SENATE SELECT COMMITTEE ON MENTAL HEALTH

Submission by **Jon Chesterson, NSW**
Status **Independent/private submission**
Date **28 April 2005**

Professional Background

I have worked as a mental health nurse (MHN) and Registered Nurse (RN) for over 17 years in Australia and 10 years in the United Kingdom. During this time, I have worked substantively as a clinician (RN, clinical nurse specialist and consultant) in acute inpatient psychiatry, community mental health, psychiatric rehabilitation, and promotion and prevention, and in education and management. I have held numerous offices and continue to hold others within three professional bodies including ex-president of and current project consultant for credentiling for the Australian & New Zealand College of Mental Health Nurses and ICN expert for the International Council of Nurses appointed by the Royal College of Nursing Australia, and a range of non-government organisations including two recent board director positions with PRA and Lifeline Newcastle. I am a reviewer for four professional refereed nursing journals, have served on an advisory committee/ taskforce to the Federal Minister in 1996/7 on the establishment of a peak national body – the Mental Health Council of Australia, and was consultant to the Health Complaints Commission, Tasmania in the investigation and clinical audit of a mental health service in 2004. I am a credentialed MHN, and have been a foundation fellow of the Australian & New Zealand College of Mental Health Nurses since 1993.

Introduction

In this submission, I propose to raise a number of issues specifically in relation to the Terms of Reference, primarily focusing on the role of the nursing profession and national workforce issues. I also provide comment with respect to Non-Government Organisations (NGO's), family and carers including respite care and support, consumers, and the special needs groups, refugees and dual diagnosis. An executive summary (page 20) outlines some key strategies for a national reform agenda of the mental health nursing workforce and the broader mental health sector, followed by key references and a specialist bibliography on problems in acute psychiatric inpatient units. This submission is an independent submission and does not represent in an official capacity any professional body, position of employment or employing mental health service. However as one of two appointed ICN experts in Australia for mental health nursing, I attempt to provide an intelligible and reasoned account and analysis substantiated by the Australian and international literature, of some of the key issues facing the Australian mental health nursing workforce, which being the largest employed group within public mental health services, is of serious concern to the success of the National Mental Health Strategy and provision of mental health services in Australia.

In summary on the mental health nursing workforce, it is my observation and conclusion, that there are four over-arching requirements that underpin the nursing profession and workforce capacity to engage people with or affected by mental illness and provide suitable access and effective services to all Australians who need them:

1. **Recognition and support of the professional caring and therapeutic role of mental health nursing** – Role development, valuing, empowering and supporting nurses to do their work.
2. **Routine adoption of evidence based practice/practice development in mental health nursing** – Development and access to postgraduate education and research, professional preparation for the specialty, ongoing education and workforce skilling, the building and dissemination of disciplinary knowledge.
3. **Development of professional identity, critical mass, and reasonable workloads** – Ensuring effective networking, professional governance, leadership, workforce planning/development in relation to population health

need, and representation of mental health nursing at professional, health service policy, State/Territory and Commonwealth government levels.

4. **Fostering collaboration and partnership with intelligent and shared responsibility for provision of care** - Between the profession and other disciplines, NGO's, carers, consumers, health service providers and governments.

Arguably all of the issues concerning the nursing profession and this sector of the mental health workforce: may be defined within the above parameters; require proper, sustainable, equitable financial and human resources (capacity building); and demand comprehensive workforce planning and strategic development, within the spirit of, and support of the National Mental Health Strategy and 3rd National Mental Health Plan. It is my thesis that this has been one of the key failures of the National Mental Health Strategy, and that despite admirable and sound policy and direction, this government and previous governments of the last two decades have singularly failed to recognise and address any of the systemic, educational, resource and infrastructural issues facing the profession and the mental health nursing workforce. There are 10,471 FTE (full time equivalent) nurses employed in Australian public mental health services, representing 65% of the clinical workforce (National Mental Health Report, 2002).

Background on Mental Health Nursing Workforce Needs

With reference to the following Terms of Reference, collectively:

a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.

The Prevalence of mental illness is well documented: 20% (1 in 5, 1.7 million pa) of the Australian population experience mental disorders and illnesses and another 2 in 5 Australians are estimated to know or be affected by someone with a mental illness. The World Health Organisation estimates mental and neurological disorders accounted for 12% of total disability-adjusted life years (DALYs) lost due to all diseases and injuries in 2000. By 2020, it projects the global burden of these disorders will increase 15% (World Health Report 2001), with depression as the second most prevalent disorder, behind heart disease.

In contrast, 6.6% of the national health budget is spent on mental health services, approximately half that of similar countries such as New Zealand, Canada and the United Kingdom. 224,000 nurses are employed in Australian health services representing 1% of the Australian population (ANCI, 2004). 10,471 FTE nurses are employed in Australian public mental health services, 65% of the clinical workforce (National Mental Health Report, 2002), but only 5% of the total nursing workforce. Thus 5% of nursing workforce/resources are directed at a public health problem directly affecting at least 20% of the Australian population in terms of morbidity (ill-

health), and significantly greater if we are to account for psychiatric disabilities, loss of work due to depression, and family/carer burden, health and quality of life. The logical consequences of this lead to unreasonable workloads, occupational stress and burnout, increased risk of aggression and critical incidents, shallow and ineffective treatment-care-support compromised by bed shortages and briefer episodes of care, poor access to mental health services, and significant unmet need within the community. The public mental health system cannot deliver on the goals of the National Mental Health Strategy today due to inappropriate staffing levels and formulas, further compromised by current workforce shortages. In addition to this the average age of the mental health nursing workforce is 47+, and more than half of the existing workforce is expected to retire within the next 15 years. The pitifully small trickle of new graduates into mental health today compared with the late nineteen seventies and early eighties has already resulted in a workforce crisis. All these problems have been reported and are clearly visible in our public mental health system, added to which there are also significant workforce shortages of RN's and skilled mental health nurses (MHN's) within existing services across all jurisdictions.

Taking into consideration many other factors and variables, I would estimate that to provide effective treatment, care and support services to Australians today, the mental health nursing workforce and/or equivalent resources need to be doubled. This, alongside other strategies to address workforce skills (both mental health nursing and nursing generally) should be the target of any national mental health workforce reform strategy over the next 10 to 15 years, including the current 3rd National Mental Health Plan. It is abundantly clear why the mental health nursing workforce logistically struggles with best practice, despite significant efforts by the profession itself to address intrinsic factors such as standards of practice for mental health nursing in Australia (ANZCMHN, 1995), ongoing education and clinical governance (introduction of credentialing nationwide, 2004), research development and dissemination (Board of Research, National Research Fund, International Journal of Mental Health Nursing, research monographs, and in 2005 the culmination of 31 annual national/international conferences).

