

Mental health nursing standards and practice indicators for Australia: a review of current literature

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Executive Summary

There are many changes and challenges facing the mental health care professional working in Australia in the 21st Century. Given the significance of their number and the considerable extent to which care is delivered by them, mental health nurses in particular must be at the forefront of the movement to enhance and improve mental health care. Mental health nurses in Australia must not only keep up with the changes, we should be setting the pace for others across the profession worldwide. The increasingly complex field of mental health nursing demands nurses who are not only equipped to face the challenges but are confident in doing so. Definitive guidelines for practice, clear expectations regarding outcomes and specific means by which to evaluate both practice and outcomes are vital.

Strengthening the role and vision of mental health nursing so that there is clarity about both and highlighting core values by which to perform will enable us to become focused on our future and what we can expect to both give to and receive from our chosen profession and how we can, and do, contribute to mental health care. The role of the mental health nurse is undergoing expansion and there are new hurdles to overcome along with the new benefits this brings. To support this, nationally adopted, formalised standards of practice and means by which to measure these, i.e., practice indicators formerly known as clinical indicators, are required. It is important to have national standards and practice indicators because of the variances in the provision of mental health across Australia – different legislation regarding mental health policies and processes, different nursing registration bodies and Nursing Councils, for example – which create additional barriers to cohesion and uniformity.

Improvements in the practice of mental health nursing lead to benefits for consumer outcomes as well as the overall quality of mental health care available in Australia. The emphasis on rights-based care, particularly consumer and carer rights, demands evidence-based, up-to-date mental health care delivered by competent, capable professionals. Documented expectations for performance by nurses will provide all involved with yardsticks by which to evaluate outcomes. Flowing on from these benefits are advances in mental health care generally and enhancements to Australia's reputation and position within the health care arena throughout the world.

Currently, the 'Standards for Practice' published by the Australian New Zealand College of Mental Health Nurses (ANZCMHN) in 1995 and the practice indicators developed by Skews et al. (2000) provide a less formal guide for mental health nurses working in Australia. While these earlier standards and practice indicators have played some role in supporting mental health nurses they have not been nationally or enthusiastically adopted and there are a multitude of reasons for this. This report reviews the current literature available on practice indicators and standards for practice and describes an evidence-based rationale as to why a review and renewal of these is required and why it is important, not just for mental health nurses but to the field of mental health in general. The term 'practice indicator' is used, except where a quotation utilises 'clinical indicator', to more accurately reflect the broad spectrum of nursing roles, i.e. not all mental health nursing work involves a clinical role.

There is an Australia-wide epidemic far more real and insidious than the risk of bird flu, more immediate than the threat of terrorism...the mental health epidemic has for decades left a trail of devastation the like of which should not be tolerated in a wealthy, supposedly civilised and caring society (Crawford, 2005).

1.0 Introduction

Statements in the news media such as the above may seem alarmist but in Australia there is a real and growing concern for the welfare of people who receive (or in some cases, fail to receive) adequate standards of mental health care. The report for the Mental Health Council of Australia (MHCA) by Ozdowski, Wilson and Hickie (MHCA, 2005, p.14), claims that the mental health system in place in Australia is in danger of '[failing] to provide basic medical and psychological healthcare and includes the inappropriate use of short term seclusion, confinement and the over-reliance on sedating medications'.

It appears then, that at best modest improvements have been made to the mental health system since the publication of the Burdekin Report (Burdekin, 1993 Ch. 31). It concluded that 'mental health services in the community [remain] seriously under-funded, as do the non-government organisations which struggle to support consumers and their carers'.

Acknowledgement should be made of the progress that has occurred in our mental health system. This includes increased involvement of both consumers and their carers and the emphasis on strengthening consumers' life skills for independent living. However, more needs to be done (MHCA, 2005, p.18).

One means of improving the quality of mental health care in Australia has been the increasing use of clinical and other data measurement sets in service provision. The trend started with the introduction of National Mental Health Reports in the early 1990s. Compliance monitoring of services against the National Standards for Mental Health Services (1996) was underway by the late 1990s. The first few years of this decade saw the routine introduction of consumer based outcomes measures (DoHA, 2002). Alongside these broad developments, mental health nurses developed their own Standards of Practice in 1992 which were formally adopted as the 'Standards of Practice for Mental Health Nurses in Australia' in 1995. The current project seeks to revise the current set of 'Standards' and their associated 'Practice Indicators'. They serve the dual purpose of measuring the performance of mental health care providers and ensuring consumers receive the level of care needed.

2.0 What are 'standards' and 'practice indicators'?

The use of appropriate standards and practice indicators is an integral aspect of health care and serves to guide mental health professionals in achieving successful outcomes for people with mental illness. As Mainz (2003) reported, standards and practice indicators are an important way of 'managing' the consumer while in receipt of

mental health care. Focusing on nursing practice, Elder, *et al.*, (2005, p.66) stressed that it is in the development of standards of practice that the 'professionalisation of mental health nursing is reflected'. Standards, as described by Elder *et al.*, (2005, p.66) characterise mental health nurses' dedication to 'accountability in professional practice' but do not provide the means by which to measure quality of care. For this to occur, report Elder *et al.*, (2005), there must be objective, specific, quantitatively measurable statements of outcome – in other words, practice indicators.

According to the ANZCMHN Standards of Practice for Mental Health Nursing in Australia (1995, p.1) standards represent the expected performance of registered mental health nurses. Standards set the foundation for mental health nursing practice and should be considered to be the minimum level of achievement required by competent individual nurses. Standards serve the two-fold purpose of providing the basis for 'public accountability' as well as guiding the evaluation of the practice of mental health nursing. Ongoing relevance and contribution to the continuing development of mental health nursing knowledge necessitates regular review of the standards by consistent means.

O'Brien, *et al.*, (2004) argued that standards ensure members of professional groups provide quality care to the individual consumers and that this is particularly important for mental health nurses as a group due to their significant contribution to the health workforce and mental health service delivery. There are generalist nursing standards available such as the recently published Australian Nursing and Midwifery Council (ANMC) 'National Competency Standards for the Registered Nurse' along with competencies for, amongst others, enrolled nurses and nurse practitioners with the stated intention of providing a benchmark against which to assess competence to practice across a variety of settings (2005, p.1). For the purpose of clarification 'competence', as defined by the ANMC (2005, p.8) refers to:

...the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

Competency Standards are the resultant products of combining competency units and elements (ANMC, 2005, p. 8). A competency unit may be seen as a stand alone, specific function or functional area which a Registered Nurse can perform in a nursing context while the competency element is a sub-function of the competency unit (ANMC, 2005, p.8).

Practice indicators, on the other hand, provide a quantitative means by which providers of mental health care can achieve 'improvement in care and the processes by which patient care is provided' (Mainz, 2003, p.524). As defined by the Australian Council on Healthcare Standards (1996) practice indicators are a strategy used to monitor care and services that identifies areas of concern, evaluates trends and highlights issues requiring further review. Practice indicators are not, however, to be accepted as a standard of quality nor as being representative of nursing in its entirety (O'Brien, *et al.*, 2004). They are a means, Mainz (2003, p.523) argued, of assessing 'health structures, processes, and outcomes'.

[Practice indicators] can be rate- or mean-based, providing a quantitative basis for quality improvement, or sentinel, identifying incidents of care that trigger further investigation. They can assess aspects of the structure, process, or outcome of health care. Furthermore, indicators can be generic measures that are relevant for most patients or disease-specific, expressing the quality of care for patients with specific diagnoses. (Mainz, 2003, p.523)

As Brooker, *et al.*, (1999, p.45) highlighted ‘it is essential that nurses can — and do — define and measure their contribution to health care, not merely to justify their place in the health care team, but to ensure that people using the health service receive effective and efficient treatment, care and support’. While Kurth, *et al.*, (2003, p.22) identified the development of national benchmarks and clinical auditing practices as being the tool to assist nurses to work together to achieve the common goals of advancing professional accountability and enhance the credibility of the mental health nursing profession.

In addition to the issues raised above, technological and other developments within health care, the mental health field, and society generally, have necessitated a review of the standards and practice indicators to ensure they still represent the most appropriate means of achieving compliance with current ‘best practice’ (Clinton & Hazelton 2000). As Gaskin, *et al.*, (2003, p.260) stated:

There is a need for research on clinical indicators to focus on the contribution of nursing to clinical outcomes, especially within complex organizations and multidisciplinary teams within the mental health setting.

This report aims to begin that process by undertaking a comprehensive review of current literature relating to mental health nursing standards and practice indicators.

