A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards - The nurses' perception

Joconnie Bartolo

A dissertation presented to the Institute of Health Care Department of Health Services Management in Part Fulfilment of the Requirements for the Degree of Master of Science in Health Science at the University of Malta.
Statement of Authenticity

I declare that the project entitled "A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards- The nurses' perception", which is being submitted in conformity with the requirements for the Masters in Health Service Management is solely the work of Ms. Joconnie Bartolo, as supervised by Mr. Michael Bezzina.

Ms. Joconnie Bartolo
Student

Mr. Michael Bezzina
Supervisor
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This is dedicated to all people with mental health problems.

May they find courage and support to overcome the problems that such illness an illness brings in its wake.
Executive summary

Mental health care is an essential but often forgotten component of health care. Nurses as health care providers, need to be able to contribute effectively to mental health care.

The education and training of nurses in Malta does not equip them with the necessary knowledge and skills that would help them provide proper mental health care to patients in the medical wards. The result is an inferior, type of mental health care being offered to those who need it.

If nurses on the medical wards are better trained, any signs of mental illness will be detected more quickly. This would lead to economic benefits by decreasing the length of the patient's stay in hospital and preventing unnecessary readmissions. It is common practice in the Maltese Health Care system to admit to Mater Dei Hospital patients who have no one to care for them or who are unable to care for themselves.

Methodology: Due to the complexity of the issue under study, both qualitative and quantitative measures were used by collecting original information and adapting what was already available as suggested by Williams, R. & Wright, J.(1994).

A self-administered questionnaire was distributed to all nurses (N=54) working on the general medical wards at Mater Dei Hospital (MDH). Questionnaires were used to
identify the needs of a larger population. A structured interview was carried out with all Nursing Officers (NOs) and Deputy Nursing Officers (DNOs) (N=10). The aim was to identify the needs of nurses from different perspectives. A semi structured interview was also carried out with key persons of nursing management (N=2). These could play an important role in organising training sessions for nurses working on the medical wards. They could also help promote the introduction of the Mental Health Nurse (MHN).

**Findings & Discussion:** All nurses, DNOs, NOs and key persons stressed the need for more training as well as support from a mental health nurse. They also identified the need to improve the service being offered to this client group. However, these key persons had some reservations as to how much nurses in medical wards would benefit from the presence of a MHN on the medical ward.

Nurses admitted that, when dealing with mentally ill patients, they lacked proper knowledge as well as being unsure of the type of care expected from them. Stigma also played an important role in the nurses' perceptions of this client group. Participants labelled mentally ill patients as pessimistic and cold hearted.

It was evident that participants found it difficult to identify patients with mental illness and also had difficulty in communicating with such patients. Participants acknowledged that they need training in certain areas. Communication skills topped the list. Five participants expressed a desire to learn more about the signs and
symptoms of treatment withdrawals and drug interaction. Another three participants expressed a need to learn how to identify mentally ill patients from behaviour or other symptoms. Knowing and learning how to deal with the relatives of a mentally ill patient on the medical wards was an issue brought up by one participants.

Requirements identified in this study were similar to the findings in the literature. The key persons stressed the necessity of having a case summary about the patients' condition when these are transferred from an institution to the medical wards. Unfortunately there exists no mechanism in the health care system in Malta which provides information from one institution to another. This would ensure continuity of nursing care on the medical wards.

**Conclusion & Recommendations:** The study shows how unprepared nurses on the medical wards are when they have to care for mentally ill patients. This explains the desire of participants to have further training and mental health nursing support. This research recommends that the Ministry of Health, Elderly and Community Care (MHECC) should implement a policy that promotes the allocation of at least one mental health trained professional nurse within the general hospital.
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Chapter 1 - Introduction

1.1 Background of the Study

Review of prevalence studies on the co-occurrence of general medical and mental illnesses illustrates that this is becoming more frequent and numbers are increasing as patients move from the community setting and on to the outpatient medical setting to inpatient medical wards. Hence a structural reorganization of the way that health care is administered and provided is required so as to move from an independently managed to an integrated model of general medical and mental health care (Kathol & Clarke, 2005).

Nurses working on the medical wards in an acute general hospital continue to view mental health care as a distraction from their general nursing duties rather than as a fundamental element of nursing practice (Harrison and Zohhadi, 2005). The medical wards in Malta have the highest mean length of patients’ stays of 6.7 days with a mean bed occupancy rate of 106.3% (Annual Report, 2003). A recently published report of Mater Dei Hospital (MDH) showed that during 2008, 7,673 patients were discharged from the six general medical wards (Annual Report, 2008).

According to the WHO (2008) one in four patients visiting a health service has at least one mental, neurological or behavioural disorder but most of these disorders are neither diagnosed nor treated. Apart from the patients receiving treatment in a
psychiatric setting, over half also suffer from concurrent medical conditions (Dickey, Normand, Weiss, Drake & Azeni, 2002).

1.2 Measuring for Needs

A need is not "a want or desire" but is a gap between what is and what ought to be (Swist, 2001). Moreover, Reed and Fitzgerald (2005) identified factors such as life experiences, beliefs, attitudes and knowledge that greatly affect the nurses' ability to care. The rationale behind the tools chosen and constructed for this study will be described later in the discussion chapter (section 5.1).

1.3 The rationale behind the use of a needs assessment through the nurses' perceptions

Experiences with mentally ill clients can either strength or weaken one's perceptions. Negative experiences can even influence the nurses' perceptions, about their ability to provide care for these patients (Ashmore, Jones Jackson & Smoyak, 2006).

However, research has shown that negative attitudes are associated with lack of knowledge and skills. Because of their limited knowledge, nurses tend to rely on their personal beliefs, perceptions and values when setting standards in their care for mentally ill patients (Reed & Fitzgerald, 2005).

This widens the gap between nurse and the patient. Hence, nurses end up avoiding the patient, keeping their distance and taking short cuts when interviewing them. If
communication is to be effective in the nurse-patient relationship, the nurse has to show empathy, warmth, respect, patience and trustworthiness (Foster, McAllister & O’Brien, 2006). Therefore when nurses have negative perceptions of these patients, they cannot empathise with them, thus making the whole process more difficult.

There exists compelling evidence which suggests that patients found in medical wards with untreated or ineffectively treated mental health problems (including chemical dependence), have worse health outcomes, substantially higher total health care costs and reduced productivity when compared to people with no mental health problems (Kathol & Clarke, 2005).

Separation of medical and mental health care is a world-wide problem and Malta is no exception. This practice leads to unacceptable clinical and economic outcomes in virtually all countries and culture (Kathol & Clarke, 2005). Therefore, this is one of the main reasons for carrying this study of “A needs assessment of the delivery of nursing care in the general medical wards- The nurses perception.”

1.4 Problem Statement

The introduction of the Community Mental Health Services Department and the work of the Outreach Service, which visits patients in the environment in which they live and work (Caruana. M, 2006), is not enough. The needs of the mentally ill have to be met by the general health services.
According to Akasheki and Sedighi (2009), mental disorders are one of the biggest problems in the world that have an influence on medical diseases. It was also found that about 27% of those who seek medical care for physical problems actually suffer from a mental health condition (CNS, 2005).

People with a severe mental illness experience increased morbidity as well as mortality from heart disease. The aetiology is multi factor, including lifestyle factors such as diet, exercise, smoking, social adversity, poor knowledge of health and adverse pharmaceutical effects (David, Osborne & King, 2007).

Moreover, according to the U.K Department of Health (DH, 2005), it is estimated that 60% of people aged 65 and over have or have developed a mental health problem. To make things worse, older people consume three to five times more health services than any other age group (Center for Strategic and International Studies CSIS, 2000).

Besides mental health patients, have a unique set of needs, which are quite different from those of patients with a physical illness. The hospital environment is more suited to the needs of the physically unwell than to mental health patients (Baston & Simms, 2002).

Another problem is the social stigma associated with mental disorders. This is widespread. Some people believe that those with serious mental illnesses cannot recover, or are to blame for their problems. The U.S Department of Health and Human
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Services (1999) stated that: 'Powerful and pervasive' stigma prevents people from acknowledging their mental health problems, as well as disclosing them to others. People with a history of mental illness are refused insurance coverage. This in turn discourages this client group from making use of other health care services (Page, 1995; Wahl, 1999).

Moreover, patients admitted to medical wards may not want to be placed near patients who are mentally ill. It is up to, health care personnel to serve as models for society, in the development of positive attitudes towards this client group (Kukulu & Ergun, 2007).

Providing community outreach service to the mentally ill patients has been one of the Maltese socio-political achievements. Having the community mental health services in place and integrating the mentally ill to the community has been a step in the right direction. However, there is still much to be done to ensure appropriate care. The health care system has to be tailored to meet the needs of these patients.

In the absence of adequate services patients keep returning with the same problem with the result of repeated readmissions. The system will never be sustainable unless all the support systems are in place. Therefore, it is up to policy makers to prepare for the provision of adequate general medical services which can help the mentally ill to remain in the community as much as possible through proper medical treatment.
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1.5  Purpose:

The purpose of this study is to assess the needs of delivering nursing care to adequate mentally ill patients in the general medical wards. It also seeks to review the nurses' perception.

1.6  Aim:

This study aims to put forward a model proposal to improve this service in Malta.

1.7  Objectives:

• identify the nurses' perceptions of the quality of care given when mentally ill patients are admitted to the medical wards
• identify factors which help nurses to deal effectively with the mentally ill patients
• identify factors that hinder nurses from caring effectively for mentally ill patients
• explore whether nurses are aware of the learning needs to care for the mentally ill
• explore whether they identify any limitations in the care given to the mentally ill
• explore whether different levels of grade affect the delivery of nursing care
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1.8 Research Question:
What are the main needs of general nurses caring for the mentally ill on the medical wards?

1.9 Significance of the Study:
Mental health care in the general setting will provide the Maltese health care system with an integrated health care. To provide patients with a holistic care one needs to set up a service which provides both medical and mental support to this client group.

Setting up primary teams of community mental health services and not identifying the problems of the mentally ill when they are being cared for in the general setting is a non-completed project. Unfortunately, it is not possible to meet every need when allocating scarce resources in accordance with needs (Baldwin, 1998).

Economic considerations constitute one of the most interesting factors in decision-making (Baldwin, 1998). It is tempting to say that this factor should actually influence the decision. For instance, if only a certain degree of healthcare can be afforded, it may seem pointless to aim at a higher degree (Baldwin, 1998). Obviously this attitude is not correct. There is no contradiction in saying that there is a need but this need cannot be satisfied.

Noteworthy is the fact that health service purchasers are increasingly demanding evidence of effectiveness for all aspects of patient care. This is still evolving in the
nursing care but where the evidence exists (either positive or negative), it should be incorporated into the nursing practice to optimise patient care. As mentioned earlier, it is important to note that the health and happiness of the mentally ill is dependent upon social, emotional and psychological factors. Therefore, it is imperative for nursing care to address these issues and treat the mentally ill clients as a whole person and not just the condition they are suffering from. Perhaps, the best way to do this is to provide better training for the general nurses caring for the mentally ill. In this way, nurses will be able to identify problems that would otherwise go undetected.

Solving these problems, even if insignificant for others, might make a huge difference for these mentally ill people living in the community and in other institutions. An integrated service will help the mentally ill remain in the community, be more independent and still be able to make a contribution to our society for a longer time. Thus, the aim of the nurses caring for the mentally ill in the medical wards should be to provide a better quality of care and reduce the distress that mentally ill people experience when receiving care in the general hospital.

Taking all this into consideration, this study should provide policy makers with an insight into the needs of the Maltese general nurses to care effectively for the mentally ill. It also attempts to identify lacunas in the present practices of providing care to the mentally ill when admitted into hospital. Furthermore, this study also aims to establish a specified goal of health care needed in a joint venture between the mentally ill, administrators and nurses.
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1.10 Work Definitions

Needs assessment: Analysing the requirements of nurses.

The delivery of nursing care: The care given to patients on the ward.

Mental illness: Is as an illness or syndrome with psychological or behaviour manifestations and / or an impairment in the functioning due to a social, psychological, genetic, physical, chemical or biological disturbance.

General Medical Wards: Wards at the Mater Dei Hospital (MDH) offering the service supplied by the Ministry of Health, Elderly and Community Care (MHECC).

Nurses’ perception: Perceptions of nurses understood as their personal understanding, interpretation, opinion, mental attitude, awareness or insight into the issue of mental illness reflecting their knowledge and the experience which is influenced by the environmental and situation factors.
Chapter 2 – Literature Review

2.1 Introduction

Nurses represent the single largest group of professionals providing hospital care (Institute of Medicine, 2001). Nurses working on the medical wards are quite likely to come across patients suffering from mental illnesses. If these mental problems are not recognised they can give rise to unhealthy behaviour, non-compliance with prescribed medication and diminished immune functioning with poor prognosis (Ramirez & House, 1997). Hence the need to care for mentally ill patients effectively has become a central element of the NHS policy (Evans, Greenhalgh & Connelly, 2000).

All patients have a right to the best available mental health care, which should be part of the health and social care system (United Nations, 1990). This is the first principle of the fundamental freedom and basic rights. Estimates made by the World Health Organisation (WHO, 2008) showed that 154 million people globally suffer from depression; 25 million people suffer from schizophrenia and 91 million from drug use disorder. Another recent report published by WHO (2008) shows that 50 million people suffer from epilepsy and 24 million from alzheimer and other form of dementia. The report also shows that another 877,000 people commit suicide every year globally, which can be the result of mental illness.

WHO further stated that one in four patients visiting a health clinic has at least one mental disorder. Unfortunately, most of these disorders are neither diagnosed nor
treated (WHO, 2008). Meanwhile despite knowing the high rate of mental illness worldwide health care professionals are still not recognising the need to care effectively for the mentally ill.

Admission to a hospital is a stressful situation for everyone. It is even more so if the patients has a history of mental illness (Brewer & Melnyck, 2007). Research over the past half century shows that hospitalization triggers stress that can be documented even physiologically (Kiecolt-Glaser, 1999). When patients who are severely mentally ill (usually referred to as SMI) are admitted to hospital, they may suffer fears that may cause them to break with reality. People who are SMI may exhibit a range of symptoms such as hallucinations, delusions, burst of anger and difficulty in communicating, all of which can be a threat to their own safety and that of others. They may also lose their independence (Wichowski, 2004). Such behaviour poses a great challenge to the nurses caring for mentally ill patients on the medical wards. Nurses may also have to cope with young drug addicts and alcoholics. Though not mentally ill their behaviour is often equally challenging. Coping with such patients is rather stressful for the nurse who does not have the time nor the knowledge how to handle such people.

2.2 Defining Mentally Ill Patients

Mental illness can be defined as an illness or syndrome with psychological or behaviour manifestations and / or an impairment in the functioning due to a social, psychological, genetic, physical, chemical or biological disturbance (APA, 1994). This disturbance is not limited to relations between the person and society. Shives (2005)
defined mental illness as a disorder causing people to display abnormal behaviour more consistently than other so called normal people. Patients with mental or behavioural problems usually behave irresponsible and are unable to cope with the demands of society. They may also have an inaccurate perception of reality. However Crouch (2003) stated that people who exhibit a constant specific behaviour of addiction such as alcohol and drugs can equate mental illness which is increasingly recognised as a common and not exceptional among people with mental illness.

In addition to the above, Harrison (2001) classified mentally ill patients with clinical problems into three main groups. Those suffering from:

1. *acute primary psychiatric disorders including self harm, psychiatric crises and emergencies*

2. *psychiatric disorders with any type of physical illness*

3. *psychologically based physical symptoms, e.g. Somatisation.*

(Harrison, 2001)

Together with the above one may include schizophrenia or mental health problems which are a result of a physical illness such as adjustment disorder and depression (Harrison, 2001).

In order to identify the nurses' needs to care for the mentally ill on the medical ward one must first seek to understand the real needs of this client group. This leads to the objective the literature search will focus on.
2.3 Needs of People Suffering from Mental Illness

Physical illness is known to increase the risk of psychiatric disorder (Clarke, Minas & Stuart, 1991). In addition, people who have a psychiatric disorder are more likely to have physical problems and are more likely to access general hospitals to meet their health needs (Lawrence, Holman & Jablensky, 2001). The importance of hearing from mentally ill patients about their perceptions and needs is a new concept, which has received limited attention (Thapinta & Kitsumbau, 2004).

Pollock, Grime, Baker & Mantalia (2004) carried out a study investigating ongoing patient concern. The complaints of the mentally ill were mainly inadequacy of information and consequent exclusion from discussions about the decisions of treatment being prescribed to them. The main complaints were analysed through the involvement of a wide range of different stakeholders formulate ways of improving the quality and accessibility of patient information materials. Focus groups consisted of patients, carers and health professionals. All groups agreed that the current provision of written and verbal information was inadequate and should be improved. Patients and relatives gave a higher priority to having information material than most professionals. Staff were concerned about providing medication information since they often focus on the consequences of compliance rather than benefits.

In contrast to the above, several studies have reported that increased knowledge of medication, including serious side effects, did not affect compliance, either positively or negatively. However it did increase patients' insight and understanding of their
Greater involvement of mentally ill patients in the planning, delivery and evaluation of health care and research, is an important lever to improve the quality of services and bring about the change in organisational culture (Crawford et al., 2002; Faulkner & Thomas, 2002; Sainsbury Centre for Mental Health, 1998; Townend & Braithwaite, 2002; Trivedi & Wykes, 2002).

In line with the above, Shattell, Starr and Thomas (2007) identified themes needed by the mentally ill while being inpatients in the general setting. The mentally ill (MI) needed the health care professionals to restate and clarify words that they did not understand during information giving sessions. The second theme that emerged was that the MI did not wish to be regarded as a number, diagnosis, or a set of a diagnosis. The last theme was that the MI wanted the health care professionals to ‘get to the solution.’ The clients wished that they could be offered advice and information about medications. Participants in this study needed solutions to problems such as dealing with symptoms of the illness, medical problems as well as financial and economic issues. Participants saw these needs as being part of the therapeutic relationship which was expected from several health professionals such as general physicians, psychiatrists, social workers, counsellors and nurses.