The profession itself struggles with issues of public image, profile, identity, unity and critical mass, on the one hand surviving in the shadow of medicine and psychiatry, and on the other subjugated by the large and popular mass of mainstream nursing, nursing education, and generalist priorities and agendas, often viewed from a relatively poorly connected, informed and advised nursing leadership, when it comes to matters of mental health. Mental health nursing workforce issues are generally poorly understood, receive deaf ears, poor media and policy analysis, nursing shortages scarcely get onto the political agenda, frequently overshadowed by the powerful lobby and media coverage afforded to shortages in medicine and psychiatry. The issue of professional identity is critical since it is inevitably linked to workforce competence, skill, and capacity for self-governance of these issues. In the advent of comprehensive nursing education and statutory de-regulation of mental health nursing across all jurisdictions, professionally trained mental health nurses have been gradually replaced by the comprehensively trained Registered Nurse during the past two decades. Graduates, themselves argue today, that they are inadequately prepared for mental health practice in their undergraduate degree, and few enroll in appropriate postgraduate specialist programs, due to expense and lack of imperative. The crisis of nursing workforce shortages, lack of specialty preparation, slow disintegration of the specialty, against a general backdrop of government and mainstream health service,

nursing, and academic indifference, has made it difficult for the profession to gain critical mass, capacity, and to speak with a collective voice on matters of vital importance, impacting on the delivery of mental health services in Australia for close to two decades.

When mental health nurses or the profession state their case, all too frequently, the response from various quarters is, "get in line", "stop winging", or "you need to move on - comprehensive nursing education is here for good, mental health is no more a specialty than any other field of nursing, you don't have the numbers (supply and demand), we are not interested unless it has a multi-disciplinary focus, there is no budget for this, you need to face economic reality". Quite frankly, these excuses, these commonly cited overt and covert dismissals over the years, plus the continued stigma associated with mental health nursing and mental illness, and a series of systemic trends and changes, with no systematic analysis of impact or planning of the national workforce and affects on the profession itself, have brought us to where we are today. That is – a public mental health system that has become starved of resources, inconsistent and inequitable across jurisdictions, operates at crisis point, is defensive (pre-occupied with safety and protection from litigation), restrictive (on practice, consumer choice and human rights), managed by a dysfunctional health care system and disconnected self-serving political interests (governmental/departmental), that does not consider the capacity, the value, the potential, the skill, the health and wellbeing of the majority of its own workforce. We could have had so much more – consumers, carers, families, the general public could have so much more.

There have been two Commonwealth funded national workforce studies in the past 5 years, most recently: the *Australian Mental Health Nurse Supply, Recruitment & Retention*: AHWAC Report (2003), auspiced by the National Mental Health Working Group of AHMAC; and the *Scoping Study of the Australian Mental Health Nursing Workforce 1999* (Clinton, 2001), conducted under the auspices of the Australian & New Zealand College of Mental Health Nurses, which incidentally is and has not been publicly available on the Government website, despite being a public document. The Commonwealth Government has failed to act on any one single issue, concern or recommendation poroposed by both these reports, which were remarkably consistent in their findings. The more recent study, in fact emphasized, that the problems and issues found have already been well documented in the literature and are well known, what is bewildering is that so little has been done to address them.

In 1998/9, the Australian & New Zealand College of Mental Health Nurses drafted and submitted a comprehensive and strategic proposal to establish a National Institute for Mental Health Nursing to both the Mental Health Branch of the Commonwealth Department of Health and Aged Care and the Centre for Mental Health, NSW Department of Health. This proposal was initially supported by NSW Health with a seeding grant promised/set aside, but on condition that the Commonwealth Government would share financial responsibility for its establishment. The proposal involved sector and key stakeholder consultation and engaged a range of consumer and mental health nursing consultants at professorial level in Australia, USA and the UK, and gained their commitment and confidence. The mission of the Institute was to build the image, profile and capacity of the discipline to a new level, where mental health nursing could more effectively contribute to mental health care and consumer outcomes by the conduct and dissemination of research on evidence based practice, practice development, provision of ongoing education especially workforce skills development, and progress course accreditation and credentialing systems for the

profession. The proposal was rejected by the Commonwealth Government despite there being no such institute or centre anywhere in Australia, noting numerous such centres and institutes in psychiatry. It was written with a collaborative brief, both with other disciplines and to develop international links/networks. It was to be fully self-funding after 3-5 years, utilizing the existing infrastructure and energy within the College, which by way of enhancement funding might have generated significant returns by today (just 6 years later). It is one of many innovations that have been proposed and/or developed by the College in recent years, but required some external support from government. In fact it was scarcely even considered or raised a murmur on the political agenda. As president of the College at the time, I do not recall even receiving a written response or explanation. On meeting with members of the Mental Health Branch, I was astonished to discover that after several months, no-one who met with us seemed to have any real knowledge of the contents of the proposal, and I doubted it had even been read. I was left with the impression of having wasted valuable government time and naturally our valuable time had been wasted, despite many having spent hundreds of hours developing the proposal in response to the needs of the profession at that time – Needs that have not changed since and are largely summarized in dot point below, and clearly supported by the two workforce studies that have been published since. This is just one example of the dismissive attitudes of the Commonwealth Government when it comes to nursing. I later discovered that the funding set aside from NSW Health was later dismissed and denied. It is little wonder, the lack of trust and confidence mental health nurses have in government matters, when their best efforts are simply rejected without any proper consideration of their validity and significance, let alone good will. The only initiatives to systematically address workforce needs seem to be generated by the College.

Another such example is the College's development of credentialing (The Credential for Practice Program – CPP), backed by extensive national stakeholder consultations, a research program in 2003 to validate the principles, values, criteria and operational components of the program, and launched nationally in Canberra at the 30th International Conference in September 2004. Once again this program has no external funding or support from government, despite the Commonwealth Government now relying on this program to determine who within the nursing profession is eligible to bulk bill for mental health service provision through general practice under the new Medicare Plus arrangements. This program has only just been initiated, however I believe it may be difficult to sustain without allocation of suitable financial, administrative and human resources. It has the potential to be fully self-funded – User pay, but is in need of an external seeding grant to effectively establish, market, and administer the program nationally.

Governments needs to realize, that mental health nursing is starved of infrastructure and resources in order to develop a sustainable system of self-governance, such as medicine and psychology. There are issues of identity, commitment and critical mass to overcome before that point is reached. The benefits of which are potentially quite considerable over the next few years, in terms of influencing practice, practice development, improved contribution to mental health service delivery and outcomes, and ultimately professional and public accountability and confidence.

The mental health nursing workforce is straddled with the following systemic problems, which while complex and multi-faceted are all underpinned by a

fundamental lack of government funding, resourcing and recognition (State and nationwide):