3.0 Methodology

In order to ensure a comprehensive review of current literature in relation to mental health nursing standards and practice indicators the procedure outlined below was adhered to:

- A review of academic journals was conducted. The journal databases EBSCO, MEDLINE and CINAHL were searched using a variety of keywords such as ‘clinical indicators and mental health care’, ‘mental health care and standards’, ‘performance measurement and mental health care’ and so forth. The search was limited to documents published between 1995 and 2006.
- The reference lists for a number of articles (such as Gaskin, *et al.*, 2003; O’Brien, *et al.*, 2003; Skews, *et al.*, 2000) were perused to identify certain influential authors or ‘seminal’ papers.
- The search engine ‘Google Scholar’ was used to identify and retrieve relevant articles.
- Websites from the UK, USA, Canada and Australia were searched for relevant publications and background information.

While the searches conducted identified a considerable quantity of potentially relevant papers, the number actually deemed worthy of inclusion in an Endnote database amounted to 211 publications. Of these, 67 papers, books and reports were finally reviewed and incorporated into this document.

As a result of the search, the literature reviewed includes papers published on the subject in academic journals, Australian state and federal government reports and general information available on the World Wide Web. Documents on mental health nursing specific standards, values, and/or guidelines released from other countries were also utilised in both draft and final forms. The search also included a variety of publications dealing with the topics of performance measurement (for example, Koch, 1992) and practice indicators in the general health care fields (for example, Mainz, 2003). While not *specifically* concerned with mental health, the authors felt it was important these papers be included as valuable insights into the care of people with mental illness can be gleaned that might otherwise have gone unnoticed.

4.0 Background

Skews, *et al.*, (2000, p.12) pointed out that practice indicators in the mental health field have their origin in the pioneering work of Avedis Donabedian (*esp.* 1966). In assessing a health organisation's efficiency and effectiveness, Donabedian (1966, 1986, 1992) stressed the importance of examining 'structures, processes and outcomes'. Skews, *et al.*, (2000, p.12) adopted similar terms arguing, 'clinical indicators provide a measure of how well *structures, processes and outcomes* of care are achieved'.

The mental health nursing practice indicators (Skews, *et al.* 2000) used in Australia are based on standards developed in 1995. It is important to note that these indicators are not universally endorsed or adopted, however. The Skews, *et al.*, (2000, p.15) indicators focus on 8 issues:

1. Communication (relates to use of interpreters)
2. Documentation (relates to the existence of 'adequate nursing care plans' and appropriately written progress notes)
3. [Patient]/client care – collaboration (refers to participatory planning in all 'key elements' of nursing care plans)
4. [Patient]/client care – education (refers to client attendance at information sessions as recorded in clinical files)
5. Legal and ethical issues (refers to current registration, familiarity with the Nurses' Code of Ethics, and the use of ANZCMHN Standards of Practice as a major reference for Peer Reviews)
6. [Patient]/client safety (refers to regular reviews of critical events and nurses' attendance at critical incident/risk management training)
7. The nurse therapist (refers to the number of therapeutic patient contacts, the case load number, clinical supervision contacts and case review occasions and nurses' attendance at these)
8. Professional development (refers to attendance at professional development conferences/seminars).

The underlying basis for the Standards of Practice (1995) is a set of three principles:

- Standards are concerned with the performance of professional practitioners in their working environments.
- Standards for professional practice include professional attributes that are believed to underlie competence in the context of mental health nursing.
- Standards for professional practice specify the minimum level of performance required, the outcomes to be anticipated and, the context in which the performance takes place.

The Standards of Practice for Mental Health Nursing (ANZCMH 1995) derived from those principles are:

1. The Mental Health Nurse ensures his/her practice is culturally appropriate through the sensitive and supportive identification of cultural issues.
2. The Mental Health Nurse establishes partnerships as the working basis for therapeutic relationships.
3. The Mental Health Nurse provides systematic nursing care that reflects contemporary nursing practice and the client's health care/treatment plan.
4. The Mental Health Nurse promotes the health and wellness of individuals, families, and communities.
5. The Mental Health Nurse commits to ongoing education and professional growth and develops the practice of mental health nursing through the use of appropriate research findings.
6. The Mental Health Nurse practices ethically incorporating the concepts of professional identity, independence, interdependence, authority and partnership.

In addition to the broad statements outlined above, each principle includes a rationale for the inclusion of the principle and a list of attributes (knowledge, skills, attitudes and practice outcomes) related to the principle, with which the mental health nurse is expected to be familiar (ANZCMHN 1995, p.4).

There is an additional 'Advanced Practice Standard' which outlines that the Mental Health Nurse is able to integrate the first 6 standards at a 'level of excellence' using skills in 5 areas – clinical practice, leadership, management, research and education (1995). This standard is of particular interest and significance currently with the recognition by the Federal Government of the role of Nurse Practitioners. Some mental health services are demonstrating the increasing value of mental health nurses beyond the traditional hospital or community-based mental health service settings by developing strategies for incorporating mental health nurses into local general practice surgeries. The benefit of having nationalised, advanced standards of practice and practice indicators in the likelihood of both these additional roles becoming more common practice cannot be overstated.

5.0 Rationale for review of the current mental health nursing standards and practice indicators

Despite the stated intention of practice indicators as providing a quantitative means by which to measure health care performance (Mainz 2003) Skews, *et al.*, (2000, p.12) argued, 'such indicators do not provide a direct measure of the "quality" of care provided; rather, they are useful in identifying areas of practice that require more detailed scrutiny'. Similarly, Koss, *et al.*, (2002, p.83) highlighted that 'the relationship between standards and performance measurement is not currently well understood. Koss, *et al.*, (2002, p.83) continued, arguing that the relationship between standards and measures is not necessarily equal, rather it is believed that some aspects of health care are best measured by standards alone and other areas by performance measures'. This confusion may contribute to the difficulty for practitioners in sufficiently separating standards from practice indicators complicating the review process.

An important aspect of practice indicators is, as Carpinello, *et al.*, (1998) explained, their 'measurability'. Carpinello, *et al.*, (1998) maintained that an essential element of the development of practice indicators is that they be derived from standardised instruments of measurement. Concerns in relation to this characteristic and the existing standards used by the ANZCMHN (1995) were expressed by O'Brien, *et al.*, (2003) who argued that 'the performance criteria are not sufficiently developed to enable reliable measurement and they have been limited in terms of their scope'. This is a challenge to be met head on in the revision and reconstruction of practice indicators to support updated standards for mental health nurses.

The existing Australian practice indicators are perceived deficient because of a number of inadequacies found with, and questions arising from, the initial research that informed their development. When developing practice indicators for mental health nurses in New Zealand, O'Brien, *et al.* (2004, 2003) identified a number of concerns with the Australian indicators. These concerns were largely related to reliability and validity in measuring the conformity with the ANZCMHN Standards. These indicators were also understood to be lacking in recognition of bicultural issues. Further to this, review of the research of Skewes, *et al.* (2000) raises other questions. Importantly, the research appears to be flawed from the initial actions in that the stage one focus groups were constructed from nurses attending national ANZCMHN conferences in Australia and New Zealand rather than from their workplaces. Firstly, the actual number was very small (n = 39) and, secondly, results are highly likely to be skewed by the characteristics of the nurses attending a specific event such as a national conference. It is quite possible that the larger workforce of nurses from various clinical positions was not represented at the national conferences but nurses with management and/or academic positions and a different perspective on mental health nursing were predominantly in attendance.

The method of data collection following on from the early interviews also raises concerns. Records review (consumer medical records, ward records related to nursing staff and risk management training) was the technique utilised and this can

significantly reduce the range of information obtained. Documentation is only as accurate and/or reliable as the writer and there is a multitude of inaccuracies or exclusions that may be bound in the writing. Time constraints, personal preferences for writing styles, interpretation, and organisational directives are just a few of the issues that can impinge on the documentation reviewed thus damaging any research results. The later National field study also drew on records review further restricting reliability and validity.

The Delphi technique phase also raises concerns with another small number (n = 33) involved with these participants having been selected by chairpersons of State branches. Selection was to be on the basis of a known 'keen interest' and expertise or leadership in the field (Skewes, *et al.*, 2000, p.14). This opens the door to personal bias regarding possible candidates and a more limited group from which to draw participants. For example, a suitable, potential candidate may be excluded because the chairperson did not know of them or because of personality difficulties. Furthermore, selection of participants in this manner may result in an unrealistically 'ideal' group rather than reflecting the 'real' nurses. Added to these problems, the final practice indicators do not reflect issues such as consumer and carer involvement or community inclusion to mention just a couple.