Understanding the vital need to develop a therapeutic relationship with the mentally ill has been highlighted in several studies of the nurse-client relationship (Bedi, 2006;
Bedi, Davis & Williams 2005; Littauer et al, 2005). According to these studies, clients desire the nurse to be friendly, calm, understanding and prepared to listen. She should seek to balance specific questions and comments with listening (Littauer, Sexton & Wynn, 2005). Mentally ill patients sought valid confirmation of their experiences, emotional support and care and appropriate education and referrals. Honesty in the nurses dealing with mentally ill patients is important, as are positive non-verbal gestures and personal presentation (Bedi, 2006; Bedi, Davis & Williams, 2005).

However, it was concluded that a therapeutic relationship between persons with mental illness requires in-depth personal knowledge, which is acquired only by time, understanding and skill. Having a holistic knowledge of the patient, rather than knowing the person only as a service recipient, is the key for practising nurses and nurse educators interested in enhancing the therapeutic potential of relationship.

Forchuk & Reynolds (2001) reached conclusions, which substantiated the above findings. To answer their question "How do clients perceive the evolving therapeutic relationship with nurses?" these two authors compared the results of two qualitative studies carried out in two different countries - Scotland and Canada. Forchuk & Reynolds (2001) stated that all participants described a positive nurse-patient relationship as a cornerstone of their inpatient care. They pointed out that when the relationship worked, these emerged a feeling of genuine likeness, trust and respect. However, when the relationship failed it was a painful experience. In addition, the Canadian participants identified listening and a friendly approach as crucial in the
Chapter 2 Literature Review

nurse-patient interaction. The experiences of patients reviewed in the local study showed similar findings. Zammit (2008) identified patients' experiences that resulted in failure to maintain a therapeutic relationship. The reason was that, at times, the attitude of the nursing staff created an atmosphere of fear. One negative encounter can profoundly impact a patient's attitude even though patients generally feel positive about the nursing staff.

Good communication is essential for quality nursing care. However this is not always achieved. This was also confirmed by Mc Cabe (2004) when he identified statements that nurses are more concerned with tasks rather than providing sufficient information to patients on the ward. Chant, Jenkison, Randle and Russel (2002) argued that nurses do not communicate well because of an organisational culture. Traditional nurses were not encouraged or supported by ward or hospital management to establish therapeutic relationship with patients. Bowles, Mackintosh and Torn (2001) support this view but add that criticism of nurse communication may be unrealistic as no benchmark for effective nurse-patient communication currently exists. In order to establish a benchmark for effective nurse-patient communication it is essential to be aware of patients' experiences and views of their own needs.

2.4 The Effect of Working With the Mentally Ill

Lack of experience in the mental health field among the nursing staff was identified as affecting the nursing care process of the mentally ill in the medical wards. Several authors have stated that individual carers who have family or friends with mental
illness perceive such people as less dangerous and desire less social distance from them (Corrigan et al, 2001; Holmes et al, 1999; Link & Cullen, 1986; Penn et al, 1994, Penn et al, 1999).

Brinn (2000) compared the emotional reactions of qualified staff who had completed a psychiatric module in the field of mental health with non-qualified staff. Results showed that qualified staff who had more working experience in the field of psychiatric nursing felt better equipped to care for clients with psychiatric diagnosis.

In a later study carried out by Caroll (1993) it was shown that the environment of working with the mentally ill can affect the perceptions that nurses hold towards the mentally ill. Caroll interviewed and grouped 248 different professional and examined their views. The group consisted of addiction counsellors, general nurses, prison nurse officers, psychiatric nurses and social workers. Findings indicated that addiction counsellors placed first for their positive perception. They were followed by mental health nurses and social workers. General nurses were marginally negative in their attitudes. Prison nurses had the most negative attitude, as a result of their dual role, that of guards and nurses. It was also noted that the difference in perception was largely dependant on their work area, e.g. respondents who worked in the AIDS unit were markedly more positive than respondents working in other areas, such as A&F departments.

Anderson (1997) took this step even further, by comparing and exploring the attitudes of 80 nurses working in the same locality. Nurses who are Community Mental Health
Nurses (CMHN) with 5 to 10 years experience were compared with accident and emergency nurses (A&E) with 5 to 10 years. The A&E department nurses with 10 years of experience were more positive in their attitudes towards patients with mental illness. In contrast, CMHNs with 5 years experience appeared to hold more positive attitudes towards mentally ill than the CMHNs with 10 years experience. The reason for this might be that educational experiences and the transition from novice to experienced practitioner have a much more latent and complex influence. One of the major limitations of this study is that it had to be restricted to the CMHNs and an A&E department in one area of the country. Furthermore, it is recognized that both groups of nurses may have undergone different forms of training and education in mental health a fact which could have altered the findings.

2.5 Experiences, Education and Support

In view of the evidence that general nurse in medical wards have difficulty in caring for patients experiencing mental health problems, Sharrock and Happel (2006) collected data from 4 nurses via semi-structured interviews to identify the reason for this. Participants were asked to describe their experience in the previous two months of caring for at least one patient who experienced a mental health problem during their stay on the medical wards. Responses clearly indicated that these participants had a positive attitude towards people with mental health problems. However, the participants highlighted a discrepancy between the holistic philosophy encouraged at undergraduate level and what is often experienced in practice. The need to care for the mind and the body in a holistic manner was important to the participants, but they
worked in an environment that focused on the physical, and organised nursing work into tasks. In addition, three of the participants stated that their undergraduate education was fragmented, with mental health and general nursing theoretically and clinically separated. The participants appeared to have difficulty in reintegrating the fragments of their undergraduate education to implement it with the multiple patient needs on the medical wards. However, participants could not determine whether the practice was congruent with the positive attitude presented to the researcher and their skills were as limited as they perceived.

On the other hand, Reed and Fitzgerald (2005) showed how education and support at a post graduate level affected the nursing care in the general hospital setting. In a qualitative descriptive study 10 nurses, from two medical wards were interviewed. Participants from one ward had some education and support from mental health nurses whilst the other ward had no support or education at all. Participants indicated that the nature of their experiences, whether positive or negative, had had the most significant influence on their attitudes. However a number of factors appeared to have influenced these attitudes: inequality in the provision of specialist mental health services, the high perception of danger due to the unsafe environment, lack of time, support, education and the stigma of mental illness. Those receiving support and education during their work experience described increased comfort when caring for patients with mental illness. Besides, they identified mental health care as being an integral part of nursing.
One of the main limitations of this study is that the research was limited to a small sample of nurses in one rural hospital, and thus cannot be generalised.

Arguably, Olade (1983) claims that attitudes to mental illness may be based not only on experience, education and support but also on values and beliefs shaped by environmental and social influences. It is possible that experiences related to these studies, and their interpretation, relied heavily on existing attitudes.

2.6 Nursing the Mentally Ill on the Medical Ward

People with serious mental illness are at increased risk of suffering from physical illness such as heart disease, diabetes, infections and respiratory diseases (Wallis, 2006). Apart from the physical illness, the same patients may be diagnosed with psychorganic and dual diagnosis. These client groups are seen as patients who disturb the atmosphere in medical wards, where there are patients suffering from illnesses and other injuries causing severe pain (Mavundla, 2000).

Mavundla (2000) explored professional nurses’ perception from different aspects of self, patient, feelings and environment that hinder nursing care for the mentally ill. Nurses in this study were of the opinion they needed to be skilled and knowledgeable to understand the patients. Negative perception was associated with the lack of knowledge and skills whereas the positive perception was associated with the possession of knowledge and skills. Perceptions of patients were found to be very negative since the same nurses claimed that they lacked both knowledge and skills. Before attending to
patients with a mental illness nurses experienced feelings of fear, despair and frustration that made it difficult to render the proper care. They perceived mentally ill patients to be violent, noisy and tended to wander around. The ward environment, with its staff shortages and overcrowding, was additional problem that made it very difficult to render adequate nursing care to mentally ill people.

In line with the above, Harrison & Zohhaddi (2005) conducted a thematic content analysis of which four themes emerged where the same nurses gave reasons for their failure to provide proper care. The first theme highlighted, disruptive behaviour: mentally ill individuals repeatedly calling out and shouting, wandering around the ward and interfering with other patients’ belongings. Role conflict was the second theme where staff perceived themselves as being there to attend to physical needs. The third was professional distress, as participants found the experience exhausting and emotionally draining. Professional resources, being internal and external to nurses, were the last theme that emerged. The internal resources included, lack of skills, lack of knowledge and lack of time, whilst the external, included inadequate access to training, lack of support and understanding from management, and lack of access to clinical supervision.

In collaboration with the above Reed and Fitzgerald (2005) also identified attitudinal themes of the medical nurses with no mental health education giving care to mental health patients on a medical ward. Participants stated that nursing the mentally ill ‘was not their role’. They disliked caring for people with mental health problems and would
not do so if they had a choice. Other participants stated that they ‘feared’ the mentally ill and did not feel comfortable caring for people with mental health problems despite expressing a desire to help. Some nurses who expressed fear appreciated the patients’ need for care but felt threatened by the potential for harm to themselves and others. Their lack of knowledge caused them to feel inadequate and unsure of their skills in providing care for these patients. However the study found that positive experience was promoted through education and support, which was required by nurses to improve care and attitudes.

2.7 Stigma, Stereotype and Prejudice

The stigma attached to mental illness is widespread (Lauber, Nordt, Falcato & Rossler, 2004). Different forms of stigmatising attitudes are known, mainly stereotyping, prejudice and discrimination. These attitudes are generally negative. Stereotypes result from judgements that characterise collectively agreed upon qualities of groups or persons. They mostly represent the false pairing of person and behaviour, for example, that individuals with mental illness are dangerous (Lauber & Rossler, 2007). Stereotyping has devastating consequences because people quickly generate impressions and expectations of individuals who belong to a stereotyped group. These impressions give rise to prejudice, which is, a consenting emotional reaction to a stereotype. Consequently, people with mental illness are stereotyped as dangerous, thus, individuals are afraid of them (Lauber & Rossler, 2007)
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Having a mental problem often carries with it a stigma and nurses are not immune to feeling negatively disposed towards such patients (Brinn, 2000). Moreover, the negative attitude resulting from the stigma may also affect the physical care given to the mentally ill patients while being cared for on the medical ward (Druss & Rosenheck, 1997).

To examine the effect of stigma and the contribution to the management of care towards the mentally ill. Chow, Kam & Leung (2007) distributed 1,200 questionnaires devised with case vignette of either a psychiatric patient (case group) or a diabetes patient (control group). It was found that two thirds of the statements in the case group contained negative connotations. Psychiatric patients in the case group were assumed to lack the capacity to give consent and were excluded from the decisions regarding their own treatment options. Participants maintained that mentally ill patients lacked the ability to give a constructive opinion about their treatment options and to make decisions about their treatment plans. Participants also felt that it was inappropriate to allow mentally ill patients to go home or leave on request after being admitted on the medical wards. Participants believed that psychiatric patients would be more violent than others. They tended to adopt a self-protective way of handling mentally ill patients in the medical wards to avoid unnecessary conflicts. To support the stigmatisation held by the participants questions, were asked to explore each subject’s views about psychiatric patients. The most common responses in descending order of frequency were: such patients are unstable, emotional, dull, difficult to understand and to be pitied.
An alternative approach to understanding stigma and the attitudes of health care professionals towards the mentally ill patients in a general hospital would have been through conducting focus groups. An other limitation to this study is that it was only carried out in one general hospital.

Hunt (1996) came to the conclusion that stigmatisation occurs in the caring professions because it serves to rationalise the avoidance of a patient who is somehow different. By avoiding the mentally ill patient, nurses concentrate their efforts on others who will more than likely reassure them that they are competent as they carry out procedures designed to meet physical needs. The researcher came to this conclusion after 17 staff nurses out of the 64 nurses that participated in the study commented that their training was insufficient to equip them to deliver the care to an adequate standard to patients with schizophrenia and dementia. Furthermore, Heginbothan (1998: 125) gave another rational why nurses avoid the mentally ill. He stated that general hospital nurses are often under stress when attending to patients with physical and mental illness as they believe that such patients should be admitted to the psychiatric unit instead.

2.8 The Effect of Education on the Nursing Care

Nurses see education in mental health as a priority to help them care for mentally ill patients more effectively.

Puntil (2005) reported that nurses who are interested in medical nursing are not usually interested in psychiatric nursing while nurses with an interest in psychiatric care are not interested in caring for medical patients This is in line with the findings of Gerald and
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Farell (1991) where he found that general nurses tended to achieve most success in estimating physical needs, whereas psychiatric nurses did best at estimating emotional needs. This was predicted because of the difference in training and practice emphasis in each setting.

This is also in line with what Yeo, Parker and Mahendrian (2003) found. He compared enrolled nurses with no mental health education with psychiatric trained registered nurses having an 9-18 month post basic course in psychiatric. Prior to the comparison, all nurses received a one day lecture on management of psychiatric patients, and two days of assignment to specialised wards and departments. However, findings indicate that Enrolled Nurses were constantly less accurate in giving the care to the mentally ill than those trained in psychiatric care. This simply proves that having an occasional orientation programme is ineffective. The author identified important issues for considering more education programmes and training, especially for Enrolled Nurses, which included diagnostic components, such as case studies and participation in case presentations.

In a previous study Olda (1983) had concluded that positive change occurs in attitudes towards people with mental health problems as a result of better education. This research shows that the provision of a relatively small amount of education can be effective when delivered appropriately in the workplace in an ongoing manner.

To support the above, Baston and Simms (2002) claimed that education on mental health issues is essential and has to be on-going if one really wants to develop proper nursing skills. In his study, he identified staff learning needs prior to an education
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programme and before teaching took place. Another questionnaire in the same format was repeated 12 months after the commencement of the education programme. In this study staff continued to identify many areas for training. This was achieved by having a lecture per week with repeated sessions at intervals. The same staff were encouraged to spend time with the mental health team and members of the team spent time with the learners whilst on duty. This is also in agreement with both studies of Holmes (2003) where participants felt that training should be ongoing, on or near the ward, and that post-qualification training would be a great benefit. Role modelling was highly beneficial. Participants wanted training with formal accreditation as a means of developing and recognising expertise. However, participants unanimously agreed that training alone would not improve care. They believed that training must be supported by greater access to and more integrated work, with the introduction of liaison mental health services. To remove barriers to communication and lesson response times, Holmes et al (2002) also suggested that each acute general hospital should have access to specialist mental health professionals in the form of a Mental Health Liaison Team (MHLT). The MHLT should be based in the general hospital setting and work in a flexible way, be available to undertake both direct patient and nurses assessments and provide advice, support and supervision for non-mental health colleagues (Harrison, 2006).

2.9 The Effect of the Mental Health Nursing Support

The Psychiatric Consultation–Liaison Nurse (PCLN) has an important role in supporting nurses and other health care professionals in caring for patients experiencing
mental health problems in a non-psychiatric environment (Sharrock & Happell, 2001). It is a service provided to patients who are admitted to a general hospital for a non-psychiatric condition and whose case may be enhanced by the expertise of health workers with mental health care training (Psychiatric Services Division, 1996).

Nelson and Schilke (1976) defined the characteristic of the PCLN as a consultation with the nursing staff. This provides the education of patient care team, direct specialized psychological care to patients and their families, expertise in psychiatric problems, normal and abnormal responses to illness adaptation of patient and family, understanding of the interrelationship between physical and psychological states, knowledge of systems theory, group processes and liaison between disciplines. They further stated:

"The unique aspect of her role is that it provides, through psychiatric expertise, a framework within which the nursing staff can understand the patients' experience of illness and hospitalisation and their own experiences of caring for patients within the hospital system. Also, as a result of her close alignment with nursing, the liaison nurse frequently is the psychiatric liaison team's link to the daily care and management of the patients."

(Nelson & Schilke, 1976 p. 64)
Happell and Sharrock (2002) evaluated the impact of the PCLN role. Focus groups were conducted with 17 nurses employed at a large general hospital in Australia. To avoid any possible coercion, participants were asked to contact the co investigator directly if they were interested in participating. The co investigator was unknown to the participants and was not employed at the hospital. The responses of participants were overwhelmingly positive. Four themes emerged from this study: helping staff, making contact, implementing strategies and utilizing attributes. The support of the participants for the PCLN role strongly suggests the importance of this position. It is important to note, however, that this study does have limitations. While the 17 participants were able to provide a number of different perspectives and opinions, this number is not sufficiently large to allow these findings to be generalized to the wider hospital. Furthermore, the study was undertaken in one hospital. It is therefore not possible to accurately estimate the degree to which similar results might be obtained in another hospital setting.

Liaison mental health nursing (LMHN) is an evolving specialist area of mental health nursing in the United Kingdom (U.K.). It has many similarities with psychiatric consultation liaison nursing (PCLN) practised in the United States of America (USA) (Roberts, 1997).

In a qualitative study, Roberts (1998) interviewed a single focus group of 3 nursing staff of a haematology ward in Britain where LMHN services were provided on a regular basis. The nurses valued the LMHN availability and accessibility and appreciated the specialised expertise and skills in counselling that the LMHN offered.
Assessment of patients' reactions to illness, input into managing mental health problems of patients, facilitating skill development in the nursing staff and assisting nurses in development of the nurse-patient relationship were specifically identified as a significant contributions made by the LMHN. Whilst this was also a small group, the fact that the participants knew each other meant that rapport was quickly developed. Another limitation was that the group interviews were conducted by the same nurse providing the service to the participants, which may have influenced the honesty and reliability of the comments made by participants. Although the findings of this study cannot therefore be said to represent the views of the whole ward team, it did provide a useful insight into them. In as much as they are consistent with previous findings, they have implications for the Liaison Mental Health Nurse (LMHN) role generally.