1. Poor public image/profile, lack of professional recognition, low professional morale, exacerbated by the continued social stigma of mental illness, lack of mental health nursing visibility/audibility, regurgitation of historical archetypes-practices-sensational reporting by the media, and government dismissal/denial of mental health nursing workforce needs.
2. Inadequate undergraduate preparation of RN's for practice in the mental health field.
3. Inadequate postgraduate preparation of mental health nurses, access and affordability of postgraduate programs, relevance of postgraduate programs to clinical/evidence based practice and mental health nursing workforce, lack of scholarships and grants for clinical based courses. RN's cannot afford postgraduate education early on in their career when they are already paying off their HECS debts.
4. Lack of funding for continuing education, access to educational programs (especially those focusing on skills acquisition and evidence based practice/clinical effectiveness), budgetary constraints restricting release from rostered shifts and backfilling of staff, lack of evidence based training with demonstrable clinical or practice outcomes.
5. Gradual systemic decline in mental health nursing workforce skills mix, and nursing workforce skills, due to the above, which has been in decline since the mid nineteen-eighties and comprehensive undergraduate education. This has been further eroded by statutory de-regulation of mental health nursing and introduction of single registers within States and Territories of Australia throughout the nineties brought on by the Mutual Recognition Act 1992; and more recently compounded by cut backs in postgraduate nursing studies in Australian Universities, where emerging postgraduate programs in mental health nursing are being threatened or superseded by generic/umbrella courses, which lack content validity and clinical relevance to contemporary mental health nursing practice. This latter trend emerging appears to be largely on account of universities cutting back on specialty courses due to inadequate government funding, lack of recognition of mental health nursing as a special needs case, and ongoing stigma associated with senior nursing academics who fail to see the relevance of mental health nursing as a critical field of practice or service provision with a population based need or as a viable/desirable career option such as midwifery, paediatrics or critical care.
6. There has been a decrease in staffing levels and staff to patient rations over the past 25 years, whilst the population has grown, mental health needs of the population have grown, inpatient bed numbers have fallen dramatically, decreased length of stay from around 25 days to between 8-12, increased acuity and co-morbidity (with drug and alcohol related problems), and increased risk of violence, aggression and injury – Not just to staff but other patients in our acute psychiatric units.
7. The nursing workforce is subject to greater stress, burnout, risk of injury, lack of job satisfaction, unreasonable workloads (both quantitatively and qualitatively – breadth/depth/choice of interventions) in acute care facilities,

such that the only tangible, consistent and reliable treatment offered routinely is medication, aggression and behaviour management within a system that is pre-occupied with occupational health and safety, bed occupancy/ management, and the unrelenting juggling of inadequate budgets, structural reforms, and unrealistic policy and political agendas. There are insufficient nurses to provide appropriate treatment and care, insufficient time and emphasis devoted to care and effective interventions, insufficient time spent with patients, insufficient skills, and insufficient training.

8. Lack of funding to support research into mental health nursing and best practice within a competitive grant system where nursing is forced to compete with medicine and allied health or multi-disciplinary projects. There are well founded arguments for nurses to engage in collaborative multi-disciplinary research, but this is unrealistic when so little funding goes to support nursing research into care and care practices vs cure or outcomes, so little to develop nursing's capacity to make such a contribution to multi-disciplinary research, or so little recognition of nursing's legitimate involvement and participation in research at all. There are of course citable exceptions to this, but this is not the norm, and neither is it the expectation we should accept from/of nursing. Perhaps this to be expected of the current professional and academic growing pains of nursing generally, but there are many more mental health nurses today prepared for research with higher postgraduate degrees and doctorates.

9. Lack of representation and genuine consultation or collaboration with the mental health nursing discipline from senior administrative and policy levels in health services right up the ladder through to State and Commonwealth Departments and health committees such as AHMAC, NHMRC, AHWAC, AMWAC, NMHWG, SPGPPS and the Nursing Education Taskforce (N^3NET). There are no senior or chief mental health nurse advisors at State or Commonwealth level. Government strategy, policy and priorities are blind, starved and stunted by existing power structures and the critical absence of the reasoned and practical voice of mental health nursing, and the contemporary knowledge and skill (humanitarian, ethical, therapeutic, scientific, social and health system related) the discipline has to offer. It is unfortunate and quite demeaning that senior policy advisors, directorates, ministers and successive governments simply ignore these facts, and when raised by members of the profession, excuses made to defend a constitutional structure which systematically and methodically disadvantages and disempowers nursing, probably more out of convention, mediocrity, deliberation and design rather than purpose.

Specific Terms of Reference

a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

Resources committed to the National Mental Health Strategy have been inadequate, inequitably distributed, and have not met the needs of the majority of the mental health workforce – specifically the mental health nursing workforce, inhibiting progress, workforce development and capacity, thus a key barrier to effective service provision.

The division of responsibility both in policy and funding between Commonwealth Government and State Governments continues to be a

fundamental barrier to mental health service provision. Mental health services continue to be the political football kicked from one level of government to another, in which the current funding crisis fails to be addressed. Within the media, I hear both the Minister for Immigration and Multicultural Affairs and the under-secretary 'bagging' mental health services on TV and radio in the past few weeks, over the Cornelia Rau affair and refugee mental health, when the fundamental issue is concerned with the conduct and practice of Commonwealth government policy, where refugees in detention centres do not have suitable access to mental health services and practitioners, where refugees are treated appallingly, and where 70-80% of refugees are experiencing and suffering major depression, anxiety and other mental disorders, far exceeding the general population of origin or within Australia. Such political sniping at mental health services is a cheap shot at State governments and health departments, which only further stigmatizes mental health services, and denies those suffering in Australian immigration detention centres from receiving due care and attention.

The Commonwealth Government, its various departments and committees spend too much of their time, wasting public money on glossy policies and publications, instead of directing funding to support the mental health workforce to improve practices and provide better services. A good example of inappropriate policy and expense was the development of the National Practice Standards for Mental Health Workers, developed over a period of 6 years from initial consultations to publication in 2002, and a further 3 years to date consulting and deliberating on their implementation. National Standards for Mental Health Services were already appropriately in place for service provision, and the development of National Practice Standards are an inappropriate and constitutional intrusion into the practices of the health caring professions, whose charter are to develop Standards of Practice, supported by research and evidence based practice. Instead, the money would have been better spent on supporting and ensuring Standards of Practice of different professional groups were reviewed and updated, contemporary and relevant to population needs, and assisting professional groups to develop their own strategies for implementation, and recommendation that was clearly put by several professional disciplines at the time. Such an approach would have engaged partnership and ownership, where the driving force would come from the workforce itself. Enhancement funding, which builds on existing professional resources, infrastructures and initiatives is potentially less costly and has greater impact than inventing something that competes with and complicates practice and service delivery.

The Commonwealth Government has a plethora of committees in which the National Mental Health Strategy and workforce issues are discussed, planned and implemented eg NHMRC, AHMAC, AHWAC, AMWAC, NMHWG, SPGPPS and the National Nursing Education Taskforce (N^3NET), to name but a few. Firstly, there is no mental health nursing professional or workforce representation or expertise on any of these committees. There is no chief mental health nurse to coordinate and track

mental health nursing workforce issues that fall in and between these committees.

A good example of the problem this presents, is the recommendations that came out of both and more specifically, the second mental health nursing workforce study (the *Australian Mental Health Nurse Supply, Recruitment & Retention Report, 2003)*. AHWAC was responsible for the study, AHMAC, the NMHWG and National Nursing Education Taskforce were responsible for different sets of recommendations from the one report. 6 months after the report had been published and made publicly available, the National Nursing Education Taskforce was not even aware of its existence, let alone the recommendations they had been delegated responsibility for, based on my communications with them in June 2004 and attaching a copy of the report to my email. The National Nursing Education Taskforce has no representation or expertise on mental health nursing/mental health nursing education, so how is this group to competently implement any of the proposed recommendations? Conversely, the NMHWG has no nursing representation, so fails to appreciate the critical nursing elements and their significance in relation to service provision. Nearly one year later, the National Nursing Education Taskforce has still done nothing, achieved nothing to address these recommendations, and consulted with no-one in our industry to my knowledge. Once again, the welfare and development of mental health nursing is in the charge of bodies that are ill-equipped, lack commitment to the specialty, and are arguably too busy with other matters to work on the problems specific to mental health nursing. There is no medical college in Australia that would accept this kind of incompetent delegation of responsibility. It is easy to understand how nothing gets done, as the issues get neglected and fall between the differing agendas of each Commonwealth Committee, none of which have any particular interest in tracking the issues and recommendations of the mental health nursing workforce (65% of the mental health workforce). Thus studies are done, 1999, repeated 2003, with no significant new findings, and five years later after the conduct of the first study, still no action.