Additional concerns are identified by Skewes, *et al.*, (2000):

- Variations in language and Mental Health Acts across the States and Territories
- Varying scales within the indicators reduced the ability to compare between individual indicator scores
- Lack of previous studies with which to inform this study
- Need for an understanding of the contextual factors in interpreting the findings
- An insufficient database for comparing services and limiting usefulness of the study results to internal service reviews.

While this study is not without its flaws and there are major restrictions for the practice indicators derived from it is important to recognise that this was the first of its kind in Australia and New Zealand. Furthermore, the study has provided the impetus for others to delve further, and more comprehensively, into this field.

Although the existing standards were comprehensive at the time of their completion, there are a number of areas of inadequacy related to the ability of the standards to reflect adequately the dynamic culture and values of Australian society or fit the changing requirements of Australian mental health care in the 21st Century. There is also a notable discrepancy in the standards in terms of the 'fit' with the National Standards for Mental Health Services (DoHA, 2002) as prescribed for all Australian mental health workers.

The ANZCMHN Standards of Practice (1995) are believed to be deficient in at least the following areas:

1. Conformity to the National Standards for Mental Health Standards (NSMHS) (1996)
2. A need to allow for culturally-specific mental health nursing practices
3. The provision of additional guidance required for mental health nurses operating within a community-based system

4. A need to conform to United Nations' Conventions
5. Recognition of the mental health needs of marginalised groups
6. A need to incorporate 'recovery' into the mental health nursing standards and clinical indicators
7. General changes to mental health care in Australia.

These issues will now be addressed in turn.

1. Conformity to the National Standards for Mental Health Services

The National Standards for Mental Health Services are divided into 11 standards with several sub-sections. These standards are outcome oriented, designed to reflect a values base of human rights, dignity and empowerment, and are guided by the principles found in the National Mental Health Policy (1992) and the United Nations (1991) *'Principles for the protection of persons with mental illness and the improvement of mental health care'* (NSMHS, 1996, p.1) . As these standards guide the care provided by all mental health workers in Australia it is essential that the specific standards for mental health nurses are found to be in concert with, if not exceeding, the generic governmental standards.

Two of the identified uses for the NSMHS relate to the development and quality improvement of mental health services (1996, p.4). These issues are at the heart of the impetus behind the review of existing standards and clinical indicators for mental health nurses, the overwhelming majority of workers in the field of mental health. The NSMHS demand quality of service to a minimum level and it would seem to be imperative that mental health nurses ensure that their guiding standards are at least supportive of these standards if not extending further to being the flagship, 'setting the standard', so to speak. Currently, this is not the case. It is important to point out, however, that the variance in layout of the two sets of standards makes a significant difference in the reading and, consequently, any comparisons. For example, Standard 1 of the NSMHS is that of 'Rights' (1996, p.7-8). While recognising the individual consumer, their families and significant others have rights which should be attended to and respected in the first standard and hinting at these throughout the other standards, the current ANZCMHN standards do not go far enough in emphasising these rights.

A single statement, in one standard, regarding the nurse being 'familiar with the rights of consumers, their families and/or significant others' is unlikely to impress upon the reader the need to prioritise rights. Consumer rights are not a simple, single artefact which requires minimal effort to ensure and protect. Indeed, this area is a complex one in mental health and entails considerable consideration of a myriad of legal, ethical and moral concerns and should be more comprehensively dealt with as it is in the NSMHS. As mentioned earlier, the issue of rights recognition is found in various formats throughout the ANZCMHN Standards but not in a comprehensive, cohesive block.

The second of the NSMHS standards is 'Safety' and this highlights the need for nurses to protect the consumer from exploitation and abuse as well as having the necessary knowledge of, and access to, policies, procedures and resources to protect consumers, carers, staff and the community from aggression. While this is, in part,

alluded to in the 3rd ANZCMHN standard via ‘Skill’ 17 (1995, p.9) ‘use nursing strategies to defuse potentially dangerous situations’ it is evident that this does not properly outline the range of protection issues involved in maintaining a high level of quality mental health nursing care or meeting the NSMHS. The issue of consumer and carer participation is, on the other hand, more uniformly dealt with by both sets of standards with significant emphasis in the third standard from each. It would be advantageous to progress the mental health nurses’ standard to include more detail in regard to the review processes involved in monitoring genuine participation.

While the ANZCMHN Standards identify health promotion and collaborative efforts to enhance awareness of mental illness in Standard 3 it doesn’t go as far as to identify the need for inclusion of the consumer into the community as raised by Standard 4 ‘Promoting Community Acceptance’ in the NSMHS. Increasing a community’s knowledge of mental illness, progressing health promotion activities do not guarantee or necessarily address the issue of inclusion into a community. Specific activities targeted at inclusion are required and this needs to be highlighted in any future standards in order to conform to the NSMHS. As with participation, privacy and confidentiality are recognised in the ANZCMHN Standards but not in an emphatic manner, rather as part of several standards and, as such, this could be misconstrued as indicating a level of less importance.

Health promotion is addressed in Standard 4 of the ANZCMHN Standards and this is in line with the similar emphasis in the NSMHS. What is missing, however, is the attendant emphasis on prevention, early detection, and early intervention, which is highlighted in the NSMHS. As with the issue of inclusion, for prevention and early action to become a ‘first’ response a genuine preventive philosophy is required and this must underpin the approaches of the mental health nurse attempting to make inroads into the quality, holistic health care of the community ‘consumer’.

Cultural awareness in the ANZCMHN Standards is generally appropriate to the level of the NSMHS Standards. The issue of ‘Integration’ is not. The NSMHS deals with 3 aspects of this theme – service integration, integration within the health system, and integration with other sectors. The ANZCMHN Standards mention continuity of care briefly as with the role of collaboration with other services but they do not go far enough considering, for example, the increasing reliance on external agencies, non-Governmental and community/volunteer organisations, to provide support and service to mental health consumers and their families given the lack of comprehensive Government services available. The issue of formalising processes and recognising the increasing impact of these services on the lives and wellbeing of mental health consumers is not adequately addressed within the ANZCMHN Standards.

The NSMHS ‘Service Development’ Standard (no.9) is somewhat covered by the ANZCMHN Standards but there is a deficit in the attendance paid to the development of components of care beyond the development of the nurse. The NSMHS emphasise the need for the mental health service to be managed in such a way as to facilitate coordinated and integrated care involving a number of different components. These components, beyond staff training and development are: organisational structure; planning; funding; resource allocation; information systems and service evaluation, research; outcome measurement, and quality improvement. Not enough recognition is given to these other components within the ANZCMHN Standards.

Neither is documentation given enough attention in the ANZCMHN Standards to conform to the NSMHS nor is the issue of 'Delivery of Care' (no.11) sufficiently highlighted. A broad range of care issues are addressed in Standard 11 of the NSMHS such that there are 6 sections with section 4 having a further 5 subsets. Themes in the NSMHS Standard 11 are: access; entry; assessment and review; treatment and support (containing community living, supported accommodation, medication and other medical technologies, therapies, inpatient care); planning for exit; and exit and re-entry. Importantly, the issues of exit and re-entry are not even mentioned in the ANZCMHN Standards and, given the potential impact that both of these situations may have on consumers, carers and communities it is vital that this deficit be addressed.

It is important to identify deficits in conformity between the two sets of Standards but it is also important to remember that each was developed within their own context and with their own purposes in mind. The variances in style and presentation must not be ignored as contributing to the seeming lack of fit of the ANZCMHN Standards to the NSMHS. There is outstanding evidence however, of a need for review and revamping of the ANZCMHN Standards if they are to be equal to or better than the NSMHS.

2. The need for culturally specific practices

While the standards go some way towards recognizing cultural issues, they need to take into account the growing cultural diversity in this country and to deal, in a more specific way, with the unique requirements of social and cultural groups within Australian society. As O'Brien, *et al.*, (2004) stated, mental health nursing practices should be appropriate to the cultural setting in which healthcare occurs. The article by O'Brien, *et al.*, (2004) is specific to New Zealand and discusses the need to acknowledge Maori history and culture. In particular O'Brien, *et al.*, (2004) emphasised the 'bi-cultural' nature of New Zealand society. Taking a bi-cultural view is, of course, important as it reflects the historical circumstances and political structure of New Zealand society and it would also be appropriate to incorporate similar provisions into the Australian standards to acknowledge the mental health needs of indigenous people. It is possible to argue, however, that due to the diverse nature of Australian society, it may be necessary to incorporate notions of 'cultural diversity' to more adequately account for the heterogeneous nature of Australian society (see also Gaskin, *et al.*, 2003).