Whilst the LMHN is not being proposed as an alternative to a psychiatrist, it may be viewed as a cost-effective member of a liaison psychiatric team, or as an independent practitioner (Roberts, 1997). Moreover, the report of a joint working party of the Royal College of Physicians and the Royal College of Psychiatrists (2003), describes what the components of a liaison psychiatry team should be. It states that psychological care for an entire general hospital is best delivered by the multidisciplinary liaison psychiatry team based at the general hospital site. It suggests that a typical general hospital comprising 600 beds and serving a population of 250,000 should have one consultant liaison psychiatrist, one trainee doctor, five mental health nurses, a secretary and one or two health or clinical psychologists. It states that the numbers should be modified upwards according to local conditions.
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2.10 Conclusion

Patients with physical and mental health co morbidities are, more often than not a high utilization group. Mentally ill patients can identify the challenge they pose to the general nurses when being cared for in the medical wards.

This presents an opportunity to enhance the care given to this client group as well as to reduce health care costs by improving the way that health care services are presently being provided in the medical wards. Nurses working in the medical wards lack the necessary skills, knowledge, experience and the tools to deal with the mentally ill. Support, formal or informal, and having the resources in place, also affect the delivery of care to this client group. Education is the key to changing the attitude and perceptions amongst nurses towards this client group. However, together with education experience ranks as a necessary requirement. If nurses do not perceive themselves competent to care for the mentally ill, they will never be able to care effectively for this client group. Mental health training should be specifically tailored and designed to meet the same needs of nurses caring for patients with physical and mental illnesses on the medical wards.
Chapter 3 - Methodology

3.1 Introduction
In order to answer the research questions mentioned in the introductory chapter, and to obtain all the necessary information regarding the needs of nurses caring for the mentally ill on the medical wards, different study methods were made use of. These methods are:

- Data collection from the registers of Departmental Nursing Managers (DNMs) of Mater Dei Hospital (MDH) with the aim to establish the number of nurses working on the medical wards and also their qualification.
- Self-administered questionnaire to all nurses working in the medical wards to identify the needs required to care for the mentally ill.
- Structured audiotape interviews to all Nursing Officers and Deputy Nursing Officers to evaluate the needs to care for the mentally ill.
- Semi-structured audiotape interviews with key persons who can influence the nursing care on the medical wards.

3.2 Defining Needs Assessment
The first step in planning any professional development activity is to assess the learning needs of the target group or individual so as to determine the structure of the programme in terms of objectives, organization, which must be clearly defined during the planning process (Lynore & Desilets, 2007). Alspach (1995) defines a need as “an
interruption along continuum between a learner's present level of cognitive, affective or psycho motor performance and the desired or necessary level of knowledge or performance" (p.33). To identify needs, a planner should collect as much information as time and resources allow. Because various people view needs differently, it is important to gather data from various perspectives (American Nurses Credentialing Center Commission on Accreditation, 2006)

3.3 The Study Design

A descriptive survey research design was used to identify the needs of nurses to care for the mentally ill and gain more information about this particular field. As Frankling and Cutler (2000) observed, health planners use descriptive survey research as the basis for needs assessment for developing health strategies, programmes and physical plants. A research design is the planning of any scientific research from the first to the last step. In this sense, it is a programme to guide the researcher in collecting, analysing and interpreting, observed facts (Bless & Higson-Smith, 1995). Bowling (2002) stated that the data obtained through this type of research can then be used to justify and assess current conditions and practices, or to make plans for improvement. To increase data credibility, data was gather from different sources which include nurses, NOs, DNOs, as well as other Key Persons.

This study was a cross sectional study using mixed approach methodologies, which could be used to attain the subject objectivity (Pope & Mays, 1995). Qualitative research tries to understand events and situations from the perspectives of the
individual concerned while quantitative data involves the systematic collection of numeric information often under controlled condition (Polit & Hungler, 1993).

A descriptive survey research was used to meet the set of objectives (see section 1.7). A study on this particular topic has never been carried out.

3.4 Research Setting
The study was conducted on the medical wards at Mater Dei Hospital in Malta. The island of Gozo was excluded from the study due to time limitation and travel time requirements. Private hospitals were also excluded from this study due to time constraints. The reason for choosing medical wards from the only public hospital in Malta is that nurses working in these wards receive a higher number of different client groups. On the other hand, general nurses with little or no psychiatric background are the major providers of hospital care. The medical wards in Malta have the highest mean length of patients’ stay of 6.7 days with a mean bed occupancy rate of 106.3% (Annual Report, 2003). A recently published report of the MDH showed that during 2008, 7,673 patients were discharged from the medical wards (Annual Report, 2008).

Dr. Vassallo (2009) also stated that admissions rate to MDH will increase every year. “The reason for this is that thanks to advances in medical technology, and the fact that people are living longer, hospitals today can offer procedures which were unheard of a few years ago.” Hence that Mater Dei Hospital may well be the victim of its own success.
Mater Dei Hospital provides medical care, in both male and female wards. Male wards consist of M1, M3, M5, whereas M2, M4, M6 are female wards.

There are specialised medical wards which cater for patients with specific diseases. These are the Infectious Disease Unit (IDU), Neuro Medical Ward (NMW), Medical Investigation and Treatment Unit (MITU) which also caters for the haematology patients, Emergency Admission Ward 1 (EAW1), Coronary Care Unit (CCU) and the Cardiac Medical Ward (CMW). All these were all excluded from this study.

In order to answer the research question and to reduce bias, only nurses working in the general medical wards were selected for this study. This means those nurses working in M1, M2, M3, M4, M5 and M6.

Bias may occur if the sample does not represent the population of interest (Bowling, 2005). Hence, nurses working on the specialised medical wards were excluded since their needs may differ from those of the other nurses working in the general medical wards. Nurses working in specialised areas usually cater for patients with similar medical conditions. As a result the ratio of patient to nurse is generally smaller than that found in the general medical wards.

Nurses in the general medical wards have different levels of knowledge as well as qualifications. The nurses participating in this study were Enrolled Nurses, Staff Nurses (SNs) in possession of Diploma or a Degree, those with Conversion Course and
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Traditional Nurses. Each ward has a Nursing Officer and a Deputy Nursing Officer who also took part in this study.

The first part of the study included the collection of information about the nursing staff (mentioned above) at the new MDH from registers of the Nursing Manager Department. The information included the number of nurses employed in each ward, their qualifications and the roster schedule.

The second part of the study included the distribution of self-administered questionnaire to the entire nurses (N=54) working within the same medical wards with the Ministry of Health, Elderly and Community Care (MHECC). Thus, this part of the study was conducted in all medical wards excluding the speciality medical wards. The nurses participating in this study work on a regular roster. Other nurses working in the relieving pool or an irregular roster were excluded from this study.

The third part of the study included semi-structured interviews with Nursing Officers and Deputy Nursing Officers (N=10).

The fourth part of this study included interviews with two Key Persons responsible for the administration of the medical wards involved in this study. The Key Persons were people from the higher authority in the nursing management.
3.5 Target Population and Sampling Techniques

3.5.1 Nurses

Having outlined the research topic, “A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards- The nurses' perception”, I then identified the ‘relevant population’ these were the nurses who are constantly caring for patients with physical and mental illness on the medical wards.

This second part of the study involved all the nurses working in the general medical wards mentioned in Section 3.1. It is to be noted that not all nurses working in the medical wards have the same years of experience or the same level of educational. This target population was chosen because they form the biggest number of nurses employed by the Health Department. Besides it is the general nurses who come across patients with physical and mental illness. An other reason for choosing the general nurses working in the medical wards is because they are the ideal candidates to answer the research question as well as being more accessible to the researcher.

All nurses permanently working in the medical wards (N=60) formed part of the target population. However all nurses working in Gozo, those on maternity, emigration or study leave, part-timers working irregular hours and relievers were excluded from the study. Polit & Hungler (2002) stated that the larger the sample the smaller the sampling error. As the sample size increases, the averages not only get closer to the true population value, but the difference in the estimate between samples gets smaller as well.
3.5.2 Nursing Officers (NO) and Deputy Nursing Officers (DNO)

The third part of the study involved all NOs as well as all the DNOs (N=12) working in the medical wards. This target population was chosen because both NOs and DNOs work close to the nurses giving direct care to the patients. Apart from that they can easily observe the staff’s needs to care effectively for the mentally ill.

3.5.3 Key Persons

The fourth part of the study involved the key persons who are highly knowledgeable about the nurses’ needs under study. Key persons are those people in higher authority in nursing management who can take part in the implementation of educational activities as well as support nurses in the medical wards.

The persons selected are employed by the Ministry of Health, Elderly and Community Care (MHECC) and they are the people who have most contact with the Nursing Officers, Deputy Nursing Officers and nurses.

3.6 Research Method

This study aimed to use multi-dimensional methodological approaches in order to reach its aim and objectives because:

- Quantitative methods are advocated in view of their practicality. These methods are generally less time consuming and require less personal commitment. It is also possible to study larger and more representative samples, which can provide an overall picture of a larger category.
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- Qualitative research has often to be confined to the study of small numbers because of practical limitations. It is more suited to providing an in-depth insight into a smaller sample of people.

(Haralambos & Holborn, 1995)

Patton (1990) and Pope and Mays (1995) are in favour of using both qualitative and quantitative data to be collected in the same study. Since both methods involve differing strengths and weakness, they constitute alternative but not mutually exclusive, strategies for research.

3.6.1 The Questionnaire

A self-administered questionnaire was chosen for nurses as it allows a large number of subjects to be surveyed in a relatively short period of time (Polit & Hungler, 2002). The questionnaire chosen for this study is currently being used in a variety of settings internationally. Countries in which the scale has been used include the U.K., Australia, Ireland, Canada, Ireland, Holland and Fiji. Permission to use this tool was given by J. Baker via e-mail (see Appendix V).

A questionnaire is a standardised list of questions requiring both objective and personal answers (Franklin & Cutler, 2000). This method is less of a social encounter than interviews and so eliminates the problem of interviewer bias. It is only suitable when the issues and questions are straightforward and simple, when the population is 100% literate and speaks a common language. Thus, this was suitable for nurses.
Self-administered questionnaires have other advantages. They are unambiguous and answers are easy to count providing quantitative data for analysis (Polit & Hungler, 2002). Sweet (1990) suggests that self administered questionnaires allow respondents more freedom, and provide more accurate answers.

Pre-coded response choices may not be sufficiently comprehensive and not all answers may be easily accommodated (Bowling, 2002). Respondents might choose inappropriate answers that might not fully represent their views and elimination of control leaves respondents free to answer questions in which ever order they choose. According to Haralambos and Holborn (1995), fixed-choice questions do not allow the respondents to qualify and develop their answer, which makes it difficult for the researcher to know exactly what is being measured. However the Likert Scale questions found in this questionnaire from 1 - 25 (see Appendix II) are to be coded from 1 to 7.

The semantic differential in (see Appendix II) was designed to measure the connotative meaning of concepts. The respondent is asked to choose where his or her position lies, on a scale between two bipolar objectives.

3.6.2 The Structured Interview

The structured interview with the nursing officers and deputy nursing officers was conducted in four parts. This was carried out by face-to-face structured interviews. Structured interviews pre-establish the set of questions in a uniform manner and the
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pre-determined format cannot be changed by the interviewer (Franklin & Cutler, 2000). They aim to achieve as close as possible a standard format between interviewers and respondents.

In fact, it has been pointed out that structured interviews try to measure facts, attitudes knowledge and behaviour in such a way that if they were repeated at another time or in another area the results would be comparable (Bowling, 2002).

A disadvantage of this type of interview is that the interviewer is not able to pursue topics of interest that arise during the actual interview. For this reason open ended questions were included in the interview as they give freedom to respondents to let their thoughts roam freely, unhindered by a prepared set of replies (Oppenheim, 1992). Thus, open-ended questions enable the researcher to explore all the possible alternative responses (Polit & Hungler, 2002).

3.6.3 The Interview with Key Persons

These interviews were semi-structured. This method was selected for its flexibility, while presenting a compromise between more structured research methods like questionnaires and more in - depth methods (Haralambos & Holborn, 1995). Semi-structured interviews utilise a general interview guide where issues are predetermined but the question format and the exact content is not pre-specified for this allows any adaptation necessary during the interview (Franklin & Cutler, 2000). Thus, the participants can expand and clarify their responses as these rely on the
assumption that the perspective of others is meaningful, knowable and able to be made explicit (Patton, 1990).

The disadvantage of interviews is that there is subjective interpretation on the researcher's part (Haralambos & Holborn, 1995). Also, as Oppenheim (1992) highlighted, the interview, unlike most other techniques, requires interpersonal skills of a higher order, such as putting the respondent at ease, asking questions in an interesting manner, noting down the responses without upsetting the conversational flow and giving support without introducing bias.

3.7 Research Tools

3.7.1 The Questionnaires Used for Nurses

The questionnaire research tool used to collect data has already undergone validity and reliability testing since it has already been used by several other researchers. Therefore the researcher did not have the need to recheck the tool for validation and reliability. However a pilot study was carried out to ensure that all the respondents understood the questionnaire. The aim of this measure is to develop an understanding of the attitudes and knowledge of staff in medical wards towards patients with mental health problems, in order to identify nurses' needs. The questionnaire is constructed in three parts (See Appendix II).

The first part of the study involved a demographic data. The second part consisted of the Likert Scale where questions are coded from 1 to 7, left to right (7=best attitude),
and the scoring is reversed for negatively worded statements (Roberts, 1999). These are questions 12, 23, 24 and 25 (these are scored 7 to 1, right to left).

The third part consists of the semantic differentials, of a unipolar scale of 0 - 10. A measurement should be taken from the negative word, for example - dangerous. To the indicated staff mark. Scores should be calculated to one decimal place, for example, 4.4. The line is ten centimetres with 5 being the mid point, <5 indicates a negative perception.

3.7.2 **Structured Interview Used for the NOs and DNOs**

The researcher constructed a structured interview, which was tested for reliability and validity in a pilot study. Open and close-ended questions were used in the structured interview. The questions of the structured interview were constructed following a literature review on the subject. The interview questions were divided into four parts (see Appendix II).

The first part consisted of the demographic data. This was purposely placed in the first part of the interview questions because they are easy to answer and so will encourage respondents to continue answering the rest of the questions.

The second part was related to skills the nurses had with mentally ill patients. The third part dealt with perceptions of nurses towards the mentally ill. Knowledge was the fourth part, which assessed the nurses’ educational needs from their point of view.
3.7.3 Semi Structured Interview Used for the Key Persons

The semi structured interviews (See Appendix II) which were also developed by the researcher following literature review and the analysis of data collected, consisted of guidelines issues that were read aloud to the respondents. The semi structured interviews was so designed as to enable the two people in higher authority in nursing management to obtain a more comprehensive overview of the needs of nurses working in medical wards and also to assess whether these needs interfere with the nursing care.

The same interviews comprised of open ended questions to allow expansion to relevant topics regarding the person being interviewed. The same participants (N=2) are also more knowledgeable about the nursing services being offered in the medical wards.

3.8 Reliability and Validity of the Tools

3.8.1 Reliability

Reliability refers to the reproducibility and consistency of an instrument. It refers to the homogeneity of the instrument and the degree to which it is free from random error (McKinley, Marku-Scott, Hastings, Fenech & Baker, 1997). There are certain parameters, such as test-retest, intra-reliability and internal consistency that need to be assessed before an instrument can be judged to be reliable (Bowling, 2002).

In this study the questionnaire used has already gone through preliminary analysis, which reduced the 64 original questions to 33 (Baker, 2005). In the original study, components were drawn from a number of previously validated attitudinal measures.
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(Singh, Baxter, Standen & Duggan, 1998; Read & Law, 1999). Additional questions were constructed by the authors as a result of reports, guidance documents and their experience (Baker 2000; Higgins, Hurst & Wistow, 2000; Bowles & Bowles, 2000; Department of Health, 2002). Five components were identified which accounted for 42% of the variance. The questionnaire used in this study has achieved a good internal reliability, with Cronbach's alpha of 0.72. A reliability of coefficient of 0.72 implies that 72 per cent of the measured variance is reliable and 28 per cent is owing to random error. A low coefficient alpha indicates that the items do not belong to the same conceptual domain (Bowling, 2002). Moreover, one is to note that reliability affects validity. An unreliable scale inevitably has low validity (Bowling, 2002).

3.8.2 Validity

Validity is an assessment of whether an instrument measures what it aims to measure. It should have face, content, concurrent, criterion, construct (convergent and discriminant) and predictive validity (Bowling, 2002).

In this study, the tool was tested for content validity. This relies on making a judgement about the content of the tool relative to its intended purpose (Nolan & Behi, 1995). The simplest form of content validity is face validity, where the instrument is given to an expert, who assesses the questionnaire at face value. Such a method is very subjective and cannot stand on its own. Hence, the researcher contacted three experts from the management, research and mental health nursing fields, who are conversant with the topic of needs assessment. These experts were given copies of the
questionnaire as well as being informed of the purpose and objectives of the study. They were asked to evaluate the instrument individually, which allowed the researcher to identify any necessary changes.

3.9 **Pilot Study and Modification**

A pilot study is a small scale preliminary study conducted before the main research in order to check the feasibility or to improve the design of the research (Polit & Hungler, 1999). A pilot study is usually carried out on members of the relevant population, but not on those who will form part of the final sample (Haralambos & Holborn, 1995). This is because it might influence the later behaviour of research subjects if they would have been involved in the research. Pilot studies can be useful for a number of reasons:

- interviews or questionnaires may be tested to ensure that they make sense to respondents
- may help researchers develop ways of getting the full cooperation of those they are studying
- may be used to develop the research skills of those taking part in the study and
- may determine the continuity of the study.