An obvious consequence of the above situation, is that resources never get equitably prioritized and allocated to the profession, after medicine, psychiatry, and all other influential agencies and political agendas have run their course.

These are some of the barriers the profession and vicariously, mental health services are up against in relation to resources and division of responsibility.

b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

The various modes of intervention and the plethora of evidence based literature emerging on mental health have not been implemented either systematically or substantively into routine service provision. This goal cannot be achieved in the current climate, directions, priorities and funding associated with the current national Mental Health Strategy and 3rd National Mental Health Plan while ever the majority of the mental health workforce and specifically mental health nursing workforce needs are ignored.

Promotion and prevention is predominantly a symbolic gesture configured in nicely worded policies and political rhetoric. Early intervention is confined to isolated yet highly successful program areas. Acute care is shallow and offers little in the way of treatment choice, breadth, effectiveness or consumer satisfaction. Community care is stretched and does not meet the complex needs of people with mental illness and fails to engage and support families and carers. Consequently, mental health crisis services where they genuinely exist are flat out and overflow into the realms of NGO's such as Lifeline, where a large number of crisis calls are attributed to people with mental illness.

Respite care services for people with serious mental illness, particularly focusing on the needs of family and carers are practically non-existent in many regions, and where they do exist are either under-utilised or lack flexibility to meet the needs of carers. A recent integrative literature review and meta-analysis published in the Journal of Advanced Nursing by Australian authors Jeon, Brodarty & Chesterson, 2005, states that,

> *The majority of family caregiving studies identified a need for greater quality, quantity, variety and flexibility in respite provision, and the literature has remained largely silent in relation to those affected by severe mental illness [the majority of respite literature has focused on the elderly population, dementia, children, and developmental disability]. There are contradictory findings on outcomes of respite care services and a lack of controlled empirical studies and evaluative research on effectiveness.*

Carers and family members themselves experience and relate physical and emotional stress, poorer health and quality of life, frustration, anger, family conflict, high levels of anxiety, depression and guilt, loneliness, and constant worry about the one they care for, their safety and their own safety, due to the episodic, fluctuating and often chronic or persistent nature of serious mental illness (Broe et al 1999, Schofield et al 1998, Jeon & Madjar 1998, Bland 1996).

These concerns have been frequently advocated by ARAFMI (Association of Relatives & Friends of the Mentally Ill), which subsequently led to the hosting of a conference in Hunter NSW by ARAFMI in November 2003, focusing on the issues and title theme, *Who Cares for Carers*, which I co-convened with a carer on behalf of ARAFMI.

c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

This question is largely addressed in response to the previous section (b) above. However, an additional concern that has been commonly related, is the lack of recurrent funding sources. Many special projects conducted under the National Mental Health Strategy are funded for a limited life (2-3 yrs). When the funding runs out, the project or continuance of its findings falls apart. Even if the project has run its course, newly developed programs disappear unless the State Government picks up the tab. More commonly, if it does, another program area is axed to continue with the new one or existing services and health care professionals within them are left to add this to their current workload. Thus we create a static cycle of invent,

improve and discontinue or overload. Once again, too little effort goes into ensuring sustainability of programs and services or respective funding sources.

i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

How can iatrogenesis be addressed when governments do not invest in their workforce? Undergraduate nurses are largely inadequately prepared for mental health, and highly dependent on transitional support programs. There are no incentives for nurses to go on and do postgraduate specialty study in mental health nursing, and postgraduate courses within the tertiary education sector have little accountability to the profession and professional standards, workforce needs or mental health services, with some exceptions. Mental health services stretched for funds to provide basic services, have no room in their budgets to support continuing education and professional development. Mandatory education such as occupational health and safety, fire safety, CPR, manual handling, aggression management, and sexual assault training are the only regular educational opportunities that are universally guaranteed, at least at a policy level. It is not uncommon for nurses working in inpatient areas on rosters, to be unable to attend in-services, conferences, seminars, workshops etc because they cannot be replaced/backfilled. Community mental health nurses know if they take a day out for practice development or education, they come back to two days work, because they are not routinely replaced, indeed I do not know of a recent situation where they are ever replaced except in some cases for periods of leave of more than a week. Unlike medicine, there are no locums or budgets to cover a locum, one day at a time or even longer periods. There is a current nursing workforce shortage, and all areas appear to operate on minimum (arguably safe) staffing levels these days, compared to the past where there was often surplus to requirement, allowing flexibility. Today, tight budgets result in fixed arrangements, where it is considered financially irresponsible or simply unrealistic to budget beyond 'so called' minimum staffing levels. Thus the nursing profession is severely disadvantaged in being able to attend continuing education opportunities including clinical grand rounds and multi-disciplinary case reviews, where a significant amount of formal and vicarious clinical education occurs.

Refer to earlier section on background for broader summary of some of the issues and barriers here. Also I was involved as an external consultant in the conduct of a clinical audit of a mental health service in Tasmania in 2004. The 69 page report to the Health Complaints Commission and Nurses Board of Tasmania, highlighted many service provision and practice issues and shortcomings, which has been tabled in the Tasmanian Parliament as part of the Health Complaints Commission's overall report of their investigations and recommendations. I would suggest that many of the *routine* practice and service issues identified are likely to be reflected to varying degrees across mental health services throughout Australia, since services experience similar funding constraints, infrastructures, policy and governance systems wherever they are located. Few services will have undergone the examination and scrutiny that was commissioned in this very recent case.

Most consumers will tell you there has been little change at the *shop front*. Where consumer consultants and representatives are employed, their input is highly valued, but they are too few to negotiate a large and complex health care system.

n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.

The Australian & New Zealand College of Mental Health Nurses has successfully raised a small but modest national research fund (by national mental health standards) out of its own operations and supplemented by funds from two leading pharmaceutical companies for specific purposes. The aim of this research fund is to support research and practice development and is managed by an independent Board of Research. However, there is a huge demand for ongoing research into nursing practice, clinical effectiveness, evidence based practice, and practice development, for which there are few external funding sources. Existing funding sources are highly competitive, and despite the growing ability and capacity of mental health nurses to conduct clinical research, few grant proposals succeed, and many very worthwhile projects never get up. Commonwealth and State Governments need to earmark research funds specifically for mental health nursing research. Compared with general health and medicine, there is far too little funding and resources directed at mental health research and collaborative, multi-disciplinary projects.