In the United States, a country subject to similar issues of social and cultural diversity as Australia, elaborate and extensive guidelines have been developed to more adequately cater for the variety of social, ethnic and cultural groupings within that country. Aisenberg, *et al.*, (2003), for example, made a case for the development of mental health practice indicators that are specific to peoples' social and cultural backgrounds. Aisenberg, *et al.*, (2003) recommended the development of indicators that not only address the needs of people from different cultures but also to a range of other social characteristics, such as age, gender, sexual-orientation and so forth. In the context of the United States, yet relevant to the Australian context, Aisenberg, *et al.*, (2003) maintained that mental health nurses need to be cognizant of the needs of a diverse range of people with mental illness, such as:

- Children
- American Indian/Alaska Native children
- Ethnic minorities
- Gay, lesbian, bisexual and transgender individuals
- People with co-occurring mental health problems and substance use disorders
- Older adults.

Similarly, Hanlon (2005, p.44), referring to the situation in the United States, asserted that:

Mental health professionals today can expect to encounter a multiethnic, multicultural population in their practices. As the influx of immigrants continues to grow, clinicians must meet the challenge of treating a diverse patient population in ways that coincide with its ethnic principles.

Along similar lines, Chisholm, *et al.*, (1997) pointed to the need for cultural sensitivity and awareness of the needs of people from diverse social, ethnic and language backgrounds as a means of ensuring positive and fruitful relationships between mental health nurses and people with mental illness.

If Australian mental health nursing standards and practice indicators are to be at all effective, it is reasonable to expect the specific cultural needs of people with mental illness to be catered for.

3. The provision of additional guidance for ‘community-based’ mental health nurses

An important change that has occurred in Australia is the escalation of ‘de-institutionalisation’ of mental health care and a move towards a system that is based on ‘community-care’ and reduces resources for inpatient services (Whiteford, *et al.*, 2002). Whiteford, *et al.*, (2002, p.211) explained that with the implementation of the National Mental Health Strategy (Australian Health Ministers, 1992), ‘[a] substantial expansion occurred in community and general hospital services in parallel with a reduction in the size of stand-alone psychiatric hospital services’. As a result of the strategy, ‘spending on community mental health services grew by 87%’ in the period from 1992 to 1998 and a substantial number of ‘stand alone’ mental health facilities were replaced by a combination of ambulatory services, specialised residential facilities and not-for-profit non-government organisations.

With a significant move away from institutionalised mental health care, there is a need for standards to more adequately provide greater guidance for mental health nurses who provide services within a diverse community care framework. Recognition of the range of community service styles currently in existence, the accompanying skills required, and the situations in which the mental health nurse may work should result in a more comprehensive and supportive set of standards. It is more important now than ever to assist consumers to maintain or attain the skills required to enable them to maintain relationships with their local communities and carers and/or to reintegrate with the wider community if disengagement has already occurred. Carpinello, *et al.*, (1998) provided an example from the United States where

it was recognised that psychiatric institutions needed to facilitate the acquisition of social and coping skills as a way of enabling people with mental illness to more effectively reintegrate into the wider community. Carpinello, *et al.*, (1998, p.273) maintained that integration with the wider community is particularly important as a way of enabling people with mental illness who had been institutionalised to ‘regain and expand [their] social roles’.

Rowe, *et al.*, (2001) argued that the concept of ‘citizenship’ is a useful means of conceptualising community membership in relation to the care of people with mental illness. Drawing from the work of political philosopher, Alexis de Tocqueville, Rowe, *et al.*, (2001) asserted that an implicit goal of mental health care is assisting people with mental illness to become active ‘citizens’ and re-engage with the general community. There is a need, Rowe, *et al.*, (2001) stated, to ensure that the care of people with mental illness is directed towards the goals of social integration, consumer empowerment and meaningful employment. Along similar lines, Challiner, *et al.*, (2003) highlighted the importance of adequate levels of ‘physical and mental functioning’ as a precursor to re-integrating the person with mental illness within the wider community.

In a paper that takes a slightly different approach, Davidson, *et al.*, (2001) drew inspiration from the poetry of Jorge Luis Borges and put forward the case that the ‘inclusion’ of people with mental illness into the wider community should not be contingent upon them becoming ‘well’. Adapting a line from the Borges poem, *Fervor de Buenos Aires*, Davidson, *et al.*, (2001, p.375) maintained that the person with mental illness should simply be allowed ‘to be let in without being wondered at or required to succeed’. To Davidson, *et al.*, (2001) it is unrealistic to expect people with mental illness to recover completely from their affliction and it is the responsibility of members of mainstream society to change their own ways of thinking and accept people with mental illness into the wider community. Mental illness, Davidson, *et al.*, (2001) stated, is often exacerbated by people with mental illness being separated from mainstream society and by the negative attitudes of community members. The authors argued that by adopting a more positive and ‘inclusive’ attitude towards people with mental illness, the incidence or severity of mental health problems will be lessened. Lasting attitude changes must be supported by definitive guidelines to structure practice.

The inclusion of appropriate mental health nursing standards and practice indicators in relation to reintegration is one way of achieving this aim. It is interesting (and relevant) to note that the United Nations principles for the care of the people with mental illness specifically includes the principle that ‘every person with a mental illness shall have the right to live and work, as far as possible, in the community’ (Principle 3).

4. United Nations principles for the protection of persons with mental illness and the improvement of mental health care

It would be desirable if the principles were to more closely follow the United Nations convention ‘*Principles for the protection of persons with mental illness and the improvement of mental health care*’ (United Nations, 1991), which emphasise fairness, equity and respect for individual rights. Essentially, the United Nations

document (United Nations, 1991) revolves around twenty-five core principles. For a more comprehensive explanation of each principle, the reader is directed towards the United Nations document '*Principles for the protection of persons with mental illness and the improvement of mental health care*' (United Nations, 1991).

The principles described by the United Nations (1991) document are extensive and while some may not be appropriate for the purpose, they could potentially form the basis for a comprehensive set of mental health nursing standards and clinical indicators of mental health care in Australia. O'Brien, *et al.*, (2004), also highlighted the need to incorporate guidelines in relation to 'informed consent, information about legal rights, and provision of culturally safe and recovery-focused care', which have a number of parallels with the United Nations guidelines.

Dr. Sev Ozdowski, the Australian Human Rights Commissioner affirms that view and, in particular, draws attention to principles 7, 8(1) and 14, which as Ozdowski (2005) asserted, 'reinforce the rights enshrined in the International Covenants and provide valuable guidance as to how those rights should apply to people with mental illness'. As Australia is a signatory to the convention, it would be preferable for any mental health nursing standards and practice indicators developed to conform as closely as possible to the principles outlined by the United Nations.

5. Addressing the mental health needs of marginalised members of society

There is a growing recognition of the mental health needs of marginalised groups such as the homeless or people subject to various forms of incarceration. The standards need to be able to provide guidance to mental health nurses who operate within such environments. People can become 'marginalised' in a variety of ways such as by:

- Being incarcerated (e.g. in prison or illegal immigrant detention centres)
- Lacking a permanent place of residence
- Geographic isolation
- Being isolated from mental health facilities by reasons of language or culture
- Being part of the older groups of the ageing population.

Mental health care for people subject to incarceration has attracted significant attention in the literature and was the subject of a review by the Mental Health Council of Australia in 2005 that resulted in the '*Not for service*' report (MHCA, 2005). The way in which the prison system has become a substitute for mental health care was a particular area of concern, as one submission to the review states:

As psychiatric services struggle to respond to the needs of the mentally ill, the criminal justice system becomes a substitute. Prisons are now accommodation for more mentally ill people. How many will remain incorrectly diagnosed and return to the community without psychiatric treatment? (MHCA, 2005, p.211)

The incarceration of people with mental illness and the post-release assimilation of the person into mainstream society were also issues of concern, as another submission to the review states:

My primary concerns in relation to mental health, are the extremely high rates of incarcerated women (and men) with both diagnosed and undiagnosed mental illness, and furthermore the treatment they receive from health services whilst in prison. There are also serious issues relating to treatment, post-release, from community mental health services... (MHCA, 2005, p.211)

Pandiani, *et al.*, (1998) asserted that incarceration rates can form the basis for measuring the success of mental health care. While the measures are primarily associated with organisational performance, the paper does raise a number of interesting and relevant points. In particular Pandiani, *et al.*, (1998) drew attention to the situation in the United States where declining admissions to state psychiatric institutions (due to reductions in funding and a general trend towards community-based care) have been matched by an equivalent increase in the rate of incarceration.

The obvious conclusion reached by Pandiani, *et al.*, (1998) is that incarceration has become a *defacto* treatment for mental illness and a means of accommodating the person with mental illness.

