment and looked at what the Council delivered in those timelines and from ’93 to 2002, we see things like scope of nursing practice decision making framework, accreditation
policy for accreditation of nursing courses, a research grant, a scholarship policy and then from 2002 onwards, it’s review of those things, but no real new things. So it was an innovative time.

In terms of working within with the medical profession and the other allied health professions, again another opportunity to work with different groups to achieve something similar in the outcome as the PLC had achieved but to actually make an organisation that provides multi professional regulatory services work so that there is consistency in process but no control over what the professions do in setting their own standards and that was always an enjoyable thing to make work. Patel was really an issue of systems failure, the Medical Board processes were part of that systems failure but were only a minor part of it and I led the strategic response to the Commission of Enquiry and managed the processes for the Commission of Enquiry and of course the Enquiry found similarly that the Medical Board only had one small part in the systems error, but it was a systems failure and no adverse findings against the Medical Board, so that was a very stressful, but I think a learning experience on a whole new pressures, a whole new set of pressures that not many people experience. How many people manage an organisation’s response to a Commission of Enquiry? We probably only had 10 in Queensland and they’ve all been significant ones. With the State Office of APRA, I’m very pleased to be taking the step of assisting in implementing National Registration because for the first time in our country’s history, we will have one standard that applies. We won’t have, for example, in nursing we have eight jurisdictions, eight recency of practice policies, and none of them working really effectively, and we now have one national Nursing Administrative Board and one standard for recency practice and one standard for CPD. It has got to deliver a better outcome and I think it’ll also close those gaps that always occur when you’ve got legislation operating in different jurisdictions that provides different powers and processes, and people will always look through those gaps, so I think National Registration is a significant benefit for both registrants but the public, because it closes the gaps.

You can’t, you’re not in a position where you have to register someone of course they’re registered elsewhere. You make one decision, one decision to register and one decision if you want to change that registration status and it applies within the nation, very important.

How did mental health nursing prepare you for this role?

Probably two or three key things, first I think mental health nursing prepared me in a framework that said you achieve outcomes through relationships and communication from those relationships so I think that’s one of the key skills that I have. I develop good strategic and business relationships with everyone to achieve outcomes. We work together. And second, its communication. It’s interesting, I’ve always said that I started off as a nurse and I’m still a nurse. I learnt to look after people that were unwell and to support them through relationship to wellness, I do that for organisations now, so in that sense it’s a similar school set. So mental health nursing, from those two aspects I think, are very important.

Was it ever a hindrance to you?

Oh look, I think initially with, when I moved into regulation, it may have. I was probably the first male to head up a nurse regulatory authority in the nation and I was the first non-nurse educator so the fact that I was a mental health nurse was unusual, but it really didn’t, it’s never come up as a barrier and I’ve always been quite proud to say my initial qualification was as a mental health nurse.

I don’t think they see me as a nurse anymore because I’ve been regulating now for two decades, two decades, seems a long time, 1993, going on two decades, so I’m now, my reputation now is that I’m one of the more experienced people in delivering good regulation. And in fact I’ve just been asked to take on a national role but I’m not quite sure I’m wanting to move to Melbourne.
On entering mental health nursing

I always wanted to be a nurse, I had sisters that were nurses, I had a brother-in-law that was a nurse, and he was actually mental health nursing at Baillie Henderson Hospital so I knew nursing, and it attracted me. Some people say, it was because it was a paid education, because you earned money while you were being educated - that really wasn’t the attraction. I could have done many things. I’d been offered article clerk work both in an accountants firm and a law firm, straight from school. I had firms head hunting me for that. I wanted to be a nurse from the time I was about 15.

I went for an interview with the local general hospital at the middle of Grade 11, for, to find out what I needed to do to get entry to the nursing course when I finished senior, and I had an hour interview with the Director of Nursing of the day, she might be dead now, and at the end of the hour she said, “Mr O’Dempsey you’re a very impressive young man, but, I don’t believe males should be in nursing and I’m forced to take them on my terms, and my terms are they must be married, and they must have their mental health nursing qualification”.

And I asked her whether she wanted me to get married or do my mental health nursing first.

So that’s how I came to be, to do my mental health nursing first.

So I went and organised myself from that interview to go and do mental health nursing. I told that story, in fact when I went to do my general course, the Director of Nursing who interviewed me for that course and interviewed me in ’84, she asked me why I did my mental health nursing first and I told her that story and she looked down at my application and she looked up and said Mr O’Dempsey, I see you’re not yet married [laughs].

Do you think we should take you [laughs]? I said Miss Drew, I’m marrying one of your third year students next week [laughs]. She was a very funny lady Patrice Drew, so mental health nursing was not an initial choice, nursing was the choice, but I’m glad I did mental health nursing. I think it rounds you as a nurse, I think it makes you think about the person and my experience in general nursing, and I worked after I was qualified in general nursing for two years in an oncology ward. It was evident in my practice there, the nurses that the patients always asked for were the nurses with mental health qualifications and it was interesting because a third of the ward, a third of the registered nurses in the ward were mental health qualified, and it was an interesting, I think it’s, I’ve never gone and looked at it since, but within that particular environment, the mental health nurses were attracted to that type of work because they got to use both sets of skills.

I also liked orthopaedics, and that was again because you could form a relationship. And the one that I hated the most was surgery wards, not because of the work, the work was easy, you didn’t get to know people. and I like to know people, I won’t get on an email if I can get on a phone and talk to someone. I find emails quite offensive in a sense [laughs].

Remembering back to when you first started mental health nursing, what were your initial impressions?

I started as an assistant nurse, because they put you on as an assistant nurse until your course started, you remember all those things don’t you?

Look it was the roughness of the group. They weren’t really a group. There were some shining lights of professionalism, but it was a rough group. The sense was that they’d done nursing because that was the family tradition and you see that in the big mental health hospitals - a family alliance within the hospital,
so that was my initial impression. I think the education was just fantastic, I think the group educators that we had, particularly the leader, Chris Cambley were just doing a wonderful... and I always remember Chris Cambley saying to my group, if you want to learn to be a real mental health nurse, get out of here and experience, get your post graduate somewhere else. Come back, but get out. So that’s what I did, and I was one of two that did that, the rest remained, the rest are generally still in psyche services, the other was Ken Walsh.

I thought the practice was, it was production line type of stuff. The junior people did the yard and as you became more senior you got to sit inside and everyone was, it was an institution, there were times and rules and everyone did it, people didn’t shift out of that. It was different in the acute admission area, and everyone wanted to go there, to the acute admission area as students because that’s where you actually got some sort of real practice. That’s probably my memory of it. It’s now, I’d hate to think how long ago, 17 I started, so we won’t try and do the sums.

Where did you go to after training at Baillee Henderson?

Belmont Private Hospital. I made the decision to go to an acute private hospital to see the difference and there was a significant difference actually you got to use the skills. People always had the view that private hospitals were about the worried well, and there were some worried well, but there were some very unwell people, and Belmont was the biggest private hospital in Queensland providing psyche services at that time. There are a couple of units in, Wesley had a unit at one stage, but they tended to look after the anorexic and I wasn’t, so Belmont, I went there for the acute experience, had some really good mentors with registered nursing staff that had all come from the public sector and the majority of them left because they didn’t like the practice environment and after a year or two, I was asked to lead the hospital outside normal work hours and then there was a bit of a blow up within the admission unit which has half the hospital basically, 54 people, and there were problems in the standards of practice at that time, and management of staff and management asked me to go and take over the running of the unit.

So I took over the running and we took occupancy rates there, because as you know in private hospitals if the psychiatrists aren’t satisfied with the standards of care, they just send their patients to other hospitals, until the standards are fixed, so we went from occupancy rates of about 50% to 97% in 4 years.

So I did that for about 3 years, and I decided I didn’t want to get stuck just as a mental health nurse for the whole of my career, and I didn’t want to get stuck as a hospital manager because when I made noises about leaving my employers at that time made noises about supporting me into the management stream because they wanted me to stay, but I decided it was time, so, and it was, at that time when we knew University based education would be the primary base, primary form of education within a number of years and I was already on an income so I needed to make sure that I got my general sort of paid employment at that stage, it was just a, and I didn’t want to do a post graduate, just a non clinical degree, because that wasn’t what I wanted, I wanted the skills, the clinical skills, so I only had two options at that stage, it was either do it at the Gold Coast, they only had one post graduate course for psyche nurses and health nurses to enter at that stage because they were closing them down. It was Gold Coast or to do it through Repat Greenslopes and I got accepted to both and decided that driving to the Gold Coast on a daily basis to do shift work wasn’t really attractive, even though it was only going to take 18 months for post grade, I went to Greenslopes instead, because it was about five blocks away, my wife was training there and I knew its reputation and the quality of education, so I went there and did a full undergraduate course from PNC through to third year and it was like a holiday Brenda, for the first 3 months, I went from running a 54 bed acute mental health unit dealing with 30 psychiatrists and 40 staff to being a PNCer and it was just like a holiday, but guess what, I was bored.
Within 6 months I was bored.

But I survived. I survived and as I said before, I really looked for, I really looked for a clinical unit where I could use both sets of skills, and not many people wanted to work in oncology, because it is, it's a draining work environment.

So I did that for a couple of years and then decided well, I'm either going to stay in clinical for the rest of my life, and while I enjoyed clinical, I get bored, I got bored with it, it wasn't an intellectual challenge any more, I decided I'd look for something else and I got, I applied for a position back within one of the major psyche hospitals as a charge nurse and I was successful in that, I was the first person appointed within that hospital from outside psyche services at that time, and from outside the hospital particularly, in 20 years. It was interesting [laughs].

Oh look I always remember my days in Bailee Henderson- asking deputy charge nurses when they would be a charge nurse and having one of them come back to me and say on 28th December 1985 I'll be promoted because it was time and service then, it was interesting, but they, and when I look back at it, they'd selected me particularly for a particular role and that was to run a closed unit which was, had been established as a clinical research unit and they'd had some problems in the standards of care again, and they needed someone that had the skills in bringing a staff group back from the brink of a crisis in standards of care, and so, in a sense I was protected because in that unit it was staffed from the rest of the hospital but to get into the unit you had to apply to get in, so that's what I meant by a closed unit, and it was doing clinical trials and research, I'm not quite sure whether it still is. So I had my own stuff, I employed them, I selected them, I didn't employ them, but I selected them myself and we turned it around, within 12 months it was back to having the reputation it should have had. And then they tapped me on the shoulder to go out and do supervisors work.

And from there, that was nursing career structure days and they needed a project team to implement the career structure in Queensland and I got, I expressed interest in it because it was very involved professionally in development of the profession even then, and got selected for that so I ran the project team for the year it took us to implement the new clinical nursing structure in Queensland. So, and that was a really fantastic experience and you know why?... I visited most hospitals in Queensland. I did from Goondiwindi into Brisbane. I did from Roma into to Brisbane. I did from Cairns up to Thursday Island out to Weipa. I did Townsville down to, I did Cairns down to Townsville. I did Gympie to Brisbane and I went and visited at each of the hospitals and met with the local nurses and presented at local seminars and met with local steering committees. I got to know what nursing was about out in the bush, without actually having to go there. One of the few people I think that's not in a senior health position that had the opportunity to actually go and see what nursing is, across the State.

And after that, I built a reasonable reputation for not only delivering a major project but the intellectual sides of it in terms of managing the crises, managing the people, managing the processes, and, and people found out that I could write [laughs] so I did all the written work of the project team, I did the monthly reports, I did the submissions to ministers, I did the final report of the project, I couldn't type at that time, I had a lead pencil, I could write.

I wrote a full final report of the 12 months. And we had one admin staff member with this six member project, so out of that, the coordinator, the project team had, or the career structure two coordinators and the project team reported to them, there was a union nominator and a health department nominator and they ran the project through the project. One of them was so impressed with my particular skills, and she was on the Nurses Registration Board, and they needed, the Board had been arguing for a number of years for its own resources because they weren't satisfied with the support they were being provided by the multi service office [laughs] at that time, and they approached the minister to have me seconded to a
role there to prepare them for cessation of their business as a Board because they were to disappear, so I got seconded in there for 12 months to tidy them up to go out of business and from there I was seconded to set up the Queensland Nursing Council, so I’ve never, I’ve got to say, I’ve really never planned a career path, I’ve always made decisions when decisions have needed to be made.

So I build a reputation and you come an interview me!

**Some of the most positive things about your career?**

Oh I think establishing the Queensland Nursing Council, having an influence on nursing generally, I think protecting the mental health nursing qualification SA for recognition under the Nursing Act here in Queensland. I notice that that’s disappeared under the National Act. I led the charge here in Queensland when it was proposed that it wasn’t going to be included as an endorsed qualification in Queensland. I led that charge from outside regulation, I hadn’t been party to the decision about it not being recognised now, and that, it surprises me that that’s been so quiet, you know.

It’s interesting because there’s a lot of, there’s actually a lot of difference of opinion from within the profession...

The nub of it for me, and it’s a question that I’ve never been able to answer is: is mental health nursing a separate profession? I am worried and I’ve been worried from a professional background that we’re denuding the skill set, because I know the mental health units now are not getting mental health nurses because we’re not producing enough, and if there’s no recognition at the end of it.

There’s no direct entry programme down there.

So I’m surprised, I would have thought that the question needs to be asked, “Is mental health nursing, nursing nowadays?” But I’m not into doing that type of philosophical thinking [laughs].

**Have there been any low lights?**

Oh look I think that everyone has low periods, I don’t like seeing people lose their livelihood because they’ve had misconduct and you’ve known them. But no, I think generally there’s nothing that I can point out, looking back saying oh no that was awful, not even, not seeing daylight for the 9 weeks of the Patel media crisis, the experience of that was just, it was a new experience, and you don’t feel it when you’re in it, because you’re too busy. I think politics and dealing with politics is always, is not the most enjoyable thing, but that’s how our country is structured.

I don’t think I’d be here without doing mental health nursing. Which other qualification actually gives you communication skills, makes you think about the impact off you on others. And it might be a sort of, I don’t know, it might be a chicken and egg argument, but I thought that the education was just like I mean I just thought it was wonderful, I went from someone that was, a bludger at school and just cruised through without doing much and never saw myself as someone that wanted to be top marks in anything, and I got into mental health nursing and I wanted to learn everything, I wanted, and not only I wanted to learn it, I wanted to know it [laughs], and I wanted to use it, and I went from someone that wouldn’t do any study to actually studying quite constructively, so I think that’s something else it gave me, it taught me that I could actually, with effort, or with a bit more, actually achieve things, so that’s why I always remember Ken, because Ken and I vied for top marks the whole time through our course, and we lived, and we shared flats and that type of thing too. He went down the academic route though, which was always his bent, it wasn’t mine.
Anecdotes?

I’m not good at remembering those type of things, I’m just. Look, I talked about the shining lights, and there’s always, there’s always that group that aren’t just there to do the job, they’re there because they care and I remember second year blues, getting pissed off with things and the charge nurse of a psycho geriatric unit who gave me some special projects, well my turn was there because she could see that I was, the work was done, I was a good worker but I wasn’t being able to learn, and she gave me some special projects and support, a learning environment for me and I’ll always, her name was Fay McGrath, I’ll always remember that, she set me up to do special assessments and reporting to the clinical team, so it probably saved me in nursing, because I was bored, I had the second year blues and I wasn’t doing much,. That’s about the only anecdote I can remember.

I always considered myself as being uncomfortable, I always want to do the right thing, in fact I remember Chris Cambley saying that I was going to have a hard life because I was one of those people who could sit in the group and tell the group that they needed to change [laughs] and I would always be a challenge to other people in that sense, and I think that was a pretty good assessment. I’m happy to sit within a group but I’ll also tell the group that this is not the right way of doing things.

...I did have one very enjoyable experience, it was actually being invited back to do a speech for the last group at Baillie Henderson. And it was just very nice to be home again. It felt nice. And it felt nice that the organisation itself had seen me as one of its sons that they’d sent out to the big wide world.

I am quite happy to share that I got promoted fairly quickly after I finished at Baillie Henderson and it’s probably part of the culture, there was a particular group within Baillie Henderson, because I had still a lot of friends and mates within, employed up there, the rumour going round Bailey Henderson when I got my first promotion was that I’d got it because I’d been sleeping with someone else [laughs].

I think what it was saying to me was there had to be a reason for a fast promotion because they didn’t experience fast promotion. You had to do your time. Whereas in the private sector, if you were someone that they could get something out of, they didn’t employ duds, they only employed people that delivered something for them, and I think that that was, that was also a learning for me because I saw Baillie Henderson, I could never have stayed there because, I wasn’t going to sit there for 20 years doing the same thing, I made it up the chain, I wanted to get out and experience that life.

As a young boy, 21. I always remember being 21 as the charge nurse. And the next youngest person on my team was 28, and my senior nurse, and one of my senior nurses was 54 ... ... and she said Jim it’s just lovely to work with you ... I had big brothers and sisters and I could get away with it [laughs].

So, rather than radical, perhaps you would consider yourself a challenging person and people find that difficult at times?

Yes they do. And I probably come, I’ve become less challenging, maybe I’ve just become more subtle as I’ve got older.

I’m having an interesting life at the moment because my skills are having to be re-honed because for the first time in 20 years or so, I’ve actually got a boss. So I’ve actually, I’m within a structure where I’m very senior in it, but I’ve got a boss. In the last 20 years, my boss has been a Minister of the Crown. And you don’t see them very often. I’ve never had to manage up, so it’s a particularly interesting set of communication skills that I’m developing again.
On humour in mental health nursing.

But this is the one, now I remember it. Look I think the ability to enjoy a relationship has to have humour in it so if you’re, if you’re from a, if you take the position that mental health nursing is about how the relationship assists an individual to develop change and become well or whatever, then the absence of humour means there’s no relationship, and in fact I think if there’s humour there, and it’s a reciprocal thing, then I think the humour does play a central role in it, but it’s a pointer I think of the relationship rather than a vehicle itself.

On changes
I haven’t functioned within mental health nursing structure since probably 1989, 1990, so it’s a long time for me since I’ve been there.

And I’ve seen changes from outside but I haven’t kept up with those changes, but again, it’s that worry about is mental health nursing disappearing, and if it is, why? And should it, I’ve got to say I don’t think so, I think that there have always been very, very good nurses without the qualification that have functioned very well within mental health care profession, but they don’t know what they don’t know, and I am concerned that, we’ve got a lot of resources now being directed to mental health care, I think I’ve mentioned 15 times in the last month by senior politicians but if there are no nurses there with the polls, you have to get on with your credentialing, how are you going to credential?

Well I mean it’s moving, there’s a lot more people getting credential but it’s, they don’t have to and that’s the whole process.

No, and that’s always the issue around ...

Yeah, if mandatory for practice would be an entirely different ...

Nothings mandatory for practice nowadays, you know.

No.

I want to make things change if it’s been on the basis of nomination then it’s, you’ve got the obvious result that they’re picking like people to nominate [laughs].

Christine Palmer
Current Role: Private Practitioner

On being nominated: [Inspirational role model]
I’m not really sure. Maybe I’ve seen a lot of change. Maybe I’ve provided some leadership along the way particularly with the college and... I suppose I’ve studied and taught I don’t know. Doing something quite different and out of the box... I work in private practice. See clients privately and do private consulting and teaching and a whole lot of different things so [pause] published a few things and presented at conferences those sorts of things. I suppose that’s maybe why I don’t know.

Tell me about your life as a nurse.

I started nursing because that’s well [long pause] I think the family thought it was a good idea that I went nursing. I had a Great Aunt who was a nurse and then my grandmother used to liken me to her and to say that I should be a nurse like my, like her sister. And so and I couldn’t really think, what I really wanted to do actually I wanted to be a vet, don’t tell anybody that [laughter]. But I realised at 16 that you had to go to University for 5 years I thought, “Oh won’t do that.” So I went nursing. Well I went, I was interested also you know I was quite interested in doing it and so I went did general nursing this is back in New Zealand in 1975 and that was a three and a half year hospital based program that I started and while I, during the course of that training I in my second year was sent off to the Psychiatric Ward at this provincial hospital on night duty on my own and I can still distinctly recall that shift where I sat in the office in my own running the shift, second year, 18 years old, eyes like saucers, terrified what was going to happen and had been told you know scary stuff at the handover that one of the patients had smashed through a window the night before and so you know all this, I was terrified, I was terrified and so when people started getting up in the morning I was sort of even more terrified but nothing happened [laughter] and because they sent me there that one time they sent me there, they kept sending me back so I spent a lot more time in the psych ward than my peers. And just really enjoyed it really kind of latched onto it and so that was actually where I was working when I graduated. And so 2 months after I finished the nursing program I left New Zealand and went travelling and came and got as far as well I moved to Melbourne for 6 months and then I came to Brisbane where I had some girlfriends living and then a couple of months of that so it was within less than I had probably 4 months, 5 months post grad experience as a general nurse and then I started doing and then I went out and started a psych nurse course, nurse training program out at Wolston Park, out at the Park at Wacol and that was in June ’79.

I did the 18 months there and stayed on for another couple of years working in the rehab area. From there I went just down the road actually to Wooloowin, let me think. Yes that was when I went there. I went to work for what was then the Department of Families, or Family Services or something as it was called then and worked for 2 years in a residential setting for children in care and protection, care and control. It’s probably one of the hardest jobs I’ve ever done it was very challenging. And then I went to QUT to do the Diploma of Applied Science, Nursing Education that was in ‘85. So by that time I’d only been a registered nurse for 6 or 7 years not very long, so I went, put myself through, paid for myself for that year, studied full time, had never thought that I was capable of study really. I just kind of always squeaked by even through my general nurse training I was told that I wasn’t going to pass because I never learnt how to study.

So when I went to, when I did, when I went to psych nursing I was actually really nicely mentored by a couple of the nurse educators there and it was the first time that I was actually told that I was bright and that I you know could be doing more and so that’s why I went to nurse education. And after that, that was ’85 (8.08), ’86 I went teaching at the Royal Brisbane in the hospital based program. Taught all the mental health and [pause] behavioural sciences type stuff into the general hospital program. God I hate general nursing [laughter] – so rigid and regulated.

So I became a mental health nurse. When I think back to those days and I think how I thought I knew quite a lot then but I realise now that I knew bugger all and it’s such a lifelong journey isn’t it? You just never
stop learning stuff. So I taught there for a couple of years and then motivated by the fact that I was going to be turning 30 and I was terrified by that I ran away and went overseas for a year, travelled around and when I was in America I did actually work as an assistant nurse for a couple of months in Florida which was oh very physically demanding work. So when I came back I decided I needed to get back into proper psychiatric nursing and I went to work at inpatient unit at the Royal. So I was the charge nurse there for nearly 5 years. It was about 4 years, 9 months and 20 days or something.

I started counting near the end that's for sure and that was a result of having an Assistant Director of Nursing who was brought in who was not a mental health nurse and who just came in to dismantle the place really so she completely destroyed teams and groups and staff (10.28) anyway. So I learned a lot of stuff actually then. I really respect the work that inpatient nurses do and that's why, that's what my PhD's actually around. And so from there what did I do? While I was there, while I was working there that's right I completed a Bachelor of Applied Science Nursing and Master of Nursing and then I, so then I went to QUT to teach. I was 5 months pregnant with her when I went there. So that was in early '93 and taught there for almost 5 years as well. And that was, I quite liked working there actually. It wasn't a bad place to work. At that time the Head of School was a mental health nurse so there was a really strong contingent of mental health nurses, psych nurses working on the team there so it was, it felt good. Then I went to New Zealand, went back to New Zealand from whence I came and took on a joint appointment at Senior Lecturer Level with Massey University in Auckland and with Waitemata Health in Auckland on the north shore and that was a fantastic job. That was really I really enjoyed that because I got to do a bit of everything. I got to work with clients I took on a small client caseload in the community and taught post graduate mental health nursing at Massey and did a whole lot of things as well within Waitemata Health and ran journal class, starting going into the local inpatient unit and running groups to just to model nurses running groups so that nurses could recognise that yes this is actually, we used to always do this, we can do it again and so they did. While I was there actually it was soon after I arrived in New Zealand in 1997 that I was fortunate to be invited to an introductory clinical supervision session with Mike Considine. It was a two days introduction and I really enjoyed it I thought, “Hey this is…” and it was something completely new to me because we didn't have it at all in Queensland at that stage for nurses. So I got stuck into that and did the advanced program the following year which was 10 days over the 12 month period and so that’s why I’ve and I got an excellent clinical supervisor while I was there and I started providing clinical supervision so that’s been a passion of mine since then. So now I'm involved in teaching clinical supervision and providing at my next client's actually a clinical supervisee mental health nurse who works in a private hospital; that was her calling on the phone just now just to check where we were meeting. So I have a number of private clinical supervisees and also provide supervision now over at a private hospital a half a day a fortnight. But where was I? [laughter] I was in New Zealand kind of getting the best of both worlds, teaching and you know clinical practice so and it was I mean it was a great job in lots of ways because I, it was a new position and I got to invent it how I liked it so...

I had to do quite a bit of travelling down to the parts of north campus of Massey, which is the mother ship if you like, and do a bit of teaching down there periodically but it all just seemed to work really well. It wasn’t you know a lot of universities then there’s so much pressure, so much teaching pressure that it’s not necessarily an enjoyable experience but it was this was well balanced, pretty well balanced so it’s really enjoyable worked with a really great bunch of people as well. So I stayed there for 6 years. So that’s the longest I’ve worked anywhere just over 6 years. And came back basically after 6 years, after 2 terms, two 3 year contracts the health service decided under new management, under new leadership that they couldn’t continue to fund that position and Massey could only support my position full time down in Wellington and I didn’t want to move to Wellington and so the plan had always been to come back to Brisbane actually at that time so it was just perfect. Because I was only there really in Auckland to be with family. And so moving to Wellington was counter-productive. But anyway so came back to
Brisbane and worked half time at a private hospital, working in the eating disorders program. I really enjoyed that work it was great. Learned a lot. I was a Level 1 RN on the floor [laugh] and I think that’s an interesting term we use, we call it on the floor and I think when you break that down, qualitatively it’s an interesting…It comes through a lot in my [PhD] research.

To be on the floor is to be on your feet, practising, doing the hard yards.

So I did that for about oh a bit over a year I think and then I took on full time PhD study. Still not finished. It’s driving me crazy. I’m in, I think I’m in transition, you know when you’re talking about childbirth just that transition period just before the birth when you’re irritable and crabby and want to scream at people. You know it’s like do not mention the PhD [laughs]. Yeah I’ve got probably about another three chapters on working in private practice.

Mm yes well I suppose yeah. It’s just kind of happened. It’s really interesting how it’s just happened. You just kind of get different contracts and work just keeps, one job will finish and something else will come in straight after it’s amazing. It just keeps on rolling.

It gets a bit chaotic in my head sometimes, which is why there hasn’t been much space for the PhD writing but just even taxes and but that whole big plastic bin over there that’s just full of tax stuff [laughter]. And the thought of diving in there and sorting it all out for the last year and the current year now I’ve registered for GST I’ve got this yeah anyway. It’s a whole different kettle of fish but the work is really, I really enjoy it; it’s great it’s fantastic. And I’ve always enjoyed autonomous practice and I always felt constrained by bureaucracy and rules.

Anecdotes

My first experience I suppose was not as a mental health nurse it was as a junior general nurse trainee and it was like seven o’clock in the morning the shift was due to finish at seven thirty, been on the night shift and there was me and an enrolled nurse and this was going back in the day when it was a second year student nurse you’re running the ward, medical ward and this client had been quite sick and we knew that she was terminally ill and she was dying, well she started to cheyne stoke breathing at seven, ten past seven and the other nurse and I we just kind of looked at each other and went, “Ooh” turned the oxygen up and we just laughed. We just laughed. You know there’s nothing to laugh about, the fact that we’re trying to keep this woman alive past the end of our shift so we didn’t have to lay out the body and be you know held back at work for an extra half an hour or hour or something. I guess it just kind of lightens the load. But humour’s been it’s an interesting thing that’s come through in my research as well. That we use humour for lots of different reasons and not all of them are good.

Humour seems to be fundamental to being a mental health nurse. And I think it is. I think that people who work as mental health nurses who don’t have that humour, that thing that we call humour, aren’t warmly regarded by other mental health nurses. They actually sit outside the pack, they don’t belong and it’s that personality difference that’s something around being able to engage in a laugh and have a joke and you know say some negative and entirely derogatory thing about a client in a joking way. I think it’s terrible, sometimes I think it’s terrible but it helps people to be able to keep on keeping on.

Significant moments in mental health nursing

When I think of significant moments I think of things that are more recent than things that have happened in the past. Like well I kind of think more about well one thing in particular is when I worked in the early ‘80’s for Family Services I worked with a kid then who was 12 years old who was extremely messed up by her family and who was such hard work. She was really, really, really tough to work with probably
the most difficult of all children I worked with over those years. She’s now 36 years old and I’m the godmother of her little boy and she’s probably more like a daughter now and I see that as an incredibly monumental thing. And she’s a constant reminder to me that kids who are profoundly abused and who’s early years are just rotten beyond belief can still actually survive and thrive and do well and she’s an amazing parent. She’s a wonderful mother. You know and she says not a day goes by that she’s not disturbed and distressed by her childhood experiences but she’s kind of, she’s been able to just get on with her life and you know make some meaningful inroads in the world and she’s actually now just about to complete a Diploma in Social Welfare. She’s working with kids who have had you know similar sorts of lives and she’s doing wonderfully well. I’m so proud of her. And just that little thing that you know I think is really profound. And just a number of clients, the number of people I’m working with now under the Mental Health Nurse Incentive Program who benefit so much from having access to a mental health nurse that and this is a new service, a really new service, it’s 2 years old. People haven’t been able to access these services and there’s just this huge population out there of people who would otherwise be going without any support, you know emotional mental health support. I think it’s fantastic that they’ve made this change and that we’re able to get out there and support people in that way.

it’s making a huge change, impact on people’s lives. Not everybody you meet but yeah a lot.

A negative well actually one of the big events also in the past in my past history was having a client hang himself on the hospital grounds and that’s something, that’s a, what was the question, it was actually what was a significant moment.

Yes a significant event that’s not particularly nice at all and there are still lots of awful visual images that go with that even, but it was a really significant event because of the impact that it had on all of us in that team and we were really tight. We were an incredibly cohesive working team in the (26.41) patient unit. So there are lots of really kind of warm fuzzy memories around my time working with those people but that was a really kind of significant negative event that we still all share you know. Interesting stuff at times. Only in all the years I’ve worked in mental health I’ve only ever had two clients commit suicide.

Best times

There are lots of best times. The best times probably were working at that cohesive group some of whom are you know my best mates and we just started out as people working on the team together. I like to think I might have had something to do with it [laughter] since I was the team leader.

Because I think I’ve well the people from that team will say that what I did was when things were rough, when things were awful when they brought that other manager in, or even prior to that when there was any kind of shit falling from above down that I would block it before it got to them. So they didn’t really they weren’t really aware of how much fallout they didn’t get to experience because I was there kind of blocking it and defending them and keeping them safe. But it was more than that it was about you know just being equals and I saw my role very much as, this was in the days when we were called, we went from charge nurse to in ’91 I think to clinical nurse consultant...

And for me that meant you know there was a clinical in there. So as far as I was concerned I still had a clinical role and so I always maintained a clinical caseload and I would also get in and be down in the showers and bathrooms in the morning with everybody else and doing all that sort of stuff and so, so it was very much kind of shared, shared leadership really but with me also kind of [pause] as I said before, blocking a lot of the fallout from upper management so that they didn’t really cop it. They said they really only realised that after I left. I left them to it [laughs]. But it was a really, that was a fantastic time we still always, we still often talk about the good old days back there on B ward and we did pretty
good work. Although when I think back now I’ve learned so much more since then that there are some, like there was a client there who was really difficult to work with a woman with a very troubling borderline personality disorder and you know I’ve learned so much more now about how to work with people with borderline personality disorder that I still sometimes wonder how she is and whether she’s still alive and [pause] whether we actually added to her disability really God. Because she was ultimately you know abandoned again, rejected by the hospital and turfed out against her wishes so you know it wasn’t it didn’t go very well. But most of the time we had a sense that we were providing a fairly good service in the hospital.

Other best times, when I think about the when I was working in New Zealand that type position, I worked with the same five or six clients for the whole 6 years, nearly 6 years that I was there. Well I was there for more than 6 years but I started taking on clients after a couple of months so there was you know I was, that’s really unusual for somebody to have the same caseworker in a community team for that long. So I was kind of part of the family I got to do, in one with one particular family the wife was the identified client if you like. But I did a lot of family work as well. Did some family therapy. I had to bring a whole family into the University. I’d see her in the home and over a period of time I did some family therapy back at the University to kind of separate the two out. That was really rewarding and just to see the shift you know people getting, just little changes. Like another one of my clients that I worked with all of that time was a woman with a bipolar disorder who had had bipolar disorder for more than 30 years and it had taken her, I mean I’d been working for nearly probably 3 years, 3 or 4 years even before she’d actually begun to recognise her early warning signs and to notify them to me. You know because there was so much shame around getting sick for her, even if she recognised that things were going a bit haywire she didn’t want to have to acknowledge that and so just that tiny little change that had such an impact on her wellbeing really, for her to recognise her early warning signs and to tell me about them so that we could do something there and then and head it off at the pass. A huge impact on her life really. So working for a long time with people I think is really, really worthwhile you become a part of their family.

Worst moments?