The profession also struggles with the cost of disseminating best practice across the workforce. In order to do this, requires publication of results, reports, journal articles, fact sheets, coordination of activities, development of training modules and programs, and critical mass to reach the whole of the workforce. To date, the College achieves this through the International Journal of Mental Health Nursing, hosting annual international and regional conferences, publication of research monographs, the College website and email discussion group. At present, this probably reaches about 20-30% of the nursing workforce in mental health. Much more could be achieved through enhancement funding to improve and broaden these operations in a more systematic and coordinated way. The proposal to establish an Institute for Mental Health Nursing in 1999, which was dismissed by the Commonwealth Government, was a serious and genuine attempt to address this problem (discussed in earlier section under background). Unless the Commonwealth and State Governments are prepared to provide significant support of such operations, I predict practice development will remain painfully slow and inadequate, especially in respect of the goals of the National Mental Health Strategy. As mentioned before, a reasonable investment now in the profession would have a profound impact on practice and service delivery, the marginal room for improvement here is arguably far greater than in any other single initiative of the National Mental Health Strategy, both short and long term.

d) the appropriate role of the private and non-government sectors;

Having worked closely with a range of non-government organizations (NGO's) in recent years, and more recently as a Board Director with both Lifeline (Newcastle & Hunter) and PRA, it has become quite clear that mental health NGO's struggle to provide valuable services, due to barriers

in funding and resourcing. NGO's provide a range of vital services in support of the mental health and wellbeing of people with mental illness and their families. These services include housing/accommodation support, supported and open employment opportunities, vocational training, psychiatric rehabilitation, social support networks, clubhouses, day-time activities including drop in centres and respite, self-help support groups, family support, information to the public on mental health and resources, counseling and phone counseling services, and selectively funded promotion and prevention programs/projects. These services can be extremely difficult to sustain when the NGO sector is poorly funded as it is, which varies between States and is particularly scarce in rural and remote regions, where often there are no such support services at all. NGO's are often faced with limited project funding, especially recurrent, and the prospect of discontinuing services when such funding runs out. They also have to waste valuable time and resources attempting to raise funds through private and charitable sources, which is exacerbated by a lack of public sympathy and recognition for people with mental illness, which inevitably draws them away from their primary role and function. Campaigns for heart disease, children, cancer and competition for overseas poverty and disasters capture the public's imagination, but this is not so in mental health. It therefore falls to governments with a social responsibility to either provide the socio-economic balance where public funds are more readily available to support NGO capacity within the mental health sector and contribute to sustainable de-stigmatising public awareness campaigns – In fact a multi-pronged approach to this problem is of critical importance. The public awareness campaigns in the media during the first mental health plan in the mid-nineties were not sustained, and consequently the benefits from these campaigns have been arguably negligible over time. The Commonwealth Government needs to allocate more funding and resources to the NGO sector and public awareness campaigns and maintain this effort until there are signs of benefits sticking or the NGO sector has the capacity to support itself without spending too much of its resources at the expense of meeting community needs.

Private psychiatric services appear to be predominantly invisible and more attention needs to be given to the relationship between and shared responsibilities and resources of the public and private sectors. More flexibility and partnership between these two sectors could result in better management of inpatient beds and community services, greater accessibility of services, minimization of duplication, and more effective use of existing resources.

Having attended several meetings of the Strategic Planning Group for Psychiatric Services (SPGPPS) a few years ago as College president, we were removed due to an internal re-structure, almost as soon as we were invited. The SPGPPS needs to demonstrate greater accountability and transparency in its management and planning, especially when public funds are directly or indirectly provided to support this sector. It is not acceptable that nursing and other disciplines have been excluded from this group, which is simply not representative of the private mental health workforce and professions involved in the delivery of private psychiatric services. It is

almost entirely dominated by medicine, psychiatry, private hospital management and insurance companies, and accordingly lacks insight, credibility, and social equity, in contrast to the valuable contribution that could be made if nursing were to be included at the table. Not surprisingly, nursing's contribution to the provision of psychiatric services goes unrecognized, unrepresented at strategic and planning levels, and consequently under-resourced and under-utilised. Mental health nurses can make a considerable value-added contribution here, not just in informed decision-making and strategic planning, but in the effective deployment of resources and diversity of clinical expertise to enhance existing private psychiatric services.

e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes.

There are numerous studies and reports available, including government reports and surveys that have clearly shown that there is a huge unmet need with respect to suitable housing and accommodation, supported and open employment opportunities for people with mental illness (Harvey et al 2002, Frost et al 2002). The majority of homeless people in Australia have a mental illness, and the rates of unemployment are significantly and unacceptably higher amongst people with a mental illness than any other sector. Part of the problem is associated with the fact that people with a mental illness are less able to advocate their needs, defend their rights or find the support they need to stay well and gainfully employed. Public misconceptions of mental illness still creates major barriers/social disadvantage in open employment situations. Negotiating the welfare system, let alone the health care system, claiming a pension for psychiatric disability and fulfilling the requirements of this safety net is full of hazards that people with a mental illness and their families find bewildering and confusing. Psychosis and depression are not so easily understood and recognized as people with physical disabilities, where the problem is visible and measurable. Consequently, people with a mental illness are amongst the poorest socio-economic groups, which is further compounded by the fundamental lack of support for families who have to cope with these situations. Studies, previously cited earlier show that carers and families themselves are profoundly affected in terms of their own health and quality of life, and have limited or no access to appropriate respite and support. In order for people and their families to stay well, as much attention and additional resources need to go into the NGO, community support and welfare sectors as the health service itself. Treating people for their illness without addressing their capacity to gain socio-economic independence when they are well, is all too often a false economy that successive governments have failed to provide adequate safety nets for. The economic burden to society in terms of lost productivity due to psychiatric illness and disability is huge, unacceptable and unnecessary as many people with mental illness are quite capable of sustained open and supported employment during remission, even apart from the suffering and hardship this causes them and their families.

f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Two special needs groups/issues I would like to bring to the attention of Senate Select Committee are the rising prevalence of co-morbidity – dual diagnosis mental illness and drug and alcohol problems, and the mental health and wellbeing of refugees in Australian detention centres.

It has been well documented and the observation and experience of many mental health and drug and alcohol workers, that there has been an alarming increase in the prevalence of comorbidity, where as many as 80% of people receiving treatment for acute psychosis have had a history or presenting problem of drug and alcohol related use, and of particular note, cannabis or marijuana use. The National Comorbidity Project (Teeson & Burns, 2001) summarises many of the issues. Whilst the cause for this is much debated, including the more ubiquitous use and availability of drugs, lack of health caution on the use and harmful effects of substances such as cannabis which have traditionally focused on physical effects versus nicotine and cigarette smoking, and changes in supply, where for instance the more toxic heads of cannabis are used, compared with the leaves, years ago, the fact remains that comorbidity presents a very real challenge to both mental health and drug and alcohol services. There are indications for instance, that cannabis and other substance use including alcohol are an indicator of higher risk of aggression and violence in our acute psychiatric facilities. Despite this, it is not uncommon for drug histories and presenting problems of substance use to be missed on admission and assessment or at least a lack of routine or systematic assessment and risk management planning (Chesterson 2004). All too often, mental health workers are inadequately trained and prepared for this, just as drug and alcohol workers are frequently ill-prepared for presenting mental health problems such as psychosis. Despite this trend for a good number of years, little has been done to address this problem, and too few acute inpatient facilities operate a dual diagnosis philosophy or program, which is essential both for recovery and safety within our inpatient units. Many vulnerable patients who are treated for other psychiatric or single disorders are frequently subjected to shared inpatient environments where they feel unsafe, unprotected and threatened by other patients, particularly by young males who may be acutely unwell during the initial phase of treatment or detoxification, whether vicariously or planned. It is not uncommon for patients with a dual diagnosis to continue using whilst receiving inpatient treatment, and despite clear policies and procedures, it can be extremely difficult and often compromises the therapeutic relationship and environment, when nursing staff are expected to police these situations. Not only are health service staff, particularly nurses exposed to these noxious and often aggressive acute environments, but more importantly, patients themselves are unable to escape or find a place of safety and restitution, whilst recovering from their own frightening experiences. Consequently, many patients describe experiences in acute psychiatric units where they have been traumatized by the treatment environment itself or another patient, especially where both cohorts may be detained and treated involuntarily under a mental health act in the same environment. As mentioned in previous sections on workforce issues, nurses simply don't have the 'man-power' to provide effective care in these kinds of environments, which are further compromised by lack of specialist training, skills development, ongoing education, evidence based approaches