As Pandiani, *et al.*, (1998, p.300) noted, the ‘criminalization of mental illness’ and the derogation of the person with mental illness are undesirable and it is the responsibility of mental health nurses to ensure that the incarceration of the person with mental illness is, as much as possible, prevented through effective care. Nevertheless, any standards and practice indicators developed must be able to measure the extent to which the care of incarcerated people with mental health illness is not only appropriate to their situations but also effective from both therapeutic and rehabilitative perspectives.

The second area of concern is in relation to the mental health needs of people who lack a permanent and stable place of residence. As the *Not for service* (MHCA, 2005) report makes clear, addressing the mental health needs of the homeless is an issue for mental health nurses to be aware, and for which standards and practice indicators need to take into consideration. The paper by Rowe, *et al.*, (2001), who discussed the notion of ‘citizenship’, is again relevant to this issue. Rowe, *et al.*, (2001) argued that processes to encourage ‘social integration, consumer empowerment and meaningful employment’ (as a means of fostering social inclusion) are important for those who are in the unfortunate position of not only having mental illness but also homeless.

As Young, *et al.*, (2005) noted, homeless women and men have a tendency to access emergency services for acute mental health care at a higher rate than the general population of people with mental illness. The inference to be drawn is that emergency services are being used by the homeless (or those who lack family support) as a substitute for appropriate institutional or community-based mental health services, or perhaps as a surrogate ‘family’ and a means of emotional support. As the literature indicates, mental illness and homelessness often occur concurrently. What is unclear — and may not be particularly important in the context of this study — is whether the relationship between mental illness and homelessness is causal or whether their mutual occurrence is merely the reflection of wider, underlying issues of social exclusion or marginalisation.

Whichever is the case, it will be necessary that any mental health nursing standards and practice indicators developed help to ensure that:

- early intervention is undertaken to prevent ‘at-risk’ people with mental illness from becoming homeless and
- adequate levels of care are provided to people with mental illness who are already homeless.

In addition to social isolation through homelessness, people with mental illness may be isolated in a number of other ways. Fuller, *et al.*, (2000), for example, highlighted the problems experienced by people living in remote locations or on rural properties whose mental illness may occur, or be made worse, as a consequence of economic downturns and environmental events, such as bushfires, and further exacerbated by geographic isolation. Treatment and intervention options are also reduced for those living in rural settings. Fuller, *et al.*, (2000) also claimed that, in Australia, a rural culture that idealises ‘virtues’ of stoicism and self-reliance also serves to inhibit the degree to which rural inhabitants are prepared to access mental health services, perceiving them as the preserve of people with a serious or ‘unmanageable psychosis requiring detention’ (2000, p.150). Mental health nursing standards should be formulated in such a way as to give proper recognition to the impact of rural culture and geographic isolation on the acknowledgement, prevention and treatment of mental illness.

Cultural isolation is also an issue in relation to the accessing of mental health services. This is especially the case for cultures in which problems such as depression are customarily addressed ‘within the family’ or by way of ‘traditional’ remedies or therapies. In addition, the inability to communicate effectively can inhibit the extent to which people from non-English speaking backgrounds are prepared to access mental health services. To add to the problems faced by nurses, ‘...conceptualization of health and illness differs across cultures, with some cultures giving prominence to domains (such as culture and spirituality)’ that are difficult to explain in a clinical setting or a quantitative manner (Slade 2002, p.749).

Steel, *et al.*, (2002) also identified the difficulties faced by people from overseas who have settled in remote or rural areas of Australia. With increasing numbers of immigrants living in non-metropolitan areas, the mental health problems of these people may be intensified by a combination of cultural, language and geographical barriers. Furthermore, with increasing numbers of political and other refugees being settled in rural areas, the mental health problems experienced may be further aggravated by their past experiences of war, torture, imprisonment or detention (Steel & Silove, 2001; Steel, *et al.*, 2002). Building both trust and collaborative, service networks are identified by Procter (2004) as significant tasks for any health care workers assisting asylum seekers with mental health problems and illness.

Realistically, it may be necessary to highlight these via standards and practice indicators to ensure that they become a part of standard, professional mental health nursing practice.

The Australian Bureau of Statistics publish details of Australia’s population on their website (www.abs.gov.au) and highlights the ageing nature of our population. As a result of both low rates of fertility over a considerable period of time and an

increasing age expectancy the median age is currently 36.6 years, up from 30.8 years 20 years ago (ABS, 2006). Between 1985 and 2005 the proportion of Australia's population aged 65 years and over rose from 10% to 13% while the proportion of Australians less than 15 years of age dropped from 24% to 20%. Significantly, the proportion of those aged 85 years or more has increased by 102% to comprise 1.5% of the total population (ABS, 2006).

These population changes bring new challenges for mental health nurses. Some of these challenges include not only caring for larger numbers of people experiencing the diseases, both physical and mental, of ageing but also for their families and other support systems. As the mental health care consumer moves further away from the hospital and into the community in a range of settings the mental health nurse is required to adapt as much as the consumer in many ways. Nursing homes, in-home support services and other community supports all vie for the time and expertise of the mental health nurse in maintaining the aged in acceptable health and living conditions. Caring for this consumer group is often a lengthy process and one entailing risks such as considerable emotional investment related to the often extended period of care and the reduced options for onward progression. Ensuring that nurses are assisted confidently and capably through the maze of the illnesses of ageing requires explicit guidelines in the form of sturdy and specific standards and practice indicators.

6. Recovery

There is no requirement for the 'recovery' of the person with mental illness to be considered (O'Brien, *et al.*, 2004). Although in many cases, *complete* recovery from a mental illness is either extremely difficult or impossible to achieve, there may still be a need for a general statement that refers to 'facilitating recovery' and/or 'assisting the person's return to mainstream society'. The notion of 'recovery' is generally assumed to be the goal of mental health care. A statement to this effect would provide a focus for mental health nurses in relation to the care of people with mental illness. The 'Recovery Approach' has been identified as a key direction for mental health services internationally as well as in Australia and the standards for mental health nursing in Australia should reflect this change of direction. The emphasis incorporated into 'recovery' on improving the informal support systems of people experiencing mental illness should not be neglected either.

O'Brien, *et al.*, (2004, p.85), for example, proposed that a 'consumer-recovery philosophy' be incorporated into mental health nursing standards and practice indicators. Indeed, research undertaken by O'Brien, *et al.*, (2004) indicated that mental health nurses see 'recovery as an important principle of nursing care...' Davidson, *et al.*, (2001) noted, however, that complete recovery from a mental illness, while desirable, it is not necessarily essential for a person to take their place in mainstream society. Therefore, it is the responsibility of mental health nurses to do everything possible to facilitate the reintegration, if they are unable to prevent separation beforehand, of people with mental illness into the wider community provided the person has achieved an adequate level of 'social functioning' (Slade 2002).

As Slade (2002, p.746) maintained, there is a need to differentiate between ‘clinical and humanistic’ goals or outcomes. Deriving his line of reasoning from Ware (1995) who contends that mental health encompasses aspects of behavioural and social functioning, Slade (2002, p.746) asserted that there is not only a need to improve or cure a disorder, but also to ‘maximise the patient’s and the family member’s sense of well-being and personal fulfilment’.

A potential mental health nursing standard and practice indicator that incorporates some notion of ‘recovery’, or ‘restoration to a satisfactory level of social-functioning’ would be useful as a way of measuring the success of mental health nursing care.

7. General changes required

Generally speaking, there have been considerable changes, if not improvement, in the care of people experiencing mental illness since 1995 and the standards and practice indicators need to be able to recognise and adjust to service initiatives. Some examples of these changes are: the increased community emphasis on community treatment and support; the increasing scrutiny of mental health care via the media; greater involvement of the individual in their treatment; the increased emphasis on the ideals of family/carer involvement and the incorporation of the non-government and community services into more individualized treatment plans and processes (i.e. partnerships).

Mental health care and mental health nursing are dynamic, or should be so if they are to appropriately respond to both the human and environmental conditions. Updating and modernising the standards and practice indicators for mental health nursing is essential if we are to provide adequate care, let alone to set benchmarks and advance both the nature and name of mental health care and mental health nursing.

Specifically, changes refer to such things as:

a. Continuity of care

‘Continuity of care’ has been identified by a number of authors (for example, Adair, *et al.* 2003) as important to the ongoing success of mental health care. It would be valuable for the standards to reflect this. The National Mental Health Plan 2003-2008 (2003) released by the Australian Federal Government highlighted continuity of care as an issue to be addressed by Australian mental health services. Including a statement in relation to mental health promotion and illness prevention, early intervention and postvention following illness episodes could more accurately reflect current and future nursing roles.