Oh the worst moments, okay that would probably go back to being a student psychiatric nurse at the Park. I found the experience was quite traumatic sometimes. I can remember when I’m, I had heard that around the 6 month period for general training nurses doing the post-basic course that was a sticking point that was the time where you actually endured or you left. And I can remember coming so close to leaving because I was just so disgruntled really with the way the place operated and some of the staff and some of the dysfunction that went on there. And one of the girls in my group had actually witnessed a charge nurse and deputy charge nurse physically assault a client and break his arm and she was so distressed that she went down to the central office just to say that she was going home, that she needed to go home. She had not intended at all to tell them why she was going, what she had witnessed because it was just taboo you didn’t do that. Anyway she was so distressed that they said, “What’s going on, what happened, what’s happened?” And so she spilled her guts. Anyway she was absolutely, what’s the word? [pause] You know the backlash against her for telling was enormous and you know her car was scratched, you know sugar in the petrol tank that sort of stuff it was just awful. Because as a consequence what happened to those two people was that they were shifted into different wards. Hardly punishment really, certainly not what would happen today. But that was the punishment strategy in those days that you just moved people because that was punishment enough because they had their comfortable places. Anyway this happened about the same time as I was really fed up and I thought, “This is terrible, this is awful this stuff” and I could see (36.34) not very good care and I remember one of the nurses, one of the assistant nurses I think he was who was alcohol dependent, he would just come onto the shift and they’d just kind of put him in the linen cupboard to sleep. To drink and sleep the shift through you know. So that sort of stuff was quite upsetting.
I think I just kept going to work and didn't get around to resigning. I think so. I think that's what happened. And then I was out the other side and I was okay and I managed to stay on. But what was worse came probably a little bit later when, for most of my time there I had been in a secure relationship with a fellow and we'd been living together and then that broke up and it was amazing how it got around the hospital that I was now single and I started, and I was the subject of quite a lot of sexual harassment by you know male nurses. And some of them, one of them in fact who was a charge nurse who was probably in his sixties, and I was 21, or 22 or something. You know mind blowing stuff. I've still got really traumatic images of you know having to duck away and duck out of the room and you know get away from these men who were not at all subtle about their intentions. Anyway. I got through that as well. And I'm so glad I did because I can't imagine doing anything else other than mental health nursing. And I don't I wouldn't go so far as to say those experiences make you stronger or tougher but they are just experiences along the way. It's just how you you deal with it, just get on with it. So (38.40) probably the bad times and also another bad time was actually leaving that acute inpatient unit because well I had actually been planning to leave anyway because I had almost finished my Master's Degree and the plan was to go and do some teaching, get back into teaching somewhere but by that time I just decided there was no way I could continue to work with that particular woman who was causing chaos and mayhem at the unit.

**What is it about mental health nursing that's kept you being a mental health nurse?**

Well I think it's a part of my identity. It's who I am as much as what I do and so you know like it surprises me when I hear mental health nurses say that they want to do something completely different, although they don't really like it and they want to get out or they're not sure this is really what they want to do.

I can't imagine feeling that way. I can't see outside of that box you know that I'm so kind of firmly in that box that I can't imagine being say an interior designer or a I don't know, a conference organiser or something I don't know. I couldn't imagine doing something else. And as a good friend of mine said, “We spend all of our lives learning how to be good at this and the irony is that when we get to be really good then we retire.” -- Doesn't make sense. And so that's why I really admire the likes of Judy Boyd who's still practising. She was one of my nurse educators at the Park...

There's this whole thing about info glut, there's so much information to take on. So many new theoretical perspectives, new ways of being, but that whole I mean we never learned anything about cultural issues and we never learnt anything about consumer rights. And yet the consumer movement was already underway back in those days in America at least but it's been very slow to catch on here and even though it's written into all the national documents and state documents around mental health service provision it's still largely lip service while it's translating into practice to some extent I can't say that psych service is certainly not the same today as it was back in the seventies. No it was quite different, people do have a lot more rights and you don't have to work in smoking environments.

I think to kind of join the health professions you have to have quite a strong rescuer within and although that can be a negative it's also I think what keeps you in working in the health professions. But you actually learn how to moderate the rescuer and sharpen the therapeutic side of things. Although you know the rescuer is still very strong. Like the other night when I landed from New Zealand I switched my phone back on and I got this text message from an 18 year old boy that I've just started seeing and he's on bail and he's in crisis and his text message says something like, “Hi Christine I need you to help me find somewhere to live, my father and stepmother have assaulted me and they've locked me in my room and they've locked the windows and won't give me any food or water” and I'm thinking, “Who the hell is this?” I was so disorientated. I'm thinking, “What is this all about?” And then I realised who it was and he said, “it was so hot in there that I left.” And his bail conditions require that he stays living at his father's
place here in Brisbane and stay away from the Gold Coast where he was getting into trouble with kids
down there. But you know you just want to run over and grab them and bring them home [laughter]. So
inappropriate but that nurturing kind of rescuing parent on board all the time that you just have to keep
in check. And I think that that’s a part of being a mental health nurse that you really want to help people
live better lives, get on with living a decent life. Getting some satisfaction, getting some enjoyment out
of your lives… this morning is a 48 year old lady I’ve been working with who’s a sex worker and has
been working in the sex industry since she was 13 so you can only imagine what her childhood was like,
and it’s only in the last couple of years got addicted to drugs and you kind of wonder when she talks
about her history and how she’s got to be where she is, why she wasn’t actually addicted to drugs at 15
and not 48. So this is a woman who’s well sold herself, sold her soul to the devil in order to support and
raise her four children, put them all through private schooling and give them the sort of life that she never
had. But it’s all kind of backfiring on her at the moment. So I mean there’s people like her and like the
young fellow that what they really lack is a positive sense of self. They don’t recognise any of the own
inner strengths and capacities and what they’re capable of. They only see the negatives and so part of
my work I think is helping people to see their potentials and to being to live life in different ways and just
to, I, it gives me a great deal of pleasure to see people make changes in their lives and get on with living

I just started out 6 weeks ago working with this absolutely gorgeous, delightful 77 year old lady who’s
just realised that she suffers from quite a lot of anxiety and she didn’t, didn’t want to really believe that
it was anxiety. She always thought it was something physical going on. But actually after working with
her over a number of weeks and just going through anxiety management strategies and with her doing
everything that she needed to do, she’s wonderful. She said to me right at the beginning, “I’m the sort of
person who needs to be told what to do and if you tell me what to do I’ll do it.” And I’m thinking,
“Fantastic.” And so she embraced every little bit of homework I gave her and she’d go and, just and the
impact has been phenomenal and she’s, we’re now in maintenance basically and she’s just fantastic.
She’s made such a shift in her behaviours and her responses and her general wellbeing. And it’s so
rewarding to see those sorts of changes in people.

The stuff that keeps me being a mental health nurse - those sorts of rewards. And I mean there are shit,
crappy times as well like probably about this time last year I had a young woman with a borderline
personality disorder who was in a really dysfunctional relationship with a young man who is probably
antisocial/narcissistic and you know it all went to shit in a handcart one day because oh, because of a lot
of things, there was probably a little bit too much rescuing with her, I’m not sure. I like to think not, I’ve
certainly been taking her to clinical supervision quite a lot but it all just, because of the nasty stuff that is,
that resides in him, it all went awful really so they, so then she refused to continue to see me. He has
always and will always separate her from any of her supports and so that was inevitable really but still
it was quite upsetting when I think about that young woman in this abusive and violent relationship with
their little baby in the middle of it. You know it really is not very nice (49.59). But anyway you can’t
save everybody that’s the thing.

Major achievements

I’m very proud of the college. I think the college is doing wonderful work and I’m really happy to be a
part of that. Because I’m on the college board and I’m also the secretary for the Queensland branch
and I’m now an ambassador as well for the College for Mental Health Nursing which hasn’t translated
into a lot at the moment because I’m just not sure where to fit it into my life but I can see opportunities to
actually go into the local schools and high schools and talk about mental health nursing and how you can
get to be one. So there are a lot of opportunities, well I mean I’ve been to Nursing Expo, the Nursing
Expo. And actually that was fantastic because I went along to the Nursing Expo with Marilyn and I was
supposed to be there for half a day but Peta couldn’t get there, she was sick she had to go home sick so I
was there for the whole day and I literally, like I thought, “Oh you know we might get a little bit of
interest” but we literally didn’t stop all day. We had so many people so much interest in mental health nursing, it was phenomenal and it was really heart warming, it was really inspiring that there was just this incredible interest out there from all these young people from…

Some of the, some of the kids, and they were kids, like grade 10 grade 11 kids came to the stand and were saying, “I’m going to be a mental health nurse. I want to be a mental health nurse this is what I want to do.” And so talked to them and they know they have to go off and be a nurse first and they have to go and already decided which University they’re going to and these are kids who are 16, 15, 16 some of them, 17. Already made that decision and that’s where they’re going. And it was really a lovely experience just to get all that, see all that interest. Because we feel you know when you look at the problems we have attracting and retaining people into mental health nursing you kind of get this impression that we’re going to be extinct in a very short space of time and I would be devastated.

Yeah and you know this, there’s so much ambivalence around that. I strongly advocate a direct entry program because I believe that the people who want to be mental health nurses are different to the ones who want to be general nurses.

And so you know they’re not going to come in and do general nursing and (53.18) actually mental health nursing looks interesting to me. But these are people who are whose interest is in mental health nursing and so they should have an opportunity to directly access…

I think we lose a lot of people to psychology and social work. Yeah so how do we get the Universities to embrace that? How do we get the academics to embrace that? Because it’s the academics actually that put the barriers up. Because they say this is not going to work. It’s not going to be embraced by the University and of course it’s not if they don’t…

I know there are a lot of pessimists in the profession actually who think that we’re going to be extinct in a very short space of time but I really, I hope that’s not the case and I know in New Zealand they’ve got a generic mental health worker that’s well I presume it’s still going it’s been nearly 6 years since I left there. But it went from a Diploma, no it went from a [pause] I think it went from a Certificate, Associate Diploma Program initially to a Diploma to a Degree program in a very short space of time and being taught by mental health nurses, which I think, is a travesty really. So training up a or teaching a group of mental health professionals who are effectively going to take over in some respects the work of mental health nurses. So you know if you’ve got a whole bunch of those people you could have for example, on a the way it works in the States often you know have a registered nurse or an endorsed, enrolled nurse on the ward to give out the medications and all the rest of the staff are the generic mental health workers.

George Plint

On being nominated : [far reach of influence]
I have no idea because I don’t know that anything that I do is in terms of my practice or the work that I do is well known by others. I can only assume that perhaps some of the people that I work closely with at the present time felt that you know there was for some reason something occurring that was of note in some way... about how we’re trying to develop the service here at Fraser Coast and Wide Bay and some of those achievements or some of the direction that we’re setting in terms of contemporary practice I think are important and possibly others feel that those things are important as well, so there may be some value in having that conversation.

One of the things I suppose in terms of my own perceptions or my own drivers, I’ve always felt as a nurse that nursing was a profession that in some ways has always needed to develop the profession, needed to develop as a profession to receive the recognition that it deserves in the context of the health professions if you like. So in terms of looking at the medical profession, the allied health professionals and the nursing professional I think nursing over the 30 years that I’ve been a nurse, I’ve recognised that nursing needs to develop in terms of a profession in its own right and even though it exists as a profession in its own right, there are just some subtleties about the way nursing is received and nurses are perceived and the subtleties around how the profession is perceived, but I think they’re, I’ve always held the view that we need to try and actively develop the nursing profession as a profession, so.

On your career

To be perfectly honest nursing to me is a job. It’s not something that I ever dreamed about as an ideal job, but then I’m of that generation where you left school and you got a job.

I was born in the late fifties and so you know we as a generation really didn’t have a lot of choices. We were expected to stand on our own two feet, go and get a job and kind of be happy with it. So I knew 30 years ago, a friend of mine said they’re employing people out at Baillie Henderson Hospital. Why don’t you go out there and see if you can get a, you know a job. I was working at the time but Bailee Henderson was a higher wage and there were opportunities there. So I went to Bailee Henderson and said look, “I’m interested and what do I have to do to get a job?” and I was offered a job basically. So, I was offered a job as an assistant nurse which means that we performed basic things like sweeping the floors, cleaning floors, mopping, polishing the floors and those kind of duties, domestic type duties I suppose, so I was offered that work initially with a view to becoming a student nurse a few months down the track and that’s how it progressed. So I started out as an assistant nurse and then progressed to becoming a student nurse and then went through my psychiatric nursing training.

At the completion of that I decided to, I decided I needed to continue to have a job basically because by that time, by the time I completed it I was married and had children, only 3 years later. So I applied to work at the Gold Coast Hospital to do general nursing and went and worked there. So I did general nursing and then stayed in nursing. I am still a nurse.

In terms of career development I’ve never, ever really had a career goal of any kind. I’ve, but I gravitated towards aged care nursing. I like working with elderly people, I like working in that environment, I like the autonomy of working in aged care. I like the people that I was working with and so I gravitated towards aged care and worked in aged care in Toowoomba and in Maryborough. I did some work with the Red Cross Blood Service in working with the blood transfusion services and then eventually returned to mental health in the form of Community Mental Health and what I found when I returned to Community Mental Health, which was in 1996 I’d say, mid nineties let’s say. And I had left psychiatric nursing at Baillie Henderson, the last time I had worked in psychiatric nursing per se was the mid eighties, so I saw a real change in terms of the expectations of myself as a mental health nurse working in a community mental health setting as compared to a mental health nurse working in an
institutional setting, which is an experience I didn’t find particularly rewarding. But I certainly found working in the community mental health setting very rewarding in that we were a very small team, there was only four of us and we had no other mental health resources available to us. So we had a small team and we were our psychiatrist was in Bundaberg so 120 kilometres away. The inpatient unit was 120 kilometres away and there was only four of us in town, a population of about 60,000 people. And you know housewives and teachers and homeless people and people from all walks of life would come in and discuss their mental health needs with us as mental health professionals and we provided care to people in the context of their real lives, not in the context of a patient in an institution and that work is for me very rewarding.

In terms of being able to see people in the context of being a husband or a wife or an employee or a professional or an itinerant or whatever person with an illness seeking treatment for their illness. And so I stayed in that work and ultimately had the opportunity to take over the management of this Fraser Health Mental Health Service when it was established in 1999 and now I’m the Executive Director of Fraser Coast and Wide Bay. So I’m still a nurse but my career progression I guess has been something that’s been unplanned but in terms of working at Fraser Coast and Wide Bay we’ve taken a particular direction in terms of service delivery that is the subject of probably a conversation that could go on for hours but I guess we’ve established a culture, or we’re trying to establish a culture within the service that our model of service delivery and our strategic plan for service development involves two fundamental questions and the first question is; do we provide the type of service that we ourselves would be happy to receive or for a member of our family to and if we answer yes to that question, how do we know? So we can go to community meetings and say that we think we provide a very good service and happily say that but if we go to the community meeting we can’t say that we believe we provide the best possible mental health care to this community. I can’t honestly say that and so there’s a deficit. We should be able to say we provide the best possible mental health care to the community and so that’s the aim. Not just a good service, but the best possible care one could receive and we provide that routinely so we’ve taken a focus that we provide a family oriented recovery focussed mental health service that is consistent with evidence based practice and we, we aim to routinely provide the best possible care that we can.

So the important words there are routinely providing the best possible mental health care to the community and so that’s the aim. Not just a good service, but the best possible care one could receive and we provide that routinely so we’ve taken a focus that we provide a family oriented recovery focussed mental health service that is consistent with evidence based practice and we, we aim to routinely provide the best possible care that we can. So if we look at what drives that concept if we consider that medications and psychotherapies are effective evidence based treatments of mental illness we also need to understand though additionally and probably equally in some ways that housing, family involvement and employment are also evidence based treatments of mental illness. And a particularly good example is employment you know. An employee must be organised, must be able to plan. Must be able to prepare meals. Must be able to keep deadlines and timetables, must be able to care for their personal hygiene, must be able to care for their personal life because it can impact on employment. So a person, if we work in a service that recognises that it’s possible to treat mental illness to the extent that you can relieve the symptoms of psychosis or a mood disorder or whatever and do that reasonably successfully in many cases, if we don’t then provide that individual support and with services that deal with the disability associated with the illness, we’re simply returning the individual symptom free to a meaningless life that ultimately will almost certainly end up in relapse because if the person has no meaningful life, if the best they can do it watch TV and drink too much and smoke too much dope on pension day or whatever, then clearly they’re going to relapse would. So I guess that’s sort of the background and we’ve got processes and business practices in place to try and influence that philosophy. But that’s the underlying philosophy; we try and deliver services that’s Fraser Coast and Wide Bay.

Having a strong vision
Well yeah I suppose that’s what drives me, what’s important to me and what I try and promote within the service. It’s not easily achieved…and I can’t say that we are successfully you know fully achieving the vision, but I can say that the vision is real and that we’ve got clearly defined steps along the way that we are implementing and intend to continue to implement to try and have that impact on our community. So that I suppose we leave a legacy of at least having made an attempt to provide the best possible services because I guess if we consider the asylum era and the institutional era of mental health care, asylum care was established a long time ago, over 150 years ago - 1865.

Asylum care was established for very good reasons and it had its place. However, asylum care also, through over a period of time, became the subject of criticism and could be considered in some ways to have been a failure. Now that may or may not be fair but it’s possibly a criticism that’s levelled at asylum care in some way there were failings in the system. So being aware of that in the enlightened 21st Century I suppose we have to also recognise that the recovery era can also fail and possibly is and so possibly what is going to happen when we retire and move on, as service providers, we potentially can be criticised and considered to have failed in the implementation of recovery oriented mental health services as the next sort of phase in the evolution of mental health care from the 19th, 20th and 21st centuries. So I think that would be a tragedy if we consider to have failed and to be failures and to be criticised in the future so I think we have to as service providers have some understanding of that potential and try and deal with that so that we leave a legacy of success in terms of delivering mental health care rather than a legacy of being seen as being ineffectual.

And so it may be considered to be a personal goal, but I think again in terms of understanding that we’re not only making contribution, we’re not only doing a job which is to me a very important, to have a job and a family. That’s why I say I have a job rather than a career, I think a job’s an important thing to have and to do it well is important. So, so it’s not only about doing it, having the satisfaction of having done a good job, it’s also about understanding that whole process then adds to the profession, nursing profession and adds to the medical profession and other professions. But importantly as a nurse in making a contribution to the profession by being able to influence clinical practices over a period of time in the way we do business is fundamentally important and it also, if we have a strong vision and the determination to achieve that vision we also can feel that we are meeting the needs of the community in a best practice way, so we are also making a contribution to the community. So there’s a, there’s the satisfaction of knowing personally that you’ve attempted to do a good job, can somehow rationalise that you have that you’re making a contribution to your profession and you’re also making a contribution to your community so you know we’re leaving behind I suppose a valuable contribution and giving something back, not only to your know profession but community as well. So I suppose that’s the thing, they’re the things that drive me. In a nutshell.

**Impressions of Baillie Henderson Hospital**

I wouldn’t like to make statements that are shallow and meaningless and critical. But I suppose I found Baillie Henderson to be you know initially an employer, somewhere I could work and make relatively good money at the time compared to what I, I went to Baillie Hendersons making three times the amount of money each week as what I was in my previous job, so as a 21 year old or 20 year old, 19 year old or whatever I was, that was important to me, 19 year old. That was important. I found that the work that I was doing was different to anything that I would have expected through my upbringing in that it wasn’t active, physical active work and that was contrary to my ideals as a person, as an adolescent and as a young adult. My ideals were that you there was an expectation that you worked hard before you were paid and you worked physically hard and so I found that that wasn’t the case when I started at Baillie Henderson so there was a bit of a conflict in my own mind about it at the time. Although I found the work challenging in a lot of ways but reasonably enjoyable in a lot of ways. And I think it was enjoyable because the staff were good to work with and the atmosphere was, it was a challenging
But it was a very confronting environment; it was an institution you know? It, it involved, it involved people treated, nursing people who had intellectual disability as well as psychiatric illness and possible predominantly people who well were severely disabled in many ways, either psychologically or intellectually or physically but certainly a strong focus on possibly palliative care if you like care of people who basically were disabled and a workforce that was going through a huge transition. The people who had started worked there 10 years prior to myself had worked in a very different work than the work environment I worked in and the people who are working there now I’m sure are working in a very different environment than I worked in. For example, patients would have communal showers when I started at Baillie Henderson, there would be communal dining and a dormitory style bedding. People were basically moved from where they slept to where they had breakfast to where they went for the balance of the day, in the lounge room or an open yard, it was, people were locked in those areas and then from there through the communal showers and then back up to the communal bed at night. So it was a very regimented, very regimented life for those people and probably in terms of our expectations of our personal lives, quite different. In the acute psychiatric wards I didn’t spend a lot of time and possibly can’t really comment a great deal, the majority of my time at Baillie Henderson through my training and through my work was in those areas where people were most severely disabled rather than acute areas. So I have little experience, had little experience in those acute areas at the time. Certainly some but not a great deal.

We were probably one of the very early groups that went through training in a School of Nursing so we had blocks of training and lectures of 1 month, I think a couple of months a year, two blocks of 1 month each where we had theory and then there were assignments to do and exams to sit. The majority of the time was spent basically working in the institution, in the wards of the hospital with, I think arguably little, little if any, active training in that environment. So again the training experience for me didn’t seem to, didn’t seem to be something that was [pause] didn’t seem to be something that was particularly targeted or I don’t know, I don’t know the correct way to describe it, but it was at the time it was training that we accepted and were happy to participate in but I suppose I didn’t feel inspired by the training to want to learn more and perhaps that’s why I was considered at the time to be a bit negative. Now I don’t want to sound narcissistic in this conversation but didn’t feel inspired or driven by the training.

So perhaps that’s a reflection on the training. Although it at the time we felt that well it was the expectation and that’s what we did. Happily so. Participated in the training, got on with it and had to do the exams and all had a good social life and got on with the business I suppose. So we were happy enough to do it at the time.

Anecdotes
I suppose in general there was what we call black humour. We would laugh at adverse events and adverse situations in a way that was I suppose some kind of release for you. I think, I think there were often stories at Baillie Henderson if you like, stories around practical jokes that others had played on each other and some of the things that occurred in the hospital and in the institution at the time and thinking back to some of those stories which I probably couldn’t repeat probably is what, is what we often talk about if we meet people who worked with, back 20, 25 years ago, or 30 years ago, some of those sort of, some of the characters that we worked with in terms of the staff and some of the patients who were characters too. Because the patients had very real personalities and would you see their personalities come out in the way things occurred and things that people said and things that people would do and some of the practical jokes that the staff and the patients would do together. So I think there was a lot of fun. People created fun in the institution because I suppose it was a community within itself. So yes I think that’s true, it was a lot of fun and possibly you know it was, in a lot of ways it was quite personal in that it was within that cloistered environment and the fun was occurring within that community, with the institutional community and probably people outside of that community wouldn’t appreciate the significance of what was occurring so I don’t have any particular anecdotes myself but I do reflect on some of the things that occurred and they were, but that was years ago and more so than what occurs now.

I think still we rely on humour in adverse situations to get us through from time to time. So I think we still you know sometimes laugh in the face of adversity in particular situations but I honestly don’t have any particular anecdotes now. I suppose one of the things, one of the impacts of being in management is that you do become a bit isolated from others and from, so you know things are going on around you, but you’re not particularly, not always involved with them. So I still think we have a workforce that can still enjoy itself. I can certainly see that but it’s different than what it was like in those days.

**Significant moments**

I suppose I’ve alluded to already the thing that I felt was most noteworthy was the experience of working in an institutional setting, leaving that setting for a period of up to almost 10 years and then returning to mental health care in a community mental health setting and there was a dramatic difference in my view in the way care was being delivered and the expectations of care and I suppose it was that experience that really helped motivate me to stay in mental health. Had I, I couldn’t have returned to an institutional setting that I had been in many years ago and found that same inspiration so I felt that the significant impact of seeing the change and the changed expectations has had significant impact on me personally.

I think that’s when the learning started. So I and I suppose that’s what I’m saying about the experience of education in an institutional setting. It wasn’t particularly inspiring for me personally. However having, having the responsibility of providing care to people in the community in the context of being a member of the community and being directly responsible for that care changed, gave me I suppose the opportunity to accept far more and be prepared to accept far more responsibility for what I was, the service I was providing for others and also my knowledge around that and so it was far more stimulating and the desire to learn more about psychiatry really only kicked in then for me.

I think we well did a couple of things we, I enrolled in a graduate Diploma in Community Mental Health through the University of Queensland and through that process I suppose I learnt from other students who I came in contact with, learned from friends who or people I was working with at the time in Maryborough and sought out the knowledge of others before to, I suppose to initially establish some knowledge of what it is we were trying to do in that setting but then took further education in Community and Mental Health and through that process, through that process I sought out when I was given the opportunity to manage Fraser Coast Service and establish the service I suppose you know in many ways because when I commenced managing the service it was basically a building and an increase in staff so
took on the process of establishing the service. I then sought out other best practice service providers through with the advice of some people from the University of Queensland and sourced other services interstate and as it happens and sought their advice in terms of delivery of contemporary mental health and it’s those people who really assisted me to understand the direction or to establish a direction and culture and expectation for services here. So it’s that influence from you know colleagues and seeking out, seeking out an organisation that, or other service providers that are recognised for making you know a contribution, a valuable contribution in an effective way. So not just going to next door. I actually tried that, did go to you know the services within Queensland and found that without, found that experience to be reasonably fairly shallow so went to one of the larger services, south of here, yeah way south of here, crossing the border and found that you know there wasn’t, there wasn’t a real, there wasn’t a willingness to look outside of the square. More saying, “Well this is how you do it, why are you here?” “Why are you here asking some questions.” So it was that process of seeking out the service that was doing something innovative and learning from those people and I still have those same contacts now. That’s been a very valuable experience and it still drives us to this day.

Most rewarding times

The most rewarding times I think, I think the most rewarding times [pause] it is around patient care. Clearly the most rewarding times are around seeing people recover to an extent where you can really see that the person has returned to a functional life. And so we work with patients every day, I don’t now, I don’t work clinically per se on a daily basis but seeing people having, having the experience where a partner or a carer will seek you out and say, “Look I just wanted to, I just wanted to tell you how well X is going and this is what they’re doing and how they’re working as a whatever and their life is on track and you know they’re managing their illness well.” So I think those rewards are very important and I suppose I would hope that the experience in the future of being able to look back on making a meaningful contribution will be rewarding one day. So I would hope like Maswell I would hope that I am not disappointed in the contribution we’ve made when it comes to retirement time. But for now the most rewarding experiences have been the feedback you receive when people have really truly recovered yeah.

The worst times

Worst times I suppose and again it’s a very difficult question to answer because working in management I work with people with staff and manage staff and I think the most, I suppose the worst times are obviously when there is an adverse event and there’s a patient death or there’s something tragic that occurs, is extremely challenging and you know it’s an experience you wouldn’t wish on anyone understandably but in some ways some of the most can be disappointing when you feel that [pause] you feel that more the ideals that you have in terms of your expectation, expectations for service delivery are incongruent with the ideals that sometimes others have and so there can be a conflict there you know and you can put it in simple terms. Sometimes simply expecting that people are diligent and productive, when people aren’t diligent and productive you can feel very disappointed when people don’t perform at a very basic level. If you have a particular ethic and that ethic’s not recognised in others that can be disappointing I suppose yeah.

Even in simple terms, like “Why haven’t you involved the family?” [Answer] “No reason”. It’s not good enough. And that can be very challenging. Although you know in general I think we have a very solid workforce and I suppose that’s one of the other things that is rewarding. One of the things that it’s important to recognise is that no matter, in general the mental health workforce shares similar ideals and expectations of themselves. We all share a similar vision; the challenge is the implementation of the vision. It’s not the articulation of it, which is easy. It’s the implementation of the vision is the difficult part and so it’s rewarding to at least recognise that we all share a similar vision and I think that’s generally
true. Everyone’s trying really generally. Most people are generally trying to do a good job. But it’s the implementation that can be challenging.

**Challenges for Queensland**

That we develop and maintain a focus on the development of the mental health workforce. Because I do think there are gaps. I think we do have to understand the role of the mental health professional as a professional. We have to understand discipline specific functions and generally we do and we have to understand there’s a generic role as well and it’s the combination of the generic role and the discipline specific role that forms the basis of what a mental health professional does and that’s quite specific in some ways so a psychologist working in mental health care, a community mental health setting, has a there are specific expectations that are not the expectations of the psychologist working in a general hospital. So there are specific, there are generic expectations and I think, I think that we rarely as a nation need to understand and comes to term with what that role and function is and what those generic expectations are so that we can more adequately develop our mental health workforce because I think there are gaps remaining in terms of understanding the role of the mental health professional and so it is very important that we maintain that focus and maintain if you like a commonsense approach to understanding how to develop that workforce and how to best utilise that workforce. Yeah I think that’s very important, I think to inject, to inject some commonsense into the whole debate in terms of just understanding that there are some practical things that need to occur.

Every one of us receives health care and every one of us has certain expectations in terms of our health care. Each one of us want to be able to access health care, we want to be able to access health care and we each want to know what our diagnosis is, we want to know what that means, we want our carers to know what that means.

We want to know what our treatment is and our medications are and how to stay well and we don’t want to be dependent on the system. We want to be able to function in our normal lives and return to our normal lives so every one of us have that expectation and every person receiving mental health care has that expectation so just looking at things in a less sophisticated way to say, “Look really this is what we’re trying to achieve.

The fundamentals and the basics are important as well as the more sophisticated principles of evidence based practice.

![Syd Roberts](image)

**Syd Roberts**

Current role: Court liaison officer in Southport Magistrates Court, Qld Health

**On being nominated:** [Inspirational role model]
I don’t think I’m outstanding in any way but I have had a fairly long history in mental health and I suppose I’ve seen a lot of changes and what not and I’ve done different things but nothing spectacular really but my background mainly is, I came from Scotland, and worked in psych nursing for about 20 years prior to coming to Australia. So I’ve done all registered nurse things but I suppose I was in a responsible position when I was about 22 I think, when I became a charge nurse. So leadership started there I suppose and then I did that for 3 or 4 years and then I went to sort of middle management position as we would call it mostly supervisor here, it was a middle management officer in Scotland. So I had this section that I was in control of at, we had a lot of staff, I suppose 50 or 60 staff maybe more and 100 client beds. So I did that for a while but we were always, we had lots of courses and professional development stuff going on as well so not only did we get our hands on leadership stuff but we also got lots of support with the Glasgow Health. So they did lots of courses and professional development stuff, management courses. It was all complemented by that and I came back to registered nursing which was very hard to do actually and came back up through and got a similar position there as well.

So when you came to Australia, did you come to Queensland originally?

I went to Sydney first. I went to Gladesville, I worked down there for about 8 months or so but I always wanted to come up to Queensland so that was always the plan. My contract was for 6 months down there so I came up, my family were quite young then, my daughters were young and then we came up to Queensland after that. I went to the Prince Charles and worked there for quite a long time, quite a number of years because it was a really good place to work, for many reasons. A couple of main reasons were the standards were high, the nursing standards were high and the culture was very amazing, conducive to good patient outcomes and the staff were, the staff were very professional, very knowledgeable and very experienced staff and it was somewhere I liked being. It was a good place to work and I was very comfortable there. So I stayed quite a number of years, became charge nurse there as well. I did some after hours management and things like that but I became a charge nurse and there was a ward set aside there, I met Margaret before we worked in a ward set aside for registered nurses only, it took in nursing graduates and what not. So it was totally registered nurses that ran that ward. So it was a sort of focused ward and special ward in many ways and then I worked in acute lock-up and all that sort of thing and discharge nurse there. So that was very varied and very challenging but interesting and then I became a community team leader for nearly 10 years and a community mental health team leader for more real intensive support to then three years ago to this court liaison role, consulting here. So I’m the sole person working here, until this week I’ve got a colleague now, until this week I was the sole mental health resource person for Magistrate’s Court here. I still work for Queensland Health but interface with the criminal justice system. So anyone who comes into the watch house; or through the court for that matter, referrals can come from anywhere but it’s mainly through the watch house. Anyone who’s got psychological, psychiatric issues and may need intervention then they call for me to do assessments and try and transition them into mental health if they require that and feedback to the court and advise the court and things like that. So that’s what I’m doing right now.

On leadership

Yes. You know I don’t find leadership all that difficult although I’m a fairly quiet person as an individual but in that role I didn’t find that particularly different. I had a stay-op which I wasn’t conscious of but I’ve had quite a lot of feedback over the years to say that my styles fairly good, it was quite acceptable and I had quite a good way with, and I always prioritised, patients outcomes, I always prioritise individuals, I always felt and I try not to be pre-judgemental and I try to let people work within the parameters of what is in their job description. I was always quite democratic and I always treated people fairly and I was never judgemental. I tried not to be judgemental, particularly for, and under stress and what not, I could cope quite well with stress and I could always advise people properly and I could always support any situations where there were difficulties and challenges and I seem to manage
that quite well. The interface is about label, you know an acute psych, there’s so many interfaces and it’s so, very challenging position to be in and I always managed to be a fairly good team member and I could always deal very well with the different disciplines and work collegially like ...

With other service and disciplines and I always felt that I upheld the nursing scene pretty well, I was always able to do that and I was always aware that I was an ambassador for nursing and I always tried to have high personal standards and ensure that my staff has high personal standards too and there was a certain understanding that that was required but I didn’t go preaching and wave my finger or anything like that but I did make a list, these are the certain standards that had to be upheld and people were expected to perform to a certain level and I was always there for people who were needing counselling, and needing instruction, and needing assistance, and needing advice, and just wanting someone to speak to and I suppose, but I didn’t feel that, I felt leadership really rewarding and challenging but it was something I never really struggled with really, I could do okay, it just felt comfortable being a leader of the team, a small team, a large team or whatever. Having said that [laugh] now the position I’ve been in, I’ve been in this position for 3 years and I’m responsible for me and I’m part of a team but I’m not responsible for anyone else and I don’t miss the PR stuff and all of that admin stuff, I don’t miss that. So I can work individually and independently because I had absolutely, until this week, no support here and I worked, my headquarters are Brisbane and I’m a remote practitioner here, a very much independent practitioner and I sink or swim by the decisions I make in the morning which are quite, you know you’ve got to be accountable for because the decisions I make can have quite large ramifications for people. So I’m pretty comfortable doing that as well.