(Haralambos & Holborn, 1995)
3.9.1 Questionnaire

The questionnaire was not tested for test retest reliability since it has already gone through preliminary analysis. However, the questionnaire was piloted to ensure that the minimal changes made were measuring what they were supposed to measure. A minor amendment in one of the questions asked in the questionnaire had to be made to obtain a better answer.

The pilot study was conducted two weeks prior to the actual study in six wards. Questionnaires were personally handed to 6 nurses in each of the participating wards. The six (N=6) nurses who took part in the pilot study were later excluded from the main study.

Initially the questionnaire was distributed to the nurses and verbal feedback was given on layout, wording, whether it was sufficiently comprehensive and time taken to complete. The questionnaire was re-piloted with the same nurses. No problems were identified.

3.9.2 Structured Interviews

One NO and one DNO were randomly selected to take part in the pilot study. The two participants were then excluded from the main study. The aim of the pilot study was to check the clarity of the instructions and questions and to assess the suitability of the format of the questions. To avoid bias, care was taken to maintain objectivity and keep each interview focused on context as allowed by Smith (1992).
3.9.3 Semi Structured Interviews

A pilot study was conducted to pre-test the guidelines of the semi structured interview. This involved three participants from the field of nursing and management. No changes were deemed necessary.

3.10 Ethical Considerations

Permission to carry out this survey was sought from the Hospital Administration and Ethics Committee. Ethical considerations entailed obtaining permission to administer the interview and questionnaires from the Dissertation Panel at the Institute of Health Care (Data Protection Act, Act XXXVI of 2001).

For the study to be carried out informed consent had to be given by all participants. Informed consent means that participants have adequate information regarding the research, are capable of comprehending information and have the power of free choice to enable them to consent to or decline from participating in the research voluntarily (Bork, 1993).

3.10.1 Voluntary Participation, Informed Consent and Participant Autonomy

In view of the ethical demand of participant autonomy, the researcher is obliged to ensure that potential participants are given as much information as possible in order to voluntarily decide whether or not to consent to participate in the study (Rubin &
Babbie, 2001). This entailed giving potential participants a thorough research information letter together with a consent form which they were required to sign.

Individual protection and confidentiality as regards privacy and protection from manipulation by research was established during and after the interviews and questionnaires.

Respondents of the questionnaire were instructed not to put their names anywhere on the form, to ensure complete anonymity. In the case of the interviews with the DNO, NO and the Key Persons anonymity was not possible but appropriate confidential procedures had to be implemented, as suggested by Polit and Hungler (1999):

• an identification number was assigned to each participant
• identifying information and lists with corresponding identifying information were kept in a safe place
• access to information was restricted to a small number of individuals on a need-to-know basis
• identifying information was destroyed as quickly as possible and
• research information was reported in an aggregated form or through the use of pseudonyms
• tape recordings used during the interview were erased immediately after transcription and data analysis were completed.
Chapter 3 Methodology

Transcriptions were also coded and used only for the purpose of the study. Information derived from the key person was treated in the same way as information derived from interviews.

Finally, Franklin and Clutier, (2000) in their three-point guide show us the importance of exercising moral responsibility towards research participants:

"To our subjects first, to the study next and ourselves last."

3.11 Data Collection Procedure

3.11.1 The Self-Administered Questionnaire

The list of all the nurses in the sample and their respective wards was essential for the data collection procedure. Every selected nurse was personally contacted at the place of work on the first day of Shift-Day 1, as illustrated in Table 1. On encounter each nurse was introduced to the study, asked if willing to participate and if consent was given a questionnaire was than handed over. Information about the study was printed on the consent form. All writing was submitted in English (Appendix III).

According to Oppenheim (1992), personal distribution as opposed to mail, has the benefit of a degree of personal contact and ensures a higher response rate. In this way, the major disadvantage of questionnaires is minimised.

If nurses chose to participate, the questionnaire was collected after five days on the first day of their next Schedule-Day 3. Hence a date was set to collect the
questionnaire. If the questionnaire was not completed by the agreed date, another date was fixed, preferably on the second day of their shift Schedule-Day 4. Nurses, who were not on duty when the researcher went on their ward, were contacted on their next day duty. Any nurse on long vacation or sick leave, was eliminated from the study. All nurses in the list were followed so as to increase response rate. It took approximately two weeks (14 consecutive days) to distribute and collect questionnaires from all nurses in the sample. The best time to collect the questionnaires was between 4pm and 7pm (when the workload is usually lighter).

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Day 2</td>
<td>Night</td>
<td>Rest</td>
<td>Off</td>
<td>Day 3</td>
<td>Day 4</td>
</tr>
</tbody>
</table>

Table 1. The shift schedule of an individual nurse

Several measures were taken to overcome a low response rate, which is a major limitation of questionnaires. These included instructions for participants, a statement displayed on the front of the questionnaire promising confidentiality, personal distribution of the questionnaire and the use of closed questions, which are easy and quick to answer (Oppenheim, 1999).

Moreover the length of the questionnaire was reduced by J. Baker so as not to influence participants' responses by inducing fatigue or boredom (Treece & Treece, 1996).
3.11.2 The Structured Interviews

As already stated, the tool consisted of a face-to-face structured interview. After participants had consented that they wanted to take part in this study, they were contacted by telephone to fix an appointment at a time convenient for NOs and DNOs. If an appointment could not be made due to a busy schedule, long leave or any other absentism from work, the participants were contacted at a later date.

At no time the profession of the assessor revealed. However the interviewer revealed that she was a student carrying out study in part fulfilment of the Masters in Health Services Management course. The participants were also informed that the assessor had nothing to do with the management of the Mater Dei Hospital Management Strategies.

The researcher always had available a copy of the permission of the approved study granted by the ethics board in case participants asked for any approvals.

3.11.3 Semi Structured Interview

The participants were contacted by telephone. Information about the topics to be tackled, including an outline of the questions were supplied. If they agreed to take part in the study, an audiotape recorded the semi-structured interview, which lasted about thirty minutes was carried out at the respondent’s office.
Chapter 3 Methodology

The interview was tape recorded as it is an efficient and accurate method to record an interview, though this needs to be done unobtrusively so as not to inhibit the interviewees' responses (Franklin & Cutler, 2000). Protecting participants' identities, interests and well being is a major concern. Participants were free to choose whether to allow the researcher to delete the recorded interview or to have it returned to them after the transcriptions and data analysis were completed.

Anonymity was assured and codes were used instead of participants' names. Sandelowski (1999) warned that the use of quotes in reporting results, may be too revealing especially when the sample is small and when participants in the study are likely to recognize each other in the quotes selected. Thus, permission to use their quotes was sought from participants. It was explained to them that they could withdraw information provided by them at any point in the study.

The structured interviews carried out with the NOs and DNOs were tackled in the same way.

3.12 Data Analysis

Both qualitative and quantitative data were derived from the questionnaires and interviews. Likert Scales and ranking questions were coded and transformed to the Special Package to Social Science (SPSS), which was used to generate tables, graphs and to carry out statistical tests. A statistical significant test was used to analyse the contingency tables. Since the population consisted of <54 participants a non-
parametric test, the Fishers Exact Test was used. The Kruskal Wallis test was used for the semantic differentials since there is one attribute variable and one measurement variable, and the measurement variable does not meet the assumptions of an anova.

Content analysis was used to analyse the structured and semi structured responses. A thorough manual analysis of each question was used and several themes were developed. Narrative description was chosen to form an explanatory theory, based on the experiences and understanding NOs, DNOs and Key Persons interviewed (Rubin & Rubin, 1995).

3.13 Limitations

Due to time and financial constraints, this study only examined the nurses who are employed with the Ministry Health, Elderly and Community Care (MHECC). This may be a major limitation, as the results obtained cannot be extrapolated to other areas since only a small sample of the nursing population was assessed.

The needs of nurses could be identified through interviewing the patients who are admitted to the medical wards. However, patients admitted to medical wards from community, emergency department and other institutions are not assessed for any kind of mental illnesses. Therefore, if patients admitted from the community through casualty do not reveal that they suffer from any kind of mental illness they will not be treated for the illness. Patients receive treatment for mental illness only if they
themselves reveal they have a condition, or if they would have been transferred from the Mental Health Hospital.

The researcher had no formal training in conducting and analysing interviews. This makes the study liable to interpretation bias, interviewer bias and subjectivity. Recall bias relates to respondents’ selective memories in recalling past events and selection bias can occur if the sample differs from those of the wider population (Bowling, 2002).
Chapter 4 - Findings

4.1 Introduction

The overall purpose of this study is to investigate the nurses' needs to care for mentally ill patients through their attitudes, experiences as well as their knowledge. Data was collected using a questionnaire personally supplied by Baker (2005), see (Appendix, V).

Section 1 deals with Demographic Data whilst section 2 deals with the Likert Scale and section 3 deals with the Semantic Differentials. Likert Scale questions which are coded from 1 to 7 left to right (7=best attitude), and the scoring is reversed for negatively worded statements (Roberts, Laughlin & Wedell, 1999), these are questions 12, 23, 24 and 25 (these are scored 7 to 1, right to left). The question numbers correspond to those of the questionnaire. Fisher's Exact Test was used to analyse the data. Later in this chapter data collection was further summarized through another 2 sets of interview questions.

4.2 Background Descriptive Data

Fifty-four (54) questionnaires were distributed to nurses for data collection. The nurses who participated in this study consisted of 28 males and 26 females. Forty (40) questionnaires were returned giving a total response rate of 74.1%. All questionnaires returned were considered valid. These were analysed and yielded the following findings.
Section 1: Demographic Data

Out of the 40 nurses participating in this study, 2 (5%) were Traditional Nurses, 10 (25%) were Staff Nurses/Degree, 17 (42.5%) were Staff Nurses/Diploma, 7 (17.5%) were Enrolled Nurses and 4 (11.1%) were SN (Conversion Course). This distribution of grades is shown in the pie chart below.

![Pie chart showing the distribution of grades](image)

Figure 1. Distribution of participant’s grade

Age:

The participants’ ages ranged from 21 to 61. The number of participants grouped in intervals of 9 years was as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Participants</th>
<th>Percentage of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>28</td>
<td>70%</td>
</tr>
<tr>
<td>31-40</td>
<td>9</td>
<td>22.5%</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>51-61</td>
<td>3</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

Table 2. Distribution of participant’s age
The age distribution is depicted in the pie chart below.

![Figure 2. Distribution of age in sample](image)

**Gender:**

Fourteen (14) male nurses and twenty-six (26) female nurses were recruited for this study, thus resulting in 35% of the sample males and 65% females. The gender distribution is depicted in the pie chart below.

![Figure 3. Distribution of sample by gender](image)
Chapter 4

Findings

Years in Nursing Service:

The participants’ years in nursing service are illustrated in the table and bar chart below.

<table>
<thead>
<tr>
<th>Years in Nursing Service</th>
<th>Number of Participants</th>
<th>Percentage of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td>3-5</td>
<td>19</td>
<td>47.5%</td>
</tr>
<tr>
<td>6-10</td>
<td>10</td>
<td>25%</td>
</tr>
<tr>
<td>11-15</td>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td>7.5%</td>
</tr>
<tr>
<td>20 years and over</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 3. Distribution of participants’ years in nursing service

Figure 4. Distribution of sample per years in nursing service

Years in Mental Health Service:

None of the participants had ever worked in the mental health sector.
Chapter 4  

Findings

Section 2: Questions 1 to 25

The system used to describe the results of each of the questions was as follows:

The question number and the actual question are stated as a subheading, and followed by a histogram to illustrate the frequency of ‘strongly agree’, ‘agree’, ‘slightly agree’, ‘neutral’, ‘slightly disagree’, ‘disagree’ and ‘strongly disagree’ responses. Each question was then analysed in correlation with a grade.

The reason for using grade as a correlation analysis is due to the fact that grade was highly aligned with age and years in the nursing service. Thus only analysis by grade was carried out since it reflected difference by age and years of experience as well. In order to reduce the risk of bias, gender issues were not compared. Only half of the male (14) population returned the questionnaires. Bias could have been induced since the other half of the male (14) population which decided not to participate in this study might have held other perceptions.

**Question 1. – Alcohol abusers have no self control.**

27.5% (n=11) of respondents strongly agreed with the statement, 50% (n=20) agreed, 20% (n=8) agreed slightly, 2.5% (n=1) were neutral. No responses of slightly disagreed nor disagreed nor strongly disagreed were given. This illustrates that the majority of respondents agreed that alcohol abusers have no self control.
The p value of 0.972 shows that responses were not affected by the nurses qualifications.

**Figure 5. Sample response of Question 1**

**Figure 6. Sample of Question 1 according to grade**

**Question 2.** - *Patients with chronic schizophrenia are incapable of looking after themselves.*

7.5% (n=3) of the respondents strongly agreed with this statement, 50% (n=20) agreed, 12.5% (n=5) slightly agreed, 7.5% (n=3) were neutral, 15% (n=6) disagreed. None of the respondents strongly disagreed with the statement. Overall results shows that,
participants agreed with the statement that patients with chronic schizophrenia are incapable of looking after themselves.

Figure 7. Sample response of Question 2

Results show that the majority of the respondents in all different grades sampled agreed with this statement. A p value of 0.595 shows that grade does not influence result.

Figure 8. Sample response of Question 2 according to grade
Question 3. *Members of society are at risk from the mentally ill.*

5% \((n=2)\) of the respondents strongly agreed with this statement, 15% \((n=6)\) agreed, 35% \((n=14)\) slightly agreed, 12.5% \((n=5)\) were neutral, 7.5% \((n=3)\) slightly disagreed, 15% \((n=6)\) disagreed and 10% \((n=4)\) strongly disagreed. Thus results show that most of the nurses slightly agreed that mentally ill patients are a threat to members of society.

![Sample response of Question 3](image)

Figure 9. Sample response of Question 3

Results obtained by participants follow the same pattern as the main result. However the majority of the SN's with Diploma holders slightly agreed whereas Enrolled Nurses disagreed with this statement. A p value of 0.663 shows that grade made no difference to results.
Chapter 4: Findings

Figure 10. Sample response of Question 3 according to grade

**Question 4.** - *Mentally ill patients have no control over their emotions.*

5% (n=2) of the respondents strongly agreed, 12.5% (n=5) agreed, 12.5% (n=5) slightly agreed, 42.5% (n=17) were neutral, 5% (n=2) slightly disagreed, 20% (n=8) disagreed and 2.5% (n=1) strongly disagreed with this statement. This shows that nurses working on the medical wards neither agreed, nor disagreed that mentally ill patients have no control over their emotions.
Chapter 4

Findings

Although the majority of the results were neutral, one must note that SN's with the Conversion Course disagreed with this statement. The p value of 0.478 shows that grade does not affect response.

![Figure 12. Sample response of Question 4 according to grade](image)

**Figure 12. Sample response of Question 4 according to grade**

**Question 5.** – *Staff should not talk to patients about their delusions.*

7.5% (n=3) of the respondents strongly agreed, 20% (n=8) agreed, 7.5% (n=3) slightly agreed, 40% (n=16) were neutral. 7.5% (n=3) replied that they slightly disagreed, 15% (n=6) disagreed and 2.5% (n=1) strongly disagreed with this statement. Results show that these nurses neither agreed, nor disagreed that staff should not talk to patients about their delusions.
Chapter 4

Results follow the same pattern as the main results for this statement. The p value of 0.793 shows that grade did not influence responses.

Question 6. – *Deliberate self harm more often happens when other people are around.*

None of the respondents strongly agreed with this statement, 42.5% (n=17) agreed, 12.5% (n=5) slightly agreed, 20% (n=8) were neutral, 5% (n=2) slightly disagreed, 15% (n=6) disagreed and 5% (n=2) strongly disagreed. This illustrates that the majority of the respondents view self harm as attention seeking behaviour.
Results show that the majority of the respondents, irrespective of grade agreed with this statement. A p value of 0.896 illustrates this.

Question 7. – Depression occurs in people with a weak personality.
17.5% (n=7) of the respondents strongly agreed, 20% (n=8) agreed, 10% (n=4) slightly agreed. None of the respondents were neutral, 12.5% (n=5) slightly disagreed,
30% \((n=12)\) disagreed and 10% \((n=4)\) strongly disagreed. This reflects that the majority of the respondents do not associate depression with a weak personality.

![Figure 17. Sample response of Question 7](image)

Results follow the same pattern as the main results for this statement. Grade did not affect responses, a fact substantiated by a \(p\) value of 0.434.

![Figure 18. Sample response of Question 7 according to grade](image)
Question 8. – Patients with mental illness are more likely to harm someone else than themselves.

5% (n=2) of the respondents strongly agreed, 7.5% (n=3) agreed, 10% (n=4) slightly agreed, 37.5% (n=15) were neutral, 15% (n=6) slightly disagreed, 22.5% (n=9) disagreed and 2.5% (n=1) strongly disagreed. Results show that these respondents, neither agreed, nor disagreed that patients with mental illness are more likely to harm someone else than themselves.

![Graph showing response distribution](image)

Figure 19. Sample response of Question 8

Results show that the majority were neutral. However SN's with the Conversion course slightly disagreed with this statement. The p value 0.417 shows no statistical significance in responses given by participants in different grades.
Question 9. – **Staff needs to be more educated about the mental health patients on the medical wards.**

55% (n=22) of the respondents strongly agreed, 30% (n=12) agreed, 7.5% (n=3) slightly agreed, 7.5% (n=3) were neutral. No respondents either slightly disagree, nor disagree and nor strongly disagree were returned. This amply illustrates that most of the nurses working in the medical setting, strongly agree about the need to be more educated about mentally ill patients in medical wards.
Chapter 4

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Results show that irrespective of grade, the majority of the participants strongly agreed with this statement. A p value of 0.626 shows that none of the participants, whatever their grade, feel that they have the necessary skills to cater for mentally ill patients on the medical wards.