Ware, *et al.*, (1999) pointed out that continuity of care generally refers to the management and care of mental health conditions that are both chronic and debilitating. Consequently, ensuring that treatment is effective requires that care and follow-up is maintained over the long-term. Beaudin, *et al.*, (2005) stressed the need for early intervention and continuous monitoring of people with mental illness to prevent relapse occurrences. To Sytema, *et al.*, (1997) continuity of care referred to:

the degree to which patients receive over time the care they need. Care needed and care delivered can be expressed in terms of inpatient, day, or outpatient care. Continuity of care exists when the need for care and the care delivered are identical.

In a large quantitative study (n=37,852) undertaken in the United States, Dausey, *et al.*, (2002) found positive relationships between the provision of adequate outpatient care prior to admissions, the length of hospital stays and subsequent treatment success. Using a combination of linear and logistic regression, the study examined the relationship between receipt of preadmission outpatient care and length of hospital stay, use of post-discharge aftercare, and readmission (see also Druss, *et al.*, 1999; Druss, *et al.*, 2004; Druss, *et al.*, 2002). The study undertaken by Dausey, *et al.*, (2002) found significant relationships between outpatient care and future treatment regimes, and highlights the importance of people experiencing mental illness receiving appropriate levels of preadmission outpatient care. The indication is that early intervention in mental health nursing care can not only benefit people with mental illness, but also provide significant benefits to hospitals and other institutions by reducing the amount of time people with mental illness spend in their care (Dausey, *et al.*, 2002; Desai, *et al.*, 2005).

It should be pointed out that ensuring people experiencing mental illness receive the care they need (Sytema, *et al.*, 1997) on a 'sustained' basis (Greenberg, *et al.*, 2003) presents a number of challenges for mental health service providers. This is especially so in an era when 'community-care' (Carpinello, *et al.*, 1998) is being promoted and people with mental illness are situated in remote, often rural, locations where mental health services are in short supply (Fuller, *et al.*, 2000). In these cases, maintaining contact by way of telephone or other telecommunication technology may be the only feasible option. Indeed, as Hovenga, *et al.* (1998) reported, the field of Telepsychiatry, which uses a range of telecommunications technology to provide mental health care to remote communities, has been at the forefront of Telemedicine and Telehealth initiatives in Australia.

Greenberg, *et al.*, (2003, p.203) conceptualised continuity of care as sustained care, which embraces three main concepts. These are:

- regularity of care
- continuity of care across organisational boundaries
- consistency of care provider.

An aspect of care related to continuity of care is, as Baker (1998) contended, the notion of 'loss to follow-up'. Implementing procedures to ensure 'at-risk' people with mental illness remain within the mental health system would be valuable as a means of ensuring adequate continuity of care and an appropriate level of care. The concept of postvention, as used in suicidology may be a useful one to adopt with regards the impact of an episode of major mental illness. Conceptualising continuity of care as involving a 'debriefing' period and support role for the mental health nurse during this time may make for a more comprehensive set of standards by which to guide professional, proactive practice. Indeed, given the current, and likely to continue, emphasis on mental health promotion and illness prevention in mental health services per se it would be a more meaningful document which reflected these issues within the concept of continuity of care.

b. Statement of core-values

A general statement of 'Core Values' would be valuable in assisting mental health nurses more clearly define their roles and responsibilities towards people with mental illness. This approach has been adopted by several other mental health nursing groups such as those reflected by the 'From values to action' (UK) and the 'Scope and Standards' (US) draft document. The Scottish Executive recently produced a document on mental health nursing standards which also emphasised the need for a basis of core values.

c. Satisfaction with mental health nursing care

It is possible to make the case that the level of mental health 'patient satisfaction' (Berghofer, *et al.*, 2001) can influence the extent to which subsequent care is sought. Satisfaction can impinge upon other quality factors, such as 'continuity of care' or 'loss to follow-up' with dissatisfaction leading to relapse of their mental illness and the possible marginalisation of the person from mainstream society. Interestingly, Berghofer, *et al.*, (2001) found that patients' satisfaction of care is related to how they perceived other patients, suggesting that some notion of 'patient relationship to other patients' could be incorporated into the mental health nursing standards and clinical indicators.

Beaudin, *et al.*, (2005) called for a means to monitor patient satisfaction and response to care. A number of authors (such as Berghofer, *et al.*, 2001; Ahlfors, *et al.*, 2001 and Druss, *et al.*, 1999) made a case for a more rigorous assessment of how satisfied people with mental illness are with mental health care. Ahlfors, *et al.*, (2001) and Druss, *et al.*, (1999), in particular, pointed to the need to include 'patient-satisfaction' as an indicator of the quality of care, arguing that both 'clinical and care' aspects of treatment need to be taken into consideration when determining the quality of service provided.

d. Other significant changes

Given the scope of this report and the multitude of issues that would be required to be discussed making it an unwieldy and cumbersome document simple mention will be made of the fact that mental health care has changed as dramatically as have the faces of clients. A measure of the degree of change is seen, for example, in the terminology given to consumers over recent years; 'patient' has changed to 'client' to 'consumer' and now, in many circumstances, 'service user'. Some other general changes include the significance of dual disability and substance use disorders, and the increasing emphasis on rural and remote care (generally stemming from the increased reliance on community care) and the technologies used to confront this.

Another issue is the increasing inclusion of physical health care responsibility into the arena of mental health care. The potentially fatal and always important impact of the major psychotropic medications on the physical health and wellbeing of mental health consumers has introduced a new arena of responsibility and accountability for mental health workers, including nurses. No longer is there justification in turning responsibility for physical health problems, particularly those related to the therapies employed in the mental health treatment of consumers over to the general medical

field. Furthermore, the push for genuine holistic care demands a comprehensive model of treatment which includes the physical domain.

Yet another issue is the blurring of boundaries introduced by the emphasis on 'relationship' and the community treatment models. The distinction between 'professional' and 'patient' no longer exists as clearly now that there are no 'patients' and the 'professional' is required to trespass into the very heart of the consumers' existence – their homes, their families and their communities (Walker & Clark, 1999). Institution-bound care provided more formal, distinct boundaries (uniforms are a prime example) than the community-based care of today – greater time spent with consumers, increased time spent with their families and in the home, increased emphasis on 'getting to know' the consumer and, in turn, therapeutically revealing aspects of the therapist's self to the consumer have all contributed to a more challenging tightrope walk over the 'Grand Canyon' of the boundary issue. Walker and Clark (1999) raise the important issue of clinical supervision in the context of managing boundary problems but this is yet another area of growing importance in mental health work per se and should be addressed to reflect this new significance in new standards and practice indicators.

All of these issues, and more, support the need for a comprehensive review and revamping of the existing standards and practice indicators.

6.0 Measures, mental health nursing standards and practice indicators adopted by other organisations in the UK and U.S.A.

A review of the literature suggests that few, if any, nations have adopted universal, national, mental health practice indicators, opting instead for performance measures that either assess the performance of particular mental health organisations or the effectiveness of the mental health system as a whole. Nevertheless measures currently used in the United Kingdom and the United States of America are worthy of examination for insights they may offer into the development of mental health practice indicators in Australia. There are three significant documents relating to the use of standards and practice indicators in mental health nursing in the United Kingdom, Scotland and the United States.

United Kingdom

Although developed in Britain the Health of the Nation Outcome Scales (HoNOS) is also in use in Australia and is familiar to Australian mental health workers as it forms part of the Outcomes Initiative adopted by the Commonwealth and State governments (DoHA, 2002). The HoNOS is a twelve item scale primarily used as an organisational performance assessment tool (Callaly, *et al.*, 1998; Clarkson & Challis, 2002). Elements of the scale could, potentially, be suitable for inclusion in a set of mental health nursing practice indicators. For example, Brooker, *et al.*, (1999) used a data reduction (statistical analysis) tool to condense the twelve item scale (used to determine the HoNOS score) into four measurable factors which may be applicable to the development of practice indicators. The four measures are:

- Symptoms
- Social functioning
- Behaviour
- Impairment.

In effect, the four elements encompass the notions of ‘recovery’ and ‘reintegration with the community’, which, as we argue earlier in this paper, form a basis for assessing the relative success of mental health care. It would be appropriate, therefore, for ‘recovery’ and ‘reintegration with the community’ to be included in the mental health nursing standards and practice indicators when they are revised and developed. The inclusion of ‘recovery’ and ‘reintegration into the community’ are strongly called for in the recently released UK document ‘From values to action: The Chief Nursing Officer’s review of mental health nursing’ (DoH, 2006). While not using the terms ‘standards’ or ‘practice indicators’ the document outlines 17 ‘Recommendations’ with ways of ‘Making change happen’ for each and identified ‘Key contributors’. Recovery is covered in the first ‘Recommendation’ and social inclusion in number 9. The ‘Recommendations’ describe mental health nurses as MHNs.