(especially concerned with dual diagnosis), and the often confined spaces and design of many of our acute units, not to mention 100% plus bed occupancies. I have worked in one service where an acute unit, built in the early nineteen-nineties, had to be knocked down and rebuilt less than 10 years later because of poor design, when it's use by date should have been closer to 30-40 years. The issues here are again multi-factorial, but clearly, in addition to the co-morbidity problems, we are not building our psychiatric units to therapeutic proficiency, often due to lack of proper funds/capital investment strategy and lack of consultation in architectural design with nurses, who are frequently able to pin point the problems associated with these environments.

Refugees and people in detention centres, have been a major public issue for a number of years. The psychiatric and mental health nursing professions have cautioned successive governments over the inhumane treatment of refugees in Australian detention centres. We now have a situation where, detention centres themselves are probably the major cause of psychiatric illness over and above the traumas of country of origin and prolonged experience and uncertainty of refugee status. The prevalence of mental illness, including both depression and psychosis in Australian detention centres is epidemic, more than four fold that of the general population. I refer the senate select committee to many other sources on this issue including the College Press Release on *Mandatory Detention of Australian Citizen and Mental Health of Refugees in Immigration Detention Centres* (February 2005), and *Letter to Senator Amanda Vanstone, Minister for Immigration & Multicultural Affairs* (February 2005).

Our detention centres including how refugees are treated are the true iatrogenic psychiatric institutions of today, and are a shameful blot on our landscape, causing unprecedented human misery and degradation. This is further compounded by the fact that refugees do not have remotely reasonable access to mental health services or health care professionals, and all too often don't even get reviewed or assessed by a mental health care professional until after an attempted suicide or it is too late. Whilst the National Mental Health Strategy champions early intervention and prevention, and Australia is a signatory to international conventions on human rights, we continue to deny refugees very basic human rights, dignity, access to health care, humane holding environments and practices. Australian detention centres are *the* most toxic Australian environments and institutions of our age, where conditions are reported worse than in our very own prisons. Yet senior ministers including Senator Amanda Vanstone see fit to blame mental health services and health care professionals for their own political and social failings.

I cannot put in any stronger terms my objection to my identity as an Australian, and that total reform is called for and nothing short of this will place us on a socially just, ethical, moral or humane national path. How we treat the most disadvantaged in our society is *the* measure of how civilised we are or can become. This issue is the ultimate symbol and archetype of the indignities and social injustice of how we treat our own citizens with mental illness, and how our most valuable asset to engage these moral and social dilemmas, nursing (that part of the mental health workforce which

often finds itself in the front line – 24 hours a day), is seemingly swept under the political carpet, starved of resources, critical mass and identity to provide the glimmer of hope, reason, and healing potential the profession has to offer, even in the most remote and inaccessible locations.

Our humanitarian, charitable and privileged heritage as Australians, exemplified by the recent overwhelming public response to the Tsunami disaster is wiped clean by our treatment of refugees. Indeed it demonstrates the stark contrast between government behaviour and that of our own citizens. At the very least it illustrates how much money can be raised to support humanitarian efforts overseas, yet so little is achieved for people whose lives are also devastated by mental illness at home, and how we impose such illness on fellow human beings fleeing from their own countries and find themselves at the mercy of our own government's oppression and indifference. This a paradox, a reflection of public indifference when it comes to mental health, to which I refer earlier, when mental health NGO's cannot secure the non-government funding shortfall they require to meet the needs of our communities.

j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people.

The prevalence of mental illness is significantly and unacceptably higher in the criminal justice system than the general population. Many of our prison environments like detention centres are toxic environments which create and exacerbate mental illness. Human rights are not adequately protected and advocated, and health care professionals are often subjugated to conflicting philosophies to treatment, care and rehabilitation. Many people convicted of a criminal offence will eventually return to the community, and the humiliation of how they may have been treated in prison not only negatively reinforces their view of society and risk of re-offending, but inadequately prepares them for community re-integration, a constructive and productive role in society, as well as poor recovery and outcome from a mental illness. The promotion of mental health and wellbeing, prevention of mental illness, early intervention, access to mental health care, focus on recovery, vocational skills training, and protection from abuse – human rights with a context of social justice need to be key drivers of reform within the criminal justice system. Punishment and serving a sentence should be delivered justly and firmly, but social justice and protection from society is not served, if we do not invest in the mental health and human rights of this specific population. It may be idealistic in this setting, but bullying, abuse, and retaliation of all kinds including systemic and iatrogenic, must confronted and extinguished within our prisons and the social justice system.

g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness.

Education and training of primary health carers, GP's, community and family nurses, practice nurses, welfare workers, and officers within public and private services who deal with members of the public in provision of related services such as employment, housing, vocational training, employment and disability pensions and benefits all need improved access to mental health awareness education in their initial and ongoing training.

Evidence suggests this is inadequate, their needs and skills are not being addressed, and mental health services do not have sufficient resources to provide the expert consultancy, education and support required. There is a need for more primary mental health care specialists in such roles as Practice Nurses, Nurse Practitioners, Consultation Liaison Nursing, consultancy, and private practice, however there are few incentives to support this development, which would currently draw mental health specialists away from their current roles, due to workforce shortages. This lack of service capacity is particularly lacking or absent in rural and remote areas, and socially disadvantaged/deprived areas such as inner-cities, where many of the homeless and unemployed might congregate.

Nurses and allied health care professionals with a background in mental health have proved to be an effective resource working closely with GP's, providing mental health assessments, treatment, care and consultancy in the primary health care setting, including individual, family and group cognitive behavioural interventions with depression and anxiety, and access to bulk billing arrangements. Well trained mental health practice nurses, nurse practitioners are a cost effective and valuable resource for future development, however this will be difficult to implement if basic specialty education and training and mental health nursing workforce issues, from which this pool are derived, are not addressed. There are a few nurses working in private practice, however compared with the USA and UK, this is a sector that needs further development within Australia, to ease the burden on public mental health and primary health care services, and general practice, as well as giving the general public access to affordable health care choices. General Practitioners who have had access to or employed the services of these specialists have been highly satisfied, and the Australian Medical Association and Australian College of General Practitioners' alarmist public media attacks on Nurse Practitioners are entirely unfounded, without evidence, protectionist (not of the public but of themselves, when evidence suggests it enhances their practices), and exhibits social stigma against both nursing and mental health (AMA 2005, CDNMANZ 2005).

k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.