![Graph showing response of Question 9 according to grade]

**Figure 22. Sample response of Question 9 according to grade**

**Question 10.** — *Clients with mental illness need a specialized nurse to care for them.*

30% (n=12) of the respondents strongly agreed, 42.5% (n=17) agreed, 15% (n=6) slightly agreed, 5% (n=2) were neutral, none of the nurses slightly agreed, 7.5% (n=3) disagree and none of the respondents strongly disagreed. These results show that most of the respondents agree that there is the need of a specialized nurse to care for mentally ill patients.
Results follows the same pattern of the main result irrespective to grade. The p value of 0.314 shows that grade has bearing on the realisation of the necessity of having a specialised nurse to care for the mentally ill in medical wards.

Question 11. – *Mental illness is the result of adverse social circumstances.*

None of the respondents strongly agreed with this statement, 15% (n=6) agreed, 12.5% (n=5) slightly agreed, 37.5% (n=15) were neutral, 17.5% (n=7) slightly disagreed, 12.5% (n=5) disagreed and 5% (n=2) strongly disagreed. This result shows that the
respondents neither agreed, nor disagreed that mental illness is the result of adverse social circumstances.

![Figure 25. Sample response of Question 11](image)

Results follow the same pattern as the main results for this statement. However the majority of Staff Nurses with possession of a Degree slightly disagreed. The p value of 0.128 shows grade did not influence responses.

![Figure 26. Sample response of Question 11 according to grade](image)
Question 12. - Many normal people would become mentally ill if they had to live in a very stressful situation.

10% (n=4) of the respondents strongly agreed, 17.5% (n=7) agreed, 42.5% (n=17) slightly agreed, 10% (n=4) were neutral, 7.5% (n=3) slightly disagreed, 5% (n=2) disagreed and 7.5% (n=3) strongly disagreed with this statement. There is a high agreement rate about the notion that normal people would become mentally ill if they had to live in a very stressful situation.

Figure 27. Sample response of Question 12

Results follow the same pattern as the main result. The p value of 0.778 shows that grade does not affect response.
Question 13. - *Those with a psychiatric history should never be given a job responsibility.*

5% (n=2) of the respondents strongly agreed, 5% (n=2) agreed, 12.5% (n=5) slightly agreed, 12.5% (n=5) were neutral, 17.5% (n=7) slightly agreed, 17.5% (n=7) disagreed and 30% (n=12) strongly disagreed with this statement. It is clear most nurses disagree with this statement and feel that individuals with psychiatric history can hold a job.
Results show that the majority of nurses irrespective of their grade, strongly disagreed. Staff Nurses with Diploma holder expressed mixed views. No difference was noted with a p value of 0.280 between grade.

![Histogram](image)

**Figure 30. Sample response of Question 13 according to grade**

**Question 14. - Those who attempt suicide leaving them with serious liver damage should not be given treatment.**

5% (n=2) of the respondents strongly agreed, 2.5% (n=1) agreed, 5% (n=2) slightly agreed, 10% (n=4) were neutral, 5% (n=2) slightly disagreed, 27.5% (n=11) disagreed and 45% (n=18) strongly disagreed with this statement. The majority of respondents feel that treatment should never be denied, ever after a suicide attempt.
Results shows that, irrespective of their grade the majority strongly disagreed with this statement. The p value of 0.516 shows this.

**Question 15. - Violence mostly results from mental illness.**

5% (n=2) of the respondents strongly agreed, 10% (n=4) agreed, 17.5% (n=7) slightly agreed, 15% (n=6) were neutral, 12.5% (n=5) slightly disagreed, 37.5% (n=15) disagreed and 2.5% (n=1) strongly disagreed with this statement. Respondents do not agree that violence usually results from mental illness.
Results show that the majority disagreed with this statement. However one is to note that SN's with Diploma holders strongly disagreed. The p value of 0.010 shows a statistical significance. Their grade accounts to this difference.
Question 16. - Psychiatric patients are generally difficult to like.

2.5% (n=1) of the respondents strongly agreed, 7.5% (n=3) agreed, 12.5% (n=5) slightly agreed, 25% (n=10) were neutral, 7.5% (n=3) slightly disagreed, 40% (n=16) disagreed and 5% (n=2) strongly disagreed with this statement. Results show that nurses do not consider psychiatric patients difficult to be liked.

![Sample response of Question 16](image)

Results show that the majority of responses fall into the same pattern as the main result. The p value of 0.231 shows grade did not influence responses.

![Sample response of Question 16 according to grade](image)
**Question 17.** *Patients who abuse substances should not be admitted to acute wards.*

12.5% (n=5) of the respondents strongly agreed, 15% (n=6) agreed, 7.5% (n=3) slightly agreed, 15% (n=6) were neutral, 12.5% (n=5) slightly disagreed, 27.5% (n=11) disagreed and 10% (n=4) strongly disagreed with this statement. Although responses show mixed views towards this statement, the result is more towards a disagreement with this statement.

![Figure 37. Sample response of Question 17](image)

Results follow same pattern as the main result. A p value of 0.915 shows grade did not influence results.

![Figure 38. Sample response of Question 17 according to grade](image)
Question 18. - *Psychiatric treatments cause patients to worry too much about their symptoms.*

None of the respondents strongly agreed with this statement, 17.5% (n=7) agreed, 12.5% (n=5) slightly agreed, 50% (n=20) were neutral, 10% (n=4) slightly disagreed, 7.5% (n=3) disagreed and 2.5% (n=1) strongly disagreed. Results show that nurses working in medical wards neither agreed, nor disagreed that psychiatric treatment can cause patients to worry too much about their symptoms.

![Figure 39. Sample response of Question 18](image)

Results shows that the majority of the staff were neutral, those who agreed or disagreed were Enrolled Nurses. This statement also shows that with a p value of 0.276 no difference was noted between the different grade of nurses.
Question 19. - *It is difficult to negotiate care plans with patients in acute environments.*

5% (n=2) of the responses strongly agreed, 17.5% (n=7) agreed, 42.5% (n=17) slightly agreed, 22.5% (n=9) were neutral, 7.5% (n=3) slightly disagreed, 2.5% (n=1) disagreed and 2.5% (n=1) strongly disagreed. Results show that most of the nurses think that it is difficult to negotiate care plans with patients in acute environments.
Although the majority slightly agreed, the majority of SN's with the Conversion course slightly disagreed. However the p value of 0.423 shows grade made no difference.

![Figure 42. Sample response of Question 19 according to grade](image)

**Figure 42. Sample response of Question 19 according to grade**

**Question 20. - It is hard to help patients who are emotionally disturbed.**

7.5% (n=3) of the respondents strongly agreed, 50% (n=20) agreed, 22.5% (n=9) slightly agreed, 12.5% (n=5) were neutral, 2.5% (n=1) slightly disagreed, 5% (n=2) disagreed and none of the nurses strongly disagreed with this statement. Results show a high rate of agreement that it is hard to help patients who are emotionally disturbed.
Results follow the same pattern as the main result. However SN's with Diploma holders highly agreed with this statement. No difference resulting from grade was identified in a p value of 0.779.

Question 21. *Psychiatric drugs are used to control disruptive behaviour.*

12.5% (n=5) of the respondents strongly agreed, 17.5% (n=7) agreed, 20% (n=8) slightly agreed, 42.5% (n=17) were neutral, 2.5% (n=1) slightly disagreed, 2.5% (n=1)
disagreed and 2.5% (n=1) strongly disagreed with this statement. Results illustrate that the majority of the respondents neither agree, nor disagree that psychiatric drugs are used to control disruptive behaviour.

Figure 45. Sample response of Question 21

Results show that although the majority were neutral, the participants irrespective of their grade mostly agreed with this statement. A p value of 0.084 shows a marked significance with a slight difference by grade.

Figure 46. Sample responses of Question 21 according to grade
Question 22. - *Mental illnesses are genetic in origin.*

None of the respondents strongly agreed with this statement, 20% (n=8) agreed, 22.5% (n=9) slightly agreed, 42.5% (n=17) were neutral, 5% (n=2) slightly disagreed, 5% (n=2) disagreed and 5% (n=2) strongly disagreed. Results show that the majority of these nurses neither agreed, nor disagreed that mental illnesses genetic in origin.

![Figure 47. Sample responses of Question 22](image)

Although the results show that most answers were neutral most of the Enrolled Nurses and SN's with Degree holders agreed or slightly agreed with this statement. This statement also gave an almost achieved significance of 0.072 with a slight difference depending on respondent's grade.
Figure 48. Sample responses of Question 22 according to grade

Question 23. - *Psychiatric illness deserves as much attention as physical illness.*

77.5% (n=31) of the respondents strongly agreed, 15% (n=6) agreed, 7.5% (n=3) were neutral. No respondents chose to slightly agree, slightly disagree or strongly disagree. Results show that nurses consider that individuals with mental illness deserve the same attention as any other patient suffering from a physical illness.

Figure 49. Sample responses of Question 23

No deviance from main results was seen when data was analysed by grade. A p value of 0.272 shows grade did not influence responses.
Question 24. - *The manner in which you talk to patients affects their mental state.*

40% (n=16) of the respondents strongly agreed, 15% (n=6) agreed, 32.5% (n=13) slightly agreed, 5% (n=2) were neutral, 7.5% (n=3) slightly disagreed. None of them either disagreed, nor strongly disagreed. Results show that there is a firm belief, that the manner in which one talks to patients affects their mental state.
Although the majority strongly agreed, it should be noted that a number SN's with Diploma holders only slightly agreed with this statement. The p value of 0.317 shows there is no relation between answers and grade.

Figure 52. Sample responses of Question 24 according to grade

Question 25. - People are born vulnerable to mental illness.

2.5% (n=1) of the respondents strongly agreed, 47.5% (n=19) agreed with this statement, 15% (n=6) slightly agreed, 20% (n=8) were neutral, none of the nurses slightly disagreed, 5% (n=2) disagreed and 10% (n=4) strongly disagreed. Results show that the majority of the respondents agree that people are born vulnerable to mental illness.
However when analysing the data a p value of 0.045 showed a statistical significance with a difference related to grade.
Section 3: Questions 26 to 33

Questions 26 to 33 were analysed using a non parametric Kruskal-Wallis test. Only 36 out of 40 participants replied to these questions. This gave a total response rate of 66.6% out of the 74.1% who took part in section 2.

For the semantic differentials, a unipolar scale (0-10) is used. A measurement should be taken from the negative word, for example, dangerous, to the indicated staff mark. Scores should be calculated to one decimal place, for example, 4.4. The line is ten centimetres, with 5 being the mid point, <5 indicates a negative perception.

The table below illustrates the mean scores results to the semantic differentials attributed to the patients. Semantic differential was designed to measure the connotative meaning of concepts. The respondent was asked to choose where his or her position lies, on a scale between two bipolar objectives.

The 10cm line used to indicate whether the participants identify the patients to be positive or negative was not drawn all to one side. Therefore the scores of less than 50% can either be or neither be positive or negative e.g. 48.14% scored to be positive which is less than 50% facing the safe question, whereas 55.94% participants identified the mentally ill to be pessimistic. Respondents identified their patients to be safe, adult, mature, polite, beneficial and clean. On the other hand respondents also
identified their patients to be pessimistic and cold hearted. Table 4 represents the percentage obtained for each question. Tables 5 to 12 indicate the response rate to question depending on participants' grade.

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe - Dangerous</td>
<td>48.14%</td>
</tr>
<tr>
<td>Adult - Child</td>
<td>26.3%</td>
</tr>
<tr>
<td>Mature - Immature</td>
<td>43%</td>
</tr>
<tr>
<td>Optimistic - Pessimistic</td>
<td>55.94%</td>
</tr>
<tr>
<td>Cold hearted - Caring</td>
<td>48.56%</td>
</tr>
<tr>
<td>Polite - Rude</td>
<td>48.64%</td>
</tr>
<tr>
<td>Harmful - Beneficial</td>
<td>51.53%</td>
</tr>
<tr>
<td>Clean - Dirty</td>
<td>49.11%</td>
</tr>
</tbody>
</table>

Table 4. Average response rate of Questions 26 - 33

Table 5, illustrates the average scores to the semantic differentials obtained by the different grades of nurses. Although results follow the same pattern as the main analysis, results show that SNs holding a Degree have a higher average score rate, thus contributing to a more negative response. However a p value of 0.873 shows that there is no difference by grade.

<table>
<thead>
<tr>
<th>Question 26.</th>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe -</td>
<td>TN</td>
<td>2</td>
<td>30%</td>
</tr>
<tr>
<td>Dangerous</td>
<td>SN / Deg</td>
<td>9</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>SN / Dip</td>
<td>15</td>
<td>48.67%</td>
</tr>
<tr>
<td></td>
<td>EN</td>
<td>6</td>
<td>45.50%</td>
</tr>
<tr>
<td></td>
<td>SN / Con</td>
<td>4</td>
<td>43.75%</td>
</tr>
</tbody>
</table>

Table 5. Average response rate of Question 26 by grade
Table 6, illustrates that the majority of the respondents identified their patients as adult. A p value of 0.492 grade makes no difference to responses.

<table>
<thead>
<tr>
<th>Question 27.</th>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult - Child</td>
<td>TN</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>SN / Deg</td>
<td>9</td>
<td>17.22%</td>
</tr>
<tr>
<td></td>
<td>SN / Dip</td>
<td>15</td>
<td>29.33%</td>
</tr>
<tr>
<td></td>
<td>EN</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>SN / Con</td>
<td>4</td>
<td>37.50%</td>
</tr>
</tbody>
</table>

Table 6. Average response rate of Question 27 by grade

Table 7, illustrate that the majority of respondents identified their patients to be mature rather than immature. However a p value of 0.973 shows difference is not related to grade.

<table>
<thead>
<tr>
<th>Question 28.</th>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mature - Immature</td>
<td>TN</td>
<td>2</td>
<td>42.50%</td>
</tr>
<tr>
<td></td>
<td>SN / Deg</td>
<td>9</td>
<td>42.78%</td>
</tr>
<tr>
<td></td>
<td>SN / Dip</td>
<td>15</td>
<td>42.67%</td>
</tr>
<tr>
<td></td>
<td>EN</td>
<td>6</td>
<td>45.50%</td>
</tr>
<tr>
<td></td>
<td>SN / Con</td>
<td>4</td>
<td>41.25%</td>
</tr>
</tbody>
</table>

Table 7. Average response rate of Question 28 by grade

Table 8, illustrates that the majority identified their patients to be pessimistic. However a p value of 0.333 shows this.
### Chapter 4: Findings

#### Question 29

<table>
<thead>
<tr>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>2</td>
<td>77.50%</td>
</tr>
<tr>
<td>SN / Deg</td>
<td>9</td>
<td>52.89%</td>
</tr>
<tr>
<td>SN / Dip</td>
<td>15</td>
<td>51.67%</td>
</tr>
<tr>
<td>EN</td>
<td>6</td>
<td>63%</td>
</tr>
<tr>
<td>SN / Con</td>
<td>4</td>
<td>57.50%</td>
</tr>
</tbody>
</table>

**Table 8. Average response rate of Question 29 by grade**

Table 9 illustrate that the majority of the respondents identified patients to be cold-hearted rather than caring. However a p value of 0.151 shows this.

#### Question 30

<table>
<thead>
<tr>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>2</td>
<td>17.50%</td>
</tr>
<tr>
<td>SN / Deg</td>
<td>9</td>
<td>43.33%</td>
</tr>
<tr>
<td>SN / Dip</td>
<td>15</td>
<td>56.67%</td>
</tr>
<tr>
<td>EN</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>SN / Con</td>
<td>4</td>
<td>58.25%</td>
</tr>
</tbody>
</table>

**Table 9. Average response rate of Question 30 by grade**

Table 10 illustrate that the majority of Enrolled Nurses identified the mentally ill patients to be rude rather than polite. However a p value of 0.228 shows this.

#### Question 31

<table>
<thead>
<tr>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>SN / Deg</td>
<td>9</td>
<td>54.67%</td>
</tr>
<tr>
<td>SN / Dip</td>
<td>15</td>
<td>45.27%</td>
</tr>
<tr>
<td>EN</td>
<td>6</td>
<td>55%</td>
</tr>
<tr>
<td>SN / Con</td>
<td>4</td>
<td>52.50%</td>
</tr>
</tbody>
</table>

**Table 10. Average response rate of Question 31 by grade**
Table 11, illustrates that both Traditional Nurses identified the mentally ill to be more beneficial than harmful in a ward environment. However a p value of 0.217 shows this.

<table>
<thead>
<tr>
<th>Question 32.</th>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harmful - Beneficial</td>
<td>TN</td>
<td>2</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>SN / Deg</td>
<td>9</td>
<td>51.11%</td>
</tr>
<tr>
<td></td>
<td>SN / Dip</td>
<td>15</td>
<td>52.80%</td>
</tr>
<tr>
<td></td>
<td>EN</td>
<td>6</td>
<td>41.67%</td>
</tr>
<tr>
<td></td>
<td>SN / Con</td>
<td>4</td>
<td>48.25%</td>
</tr>
</tbody>
</table>

Table 11. Average response rate of Question 32 by grade

Table 12, illustrates that the majority of the respondents identified the mentally ill patients to be clean rather than dirty. A p value of 0.192 illustrates this.