For each ‘Recommendation’ there may also be referrals to other Recommendations and/or other documents as appropriate, as evidenced by Recommendation 5: All MHNs will be able to form strong therapeutic relationships with service users and carers’ which directs the reader to Recommendations 1.2, 1.6, 6.1, 8.1, 12.2, 12.3, 14.1 and 14.4 (DoH, 2006, p27). This document is quite comprehensive and provides supporting documentation and explanation for every Recommendation. It provides a useful format to inspire the restructure of future Australian standards and practice indicators.

The remaining Recommendations (DoH, 2006) are:

- Equitable care
- Evidence-based practice
- MHNs to focus on those with more severe levels of illness/need
- Comprehensive assessment and response to individual needs and identified risks
- MHNs to have skills and opportunities to improve the physical well-being of people experiencing mental illness
- Increase availability of evidence-based psychological therapies
- Recognition and response to spiritual and religious needs of service users
- Responding to needs of those with mental health and substance misuse problems across all settings
- Safe, supportive service responsive to individual needs
- Develop new roles in response to local need
- Pre-registration education will prepare MHNs to provide effective, values-based care
- Effective contribution to multi-disciplinary teams
- Continued development, throughout the career, of skills and knowledge
- Improved recruitment and retention supported through processes, roles and systems.

There are a number of valid issues raised in this document as to where and how mental health nursing should be moving in order to provide and progress both mental health care and mental health and psychiatric nursing. Several issues highlighted in the summary are worth mentioning at this stage.

1. Mental health nurses are the largest single profession in mental health care today. It is vital that mental health nursing is developed to prepare for the future in order to ensure we are able to improve both outcomes of and the overall experience of mental health care for consumers.
2. Mental health nursing should adopt a Recovery Approach focus which translates into positivity about change, promotion of social inclusion of consumers into their communities, and maintaining aims of care that are meaningful to both nurse and service users.
3. Mental health nurses should endeavour to ensure that all groups of society can access equitable service and that the local population groups are reflected within the mental health workforce.
4. Mental health nurses should ensure that the development and maintenance of therapeutic relationships with consumers, their families and carers is integral to all care provided.
5. A truly holistic approach requires mental health nurses to broaden their skills base to improve consumers' physical well-being via improved assessment, health promotion activities, and the provision of evidence-based therapies. This then requires that mental health nurses receive appropriate training, supervision and managerial support.
6. Improving inpatient care entails, amongst other things, a review of the time spent in direct clinical contact with consumers by mental health nurses and the incorporation of strategies to minimise time spent on administrative roles. Modern Nurse Managers should ensure that they role model behaviour which emphasises treating consumers with dignity and respect.
7. Risk assessment and management are significant tasks of the mental health nurse and they should work closely with service users to develop meaningful and realistic individual care plans.
8. Mental health nurses should use their skills in the most efficient and effective manner by focusing on direct work with people with high level, complex needs and support other workers to focus on consumers with less complex needs.
9. Relationships between service providers and educational institutions should be strengthened to support the advancement of mental health nursing practice.
10. Positive messages regarding mental illness and mental health should be presented to the media and reviewing current roles may assist in retention and recruitment of mental health nurses.

This year the Scottish Executive (National Health Service) has released a document of their own entitled 'Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland'. Recurrent themes occur within this document as with others from the U.K. and the U.S.A. as well as governmental mental health policy documents from Australia. The Scottish Executive identifies their 'Key Messages' (2006, p.5) under 4 headings:

1. Culture and values – strengthening the climate for care

- 1.1. Mental health nursing is focused on caring about people...on developing and maintaining helpful relationships with service users and their families and carers.
- 1.2. There is a need to continue to develop rights-based and person-focused mental health care by promoting values and principles-based practice in mental health nursing.
- 1.3. Mental health nursing care and intervention should be led by the Recovery Approach, particularly when working with people experiencing long-term mental illness and/or health problems.
- 1.4. Models of practice are required that centre on the relationships between mental health nurses and people, maximising time spent with service users and their families and promoting rights and recovery-based work.

2. Practice and services

- 2.1. There is a need to support the development of mental health nursing roles in the priority areas of acute inpatient, crisis care, and intensive home treatment services.
- 2.2. Particular support needs to be given to developing the role of mental health nursing in acute inpatient settings.
- 2.3. Working with those people experiencing long-term and complex mental health problems and utilising strength-based approaches towards recovery should be key roles for mental health nursing.
- 2.4. The support of older people with mental health problems should be a high priority and requires that mental health nurses be prepared and developed to deliver this care.
- 2.5. The provision of early intervention care for people at risk of developing mental health problems is a major role for the mental health nurse and this role should be developed and strengthened.
- 2.6. The mental health nursing role in health improvement, health promotion and tackling health inequalities should be developed.

- 2.7. Mental health nurses need to have opportunities to deliver ‘talking therapies’ such as psychosocial and psychological interventions.
3. Education and development
 - 3.1. A national framework to ensure consistency of contents and standards is necessary to ensure that the right people are recruited to mental health nursing and that they are prepared appropriately.
 - 3.2. Opportunities to continue learning and developing are required for all mental health nurses regardless of their area of practice.
 - 3.3. Service users, their families and carers and practitioners in the design and delivery of mental health nursing education programmes should be actively involved in nursing practice.
 - 3.4. Health care support worker roles should be developed in mental health to match the roles and skills of health and care workers to consumers’ needs.
 - 3.5. Leadership is a key component of ensuring the potential of mental health nursing in Scotland is achieved and leaders in nursing are required at every level and in all areas of practice.
 - 3.6. Research and evaluation capabilities in mental health nursing should be strengthened.
 - 3.7. Sharing and building on innovation is a must on a national basis to inform developments and develop a healthier learning atmosphere.
 4. To make this happen
 - 4.1. Everyone involved in mental health services needs to play their part and work together to form strong alliances to bring about change.

United States of America

In the United States of America, comprehensive systems are being developed by various state health departments and individual institutions for two purposes. The first is to measure and report on the experiences of people who receive mental health services and the second is for assessing the impact of managed care strategies on the service delivery system.

The broad set of guidelines developed by Aisenberg, *et al.*, (2003) for the care of people from a range of social and cultural backgrounds has already been dealt with in some detail and it would be valuable if elements of those were to be included in mental health nursing standards and practice indicators in Australia. In addition, it would also be useful to examine another program used in New York State, known as the ‘Prepaid Mental Health Program’, for its potential applicability to the development of Australian mental health nursing standards and practice indicators.

As Carpinello, *et al.*, (1998) outlined, the Prepaid Mental Health Program is effectively a performance management system for public sector managed behavioural health. Included in the program are a variety of 'individual-level outcomes' (Carpinello, *et al.*, 1998) that are relevant to the development of mental health nursing standards and practice indicators in Australia.

The outcomes encapsulate the notions of:

- Wellness
- Skill acquisition
- Community integration.

In a similar manner to the British Health of the Nation Outcome Scales (HoNOS) discussed above, the indicators are important measures of the outcomes of mental health care as they relate directly to the desired outcome of mental health care of enabling people with mental illness to 'regain and expand social roles' (Carpinello, *et al.*, 1998, p.273).

Currently, there is a document resulting from a joint exercise by the American Psychiatric Nurses Association (APNA) and the International Society for Psychiatric-Mental Health Nurses entitled 'Psychiatric Mental Health Nursing: Scope and Standards Draft Revision 2006'. This draft document describes both the scope of mental health nursing in the US and the standards expected to be met by nurses. There is the expectation that this document, when finalised, will provide for consistency across the breadth of the professional in the U.S. regardless of county, coast or State. This level of national standardisation should be a goal of any review of the existing standards and practice indicators for mental health nursing in Australia.

The 'Scope and Standards' document details the standards of psychiatric mental health nursing practice as 'authoritative statements' to express the responsibilities for 'which its practitioners are accountable' (APNA, 2006, p.2). There are 15 standards detailed and each has 'measurement criteria' and 'additional measurement criteria for the Psychiatric Mental Health Advanced Practice Nurse'. The standards described in this document are considerably more comprehensive than the current ANZCMHN Standards as are, consequently, the 'measurement criteria' in comparison to the Skewes, *et al.*, (2002) practice indicators. The document provides a meaningful, in-depth description of what a mental health nurse can expect to be doing in their work and why and presents a good example of how to structure such information in a user-friendly fashion.

Standard 1 Assessment (APNA, 2006, p.20), for example, sets out the statement:

The psychiatric mental health registered nurse collects comprehensive health data that is pertinent to the patient's health or situation.