On the court liaison role

Yeah my role is the court liaison officer in Southport Magistrates Court, employed by Queensland Health but it’s mainly to identify and manage and advise and educate for people who come through the criminal system of mental health issues. So I’ll deal with them, so I work very closely with legal aid of solicitors who have presented the individual, I work closely with the magistrate who over arches everything here and I work very closely with the police department. I work mainly; I get most of my clinical work from the watch house, people who are brought in, arrested and what not. So I work very closely but I’m only a guest down there, I don’t work there, I don’t have any major influence down there but I try and work in very closely just to get and to work with the forensic medical officers who come into the watch house, I work very closely with the district mental health service here which is the Gold Coast nursing although I work for the Royal, I’m employed and I work very closely because most of the clients are known to the service or(10.40) onto the service through me so I work very closely with the mental health service here, the local authorised mental health service. So every morning there’s all that coordination to do to try and get someone’s needs met ASAP, before 9:00 in the morning, before the district sits. There’s a lot to do and because it’s the Gold Coast a lot of people/clients from southern states drop out of treatment, come interstate, and become unwell. So many are drug related issues on the Gold Coast and so the assessment that I do, has to be done and you work on a small window of opportunity because of time restraints in the morning. So I’ve got to try and do that and give them appropriate assessment, because there’s often no collateral. Anyway, you’ve got to work through that and in conjunction with all these people I previously mentioned but there is, because it’s forensic mental health there are people we are obliged to see, people with serious offences, murder, attempted murder, rape, attempted rape and stalking and all that sort of thing. So there are some major crimes that we are obliged to see and do an assessment with as well as are a few people. Referrals can also come from the Magistrate. If someone’s in the dock and the Magistrate feels a bit concerned he’ll ask me to see them or people are in court situation, they register someone they are concerned about, I can’t provide treatment here but I can do an assessment and put some intervention into place most of the time. I often get people referred by the legal representatives who’ve seen; they go into the watch house every morning and see their clients. If they’re a bit concerned of someone being unfit to provide direction and provide their instruction to them
they’ll ask me to see them. There’s a nursing service in the watch house for medical issues, I get lots of referrals from them because they’ll interview people for medical reasons but they’ll often find there’s some other issue that needs to be dealt with, so I get lots of referrals from there. I also get lots of enquiries from the general public coming through the court asking about 100 million things about family members, about how do, you take care of a justice examination order. I don’t know if that’s unique to Queensland but it’s where someone’s very concerned about someone they know or a relative, they need to get them assessed so they take care of this court order so they come here to get the form and they’ll come up for advice how to do that. So there’s a whole complex myriad of things with this job.

**How did you come to that?**

I worked in Prince Charles for quite a number of years but I moved to the Gold Coast about 10 years ago and I liked where I was working, I liked where I was living as well. So I travelled, I was travelling by car over 3 hours every day to get to work. I did that for 7 ½ years and I just got fed up with it. So this job came along and I applied and got it. That was 2 years ago and I’m only 20 minutes to the door now and it’s very, very convenient but it’s been another different slant to mental health and it’s the sharp end stuff. I mean, you’re doing acute psych, acute assessments of really people who are just dragged in off the street virtually so you’re getting them very raw. So I still quite enjoy it, I like to be kept busy and I enjoy that side of things. I would rather do that than a whole lot of other things in psych and as I say I’m very much [pause] individual, not in the true sense of the word but I do attract a sort of independent and sink or swim by your decisions I think [laugh]. There is a lot of advisory stuff too and education. I do talk to, when I came here first, particularly because it was a new district, this was a new position, I went around the district and spoke to different groups of health workers, I speak to registered staff in regard to mental health and as I said, I’m doing a thing with the watch house police. It’s not often formal; sometimes it is but a lot of informal advice in the management of people with mental illness in the custodial setting. So there was quite a bit of educational component to the job as well, more formal than informal.

Forensic mental health, we’re part of the court liaison service. There’s no State wide. At that time when I started it was only present in the Brisbane Magistrates Court because that’s the biggest court in the State. When I started they just nominated a few other people, another extra one for Brisbane, someone to work in Pine Rivers and someone to work at Ipswich I think it was then they employed another three people. So they were just addressing the major courts in the State so they employed, they advertised this one for Southport and they advertised one in Mooloolaba, in Maroochydore and Mooloolaba and they advertised one in Toowoomba. So that was almost 3 years ago now but there was an existing, they all had worked in other courts but not in Southport. So it was a new job and initially it was a lot of establishing of and building relationships and all that sort of thing and really getting into the role and formulating and establishing the role and ...

**You probably had a broad framework that you were operating from but you really had to develop it yourself?**

Pretty much. Very much pioneered down here because mental health in this court was unheard of and people I think were quite, they didn’t know how to react to it really and a lot of people initially thought I was bringing in some sort of defence and get people off and that was this, I mean you can understand why people thought that but that turned out just not to be the case at all. I mean if people do require help and treatment then that’s fine but the police are okay with that and they understand it. Anyway, it doesn’t get them off with the sentence, all it does is delay. They go for treatment then come back and face the charges. They may stay under the mental health act for quite a long time and be chartered 7.2 but eventually they will come back and face their charges. Also the district were a bit unsure because they thought I would be generating lots and lots of work by taking people up to hospital non-stop but
that hasn’t proved to be the case. I mean I do take people up there who are unwell but there’s other, that’s the least, I mean it’s always the least restrictive way of treating people and that’s the last resort is to take them up to hospital. So I usually can manage to get people treated without, I link them up with someone before they go to hospital. So that didn’t eventuate either, that was going to be trouble for people going from here to hospital, that hasn’t happened but no, it’s quite well established now and it’s quite valuable. I know the feedback I’ve got, they do appreciate and they had a stakeholders meeting just 2 weeks ago here at the magistrates, forensic medical officers, the watch house staff, the registry staff, all of the major key stakeholders and it is actually good for the service.

_Did you enjoy that, setting the role up?_

Yeah I did, I didn’t mind doing that because I can normally, I don’t feel about people and I know, I’m not an outward going person but I do steadily work at things and I can usually establish things and you’ve got to sell mental health to people all the time and it’s got so many bad connotations but you’ve just got to plod away to work at it and I know that in mental health people don’t just throw their arms up in horror when they’re caught here and they hear mental health. It’s not like that, it’s people, well some people it’s they’ll never get it but I mean it’s really seen as something which is a very real problem, can be managed, it can be coordinated properly but it’s not like they just used to freak out when they heard there was someone coming through the court with a mental health problem.

_On becoming a mental health nurse_

Well it wasn’t a calling I must be honest, it wasn’t a calling. I left school and I didn’t do as well at school as I thought and that’s mainly because I didn’t apply myself probably much to the disappointment of my parents, particularly my mother but I lived in a village between Glasgow and Edinburgh, about 12 miles north of Glasgow, in the country side, a really nice spot. This little village had a massive psych institution just on the door step and that was the main employer for that village. Between that and there was a big sort of factory which made nails. They were the major employers for the village and when I left school I didn’t go there but my dad worked up there and my mother was a pharmacist and I went into Glasgow and worked in an office because I wanted to do other things. But I didn’t qualify and didn’t study at school. So I went in there and plodded away for a while and then I had friends who worked in the hospital and I would get fed up with the travelling a little bit so I went up and got an interview with the chief [laugh] male nurse and he said, “Yeah, yeah, yes, come up and start.” So I went to see the guy who was in charge of education department and did this test here, either if you passed the test you become a student, if you failed the test you became an adult nurse and if you didn’t do the test then you were nursing and assistant nursing. So I passed the test, I started my student nurse training but it wasn’t my calling but when I started there I must say, it was a large hospital but they had quite a good culture really and there was a lot of, I mean it was still an institution but they gave quality of life to a lot of people who were otherwise, they don’t have it now because these institutions aren’t there. I’m not saying institutions were 100%, there were all the bad things in it as well but there was a lot of good things happened and that was never really acknowledged I don’t think. The press was always bad but day to day work around in these hospitals which was really exceptional but it was never mentioned, anyway, that’s beside the point. So I enjoyed working there, so I did my student training and part of that training these days would be 8 weeks exposure to general nursing and I didn’t mind it but I didn’t really like it. I wanted to stay in mental health and the hospital I worked in was mainly for intellectually handicapped but in Scotland that was a 3 year training, similar to psych. So I did that and then I went off and did my psychiatric training in a hospital nearby, there was another big hospital 5 miles away which was purely psych. So I did my psych but I enjoyed staying, I mean the Glasgow people knew because it was a small community where a nurse is males and females and so nurses were unusual people, I mean they were ordinary people, they were a large part of that population so it was like, and it was that type of culture. People knew, it was a small village anyway and that was why I went to nursing really. It wasn’t
something I always wanted to do or had a hankering to do. I wanted to do other things actually but it was just the way it worked out. I was still fairly young, I was only 17 or 18 when I did that and I've been in nursing, I've had occasions where I thought I might do something else but I just didn't stick with it. I'm still here.

*Why do you stay in it?*

Because it's something I actually enjoy doing and psychiatry particularly, I mean psychiatry, there's lots of research goes into psychiatry so it's an evolving subject, it never stays still and the individuals are all, I know it sounds a bit corny but everyone you meet is an individual and they've all got a story to tell and I still find psychiatry quite fascinating actually because it's mainly, well it's not an exact science in any ways but the behaviours and what not, I just find it very, very interesting and psychiatric illness I just find fascinating and I still enjoy trying to keep up the best with trends and developments and things like that. It doesn't always go down well at barbeques when you tell people what you do [laugh] but that's still my flavour of the month but I do enjoy it and I've just hung on with it. There's really good things and bad things, I mean when we started to do all that we were paid peanuts really, absolute peanuts and our friends were doing trades and making big money but they were often unemployed because it was a hit or a miss thing and depended on the time of the year. So although it wasn't the best job in the world and in fact many ways it wasn't but it was secure and at that time training was different, there was hospital training so you were working and getting paid for your training and you were exposed to raw psychiatry every day of your training and I must say I met some really wonderful individuals, retired nurses, a lot of people who were just really, really, to me being a young impressionable guy, was just I thought this was, I really did enjoy and I enjoyed the experience and exposure to all of these people. It was just something I enjoyed doing.

You could split the good from the bad because not all the exposure you had was good but if you could just see where you were going and try and, but anyway. And then, I got a promotion very young. At that time, a little bit's changed much in now days but people in senior positions then were a lot older than 22 particularly at the hospitals that I worked around. So I got a promotion fairly quickly and I thought that was quite good and I was quite happy with that. So I just and then decided when often you'd become comfortable with what you were earning and you got commitments. And I just did that and because I had young children I didn't want to dodge around and I like stability in my life and that's why I stuck with it I suppose, not only that but I did enjoy it and I still enjoy it. I still find coming to work every day, maybe I don't have the spring in my step that I used to have but I do enjoy it and every day like today has been different from yesterday and we just see so many diverse individuals here. It's quite fascinating really, it's fascinating. So I suppose that's that and yeah that's why I'm still with it I suppose. It's something I've never grown bored with really and I know you can become, and sometimes particularly in acute psychiatry, day in, day out, in locked areas and challenging areas, there's quite a high bomb out and that sort of thing and sometimes you think, “Well maybe I'm getting a wee bit tired,” and you can always change so you go somewhere else and do something else but if you recognise that that's happening, but I think if you stay in a situations that's got you really down then you will get out of nursing, you will. I mean it's not for everyone but...

*On your education*

Yeah well it wasn't, I must say and maybe I'm biased but in these days hospital training was, well we had a guy and he was the only guy in the Glasgow area in these days, I'm talking in the 1960's, late 1960's who had done a degree in education and he was just a wonderful tutor and he had two other wonderful tutors and we used to go to block, I think it was a total of 15 weeks or 14 weeks a year in block just doing all of that but it was still diverse. I mean anatomy and physiology was absolutely brilliant, fantastic, I love anatomy and physiology these days. The nursing part was very good too and I
specialised in other, you know the psych stuff. I just loved going to it but, I just loved it. The education I thought was really good. It failed only when you went to the wards and in those days we used to do basics, make up trolleys and that sort of thing. Then you went to the wards [laugh] and nothing happened [laugh].

In fact I remember one particular ward, this is so hilarious but it’s not really funny but this charge nurse used to give her his tablets in a baking tray. in Europe, he’d put the bottles in the baking tray, that’s how he got in block in school but as I say the on hands education was really good because the only way, not the only way but often I thought it most beneficial to deal with people in psych issues face to face. Every day you were exposed to psych patients and you just learn all the time and I found that type of exposure was excellent, I really did. It was formalised and a lot of it was practical as well but the bedside nursing wasn’t practical but the actual exposure to people, picking up behaviours, seeing the signs and symptoms, dealing with them, managing people signs and symptoms, acute stuff, chronic stuff, was all there and you learnt how to manage it, you learnt how to interact with people, you learnt how to communicate. It was superb, the opportunity was excellent. I did that in intellectual handicap, I did that in psych and I did lots of other courses off and on and I also did my degree in nursing over here in Australia. That was, I started off in Central Queensland University and I finished off in Northern New South Wales. I did it by correspondence. So I did that and a health science degree in nursing. Yeah, so I’ve seen that side of it as well.

Career highlights?

I haven’t achieved anything major. I think what I’ve achieved is sort of steady contentment of, I’ve had lots of challenges, I’ve made a lot of challenges, that’s been satisfying. Positions I’ve held, I mean I haven’t held super high positions. I’ve relieved in particularly high positions but I’ve never held really high positions.

I mean when I was younger I did, I had exposure to them. I thought I really, the higher you get the colder it becomes and it became less clinical, obviously it does and it becomes, I mean it may sound pretty corny but it does become pretty cold up there and it becomes an administration position, it becomes a political position and there was enough of that, that I just didn’t like too. Then, and you’re so, you’re accountable at every level but you’re often accountable for things that were not within your control a lot of the time and other disciplines anyway. Highlights would be, I mean the first nursing officer position I got, I was fairly young. I was the youngest to ever become a nursing officer which was a supervisor, aged 20 years and that was sort of fairly big then. It was quite an achievement, it all seems really wrong there but it wasn’t then. So that was a highlight and that exposed me to that middle management level and I really enjoyed that but that was a big learning curve, dealing with people and that was a pretty big learning curve. This job, I like this job. I’m quite content here although it’s sort of a very tiring, a very complex job, it’s very challenging. Other highlights would be I mean highlights would be sometimes just not because of academic achievement or because of promotion, it would just be working in a situation where you’re very content and these were how I see my career. I remember working wards where it was just so good to be, it was just so nice to be and it’s so pleasant and working with a really good team pulling together was a satisfying thing. So that’s not a highlight that you would call in the true sense of the word but to me it was a very nice situation but (34.41) I suppose. I suppose, as I say when I sent you an email, I don’t think I’ve achieved anything out of the ordinary but I’ve had highs and lows yeah and I’m still in there about 40 years later, I’m still doing it [laugh]. I’m not going to do it for much longer.

[I am] Planning [to retire] in 18 months or so I’ll call it a day. Yeah, I’ve made that decision. I’ve only made it recently. Yeah, I’ll probably; I’ll go after that so yeah, yep.

Worst things
Bad things that happened? I passed all my exams and that - I used to get worried sick but I passed all my exams [laugh] but lowlights. I suppose no. I really don’t know, I mean there were times when, there was occasionally, there was a lot of violence in acute wards, police would bring people in and things weren’t handled properly and I used to get, there was often in these days, there wasn’t any proper way of dealing with challenging situations and it used to get a bit messy I suppose. I really hated all of that.

**So you mean when the patients came in they weren’t properly, the way they were dealt with?**

Well we just didn’t have the training and people were just, people deal with violence and things like that really, so there was no coordinated response to challenging behaviour and that used to worry me a lot but I didn’t like it in that sense. Having said that the Prince Charles, things did get a lot better, we got it all worked out but I’m not sure that there was really, I’m not really sure. I mean I did enjoy going to work most days I must say and despite, I mean I worked in some horrible situations but you just did it because, and I honestly, I’ve had few days sick in 40 years apart from I had some problems earlier this year, apart from that I’ve probably had a handful of days off sick.

**So you didn’t feel the need to take mental health days just that, “I can’t bear it today.”**

No, I just had a professional idea that we had to be there and I used to go and sometimes you’d go there when you weren’t feeling up to it and that’s not right either but I just had this attitude with work, that this highly principled attitude about work and I think I carried that through to leadership and things like that. Yeah, I just felt, I just sort of yeah, minor I suppose about things and attitude that I felt highly principled.

**What would you advise others thinking of mental health nursing**

I wouldn’t, yeah, I would probably advise them, “You need to keep an open mind,” but I would advise them not to consider, I would say it was a very rough world occupation. It wasn’t maybe, well I need to ask what their expectations were first of all I suppose because you need to dispel any myths and I think you need to be very realistic about what, it’s not always reporting, you don’t often get the outcomes you want, the rewards and people you’re dealing with won’t always appreciate what you do for them and if you’re looking for, you’ll get more bricks back than you will praise. You need to, it needs to be something that you really want to do, if you want to help people try and help them through a major illness and if you want to accept that, all the decisions and all the behaviours that you put into your work may not have the outcomes that you want to but if you certainly want some challenging occupation then that would be it but mental health has got lots of small subsections, lots of small specialties that people might think were attractive. For instance the elderly, the acute, the whatever, there’s lots of little pockets that you can go into but mental health is such a broad thing. You can work in a community, you can work in a hospital, you can work almost anywhere because mental health is such a broad issue for society, a big, big issue. Yeah, I would say yes, but you need to keep an open mind and you need to think about it very carefully if that’s what you really want to do. Don’t enter into it lightly. Yeah and don’t get a commitment that you don’t think you can follow through with it.

**On humour**

There’s a place for that, I love humour, life in this thing. Well I don’t know, I suppose I’ve got a good sense of humour anyway and I’m a fairly level stable guy. I don’t get depressed, I don’t get low, I’m just really and I do enjoy humour, I just do and I do try and impart it but not over the top. I just find things humorous and I find situations humorous but not to laugh. You’ve got to laugh, not at people and you find a lot of situations in psychiatry that are very funny but they’re not, they’re fairly serious but you might, you’ve got to have a sense of humour in psychiatry
otherwise I think you’d be really struggling if you saw the serious side of everything and if you saw, if you couldn’t look at it differently I think you would sort of very quickly succumb. Yeah so humour plays a big part.

I think it’s [useful in] defusing situations, I think you use humour. It becomes serious when you have serious incidents and things like that then when you’re sort of the escalating and the debriefing afterwards and things like that then I think you’ve got to often sort of lighten what was, what could have gone wrong and what did go wrong and sometimes you’ve just got to tease out some of your wrestling’s that happened and make it a bit lighter sometimes but I just think there’s humour in everything and I just see situations and like to do, I mean in the watch house it’s just not a humorous situation at all. It’s not humorous at all because it’s so serious and but you can always see a bit of fun and a bit of sun you might just sort of step back and think, “Gee, that’s quite funny,” [laugh]. So it’s just an attitude of mind I think, you know and you know with colleagues’ etcetera, I don’t like to be overly serious. So but I think and I think if people who are working in your team and with you see you that, I think that helps just to sort of team building and team morale and things like that. Humour is a very big part of that and I find with psychiatric nurses, they’ve got a good sense of humour, they really have and I think that’s maybe why, they’ve got to get through what they do and do what they do, I really do because you’re not laughing at people and not making a fool of people but you’ve got to appreciate there’s some situations [laugh] too of humour, they’re quite funny but then you’ve got to leave it that and you’ve got to remain professional a bit and also humour in the communication sense with others is quite a beneficial thing.

Anecdotes

There are probably a million things, I just can’t pick one. But mental health, you can’t enter lightly, you can’t walk away from situations, you’ve got to stick with it particularly if you’re in a situation day after day and these people day after day. Mental health is all about being, caring is an old fashioned word but you’ve got to be caring, you’ve got to have interest, you’ve got to support people and you’ve got to help people and you’ve got to be there, you’ve got to advise people, you’ve got to [long pause], you’ve got to [long pause] try and get people through very, very serious situations day after day because often, I’m thinking back to the old institutions, some peoples quality of life and conditions and what not weren’t good at all, but to be a mental health nurse you’ve got to try and stick with that, be aware of it and try and improve it but you’ve always got to do it for that individual, you’ve always got to be aware of that individuals wants, not what you want, not what the organisation wants. You’ve got to be trying to achieve what that individual wants to achieve and you’ve got to do the best that you can. So it’s not just a matter of turning up to work every day, getting food, getting the beds made, getting this done, getting medications out, there’s more to it than that, interacting with people, you’ve got to communicate with people, you’ve got to know people, understand people, understand with one, understand (46.26), understand their country and coordinate lots of health advice services and whatever.

On being an ambassador

I see myself as an ambassador.

But I’m here in the sense of a very non health situation, very low mental health situation, surrounded by general public, legal people perception. Mental health is not something that they increase day in day out. I’m the face for mental health in this situation and I think that’s and I’ve got to portray mental health and portray myself as professionally as possible and try and, well advocate for people. I’ve got to support the people and take them through the process if they come into the watch house or into the court unwell, then I’ve got to be that person. So I’m always very, very aware of that but how people see me is reflected on mental health, yeah, the perception of mental health and how mental health clinicians behave because people do generalise.
Well it reflects, so I’m very aware of that, so I’m very conscious of that but I think I do represent, well I do represent mental health and I’m the only person who does so that’s important how I am perceived and the way I perceive myself.

In fact, apart from me, there’s a psychologist and a social worker, in 13 courts they’re mostly experienced nurses but it’s not a nursing position per say, no.

**Would you do it again if you had your time over again?**

I probably would. It depends what you want from your job. If you want reward, constant reward and tangible reward then you might not walk away from a shift and think you’ve achieved anything and you’ve got to accept that but you probably have but it’s not something that you can cash in, it’s not something ...

It’s often sort of nebulous and it doesn’t really strike you as that you’ve achieved anything. So if you’re looking for an instant reward and you’re looking for material things from your job then you’re not going to get it in nursing, mental health nursing particularly. I think it takes a certain type of person to do it really, I do, yeah. To do it well I think it does, to do it well and take it seriously and give it what it deserves really.

**On the characteristics of the good mental health nurse?**

You’ve got to be a really conscientious person, you’ve got to be very professional, caring, you’ve got to be understanding, you’ve got to have empathy, you’ve got to have a good knowledge base and you’ve got to have certain attitudes and attributes and these sort of things, you’ve got to be very good at communicating, you’ve got to be very good at understanding, you’ve got to be a very good listener, you’ve got to be supportive, you’ve got to be a good coordinator too, you’ve got to think outside the square a lot of the time.

I think you just don’t see that person in their situation. That person has lived a life, that person has a whole series of events and people and family and you’ve got to be holistic. You’ve got to take everything into consideration and just see that person and you’ve got to think out of the ordinary to achieve whatever that person wants to achieve and what you want to achieve for them. It’s not always available within your working environment and you’ve got to think a bit wider than that and see what’s possible. I think you can get very easily caught up in the here and now and do your shift and work here (51.57) but if you really want to, you can achieve a lot more than that by going the extra mile and giving a bit more and thinking a bit more sort of, publicly.
John Quinn
Current role: Manager in Queensland Health’s Mental Health Branch

On being nominated: [passion, dedication, commitment]

Mainly because of my college activities going back. I’ve been a member of the college since 1982 or 1983 so one of the, and I’ve sort of been, I’ve been to occasional branch meetings for a long time, two or three a year and I took on the, I volunteered to be Treasurer one year, back about 19…, I forget now, but they asked me to be President, so I did the President’s job for about a year or so and then took on the Secretary’s job, and was Secretary for seven years, Branch Councillor for 4 years out of that 7 years and I was Treasurer for a couple of years after that, after Christine took over as Secretary and I couldn’t get over the shock of Christine taking over Secretary took me about two days to get over because it was such, I mean, I wasn’t expected to give it up although I was pleased to give it up when I did. Mainly my college activities. I’ve sort of also been involved in, years ago Ken Haywood, he was the Health Minister here in Queensland but before he was a Health Minister he was an Accountant, and he happened to be my Accountant, just my tax return I’d see an Accountant for and before he entered parliament, then he became Health Minister and the college nominated me as a representative for the inaugural Queensland Nursing Council, the Inaugural Executive Officer. Anyway so Ken Hayward said to me, I didn’t know him that well, I knew him from seeing him once a year for my tax return, but he said mine was the only name on the list of nominees for the Council that he knew. So that was really the only reason I got appointed. But it sort of gave me a bit of a profile over and above, just through like really circumstance really. So it gave me a, but I’ve always had a bit of a profile in nursing too, going back.

I’m expecting to be close to retirement but back in my first hospital job, it was at Royal Brisbane Hospital across the road here, and I was a Wardsman then - an Orderly for a couple of years and I was a Student Nurse, and I was um, ah, a bit of a radical and I was involved in left wing politics around about the same time as I became a Student Nurse and I got involved in the RANF back then, I was a Councillor on the RNAF back in, the only reason I was a Councillor was that they were struggling for appointees, they didn’t have enough people nominating, so I had a profile there in, and around about that time, towards the end of my generalness in training, there was a breakaway union from RNAF in Queensland which became the Queensland Nurses Union and I remember we had some big meetings of the RNAF back then and the RNAF was dominated by Matrons and was quite polarised meetings and I remember the chant in the audience a union for the Nurses, not the Matrons. And no more garden tea parties and so that was polarising. And also at the same time the old Matron of the RBH, Elizabeth Annabel, so was a fairly famous nursing Matron leader in Queensland, as she was sacked by the Hospital Board, and even though I was no friend or ally of her, the nurses were outraged at the hospital, she was an in contact with the doctors basically and the Hospital Board sacked her because supporting the doctors, and they told the doctors how they sacked her the day before they told the nurses that she’d been sacked, and there was quite a campaign. And I remember Gaye Hawksworth, at the time, she was a Charge Nurse at the Coronary Care Unit and she wanted to make sure I was onside about the campaign to state it, Isabelle, and I remember telling them, Miss Abel we used to call her, telling her that my support for her wasn’t personal, it wasn’t, but it was more the social position of nurses versus the hierarchy, the hospital hierarchy. So I had a profile and after that I did psych nursing and…

What led you to psychiatric nursing?

Oh, two reasons. I mean I felt I had more, as a male in nursing, males were less back then you sort of almost knew all the, out of the thousand nurses there’d be maybe 40 males, you knew them all. And I felt I had, it was, and I was fairly influenced by feminist politics too, I was a band leader of that, I felt I had a, not a better career, I had a, it was a better career being a male in psych nursing than being a male, I
know feminists would say that males have got it easier in general nursing, I think often that was true, particularly back then, because I think, well the females didn’t have a, knowing their colleagues quite well and knowing how the leadership worked, didn’t have a lot of confidence, sort of had aspirations that males would be better, so males got an easier run. But I didn’t sort of go, I knew males got an easier run, I don’t know whether that’s still true now but I think it was true back then, because there was quite a few incompetent males in some leadership positions. So anyway I felt it was sort of more natural for a male to have a career in mental health nursing and I sort of had a bit of an interest in mental health. I was a bit of a thinker and when I was nursing it seemed like a bit more of a cerebral occupation and when I first started mental health and I was intimately involved in general, as a student nurse, in the Union and that and I sort of tried to really get to know people from my left wing political view how people thought, how nurses thought. When I came to psych nursing, I thought the psych nurses were so much more intelligent. And I would tell the story but I realised it wasn’t true. They’re not more intelligent, they just talk more, they talk more and they’ve got often better communication skills from the nature of their work and coming from general nursing where you’re encouraged not to talk and where communication is, talking to the patients was frowned, I can hear the story over and over again, I remember some wards you’d spend an hour folding and unfolding towels in the linen room just so you would look busy so you wouldn’t be caught not doing nothing. I was always a hard worker. But I mean, but it was a shock going into psych nursing, being encouraged to talk and talk and in a way I wasted my first two or three years of my psych nursing training getting to know staff. [Laugh] Because that was my politics really, we could talk more about that, but that’s another story.

Memories?

I had a bit of a struggle to get into psych nursing because I had a reputation of being a radical and a troublemaker. And that was true. I was a radical and a trouble maker and an angry young man and even though I had a good interview, initially I got rejected from the intake and I made representation to the HEF, I was in the RANF, but it was HEF that looked after, and a couple of people turned out to be ultimately my adversaries, but made representations on my behalf and a couple of people pulled out of the intake and anyway I got accepted. So I kept a low profile of my first 18 months of my training until I became a psych nurse, and I was, then I got more, joined the college, Andrew King got me to join the college back then. He was a bit notorious too in a way. My first impressions, um, [pause] it was Wolston Park, it was 1981 and it was a large hospital and I remember some of the intellectually disabled patients who were noisy and boisterous and a bit intimidating until you got to know them. That was a bit of a shock to me. In my first ward I got assaulted (11.06) but I got kicked in the stomach at my first placement, and I was traumatised for at least a few years after that. It took me a few years to get over. I’m an anxious person and it took me a few years to get over that. My first impressions, oh, I didn’t, it took me a long time to become a good psych nurse, a proper psych nurse, you know. It took me, it wasn’t until I left Wolston Park really that I felt that I started to really learn stuff, (11.48) community nurse, I spent 5 years at the park and 3 ½ years as a RN and I mainly did afternoon shifts. But anyway when I got a job at the community over a few that I started studying the academic sort of stuff, so that sort of set me on the path to learning good psychiatric nursing skills. I remember one person taking me aside, towards the end of my training, just before the final exams, saying I was going to fail unless I did some work, and I pulled my finger out and said this is my habit and applied myself enough to pass but I was more engaged in the Union and political activities than I was in learning to be a good nurse. And I don’t know, most of the nurses in my group, I was a GT, general trained nurse, and there was about 12 or 13 in my group and a few of them, maybe 2 or 3 of them are still working as psych nurses, most of them left, you know. So I don’t know why I survived or how I survived, I don’t know.

What is a good nurse?
I had relatively respectful relationships with patients as well as staff and one of the benefits of inpatient nursing is that you're part of a team, or the team that's in the here and now, I'm on the shift with you and you can have a lower profile, when in the community there's much more onus on you, and I'm talking about what you are, and on your judgement and it's more, it's less a collective response, it's more an individual response. And a collective response, plenty of times I was in charge of shifts and stuff like that, you relied on the collective ways to respond to people and you just wanted a quiet shift and wanted to keep things calm and avoid trouble and that sort of stuff. Whereas in the community, I don't know, I also, I got a scholarship back then, that made matter, a political decision that nurses in Queensland were under educated and needed to catch up and a lot of scholarships and diplomas over four or five years, and two things, I wanted to, I got very involved in the Union at the Park, Wolston Park, and it was a bit of factional struggle through the HEF and, internal factional struggle in the HEF, I was in one side, the left side, and sort of the left side was, and there was a right, middle of the road aspiring careerists side on the other side, and it ended up in a court battle over the Federal Union verses the State Union and I forget the, I'd have to think about what the intricacies were but anyway, in my mind it's too silly for words, I shared, I had things in common but anyway people started forking out thousands of dollars of their own money for legal fees over a court battle which was just over, over some peripheral issue, I just thought it was a waste of time. So I got married, the factional struggle at the Park was just too silly for words and I decided, I had a couple of goes at getting a community job, and I think they gave me a community job to get me out of the Park. And I was in the community for about a year and a scholarship came up for 10 months off to do a Diploma and it was good. Actually the amount of work they expected you to do for those Diplomas back then, I think it was nine subjects or something like that. Incredible.

It started me on the thinking and did the nursing degree and after that, two years part time and then, yeah, I sort of, and by that time I'd got a set, getting degrees wasn't that common, while we're speaking back then and then I started a Master's Degree. The nursing degree I didn't like that much. Actually I didn't like the nursing degree much at all really, the Diploma. I did a Diploma in community nursing and a nursing degree, because it wasn't that relevant to mental health nursing, but then I did a research masters, looking at the homeless mentally ill people, I'd had a lot to do with clinically in my roles and anyway I just got more involved over time and about, at that stage, about proving my clinical skills and my clinical acumen and my clinical interventions, and I was also very influenced by, I worked in the Valley for seven years here and Karli, Dr Kiliansanderam(18.40), he's a Psychiatrist in Brisbane now, and he's semi retired but um, he was quite a progressive, anyway, he always thought that the solutions to all the problems of mental health was the next visiting guru, and Ron Diamond and, I forget all their names, Courtney Harding and two or three times a year we'd have someone from overseas come and spend a week at our service and he'd, but um, I learned a lot from it, I'm a bit of a sceptic about education, about training, not really a sceptic, you can sort of overstate it. But I was really influenced by people like Ron Diamond and Courtney Harding and that about trying to be better at what we do.

On education

I was warned by Diane Warne, she's still around, she's a nurse educator, I was warned that I was going to fail and I think I got three P's or whatever it was, so I wasn't a high achieving student.

I was more interested in the Union and how, politics outside of work than I was in being a good student. But having said that, I think people who are better students than me, most of my group, a lot of my group didn't last, so I don't know what that was.

I've never felt like I wanted to give up Psych Nursing. I was going to give up General Nursing. I almost gave up General Nursing half way through because of the pressure, there's so much pressure. But I've never, so how much did my education prepare me?
We had, Andrew King wasn’t a bad educator. We had some good, Judy Boyd, is she one of the people that you’re interviewing? She was the ADON at the school, whatever, the Head of the school. She only gave us a couple of lecturers and she wasn’t much good.