<table>
<thead>
<tr>
<th>Question 33.</th>
<th>Grade</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean - Dirty</td>
<td>TN</td>
<td>2</td>
<td>42.50%</td>
</tr>
<tr>
<td></td>
<td>SN / Deg</td>
<td>9</td>
<td>59.44%</td>
</tr>
<tr>
<td></td>
<td>SN / Dip</td>
<td>15</td>
<td>40.53%</td>
</tr>
<tr>
<td></td>
<td>EN</td>
<td>6</td>
<td>60.83%</td>
</tr>
<tr>
<td></td>
<td>SN / Con</td>
<td>4</td>
<td>43.75%</td>
</tr>
</tbody>
</table>

Table 12. Average response rate of Question 33 by grade

4.3 Interviews with Nursing Officers (NO) and Deputy Nursing Officer (DNO)
The second part of the study explores the needs of NO and DNO to care for the mentally ill on the medical wards. The perception of the nursing staff in charge of each

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ward expressed, evolved from their knowledge and experience mentally ill patients. Four themes were identified.

- Identifying patients with mental illnesses on the medical wards
- Communication difficulties
- The need for the mental health nursing support
- The need for education

To ensure anonymity the NO and DNO when quoted are shown in code from P1 to P10. All participants are traditional nurses except one who has a much higher level of education. None of the participants have any mental health experience. One of the first issues discussed was the frequency of having mentally ill patients on the medical wards and whether these patients are identified. Mixed responses were obtained.

4.3.1 Theme 1: Identifying Patients with Mental Illnesses on the Medical Ward

This theme highlights the fact that participants are not always aware of the identity of mental ill patients when the latter are being cared for on the medical wards. P4 stated that they have a mentally ill patient everyday, whereas P10 who comes from the same ward stated otherwise:

"we have very few patients suffering from mental illness throughout the year."

P1 stated:

"It depends; there are times when we have more than one patient a day and other times when we have no patients with mentally illness at all."
The rest of the participants P2, P3, P5, P6, P7, P8, P9 stated that they have one to two patients per week.

Participants view mentally ill patients differently. It also became clear that the participants rely on the information of other professionals when they have a patient suffering from same mental illness.

P10 stated that:

"When you look at the treatment chart you immediately realise that the patient is mentally ill because is being given psychiatric drugs."

P2, P3, P5 thought that patients with mental illnesses are identified because they are either admitted through casualty with a psychiatric consultation or have a constant watch supervision order.

P5 clearly stated:

"One can identify patients with a mental illness when they are transferred from a mental hospital."

The way patients suffering from a mental illness are identified varied between participants. Some gave personal accounts of how they identify patients suffering from mental illnesses.
P6 stated that:

"Patients are identified through their mannerism. They speak loudly and ask the same question over and over again."

Some participants labelled patients with unusual behaviour as mentally ill.

In fact P4 stated that:

"Sometimes mentally ill patients are unable to keep themselves occupied. They just stare vacantly into space."

Another P7 stated that:

"They need to smoke nearly all the time, they just do not have the patience to stay on the ward without smoking."

P9 stated that:

"Mentally ill patients are identified because they are erratic, disruptive and have death wishes."

In contrast to the above, one participant P1 stated that:

"Nowadays you cannot exactly tell whether a patient suffers from any kind of mental illness since treatment can make them very stable."

It is clear that the majority of the participants rely not only on the information of other professionals but also on their own personal perception. Moreover, participants highly associate negative attitudes with mental illness, which may not always be the case. In
fact participants identified communication difficulties to be a major hurdle when dealing with such patients.

4.3.2 Theme 2: Communication Difficulties

Most of the difficulties that general nurses encounter when communicating with the mentally ill patients with medical problems, were identified when they tried to communicate with the patients to assess their needs.

As captured by P2:

"They may be lying and you cannot know what their needs and wishes are."

P4 stated:

"I get the feeling that they do not always say the truth."

P8 also stated that:

"Getting a history from them is quite difficult."

P9 claimed it is not always easy to assess their needs:

"They are not very cooperative, and they do not answer you."

Although participants found it difficult to assess a patient with mental illnesses, all participants stated that they still managed to establish a therapeutic relationship with mentally ill patients on the ward if the same patients were able to communicate. Participants were asked whether they felt they had used the right words to communicate with mentally ill patients. Nearly all participants stated that several times
they had conflict within themselves whether they had used the right words. The following illustrate nurses' concerns when communicating with such patients.

P10 stated:

"I am very cautious about what I say, since I am afraid that I may say something wrong."

P1 also stated that:

"I may not say the right words and may hurt their feelings even more."

Only P4 stated otherwise:

"I do not have much time, therefore, I do not communicate with them that often."

Both the NOs and DNOs showed a strong sense of commitment and a genuine desire to provide high quality care. Participants realised that their expertise in mental health nursing was limited and they wanted to move from a reactive to a more considered approach to care. This was exemplified by P7 who expressed disappointment at the management of care given to the mentally ill.

P10 stated that:

"Even when patients are ordered to remain under constant supervision, the nurse appointed is not qualified in the mental health field."
The majority of participants believed that to communicate effectively with the mentally ill one has to be trained in the mental health field. On the other hand nearly all participants stated that they were able to establish a therapeutic relationship. However, they were very concerned about what to tell or could have told the patient. Participants even brought up the issue that they needed to have mental health nursing support in order to be able to communicate with the patients and identify their needs. This would help them to care for them more effectively.

4.3.3 Theme 3: The Need for Mental Health Nursing Support

Participants felt that they worked in an environment with a focus on the physical aspects of care. However the participants realised that to care for the mentally ill in a holistic way, one cannot care for the physical needs only. The work setting made it difficult to incorporate mental health care into their practice and many of the experiences described show the need for mental health nursing support.

Participants were asked whom they contacted when a patient needed urgent mental health care.

P 6 stated that:

"We call a GP and make a psychiatric consultation."

P 8 said:

"During the weekends we have to contact Mount Carmel Hospital for a psychiatrist to come and see the patient since there is no one around."

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All participants stated that while the patient is awaiting for the psychiatric consultation there is no one to help them deal with the needs of the mentally ill patients. Both participants P1, P5 stated that they never consult nurses working in a mental health setting.

Nurses on the medical wards continue to view patients with mental illness as a distraction from their main role.

P3 stated that:

"It is not the first time that we found patients diagnosed with mental illness looking into someone else's belongings."

The need for mental health nursing support was stressed when P4 pointed out that:

"It was not the first time that become distracted and walk out of the ward. Recently an M.I. patient ran away and was found at Mosta."

P5 recalls an experience with a patient diagnosed with schizophrenia.

"I remember it was Christmas time when one of our patients who had just been admitted broke all our Christmas trees during the night."

Participants stressed the need to have someone to turn to in case of emergency, since their expertise was limited to the physical care. Participants also felt the need to have educational programmes on how to care for the mentally ill.
4.3.4 Theme 4: The Need for Education

All participants identified the need for more education. This was highlighted when the participants felt that they did not understand or identify their client’s needs.

P 10 stated:

"I do not feel that I have anything to offer."

P 5 stated that:

"It has been a long time since I was involved in some kind of education in the mental health care."

However all participants stated that the standard of nursing care given to a patient with a mental illness does not differ from that given to other patients.

P 2 said:

"I would communicate with them the same way as I do with other patients with physical needs."

An other participant P 6 identified how the mentally ill on the medical wards are not being cared for in a holistic way when he claimed that:

"If we have a patient with dual diagnosis and the patient has taken an overdose, how do you work it out? What is a priority, their mental state or their physical needs? I do not know what comes first."
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Findings

P 7 stated:

"I would tend to care his physical need but avoid
talking to them about their mental problem."

P1, P3, P4 referred to dealing with relapsed patients as a waste of time. P 3 summarised it up in these words: "Inhosni nazaq f' ilma maghhom." ("I feel I am wasting my time with them").

P 8 added that:

"I get the feeling that we are not doing enough if
they keep coming in for the same reason."

Such statements made the researcher aware of the need for further education.

The last issue discussed was the way participants would design an educational programme caring for the mentally ill. They were asked to list the main issues they would tackle. Nearly all participants identified communication skills as the foremost.

Five participants expressed the desire for more education about the signs and symptoms of treatment withdrawals and drug interaction. Another three participants identified their second most important training need to learn how to identify mental illness by their signs and symptoms. Knowing and learning how to deal with the relatives of a mentally ill patient on the medical wards was an issue brought up by one participant.
Chapter 4

Findings

An other participant identified dealing with patients suffering from dementia to be the second most important educational need after communication skills.

4.4 Interviews with Key Persons

The third part of the study explores whether the needs of nurses, DNOs and NOs are identified by the key persons at the Mater Dei Hospital. The perception of the key persons involved with these nurses offers another perspective worth noting. To ensure anonymity key persons, when quoted, are shown in code from P 1 to P 2.

One of the issues discussed in the interview was whether general nurses are caring effectively for the mentally ill on the medical wards. P 1 and P 2 both stated that “the nursing care given to the mentally ill was the same as that given to any other patient with physical illness.” However both participants pointed out that no case summary is supplied by the mental hospital. This, therefore, creates a gap between the mental and the general aspect of the nursing care. P 1 expressed the same concern “Our nurses may not know anything about the patient's condition. Therefore things only get worse because they do not have a summary of what the patient needs are.” Both participants explained why the nursing care was not up to standard. This was stated by P 2, “We are not sure whether the mentally ill on the medical wards are getting the necessary mental health care. We receive complaints from the nursing staff saying that they are not getting enough information on how to care for the mentally ill and that they have no one to keep them how to deal with such cases.” Both participants justified the reason for the reality of nursing care provided at MDH. Both participants stated that
for mental health care to be up to standard the general nurses needed to be better equipped and better educated in this field.

P 2 pointed out that if nurses are not able to identify the mental health needs that care cannot be given. Moreover P 1 added that if one does not promote mental health education for nurses in general wards, one cannot expect high quality care.

When asked whether the education provided to the general nurses about mentally ill patients is enough P 1 replied “Little or nothing is being done to educate the general nurses working on the medical wards.” Both participants agreed that post graduate education will improve the nursing care and help the nurse to view the mentally ill in a more positive light.

Both participants agreed that Specialised Mental Health Nurses (MHN) working on an on-call basis could bring about a change as well as an opportunity to educate our staff. However, P 2 pointed out that the MHN could be seen as someone who came round giving orders, explaining about the care needed for the patient's condition and leaving the ward. General nurses would still have to look after them. P 1 argued that the MHN could improve the lot of the patients being cared for in our wards and provide our nurses with the continuity of care.
4.5 Conclusion

This chapter highlighted the findings of the study, both qualitative and quantitative. These findings illustrate different and similar results between both qualitative and quantitative. Their implications will be discussed in further detail and compared with those in the published literature in the next chapter.
Chapter 5 – Discussion and Analysis

5.1 Introduction

The aim of this study was to explore the needs assessment, through the nurses' perception, of the delivery of nursing care given to people with some form of mental disorder being treated in the general medical wards. However, for this care to be effective, nurses need to acquire the necessary knowledge and develop the right attitude and skills.

Due to the complexity of the issue under study, both qualitative and quantitative measures were used. Qualitative assessment gives evidence through the revision of a data analysis framework, while the quantitative analysis provides a logical explanation for those observations in a form that could be communicated effectively to others (Bamberger, 2000).

A questionnaire was used to gauge the attitudes of nurses, whereas, an interview was conducted to identify skills, knowledge and perception. Mc Gehee and Thayer (1961) cited in Eugene sadler-smith (2006), stated that to meet the required standard of performance, the needs assessment on a job level analysis, such as nursing care, has to examine the knowledge, skills and attitudes of nurses.
Chapter 5 Discussion and Analysis

5.2 Needs Assessment of the Delivery of Nursing Care for the Mentally Ill - Nurses' Perceptions

The stakeholders chosen from within the public service gave their perception regarding the needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards. The stakeholders were the general nurses, Nursing Officers, Deputy Nursing Officers and key persons who can contribute towards improving the quality of nursing care given to the mentally ill on the medical wards. The stakeholders requested for an educational programme tailored for their needs to enable them to care for the mentally ill and also to have mental health nursing support.

5.3 Factors Identified to Care Effectively for the Mentally Ill

From the self administered questionnaire, nurses of all grades, experienced a strong desire to receive further training in order to care more effectively for the mentally ill patients. This was also evident when the same participants suggested having a specialised nurse to care for mentally ill patients. This need was also established by a study carried out by Atkins, Holmes and Martin (2005). These participants further requested that this specialised nurse should also act as a trainer in the medical wards. Unfortunately Key Person 1 in this study reacted negatively to this suggestion. He viewed the specialised nurse as someone who would visit the ward when called, give orders and let the nurses cope with the situation. However, Nelson and Schilke (1976) defined the characteristic of the specialised mental health nurse otherwise than key person1. The MHN provides the education of patient care to team members, gives direct specialized psychological care to patients and their families, show expertise in
psychiatric problems, normal and abnormal responses to illness adaptation of patient and family, understanding of the interrelationship between physical and psychological states, knowledge of systems theory, group processes and liaison between disciplines.

Participants in this study strongly agreed for the need of more education. This can be caused by the feeling of not having enough knowledge to care for this client group. Several studies supported the argument of identifying participants who are in need of more education to care for the mentally ill in the general setting (Sharrock & Happell, 2002; Wand & Happell, 2001; Brinn, 2000; Roberts, 1998; Muirhead & Tilley, 1995; Fleming & Szmukler, 1992).

Sharrock and Happell (2006) identified results that explained why nurses perceive themselves as lacking the required skills. It was clear that their undergraduate education was fragmented with mental health and general nursing theoretically and clinically separated. Clark, Parker and Gould (2005) supported the argument that the current four-year courses do not allow sufficient time for the development of mental health care in medical wards.

The author continues to state that nurses needed skills to screen and monitor mental health problems of patients on medical wards. None of the present participants mentioned the need for screening tools to identify mentally illness. The majority of NOs and DNOs were of the opinion that they also needed more training. This was evident in one of the themes that emerged: The need for education. Three of the
participants stated in their own words “*We do not get anywhere.*” In line with this statement (Bailey, 1994; Fleming and Smukler, 1992) identified nurses who have been found to describe reduced work satisfaction when caring for the mentally ill. Their priority was to attend to the physical needs of patients. A participant in this study, P7, stated “*I would care for his physical needs but avoid to talking to them about their problem.*” This is also in line with one of Reed and Fitzgerald (2005) attitudinal theme where participants stated that nursing the mentally ill ‘*was not their role.*’ They dislike caring for such people and would not do so if they had a choice. Mavundla (2000) supported this argument when he stated that lack of skills and knowledge about mental illness determine the nurses’ perceptions of this client group. The author came to the conclusion that positive perception was associated with the possession of knowledge and therapeutic skills. These increase self-perception within the nurses internal environment.

One cannot disagree with the above statement since the majority of the participants in the study used several arguments which showed a negative attitude towards this client group. However, P10 said “*I do not have anything to offer.*” Similar quotations seems to indicate that nothing will change the participant’s perception. However, Puntill (2005) supported the argument that nurses who are interested in medical nursing are not usually interested in caring for the mentally ill. Therefore even though the respondents referred to above expressed a desire to have more support and education, it does not necessarily mean that they are interested in learning how to care for the mentally ill. Participants in this study identified other factors which hindered them
from giving the appropriate nursing care.

5.4 Factors that Hinder the Nursing Care

Negative perceptions of the NO and DNO arose from the fact that they work in a busy environment with a dominant focus of attention on the physical aspects of care. On the other hand P1, P3 and P4 referred to dealing with relapsed patients as a waste of their time. In fact, P8 admitted that "I get the feeling that we are not doing enough if they keep coming in for the same reasons." This shows that the work environment, lack of knowledge, skills and the negative perceptions of being unable to care effectively for the mentally ill are hindering nurses in their work.

Nurses in the Harrison and Zohhadi (2005) study described themselves as lacking the personal and professional resources to address patients' mental health problems. They identified feelings of failure, powerlessness and frustration when confronted with the realities of planning and delivering care to individuals with mental health needs. The lack of personal and professional resources resulted in the participants of this study being unable to offer anything to patients on their ward as P2 said "I would communicate with them the same way as I do with other patients with physical needs." This means that P2 does not identify the mentally ill of having additional needs when communicating with them.

On the other hand participants are fully aware that to care for the mentally ill in a holistic way one cannot care for the physical needs only. This was confirmed when,
77.5% of the nursing population strongly agreed with the statement that “Psychiatric illness deserves as much attention as physical illness.” This clearly indicates that, besides the problems encountered by the NOs and the DNOs, nurses are fully aware that both forms of illness should be given the same attention. P6 seemed to have found it very difficult to integrate the care needed, “If we have a patient with dual diagnosis and the patient takes an overdose, how would you tackle that? What do you cater for first, their mental state or their physical needs? I feel at a complete loss.”

This seems to be in line with Sharrock’s findings (2006) where participants made repeated references to the lack of support within the busy general hospital environment, workload, and patient throughput. This together with work organisation and the focus on physical care were factors that impacted on the participants’ abilities to attend to the mental health needs of their patients. P4 stated that “I do not have much time, therefore, I do not communicate with them that often.” Lack of communication was one of the themes that emerged in the study carried out by McCabe (2004), showing that nurses were more concerned with doing their work rather than communicating with the patients.

Reed and Fitzgerald (2005) provided an explanation for the above attitude. They claimed that physical care needs demand priority when there is a shortage of staff. But, very often when demands are high, mental health care may not be considered a priority.
Participants were not always sure which patients had a mental problem. The identification of such patients resulted mainly from different views as P10 stated that: "When you look at the treatment chart you immediately realise that the patient is mentally ill because is being given psychiatric drugs." or as P5 clearly stated: "One can identify patients with a mental illness when they are transferred from a mental hospital." Other participants identified the mentally ill mainly from their mannerism as P9 explained that "Mentally ill patients are identified because they are erratic, disruptive and have death wishes." P4, stated that "Sometimes mentally ill patients are unable to keep themselves occupied. They just stare vacantly into space." P7 also stated that "They need to smoke nearly all the time, they just do not have the patience to stay on the ward without smoking."