A rationale is provided:

The psychiatric mental health registered nurse uses linguistically and culturally effective communication skills, interviewing, behavioural observation, record review and collection of collateral information to make sound clinical assessments.

The measurement criteria then cover a range of actions (10 in total) such as collecting data systematically and in an ongoing manner, involving the consumer, family, other caregivers and environment in the process. The data to be included but not limited to is also set out covering 21 different topics ranging from the central complaint, historical reliability to seek help if at risk of harm to self and/or others, health beliefs and practices, motivation for health related change, and complementary therapies used to intervene in health problems in the past (APNA, 2006, pp.20-21). The measurement criteria for the advanced practice nurse emphasises, among others, the use of evidence-based clinical practice guidelines, comprehensive assessment, and the initiation and interpretation of relevant diagnostic tests.

The other Standards described (2006) are:

- Diagnosis
- Outcomes identification
- Planning
- Implementation/Coordination of Care/Health Teaching and Health Promotion/Milieu Therapy/Pharmacological, Biological and Complementary Interventions/Prescriptive Authority and Treatment/Psychotherapy/Consultation (NB some of these sections of Standard 5 are for advanced practice nurses only)
- Evaluation
- Quality of Practice
- Education
- Professional Practice Evaluation
- Collegiality
- Collaboration
- Ethics
- Research
- Resource Utilization
- Leadership.

7.0 Significant Documents in Australia

The recent publication of the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Registered Nurse (2005) highlighted an increasing recognition of the need for formalised processes to identify and measure what and how nurses 'do'. These National Competency Standards for the Registered Nurse (2005) may also provide some inspiration for the review of mental health nursing specific standards and practice indicators. The ANMC (2005, p.2) identified 5 domains within which the competencies are structured. These domains are:

- Professional Practice – relating to professional, legal and ethical responsibilities
- Critical thinking and Analysis – referring to areas of self-appraisal and professional development and the benefits of research and evidence to practice
- Provision and Coordination of Care – focussed on the coordination and organisation of nursing care involving the assessment-implementation-evaluation processes

- Collaborative and Therapeutic Practice – referring to the establishment and continuation of professional relationships and an understanding of the contribution of interdisciplinary health care teams.

These standards are intended to be the means by which the registered nurse obtains and retains license to practice in Australia whether newly registered, continuing practice, overseas-trained, or returning to work from a long absence (ANMC, 2005, p.1). Other uses are for professional conduct reviews, providing consumers with expected service standards, and for individual nurses to assess their own practice (ANMC, 2005).

The Mental Health and Special Programs Branch (MHSPB) of the Commonwealth Department of Health and Aging (2002) produced a document entitled ‘National Practice Standards for the Mental Health Workforce’ which offers considerable support to the argument for review of existing mental health nursing standards and practice indicators. The ‘Practice Standards’ outlines 12 practice standards underpinned by guiding principles all of which are supported both by existing government policy, for example, the NSMHS, and current trends in mental health care, for example, the push for a consumer and recovery focus, evidence-based practice. The guiding principles include:

- The need to promote optimal quality of life for those experiencing mental illness and mental health problems.
- The need for a consumer focus emphasising the achievement of positive outcomes.
- The need to recognise the various dimensions (i.e. physical, emotional, social, cultural and spiritual) of the consumer, their families and their carers and assist consumers to create their own supports in the community.
- The need to learn about and value the life experience of consumers’ families and carers as well as that of the consumers.
- The need to encourage individuals to engage in decision making regarding their care and treatment.
- The need to ensure children of parents experiencing mental illness or health problems are provided with appropriate information, care and protection.
- The need to ensure that the planning, development, implementation and evaluation of mental health services includes consumers, their families and/or carers and the local community.
- The need to ensure the evidence-base underpins clinical practice where possible.
- The need to provide care that is not only coordinated, comprehensive and individual but also considers all aspects of the individual’s recovery.

The 12 practice standards are:

1. Rights, Responsibility, Safety and Privacy
2. Consumer and Carer Participation
3. Awareness of Diversity
4. Mental Health Problems and Mental Disorders
5. Promotion and Prevention
6. Early Detection and Intervention
7. Assessment, Treatment, Relapse Prevention and Support

8. Integration and Partnership
9. Service Planning, Development and Management
10. Documentation and Information Systems
11. Evaluation and Research
12. Ethical Practice and Professional Responsibilities.

The Mental Health and Special Programs Branch (2002) identify the aim of the 'Practice Standards' as being the provision of 'practical benchmarks' for all mental health professionals and those who employ them. It is expected that they would provide guidance for education and training through the encouragement of ongoing education both within the workplace and/or postgraduate opportunities. Furthermore, it is expected that all health professionals entering the mental health field should be offered opportunities for education on the life experiences and the needs for support and service of consumers and their carers. There is also an expectation that new mental health professionals will be informed about the need for working in partnership with consumers and their families/carers.

Although the MHSPB (2002) specify the target audience as being members of the five professional disciplines which provide the core of mental health services (i.e. Psychiatry, Nursing, Social Work, Psychology and Occupational Therapy) it is suggested that other groups may also find these 'Practice Standards' useful. These other groups may include, but is not restricted to, primary health care workers, Aboriginal and Torres Strait Islander health workers and general practitioners.

8.0 Concluding comments

The standards currently used by mental health nurses in Australia (ANZCMH 1995) were reasonably comprehensive at the time of their publication but have become outdated and demonstrate a concerning lack of comprehensiveness such as is required today. The practice indicators, in their current state, are even less helpful to the practicing mental health nurse. There are a number of aspects that need to be incorporated to ensure that they reflect current mental health nursing practice and the changing nature of the mental health system in Australia.

In particular, it would be valuable if, among others, the following issues were included in the mental health nursing standards and practice indicators.

- Most importantly, conformity of the standards and practice indicators with the existing NSMHS (1996) and, if possible, exceeding them as well as ensuring future compliance with updated editions of the NSMHS and other relevant governmental policy and practice guidelines, especially the National Practice Standards for the Mental Health Workforce (2002).
- A nationally standardised approach to mental health nursing guidelines, practice requirements and outcome measures should be the outcome of any review and/or innovations in standards and practice indicators development in Australia. It is important to integrate recognition of the diversity in policy and processes across Australia in terms of features such as Nursing Registration and Nursing Councils, Mental Health Acts and other legislative requirements to support a nationalised form of standards.

- Need to allow for culturally-specific nursing practices.
- It is necessary to include standards and indicators that cater for mental health nurses who work within an increasingly complex community-based mental health system.
- Following from the previous point, it would be valuable if the standards and practice indicators could incorporate some notion of ‘assisting people with mental illness to more effectively re-engage (or reintegrate) with the wider community’.
- The standards should follow the United Nations convention ‘*Principles for the protection of persons with mental illness and the improvement of mental health care*’ (United Nations 1991), which emphasise fairness, equity and respect for individual rights.
- The review and incorporation of appropriate aspects of more recent documents from other mental health nursing groups, i.e. the international documents highlighted in this report, should be a high priority.
- The mental health requirements of marginalised groups, such as the homeless and incarcerated, needs to be catered for.
- ‘Recovery’ or ‘facilitating recovery’ should be an important aspect of the mental health nursing standards and practice indicators.
- General amendments to reflect the changing nature of mental health care in Australia including:
 - A statement of core-values in relation to mental health care
 - Standards to stress the importance of continuity of care across the health promotion/illness prevention spectrum and covering all aspects of active intervention and care termination
 - Recognition of the increasing complexity of mental health care across the life span and the issues with which mental health workers must be both familiar and adept at managing is vital (eg. dual diagnosis, substance use disorders co-existent with mental illness and/or mental health problems, rural and remote community nursing, boundary blurring) to ensure nurses are guided through the maze of modern mental health care. This should include recognition of the ‘shifting of the goalposts’ as occurs with increased information, advances in technology, and improvements in consumer and carer status and rights.

An additional component for inclusion could be that of a vision for the future of mental health nursing in Australia and how the standards and practice indicators can support, encourage and guide the achievement of this vision. Over the past twenty years mental health nursing and mental health care has experienced considerable change – even more is expected. It is imperative for all concerned that mental health nursing travel a road to the future of expert care guided by appropriate signposts.

The provision of mental health nursing care that is of a consistent high standard and quality, regardless of the location of the interventions, the presentation of the consumer or the background of the staff, is an essential part of mental health care in Australia. A review of the standards and further development of the practice indicators are an important aspect of mental health care in Australia to achieve the goal that Keith Wilson called for in the foreword of the ‘*Not for service*’ report

(MHCA, 2005) that 'all Australians will have their rightful access to quality mental health care'.

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