Oh, she was okay, but she was a bit of a, um, she um, we had Denny Cowel and Ian Hain and Kevin Satchell, Andrew King. Females amongst it anyway. Denny was pretty good, but anyway, I was pretty influenced by Anti- psychiatry stuff so, part of my problem was that I sort of came from this left analysis of psychiatry that, had some half smart ideas that I didn’t really, I didn’t have enough understanding to have more perspective around. And in my training, (22.38) much training, I did five months in the school, 40 hours a week, it was pretty good training, had a lot of exposure to education. But I did six months on night duty and the reason I did six months on night duty was because I was traumatised because I’d been assaulted. So I kept a low profile.

I was involved in negotiating staffing profiles but I was in charge of an open acute ward, a charge, I was the only nurse in an open acute ward on a night for six months and we didn’t have any trouble. Oh we had a couple of things but I think you manage. But anyway I didn’t learn much in my training except my training was overshadowed a fair bit by having been assaulted. And I think that’s probably not that uncommon, although I don’t think I let on to anyone how much I was traumatised by it, I didn’t let on. And I remember the Clinical Nurse asking me the next day, I was kicked in the stomach, I was winded but I sort of got up and said I was okay, but I was pretty shaken by it. But he made some pretty insensitive, as we’re inclined to do at times, pretty insensitive remark, that I didn’t take it too badly, but I didn’t take it too kindly either. I just sort of struggled on regardless. And the patient who assaulted me, he was a very difficult patient and there was one other nurse, who is still around now, is an educator somewhere, up the coast a bit somewhere, Bundaberg, not Bundaberg but somewhere up there, and he used to lay in wait and this guy got assaulted about five times in two weeks by this patient. But the patient ultimately committed suicide. A pretty bad case of schizophrenia. Quite aggressive with it. You deal with some pretty difficult people some of the time. Being traumatised, being more interested in politics, not being, not applying myself probably as well as I could have as a student. Being on night duty, so anyway… I did a year in Pearce House, Pearce House was, when I became an RN in psych nursing, so 18 months a student, I was only out for a couple of months, by that time I was getting a bit of a name for myself in the Union, so they put me in Pearce House as punishment. Pearce House was described by John Hoult as the worst psychiatric, the worst ward in Australia.

It was a locked refractory [ward] you would say. Pearce House was a house, male and female side by side. Pearce House, security patient’s hospital. It was a stepping stone to going to open wards or patients who had been very assaulted and so it was difficult. There were only 25 patients, so it wasn’t a big ward. They were fairly primitive conditions. I mean, half the patients were in the dormitory and there was a lot of sexual activity that went on there at night and the other half of the patients were in single locked single rooms on the veranda, I’m sure you’ve seen (26.44) where they’d have the bucket at night to pee in and poo in. And being a traumatised nurse, being an anxious traumatised nurse, it was a bit challenging, a bit challenging.

I needed to work and do something else. By that time I had two certificates and I’d also been involved in the RNAF and so I sort of, no, and by that time I got my, about 1984, 1985 I was married, got married, so took on nursing, and that helped save me a bit too. No, I didn’t think about giving it in.

**Career highlights**

I started Psych Nursing in 1981 and by about 9 years later, by about 1990, I was at the Valley by that time and I was a CNC and I got involved in Schizophrenia Fellowship and this woman I know got me
involved in the camp and recreation so we used to take people away to the Tallebudgera Recreation Camp, have you heard of Tallebudgera Recreation Camp?

Quality places like that anyway, so three or four times a year we’d take people away for a weekend, and people who were pretty down and out, hostel type people, people who were pretty disabled, who didn’t have much quality of life anyway so that was quite a challenge. And I remember the first camp we took was to Tallebudgera and we had 100, 120 people and it was a massive effort and it was just amazing that, there was about four or five people in the Fellowship and about four or five, most of us nurses and (29.35) fairly egoatarian and sleeping in the same dormitories as the consumers and showering in the same, to go from somewhere like Pearce House and the patients lined up naked and the staff stood at the door and made sure no fights broke out and whatever, to actually showering alongside patients, so that was a bit of a, broke down the ice significantly. Changed my attitude.

The longer you’re in the game the more you get to know people and a few suicides along the way, that always, suicides of people that you knew pretty well and um, [pause] and tended to have good relationships with the people that I worked with and you sort of saw their engagement to with, and I often had a lot of respect for, you saw the work that they did. I worked with some brilliant people and I’ve learnt, actually there was one nurse that I worked with at (31.36) and her brother had schizophrenia, and I kind of got in trouble for saying that I thought she was a bit dumb, and she was a bit dumb, but anyway that issue aside, her compassion for people, the way she could relate to people, it was just so impressive and I picked up a lot from Ruby I remember, but not just Ruby, there’s so many people I’ve seen. And another, she’s a friend of mine now, Sue, her, I remember someone with Bipolar, Schizo effect, had a five or six year old child, I forget how old the child was and there was no, backed each other up in terms of holiday relief, I sort of took on her case side a bit so I knew and she was prepared to take risks that I wasn’t prepared, that I wouldn’t, her risks were inspiring. Not, they weren’t reckless and the trust, well so many people were saying that. The complexity of some of the people that we deal with, yeah, I’m just raving a bit now.

I had a lot to do with St Vincent de Paul and the Salvation Army so from my early days at Stones Corner as a Community Nurse we set up a service at St Vincent de Paul, Bundy Weir and myself and anyway, so I sort of, then I went on to do the Research Masters of the homeless mentally ill. So I became a bit tunnel visioned about homeless people and it’s a bit, it’s almost a bit hypocritical, hypocritical is not quite the right word to describe it, but anyway I was very focussed on, a bit tunnel visioned and I saw a psychiatrist here this morning who is very focussed on forensics, people get focussed on and I was very focussed on homeless people and anyway I read everything that had been written in Australia. Not a lot had been written in Australia but a fair bit had been written overseas and I tried to get a, my thesis was “Are the homeless mentally ill different from other mentally ill people.” And basically, besides the fact that they’re homeless, the experience of most people who are homeless and mentally ill are not that different except for the home issue, from the experience of other people who are mentally ill by and large, the same poverty and isolation, the social disengagement, the stigma and all that sort of stuff. For five or seven years I was at Melbourne College intimately for five or seven years and I was involved with homeless mentally ill people for five or seven years and nowadays, there’s a 4 Corners program on homelessness on Monday night, I couldn’t be bothered watching it. And when I say I was a bit hypocritical, like I was very involved in politics so I sort of think, something about my personality or whatever, over engaging or over involving and then let it go.

My father is a shopkeeper and did okay at school, I was from Toowoomba, desperate to leave home and all that sort of stuff. So I went to Uni for a couple of years, dropped out, smoked dope and all that sort of stuff. I sort of made up my mind, I got a job as a Wardsman just by chance, and later on I wanted to do something socially useful and, I mean there’s other career choices that you could make, but I think being a nurse and being a mental health nurse, it’s not a prestige sort of high status job but I’ve
always felt that it’s been something socially useful. I remember catching the bus in my Wardsman uniform to the RBH one shift and the bus driver said to me, “Good on you, mate. You blokes do a good job at the hospital there.” And I felt so proud. [Laughs] So there’s more things that we nurses shouldn’t be so proud about either for that matter, but I do feel as though you don’t know how much, sometimes you do help but sometimes surprisingly enough you do help people. I don’t know how often we do that.

**Best things in your career?**

I’m proud of my contribution to the college. I’m proud that, and as a conscious effort to try and, conscious effort so it’s conscious, I should be able to describe it, to grow the membership, it’s more than Australian membership, the membership stayed at about 140 for about, for as long as I can, I don’t know how long, at least Clare Lees, she was the long term Secretary before me, she resigned. And so she did good work, and they did a lot of fund raising and they had a lot of money on the bank but they never got much above 140, 150 members, it was sort of seen as the educators, it was a split between the college and the more industrial type people. By that time I wasn’t, anyway when I got involved with the college, increased the membership to 320 so over about four years or whatever, and it dropped down again with the dysfunction nationally with the membership with (39.11) and Marsh and it fell down a bit then, but Christine’s got it back, I don’t know what it is now, but it’s a greater membership, increase the profile of the college, increase the professionalism and the sophistication of the image, the self image. So some of the newsletters that I was responsible for, I was solely responsible for, they reflected what was happening. I took a lot of pride in that and even though I’m, I was a bit burnt by council, council wore me out, I’m very proud of the effort and the growth of the branch, the Queensland branch. Went to, mainly through my, well it wasn’t just me but the people around me that, I spent a lot of my spare time over a number of years, working (40.29) like you do too, all of my spare time devoted, and I like doing it and I’m proud of it, so that was good. My home is mentally ill work and in my thesis, Beverley Raffael was my supervisor and I remember saying to her it was one of the best things I have done in my life. And I discovered action research and set up a homeless mentally ill advocacy group, it was around the time of the Burdekin Inquiry, and Brian Burdekin phoned me at home one night, I just about fell off my chair.

And I mentioned before about my stuff with Dr Karli so trying to reform the mental health strategies and stuff like that. Anyway working with homeless people, being a community nurse, being a Monday to Friday worker, I left the Valley to take up a job in Ipswich, a crisis team, they’ve done a lot of crisis work but I left the Valley, I was happy in the Valley, but because I was frustrated about the lack of progress about extended hours services and basically we’re just a Monday to Friday case management service, with a bit of growth but we had no real growth for five or six years that I was there, we had four nurses to six nurses, so we used to work our butts off and so… And then the development of more comprehensive services and the development of crisis teams, what am I trying to say now?

I was sort of lucky, I used to say that too, when I was in the Valley we started a Monday to Friday MITT service, it was the first mid service in Queensland. The four of us that set it up all lasted a year and we left. It’s just, so that was hard. But the first MITT service and one of the first crisis teams I was involved with and that was hard work for three years. I’m pretty involved in, I got talked into going back to Wolston Park. Kevin Fjeldsoe talked me into going back to Wolston Park. I was at Ipswich at the time and back in, it was about 1995, 1996 and in 1992, 1993 a report came out, the whole report saying that Wolston Park was the worst psychiatric hospital in Australia and Pearce House was the worst ward in Australia and that hurt me a bit, you know. I sort of felt I had no loyalty to RBH at all. I had some loyalty to Wolston Park, so I did. And anyway there was a reform plan for Wolston Park and Kevin told me the job was at Head Office, but he was lying, the job was at the Park. So I did patient relocation, and so um, I am proud of the efforts the downsizing, the decentralised, the reform to Wolston Park was, Wolston Park was pretty bad, it was pretty bad, I don’t know whether you’ve been there, you’ve been there once?
Anyway it’s a damn sight better than it used to be. And even though it was to be involved, we were hated for what we were doing, hated, and I mean, but I’d been around long enough by then, and I was hard enough by then to know what we were doing was right and the people I worked with then, and I’m still good friends with them. I’m not social friends with them, but I mean we’ve got a close bond because of what we went through together.

We employed some consumers, so it was the first time we’d had consumers employed at the Park. I’d done some part time lecturing by that stage too, did I tell you that? QUT. Michael Clinton. Michael Clinton.

I came back and worked in town for a while towards the end of the reform process. So I was involved in setting up the new services, Townsville secure and well that’s been a bit of a disaster, but all the community care units on the north side, the secure service at Prince Charles, Robina on the Gold Coast, so a mixed bag. We had this service, like reference groups, we had these groups of me and a lot of services, Prince Charles sort of didn’t quite know about many secure or a community care unit or, so setting up these new service models, a quiet psycho geriatric, I mean stuff that was done at the Park. There were some significant challenges involved in getting the services operational and some of the have worked well, some of them haven’t worked well. So I did an alright job, but anyway I had a fair bit to do with it. Not just the patient relocation but that was my main job, getting patients to move to the new services, but also getting the new services, getting their head around, just working the people and making sure we were all on the same page. So that was quite an achievement. And then I went to High Secure, John Oxley, Kev Fjeldsoe talked me into that too. And that was probably the, I don’t know whether, it was a hard job. I had ambition when I went to John Oxley to get forensic patients, it was around this time that stuff broke out on my watch.

I had the ambition, even before that there were things brewing and I had the ambition about getting John Oxley off the front page of the paper, but I failed miserably for the first couple of years. I think, it was a very, forensic mental health care in Queensland and Margaret McAlister has got me doing a talk on forensic mental health care in a month or so’s time. But it was a very liberal system, a very liberal system. A very progressive system. And very treatment and it was unusual in a way, because Queensland, politically can be, have extremes. Like Jo Bjelke Petersen was a very right wing political leader, but there have been some very left wing things that have happened too, I’m not saying that forensic mental health care is left wing, but the approach was very progressive and considering the backlash about how bad it was before that. But it got so liberal the court gave two years after he murdered this woman he picked up hitch hiking on the Gold Coast, two years after that was going on extended over night leaves, and he wasn’t too bad, but he wasn’t too good either, you know. And they, and a year later he absconded to Victoria and then (50.32) and stuff like that, so the balance had gone too far to the rights, the focus on the patient without keeping the broader context in mind and so, anyway, I was at High Secure for John Oxley and we moved to the new hospital and my main achievement then, and I think I take the most pride at the end, is closing Oxley and opening High Secure, because it was quite a challenge and it was very industrial and I had some quite difficult staff and so, yeah, so but my five years as the ADON for High Secure, and that’s a long, I’d like to say this, it sounds like I’m bragging but I’ll brag, it’s the longest surviving ADON in, anyway I didn’t survive, I had to get out in the end. And I had poisonous relationships with a NUM, who was the President of the Union, who was a bully, who made life difficult for me, made it more difficult than what it needs to be, even though I was reasonably proud of the clinical care provided by the service, there were a number of things that were, there were some things that were less than desirably about the service and became an impasse where I had to move on, or an opportunity came up for me to do a swap with others, but they’re just doing it now, so I was proud of getting the new, closing John Oxley and getting the new High Secure service open. Just in the context of forensic care in Queensland, back in the old days when I first started nursing, there
used to be a security patients hospital and patients used to be locked in cages, literally cages, and hosed and all those, some of the staff who worked there, said they used to drink out of toilets and saying those characterisations were very unfair and they were very, so you’ve got to be a bit careful about some of the stories you hear, the stories I hear and the staff were saying they’re not bad people, so they said they weren’t very, anyway SBH closed and John Oxley opened. And I remember the Director of John Oxley saying that when John Oxley opened it was like Christmas. It was just so much better. John Oxley is still a pretty horrible place, I was there towards its closure and went from John Oxley to High Secure and I said if John Oxley was like Christmas, High Secure was like going to heaven. I mean it really was that much better. The physical environment.

The male admission ward danger is pretty bleak, but the female admission ward is … I don’t want to minimise the sense of badness of being locked up in hospital and having all the restrictions, I don’t want to minimise that, but in the scheme of things it could be a whole lot worse, it’s pretty good. Anyway that’s another thing I’m proud of. I’m proud of college, High Secure, and my homeless stuff, although…

**Worst things?**

I saw a nurse assault a patient once. The patient had knocked a staff member unconscious first and I stood at the door and I saw this happen, so that’s the worst thing I’ve ever seen happen. I haven’t shared that with anyone else. That is by far the worst thing I’ve seen happen, although the patient himself, I haven’t seen him for a couple of years but he’s a notoriously difficult patient. And the staff member who did it, later on, some years later, I was only a first year RN at the time, so the staff member, he wasn’t a bad bloke, honestly. He was, there were two patients he used to take home to Christmas dinner at his house, and it wasn’t, it was genuine, you know. So, back in those days the brawn mattered more than the brain to a fair degree anyway. So that was the worst thing that I’ve seen happen and I took no responsibility for it, I just sort of shut up. What are the bad things? Bad things… Um, I’ve been, talking about deaths, patients that have died, I’ve known a few patients that died and you can think about things that weren’t done as well as they could have been done that I had some indirect involvement with. Direct and indirect involvement with, patients who had overdosed or suicided.

What are the bad things? I could say about the police, I won’t say a bad thing because I sort of, people, the police get a bad name and they do and I remember I went to a police meeting once back in Victoria and I gave the police a serve because the Victorian police, gave them a good serve actually. The consumers were very impressed when I said to them…

…people, yeah, I said it’s just over the top, anyway I gave them a bit. Sometimes I surprise myself but I mean I’ve worked very closely with the police here in Queensland. I’ve done a lot of crisis work and back in those days there’d only be a few people that had done more work with the police than I had. And I often, I used to say in my lectures, “I’m no friend of the police,” this is my old radical left wing sort of stuff, “no friend of the police, I want to say how good they’ve been.” And how good they usually were. And I mean there’s a few times when there’d be bad attitudes, they say something nasty about, I’ve had a lot of time for the police and actually I used to hate the police, I used to, I had some political difficulties with the police, but one of the (58.42) of my career over a long time has been about the relationship between mental health, we’re social control agents.

I know some people have a problem with it, but we share a similar social control function, to a lesser degree but the police are, and it’s in our mutual interests, it’s in society’s interests that mental health and police work, having said, there’s real structural issues between what the police do and what mental health do, but those things aside, and from a local level and at the clinical interface I’ve put on a, I’ve had a lot to do with making the police work better with mental health so that’s more of at a local level sort of stuff.
On Humour

I can't speak eloquently about the role of humour but it is an important, I've been around long enough to appreciate it and it helps keep you sane and that sort of stuff. Tony Morris QC, Bundaberg Enquiry, I got cross examined by him after this, I told you about the Uni stuff at the Park and there was a nurse who was charged with, he got sacked, a temporary nurse for threatening a patient and swearing at a patient and making jokes and Tony Morris sort of said, “Are you allowed to use humour in your work with patients?” And I said, and he was wearing a pink shirt, and I couldn't help thinking about men who wear pink shirts, it's either a statement that they're gay or it's, it could be anything and I was thinking to myself, I could make a joke about your pink shirt right now, but I don't know how you'd take that. But I didn't say that, I just sort of said, but you've got to be very careful about what’s humorous to us may easily be misinterpreted and you've got to be an pretty experienced player or know the person pretty well, anyway it was the right answer, the correct answer, but I mean, but um, I remember the nurse I worked with at the Valley, on her last day, the good relationship with the police, we regulated her, I went down to the New Farm police station and I didn't know them particularly well, and I sort of said, we want a regulator, so we had the real police there and he said to Irene, “We can do this the easy way or the hard way, but whatever way we're going to do it.” And we did it the hard way, we dragged her off through the waiting room into the police car and that was a, I mean we still talk about it now, but one of the OT's said, there was patients in the waiting room and we had police dragging one of the staff members in a, and so it's a fair, a bit of a, I don't like to say, I don't like her much anyway, but it's still a fair comment, so there is, when it's time to um… I remember that big one about sport and I say, and I think sport, I was never, I've become more sports focussed as a result of my psych nursing and because sport, and I was quite disinterested in sport, I'd played a bit of sport when I was a kid, but took no interest in sport until a few years into my psych nursing because it was a way of relating to people. And there's a mutuality between sport...

And I remember I sat next to Gayle Stuart, Stuart and Sundeen... actually that was an inspiring moment, my career, I was going to the college conference in Launceston and she was a key speaker but I tried to convince her about the importance of sport and she couldn't quite get it. But anyway you've got to try and relate to people.

So what keeps you in mental health?

I get paid every fortnight.

Okay, and that's it?

It's a cerebral job, it makes you think, what keeps me in my health, you know. I don't know. Yeah. I suppose you've heard that I've got Parkinson's Disease so I'm um, winding down a bit and I turned 55 a little while ago and I thought I could have retired and I was going to, I looked at retiring and anyway I'm going to try and keep going for a few more years and most, I wanted to sort of keep, have a live profile but I've still got a fair idea, having been around for a long time, like most of the, I don't want to sound like, but most have a pretty good idea about what to do and how to do it, but I don't need to go, I mean I'm not that pretty, I've learnt a thing or two and I feel like (66.12) this young person who's taking the team here is a bit ambitious. I used to be a bit anti-ambitious, having said that I was always a bit ambitious myself, so it's funny that, and I've learnt over the years that you've got to recognise and encourage ambitious people, you want ambition to be, ambition can be socially useful rather than just personally grandising. So, but encourage and nurture ambition in people. We've been an ambition to do better and have a better service, I've learnt that. How am going with that?
So I still just try to engage with people, although for the couple of years when I had Parkinson's Disease, before I was diagnosed, I've had to withdraw a lot. I was very socially anxious because I was shaking all the time, so I withdrew a lot. Prior to that, I probably had problems before that even. I always like to, the connection with people, even though I'm really an asocial person, but I know how to make the effort and make it work. Involved in P&C's, schizophrenia fellowship and KNH and college and all those sorts of things over the years gives you… Back in the old days people like us would have been Nuns and Brothers and Priests, do you reckon?

I want to go on record, on the tape saying that I hate the Catholic church and most of the things that it stands for, but anyway that's another story.

I rarely wear a tie these days, but someone I work with, Elizabeth Trelong, a psychologist, left today and she's done some of the best work I've seen in the, she's done the, she's had an instrumental role in the Queensland Mental Health and it's progress. And I'm sure other state governments have got similar initiatives in place, and Elizabeth and Kevin, but Elizabeth a lot, Kevin a lot too but Kevin's somebody I don't really talk about, yeah he's brilliant. Anyway Elizabeth is a bit burnt out and she left and I'm sorry that with her, excuse the language, she's fucked up a bit, well she hadn't. She hasn't done anything wrong. She feels fucked up a bit herself, and she's going to work as a clinician in a crisis team, she's only a young person, only 30, but very good and it's sad to see her, but she's saying that she's not going to come back. She's been out, when you see people who are good, who are very good, who go under or fall by the by you sort of, it hasn't happened a lot but you see it over the years. Yeah, but anyway I always, it's a hard job, it's complex. I haven't anything else to say. But anyway I'm proud to be a psych nurse. You say psych nurse in Victoria, don't you?

Even in Queensland, psych nurse, I always say, but anyway.

The Valley Community Psychiatry Service, I changed it to the Valley Community Mental Health Service. I opposed the changes, we're psychiatry not mental health but it's like - I don't care, so I feel strong about, but I like, even though it's not a perfect job and it's got a lot of difficulties and stuff like that, I mean I've liked doing it and I've liked the staff I've worked with, but I've liked the people I've worked with, I've liked the patients. So there have only been a handful of patients I haven't liked that much and even then, I mean, it hasn't been that bad.

Linda Salomons

Current role: Nurse educator, Centre for Mental Health, The Park

On being nominated: [Passion, dedication, commitment]

I am a founding member of the organisation [ACMHN] in the first place, and when the college came in to being, I was the Director of Nursing at Belmont Private Hospital, when we put on our first conference we
became the Congress of Mental Health Nurses. Some people have long memories and remember that, but more recently I suppose in my time in Queensland, if it's somebody who hasn't known me all that time, I've always demonstrated a passion of the college, very argumentative I suppose in a sense I've always got something to say about where I see Mental Health Nursing being. I'm positive about and passionate about getting people to join the college, I'm passionate about trying to get people to come to conferences, and certainly when I came back to Queensland in the year 1998, I was the Director of Nursing of the Mental Health Integrated Service at Gold Coast, and was very encouraging of people joining the college and for the sub-branch with the assistance of others who were keen and interested. We had a number of workshops and seminars and ultimately we convened the 2000 College Conference at the Gold Coast. So, I guess that was quite productive, plus I've always been as a, 'cause I've worked in Education and Management and been a Clinician, I tend to alternate between the three. I've always been very encouraging of people to get into Mental Health Nursing, that there's a specialisation there that is unique, and it's a wonderful area in which to work. I'm supposing that that's the reason; I also teach. Since I left the Gold Coast, I've been working at the Park Centre for Mental Health Learning and I worked very collaboratively with the University of Queensland, Dr Robert King, and again he and I have some very interesting professional, early in the piece, very interesting professional debates about the fact that that was a multi-disciplinary course which I acknowledged there are elements of a multi-disciplinary course that are very valuable I think to Mental Health Nurses, it gives them a much broader perspective about Mental Health, so that we don't get too sort of siloed into thinking that Mental Health Nursing is the only aspect of Mental Health. But he and I worked very collaboratively together and in fact we have at least six of the subjects in the 12 course Masters Program that in fact are Nursing labelled and based, and taught by Nurses, and Robert is very respectful of the fact that Nursing is to be taught by Nurses, Mental Health Nurses, which I respect highly and am comfortable with. And Clinical Practice and Clinical Supervision for Nurses within that program which is quite extensive, is to be run by and co-ordinated by a Nurse who has quite a lot of experience in that area of Nursing. At the moment we're doing very well, it was a Graduate Diploma in Mental Health Nursing; it's now a Masters Degree in Mental Health Nursing. At last, we're starting to get some of the transition candidates who've completed a year of very comprehensive program in Mental Health Nursing, coming into the Masters and articulating with the Masters. I don't really know, I suppose it's because I bleat all about Mental Health Nursing all the time until people get sick of it and they say, “Oh for God’s sake, I'll join,” perhaps it will shut her up, [Laughter] I don't know what it is Brenda, but those are the things I think. I know I've had a consistent passion for it ever since well 1976 really. And I haven't waivered in my passion for it, I never will until the day I die.

**On becoming a Mental Health Nurse**

Well I did Mental Health Nursing after I did my General. Actually, it's quite funny because I did my General training at Charing Cross Hospital in London, which was a fairly small City Hospital, very prestigious City Hospital. I got in there by default, being a working class girl 'cause they only took girls there of substance from families of substance. English Nursing at that time was very snobby and still is to a certain extent. So, I did my General and I, we were farmed out to many places. Because I started my Nursing in 1956, we had a lot of people in open Tuberculosis areas, we had no high technology, and we just nursed people in open wards. And it came to the third year and we could choose a placement, and we didn't have a lot of choice of placement. So I could go to the two choices; I could either go to the Tuberculosis Hospital or I could go to this thing called Psych. Throughout my whole 3 years, there was a niggling thing in my mind about I didn't know how to deal with people's sadness, I didn't know how to deal with people's grief, I didn't know how to deal with people's anger and frustration, I didn't know how to deal their depression, I didn't even recognise in a way, although I knew there was something there. And I thought, there's got to be something we're missing out on being a General Nurse and not having this other nebulous thing which I didn't know what it was. Anyway, I didn't know, I didn't worry too much about it, I didn't know what it was, but I said, "I couldn't bear to go to a Tuberculosis Hospital I'll go to
Making Queensland history

this thing called Psych.” So I put my name down being the only one who wanted to go to this thing called Psych. I thought, “Oh that’s okay,” I’ve always been a bit of an adventurer. Anyway, I kept asking people “What’s Psych?” Well nobody knew what Psych was you see, I thought “Okay” until the day came when I went to St Bernard’s at Southall for my placement, that I suddenly realised my horror, it was a Mental Health place. I went, “Oh my God! What am I doing here?” For 2 weeks, I was terrified, and then the penny dropped. The penny dropped and it said to me, “This is what’s missing in what you’ve been doing. This is going to make you a much better nurse as a result of this.” So I did my 3 months placement, went back, registered, and then went off and did my 18 months Post-General Nursing Psych. I was very fortunate that I didn’t go to an average public kind of Hospital. I went to, in fact, which was a very large private facility, and I always had an enquiring mind, and I have to say, the Tutors that I had really challenged us to think about what Mental Health was. And I look back on those days, and they were very contemporary I think, at that time. I didn’t realise they were contemporary until I started to get more and more experienced. And they challenged us, it wasn’t asking us factual thing, “Well what’s Schizophrenia, what are the criteria for Schizophrenia?” It was more, “What would you do, how would you manage as a nurse this kind of person who came with delusional behaviour or came with hallucinative behaviour, how would you manage” they used the word ‘defuse’ but “How would you manage to deal with somebody who was aggressive?” All of those sorts of things, which really made me, think very hard about how I practice as a nurse. When I came to Australia I went and continued in Mental Health, and then at one stage I stepped out of Mental Health for a period of time, and worked in General Nursing which I enjoyed immensely, I believe I was a much better General Nurse as a result of having done Psych. But I was always drawn back to Mental Health Nursing, so I’d say I probably spent at least 30 years of my 52 years of Nursing in Mental Health Nursing. Wherever I’ve gone or whatever I’ve done, always pivotal in my mind has been that I really am a Mental Health Nurse. But Mental Health Nurses I believe are very flexible, good ones this is of course, but flexible, and can actually turn their hand to doing anything in Nursing. I think they have the capacity to do that and the ability to that ‘cause I think people who are attracted to Mental Health Nursing are different from the average Nurse. And I am very grateful for that, I think that we get an immense amount of creativity in Mental Health Nursing that in many respects we don’t get in General Nursing; so that’s probably how I’ve stayed in Mental Health Nursing. The systems I’ve always found in the Public Health System’s, rather restricting, very concrete in the way that they operate. But, never the less they provide a major service for Mental Health Clientele and it’s one of the reasons why I wanted to teach in Mental Health Nursing because I believe there’s a much more creative way of learning about things. And certainly, when I became Director of Nursing in two places, it was to have some control over the direction of Mental Health Nursing in the place that I worked in.

I always believe that you can bring about some change from the bottom but it’s the top that really has the control over whether or not change occurs. I really had I think a fair influence over people.

In 1986 I moved into, as you know New South Wales, went into the University Sector earlier that most other States. I moved into the University of Western Sydney and worked with Alison Johnston who was a New Zealand Nurse, comprehensive Nurse, but was incredibly pro Mental Health Nurses. she rang, “I want you to come and work for me” “I don’t think so thanks very much, I’m pretty happy where I am” “No, no I want you to come and work for me” “Oh well I’ll think about it” and trotted off to the interview and because at that time I didn’t have a Masters Degree, “Oh we can only offer an Associate Lecturer position.” And I said, “Well thanks very much, but I’m gonna turn you down. For a start, I’ve got much more status outside there and I can earn much more money out there. Why would I come in, the privilege of coming in to the University as an Associate Lecturer.” “Well what do you want?” I said, “Well I want at least a Lecturer’s position thank you very much.” I said, “Look let me put it this way, you need me more that I need you. Do you want a good Mental Health Nurse? I’m a good Mental Health Nurse, you want me, you can give me a Lecturer’s position. Let me know.” Alison just smirked a little and off I went. Anyway, they rang me up and offered me a Lecturer position, so I worked at the University. With my
general colleagues, we had the interesting debates of 20 plus General Nurses who knew nothing about Mental Health Nurses and had a huge stigma about it. And myself originally, until we got some more Mental Health Nurses in and of course argued. We literally were running the course while we were writing the subjects. I insisted that we had two courses within that Undergraduate Program labelled Mental Health Nursing. Much to the chagrin If you like of my general colleagues. But Alison was supportive and we got that. As a result, we got a number of people in those Undergrad courses who in fact, been to Mental Health because they rather liked having that idea. I worked with a woman called Chris Atkinson who was into Developmental Disability, who was also passionate about Developmental Disability. So we had a lot of people who move into Developmental Disability and Mental Health because the population we had in the University of Western Sydney were from Western Sydney and they would come to interview mature aged women, left school at 13 years, got a family, and they were coming to say, “What would youse do id youse were me?” This was the colloquial language and they were the most wonderful students you could possibly have. They had such wonderful life experiences, they were practical, they were down to earth, and they wept most of them, through the first semester because Physics and Chemistry was just baffling to them. So that was the time that they all wanted to leave the course and run back home. “My husband’s let me come to do this course” and I used to say, “No no, you made the choice that you want to come to this course, how important is it to you?” “Well it’s very important to me.” “Okay, so don’t let Physics and Chemistry be the things that stop you doing. Do you want to be a nurse?” “Yes I want to be a nurse” “Okay, well let’s get on with it then.” And they were wonderful. There is one of them here today, Joanne Seymour, and the Chief Mental Health Nurse in New South Wales Government is one of my ex-students who did Mental Health, who rang me up and abused me and said, “It’s all your fault I got into Mental Health Nursing you know.” [Laughter] And it’s wonderful to see how they’ve all blossomed. They decided in the second subject of their Mental Health subject, that they in fact would go into Mental Health Nursing. So I think I’ve had quite an influence upon a lot of people going into Mental Health, and feeling some passion for it rather than not. I’m just appreciative that somebody has nominated me.

On Creativity

Well, I think the important thing about Mental Health Nurses is that they use themselves as a vehicle. In General Nursing it’s pretty structured and pretty concrete in the way things are set out, if you’re doing a wound dressing there’s a certain way that you do it, it’s evidence based, it’s being appropriate. There isn’t the opportunity or the encouragement for General Nurses to recognise any Mental Health problems or to be aware of them and if they are aware of them, they immediately want to shove them off to another Nurse or somebody else that they think is more appropriately qualified to do those sorts of things. I think what we bring to the table really, as Mental Health Nurses is ourselves and the way that we engage with our clients. And because our clients are so very very different, that’s I think where the creativity comes in because what might work with you or me isn’t going to work with somebody else. But in General Nursing, is has to work, the same thing has to work with everybody. And I think that’s where we got the creativity. Now having said that, I think there’s a lot of Mental Health Nurses who don’t tap into that creativity, who are very structured, “Oh well, this is what we do for that, and this is what we do for that, and I’m gonna treat them all the same.” And I think that’s such a loss because I don’t think that you get the enjoyment out of your work and the satisfaction out of your work, if you don’t use your brain to think about how you’ve got to engage and work with this person for their recovery.

Also of course, the other thing is to be an example for yourself. That’s one of the things that doing my Mental Health Post-grad course, really look at the way I operate in the world. And it’s only I suppose the last 20 years that I’ve accepted I am who I am, warts and all, and it’s okay to have warts, and I don’t have to apologise for my warts unless their very bad warts and they need to change. But to have that insight, because I think you also bring that to the table, the insight about your own frailties, your own vulnerabilities. And I believe that clients recognise your genuineness in your interaction with them. I think
what we’ve done in our General Nursing is we’ve had this barrier between that person who’s the patient and this person who’s the nurse.