However, in contrast to the above P1 stated that "Nowadays you cannot exactly tell whether a patient suffers from any kind of mental illness since treatment can make them very stable."

Nurses in this study described their patients as pessimistic and cold hearted. This is in keeping with findings of Chow, Kam and Leung (2007). His participants identified their patients, in descending order, as unstable, emotional, dull, difficult to handle and pitiful. It could be argued that identifying the mentally ill by negative judgements, can result in stereotyping. This can have devastating consequences because people quickly generate impressions and expectations of individuals belonging to a stereotype group. Such impressions lead to prejudice which is consenting emotional reaction to a
5.5 Training Needs Identify to Care for the Mentally Ill

According to research Atkin, Holmes and Martin (2005), participants felt that training should be ongoing, on or near the wards and post-qualification would be of greater benefit. Role modelling was valued most highly. Participants wanted some training for which formal accreditation was available. Participants in the study under review did not identify the factors of the training needs, although they did identify training needs related to their work place. The majority participants including the NOs and DNOs identified communication skills to be the most needed learning skill. The rest of the participants identified the need for more training about the signs and symptoms of treatment withdrawals and drug interaction as the second most important learning need. Three participants identified their second most important educational need to be that of identifying mental illnesses by their signs and symptoms. One participant identified the need to learn how to deal with the relatives of the mentally ill on the medical wards. The same participant also mentioned those patients under constant supervision and what care can be given. Another participant identified how to deal with demented patients as the second most important educational need after communication skills.

These topics identified by nurses working in the general setting are very similar to those ones of Atkin, Holmes and Martin (2005). Others included knowledge about commonly encountered mental illnesses, early detection of the mental illness through
the recognition of signs and symptoms, use and application of screening instruments, management of mental illness (particularly dementia and depression) including management of problematic behaviour, and preventing and managing violent incidents, basic working knowledge of psychotropic medication, including side effects and working knowledge of mental health legislation.

The researcher realised that nurses participating in this study needed more intensive training in the care of the mentally ill. This resulted from the analysis of the different type of data collected. Nurses identified learning needs on how to negotiate care plans in acute environments, the history of depression, self harm, the difference between stigma, stereotype and prejudice, gaining confidence to care for the mentally ill, the meaning of delusions, the effect of psychiatric treatment on different mental illnesses.

5.6 Limitations Identified With the Care Given to the Mentally Ill

Nurses participating in this study were not always sure of how to deal with the mentally ill. This became evident when most of the respondents irrespective of grade scored neutral rather than strongly agreed or strongly disagreed with the statement.

Most of the participants, 50%, agreed with the statement that "Alcohol abusers have no self control." This is incorrect and has been proved by the study of Happel, Carta and Pinikahana (2002). Nurses correctly stated that alcohol abusers need to increase the amount of alcohol consumed to achieve the desired effect. It is not that they lack self control.
With no difference arising from, grade 35% of the participants slightly agreed with the statement that "Members of society are at risk from the mentally ill." Richmond and Foster (2003) identified similar findings that the mentally ill are labelled as dangerous people and a threat to society. This negative attitude, can lead to social distance that reduces the ability to provide effective care.

The majority of participants in this study also preferred to neither agree nor disagree that "Mentally ill patients have no-control over their emotions" and that "Staff should not talk to patients about their delusions." This clearly illustrates that nurses working on the medical wards do not feel confident not skilled to care for the mentally ill. This has also been identified in one of the themes "Communication difficulties" in this study. As P10 stated "I am very cautious what to say, since I am afraid that I may say something wrong." P1 stated that: "I may not say the right words and so may hurt their feelings even more." This is in line with Reed and Fitzgerald (2005) where he identified participants avoiding in-depth conversation with the mentally ill, since they feared that it might have the wrong effect if not done by an expert.

42.5% of the participants in this study agreed that "Deliberate self harm more often happens when other people are around." This statement can be interpreted that participants identified self harm as being attention seeking behaviour. Bywaters and Rolfe (2002) mentioned health care professionals who perceive self harm patients as "time wasters" and not worthy to receive treatment. Only, 27.5% of the participants in this study disagreed with the statement "Patients who abuse substances should not be
admitted to acute wards.’ This suggests that although mentally ill patients are being perceived as attention seekers, participants in this study still wish and want to offer them the same treatment as others.

However, although participants agreed that the mentally ill should be cared for in acute areas, they still agreed, by 42.5%, that ‘It is difficult to negotiate care plans with patients in the acute wards.’ 50% of the participants, in this study admitted that: ‘It is hard to help patients who are emotionally disturbed.’

Participants in this study neither agreed nor disagreed that mental ill health is related to social circumstances. This reflects that participants were not sure of what causes mental illness. This was again evident when the majority of the sample, 30% disagreed that ‘Depression occurs in people with weak personality.’ There were 20% who agreed with the statement. According to current literature and as agreed by participants in Payne, Harvey and Jessop (2002) study, the cause of depression is an underlying biochemical abnormality and that depression was not caused by recent misfortunes, social circumstances or deprivation in early life.

5.7 Nurses' Perceptions of the Care Given to the Mentally Ill

Nurses in this study perceive themselves to be unable to care effectively for the mentally ill. Apart from having no-one to turn to for support, nurses on the medical wards continue to view patients with a mental illness as a distraction from their main role as. P3 stated that: ‘It is not the first time that we found patients who are
diagnosed with mental illness looking into someone else belongings."

This is in line with the nurses' experiences in Reed and Fitzgerald's study (2005) where they identified negative experiences revealed by nurses. The latter often claimed that mentally ill patients did not appreciate the care given to them and tended to be uncooperative, restless, often violent and also caused management problems.

P4 pointed out, "It is not the first time that a patient became disorientated and walked out of the ward. Recently an MI patient ran away and was later found in Mosta." This is in line with the findings of Lethoba (2006). He identified participants who claimed that a wandering patient made it more difficult for them to render nursing care.

P5 recalls an experience with patient diagnosed with schizophrenia and the chaos this patient created on the ward. It was Christmas time. During the night this patient who had been transferred from a mental institution broke all the Christmas trees.

Nurses in other countries seems to experience similar inappropriate behaviour with which they are usually unfamiliar. Mavundla (2000) identified nurses who had witnessed patients who urinated in the ward and walked about naked in front of other patients and nurses.

Nurses in this study also perceive themselves unable to communicate effectively. Nearly all participants stated that several times for several reasons. Nearly all
participants stated that several times they had conflict within themselves wandering whether they had used the right words. This issue really worries them as pointed out by P10 "Being cautious of what I say is all I do, since I am afraid that I may say something wrong."

The development of a positive nurse-patient relationship is essential for the delivery of quality nursing care. However, Hodges (1986) also highlighted the fact that nurses do not communicate well with patients having mental problems, and approach them only to deal with administrative or functional activities. In fact, according to Zammit (2008) identified attitudes of the nursing staff which created an atmosphere of fear.

This is corroborated by the evidence supplied by Mc Cabe (2004) where he found that nurses are not aware of the importance and significance of the nurse-patient relationship. This lack of awareness results in their making assumptions about the care a patient needs, purely because they do not communicate with them. Mc Coll, Thomas and Bond (1996) argue that nurses do have the necessary skills to communicate with patients but choose not to because of the lack of organizational support and encouragement. This seems to be the case with the participants of this study. They have no organisational support.

All participants stated that while a mentally ill patient is waiting for the psychiatric consultation there is no one to help them deal with the needs of this patient. According, to P11, "Even when patients are ordered to remain under constant supervision, the
nurse appointed is not qualified in the mental health field." Bowles, Mackintosh and Torn (2001) add that criticism of nurses caring for the mentally ill may be unrealistic since no benchmark for effective care exists.

Besides the perceptions of communication difficulties and of having no organisational support, the key persons in this study identified other nursing staff complaints. Nurses feel they are unable to maintain continuity of care, because the case summary and the nursing care documentation do not accompany patients when they are transferred from other institutions.

To take this step even further, this means that patients who are admitted from home rather than from an institution with no case summary they may not be treated for their mental illness.

Identification of patients suffering from mental illnesses on the medical ward also seemed to be a problem. Participants claimed they were not always sure who the patients suffering from mental illness on their wards are. More often than not participants relied on other professionals discretion. This was confirmed when participants were asked to specify how often they had mentally ill patients on the medical wards. Two participants working in the same ward gave conflicting answers. P4 stated that they have mentally ill patients nearly everyday, whereas, P10 stated that "we have very few patients suffering from mentally illness throughout the year." No records were found about the way identification of patients with some form of mental
illness in the medical wards was carried out.

This problem of lack of communication between patient and nurse is not found in the nursing staff of this study. Nursing staff in Thapinta's study (2004) scored very low in identifying the patients' needs. Participants in this study maintain that they are unequipped to care for the mentally ill. P10 admitted, "I feel that I have anything to offer." P5 also stated that "It has been a long time since I was involved in some kind of education in the mental health care."

On the other hand, this is what key person P2 said, "We are not sure whether the mentally ill on the medical wards are getting the necessary mental health care." Both participants stated that for mental health care to be up to standard the nurses needed to be better trained in this field. Reeds and Fitzgerald (2005) identified nurses who had support from the mental health nurses. This group reported greater, confidence and understanding, more control and a reduced perception of danger when caring for the mentally ill. Research shows that even a relatively small amount of knowledge can be effective when delivered appropriately in the workplace in an ongoing manner.

Baston and Simms (2002) also claimed that education on mental health issues is essential and has to be on-going if one really wants to develop proper knowledge and nursing skills. In fact, key person K 2 pointed out that if nurses are not able to identify patients suffering from a mental disorder, then proper care cannot be given.
5.8 Needs Identified at Different Grade Levels

In their responses both NOs and DNOs identified similar administrative needs. The responses given by nurses of different grades varied slightly, irrespective to grade. There are instances where there is some agreement, whereas other respondents hold divergent views.

SNs in possession of a Nursing Diploma did not agree with nurses of other grades that “Violence mostly results from mental illness.” However, Traditional Nurses and Enrolled Nurses strongly agreed with this statement. An other question which has achieved a difference by grade was that Traditional Nurses and Enrolled Nurses agreed with the statements that “People are born vulnerable to mental illness.” On the other hand SNs possessing a Degree slightly disagreed that people are born with a tendency for mental illness.

Enrolled Nurses and SNs with a Degree both agreed that “Psychiatric drugs are used to control disruptive behaviour.” In the next question Traditional Nurses and SNs holding a Diploma opted for neutral because they were not sure whether “Mental illnesses are genetic in origin.” On the other hand, Enrolled Nurses and SNs with a Degree agreed with this statement. It is interesting to note that responses by NOs and DNOs were similar to those of the participants participating in the questionnaire. However it must be borne in mind that NOs and DNOs have a managerial role and so have less direct communication with these patients.
5.9 Limitations of the Study

A potential limitation of the study is the extent to which the sample is representative of all staff working in the medical wards at Mater Dei Hospital. The overall return rate of 74.1% was reasonable, 50% is considered the threshold for analysis of returned questionnaires (Gilliam, 2000). However, the rest of the 24.9% who did not return the questionnaire could have held different needs which could have introduced bias if they had completed the questionnaires (Oppenheim, 1996). This could also apply to the four participants who did not answer the semantic differentials in Section 3 (Appendix II). They could have had a more positive attitude and could have significantly affected the findings.

An additional limitation is that only nurses from one public hospital employed by the Ministry of Health, Elderly and Community Care (MHECC) participated in this study. This could have biased the findings since the nursing care provided in the public hospital may differ from that provided in a private hospital.

Another limitation of the study is that since the questionnaire was presented only in English. Therefore, participants who found difficulty understanding the language might not have answered the questionnaire.

An major limitation is that the tool used is usually aimed to measure attitude of staff working within the acute mental health setting and in the accident and emergency department. However, in this study the tool was used only in the medical wards.
Therefore this might have influenced the reliability of data collected.

The tool is usually employed to measure larger populations, which was not the case in this study. Therefore multivariate analysis could not be included here, due to the prevalent culture and smaller population.

The interview questions were constructed by the researcher. To limit the impact of influence or bias on the person being interviewed, the interviewer had to train herself to behave and speak in a neutral non-judgemental manner, as suggested by Bowling (2002).

Finally, limitations which naturally arise when one carries out research using a cross-sectional survey with multiple methodology in particular, can be found in this study, including possible faults in quoting, sampling, coding, tabulating and data processing.

5.10 Strengths of the Study

The study uses a mixed method approach as research tool. Open and close ended questions used in for both structured and semi structured interview provided specific information and avoid deviation from focus. They provided probing in order to get further clarification. However, open and close-ended questions sum up the main concepts. In addition, both interview tools were used for NOs, DNOs and Key Persons which gave different perceptions. Moreover, inviting participants to give comments and suggestions, will give them the opportunity to vent their inner feelings and
Chapter 5: Discussion and Analysis

opinions, while giving the researcher a deeper understanding of needs through the nurses perceptions.

A provided questionnaire gave a clearer understanding of the nurses needs in a larger population.
Chapter 6 – Conclusion and Recommendations

6.1 Introduction

This chapter outlines the conclusion of the study and proposes recommendations to Management for practice and further research.

6.2 Conclusion

The study shows that participants lack the knowledge that would enable them to cater better for the mentally ill on the medical wards. These groups of participants have similar and different needs which are described in the literature. Other needs in relation to organisational needs were also identified. Although participants identified the need for more training and mental health nursing support, there still exists some doubt as to whether this is what they really need.

6.3 Recommendation for Management

This project aims to promote better quality care and a cost effective health care delivery system while maintaining healthier outcomes.

The nurses' needs to improve the quality of nursing care on medical wards may or may not be recognized. However, some changes will need to be made to prepare the health care system for the increase in patients with mental illness in the coming years. It must be realised that short-term quick-fix solutions or long term planning with no action are not the answer.
Chapter 6 Recommendations and Conclusions

Ward managers should capitalise on staff with mental health experience to facilitate in-service training for the less experienced staff. Nurse Managers should encourage staff to attend periodical seminars, conferences and workshops on mental health nursing in order to equip themselves with the necessary knowledge and skills. Staff rotation on psychiatric wards should be encouraged. This would give nurses first-hand experience in dealing with these patients. A benchmark for effective nurse-patient communication should be created to provide nurses with the necessary skills to communicate better with these patients. It would also eliminate indifference attributed to lack of organisational support and encouragement.

This research recommends that the Ministry of Health, Elderly and Community Care (MHECC) develop a policy that promotes the allocation of at least one mental health trained professional nurse to both the medical and surgical wards within the general hospital.

The literature section offers extensive information about the needs of nurses in other countries and about the mental health liaison nurses and its effectiveness on the quality of nursing care given in the general setting. Whilst models and types of care in other countries might not be applicable for Malta, still certain guidelines could be adopted.

Organizational changes often create feelings of insecurity, but can also bring about a positive cultural change. The participation of mental health nurses in the setting up of a
new service cannot be overemphasized. The majority of general nurses working in the medical wards have shown that they are willing to learn more about the mentally ill. This can be considered as an asset to the organization.

As suggested by participants, proper planning of the training needs tailored to meet the nurses’ needs to care more effectively for the mentally ill on the medical wards is an investment. Operational guidelines such as screening and monitoring tools, should be available to nurses, NOs and DNOs in each ward, to enable them to detect early signs of mentally illness. An adequate recording system should also be introduced to monitor the nurses’ intervention of mentally ill patients found in the medical wards.

In addition, communication systems between different professionals and institutions should not be left to chance but should be facilitated beforehand. This, while promoting a mental health service in the general setting would facilitate and increase awareness to care effectively for the mentally ill on the medical wards.

Providing a mental health liaison team can be very expensive. But, appointing a person who can be contacted when the need arises, could prove more cost effective.

An alternative might be to hire nurses trained in the field of mental health either to care directly to the patients themselves or to educate the same staff on the medical wards.
6.4 Recommendations for Further Research

This study explored a needs assessment of the delivery of nursing care in the general medical wards through the nurses' own perceptions. Another study could explore a needs assessment of the delivery of nursing care in the surgical wards.

Further research could also include experiences of patients suffering from mental illness being cared for on the medical wards. This would yield different results since it would bring to light those needs as seen from the point of view of the patients themselves.

Another study could focus on the needs assessment of nurses working in specialised areas such as the Coronary Care Unit (CCU) and the Cardiac Medical Ward (CMW). This would re-enforce the belief that nurses working in different areas have different needs, and therefore require specialised training if they are to give mentally ill patients effective care.

6.5 Conclusion

This study highlights the need for change in the attitude of nurses in the medical wards and the care they give to mentally ill patients. For this to be achieved the needs of the nurses must be addressed.

Malta has always been in the forefront in the care of the mentally ill, more so now, with the introduction of the community services. Therefore, one must cater for the
needs of the health care workers in the general setting since they are also caring for the mentally ill. Improving the services given to this client group in the medical wards is part of project that needs to be undertaken. On the other hand if one really wants to provide care that is holistic, an integrated service has to be provided.

This can only be achieved if there is close co-operation between the nurses who cater for medical and those who are experts in mental health care.


Dr. Vassallo, R. (2009). *Come on, Eileen... hospital is for serious cases only*. Malta Today.


Royal College of Physicians / Royal College of Psychiatrists (2003). The Psychological Care of Medical patients.. London: RCP / RCPsych.


Appendix I

Results of Mean Rank Used in the Questionnaire
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Appendix II

Measuring Tools Used in this Study
**Questionnaire for Nurses**

**Section 1: Demographic Data** Please tick your answer

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<td>3 to 5 yrs</td>
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<td>6 to 10 yrs</td>
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<td>11 to 15 yrs</td>
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<td>20 yrs and over</td>
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<td>16 to 20 yrs</td>
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<td>20 yrs and over</td>
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Section 2:

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<th>Neutral</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<tbody>
<tr>
<td>1. Alcohol abusers have no self control</td>
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<td>2. Patients with chronic schizophrenia are incapable of looking after themselves</td>
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<td>3. Members of society are at risk from the mentally ill</td>
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<td>4. Mentally ill patients have no control over their emotions</td>
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<td>5. Staff should not talk to patients about their delusions</td>
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<td>6. Deliberate self harm more often happens when other people are around</td>
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<td>7. Depression occurs in people with a weak personality</td>
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<td>8. Patients with mental illness are more likely to harm someone else than themselves</td>
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<td>9. Staff need to be more educated about the mental health patients on the medical wards</td>
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<td>10. Clients with mental illness need a specialised nurse to care for them</td>
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<td>11. Mental illness is the result of adverse social circumstance</td>
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151
<table>
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<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Neutral</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<tr>
<td>12. Many normal people would become mentally ill if they had to live in a very stressful situation</td>
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<td>13. Those with a psychiatric history should never be given a job responsibility</td>
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<td>14. Those who attempt suicide leaving them with serious liver damage should not be given treatment</td>
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<td>15. Violence mostly results from mental illness</td>
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<td>16. Psychiatric patients are generally difficult to like</td>
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<td>17. Patients who abuse substances should not be admitted to acute wards</td>
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<td>18. Psychiatric treatments cause patients to worry too much</td>
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<td>19. It is difficult to negotiate care plans with patients in acute environments</td>
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<td>20. It is hard to help patients who are emotionally disturbed</td>
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<td>21. Psychiatric drugs are used to control disruptive behaviour</td>
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<td>22. Mental illnesses are genetic in origin</td>
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<td>23. Mental illnesses deserves as much attention as physical illness</td>
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<td>24. The manner in which you talk to patients affects their mental state</td>
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<td>25. People born vulnerable to mental illness</td>
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**Section 3:**

For questions 26 - 33 please mark on the line between the two words where, in your opinion, the average patient you care for lies, for example:

26. Safe __________________________________________ | Dangerous  

This indicates that you feel patients are slightly more dangerous than safe.

26. Safe __________________________________________ | Dangerous  

27. Adult _________________________________________ | Child  

28. Mature _________________________________________ | Immature  

29. Optimistic _____________________________________ | Pessimistic  

30. Cold-hearted ____________________________________ | Caring  

31. Polite __________________________________________ | Rude  

32. Harmful _________________________________________ | Beneficial  

33. Clean __________________________________________ | Dirt  

153
Structured Interview Schedule for NO's and DNO's

Part 1. Demographic data:

Gender:

Male ____
Female ____

Nursing qualifications: __________________

Part 2. Nurse skills:

1. Specialist clinical (mental health) experience Yes No

2. If yes how long was the experience?

3. What is the frequency of having patients who are mentally ill on your ward?

4. Do you feel uncomfortable to work with patients who are mentally ill?

5. How do you identify that a patient suffers from any kind of mental illness?

6. Do you think it is difficult to assess a patient with mental illness?

7. When did you last talk to patients with mental illness? Did you think whether you have said the right words?

8. If yes can you describe an experience?

9. Can you establish a therapeutic relationship with a mentally ill patient on the ward?

10. Whom do you contact to help you clarify the best approach to a patient with mental illness?
11. Do you deliver the same standard of nursing care to clients with mental illness than to any other clients?

12. Do you tend to avoid talking to clients if you know that they are mentally ill? Why?

Part 3. Nurse perceptions:

1. Why do you think that stigma towards mental illness effect your perception of them?

2. Do you care for relapsed clients as it would be to newly admitted mentally ill clients?

3. Should mental ill patients be cared for by specialist nurses?

4. Are you scared of catching a blood borne virus such as HIV or Hep C when caring for clients’ with dual diagnosis on your ward?

5. Do you consider that working with mentally ill patients to be fulfilling?

6. How do you think that mentally ill clients view you as a health care worker?

Part 4. Nurse knowledge:

1. Do you think that you have something to offer to clients with mental illness? If yes in what ways?

2. Do you feel that you are able to give appropriate advice to clients about their mental health problems?

3. Do you think that if you know more about how to care for clients with mental illness will make you feel more positive about the client group?

4. Do you believe that nurses need to be educated more about how to deal and communicate with mentally ill? Why?
5. Do you think that present education being offered about the mentally ill can help you in the delivery of care to this client group? If yes in what ways?

6. If you were in a position to make an educational program for your staff to care for the mentally ill effectively. What do you include?
Semi Structured Interview for Key Persons

1. Do you think that the general nurses working on the medical wards care effectively for the mentally ill?

2. Do you think that the needs of the mentally ill are identified and met on the medical wards?

3. Do you believe that the present education about the mentally ill is targeted to meet the needs of the general nurse working on the medical wards?

4. What is being done to educate the general nurses working on the medical wards to care effectively for the mentally ill?

5. Do you think that nurses working on the medical ward will benefit from having a specialised mental health nurse?

6. Do you think that general nurses working on the medical wards needs to be educated more about how to care for the mentally ill?

7a. Is it often to have nursing staff encountering problems with the mentally ill on the medical wards?

7b. If yes what kind of problems?

8. Do you think that more education in the mental health field will make the nurses feel more positive about this client group?
9. From the questionnaire distributed to the nurses and the interviews with the NO and DNO employed at MDH. Most respondents showed the need to have either more education about this client group or to have a specialised nurse of whom they can contact beside the psychiatrist on call. Do you agree?

10. Do you think that by the introduction of such a service of postgraduate education on the mentally ill to staff working on the medical wards will improve the nursing care?

11. Do you think that a specialised mental health nurse working on an on call basis will enhance the nursing care on the medical wards?
Appendix III

Consent Letters to Participants
Consent letter to the participants for the Questionnaire

UNIVERSITY OF MALTA

INSTITUTE OF HEALTH CARE

A NEEDS ASSESSMENT OF THE DELIVERY OF NURSING CARE FOR THE MENTALLY ILL ON THE MEDICAL WARDS-THE NURSES PERCEPTION.

Dear respondent,

As partial fulfilment in obtaining a MSc in Health Services Management I am carrying out a research study titled A needs assessment of the delivery of nursing care for the mentally ill on the medical wards-The nurses needs project involves asking nurse about the attitudes feelings they experience when caring for mentally ill patients. The questionnaire takes about 15 minutes to complete.

As you are one of those qualifying to participate, I am writing to kindly ask you to fill the accompanying questionnaire.

I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be published. Confidentiality and anonymity is therefore guaranteed.

If you choose to participate, please answer all of the questions. Your opinion is highly valued therefore please do not discuss your opinions with others prior filling the questionnaire. All data will be destroyed after successful completion of the study. You can withdraw from the study at any time you like.

I also wish to assure you that this research study has been approved by the Institute of Health Care Dissertation Board and the University of Malta Research Ethics Committee. If you wish, I am willing to produce the approvals on your demand.

If you decide to participate please sign below, to show that you are giving consent to participate in the study. If you wish to discuss the results at the end of the study, please do not hesitate to call me on numbers: 79926883

I wish to thank you for your help.

Yours respectfully

Chircop Joconnie

MSc Health Services Management Student
If you accept to participate in this study, please sign the declaration below:

After reading the above instructions, I, ________________________, give my consent to participate in this study.

____________________

Signature of participant
Consent letter to the participants for the Interviews

Appendix 5

Draft letter to participants

Form (A)
Mr / Ms ________________

As part of the fulfillment of Masters in Health Services Management, I am carrying a study on the “Nurses’ needs to care for the mentally ill patients on the medical wards”. The study attempts to explore factors which affect the care of patients with mental illness on the medical wards.

While you are under no obligations to participate, your contribution towards this study would be greatly appreciated. Participation will involve an interview which should take about 30 to 45 minutes. With your permission, I would like to use an audio tape – recorder and take notes during interview.

Your name will not be included in any part of the information collected and no one except myself would have access to the information disclosed during the interview. All information would be erased after the study is finished.

Participation is voluntary. The chosen respondents may refuse to participate or choose to withdraw from the study at any time without giving a reason. Withdrawal from this study will have no effect or whatsoever. Respondents’ names would not appear in any related reports and pseudo names will be used.

Questions about participation can be asked at any time. I may be contacted at:

Home: ________________
e-mail: ________________
Work: ________________
Address: ________________

If you wish to participate in this study, kindly sign the consent form below and send it to me not later than ________________

Thank you

Chircop Joconnie
Appendix 6
Consent Form (B)

I have thoroughly read the information sheet (Form A) about the study on the perception of emergency nurses towards patients with addictive behavior. I confirm that the explanation is adequate.

I HAVE UNDERSTOOD MY INVOLVEMENT AND AGREE TO PARTICIPATE IN THE STUDY.

Your telephone number: ______________________
Date: __________________
Signature: ______________________
Appendix IV

Approval Letters by the Relevant Authorities
Chircop Joconnie  
121, Triq Mons. Arthuro Bonnici  
Swatar, Msida  
27th February, 2008

To: Mr. Tonna  
I/c Leaves Section

Thru: Dr. F. Bartolo  
Medical Superintendent  
Mater Dei Hospital

Re: Permission to undertake Research Study

Dear Sir,

I am currently reading for a Masters in Health Services Management at the Institute of Health Care of the University of Malta. For my dissertation I shall be conducting “A needs assessment of the delivery of nursing care for the mentally ill patient in the general medical wards- The nurses' perception”. For this reason I require all the names of nurses employed with the Department of Health, together with details of their grade status. I will use this data solely for sampling purposes.

A timely response would be truly appreciated.

Yours sincerely

Chircop Joconnie
Chircop Joconnie
121, Triq Mons. Arthuro Bonnici
Swatar
Msida
E-mail: joconnie@maltanet.net
Tel no: 21311049
25/02/08

Re: Permission to undertake Research Study

I am currently doing a Masters in Health Services management and I have to undertake a research project as part of my Final Comprehensive Examination.

The Health Services studies dissertation panel has approved my research proposal and finds no objection to the nature of this study, as it is not seen to be disruptive or unethical. I am aware that I have to strictly adhere to ethical issues especially relating to informed consent and confidentiality and that I have to consult my research supervisor, Mr. Michael Bezzina throughout the research process. The research title is “A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards - The nurses' perception”. For this purpose, I request permission to be able to undertake this study. Moreover, I will be seeking approval from the IHC and the University research ethics committee. I am anticipating that data will be collected in the months of December and January of this following year.

I would be grateful if you would allow me access to collect data from nurses working in the Medical wards section by means of interviews and questionnaires. Your support for this project is greatly appreciated.

Should you have any queries you can contact my supervisor on 21223336 or Ms. Sandra Buttigieg, Coordinator of Masters in Health Services Management studies.

Your sincerely

Chircop Joconnie
Dear Sir/Madame,

I am currently doing a Masters in Health Services Management and I have to undertake a research project as part of my Final Comprehensive Examination.

The research title is: "A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards- The nurses' perception". A descriptive survey is going to be conducted in order to assess the nurses' needs in the general medical wards, through the nurse perception. A non random sample which include all nurses, NO and DNO will be utilised. The method of data collection will be that of interview and questionnaire. I am aware that I have to strictly adhere to ethical issues especially relating to informed consent and confidentiality and that I have to consult my research supervisor, Mr. Michael Bezzina throughout the research process. Moreover, I will be seeking approval from the IHC and the University research ethics committee. I am anticipating that data will be collected in the months of December and January of this following year.

Your sincerely,

Chircop Joconnie
121, Triq Mons. Arthuro Bonnici
Swatar, Msida
29th February 2008

Board of Division
Institute of Health Care
Mater Dei Hospital

Dr Sandra Buttigieg
MD MSc MBA PhD (Astor)
Institute of Health Care
University of Malta
Chircop Joconnie  
121, Triq Mons Arthuro  
Bonnici Swatar  
Msida  
27th February 2008

Mr. L. Azzopardi  
Departmental Nursing Manager  
Mater Dei Hospital

Re: Permission to Undertake Research Study

Dear Sir

I am currently reading for a Masters in Health Services Management at the Institute of Health Care, University of Malta. For my dissertation, I shall be conducting “A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards - The nurses’ perception”. For this purpose, I am asking permission to incorporate a part of the assessment form utilised by general nurses working on the medical wards. The assessment will be used solely for the fulfilment of the study.

Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interview and questionnaire. Transcriptions will be coded and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they still will be free to refuse to continue all or part of the interview.

A timely response would be truly appreciated

Yours Sincerely

Chircop Joconnie
Chircop Joconnie  
121, Triq Mons. Arthuro Bonnici  
Swatar, Msida  
27th February 2008  

Dr. Frank Bartolo  
Medical Superintendent  
Mater Dei Hospital  

Re: Permission to undertake Research Study  

I am currently reading for a Masters in Health Services Management with the Institute of Health Care, University of Malta. For my dissertation I shall be conducting "A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards- The nurses perception". For this purpose I request permission to be able to undertake this study. Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interviews. Transcriptions will be coded and used only for the purpose of the study. Noteworthy, also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they will be asked to sign a printed consent form before being commenced to be interviewed and to fill the questionnaire.

A timely response would be truly appreciated.

Yours Sincerely

Joconnie Chircop
Appendix V

Permission Letter by Mr. Baker
Dear Joconnie,

Please find the attached scale and some guidance notes, if I can help you further please let me know. There are 2 other papers relating to this scale:


Kind regards

John

Dr John Baker
Lecturer
School of Nursing Midwifery and Social Work (Room 6.306)
The University of Manchester
Jean McFarlane Building
Oxford Road, Manchester, M13 9PL
Tel. 0161 306 7837
http://www.nursing.manchester.ac.uk/staff/JohnBaker
Member of Mental Health Nursing Academics (UK) http://mhnauk.swan.ac.uk/main.htm

From: joconnie chircop [mailto:joconnie@maltanet.net]
Sent: 26 December 2008 18:22
To: John Baker
Subject: Re: Permission please

Dear Mr. J. Baker

My study is going to be conducted among general nurses working in the medical wards in Malta. The title of my research project is 'A needs assessment of the delivery of nursing care for the mentally ill patients in the general medical wards-The nurses' perception'. However, with your permission I will use the measuring tool found in your study, to identify the nurses needs by their attitudes to care for the mentally ill in the medical wards. This is only part of the study because I will also be interviewing the Nursing officers and the Departmental Nursing Officers with another tool.

I would greatly appreciate your help if you have any other research tools which can even enhance my study. I hope, I have given you enough information about my study.

Thank you before hand

Ms. Joconnie Chircop
Bsc Mental Health Nurse
From: John Baker
To: joconnie chircop
Sent: Tuesday, March 17, 2009 6:12 PM
Subject: RE: Permission please

Dear Chircop

Yes, I would be happy for you to use the scale but would like to know a little bit more about your study?

Kind regards
John

Dr John Baker  
Lecturer  
School of Nursing Midwifery and Social Work (Room 6.306)  
The University of Manchester  
Jean McFarlane Building  
Oxford Road, Manchester, M13 9PL  
Tel. 0161 306 7837  
http://www.nursing.manchester.ac.uk/staff/JohnBaker  
Member of Mental Health Nursing Academics (UK) http://mhnauk.swan.ac.uk/main.htm

From: joconnie chircop [mailto:joconnie@maltanet.net]  
Sent: 25 December 2008 15:56  
To: john.a.baker@manchester.ac.uk  
Subject: Permission please

Dear Mr Baker

I am currently reading a Masters in Health Services Management and would like to make use of the tool to measure attitudes for use of nursing staff working in the general setting. This is found in Methodological issues in nursing research of the 'Nursing attitudes towards acute mental health care: development of a measurement tool'. Way back in the 2005. My e-mail address is joconnie@maltanet.net.

Thank you before hand.
Chircop Joconnie
Appendix VI

Approval by University of Malta Research Ethics Committee
TERMS AND CONDITIONS FOR APPROVAL IN TERMS OF THE DATA PROTECTION ACT

- Personal data shall only be collected and processed for the specific research purpose.
- The data shall be adequate, relevant and not excessive in relation to the processing purpose.
- All reasonable measures shall be taken to ensure the correctness of personal data.
- Personal data shall not be disclosed to third parties and may only be required by the University or the supervisor for verification purposes. All necessary measures shall be implemented to ensure confidentiality and, where possible, data shall be anonymised.
- Unless otherwise authorised by the University Research Ethics Committee, the researcher shall obtain the consent from the data subject (respondent) and provide him with the following information: The researcher’s identity and habitual residence, the purpose of processing and the recipients to whom personal data may be disclosed. The data subject shall also be informed about his rights to access, rectify, and where applicable erase the data concerning him.

I, the undersigned hereby undertake to abide by the terms and conditions for approval as attached to this application.

I, the undersigned, also give my consent to the University of Malta’s Research Ethics Committee to process my personal data for the purpose of evaluating my request and other matters related to this application. I also understand that, I can request in writing a copy of my personal information. I shall also request rectification, blocking or erase of such personal data that has not been processed in accordance with the Act.

Signature: [Signature]

APPLICANT’S SIGNATURE: I hereby declare that I will not start my research on human subjects before UREC approval

DATE 29th February 2008

FACTORUL SUPERVISOR’S SIGNATURE I have reviewed this completed application and I am satisfied with the adequacy of the proposed research design and the measures proposed for the protection of human subjects.

DATE 29th February 2008

MAKE SURE YOU ATTACH THE FOLLOWING TO YOUR APPLICATION: * Recruitment letter, poster * Other institutional approval * Subject instructions * Tests or questionnaires * Information sheets or debriefing materials * Written consent form (or script) * Other

Return the completed application to your faculty Research Ethics Committee
To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

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<th>Refusal</th>
<th>Conditional acceptance</th>
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For the following reason/s:

Signature: [Signature]
Date: [Date]

To be completed by University Research Ethics Committee

We have examined the above proposal and grant

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<th>Conditional acceptance</th>
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For the following reason/s:

Signature: [Signature]
Date: [Date]