While I’m a strong believer in boundaries obviously in Mental Health Nursing and not stepping over those boundaries, nevertheless I think that we engage in a meaningful relationship with our clientele, much more so than a General Nurse ever has the opportunity to do. That’s what I find so fascinating and really satisfying about being a Mental Health Nurse, this getting to know somebody and this person getting to know you. Not your intimate details but getting to know you as a person, getting to respect you, getting to trust you, and there’s a mutuality, and I think you can work collectively for the end result; that’s what I mean about creativity in Mental Health Nursing. I try and encourage that in my staff when they work for me and I try to encourage that in my students, to make them think.

**Early impressions**

I really just couldn’t relate to these people who were locked up in a room. And the first experience I had was ‘get over there love, in there, we’ll lock you in, and at 8 o’clock you unlock all the doors and you get them all to go and have, it was then a bath or a wash’ ‘cause it was in the U.K. and as you know showers were terribly thing’o when I trained in the U.K. I can remember sort of fear, absolutely feeling quite fearful opening these doors. People walking down the corridor and me saying, a very feeble voice, and “Come for a wash.” Then totally non engage in listening, me not knowing how to engage with them and most of them went to the bathroom, it was obviously a routine thing for them, and they went off to the bathroom and they did their ablutions and got themselves dressed, except for one particular client who was quite mouthy to me and she said, “I’m not having a bloody wash” and that was it. I said, “Look, you’ve got to have a wash” and she said, “No no no I’m not having a wash” and she jumped up on what was the draining board, it was a big bathroom with a sink and a big draining board, and she jumped up there. And I walked over and I thought, “Hell, what do I do now?” Anyway, I went and knocked on the big glass door and along came the Charge Nurse and she sort of said to me, “What’s your problem!” I said, “That lady won’t come off the draining board” “Ah!” she said, “Come on, I’ll come deal with this. Martha, come on, get down and we’ll go off and have this wash.” And “All right then” and she gets down and washes up. I thought, “What happened there?” I couldn’t work out what happened there, so that puzzled me for ages. Until I realised a little bit later, that in fact it was the relationship that those two had between them that it was a given that she would get off the draining board. She knew this person, she felt comfortable with this person, and off she went. That was a real insight to me. The other thing was when I went then to the next area, I went looking for the Charge Nurse, and I said to somebody, “Can you tell me where the Charge Nurse is?” “Oh well she’s down there, she’s in that line scrubbing the floor” because they were tiles. I saw a long line of people scrubbing the floor, and I said, “Well which one’s the Charge Nurse?” “That one over there.” Okay, so I went up to this woman and I said, “Excuse me are you the Charge Nurse?” “She said to me, “No that’s her” and I thought, “Oh!” She’s in the midst of it all scrubbing the floor with the patients. Not that we do that anymore, but it was this, I’d always been brought up there are real barriers between patients and staff, and to see this woman in the midst of it all, of course it was when smoking was okay, they all had fags hanging out of the mouth, [Laughter] the old bin type place. All fags hanging out the mouth, all scrubbing away, “What do you want Nurse?” “Come about my roster.” “All right, well I’m very busy now; I’ll see ya in a minute.” So those were some of the experiences that I had, and I really don’t know why I had those experiences because at that time, I hadn’t had any formal education in Mental Health about things like relationships and the significance of relationships between client and Nurse. And anything on transference or any of counter transfer or any of these sort of concept about things. So I started to learn. I more or less, I’ve always been very observational, I loved to go to airports early and observe people and speculate, “Now are they going home to their wife or have they got children?” all of this sort of stuff; I am quite fascinated the way people operate. So Mental Health Nursing very much appealed to me, for an observational point of view because we do huge amounts of observational stuff. So once I started to get
some theory, I found that the thing that bored me about General Nursing was, once I knew how to do something I wanted something more. When I came into Mental Health Nursing, constantly I was assailed by the fact that there was so much to learn. The more I learnt, the more I realised there much to learn and I still now, even after all those years, still learn constantly. This is why I love the conferences, to be they’re stimulating, I love to listen to people’s different ideas, I love to argue with people, I love to debate with people, and I can’t do that in a normal environment; and I miss that. I think it’s so healthy for us to have those, be challenging and people to challenge us. My students are highly intelligent most of them, and it’s wonderful to have these highly intelligent people who ponder about things and then come back down the corridor the next day and say, “You know you said Blah blah, well I don’t know that I believe that, and why should I believe that?” and they put forward their premise about what they think it might be or what should they read or what evidence is there, all these sorts of things. I find that wonderful about Mental Health Nursing; you know this constant. And having come to just about nearly every conference, I’ve missed about three in 35, I sit there and I think, “We were talking about this 10 years ago or 20 years ago and we still haven’t resolved it, we still haven’t got there about things,” I find that really fascinating.

**Education and on being prepared for nursing**

I think my training gave me the intellectual information and understanding. I think it took me a number of years, probably, to have the maturity to put many of that stuff into place. I think we have, for me, it’s always been that, like a Bower Bird, I tuck things in the brain and think, “I don’t know about that, I’m not sure about that, I don’t know that that applies to me or to what I do” until suddenly, I’m confronted with a situation where I think, “Aha! That bit just there that I’ve been hanging out not knowing what to do with it, that’s where that comes in.” I certainly think my training prepared me, but I think it took a number of years to really get enmeshed in what I learnt, and I think that happens with many people. I think that we learn lots of things and we don’t really think about them until a situation arises, or an environment appears or something like that, that we can utilise that information. But as I say, I think that I was very lucky in the sense that I went to a Private Hospital to get my training. I don’t know whether I would have survived in the Public System at the time when I went. And I think it was important for me to do my General Nursing first, because I was a bit of a misfit as an adolescent, and I needed the discipline I think, of General Nursing. So I am glad I did that one first, then went and did my Psych where I could do my best thinking I guess. As I’ve got older, I think I think more, and you reflect much more about your practice. I look back on some of my practical and think, “Oh dear! That was a bit of a blinder.” You kind of struggle on through I think, and I’ve always learnt the most from the mistakes in my life, both personal and professional. Some people never acknowledge that of course, but I’ve always acknowledged that, particularly over the latter years, because I do think that we have to reflect. I believe we have to reflect upon why things didn’t work or why things when wrong, what was it, what contributions did we make. I think there’s too many people in our society who blame everybody else for what goes wrong in their lives. But I think you have to take some responsibility; I believe that I have learnt from doing my training, to take responsibility. Even as a child I was brought up by two women, two very strong women because I was evacuated during the Second World War, gosh long time ago even though they keep bringing up the movies. But evacuated to the English Countryside and they were both, you’d probably say very uneducated women, but very educated. I say that because they were people who were very resilient women who were actually Feminists. If you used the word Feminist, they would have scoffed at the word, but very independent women and they taught me at a very early age that if I did something wrong, I had to take responsibility for it. If I did something right, I should take responsibility for it too. That was one of the things that I carried with me when I went and did that training and after that. I’ve always taken responsibility for whatever actions I’ve taken, some of it’s been humiliating responsibility because I’ve done the wrong thing, or I haven’t thought my actions through. I can honestly say it’s always been with a willingness to try and do something, rather than a malevolent or a vicious approach to life. I’m fairly simple really in many respects and the fact that I believe in integrity,
I believe in honesty and sometimes I’ve been probably too honest with some people when I could have been a little bit more gentle; which I’ve learnt over the years. I’ve also learnt to temper my views on things and I think all of those came A: from my childhood and B: from me going off and doing Psych training because constantly we were challenged in that course to think about what decisions we made and on what did we base it. Did we base it on biases, did we base it on the fact that it’s always the way it’s been done, as opposed to thinking about should it be done that way, is there a different way of doing it. And that comes back to that whole creativity thing that I was talking about before. That’s what I think anyway. I think it was good training, at that time.

When I went back to live with my mother, I was 12 and a half, and my mother thought I was completely off the planet, and she really didn’t know what to do with me, so she was very grateful when I went nursing at 17 and a half. I think, when I look back on my mother, I realised that my mother was chronically depressed, and I didn’t realise that when I was young, I didn’t realise that when I was a young adult. But as I became more experienced and more knowledge about things like depression, it was interesting to hear girls talk about depression this morning. I see it as the most insidious of all of the mental illnesses, because something that most people don’t pick up in somebody else. They see a distancing but they don’t know that it’s a depression that occurs in people, I didn’t recognise it in my mother until many years later. I don’t think my mother cared at that time one way or another, and I don’t mean that in the callous way. I don’t think she was callous in any way, I think that she was just so pre-occupied with the unhappiness in her life that it didn’t really matter to her one way or the other. Most of my General Nursing colleagues thought I was round the twist, but that’s never bothered me. I’ve always been a bit Thoreau who always says that follow your distant drummer you don’t have to go down the same path everybody else goes down, and I’ve never been good at going down the same path as other people. A lot of people have told me that’s partly my problem, but I don’t see it as a problem because I’ve had a very interesting life professionally as a result of being different and wanting to do different things and having a go at things. It’s never really affected me Brenda, to get back to the question, you asked me which is, “Oh well, you’re nuts if you go and do that sort of thing and what’s that about anyway?” “Well I don’t know, that’s why I’m going to find out” I had people even when I went to the University of Western Sydney who said, “Why on earth wouldn’t you go to a real University in Sydney?” And I said, “But I am going to a real University in Sydney.” “But out West? Why wouldn’t you want to go to one of the prestigious ones?” “I consider this perfectly prestigious for me. There’s a real challenge out here.” And the multicultural students that we had were just brilliant; all age groups, a lot of mature age students as I said. It was a wonderful experience for 10 years at the University, I really look back on that with great fondness, great fondness because it was really challenging. While I was at the University, one of the first Grad Dip’s in the country, I won’t say it was the first but certainly one of the first Grad Dip’s in Mental Health Medicine and feel very proud of having done that, it was just for me a real joy to have done that. Because I think I’m reasonably creative, at that time I did something that most people, it didn’t have Consumers. I know I can touch a cord in you because one of the things I’ve always recognised about you is your having Consumer involvement in things, and I’ve always attempted to have Consumer involvement in things when it wasn’t socially acceptable at all; still isn’t in many places. I am insistent on having a Consumer on the committee while I was writing that program and also Clinicians from the clinical areas. I had great difficulties with my General colleagues who said, “Well what would the Clinicians know, and why on earth would you want a Consumer on it?”

This would be about late 80’s early 90’s and I insisted. Those people were extremely valuable on that course, in the writing of it because whatever I wrote, I wrote it in the academic way, and gave to them after they’ve given my information about what they thought should be in a particular course or subject I should say, and then I would give it back to them in draft and say, “Okay, have a look at this and vet it.” I’d give it to the Consumer, “You vet it.” Even my colleagues, my Mental Health Nurses were very uncomfortable with the Consumer being on the committee and being vocal, and they’d sort of look at me as if to say, “Well shut her up! What would she know?” There’s still a lot there like that still. We’ve got
Consumer Reps at the Park for example and at Ipswich, they had a terrible time with the staff, not the clients, a terrible time with the staff and I never cease to amaze about that, and spent a lot of work trying to convince people that who are our clientele? Why are we here? Why are we being paid this salary? What are we doing if we’re not doing it for the Consumers? Those are the sorts of things that I really found very interesting and very satisfying to do that. And once that course started, of course, it made sense that the Clinicians who were on that thing, they owned it, and they went back to their workplaces and people were saying, “Oh I’m thinking I might do a course, what’s that course like?” “Oh well I was on that committee, it’s a good course.” And that’s where we got the people from; it was from the Clinical inquest and got them through, as well as some of those Undergrad students who decided that they wanted to go into Mental Health. Plus I used to take the students out in first year to the Mental Health areas, and probably you might want to obliterate this bit that I’m gonna tell you next. I can remember going to Parramatta Psych Centre and I’d been working there on a casual basis before I went to the University. And I went up to the acting Nursing Director and I said to her,” I want to bring out the students to the Psycho-geriatric area because at the moment, we’re teaching them about communications, relationships, engaging with people, respecting people and so on and so forth, this is where they’re at and I want them to be able to endeavour to do that. I also want them to have some feeling for towards people A: who have a mental illness and B: who are ageing because both of those hold huge stigma.” And she said to me, “Well fuck me, you can’t fucking well bring them out here, it’s a shit of a ward.” So I just said to her, “Well you best clean it up because we’re coming in 3 weeks time.” And she did. The students absolutely loved it; they got such a lot from it. The thing about some of the nurses that were looking after those clients was that they weren’t terribly interested in working in that area and it was the area that if they caused any havoc and mayhem or were not up to scratch in the facility, they are immediately sent to the Psycho-geriatric area as a punitive exercise. So their interest and their heart wasn’t in it. And so when these students came bounding in, after a couple of weeks of settling down, and started to take the clients out, help them wash their hair, put the lippy on, take them out for walks, go out to the movies with them and all this sort of stuff, they were just sort of “Oh my god.” And the students just loved it and I think that probably is where they got their first taste about Mental Health because they’d say to me, “But what do I say?” “What would you say to anybody? What would you say if you met me in the street and I’m a complete stranger and I’m standing in front of you?” “I’d probably say hello, how are you” “Yes, keep going.” And then they start to communicate really well with them, even though many of them had an impending sort of dementia, nevertheless they managed to get themselves communicating with them in some way; that was wonderful to see. So I think those are the sorts of things that keep me plugging along and I’m thinking of retiring at the end of next year but my heart not quite in it yet. [Laughter] I keep putting it off because I enjoy what I do. I think while you enjoy what you do, because I have a fair amount of insight about myself, I think I will know when I no longer want to do it, and I want to do something else. I have got some plans of things that I would like to do, and I probably will work part-time because I think in Mental Health we need good Clinicians and I consider myself to be a good Clinician, and I keep myself up-to-date with clinical practice and Clinicians because I think that’s, what that gives me is a perspective on what real life’s about. I talk to students about what real life is like when you work as a Mental Health Nurse. There’s nothing glamorous about being a Mental Health Nurse. Its hard work, it’s exhausting work, and that we have to look after our own Mental Health as a result of being a Mental Health Nurse because we do give so much of ourselves into it. I think that gives me more credibility and respect from my students because they believe that I really like my job. I think there’s this, no disrespect to you as an academic Brenda, but I think there is this gap between those that work in academia and those that work in clinical practice. My belief is that there has to be a melding together more, don’t ask me how but I certainly think that needs to happen. I used to spend at least one to two days a month out in the clinical area when I was in the University, even if it was just as a presence in the clinical area, even if I wasn’t doing anything specifically with clientele. If they were busy I’d help out and so on, and that really gave them a link with the University because they did think about education, they’d come up and chat to me over their morning tea, “Well what exactly do you do at the University? What do Mental Health people who are going to University, what do they do? What’s the

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program about? How do I get into it? Would they take me?” That sort of thing. There’s a real low self-esteem with many Mental Health Nurses and they see a University as being up there, and, “I’ll never be able to get there” and it makes a huge difference. I go out to the acute area once a week in my current job, I have to integrate Mental Health at Ipswich, and I’m on good terms with those Clinicians there, and they’ll start to get into the bullshit, “Oh no you can’t do this that and the other” and I’ll say, “And what textbook does that say that in?” and they go, “Oh well, um, I haven’t read a textbook for years and years.” And I will say, “I’ve read most of them, because I’m interested in looking at them, I’ve never seen that written, so where did you get that from?” “Oh well, so and so told me.” “So did you challenge them about whether that’s right or wrong? Have you checked out whether it works or not?” “Well no, I’ve just automatically taken it on board.” “Well maybe you need to think it then.” Also, I look after the students ‘cause the students get a bit of a hard time too. They’re not good at nurturing students and teaching them, and that’s one of the thing we also need from the clinical area, even though it’s tough, “Oh but I haven’t got time to sit down and teach them something.” I said, “The way you teach then is the way that you do. It’s the role modelling that you do with the clients that is teaching them much more that you sitting and telling them about schizophrenia. They can read about schizophrenia, it’s what you do and how you interact with that person that you’re teaching them.” “Oh, oh alright then, so you mean they can just tag along with me?” “Yeah, tag along. If you’re busy, nobody’s expecting you to bust your fufu valve. Let them tag along with you, let them watch what you’re doing, get them involved in doing something if they watch you do five assessments, let them have a go at doing one while you supervise.” It’s a question of you viewing it in a different way, doesn’t mean to say you’ve got to give them a lecture every half hour on something, and they get it. Is that enough?

**Career highlights?**

I think probably being the founding member of the College of Mental Health Nurses, for me, was one of the real highlights of my career. The fact that when I was Director of Nursing at Belmont Hospital, every Registered Nurse in Belmont Hospital joined the college; congress as it was then. We’d met for a couple of years before, certainly, I wasn’t one of the people who’d met in 1974 who’d already started this movement. I came on board around 1976 – 1977 and we had that conference that first conference in 1978 in Broadbeach, which they’ve pulled down of course, the old Broadbeach which was a great place. That first conference was a real highlight, wonderful memories of that conference. And Belmont were the fundraisers for that conference to get off the ground because we had nothing at all. I ended up being number 16, still am number 16, and Meryl beat me. We gave number 1 to a guy who was actually doing a Mental Health Program at that time; he’s still I think, floating around New South Wales in Mental Health. The other 14, there is a few of them floating around, not necessarily in Mental Health, I don’t know even whether they’ve continued their membership or not, but that was probably one of the major highlights. That was a successful conference as we became a congress and we formed our committee where we had a person from each State, and then we proceeded to fight. I think back on some of the guys who came from Victoria, for example, who were absolutely adamant about “Gotta be called Psych Nursing.” I had this view that we should call ourselves Mental Health Nurses, that it was a much broader term and the fight was on. It got very personal at times too. Remember John Arntz, he’s died hasn’t he?

I thought he had. But they were heady times. We had lots of fun, we funded ourselves for many years, and we, like any fledgling organisation there was this real buzz of excitement I think, about the fact, “Oh wow! We’ve got this national organisation of Mental Health Nursing and that is a real coup.” I’ve always felt that way, and I think the other thing is being a convenor for two conventions, for two conferences. One in 88 which was the one we did in Manly in Sydney that was fantastic. Great bunch of people who worked with me, I could never have done it without them, and it was the Bedland Bicentennial Beyond we called it, and of course it was Bicentennial year. We had a dinner dance and we suggested that people got dressed up in Colonial type gear; I never thought that they would but I tell you what, they did, and it was just a fabulous conference. Also, I convened the 2000 down at the Gold Coast,
which was a fun conference. My belief is, as well as serious academic work and people’s papers and everything else, people need to have fun. People still talk about that Gold Coast one, about all the fun and I met some people the other day, “Theme parks, Oh God! Such a good time!” It was awesome but it was so worrying because we kept praying it wasn’t gonna rain because SeaWorld would have been a disaster. The band we’d booked cancelled at the very last minute sort of thing two days before and I thought, “Oh my God!” Anyway, the next band that we got were just fantastic. I’ll never forget Barbara Hayes and Holly Skodol Wilson getting up there and shimmying around and dancing. They’re memorable things and Kevin Fjeldsoe, on the rides, the water ride going up and down like a kid. I just think that those were the things because the warmth and the commitment of the people that I worked with who are Mental Health Nurses, who in their own time, and we worked our bloody bums off for years, to get the conventions going, to me made it all worthwhile Brenda. The Collegiality was wonderful, and we had such fun doing it as well; up at the Manly blowing up bloody balloons ‘til we thought our lungs would burst. Those are some of the highlights. Plus I think that we have just some really wonderful people in the college who’ve done some absolutely marvellous things. Things that I couldn’t have done and I don’t say that in my own disparaging way about myself, things like getting the credentialing up and running, really having a focus on the professionalization of Mental Health Nursing which is extremely dear to my heart. And it’s with great pride that I go out and give out the standards brochures and I give out the application forms to my students and I talk about the organisation and I’m assisting people doing the credentialing at this present time. Talking to them about the significance of becoming credentialed and how important that is, the professional thing about doing that. Those are some of the highlights that I’ve got, and many others, but those are certainly some of the highlights.

On humour

I suppose coming from an English background, I have a Monty Python type humour anyway. I use humour a lot in my practice, I always try to be relevant with my humour, but I think humour is A: extremely important for the Clinician because there are ways that we when we’ve had a terrible day, or a crisis or something in the practice that we’re doing, if we make fun in some way and not in a derogatory way about the client, but fun in some way and find part of it sort of amusing and make jokes about it. I think Police do the same, I think many Nurses in ICU do the same, it’s a way of ventilating I think and feeling better about things. Certainly, with clients, I’ve used humour, you can’t use humour with every client, and there is a time when you can use humour. I think of one particular example, I tell the students and that’s when I was at PA and a particular client came in, it was incredibly belligerent and drug-induced psychotic condition and brought in by three Police and two Security Guards. I was next, I was working as a level one, and this is not that many years ago, what 11 years ago, and I can remember I was the Nurse next to admit this patient. So I walked out and I said, “Good morning” and he said, “You!" he said, he looked me up and down, “You F’n C! I wouldn’t FC you if you were the last FC on God’s Earth!” And the Cops were [sucking air through teeth] highly indignant, the Security Guards knew me well and quite respected me, and I’m “That’s not what we’re really here to talk about you know. We’ve got three options; how about, which one would you like?” So he opted for the first one which was to have a cup of coffee and a fag and cool down, had a bit of oral medication. So that was fine. Anyway, I didn’t want to put him into the security room, I didn’t see any reason to put him in the seclusion room, I think this does have an impact upon people’s relationships with the staff because it is seen by the patient as punitive. Not that I don’t believe there are times when you don’t need to use seclusion, I think there are times that you do. So anyway, I took him out, “I got no cigarettes” “Look, as a non-smoker I carry cigarettes always because I know there are people like you who need a cigarette.” “Oh alright then.” So he went out to the veranda, had about five fags, two cups of coffee, bit of oral medication, by the time the rest of the day came he’d settled a lot. So the next morning, I’m in the pill room putting medications out for my clients all ready to go out, and the next minute this guy appears at the stable door. “Sister” I said, “Call me Linda” “I think I was very rude to you yesterday” I said “Yes you were a bit” and he said “Well I’ve just come to apologise” “Look I accept your apology. It takes a big man to make an apology. I
accept your apology” I had also said to him on that day, the day before when he gave me this mouthful, I said, “Actually I feel the same way about you but that’s okay” just a throwaway line there. And so anyway, he looked at me, and I said, when I was at the pill things, “But I still feel the same way about you.” I smiled, well he burst out laughing and he thought it was very funny it was funny. It was just one of those little vignettes you have with people where he went away giggling away, quite normally giggling, seeing the funny side of what he had said, even though he’d apologised for being rude about it, but seeing the funny side and seeing I’d taken the funny side. Now our relationship was excellent because I could go up to that guy and say, “Okay, what’s happening, you seem to be arcing up a bit?” so what’s happening and he’d sit down and talk with me and he’d share what was happening in his life. I said, “Well okay, what do you want to do, do you want to take some medication, do you want to go and sit in your room and have quiet time, what do you want to do?” Whereas with other nurses he didn’t have that rapport. So I think humour, as long as it’s appropriate, can be very helpful and very useful and it shows clients a side of you that shows you’re human. And I have humour with the students. I remember saying to a bunch of first year students, many young students in the class, and I said, “I do my best thinking in the shower” and one of the male students, young guy about 18, sort of said to me, “Oh I wish I’d been there with you.” Well everybody roared laughing and he went red in the face as you well imagine, and I just looked at him and said, “Look if I’d known you were interested in being there I would have given you a personal invitation.” [Laughter] We both burst out laughing and he felt much better. I just think humour keeps you going. I think that one of the things is that laughter is one of the best things for relief of stress I think. I laugh at the most ridiculous things and keeps me sane I think. Makes me realise I’m just a human being and I’m nobody special, although some people think I am, and that’s lovely ‘cause we all need people like that in our lives, but nevertheless, I do think not taking yourself too seriously. I always remember somebody saying to me once; don’t become a legend in your own mind. You’re meant to be a legend in other people’s minds. I’ve used that many times, if I’ve seen students or RM’s getting uppity, I just say, “Hey, don’t become a legend in your own mind.” You want respect, you want people to revere you or whatever, let them do that, demonstrate something special that they will want to revere. I think humour’s great, I really do.

On the worst times?

I’ve seen some brutality, I’ve seen some very poor management, non-creative management which restricts people from doing good work, which drives people from Mental Health Nursing who would be good Clinicians and who are good Clinicians. A number of my colleagues who went to the University said that the reason they went was they could not stand the restrictions and the concreteness of working in the Public Health System. It wasn’t the clients, it wasn’t the policies and structures, it was the senior personnel who were the people who were the problems, who caused the problems. These were thinking people, not people who just wanted to be rabid people who just hate the management. I always tell the joke of the Irishman who went to America. He was in government and they said, the republican, he’s run again, so the other men said, “well I’ll show you fellas the democrats then are you, I’m against them too, I against ‘em all.” And we do have people who are against everything, it wouldn’t matter what you put forward, they’d be against it. They’re not the people who usually leave, they stay against it all the time, they’re the saboteurs, they’re the people who are resistive to change, and the good people that you really want to keep who are the thinkers, the liberal minded people. Other good practitioners become so bound down by the punitiveness of some people who cannot differentiate between those who are good and should be encouraged to remain good, and those who need to be pulled into line by some form of performance management. There seems to be a sort of philosophy which is “Oh well if one person steps out of line they all will so get those rules in fast to make sure none of them do it; this kind of behaviour. It doesn’t work, and you lose good people to Mental Health Nursing, we can’t afford to do that, we haven’t got enough good people as it is. We’ve got a lot of people who are burnt out, who are sad, who are stuck, they’re not bad people Brenda but they’re just people who contribute anything other than coming in to work on time and going home on time. Don’t take their sick days because while they don’t do too
much when they’re at work anyway. They’re the people who still, when it’s evening and are on the PM shift, ’cause they much prefer the PM shift because there’s no management sort of observing them, who watch their own television programs even though it’s the clients television. “Oh I never watch that mate, this is what I wanna watch,” and who are not supportive of the clients and anything to do with say the recovery process or anything like that. They still remain stuck in what they believe is that once you’re mad you’re mad, you never recover, and you’ve got to have me to make sure that you toe the line and take your pills. I liked that bit about compliance this morning, and I’ve always believed that, and it’s great to hear somebody else influential say that sort of thing because if people don’t take their medication, what have we not done with that client to convince them that that’s for their benefit? It’s the same with GP’s, take these antibiotics there’s five days, make sure you take them. If you don’t work hard and say why people should be taking their medication, then people once they feel better, they’re not gonna take it and we know that. To sit and make them, “Well you’ll have an injection if you don’t take your oral medication” is not the answer.

**What is it that keeps you in Mental Health Nursing?**

I think seeing the wonderful changes that are occurring in Mental Health and the real need for people who are interested in Mental Health Nursing to stay. I also have a belief as I’ve got older, I’ve always actually been quite sensitive to ageing in a sense that I’ve always been very respectful of people who age. Again, that’s a part of what I was bought up to believe that ageing people, like many cultures, they have wisdom; they have a maturity that should be respected, all of those sorts of things. It’s never been difficult for me to I suppose, accept that ageing situation. I have to look in the mirror every now and again saying, “Well you really are getting old.” But I don’t feel old here (points to head). I think the thing that keeps me is I love what I do, I have wonderful relationships with most of the people that I have interactions with, I have students who say to me, I’ve even got transition students who are saying to me now, “Well you are gonna be there aren’t you when I come and do my Masters?” “You’re not leaving are you?” And I say, “Well I’ve got to leave sometime, they can’t carry me out of here when I’m 100 years, I have got a life outside of here.” “Yeah, you can have your life outside, but you will be here won’t you?” I suppose I feel valued by many people, not all by any means, and I think we all need to be valued; we all need to feel like we’re making a contribution to something. I suppose the passion’s burning brightly, it’s only when I feel that if I don’t leave and get in the car while I can still drive and see [Laughter] I’ll never get round Australia.

When I get frustrated I think, “Oh I’m outta here, I’m just gonna work for an Agency and I’m just gonna go to work, do my shift, go home and do my own thing.” That’s not enough for me. While I know that I would be doing the right thing by the clients that I would be looking after, it’s not that. I suppose I want to have some impact on good Mental Health Nursing practice and while I still think I’ve got it, I’ll give it. When the day turns up that I can’t remember what I was talking about, or the room number [Laughter] and my students sort of say to me, “Oh I can’t remember that Linda” it’s such a relief when they do that.

The other thing is that I think I am a good role model for an ageing woman. I think our society has a poor image of ageing people, and I think we need role models in Nursing and everywhere else because the stigma of ageing is very high in Nursing, in fact the community are more accepting of ageing than I think Nurses are. Nurses are really quite stigmatised towards bias towards ageing people. This old adage of when you hit 60 years your brain dies and you really should be sitting in your armchair and watching Neighbours at 5 o’clock or whenever it’s on, or you should be watching Days of Our Lives. Those days are gone. There are a percentage of people who still believe that at 60 years, I know people who at 55 years are old way beyond their years in their head. I just want to grow old disgracefully not gracefully, forget the bloody gracefully bit; I’ve never been graceful in my life.
I just want to contribute for as long as I can because I love doing it, not because I’m a martyr; I love doing it. When I don’t love doing it is when I will phase myself out. I don’t have the belief that the place can’t survive without me or that Mental Health Nursing can’t survive without me, God no. There’s many, many good people coming in to Mental Health Nursing and many good people in Mental Health Nursing. I am quite convinced that Mental Health Nursing will thrive and survive and do very, very well. So it’s not that, I’m not a martyr where I feel I just can’t go because I’m that’s not true at all. There are many clever people in that Mental Health nursing which, something I haven’t found in General nursing too. There’s not the intellectual or ability they’ve got with some of the people in the college. You know Tanya don’t you, I mean, Tania Yegdich’s brain is beautiful. She was a student of mine at Wolston Park in the early years for a brief period of time when I taught there, and I said, and we always laughed, and I said, “Look, when I realised how intelligent you were Tanya, I backed off quickly because you were far too intelligent for me to engage with.” And she laughed and laughed. But she’s the brightest thing on the planet, but do you know there are people who tried to stifle that. Not only is she bright but she’s eccentric and one of the things about being a Mental Health Nurse is I think that we tolerate eccentricity much more that other people do; and so we should. If we can’t tolerate it in our colleagues, how can we tolerate it in our clients, is the way I view it. Her eccentricity is not tolerated by some in Mental Health Nursing, at more senior level, nor is her intellectual ability and of course people just don’t realise that if you’re going to have an argument or a debate with somebody who’s highly intelligent, you better know what you’re gonna debate about and you’d better do your homework. I have great regard for Tanya, and there’s a huge vulnerability about Tanya that I recognise, lot of people don’t recognise about her. So I am probably one of her best supports when she really gets quite stressed about things, she rushes to me and I say, “Sit down sister, I’ll even come out while you have one of your rotten fags” and we go out and she tells me what’s happening and seeks my advice often.

We need people like that, that transition program is a superb program, my only criticism of it would be, there’s too much of it really. But at the same time, it’s a fantastic program. It’s well written, it’s very medical model and she and I debate that regularly because her partner, Denny Cowell, was very much the medical model, psychoanalytical type thinking and Tanya’s very much the psychoanalytical thinking as well. Nevertheless it’s a good program, it’s a good grounding I believe for people to come into Mental Health Nursing.

I’m not paranoid by nature really, but my paranoia is that the Federal Government is much more interested in having a Mental Health Worker than at it is in having Mental Health Nurses. We’re too difficult, we’re too expensive, and we’re exerting ourselves at last and starting to be players in the big game. I think that’s one of the things we’ve been lacking I think in Nursing. And we don’t always play ladies which is what the General Nurses do; they are very nice and lovely and never rock the boat.

I used to love, what we used to call in New South Wales, the New South Wales Mafia in Nursing, and that was Judith Cornell and Judith Meppem and Judith Picone. One of them was in the Union, one of them was the Head or Director of the New South Wales Nursing college and Judith Meppem was the Executive Director of Nursing of Westmead Hospital and I tell you what, the New South Wales Government didn’t make any decisions about nursing unless those women knew what it was all about. The other one was Pat Staunton in the Union. They were such a powerful group for Nurses and they would be in there and I really admired those women, they knew their stuff and they got stuck into it. I think that had a huge affect on what was happening in Nursing in New South Wales. We need strong women as well as strong men. We’ve tendered in the college to have mostly men as representatives and I think we need to, as a bit of a Feminist...

I was [president of the college from] 1986 – 88. In fact I had some input into the Royal College of Nursing and things like that on behalf of the college. Yeah we need a woman at the helm as well. No disrespect to the guys who’ve done the job, there’s only one I had little time for, that was (1.14.35) he
was there, he wasn’t there for the college, and he in fact did a great deal of discredit to the college with his pompous attitude, but otherwise, most of the guys have been fairly good I think [it is] time for a woman. Most of our membership are women; it’s just time to have a woman because women need women role models. And men need to see the women can lead; that’s the other thing. I think that’s really important, particularly in Mental Health Nursing we need good female role models Brenda. Good to see a number of female Professors strutting their stuff, I think it’s great, doing their thing I think it’s great.

I’m honoured that somebody decided that I was worthy of this so I am very appreciative and thank you for your time.

Kim Usher
Current role: Professor of Nursing, James Cook University, Cairns

**On being nominated:** [Practice pioneer, passion, dedication and commitment]
This is something I pondered myself after you invited me to be part of this project and I thought, well, I’m not quite sure why or who, but I was happy to be nominated of course. But thinking through it, I think there’s probably three things.

One is that when I came to Queensland, I felt being up here in the north that there was lack of any opportunity for professional development for mental health nurses, and what I saw when I went to clinical areas was that, that was a real need. So as a result of that I worked with the college to try and establish, and we did eventually establish, a sub branch in north Queensland which has now gone on be become quite successful. When I first started with that group, my aim was that we would get it established and running, and I sort of recognised that it would probably be academics who would do that to begin with and of course the only ... I think there were three of us who were members at the time from Brisbane north and they were three academics. So I saw that that would be the way to establish it, but my goal was to have it taken over eventually by clinicians. And it took some years, about five I think, that we ran that group before we got into the sub branch status and eventually a significant number of clinicians as members who then went on to take on the roles of the executive for the sub branch. But I continued for some time to have I guess a leading role in that group.

So that was the first thing and the second thing would be I believe probably my championing of mental health content in nursing in our JCU program and trying to establish that and set it up so that it would continue to be recognised as an important part of an under graduate program in the north.

And as well as that I guess it was the education for under graduates but also continuing to research in the area of mental health nursing.

**On Background**
Before this I was at Newcastle University. I began in the 70s, I think it was '73, yes, and I did psychiatric nursing to begin with and ... because a lot of people thought we weren’t real nurses in those days and we’re left with a bit of stigma. But it was very important to me. I did a high school certificate and I actually had a scholarship to go to university which I turned down to go and do psychiatric nursing, much to the dismay of my parents. But I found I went there and my parents thought I was going to do it for a school holiday job at the end of Year 12 but I started with a group of us but they all left and I remained because I enjoyed what I was doing, so I stayed. And I did well; when I finished my nursing course, I topped the state in my exams and things like that, so I’ve had some good achievements.

But then I wanted to teach as well and to start with they gave me some opportunity to teach in the training school but I knew that we needed to do other qualifications. So in those days it was you did diploma of nursing education or associate diplomas through somewhere. And I chose to do it through the Armidale CAE it was in those days and I’m not sorry I did; I thought it was great, I enjoyed it, it was a good opportunity. But when I went back to the hospital, I did it part-time obviously while I was still working at the hospital, but I knew that to be really I guess respected in those days as a nurse, you needed to do general. Now, we’d actually undertaken three months of general as part of our training so I knew a bit about what it would be like, but then I went to the Mater-Misrecordiae [in Newcastle] on a scholarship and they offered scholarships in those days, so many a year, for people to do general nursing, so you went and did general nursing for the two year shortened course on full pay that you were at that level, which was significantly higher than the pay I would have been on if I was paid by the Mater.

So I continued to receive my full pay and did that course, and I must say it was interesting, but there were some dreadful aspects of that time that I was there and, in particular, it was the way we were treated because we were psychiatric nurses. And the three of us who went, in the end I was the only one to finish because the two male nurses who went from a different hospital to me, but they just found that they were given ... that they suffered so much harassment that in the end they left; it wasn’t worthwhile, but I continued. But in particular some of the things that were done to me were one day I was called up before the charge nurse of theatre, I was in theatre at the time and I found that area particularly difficult and to this day I have this sort of funny feeling about theatre nurses whenever they speak about it.

But she called me in one day and really gave me a verbal dressing down because she said that she thought I thought I was too good for my shoes or something, that I thought I was better than everyone else, which I couldn’t understand why she said that because I always did whatever I was asked and tried to not get myself into any trouble and just do what needed doing. But in the end what it came to was she said ... she asked me about the fact that she’d been told that I had a psych registration and I said that I did and she said that I had the associate diploma in nursing education and that’s obviously what it was that was really annoying her and she said she thought I was a liar, in fact I didn’t have that qualification, because she had it on good authority that only “real nurses” could be entered into that course, that would be accepted for that program of study. So I said to her, “Look, I don’t have anything to prove and I don’t need to argue with you about this and I don’t wish to enter into any dispute.” So I said, “If you wish to see copies of my qualifications you should talk to the director of nursing.” So that’s just an example. That was probably the worst, was working there.

In fact, in the surgical ward I worked in to begin with, the charge nurse there was the opposite. In fact, she decided that because I was only going to do a two year program that I should learn and do so much more than anybody else in the short time I was there. So she actually pushed me at times beyond what I thought was my limit because there were days when she actually, on afternoon shift, would make me run the ward, as what was equivalent of a second year general nurse, and she’d make me run the ward because she decided in such a short time I needed to excel at everything. So she pushed and pushed til
... she kept pushing me really so that was good but in other areas it was a bit like the OR. So I did that and then I went back to working in psych and then we had...

In Newcastle area we had a regional school of nursing, we moved to a regional school of nursing. I don’t know that that happened anywhere else but we... all of the schools, all of the education schools from across the region sent their students to the TAFE which became the regional school of nursing for all of our theoretical content and then we went back to our respective hospitals then for our clinical teaching which was added on before we went back to the ward. So there was sort of three phases: education, the clinical teaching and then you work on the ward. So that was implemented whilst I was at... doing general so it was good that at least I had that support in the block time that... for theory that I was at the TAFE, at the regional school. So then when I finished my general, I actually taught at the TAFE for a while; taught in both the psychiatric and the general nursing course and then went to... I had some time off after that because I had a serious car accident so I didn’t work for a couple of years, and then I went to the CAE and started... after I recovered from the accident I started work at the CAE in...

On being a patient

I’ve had times since then where I’ve had that experience, particularly when I had the cardiac events that I’ve had, and they’ve been quite significant I think and had a significant impact on me. But no, not so much then; I mean I had... it was quite a serious car accident and I had back and neck injuries and facial injury, head injury; I had a head injury that sort of put me out of things for a while, so. But then I went back to... but other than that it was quite really uneventful and I was well looked after; I was taken to the Mater Hospital, so as you would expect, I got the best of treatment and looked after well. But it put me out of the work scene for a few years before I could return.

...I went to the CAE is what they used to call the tutor level at the CAE. So I started there and of course then it became the university. So yes, that’s when I started back; that was in ’88 I think. Yes, about ’88.

So then in ’93 you moved up to Queensland, north Queensland...what were some of the things that you had to do to kind of get people active in the college?

There was basically myself and Fran Gallagher and Barbara Hayes were the three people... I talked to Barbara, she was the head of the school, and she said, “Go ahead if you can get people to come along, that’s a great thing.” So then we joined up Bob Munroe so then we had the three of us and we sort of started... thought we’ll have to try and work out something so we held a meeting and I think it was the four of us then who went, and from there we thought well what can we do, how can we strategise and so we had a few I think it was honour students and one or two of those were interested so we joined them up as like associate members of whatever it was, student members, and then we put some plans into place. So what we started doing to get people to come, we realised that we had to fulfil a need so we started doing education sessions and tagging a meeting onto that. So we would get people in by offering an education session and that was our main way of starting off up here. And then we would do that and then about once every two or three months, we would find a facility and put on a sort of bigger session of some sort of education thing and have three or four or five speakers. We would get people to give a gold coin donation at the door and we would have some drinks and nibbles and things and then we’d run a raffle. Now, interestingly in those days, the ones of us who were the members, we paid for the drinks and nibbles, we paid for the raffle and then we bought the tickets and so forth ourselves which was quite interesting, but anyway, to try and get some money together for the group. And then I... and we also... so then we set ourselves up and kept applying to become a branch and keeping minutes and notes and doing all the right things that you would do and have a treasurer and have an executive and meetings. And eventually we just canvassed people, we just went around talking to people, put out promotion material for the college and started trying to get people to come to conferences. And
basically when we started that up here, no-one had heard about it, it was like just unchartered territory that we went into. And we even used to go about once every two months or three months, drive out to Charters Towers to the hospital out there and run a Saturday afternoon session; talk about dedication. We’d run a Saturday afternoon session and that group out there have nothing and now they’ve got a lot more than they had, but in those days like they rarely ever saw anybody, so going in to offer something like that was amazing. And in fact, the nurses from the general hospital would come over even to hear about things that were to do with mental health nursing. But they would come because it was some sort of education offered in their town for free.

So we did that as well and we carried that on for some years, so then we got quite a few members from out there, people started to join because they saw the benefits of it, yes, and then we just kept going and kept going until eventually we ended up I think with ... well I mean I’m not sure exactly now how many there are but there was like over 40 people that we had as a sort of active group up here and it was quite successful and the college gave us some money and we already had money, but they’ve become quite entrepreneurial, this group up here now, to the fact that they had a lot of money which I think has been taken away from them now, but anyway. And then they started running the tropical symposium like replacing what we used to do as an educational focus I guess with the conferences they’ve been having.

**What were some of the education topics that you chose that seemed to resonate and people would come to?**

Well, look, they were across the board: some of them were to do with research and others were to do with ... like we would just do something on maybe ... I can’t even think now but to do with things like medications; we’d get other people to talk about just general things that students ... we might be teaching students in the under-graduate program, a lot of it was, so that then students would come out and the people would know what they’re talking about. So we’d go through a lot of the content of under-graduate program; for example, some of the illnesses and the impact of physical illness on people with mental illness, so we’d go through that sort of thing. We’d do any new things that came out, so if the college put out some sort of paper or whatever, we’d do a discussion night on it and make it available to people and talk about things. Standards, we’d do a thing on standards, guidelines.

You were putting into practice evidence based practice; you were showing them the evidence and then talking about it.

I guess so, yes, I guess so. And then the other thing I did whilst I was doing all of this was I ran like an action research group in the mental health unit for three years. So I would meet every week for two hours one afternoon and it was always done at around the handover time. So we’d meet, talk about issues and talk about the things that were going on and what the impact was and how we could do things. And we actually had a few small projects and papers that came out of that work and it went on for, as I said, a few years and it was quiet a good ... I think it helped to improve the morale and to deal with some of the issues they had in the unit there, but in a way that it gave the control to the staff so they were coming up with the solutions themselves rather than having them imposed upon them. Like people would say, “Well this is a problem that’s got to be dealt with” so we’d meet in the action research group, discuss on what could we do, what evidence is out there. I’d bring back stuff to them and I’d go or would have gone through it and given them the key points from what was available and then they’d discuss it, come up with a plan and sort of evaluate it.

**On building the mental health content in under-graduate nursing programs**

Well I guess I believe in it because that’s where I come from and I see the value. I value the fact that the notion of mental health to me is very important to everything about life and about being healthy. To me, it’s pivotal to being healthy, so I just believe it’s very important to have all sorts of ... to be underpinning
Making Queensland history

the generalist type programs that we run now, but also that we then have some specialist subjects that are dedicated to when people are mentally unwell, because as well as that I recognise the fact that we do have a proportion of the population who is going to be unwell, mentally unwell, at periods of time in their life; some for more periods of time than others. And so I think that’s really important and I’ve always kind of championed that and pushed very hard and resisted the temptation when it’s been ... might have seemed, particularly as the head of school, easier to back away from some of that, in particular the struggles around clinical education. So one of the areas that we found it very difficult up here was we could run the mental health subjects, the specialist type mental health subjects, but getting the placements for the students became quite problematic at times. And so as a head of school, it would be easier to just go, “Well let’s just cut it back or cut out the clinical” or whatever, but we didn’t. And so they’re the sorts of things I guess I pushed for over the years and they were the struggles, the struggles of being around clinical and around getting quality clinical in a regional area where there has been a culture where in the past students weren’t accepted or valued I would say.

**How do you pursue that struggle?**

Well getting the students accepted and valued is putting the hard yards in at the facility. It’s being able to sort of see that they’re getting something from you, and I think that’s part about being active in the branch and going out there and working with the group and the clinicians and the leaders out there is that they felt they were getting something. So once they felt they were getting something from the university, given that it was our free time but they still felt that they were getting something from us, I think it enhanced the relationships and started to grow a partnership so that then they felt that we were giving something back and we got a sort of two-way relationship. And nowadays it’s still up ... you still have your ups and downs but on the whole it’s pretty good now and we have relative ease of access I would say.

**On building clinical teacher capacity**

Yes, that was a struggle as well, that took a long time because this was a different area to move into than where I’d been before, but I guess from that respect we did put a lot of effort into the people and when I first started here at JCU, we used to actually go out and do the clinical ourselves, so were out there with our students and eventually that became unrealistic in many ways that we would do that amount of clinical teaching with the other things we had to do. And I actually prefer a model where the clinicians do the teaching, I prefer that, but you do have to try and get the quality in that teaching as well. I think that what happened though over the years was as the college grew, we sort of got more and more people who were interested in under-graduate education as well because obviously in the education sessions, a lot of us, that’s what we were doing and talking about, so the people who were interested in that sort of work were kind of drawn into the circle I guess a bit. And, yes, so that was a way of helping them to develop and we still had a very – we still for a long time had to have a very close role of overseeing what was happening in clinical, because I remember as head of school, like I still remember things like having students come to my door in absolute tears and saying, “Please please tell me you’ll never make me go back to that place across the road” and “I can’t possibly go there again; they made me stand in the corridor with my face against the wall.”

**Not literally?**

They did. So there have been things like that, but I have to say in defence of people from the mental health area, we had similar horror stories from general ... from the surgical wards as well. But we dealt with those effectively by I’d go back to the person in charge and talk about it and say, “This is an issue, we’ve had this student. They’re very traumatised by this now and we need some sort of assurance that this will be dealt with and it won’t happen again.” And I guess also I constantly kept reminding people
that this is the way you get students to come back and work here. If they’re given a good experience, they’re more likely to want to come and work here in the future. So if they’ve got an interest in mental health and they come here and they get a bad experience, then you’ve lost them. But if they come here and they get a good experience, you’ve got an opportunity to seduce them to your ways and to want to work as a mental health nurse in the future. And I think that’s … often you get people will tell you students are told you need to do a year of general or you need to do this, need to do that, before you can go and do mental health nursing. Well I’ve never advocated that and I would tell the clinicians, “You need to sell this area, this is your opportunity to sell this area as a good area to work, that’s worthwhile and that’s enjoyable.” It was enjoyable when I was a psychiatric nurse in the days of psychiatric nurses and I can’t see why it can’t be an enjoyable occupation now.

On enjoyable clinical experiences

Mostly I liked working with the people, the consumers. I loved it. I just loved everything about it. I loved doing different things, I’d love … yes, I just liked working with them, it was challenging and sometimes it was hard work, difficult work, and you’d have really sad people to work with or whatever, but just little things. Sometimes it was the littlest thing that was an achievement for the day that made you look back and think that was a great day. Just someone who before couldn’t talk who might have said their first word for weeks or a guy I remember we had who had been … he had schizophrenia and he was only a young guy, 19, and realised his diagnosis and tried to kill himself by using carbon monoxide poisoning and unfortunately knocked off a lot of his cognitive ability. And we were told, “You’ll never be able to teach this man anything new.” That he’d lost all the ability to learn anything new. And so we’d been away at block and learnt some things about language and how language … about different ways and things … things about language anyway. I can remember being told about people who stutter and if people who stutter, you teach them to sing, sometimes they can get beyond that. So anyway, we got together and decided if we taught this guy to sing, we might be able to teach him a song. So we taught him a song I love, Aeroplane Jelly. Now, it seemed like something very insignificant and childlike in a way, but we taught him this song and he stood up at the grand rounds the next month and sang for the group, and we thought that was just the most wonderful achievement that could ever be, so little things like that. I love things like we’d organise … when I was working in the long care area where we had a lot of people who’d been in for some time, we’d organise a barbecue. I remember I went to the charge nurse and said I wanted to organise a barbecue lunch and he said, “No-one will go.” He said, “They’re so used to just eating in the dining room, no-one will go.” And I went, “Well I’d like to try” and he went, “I don’t know, you girls, you come up with some of these weird ideas.” Anyway, he said, “Okay, I don’t care. You do it; I’m not doing anything towards it.” I went, “Okay.” So we went to the kitchen and said is it possible and they said yes; we went to the yardmen and they set up the barbecue and got all the staff onside. So we set up the barbecue, told them that lunch was going to be down in the courtyard and we’re having a big barbecue. And we had beautiful grounds there at Morisset, absolutely beautiful. This was ward 17 and you go down the back and it had this big area under trees and there were seats and everything. So we set up the barbecue and they loved it. They just loved it, they had the time of their life down there having the barbie and having a few games, so things like that. And I like, like when I did night duty, because we did 12-hour shifts and I worked in that area and I was there for some time, I would always do something during the week so that it wasn’t just the same old night every night. We’d come on at … because I got bored. So we’d come on at 6 and instead of just sitting around watching TV until they went to bed, at suppertime … have supper, go to bed … I’d do things like I’d organise we’d have cooking, so “Anybody who wants to cook, tonight we’re going to cook patty cakes so that for supper we had patty cakes.” And I had that many people that it would be just about a stampede to cook; you’d get everybody in the kitchen than you could poke a stick at. So we’d do that, we might do patty cakes and other nights we’d do something different, like make chocolate crackles or just things. And then other nights we’d have set up a quiz night, because you’ve got seven nights and I used to think if
I’m bored, I’m sure they’re bored. And they always took part, always, yes. Just things like I loved all that.

**On research and knowledge that you’ve contributed to mental health nursing**

Yes, well I guess I don’t see myself as a great researcher, I don’t think I’ve achieved ... there’s a lot of people that have achieved a lot more than me, but I’ve had a go and I’ve tried to work in an area and in particular to do with psychotropic medication so now we’ve got a book out, and a lot of what I guess I’ve researched in the past is part of that book and I’ve done a bit around administration of medications and so forth. And I’ve got some students now who are wanting to carry on work in that area. Like now we’re doing an RCT, looking at an intervention for the weight gain associated with second generation anti-psychotics and that’s funded by the QNC and Eli Lilly, so we’ve done really well with that. And now we’ve got a student who’s going to do an RCT starting next year using an alternative therapy as a way of reducing the side effects of second generation anti-psychotics and we’ve got a company prepared to give us quite a bit of substantial funding for that, probably in the order of, between the product and the money, the cash they’re going to give us probably like 50,000 and the promise of more if things look good, so.

I’ve found that a lot of the times when I think you put into the QNC and then I’d be knocked back and yet it’d come back rated really good for everything. You’d think what have I done wrong, why is mine not chosen to be funded, and then you’d look at what was funded and it was things for newborn babies or whatever. And so a lot of it was about that real cutting edge stuff that was exciting and for many people, mental health stuff is not exciting.

You’ve got 15 PhD students at the moment; have they all come around the area of mental health or are you supervising their other aspects?

No, they don’t. You have to take people in other areas, but the other area I guess that I have expertise around is workforce and some of it is to do with mental health and others not. But I’ve also got a number of students who ... because of my background in qualitative research, I’m now working with a number of students who are using indigenous research methodology, they’re indigenous students. So, excuse me, that’s really meant that I’ve had to go and follow up all of that literature which is an evolving area but exciting really. But I’ve also got students doing some fairly innovative things, like I’ve got a student who’s doing work, recovery from homelessness is really the sort of title I guess. She’s using art based therapy as a recovery from homelessness. But a majority of her people, the clients that she works with, are people with issues around mental health of some sort, that’s why they’ve ended up homeless; alcohol and/or mental health problems. And then one of the indigenous students is doing recovery from mental illness from an indigenous perspective using indigenous research methodology, so.

**On indigenous research methodology**

Well, indigenous research methodology is really based in the tenants of critical theory, so it’s about that empowerment, the freedom, the freedom for oppression, freedom from oppressive forces; helping people recognise the colonialism and the fact that indigenous people are disadvantaged in many ways. So that’s what it’s based in but it also values indigenous epistemology and ontology, so it values indigenous ways of knowing and ways of being. So it values the spoken tradition and it values their cultural belief system and the way indigenous people are in the world; that indigenous people don’t value individualistic things but there is a system of family; it’s a community to which you belong and you have to value that. Only certain people can tell you things or should know things and you have to value that to understand and to do the research in that area.
Sounds like very meaningful, significant work

I think it will be and, yes, it’s just an interesting journey at the moment being part of that with three students, but all whom’ll do it differently; they’ll all give it their own way of doing it, so.

Yes, well like one’s a Palm Island girl, the other one’s from Mt Isa area and the other one’s from northern New South Wales area, so.

Each group has its own beliefs, but overall I guess, if you could generalise it, they do believe in certain things. Yes, but it’s interesting and it’ll be particularly I guess meaningful for me doing the one around the recovery from mental illness for indigenous people or what that means.

On critical theory

I used critical theory for when I did my masters but I used phenomenology when I did my PhD. But I do have an interest and I’ve had three students I think who’ve used a critical approach to their work now, three or four.

I go back even to the work of people like Paulo Freire and that attracts me, that I like that notion of helping people become aware of those … it’s that raising consciousness about things, about the system and about who has the power and who’s advantaged and who’s not, and so it always makes you think that there’s always two sides to everything. And since I started learning about that when I was doing my masters, it just intrigued me and I guess that’s why and the work of people like Joe Kincheloe who I’ve been lucky enough to get to know as a friend and who unfortunately died suddenly last year. But because of Joe I got onto the founding scholars board of the Paulo Freire Centre for Critical Pedagogy at one of the universities in Canada. Just things like that and seeing that the whole notion of having a critical pedagogy and critical research is really important to change the world for the better, freeing people and making sure that we don’t end up with the really, really rich people and the really, really poor people who have nothing and no say. It’s one thing to be poor but to have no say in the world is another thing totally, so to think that we could maybe help people to be empowered to change things for themselves.

I guess the best thing for me has been having open access to people like Joe Kincheloe, Shirley Steinburg and friends of theirs and opportunities that go with it. And I could have gone over there and spent some time and they have offered me that opportunity and they would help with expenses and everything, but it’s just not the time, I just don’t have the time to do it. It’s really quite sad actually but I guess it’s given me other opportunities, like I got to go to Brazil and spent some time at Ribeirão Preto [district in Brazil] of the nursing group, the nursing school there, and Brazil is a country of great poverty as well and great contradiction, but it was great to do that time there. Interestingly whilst I was there, because we did a whole lot of other things to do with WHO, World Health stuff, but then while I was there the university said to me would I do something about my work around medications, would I do a session. And if you do a session here at the university and they put out a flyer saying international guest or whatever, you might get 30 people of whatever. There was a room of about 200 and they packed the room and people were on the floor and these were students and there were students for whom English was a second language, but they came to my session. It was just so wonderful, one student stood up and he had a paper of mine and he said, “I have your work.” He said, “Your work is so important to us” and sat back down. That was amazing, I just felt you really do something worthwhile. So it was great, that was great. To think that they … I just couldn’t believe it, I was overwhelmed by the fact that people just kept pouring in and sitting on the floor.
[that day] I talked about just a compilation of all the sort of research I’ve done around medications, psychotropic medications. And people came ... and he was actual a social work student and working ... he said he was specialising, doing a major in mental health in social work. Interesting, isn’t it?

**On psychotropic medications and the role nurses play**

I believe that nurses are the ones who are ... people say you put administration down as a sort of minor role but I don’t think it’s like that; I think it’s a very big role, it’s a very important role. And it’s not just about the five rights, it’s not about just that; it’s about advising people, educating them and also observing your patients; when you’re in an in-patient setting, looking and seeing what’s going on for this person; is this the best medication for them; looking for side effects. So it’s about knowing the drugs yourself, knowing what to expect; looking at people and then going, “Okay, you’re not doing really well, this is sort of doing bad things to you” and being able to go back. So we’re an advocate. We should be an educator, an advocate, communicator; all of those things. I think it’s a really important role. And then when you look at PRNs of course, it’s even a slightly different picture because PRNs are often prescribed and then whether they’re given or not is left up to the decision of the registered nurse at the time and that can ... a decision to give them can be for many different reasons and often maybe not even what they were originally intended for. So that’s one issue and the other issue is that sometimes the PRN is written with a varied dose. So I believe it’s a fairly autonomous role that often nurses play around PRN of psychotropic medications and that to be able to do that is a core skill that you do require to be well educated and to know “The effect I want now for this person, should I give the lower dose or the higher dose? Should I start with the lower dose or should I start with the higher dose?” And there are often different decisions if you know the background of the drug and looking at the presenting situation.

**And it sounds like too that the role of PRNs and of medication administration, with the responsibility that’s involved there, it can either free people or it can oppress them too...**

Exactly the same and you have to look at that. And part of what I did in my PhD because I looked at people’s experiences of side effects and in some ways what we do to people is we might be giving them something that we think is helping them and it is helping them in some ways, but in other ways it’s unhelpful. And I always remember one of the people I interviewed and he said to me, “The side effects that I end up with, I take the medication and maybe it does help with some of the psychotic effects that I’ve got or psychotic symptoms so that it helps me, but in other ways I get these side effects” and he said, “I may as well go round with a big placard on my head that says I’m a lunatic because everyone knows, people know.” He said, “I do odd things.” He said, “I go to my sister’s for a barbecue and everyone looks at me because I do these odd things that are part of the medication.” And I think that’s a really important thing that we should always remember and that’s why being a good mental health nurse to me is about that working with the consumer. It’s about being with someone. It’s paying attention to a lot of things. I’ve I guess carved off medication and it’s become important to me but other aspects are just as important in that role.

**What I hear you saying there is that when making a determination about what action do I take, we need to be kind of conscious of well who am I helping? Is it me, is it nursing, is it the system that I’m helping or is it this person that I’m with that I’m helping and so that whole balancing act.**

Am I giving this PRN because I want to help the person or am I giving this PRN because I want to quieten the person for the benefit of the ward or myself because I want to watch the cricket; what is it? So yes, I think they’re all ... it’s really important that nurses become aware of the underlying tensions I guess and also be aware of the untoward effects that you can get when you overmedicate people or when you use polypharmacy and so forth, and there are dangers in that that we need to be aware of.
On finding focus as an academic

I was like everybody else I think in nursing because we haven’t really had that mentoring, those people behind us that could show us the way. So when I first started as an academic, and I was lucky that I started at Newcastle with some good people, including John Daly and others at the time who were senior lecturers when I was a tutor there. And so I kind of had a bit of direction there and my first one or two publications actually occurred ... I think one maybe just before I left there and one after, one or two, so I still wrote with a couple of people there for a bit. So it sort of started me on the track: one was nothing to do with mental health nursing and the other one was. No, it really was to do with it but it was to do with nursing diagnoses but. I did my masters and then when I did my PhD I was interested in side effects to medication so that’s why I took that on, because I was interested and concerned about the side effects people had and I thought I’ve grown up in an era where everybody’s pushing medications but is this the best thing for the consumer. That was what I guess stimulated my interest in the area was I’d had that for some time and concerned about some of the more serious and long lasting side effects that people could end up with. But after that when I finished my PhD I was a bit like lost and thought what do I do and I’m being pressured, we’ve got to do things and do research, and if you want to get promoted you’ve got to do things. So to start with I think I went into a bit of a scatter gun approach and so I did a few different things, but I’m not sorry for that because in a way it got me into reflective practice which is sort of not a bad thing. But unfortunately, for a while there it was the only thing I could get money for was reflective practice. I kept getting like teaching and learning grants for that area so I’m still today being asked to write chapters on it and I think I really tried to leave it alone a long time ago and they won’t let me because once you’ve got in there, people keep pulling you back to the area. But that was one of the areas that developed as an aside because of that. But then it was some time after that that I realised that the way to I thought be most effective was to try and pick an area and develop a track record. And I thought well I started off with the medication and I may as well stick with that area, so I kind of moved on and did further work in that area which I think has been good but I’ve also sort of ... I’m back now in other areas which is just part of reality of taking on students and then you end up publishing in their areas, so.

On worst times

I think what it taught me was a value of having people you could trust and the people you know you can trust are really important.

I think it is a matter of taking the time and that’s probably the thing that out of it all for me, other than that, other than those people you can trust, is taking the time to do your own things; stepping back from the work and going, “Okay, I refuse to think that at the end of the day I’ve not had time to ring Kim Foster” for example or ring Lee Stewart, who were two very close allies of mine. You have to sort of think to yourself, “I’m just going to ditch all this for now, I’m just going to write Kim an email. I haven’t written her an email this week so I’m just going to write her an email and check on what’s happening with her world and talk about what’s happening in mine” and stuff like that, or ring someone up.

So it’s kind of like claiming the space?

Yes, and taking the time out, actually saying “I’m just going to take time out, I’ve had enough today, I’m going home” or taking the weekend and saying “No, I won’t let the work come into this area anymore” and so I’ve ... that was a really hard lesson for me and that made me change my ideas about things in the world and what I valued and what I didn’t, and being prepared to just go “Well I’m prepared to let that go.”
So now if people say ... I'm prepared to stand up to people, even like if the dean will push me and say this has ... I'll just go, “Well I can't do it, go and get someone else, I'm not prepared to do it.”

I used to try and do whatever they wanted. And so this year, for example, early in the year he said to me as part of this role that I’ve taken over for the lady who’s had a baby, he said he wanted me to do this big conference thing and I just said no and he just nearly fell over and sort of looked at me and I said, “No, I don’t have the time.” And he said, “But this is what I want done” and I went, “Well you’ll have to ask someone else.”

For me it was just learning then okay, I've been pushed beyond what I can take. I realised that it was the system ... the symptom was this issue I had with staff but when I reflected on it with help, I could see that I'd allowed myself to be pushed to the point where I was overworked and overloaded. And so now I'm more able to stand up and just go “No, I'm not prepared to do that, can't do that.”

It almost really pushed me right out that I was ready to just give up and not work anymore at all. I'd just resign, just retire. I was over 55, I could have taken my super and gone. Then I thought ... it took some time before I thought why should I, so I decided to stay but to do things more on my terms though.

**On working with the World Health Organisation**

I’ve done a lot of consultancies for World Health in the Pacific region in particular, mainly in Fiji but also in Kiribati and we’ve got another project for Kiribati now. And I’ve done a lot of work right across the health system in those countries. The one we’re looking at at the moment for Kiribati will be really looking at reviewing their whole health strategy and I feel very honoured that I’ve been able to be part of doing that work. I think it’s a great privilege and it’s been fantastic and I’ve worked right across the systems, but also when I went to Fiji, it was an opportunity to also champion mental health yet again because when I went there my work was nothing to do with mental health but I felt I couldn’t just go that country and work there around education and other systems and standards and not at least even follow up what’s happening in mental health and then try. So as a result of my first visit to the hospital there, St Giles, and speaking to the staff and looking at what was there and what wasn’t, and speaking to patients and seeing some of the conditions, just you’ve got to ground yourself in reality, you’ve got to know what’s there. To do WHO work, the same as AusAID work in these countries, you’ve got to understand it’s no use going in and going well these are the recommendations and no-one can afford them. You have to ground yourself in the reality of the world. That’s their world. And so when I saw the hospital I still thought even given what’s here, we could still do better. And so I decided that the thing that I could offer was education and so what I did was I pushed and pushed and pushed at government level to get change around the system of the way they employed the staff, because what they used to do was just employ nurses when they came out of the training school at the FSN, Fiji School of Nursing, and they would just go to St Giles and be rotated through so there was never any consistent body of staff. So we said that needs to change, we need to upskill people and finally got funding from AusAID and WHO to develop a mental health course that is now run by the Fiji School of Nursing, and they would just go to St Giles and be rotated through so there was never any consistent body of staff. 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people who have put some infrastructure back in. They’ve started to recognise it because I just kept ... I wouldn’t stop and I went to everybody and I went to the minister, I went right to the minister and had a meeting with him and it was a meeting about something else but I said, “While I’ve got you here, I want to talk to you about St Giles” and of course they’d ... and I’d say “There are things that need to be done and there are things that can be done and it’s possible and we could do this, and if you support that and say that you need this course, we can get funding, we can put funding in for AusAID” and so, yes.

*When I think back of this interview, it seems like there’s this recurring theme of persistence.*

Possibly, I guess so, yes.

*And it waivered three years ago but you continued on.*

Yes. Possibly, yes.

*And what’s your work with WHO now?*

Well we’re working towards getting a collaborating centre here which won’t be around mental health nursing but it will incorporate that I guess as part of what we do because it’ll be for nursing education and research capacity building across the Asia/Pacific region. So one of the things that we’re hoping to do in the near future is to roll out some work around ... and we’ll also be secretariat for the emergency disaster group, so that’s an area I’ve been pulled into that’s got nothing to do with my background, but anyway. But slightly as a way because you do see there’s a psychosocial component, so. I’ve actually taught ... I went to China and taught the psychosocial recovery component for ... excuse me ... 100 nurses there, like I trained the trainer, with Margaret Grieg and ... well Margaret developed the program and her and I have worked together a bit on that. So she’s done a bit of ... quite a lot of work for WHO as well, so more than I have, and then her and I wrote a book for or commissioned to write a book for ICN on mental health nursing which was interesting, so. I think it was supposed to be about 5000 words and it ended up being about 50, but anyway.

So it’s pitched at under-graduate [students in developing countries] and they’re kind of like a skill book that you can look and see a table and “What do I do if I’ve got this?” that sort of level, so.

And I’m sure like WHO documents, like a lot of these things and ICN documents and WHO will be sort of something that will be developed like this and go out for free to all countries, so yes.

*On being a mental health nurse in Queensland*

I’ve not ever worked as a clinical nurse in Queensland. Having said that though, I worked closely, as I told you, with the facility in Townsville doing the action research group, so I certainly saw the issues that mental health nurses in Queensland faced. I think it’s considerably better now than it was for a long time and just from a Townsville perspective, all I could say is that early on when I first came to this area in 1993, it was very medically dominated and nurses had very little room for any decision making and that has changed over the years and that’s been really wonderful to see the change, so. That they’ve started to have more say in the way the services are run and it’s like that’s great. That’s a wonderful outcome, so. And I’ve been part of a lot of different working groups of course, like I’m on the whatever it is, this expert group for mental health for the QHealth and I’m on the ... I’ve been on the ... I was on the mental health nursing education group, the taskforce, and now I’m on the implementation taskforce which is a national group. And so I’ve been part of a lot of those sorts of things where it’s been about content and things, like mental health content and in courses, under-graduate courses and then clinical and all that sort of thing, so.
I also chaired the QNC mental health accreditation group for a number of years.

**Lessons**

Well I guess the only thing that I can say is really people should be proud to be mental health nurses; they should not feel they hide behind other nurses and claim what’s theirs I think and claim the role. Because from my perspective and my background, looking over the years, there’s been areas of what would be mental health nursing eroded by other people like occupational therapists and other types of people, therapists and so forth, particularly occupational therapists I think, over the years and social work. And we have to start to be proud of what we do and claim what we do and what we offer. And I think that’s really important that we do that and stand up and let people know that we offer something special, and I think we do.

And one of the ways I guess you’re helping us to claim that practice is by talking about and showing us how nursing is more than the administration of medications, that it involves a whole complex set of decision making and verbal and physical interactions.

Yes. And I guess if I can contribute in some little way by writing and researching and putting that scholarly literature out there, that’s my challenge and that’s what I’ve certainly tried to do and will continue to do until I retire I guess.

**Sandy Wanchap**  
Current role: CNC, Child and youth mental health services, Townsville

**On being nominated:** [Inspirational role model]

I was very surprised. I was very surprised and I felt quite excited at the time because I just have been here for, sometimes it feels like a hundred years. But I like what I do and I think Mental Health Nursing is just an amazing area of nursing, and it can be adapted to any part of nursing. So, yes.

**Becoming a mental health nurse**

In the sixties you had three choices. You either became a teacher, a secretary or a nurse and I actually wanted to be an architect, and my father who was a very wonderful person said, “Well, mmm.” You didn’t see many female architects and my mum had been a nurse and my aunt was a nurse, so that’s, and they were the days of hospital training. So you left school and at 16 years and 11 months I started my training at the Townsville General Hospital in 1960.
I lived in the quarters because you couldn’t live anywhere else at that stage so that was a challenge, but being young you just did things. You didn’t question them in those days and the nurses’ quarters was an interesting place, to have a nurse, a registered nurse, sort of keeping all these nurses under control. And you had to go, if you wanted to spend time out you couldn’t do it on your shifts, it had to be on days off so you had to go and ask for, and have a pass, and you had to have your shoes polished – quite regimental, but anyhow I survived all that and I had fun. The odds against me was that my aunt was actually the matron.

The old surgeons basically would say, “Oh you’ll never make a shoelace of your aunt.” She was a very well known, dominant person, but a very fair, and those days I think they looked at the dominance more than the fairness, but yeah. So we had a few interesting interactions but I had a mother who was just superb. She was a wonderful lady. She’d experienced a lot of pain. She was a horse show-jumper and she’d come off and damaged her legs, and these were the days before penicillin. So I did, I think, start to pick up the emotional behaviours and how people really did suffer, but she was a strong lady. Yes.

You mentioned before Sandy, that your family life and your family gave you strength...

Well my dad was the second male of 10 children and in those days people didn’t go to school, but he did. He finished secondary school and he was able to play, everyone of the family played a musical instrument so that was a strong Scottish input. And I think my granddad was just a fellow that came from travelling and said, “Well this is one chap that’s going to make good.” So hence our name, I think it was, the originality was, I think, Dutch, Korean or something like that. I’ve never been that interested but, yes. So yes, my sister and I, there’s 13 years difference between my sister and I, 15 between my brother and I so when I was saying I was a precious child, I was. And I grew up in that environment with lots of extended aunts and uncles on farms, and so yes I think I had a very wealthy life, just being absorbed in that family area. And nursing, four years of training in TTH, you really do become very close to your colleagues and your peers in that establishment because they were the days, night duty, you’d shift up to the 4th Floor nurses’ quarters [where we could sleep better] and we worked 11 nights and then three nights off.

You were just basically so exhausted, but you then still got up and did all your lectures in your own time. So yeah, we had a very amazing tutorial nurse, she was an Army nurse and she was an innovative educator. She was really before her time and she actually taught us Introduction to Psychology. So in the sixties that was pretty rare, very rare and she was just a very petite, feminine, excellent articulator and it just was wonderful to listen and learn. Gentle, intelligent nurse.

Oh she really taught us a lot.

[laughs] I actually couldn’t look at a placenta and I basically, you know how you have to test them and in those days you didn’t have gloves so it was all hands on. I can remember doing my first assessment of a
placenta using Braille, with my eyes closed. And I had a photographic memory that I inherited from my mother so, but I did get better in that kind of area, so.

Then [in 1966] I returned [to Townsville] for six months. My mum had died while I was down there, so to spend some time with my dad but I knew I didn’t want to get hooked up into the family, so I’d arranged for myself to join three other midwives and we went over by sea via the Suez Canal, Singapore and we lobbed in London another time. Like January we left here, the change of the dollar, pounds to dollars and arrived in England.

It took six weeks. You know I became very ill on the boat and I had an Italian doctor trying to tell me that I had a cardiac condition, but in actual fact I’d been in Egypt and I’d picked up a wog and I had an eye infection and that affected my lungs. But I loved, I loved London. Two years. I worked at Guy’s and St Thomas’ and St Mary’s. Brilliant places to work.

[I worked mostly in] recovery. That was, you know post-surgery, so yes. It was just great. Lived in Highbury which was quite rare, as most of the other Australians were in the other side of London, so we did a lot of exciting things and met a lot of exciting people. And of course wore the fashion of the day, brilliant green stockings with psychedelic tops and yes, so it was fun. I bought a London cab and we [the four midwives] travelled around Europe and went down to Turkey and North Africa.

The first time we had a VW combie and there were two nurses and four people from other disciplines, and then the next trip we decided, nah- uh, nurses have more fun. They don't whinge. Or if they whinge they just fall about laughing, so.

And that was just absolutely wonderful - travelling through Greece with an Australian sticker on your car was just mind-blowing, you know. And of course they’d say, “Do you know such and such?” We would say, “Melbourne. Oh yes, I lived in Melbourne,” so they’d put on a big feed for you and it was just brilliant. And nurses were very accepted. You were, we only had one nasty experience in Istanbul. My colleague was rather well endowed and a very happy person and she was whisked off by two Turkish people, but by the time three other nurses had completed interacting with them they were candidates for the Vienna Boys Choir. So we rescued, [laughs] our colleague.

[Laughs] So you weren't averse to physical...

A bit of a rough-up, yes. So yeah.

So you were saying then that the nurses that you knew then were strong and...

Oh, very strong.

Living in the nursing quarters gave you that camaraderie-ship and you basically, you could talk about anything. If you see one of your peers coming off you just sit and have one of those obnoxious, great big pieces of bread. They used to feed us bread, butter and vegemite, you know. It was always there. So when it was arrived we’d all be there talking, eating these monstrous sandwiches and drinking tea. And we just laughed. We cried a lot too.

But I think that strengthened us. I think that helps when you’re a young person and your family are just so far away. But, and these are the days before telephones. We had a telephone but that was quite unusual. We also had a TV, so I really am going back. And of course I came back to Australia. I couldn’t settle. I went down to Sydney for a while. I was going to do Child Health but I just couldn’t
settle, and I did a bit of private nursing and I worked at a hospital at the Cross. I can’t remember its name. But then I came home because my dad had started talking to the cat again, said he was missing mum. And my sister had, she was still teaching and having children so I came home and I was a companion to my dad for about six months, and I worked in Emergency. And that’s where you see people experiencing trauma but they really do need, just that input of knowing that somebody was supportive and just listening [a nurse]. And I think when people realise that you’ve got empathy for them, and you can calm them just by talking, and I find that right through my Mental Health Nursing. Just by listening and reframing, it’s just amazing and people seem to just take that on board. And I’ve done that, I’ve been in some pretty spicy situations but I’ve always managed to calm the person down. And I have worked in all areas of Mental Health except the Rehab section. So I have, I run away from this place in the 32 years that I’ve been here and I’ve worked in the Unit and I’ve worked in Outreach. I went down to the Ayr Child Guidance as they only had a Social Worker there so I re-established a team and started off some groups and started some family therapy sessions, very rewarding working in a rural district. And then went over the (14.19) to the little Home Hill Hospital because a lot of people couldn’t travel. Public transport’s appalling in the smaller places so I think that was one of the most rewarding times, and I’ve always enjoyed working with teachers, within the schools. I’ve get on really, well with teachers because my family consist of a lot of teachers, and I think that’s one of my best experiences. In Townsville I think most of the educationalists just know, “Sandy, she’s still working there,” so I have a lot of calls and E-mails from educationalists.

On your mental health career

I went from Emergency, [to] Marriage, [to] Two children, [to] A husband that was injured in an industrial accident. Then [on to] working in Occupational Health and doing some Outreach nursing. I was the relieving nurse on Magnetic Island. So you had the triage, anything from a fish hook through the foot, to somebody having a baby who hadn’t basically told anybody their due date. They normally used to shift off the island about four weeks before. To somebody who was very mentally unwell so that was my introduction and then into Occupational Nursing.

You were working in large industrial complexes and you were teaching, so you really built up a rapport with people. The workers from Admin to the industrial workers and you were training them in safety aspects. You would train them in CPR and also introducing a lot of safety aspects, and I worked closely with the Safety Officer, and that was interesting.

I had a father who was of Italian descent and he had something like about seven children and he’d come in to talk about his children. Unbeknownst to me at that time he was a very dictatorial type person and he was utilising physical discipline on the kids and he was quite distressed that he was doing that, but that’s [past family history] what he came from. I think the lower part, Sicily, and that was, you know the man was the boss, so, and I spent a lot of time with him. It was his shift co-ordinator who sent him down because he wasn’t coping on the job. But money was so important to him and the seven children. So I was able to change some of his thinking about discipline, and I hooked him up with Lifeline at that stage. There was only Lifeline and DoCS at that stage, and DoCS really didn’t have a good reputation. Poor things, they still don’t have a very good reputation but we work with them and they’ve got a hard job. And that’s where I really thought I can make a change. And then the word got around that Sandy was a good listener, and my husband was a tradesperson and he didn’t like these people basically coming to see Sandy and then telling him that, “Oh yes, there’s a lady down there.” And he’d get very crabby and say, “But that’s my wife.” So, yeah it did cause a lot of angst. And then my dear dad died and my relationship [with my husband] just went pear-shaped, so, yes.

He went from a very positive, happy type person to a real grunge that was arguing and started to use physical punishment on my two boys, and they were not used to it. They have a loving grandfather and it was just really quite distressing for everyone, I couldn’t understand it because I’d never been hit in my
life, so. Only once and there’s another advocate of non-violence so, yes, I just packed up my little Subaru, my ironing board, sewing machine and two sons and off we went.

But by that time I was working for the Institute of Child Guidance. I had relieved in the past, I’d picked up the idea from a friend, my name was put forward because I was working at James Cook Uni clinic relieving. So I was just doing a lot of relieving to full-time Occupational Health and then a friend of mine was working and she wanted to move on into the Aged Care, which was her area of nursing. So, then in those days you were a Nurse Receptionist so you did the intake. I had a very, very swift introduction into Mental Health Nursing and communication skills and report writing.

And in those days your resources were a pen, paper, coloured pens [for the kids to draw] and old blocks off the newspaper role [for drawing] and a telephone.

So that’s how I started. I became very adept to making programs and photocopying, well in those days you couldn’t photocopy, it was the old purple thing [Spirit duplicator]. You’d feel as if you were an alcoholic after you’d smelt the Metho., for a long time.

But we started off as a very small group and worked as a team. And prior to that I think we [psychologists and a social worker, a psychiatrist, medical officer and a part time medical officer, one Admin officer and one nurse] stayed in our corners, except to attend meetings.

I think I changed that by bringing them all together. We had fun times. They hardly ever mix, like they’d stay in their office. We used to run activities, sort of, in October we’d papier-mâché this look alike large rock for the kids to basically have some fun in the waiting room, because it was a pretty scary place [cream walls no paintings]. Mind you some kids wouldn’t go home, they’d get in the rock and they wouldn’t go home. We had a Speech Pathologist too, which I think is very important for Mental Health. And we had fun but we were serious at times due to the work and we’ve had some very, very good people come and work with us. We used to be organised from Brisbane, so Spring Hill was our home. And there were some strange psychiatrists, that is, child psychiatrists came up to the clinic with different therapies, but we found them very interesting. And then we did get a Child Psychiatrist full-time and that was amazing full time position in Townsville. Perce Tucker intelligent and client orientated.

And he was, he taught me just so much about attachment, temperament, resilience and definitely family therapy systems and how they operated, and that was just the beginning. It just opened my eyes.

Perce was a happy guy and he shared. He shared his information and he shifted me out of that front office, being the face of the service, where people came, and he included me in therapy and I just felt very special. So, and I shared that with all of my colleagues and we were going through a pretty hard time prior to that. We had the 10B Enquiry and I had applied to do my Mental Health Nursing, but the educator at the time had basically said to me, “I think you just need to stay where you are,” you know. And that was Marg Hesslop. You don’t know Marg? Oh she’s well known, yeah. So she’s a bit of a card, so where angels fear to tread she would be there.

And why did she want you to stay where you were?

She just could see issues manifesting in psych due to working in the hospital while I was out in the community. She could see that there was going to be issues, unbeknownst to me that there was going to be some repercussions and the social model of Mental Health was quite destructive for some clients. However, when you’ve got that model and you’ve got a psychiatrist introducing it to you, most nurses worked towards that model, and we lost a lot of very good nurses during that time. They just left, and then of course we had the 10B Inquiry.
And what did that do?

I think that basically raised my awareness of the rights of the patient, and how important the patients are, and patients do need to be listened to. Basically we can’t put a very unwell person on a piece of paper, and to fit into that square that we’ve made for them, when they’re basically round. It’s the same with the kids, you know. In schools, in the education system the curriculum is there and we’ve got a lot of young kids who just don’t fit into that square, so.

So you’re saying that you need to make the service fit the person, not the other way around?

Yep. And that saddened me. Then we went back into just looking after people and we didn’t have the Psyche Unit trying to inflict their ideas on us. We were still being managed by Brisbane but, when I went down to Brisbane, I went to a few things [education sessions] and I made myself known, to get to know who were the people behind the phone. And I think that was important because I felt they I was a bit isolated. So what I think I’ve always tried to bring in too is the socialisation, because I think coming from a country and family, a bit of Irish, a bit of Scots, you know. (25.39) those two families together and there’s a bit of Russian, it’s a Heinz 57 varieties is my background, has helped me in my nursing career.

[Laughs] And Sandy, by this time had you started any Mental Health nursing training?

No, but I had been to a lot of the continuing education that was being run by Barrett. They had started some [education sessions] of their areas [mental health], and then the North Queensland Professional Nurses Association commenced with Mona Kendall as one of the drivers of that, and she was brilliant. She just was my mentor and minder. We laughed, and she was the DON at the nursing home next door [to the clinic], and I’d escape and have a little bit of a debrief to her and we’d end up laughing, and just, she was wonderful. Mona Kendall did so much for Townsville Nursing. She just changed ideas and really introduced a lot into nursing. Big changes and a wonderful lady.

Could we stay at the debriefing and laughing? So you would go to Mona and you’d talk about the challenges of the day? And what did she do to make you laugh?

Well I think some of the debriefing, there was a lot of superlatives in that debrief, and I think I’ve got a warped sense of humour, and I’d sort of basically say, “There’s a gross amount of adipose tissue over there that looks a bit like a Rottweiler and seems to be wanting to rearrange my leg.” Stuff like that, you know.

...It was just great. And she was the one who [introduced me in to continuing education]; I went to a conference at Bramston Beach and I took my sister and my kids, and they went off and saw Cairns and stuff, but that conference really just changed me and my thinking. I was just, it was wonderful. I can’t remember the presenters. There are so many wonderful people that I’ve just looked up to. But I just hung on every word and I thought, “Yes this is it.” So I applied for Central Queensland University [initial external graduate nursing program]. I missed out on the first lot, but the second, I’d applied for a continuing education in communication, and Mona was also doing that course, so it was fun. I can remember doing a whole cassette on how to grow roses [laughs] and I’d never grown a rose.

But anyhow, it was a challenge. I like a challenge, so yeah. And that was just wonderful, and the people. You’d meet more people that come from diverse aspects of life and nursing, and it was fun meeting some of the lecturers who were quite challenging. I can remember one gentleman who taught Physiology who basically just took a dislike to me, and when we took the photos I was in the dark and he used to refer to me as, “That person from Palm Island,” and I just let him get away with it for a while. And then one day I tapped him on the shoulder and we had an in-depth conversation and, of course I missed out by one mark on my Physiology exam, but anyhow. There was just an amazing Canadian, no
an American lady. No, an American lady and I can’t remember this other lady, Julie Bradshaw would know. She was over in Western Australia. She was a feminist and a very strong...

Small lady but she was great, and she said to me, “Don’t argue, he’s not going to pass you. You just know everything and the next time you go in you just blast him out of the water.” So my sister and I went over to Magnetic Island, my kids were away on holiday, and I read that book backwards. In the meantime I got (the book) Marab. We had a very, sort of a crinkly textbook that wasn’t very descriptive, and Marab, well I knew Marab backwards.

Can’t remember the person but I knew Marab backwards and I zipped that exam. But it was a learning experience for me, because I was just saying, “I thought I knew everything.” Here am I, I’m in my forties; I’m doing a degree, phff what’s this? So, of course graduating from Central Queensland, my sister of course came with me because she was a surrogate nurse. She taught physio. That was the big thing was that my sister taught anatomy and physiology in secondary school and I failed the subject. My sister was a brilliant person, absolutely wonderful, yes. She was great.

[in the degree] you covered the clinical practice, research, education and management, and it was four years. So, travelling that highway after you finished work [in Townsville] and going down to Rocky and making sure you found out where that nasty cop was on the stretch between Rocky and (? Barbara) so you didn’t get picked up for speeding. But yes, and living back into student quarters during their vacation holiday, it was no holiday, but yes, great experience.

**So four years, a degree, and then what happened in your career?**

Well I just loved it and started getting involved with Barbara Hayes in establishing the JCU building. I was on the building committee for the James Cook Uni nursing so it was just a building, but it was fun going out there and meeting such a diverse group of seniors [committee members]. I was still the only nurse at Child Guidance [in Nth Qld] but I’d got my degree and I was on top my world, then I had another psychiatrist join the clinic, who was a rather authoritarian person, but she pushed me into therapy, and I’d already had all the skills from family therapy but learnt more. I had attended South Australian (CAMHS) in Adelaide, some of their conferences and I was hooked. So I just thought I could make a change again [in my clinical practice] so I worked and learnt a lot with mentoring undergraduates and postgraduates. The teams say, “No you can’t take 200 graduates [gross exaggeration],” and I’d say, “Yes I can, and I do.” They [UG’s] leave the service with a very good understanding of Mental Health nursing in all areas.

**On unique issues are around nursing the child client**

Nursing in Child Youth Mental Health is basically having, utilising empathy and just being available, you never understand how that person, you cannot understand another person’s trauma or illness or unwellness, however you can presence yourself, and just be there, be available. The service is, it’s a bit rigid at present but I still have some people recontact, they just have a bit of a glitch, they just contact me and previous team leaders have said, “Yes, see them.” And we call it the Sandy touch up. So you just basically get them back on track and it’s a very simplistic to offer guidance, I find it, it’s very difficult for people, and I’m training all of the team. Multi-discipline, social workers, med students, I’ve got a Psych Registrar at this stage who shares, I think he may be looking more on the maternal side, you know.

Listening [to the child and to teachers].
Teachers aren’t coping and they’ve got a rigid system and they don’t have much, you know their funding has really gone backwards. So just to have somebody that’s listening to them, and I do a lot of school visits. I always take people with me so it’s a learning curve for them.

I listen to the teacher, the Principal, the Behaviour Management teacher, and of course the Guidance Officer. I’ve completed a lot of continuing education with Guidance Officers and if they have a conference I supply something [relevant] that I can present to them, and get them to talk about it more. So, do a small presentation, but I think it’s the discussion more so. I’ve been presenting to the police and also, as I said before, the school-based youth nurses because, they sometimes feel quite isolated. Like Kirwan High School here’s got 2,226 pupils at the last count and one nurse, and the Guidance Officers are very busy because they’re doing vocational guidance and they’ve got a Special Ed Unit. So the nurse sees a lot of people, and as I said before, they don’t have the Mental Health training, but they can consult with me and I can support them, and I think that helps. It just gives them the idea, by me listening and then giving them suggestions and some relevant information, they are strong enough to take it on board and put their own program in place, thus aiding the student. So it just expands their thoughts and their education, and they adapt that into the school situation, so yeah.

**On the best times**

Oh, just being with other nurses. The symposiums that Tom [Ryan] and Mick Blair started in North Queensland were just wonderful. I’m very respectful of Tom in his own way but he does pontificate a lot, but still in all he has tried to do a lot for Townsville mental health nursing, and he really did the ventilating a little bit more than just sort of working on the areas. He was our DON and Tony Swain is now, but Tom’s back in Supervision and that’s great for him. That’s another thing, I love Supervision. I supervise five of my colleagues, nurses, and I also used to be the supervisor for the Speech Pathologist, and I’m involved in peer supervision with level 4 nurses, and we’re all equal and that’s great. My best moments are being passionate at what I do. I love what I do. I love to see, maybe a kid that’s been setting fires in school, run down the corridor saying, “Sandy, Sandy, I haven’t lit a fire for…..,” you know. And in the nursing, it is just to have some person who had a difficult case debrief with me and say, “Oh, thank you, thank you.” “Oh that’s the way I was thinking but you’ve just clarified it for me.” So basically when you share stuff and you’re available and accessible, so, and I just stop everything and listen. I’m not a tidy person. I am at home but my desk looks dreadful because I’ve got so many fingers in so many pies.

And that’s one of my limitations because I have so many interests and I think way back if I would have just specialised in one area and just followed through, maybe I would have my name up in lights or something.

I don’t need it. Yeah. I did have a very bad experience, a very bad experience. I’d just flown in to Townsville, I’d lost my favourite aunt and at that time I’d lost my dad the year before, my two favourite aunts and I was quite, I think it might have been about six, no must have been about four, ’96, no it’s about 10 years after my relationship had broken down, and I was on night duty and I was in a closed psych unit and a rather dictatorial night nurse had basically put me in this unit … and I didn’t think I was emotionally strong at that time but didn’t argue. And they’d had a fly-in, a post partum depressed little mum and she’d been on the Benzo’s so the medication had been really quite… destructive and we had a very young Psych Registrar… he was inexperienced. We had one, two night nurses for the whole hospital complex and they didn’t have a nurse to special this lady. We had an orderly and this lady just lost it at about three o’clock [am]. She beat the orderly up, she beat another nurse, and I was standing at the door, and by that time her energy level had just grown. So she really assaulted me quite badly, which I still have some issues today. I’ve got, you know quite a lot of arthritis, she king hit me in the jaw, and kicked my knees. So I couldn’t walk. My sons were thrilled, I couldn’t talk or walk.
And of course I’d shifted, I have a high-set house so I couldn’t get up and down the stairs, so I’d shifted in with my sister who was a teacher. Now teachers do not make good nurses. She was good at feeding me but, nursing!

She didn’t care for you, comfort you?

No. So I had a pool and my colleagues got hold of a chair and other aids and were wonderful. They just came and supported me, but I was in a wheelchair and to, sort of just identify that, “Hey, hello all you giants, I am here.” Nobody made eye contact [except the kids].

When you were in the wheelchair?

Yes, and that was a learning curve. That stopped me, I re-smelt the flowers. I was continuing education all through this. I was also working in Aged Care in my spare time, and working full-time at the clinic. I was basically doing extra shifts to put my sons through a private school and so it stopped me, okay. They’d finished their schooling and they were starting to get themselves established and I really had to re-smell the flowers and learn to walk again. I’ve got a bit of a wobbly old jaw; I can’t yawn now because it gets stuck [laughs].

But I came back to CYMHS and stayed for six months and I thought, “No, no,” I just haven’t finished. So I went back and worked in the intake section of adults MHS and was visiting this area, and then over the Christmas time I went back and worked there. So I laid all the ghosts down and then I was right. I went back to CYHMS.

Can we just stay on that for a moment? So there were ghosts to be put to rest?

Oh, big ghosts. Big ghosts. You walked into the old Unit and you really had to, you’d be, your awareness, and you’d be very vigilant and wanting to know where everybody was. And basically I think that time I went back we had a lady that was bipolar, who was very unwell but had quite a number of borderline personality difficulties, and she had children. So it was very, I think, rewarding for me to interact with her and with her children because they used to come up and visit from out of town. And basically set the scene and give her some areas that it wasn’t just a, sort of a room with nothing in, get some toys in for the kids that were soft and cuddly because one of the children was only a toddler. So, yes it really took me back and I helped that lady just get back some kind of relationship with her children.

I felt my peers were getting very angry with this lady and there were just eight hour shifts and I suggested that, if the nurse was specialising that particular illness it was a four hour shift. That’s all you could do, a four hour, and then you needed a break. So we did that, but eight hours was just really quite horrendous.

So you instituted some positive changes there as well?

I think so, yes. Of course Aileen Colley was the, what did they call them then, they weren’t CNs, not Nurse Manager, anyhow she was the nurse in charge of that particular area. I learnt a lot in that area. I worked with Indigenous adolescents and I used to basically be their nurse and I’d roster myself that I looked after them and that was very valuable. Because that’s one of my other interests, Indigenous mental health.

On working with indigenous young people
I think it’s the listening to them or just presencing them, and that’s Barbara Hayes, she was the one who taught me just to presence unwell patients. When somebody is very unwell you don’t sit right next to them. You don’t sort of move into their space but just presencing. It’s really quite important for the person to know that you are there and you’re supportive. Also I think that it establishes an environment of calmness. So if a person is very agitated you’re not infringing on them particularly, but you’re there and I think it helps the person then just to recognise and identify that you’re not going to intervene, or just go over their boundary. And I also think in that situation when you’ve got very unwell people, if they are agitated you need to just basically establish some interventions such as, bathing. Water, I think, is a wonderful healer. I think lavender, gentle music, to encourage people to do that. I encourage our adolescents. That’s one of the areas, relaxation, music. Sometimes you may meet people who go to extremes, I’ve got one young adolescent who, their water bill is phenomenal and he turns the water off when anybody else is having a shower because that’s his therapy.

So he’s just utilised the therapy to the full.

_Sandy_ I’m interested just to learn, being involved in a major traumatic incident that you were, are there any insights about how you contain your own emotions for the next patient?

I think when you move on, you must write. I don’t write in front of the person, and I know that’s my, another limitation. I’ll basically make notes but I’m there for that particular person. Then when I come out I leave myself 15 minutes and I’ll write up the file, okay? So what you’re doing is actually externalising that particular session on paper.

So I think you’re then able to move onto the next person because we’ve got back to back people. Another area is your documentation, it’s so very important, and that’s what I hope I’ve passed onto my colleagues and also the undergraduates and postgraduates. You write a document that you can get up in a court of law and basically be able to read it, and it’s there and you haven’t got some smart-arse barrister basically picking on one word, because I’ve been there. And having to go through the courts for my sons, because my husband was allocated my kids for a fortnight and I didn’t have any money at the time. So I went and worked in a hamburger shop so I could employ a barrister. I got my kids back. I have two amazing sons and I have a nephew, and I’ve fostered another fellow that my son brought home. And another young girl, her mother died of breast cancer so instead of two sons I’ve got four sons and a daughter that I’m getting used to!

So making family wherever you are...

Very important.

Yes, and that’s why I think the Indigenous with the kinship and their land, it’s just so important.

_Insights for nurses_

I just think they need to believe in themselves and they can make massive changes. You can start off with a little change and it just grows. I think communication is just amazing. It’s the articulation, what you can do with words, the written word, is just phenomenal. And I think never to feel lonely; there is always somebody to talk to. Even though at the time nurses may think, “Well, oh that’s not interesting,” but just giving them the chance for reflection on their own clinical practice. I think reflective writing was excellent and I see they’ve taken that out of the curriculum now, but I suggest to nurses, I suggest to clients, you know writing a journal is just brilliant. That’s yours, it’s nobody else’s. But when you read back, I can
remember reading on some of mine and think, “Oh my goodness.” And then when you’re basically into your third degree your writing has improved so much.

And reflective practice was wonderful. Being able to talk with colleagues, be they from any area. So being a provincial area and rural, you didn’t have the luxury of having access to other Mental Health nurses. You had a lot of nurses from New Zealand and from England but you learnt from them. But your own Aussie people were the people that came up to symposiums and conferences and I don’t think I, I try not to miss any conferences. I’ve been to them all. But I’ve got my registration for General Nursing, Midwifery and the Bachelor. I’ve got a Graduate in Mental Health Nursing from James Cook Uni and I’ve got a Masters Degree from Flinders In Community Mental Health nursing, but it focused on child youth, community child youth. So, and that was fun, loved it. Loved South Australian model of care.

On the profession

[looks at notes] I [wrote down] a couple of funnies, but I think it’s a wonderful and valuable statement to tell people that I’m a Mental Health Nurse and I’m very reluctant to retire from this amazing profession.

I don’t, you know they say, “When are you going to retire Sandy?” I say, “Oh next year.” I started saying that in 2004.

So I still have the ability to work in Accident Emergency in the intake team. I haven’t done it for two years but, I have a lot to do with CATT [crisis assessment and treatment team] and I have some just wonderful colleagues there.

Fran Gallagher was very special. She tried to do a lot of changes. Of course Kim Usher and Barb Hayes, what a beautiful lady. I loved her war stories.

She used to tell us about, like her previous stories of clients with schizophrenia and depression. It’s just fascinating sharing those and I think I’ve also picked that up.

Anecdotes


[the client who was setting fires] he was indigenous but he had a very powerful aunt who was an elder. So I basically got him more in contact with the elder, because the mum and the sister weren’t talking but we established communication channels for this young lad, and he was doing very well. So he’s still not in jail, he’s an adult now and I see the other kids, so yeah. I think the Fire Fascination Program that I send them off to, because we’re here and we’ve got wooden homes and they go up very quickly, and I think that’s an awareness and education for everybody. What I’ve established is a lot into health promotion, Mental Health Week I’ve always been involved with, even when I went down to Ayer [health district].

This year we went to the Transcultural Fest and that was a day of just health promotion and we had some tents and some bright pink t-shirts and crazy hats, and it was all interaction. So we got up on stage and did some relaxation in a brilliant blue shirt and wobbly cellulites hanging out of my shorts, but [laughs].

But I did it. And we did, we just share our information with the other agencies and people coming to see us. We then went out to Northern Beaches, which is an isolated High School. There are not too many activities for adolescents, so we were overwhelmed by Year 8 to Year 10. A couple of seniors wandered down to have a look but, and this year they didn’t put us next to the Sex Health Promotion stall because they had a good turnout with the condoms and bananas, so...
I think there was more paint on them than here [points to a painting] but it’s just a memory. So each health has been lots of promotion. We’ve worn silver bowler hats before and been interactive with kids, yeah.

**So you think memory and finding ways to have memories is important?**

Sure. Yes. Yes. Share it. So, not much wind to blow balloons up but anyhow, yeah. And I think that’s where we’ve still got the family; seeing we’re dealing with families I feel our team is a family. So even if I’m the aged member, I’ve just lost the psychologist, he retired. So he was the poppa of our team, very sort of, beard, one of those psychologists [look alike Freud], but really made a big change too.

**And you’re the grandma?**

Well, sometimes. I think I can sometimes just hark back to adolescence very quickly.

So there’s still a lot of child in me.

**On recovering from an attack by a psychotic patient**

[The lady king hit you] Well I basically took her down gently and got her back to bed, and by that time the other two had regained their composure. They weren’t as injured as I was. We then gave her some medication that was; well it actually knocked her out.

I went back to work the next night with swollen feet, didn’t realise how damaged I was but halfway through the night I just couldn’t walk, so yeah. [this came just after a very sad funeral]

...in your life, and yet you had no anger towards her?

No I didn’t. I was actually shocked that somebody would hit me. [Laughs] I was just amazed that...

She kept on calling me her mother and her name, and really got quite verbal, aggressive. So I let the other two people just deal with the lady after we’d settled her, and I went out into the office and wrote the incident up. Then I had to contact the Registered Nurse on duty as the Supervisor, and then when she had settled she seemed to be okay. And when she basically woke up in the morning she couldn’t remember anything, and I believe later she told one of my colleagues that she really thought I was her mother, and she had some therapy, some psycho-therapy into that previous experience.

So it was a bit of a PTSD, and I think each and every one of us has got a bit of PTSD about something.

**That we’ve got unresolved issues about our earlier...**

that’s how we deal with it.

[I recovered well] but not Liz. This guy had stripped himself and he was a nasty, nasty person and she still is not working. And this goes back about four years ago now.

And he really attacked her. He assaulted her very severely and she can’t go back into that area. She can’t come back into nursing, and she’s still on Workers’ Comp.

I think it was about three years ago. I see her walking a lot.
But the thing was, I wasn’t angry, I was angry with the fellow but I was also angry with the management, that they didn’t support this lady in getting some mentor and she was basically writing out documents and being interviewed by the police and stuff like that while traumatised.

Yeah, and I just felt that that wasn’t a good situation for her. But I’ve met her a couple of times, she walks, she doesn’t want anybody to go and see her. But I have a lot of positives about our Nurses’ Union too. I’ve always been in the Union so, and I think they do a brilliant job and they try and help, so yeah.

Roianne West
Current role: Nursing Director (Aboriginal and Torres Strait Islander Health), Townsville District Health Service

On being nominated: [Inspirational role model]

I think probably the most obvious thing has been Aboriginal first and foremost as a Registered Nurse and that indigenous registered nurses working in the area of mental health are probably even few and farther between than indigenous nurses working in the health system. I think also as an indigenous person I bring a unique perspective, which I didn’t quite realise until I’d been in the clinical area maybe for a couple of years. And there were things that I was picking in an assessment that non-indigenous clinicians weren’t. So I took that on as a bit of a challenge about what are the questions am I asking in my head that need to become an integral component of mental health nursing assessment.

On becoming a nurse

Probably the main reason that I became a nurse, I have a family that’s worked, probably between my grandmother, my mother and her sisters who have worked 70 to 80 years in indigenous affairs. My mother has been working in indigenous health for 40 years and I was a health worker with the RFDS prior to becoming a nurse. Being exposed to the nurses in the RFDS who are absolutely phenomenal. And then I was lucky enough to have a community based nursing program through Deakin University that was brought to Mt. Isa - probably purely through opportunity that I’ve completed my Bachelor of Nursing. But also one of the motivations was going into the hospital setting with family members and being exposed to some of the racism that existed within the system, I wanted to play a part of actually changing those experiences for my people. And I thought one of the only ways to do that was to actually become a nurse. And what’s kept me there was probably that we have a family full of nurses so that very clearly motivates you to stay there.

Deakin University brought training a registered nurse program to the community. So we were lucky enough to actually study in Mt. Isa and I think had that not happened I never had any aspirations to leave Mt. Isa to do university. That was never even in my head. I thought I was going to be in Mt. Isa for
Making Queensland history

the rest of my life. So the opportunity come up and I took it by the horns and done my Bachelor of Nursing and haven’t looked back since.

Mental health was really interesting and I suppose I felt a little bit – it’s a love hate relationship I learned, and when we were doing the two mental health subjects through the Bachelor of Nursing I absolutely loved it whereas everybody else in the class absolutely hated it. And I was really fortunate enough to have some phenomenal lecturers. Felicity (? Hamblion), I’ll never forget her and she was a clinician that worked out of the Barwood Health Service, who was one of my lecturers. She allowed us to play with the curriculum so that we could make it relevant we could engage with it. As an example the students down at Deakin University, when we were doing mental health were doing bulimia which obviously isn’t an issue in rural remote northwest Queensland but our suicide rate at that point was one per week within our district. So all our scenarios were adapted for that, so it allowed you to get your teeth into it. There was also a lot of things that were happening in my personal life, both myself and my family, that led me to ask a lot of questions about why certain things happened in our communities and the model that best fitted that was the mental health model, even though it needed to be tweaked a little bit or maybe a bit more than a little bit.

I done the Masters and Mental Health Nursing through USQ and that came about because I’d done my graduate year through the Townsville Hospital so I relocated across to Townsville. I’d actually done a general grad year and then I went across to Townsville to do the mental health grad year. And then at that point all of the staff were being encouraged to do their Masters through USQ. And I was really lucky because without knowing, USQ was also and still is churning out the most amount of indigenous nurses with the Masters of Mental Health nursing.

After I’d done the grad year at Townsville, I moved back to Mt. Isa and done some community mental health nursing and I walked straight into a level two, so a clinical nurse position so you’ve got to learn really quickly when you go rural remote nursing. Particularly when predominantly most of your clients are from an indigenous background and you’re the only indigenous clinician within a team of mental health clinicians. You have to learn really quickly and you have to not so much defend but you have to be able to articulate your position really clearly. And that can be a little bit tiring because sometimes you have to do that twice as hard as most non-indigenous clinicians. Especially when you’re advocating for indigenous clients. So from there is when the forensic unit opened in Townsville and I sort of got headhunted I suppose. I got a call from the team leader because the unit was 90% indigenous males and they wanted an indigenous clinician and they created a position clinical nurse indigenous mental health that had never been done before. And that of course comes with benefits and disadvantages. If you go into a new role that’s never been done, you’re sort of mapping it yourself. And that was probably one of the toughest jobs I’d ever done because it was 90% indigenous and I was the only indigenous clinician. I thought it would be a good thing but it ended up being a little bit detrimental in the end because I felt like I was sort of case managing anything indigenous because there was almost a hyper sensitivity to mental health nursing our indigenous clients for fear of doing something wrong or not taking any additional culture considerations in the assessment which changes it significantly. So I found I was jumping in to do it and taking on more than what I should have. I congratulate Queensland Health for recognising the need for unique cultural perspective but there needs to be a certain amount of protection within that as well. So I’d done 3 years at the forensic unit before I actually stepped out of mental health for a little while.

[I got back in via academia] Most of my roles have always had really valued education. Specifically in the forensic unit with what I said before, Julie, I wanted to know more about the things I was asking as a Murry, that needed to be written into the mental health nursing assessment. So obviously with that comes an education component but what I found is that maybe this teaching was coming too late. It needed to come as part of the undergraduate curriculum. So after stepping out of it for a year a position became
available at JCU. I didn’t know if I was ready for it but I just threw my hat into the ring because I’m obviously academically there’s a big stigma attached to academics and they’re really smart. I didn’t know if I was quite there because I had been a clinician for so long. Anyway, I got the job I was really lucky I got the job and I done a year with the indigenous health unit before I won a position with the School of Nursing. And obviously I had the privilege of teaching both the mental health subject and the indigenous health subject which is two of my passions, but also trying to work out how these two mesh together better rather than sit like oil and water. So in the mental health subject there was always a module that was dedicated to indigenous mental health so the opportunity to be able to teach it to the next generation of nurses, was so much more rewarding than doing it as a tag line once they got into the clinical area. It wasn’t as valued as it was at the undergraduate level. And then you could also place an assessment around it as well. And then you’re also challenging students’ stereotypes before they get out there so for the most part, most of our non-indigenous haven’t had that much exposure to indigenous people. So to see an Aboriginal lecturer who has postgraduate qualifications who could teach, you’re automatically starting to chip away at some of that there and then. So that when they hit settings like the forensic unit that’s 90% indigenous, they’re not going in there with such a rigid assumption about Aboriginality.

Academic career

Just this year I helped contributed to writing to JCU’s Board in a Mental Health Major for our undergraduates, which has been great. We have a significant amount of our staff who are mental health nurses which I think also contributes to there being a much more – not only an understanding – but a much more interesting wanting to work in an area of mental health. So I think the leadership and role modelling has been in that we’re all very passionate about being mental health nurses so we teach from that same position. We teach this is a really great area, it’s challenging it’s never the same thing every day and I like that, I like being able to contribute to actually, not only strengthening our workforce, but bringing more undergraduates with fresh minds and fresh ideas into the profession.

On humour

And I think on top of the humour that we have as mental health nurses coupled with the humour that we have as indigenous Australians, I think our humour is twice as dark.

And definitely, I don’t know if I can think of any off the top of my head but I know it’s definitely been a survival technique for me especially when at times when you’re immersed in things that aren’t going so well and obviously the forensic unit stands out for me with the unit being 90% indigenous. There was the humour, the sense of humour as indigenous people that I shared with the clients that kept me there for longer than what I probably should have been. And that same sense of humour is what I try and teach the non-indigenous clinicians is what we need to capitalise on as a real strength when working with indigenous people.

With other clinicians definitely. I think there’s two dynamics to that, it’s the sense of humour that you have with your patients and then your sense of humour that you have with your colleagues as well.

I think one of the challenging things about it being an indigenous clinician in a predominantly non-indigenous workforce. When I first started nursing I was always looking for, not deliberately but you come from a – well you’re looking at the differences between a if you’re black, I’m white, you’re that old I’m this old, but the humour was the core thing, that was the thing that sorted that was the commonality, that was the connection there. And it got to the point like with Murrys when we talk, we don’t have to finish our sentences, there’s a lot of non-verbals and I actually found that with modern indigenous mental health nurses who are now probably some of my best friends. And being exposed to mental health
nurses who have made phenomenal differences and to be able to meet the Brenda Happells face-to-face through the college conferencing. You've been reading and referencing their stuff and then to just have a glass of wine with them as being relatively new to the discipline was just an absolute honour and very inspirational. Like the college conference is what gets me through the next year. It's validating, it reminds you why you're there. This is the good stuff about mental health nursing you're sort of revitalised for the next year ahead.

**Significant moments**

Probably winning the Stan Alchin by far at the Sydney 2003 conference. I went along; actually, I was doing my Masters with Deakin, … I finished it with USQ and one of the lecturers was marking an assignment and I got an HD and he said, “Did you want to submit this as an abstract?” And I said, “What's an abstract,” I didn't even know what the bloody – what it was at that point. And he explained it to me and I remember churning over it and I ended up submitting it, I was in Mt. Isa and got somebody to help me put together an abstract. And then it got submitted, which was second mind blow… it got accepted. And I went, “Oh, God, now I'm going to have to present this thing aren't I.” and I remember Sydney clear as day because I was so nervous I couldn't sleep, I couldn't sit still, I’d never, ever presented before, I'd never been barely out of Mt. Isa before, and I stood up to present, the room was full there was probably about 200 people there. The nervousness for me was that the stuff that I was presented was stuff that my people were saying 20 years ago. So I really grappled with …this isn't my stuff, it was my thinking but it was revealing knowledge that had been said many years ago, yet we hadn’t shifted and that was really concerning for me.

[the paper was about ] Indigenous mental health. It actually talked about indigenous mental health in a western orientated society that was the exact title that just come back to me then. And what was even more mind blowing was that I got a standing ovation. And I had goose bumps and I got really teary because I went through, but this stuff isn't new, how could you guys think this stuff was new. And that finished and then I won the award and that was even more overwhelming again because I really grappled with this being not new knowledge. So I didn’t think that I had the right to take the accolades for something that I was just presenting that my people had been saying for a very long time.

And that’s what somebody had said to me : “It was in your voice and it was in the forum that you said it and in the position that you were. You were a mental health nurse saying it to mental health nurses at an international conference. And then obviously with that came a lot first, the first indigenous member of the College of Mental Health Nursing is the First Indigenous Recipient of the Stan Alchin, the first time they’ve had an indigenous person present on indigenous mental health. And for me for 2003 that was – how could that be? How could it be in 2003 we’d have the highest prevalence rates of mental illness in society yet this was the first time this had been brought to this forum? And that was not only overwhelming but it was concerning.

So what come with that after the winning of the Stan Alchin and the presentation, I wasn’t ready for. Invitations to attend things, invitations to look at curriculum, invitations to go in journals. And I just went — I actually withdrew completely because no one had — I wasn’t being mentored at that time and there was no way in the world that I was prepared for that. So that on top of being in the forensic unit, I left mental health probably two years before I come back into it. I was quite — what was I probably just in my late twenties but you’re not pre-warned. There was this automatically catapulted to expertise yet I wasn’t ready for that. I wasn’t ready for everything that come with that nor maturity wise was I ready for that.

It was a positive and a negative thing and the power of reflective practice is why I'm here today. And I remember writing an assignment for reflective practise subject 2 years ago for my last subject for my
Masters and you had to write about three exemplars and that was a standout for me and the lessons that I had to learn from that experience and what do I take away from that experience. But I think I had to go through it. I think I had to go through it. But I’m a lot more conscious now about staying in control of my journey and not sort of getting it deviated by external things that come at you.

On best times

Once I’d sort of stopped personalising experiences that were happening once I’d stopped, when I’d learned about reflective practice and the power to stand back and not be under the pressure of time. When I was exposed to racism by clients as well and also by other staff, I used to personalise that but I also used to get quite disgruntled with that individual. And then once I learnt about racism and what it was and where its origins were I realised it’s actually not about that person it’s about a whole society and this person is just a consequence of that society. So I asked more questions about that individual where did that come from, what’s their level of exposure to Indigenous Australians, what school did they go to? So once reflective practice was a saviour for me and it’s probably like my bible at the moment. I love the flexibility to be able to – the discipline to massage it. I love being able to take a mental status examination and add dynamics to it and add additional questions into it so that it takes into consideration the cultural experiences. I like challenging structures that are in place like the mental status examination and any other components of the nursing assessment. But being in a position now where I can validate why I’m changing it. So as a new clinician you can have a really good idea that you might not and most times that are not, you don’t know how to articulate why you wanted it in a particular way and Academia has allowed you to do that because you have to be able to substantiate why you’re taking a particular position. So a combination of the different things, I like presenting at forums like the passion about practice and at the college because I think people listen. I think people really listen to you and the opportunity to be able to challenge things that have sort of been there for a very long time and make suggestions about how we move this or how we change this so it’s more reflective of contemporary mental health nursing. I like being in a position to be able to do that.

What is it you feel strongly about as being a mental health nurse?

I feel strongly about I feel really strongly about mental health nurses playing more of a role and closing the gap for indigenous Australians. I don’t think we do that as well, I think that we should be leading it. I’m reading documents now that are out there by psychiatrists and mental health workers and psychologists, but I don’t think we quite have the exposure that we should do. And if you have a look at not only our prevalence rates of mental illness in response to implications of past policies considering we have the greatest percentage in the health workforce, I think we should be leading that. And that’s what excites me is that the potential for us to do that and constantly strategising about how. How do we better position ourselves in this arena? Because at the moment I think we’re sitting on the periphery.

Worst times

As a new clinician as with most people probably. As a new clinician and particularly when you’re trying to challenge things, as a new clinician but you don’t know how to articulate why you want it. Because as an indigenous person you just do, that’s just the way it is but then you’re challenging something that’s just the way it is for this profession and when you’re coming up against two just the way it is, well then that’s that interface. That’s hard because you feel like you’re constantly having to justify the way that you’re doing things or suggestions about why, you know why you didn’t ask the family? Why didn’t you ask the community? Whereas sometimes it just seems like common sense Julie. And when you’re asking those questions again and again it’s like well, you just don’t get it. And the thing, my other pet bug is that if we were nursing the way we should be, as with the ethos of nursing of caring or respect of non-judgemental, we shouldn’t require a separate culture assessment, because we should just be – that’s nursing.
How did you manage those difficulties, challenges?

Family, usually I’d get in the car and drive back to Mt. Isa (which was a very long way away).

[I would] work 10 days straight and take the 4 days off. Family but I had to also learn, I had to learn a lot of stuff and you have to focus on the good things. So even though they’re a little bit harder, like when you’re discharging an indigenous back to a community, there’s a lot more complexities involved and you really need to focus on the end point. Yeah, this is really tough at the moment but the end point is this guy gets to go back to his community and be with his family. You had to really change the way that you think, you couldn’t and that’s harder than it sounds isn’t it Julie. You have to try and constantly remain positive in an environment that has a long of negative things happening. It requires you to be mentally fit.

Very resilient. And be deliberate about that like you couldn’t just sort of lapse into robotic mode when you’re working in mental health because I think that’s where you burn out. And then also recognising when I was getting burnt out. So early warning signs for myself when I was tired, when I was crabby with the kids, when I was short with the kids I knew that it was time for me to pull up take a day off or step back from it, what’s going on here. So again, reflective practice and still today you learn more about yourself but I had to learn a lot about leadership. It’s not that I wanted to be a leader but unfortunately being one of the few indigenous nurses in this environment, you’re a leader whether you like it or not. So you had to work out whether you wanted to be good at this and whether you wanted to not be so good at this. So educating myself about that stuff was also very helpful.

The rewards

I like the connectiveness between myself and patients. In the forensic unit for 3 years I was not once yelled at, spat on, didn’t have my bum pinched anything like that for 3 years. Like other clinicians, something’s happening weekly in the forensic unit to them. So what was I doing that none of this stuff happen to me and did it make me a better nurse or what was it? Can what I was doing be taught? But I actually, all my patients although the ethos of nursing is what I practice for all of my patients and I guess where that become most obvious to me was when I was in charge of the unit and there was a gentleman with an Italian background that was brought onto the ward and he needed his BSL done in the morning and he wouldn’t let the nurse do it. So I went down to his room to see if I could get him to get his BSL done and he started yelling all of these racist chants, “You Abo…you…” everything that you can thing of Julie, and I actually had lost my breath but I stepped back out of the room. And I thought, “Okay, obviously I’m not the best person to do this.” But that afternoon when I went home, I went home and I researched everything I possibly could about what were some of the attributes of Italian men, what are some of the things that I needed about the culture that would ensure that when I went back in the next day that I was providing the most culturally safe treatment to this man. And I went back in and I met with his wife and I met with his family and once he could see that stuff was happening he was far more amicable to actually taking directions from me on the ward. And that’s not brain surgery. And I guess it’s the same respect and understanding that I’d like to see non-indigenous nurses have for anyone from a different cultural background not just indigenous people. So I could have personalised that and yelled back at him or that could have just made the whole situation worse but I chose a different pathway and being able to de-escalate situations without meds and without seclusion I think that’s the stuff that’s really rewarding because the situations have potential to go absolutely wild. I love the connection between patients, I love seeing improvements in them just from the most simplest strategies like a video conference to their family that will stop them actually becoming unwell. Things that aren’t difficult but you just need to take a little bit more time to do.
**Other issues**

I think that all nurses need to probably learn from mental health nurses. I think there’s some attributes that we have that probably general nurses don’t have... [these attributes include] a level of understanding and tolerance is particularly heightened the psych nurses. Also, that some of the things that we do like the mental status assessment should be an integral component of the nursing assessment.

This gets separated all the time is so frustrating. And whenever we have one of our forensic patients have to go to the general ward, the general nurses wouldn’t even give their general medications because it was a psych patient. And we can sit around and say, “Oh, you know because they’re not this and not that…” I think the system needs to be made accountable. I think if you’re a registered nurse, whether the person’s got a psychiatric background, renal background whatever it is, holistic care incorporates that component as well. So I think that’s another challenge for mental health. I think that’s another challenge for general health is how maybe that component is considered a little bit more. And that was one of the opportunity to present at the passion about practice last week on indigenous mental health, that was exactly what I raised is that these are the skills that any nurse should have not just a mental health nurse, this stuff isn't brain surgery it’s just nursing.

**Tania Yegdich**

Current role: Nurse Educator, Centre for Mental Health, The Park

**On being nominated:** [Far reach of influence]

I would say it would have to be the transition program. That would have to come to the top of my thinking. I’ve written on clinical supervision and I think probably, in many ways, people have, I suppose, been encouraged by my writings and my support of clinical supervision, particularly in Queensland, and I guess I have to say because of my association with Denny Cowell [laugh], which is both good and sad in a way. There it is, yeah.

**Do you think there’s anything about yourself?**

Oh, well it’s very difficult to say [laugh]. I think I’ve been around a long time and I’ve been an advocate of mental health nursing. Especially, I’ve been very encouraging of the nurse/patient relationship in mental health nursing and I think people probably do associate some of the things that I’ve done with
trying to get nurses to walk along side with patients or consumers, whatever you want to call them. Personal qualities, I don’t know. I think it’s difficult again to talk about yourself, really.

But I think, I don’t pose any great threats to people and I’m quite happy to share, quite happy to, I’m very generous professionally, of my time, of materials, of my help. I think people appreciate that. I’m not particularly competitive. I believe that there’s a bigger picture than me or anything that I do and obviously, the bigger picture is our little profession [laugh] and I guess that’s what must come through with people, is that love for the profession, yeah.

On becoming a mental health nurse

Oh, by accident [laugh]. As we all did. Yeah. Well, I suppose really it was mere serendipity. Somebody came into my life who had mentioned psychiatric nursing up at Baillee Henderson and it just piqued my interest and I made inquiries here at Wolston Park and, lo and behold, they were offering training. So I put my name down and I got in. I was very fortunate, I must say. When I did my training it was in the mid 70’s, it was school. The educators here were pretty brilliant really, and people like Denny Cowell were there and to have come across someone like that so early in your adult life at a personal level and so early in your career was an enormous asset and we just struck up a friendship and a professional friendship as well. And I think he truly inspired me and my love of psychiatry, my love of doing therapeutic things. Denny was a good Freudian. I’m a bad Freudian [laughter] but that was all right. For 30 years we had this friendship where we could talk about things and we complemented each other. I’m really talking about Denny now, not me.

That’s okay.

That’s all right. It all sort of links in, I suppose. But yes, as I say, that was a really huge marker for me to have found him and I never regretted at that time not going to university because I don’t think it would have had the same creativity and intellectual stimulation. I would have probably ended up being a second rate behaviourist and I’d rather have been a bad Freudian.

But I got interested in psychoanalysis and I eventually did do training in that, very much with Denny’s encouragement. I think I was the first nurse in Queensland, first mental health nurse in Queensland to do that. So my interests out of psychiatric nursing sort of led to other things such as psychoanalysis. But as I say, I doubt that if I had not gone into mental health nursing, I probably wouldn’t have found it to the degree that I had and I’ve been exceedingly grateful for that, my entire life really, because it opened that vista for me. And what really excited me, I think, was this ability to talk with people, with our patients, try to understand where they were coming from and try to be helpful in any way that I could. I found that immensely rewarding and intellectually stimulating as well. And many times I thought, “Oh shit, I’ve got to get out of Queensland health.” But it was always the patients and working with them that sort of kept me here, I suppose.

And somewhere along the line, Denny encouraged me to write also and I did. And I was writing in the, gosh, early 90’s and those works got published and I seem to have gotten a bit of a good reputation with the journal of advanced nursing in the UK and they invited me on their international editorial board and I was on that for a few years. I was very pleased about that because I was probably one of the few clinicians who’d ever been invited. So I was very, very happy about that. And probably, I wouldn’t have written without that encouragement, I don’t know. But also I had that interest then in writing and editing and publishing and then in my later years, God we’re getting on, I went into education mainly because, having finished my psychoanalytic training, there weren’t any career paths in therapy anywhere
in Australia, least of all Queensland [laugh]. But I had a private practice for about 10 years and it was never enough to make a full time living out of it so I went into education.

What do psychoanalysts do [laugh] when they need intellectual stimulation and there aren’t the career paths there? So I went into education and again, learning is foremost there in my development as an educator. And I was very fortunate, I could use my psychoanalytic training to develop courses like supportive counselling, which I think were pretty much a first, really in Australia. I know it’s just a small course and all that but no one had ever put something like that together and I got that out of that training.

So really, mental health nursing has afforded me a variety of platforms, all of them terribly interesting and all of them, I must say, even though in education you’re not seeing patients but everything for me, again, comes back to what is it that makes people tick. What is it that makes our mentally ill patients tick and as you know there’s not much evidence in psychiatry. It’s really a wonderful area for thinking and reflecting and all these pursuits are all about that and that’s my great motivator of solving the mysteries of life, is what makes people tick; why do they do the things they do; why do they think the things they think. And everything that I do relates back to that and anything then relates back to the patients, of course. And I have to say, really if I was really honest, everything I know I’ve learnt from my patients [laugh] and I think that’s been an enormous privilege. very humbling. You can read all the books you want and all the rest of it but to really learn anything about human nature from another human being who’s struggling, really is a social privilege, I think. I can’t see that I’d have gotten that in any other kind of job.

Early experiences

Oh, horrific [laugh]. I came into an old institution which was very beautiful but probably, oh look, I don’t know. It was very institutionalised and very hierarchical, this is in the early 70’s, the early to mid 70’s. Nursing was still very hierarchical and you virtually had to salute people [laugh], wait for people to die to get a promotion. Seniority was in and I think, look, I came in so young. I came in straight out of school and I was 17, 18 and I didn’t have a fear of mental illness, strangely enough. I was curious more than afraid but when I got here I was absolutely stunned [laugh]. Who are these people [laugh]? And I’m not sure if it was the staff or the patients who troubled me more. But those early days and weeks and months were difficult, I have to say and I’d have walked out had it not been for the educators, people like Denny, Judy Boyd, Ian Hay, yeah.

Did your education training prepare you for your role?

No, I would say no. Despite all that, no it didn’t and that was why I eventually went in to psychoanalytic training. I just had a bent for psychotherapeutic stuff and it’s just, I suppose, an intellectual curiosity, psychoanalysis. It could have been anything but it was that. But no, I don’t think mental health nursing prepares anybody, even now, to really talk to patients. We talk about that all the time but really there isn’t enough in any of the training that I can see and certainly there wasn’t for me. But to get into psychoanalytic training requires a lot of preparation, too. So I didn’t get into that just quickly. But no, that’s really why I did it. I didn’t want to become a psychoanalyst. I wanted to be psychoanalytically informed and I wanted to feel competent in talking to patients and I wanted to feel that I could genuinely be of help to people. But no, I don’t think that mental health nursing training or education can prepare people for it, no.

Anecdotes
I suppose there are lots of things. We were talking about being humbled and what comes to mind was a huge lesson for me actually. I’m very grateful I learnt it. I had a patient, I was working in alcohol and drugs for a while there, I had a patient who drank excessively and all the rest of it but he wasn’t really horribly damaged. Probably, he just sort of came for help in time, and he was a pawpaw sorter, of all things. I have to admit I looked down my nose and thought, “Shit, a pawpaw sorter, who’s that?” you know. And he began talking about his work and it just absolutely blew me away. I learnt a lot about pawpaws [laugh] but it was his pride and his commitment and his passion and he totally and utterly changed my thinking. I just saw him initially as just a nobody and there I was, psychoanalytically trained, wasting my precious time on a nobody. And he was a guy who had passion, commitment and love for his work and it absolutely put me in my place [laugh] and it’s a wonderful thing to be humbled [laugh].

So I saw him in a different light after that, I must say. It’s a real growth thing for you. It’s just a bonus in the job that you can grow personally but it was a hard lesson for me [laugh].

**Significant moments**

Well I gave a paper, it was the first paper in Australia in mental health that was on clinical supervision and it was in 1994. I’d just sort of completed my psychoanalytic training so I was all revved up from that, I suppose. And it was at a conference in Brisbane, it was one of the college conferences and I was a plenary and I was very nervous and it was only later that Denny actually told me, he said to me, “I think you got three standing ovations.” I never noticed that [laughter]. I was just so pleased it was over and I was still alive and I knew it had gone over very well. So yeah, I suppose that stayed with me for a long time because it felt like a positive experience for me too, despite all the angst. I suppose when I got invited onto the international editorial board, I was absolutely rapt. I thought, “Wow [laugh], wow.” I was just stunned and then of course when I went to England and met the board members. We went over to Copenhagen for an extraordinary meeting [laughter], that’s what I called it not them [laughter]. And it was just wonderful to meet the editor, Jane Robinson, at the time. And they were so nice and kind and I felt very special, although I really wasn’t. But those moments were lovely. Obviously, the psychoanalytic training was a joy. It was hard work. It’s probably worth three PhD’s [laugh] but it was a joy to do and the mentors and teachers that I had there, some of them have passed on, they were much older than me. I keep forgetting, I’m getting old too [laugh]. You forget these things but I guess it’s really that. It’s the mentors that you’ve had and I’ve been so lucky with Denny, Judy, even Ian, I think, and then the people that I’ve met along the way in places I’ve worked and in the psychoanalytic training. I’ve just been really, really lucky that I’ve had buddies I can talk to and have that stimulation. It’s just been so fortunate to have that. I don’t think everybody gets that, you know.

and I was really, really, they’re all dead now [laugh], but I think I realised in a half denied way that I have to be one now to mentor others [laugh].

**Best moments**

I would just say really that the work I did with patients, it’s those moments that are terribly private and intimate and nobody cares about, but you feel so fortunate and lucky that you did do something right, after all. The patient’s gone away and they haven’t killed themselves or haven’t beaten you up or you just have that sense that there was growth happening in the session and not only did they grow, but you grew too. Look, there were so many of those moments and that’s what keeps you in, of course. I mean, I can’t remember any specific, well there are a few specific moments but they’re not all that interesting but you just have those times when you just feel, “My God, I am lucky to be doing this. I am really fortunate.
Where else would I get this?” and they’re just those private intimate moments that you know you’ve just done something right for a change.

**Worst moments?**

Oh gee, don’t get me started [laughter]. Well, Queensland Health’s a difficult employer and I don’t understand why, because they’ve got lots of great policies and things. But I have to say my worst moments are with horrible bosses. I can’t say I’ve had really great bosses in my life. There’ve been some. But I think it’s, what I think’s the worst that I’ve seen in mental health nursing, and probably all sorts of other nursing too, is the tendency for people to personalise things rather than keep things at a professional level. And I don’t know but I rather think there’s a lot of it going on and people just, you just can’t have a professional conversation with people sometimes. It’s all personalised and you’ve lost the game, really. But they’re my worst moments.

I suppose, well yes it’s the organisation. I mean, it’s certain people that make my life miserable [laugh], you know. I’ve generally triumphed but there’ve been hairy moments, yeah. But no, I don’t think there’s been, even my worst moments with patients haven’t been as horrible as that [laugh].

Look, I think it’s a good profession. I think it’s supposed to be an exciting career and I know this because that was the slogan I used for marketing. But there are certainly problems in terms of where are the career paths. We could certainly be doing more. You have to find those areas where you have autonomy, where you can act and use all the skills that you do have.

But in terms, at a personal level, I think it’s a great career because you don’t just learn about patients. You learn about yourself, although that should be a side effect, not the prime thing. And I was obviously doing psychoanalytic training. I obviously had my own psychoanalysis and I think there’s a lot to be said for that. It doesn’t mean I’m a more enlightened person but hopefully I’m a more interesting one [laugh]. My problems get more interesting as I get older, that’s the best I can hope for. And maybe mental health, I mean we’re always talking about reflective practice and so forth but it’s really very superficial and maybe more thought needs to go into that. I don’t know really. It’s hard to say. But no, I think it’s just that general human contact and sure, you get human contact working in a shop or a restaurant and all that. But to have that intimacy of getting into somebody’s head and letting them see who you are and you don’t have to tell them about yourself at all, they work it out[laughter]. But I think those moments of intimacy are very precious, really and I don’t think you get them in other professions. You get them in the health professions but those moment are really, they’re worth cultivating and worth practicing in and doing work in. And mental health nursing does offer that because, even in a ward, you’re there with a patient eight hours a day and you can call your own shots and work out your own regime, so to speak. So yeah, I don’t know. I think there’s something to me very exciting, very stimulating and also it’s just that human level of you’re working with the thinking part but you’re also working with the emotional part too and I can’t think of many jobs that do that. So to me, it’s just fascinating; it’s absolutely fascinating.

**What keeps you here?**

I suppose it is teaching, I sort of, I’m more of a teacher. I’ll still see patients, usually at home now and I’m very selective about it. But with teaching, I never thought I would be able to do it because all my life I spent behind closed doors where nobody could see how brilliant I was [laughter] and that suited me because I was quite shy and over the years I’ve sort of been forced [laugh] to be more outgoing, I suppose. I thought I’d never be able to do teaching, just getting up in front of somebody, “Oh, my God.” Having spent my entire career talking one to one with one person behind a closed door, even in a group situation and I was quite sort of taken aback that something in me came out, I suppose. But again, see, teaching’s a privilege too ...
... and what I probably enjoy the most is the interaction rather than, I mean, there has to be that sharing of facts and information. But what I really like to do is get people thinking and I don't have the answers but if I can get students or people to start thinking what are the questions, then I'm more than happy. And again, you see, having that interaction with students or people who come to hear you, again it’s another wonderful privilege. I feel exceedingly lucky and I can’t believe I’m being paid, really [laugh]. I try to tell them I'm not here, keep paying. But that's really the enjoyment and the stimulation for me and of course I'm learning along the way as well. I mean, I still have the mysteries of life to solve, the mysteries of mental health nursing. I'm preoccupied a bit like Leonard Cohen there, the mysteries, and of course students are wonderful to bounce your current favourite idea with. And I'm constantly surprised too that, although I keep teaching the same things, it's still as fresh as the day that I've presented it.

[students] they challenge you and they get you thinking on another path that you, in your great brilliance, had never thought of [laugh].

Again it’s humbling [laugh].

For me, mental health nursing afforded me a variety of careers or streams and I was very fortunate, I think. Yeah, but it would be nice if career paths were better formulated, such as that therapeutic one. I’d love to see that. I don’t think we ever will. The education role seems to fade in and out, in Queensland Health anyway. The research role is virtually non-existent. So it would be nice to see those other things worked out really well rather than just been given lip service to, yeah. But I suppose too, regardless of which path you’re in, everything really does relate back to your work with patients and that’s what we’re really here for.

I've always been proud that I've never abandoned the patients [laugh]. Wherever I went, I still managed to have a case load. The only time has been here and I just didn’t even bother to negotiate. But I have a couple of people I'll see from home now so I still have my finger in the pie and I think that’s all you need. You don’t need to be working full time clinically but you just need to have that dialogue going and I think that’s essential because even then, patients are helping me to refine my counselling course all the time [laugh] and it’s not the latest research, it’s the latest stuff that I’m hearing from patients that gets me thinking, “Oh gee, there’s another angle there,” and all the rest of it. So yeah, yeah that’s the beauty of it, I think, yeah.

Limitations

Limitations exist in all study designs and in this study the following limitations need to be taken into account in order to contextualise and understand the findings. The study examines the perceptions of a relatively small number of Queensland nurses, participants were accessed via the ACMHN email list, and therefore nurses who are not members of the college or those who do not use or regularly access email did not have the opportunity to participate. There may therefore be some fundamental differences between the respondents and other mental health nurses.

Conclusion

The main outcome of this study is the development of insight into what a cross section of Queensland mental health nurses value in other mental health nurses. Being committed to the profession, a leader, a pioneer, a teacher, a mentor, an inspiration and an instigator would appear to be significant
characteristics of Queensland mental health nursing’s cultural heritage. Such values should be passed down from preceding generations to promote professional identity and belonging. It would be an important contribution to mental health nursing if each of these qualities and achievements were explored in a deeper way so that specific experiences, and embodied values can be revealed. Thus it is recommended that the people identified through this study be considered for invitation to participate in oral history interviews.

Whilst this was a small study that cannot claim to represent the perceptions of the whole mental health nursing workforce in Queensland, it does provide an important record and a starting point for future historical inquiry. A key insight from the study has been that people of import to mental health nursing history are acknowledged equally for what they contributed to changes in practice and for their professional attributes. This should be heeded by all those charged with preparing future nurses for mental health.
REFERENCES