There is a general and serious lack of a range of preventative and psychosocial interventions as part of routine service delivery in mental health care, by both public mental health and primary health care services. It is of serious concern that many of our acute psychiatric inpatient units lock their doors, restricting freedom and access, which are fundamental human rights, when in fact they should be open ward environments. The practice of seclusion and coercion is outmoded and as for locking down, reflects an alarming modern trend in developed countries such as Australia towards custodial and restrictive practices, inconsistent with national mental health policy. Evidence from research suggests these practices are associated with units that are poorly staffed, low morale, are lacking in therapeutic milieu and psychosocial interventions, demonstrate poor governance and risk management, are ineffective, and do not result in positive outcomes for consumers or their families, rather the reverse - are

tense ward environments with higher rates of absconding, non-compliance, violence and consumer dissatisfaction. There is also evidence that locking down and seclusion are used as a routine option, not last resort, is not properly recorded and monitored, and deleterious to the welfare of patients placed in seclusion and other patients, whose freedom of access is denied, delayed, and forced to remain in a closed and noxious environment. Conversely, inpatient units that have implemented open door policies and a planned suite of psychosocial interventions and risk management procedures have lower rates of aggression, critical incidents, absconding and non-compliance. Current seclusion and locking down procedures are largely ineffective, foster or are symptomatic of iatrogenic treatment environments, restrictive of human rights, are socially unacceptable and contrary to both contemporary and best practice. These concerns have been reported by an in depth comprehensive clinical audit of a mental health unit conducted on behalf of the Health Complaints Commission, Tasmania (Chesterson 2004), and I suggest in my experience, that these findings are not isolated, but probably a common and growing trend, reported in the international literature (See appendix Specialist Bibliography - Problems in Acute Psychiatric Inpatient Units).

l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers.

The Commonwealth advertising campaign on de-stigmatising mental illness in the mid nineteen-nineties was inadequate and has not been sustained. There is a need to portray good practice and outcomes, featuring consumer and carer success stories, all disciplines and mental health workers, particularly nursing, since mental health workers and services are themselves heavily stigmatized, not just by the media and general public, but by mainstream health workers and tertiary education. Senior nursing academics in some universities continue to disapprove student choices of career in mental health and there is a critical lack of investment in mental curricula and educational/skills development of the specialty and mainstream workforce, despite notable improvements over the past decade and evidence of good benchmarks in individual universities. However much of the gains are likely to be lost with recent cut backs in our universities, mental health as a field remains highly vulnerable to general systems cuts, universal and cross-sector rationalizations.

A sustained and more targeted de-stigmatising campaign will maintain public consciousness and support appropriate access to mental health services, treatment, care, and non-government service provision. We need to move beyond education and encourage personal/social contact between consumers, mental health services, mental health care professionals and the general public, since research on outcomes of de-stigmatisation indicates education alone is marginal or ineffective. Media campaigns eg Media monitoring, Responsibility and Mindmatters, have had limited success, but still we experience almost every day in the popular press and TV fiction, use of archaic language and reference to stereotypes and practices that have not been acceptable or typical of mental health services in Australia for many years.

Executive Summary

Whilst this submission has focused on many problematic areas, it is not my intention to discount many excellent examples of best practice, service delivery, and national mental health policy and projects. There have been substantive improvements since the inception of the National Mental Health Policy in 1992. I have however, not documented or reported these in this submission, limited by time and resources. Instead it is my intention in this submission to emphasize that the improvements made to date are not universal, they are not well established in routine practice and service delivery, and improvements are too slow, in some instances have been regressive. Two of the primary reasons for this is the systemic lack of funding, resourcing, and investment in mental health, and more specifically planned and informed development of the mental health workforce, especially the largest, most marginalised, yet potentially most influential sector, mental health nursing, where considerable outcomes could be achieved with well targeted and selective funding.

The International Council of Nurses (2004, 2002, 2001) in collaboration with the World Health Organization have stated very clearly, that mental health nursing worldwide is poorly developed and poorly resourced. The ICN advocate to national governments the need for education, training and workforce development, and this is not isolated to poor or undeveloped countries, but also developed and developing nations. In fact evidence suggests that mental health outcomes in under-developed countries are better than in developed countries, such as Australia. National trends and issues do not occur in a vacuum, the international picture and profile suggests, that if a mediocre approach is adopted in Australia, benefits expected may be eroded by global needs - expertise will bleed overseas, and it will be, if not already, increasingly difficult to import expertise in a competitive global economy where need outstrips existing human resources.

Currently the Australian & New Zealand College of Mental Health Nurses is a world leader and trend setter with solid international contacts and networks, and strong affiliations with organizations such as the Royal College of Nursing Australia and Mental Health Council of Australia. College membership is already around one fifth of the national mental health nursing workforce, which is a larger representative membership than its counterparts overseas, and indeed most professional nursing bodies in Australia as a proportion of the relevant workforce, with the exception of the Australian Nursing Federation. There is no doubt in my mind that the current collaborative relationship with the RCNA and future potential to work in harmony with the ANF as our equivalent medical colleges work with the AMA, puts the discipline in a strong position to provide expert advice to government, and be a key instrument for change, workforce development and practice development. To achieve this goal, however, the College and the profession require the unequivocal support and commitment of government to address these problems. Because of lack of resources and funding for basic and strategic operations, a considerable amount of time and expertise is unnecessarily wasted in fund raising and acquisition of private, corporate sponsors, which although greatly welcomed and essential to operations, reduces capacity to meet essential needs and services, and places too much dependence on a single and vulnerable funding source, familiar to the problems faced by non-government organisations. The existing College infrastructure and partnerships need reinforcing, financial support and enhancement in order to deliver to the profession, to mental health services and the general public.

Key achievements and developments of the College have been built almost exclusively on health care professionals/members' voluntary contributions and internal funding (primarily membership fees), and to date include:

1. Establishment and review of Standards of Practice for Mental Health Nursing both in Australia and New Zealand (ANZCMHN, 1995), which informed the development of National Standards for Mental Health Services (1996) and National Practice Standards framework (2002) in Australia.
2. Governance and responsibility for the first Commonwealth funded and commissioned, Scoping Study of the Australian Mental Health Nursing Workforce in 1999 (Clinton, 2001), and founding member of the Mental Health Council of Australia incorporated in 1998.
3. National launch of credentialing (2004) as part of an ongoing education and clinical governance program, which involved national workforce consultation and research program to validate the components of the Credential for Practice Program (CPP), and the culmination of 8 years work.
4. Research, practice development, and dissemination through:
    a. The Board of Research, National Research Fund and annual funded research projects
    b. The International Journal of Mental Health Nursing (a fully refereed journal published under license to Blackwell Asia with College appointed editors, international editorial Board, worldwide distribution, and now in its 14 consecutive year/volume)
    c. Published research monographs on evidence based practice (1997), mental health outcomes (1998), ethical practice (1999), clinical supervision (2002), and risk management (in publication)
    d. Annual national/international conferences, now in its 31st consecutive year, and regional conferences each year throughout Australia (Hunter NSW being on its 11th annual conference in May 2005 on promotion and prevention – a critical area of the current National Mental Health Plan, and North Queensland on its 7th annual Tropical Symposium)
5. National Awards and Grants for best practice including Fellowship (recognition of significant contributions by nurses to mental health nursing practice and mental health in Australia and New Zealand, governed by a Board of Censors, and annual oration), the Stan Alchin Award established by the Rozelle Hospital Sydney and now sponsored by Bristol Myers Squibb, the Mental Health and Wellbeing Awards sponsored by Lilly Australia, and specific or regional/local awards such as the Hunter Mental Health Award sponsored by Hunter & New England Health established in 2003.
6. A comprehensive website with professional information, news, events, projects, and over 500 links to key mental health websites throughout the world, national and regional professional discussion group/listservs including mental health nursing and consultation liaison psychiatric nursing.
7. A recently appointed, fully paid executive officer co-located with the Mental Health Council of Australia, and closely located to the national offices of the Royal College of Nursing Australia in Canberra.

8. Fully established branches and representation in every State and Territory of Australia since 1993, a growing sub-branch infrastructure, having been incorporated as a national body in South Australia since 1975. The College enjoys representation from leaders within the mental health nursing field from all sectors of clinical practice, clinical and academic research, education, nursing and health service management, and health service policy, including public and private sectors (predominantly public), and all Australian universities with Schools of Nursing – Around 2000 members or approximately 1/5th of the mental health nursing workforce.

Key strategies for reform of the mental health nursing workforce

1. Establish a 5-10 year strategic plan for the development of the mental health nursing workforce as a key component of an overall strategy for the Australian mental health workforce and National Mental Health Strategy.
2. Implementation of the key recommendations from the *Australian Mental Health Nurse Supply, Recruitment & Retention*: AHWAC Report (2003) and *Scoping Study of the Australian Mental Health Nursing Workforce 1999* (Clinton, 2001).
3. Plan and fund targeted and substantive annual real growth in the size of the mental health nursing workforce eg 5% minimum per annum for 10 years, total 10 year growth 1.62% in order to adequately staff public mental health services. To allow for expected retirement over the next 10-15 years, this planned growth will need to be additional to the expected retirement of approximately half the current mental health nursing workforce, estimated to have an average age of 47+ years. 5% in real growth per annum for 15 years will ensure a doubling of the mental health nursing workforce, predicted to be required by 2020. The public mental health system cannot deliver on the goals of the National Mental Health Strategy today due to inappropriate staffing levels and formulas, further compromised by current crisis-level workforce shortages.
4. Funding and establish a National Institute for Mental Health Nursing Practice under the joint aegis of the Australian & New Zealand College of Mental Health Nurses and the Royal College of Nursing Australia. Such an institute could develop collaborative links internationally overseas, with Australian universities, Institutes of Psychiatry and Mental Health in order to conduct practice based research, and provide professional courses of education, practice development and skills training for the mental health nursing workforce throughout all jurisdictions (refer also to strategy 12k).
5. Enhancement funding of administrative and human resources for the national implementation and ongoing development of the credentialing of Mental Health Nurses in Australia (Credential for Practice Program), under the management of the Australian & New Zealand College of Mental Health Nurses.
6. Special Project funding for professional accreditation of mental health nursing educational programs and courses under the joint aegis of the Royal College of Nursing Australia, Accreditation program and the Australian & New Zealand College of Mental Health Nurses.

7. Establishment of a chief mental health nurse advisor to the Department of Health and Ageing with direct advisory links to the Minister for Health & Ageing, Mental Health Branch, NMHWG, AHMAC, AHWAC, National Nursing & Nursing Education Taskforce, NHMRC and State Health Departments to coordinate and advise on national mental health nursing workforce issues.
8. Representation of the profession (discipline specific – mental health nursing) and College at all critical levels and senior committees of the Departmental of Health and Ageing and National Mental Health Strategy, where medicine/psychiatry or other allied health is represented, noting that medicine and psychiatry is vicariously represented on a plethora of government bodies, even where that representation is not directly concerned with a specialist medical college. Nursing expertise is just as vital for health service planning as medical expertise and is more commonly complimentary (not necessarily meaning aligned or in agreement).
9. Appoint 3 mental health nursing representatives to the NHMRC: Chief mental health nurse (strategy 7), College representative and independent expert.
10. Representation of mental health nursing on the National Nursing & Nursing Education Taskforce.
11. Representation of mental health nursing on the Strategic Planning Group for Private Psychiatric Services.
12. Development and consolidation of nationally consistent courses of education within the University sector in collaboration with mental health services and the College, designed to meet the planned educational needs of the mental health workforce and jointly funded between Commonwealth Government/Department of Health and Ageing and State Government/Health Departments:

    a. National recognition of graduate diploma in mental health nursing as the current benchmark and entry point for specialty recognition, consistent with clinical governance principles and guidelines, the national credentialing of mental health nurses, and midwifery and critical care nursing practices.
    b. Quarantine special status for mental health nursing, exemption scholarships/grants and part funding positions for the graduate diploma in mental health nursing, establish national workforce education quotas for next 5 years, with an initial review of outcome for next 5 years.
    c. Review case and enhancement funding to universities for the development of a direct entry four year double-degree of comprehensive/mental health nursing, with financial incentives eg. 4th year HEC's fees waiver.
    d. Review case and enhancement funding to universities for the development of a 3 year direct entry degree in mental health nursing, adopting an integrative curricula or modular approach to allow for (i) first year comprehensive, second year combination of comprehensive and substantive mental health nursing curricula, third year devoted exclusively to mental health nursing, similar to the UK Project 2000 model; and (ii) choice of conversion/completion to comprehensive nursing degree at a later stage with recognition of prior learning or vice-versa.

e. Provide national quota of up to one year's HECS fees exemption for graduates who choose to work in mental health immediately following graduation, with a contractual arrangement eg 2-3 years in a public mental health service.
f. Provide a national quota, funding total course fees for new graduates who undertake and complete the graduate diploma of mental health nursing if completed within three years of initial degree - Review in 5 years with a view to partial course fee arrangements.
g. Provide service/education enhancement funding to local health services to award scholarships for new graduates to undertake a graduate diploma in mental health nursing.
h. Provide universities with additional base funding to retain or develop discrete graduate diplomas in mental health nursing and additional incentives in achieving quotas eg 20 postgraduates per annum, at intake or upon successful completion. Consider same arrangement for direct entry program development.
i. Encourage and provide incentives for universities to retain viable postgraduate programs in mental health nursing eg clinically relevant, training in evidence based mental health interventions, partnerships and consultation with mental health services and the professional body eg College.
j. Review case and enhancement funding for development of a special tertiary education based or with tertiary education recognition, national postgraduate course (modular format) with training in evidence based mental health interventions, contemporary mental health nursing practice, and sub-specialty programs and options for skill development eg forensic, child & adolescent, community mental health, adult psychiatry, dual diagnosis, older people, psychiatric rehabilitation, consultation liaison psychiatry etc. Develop distance education and on-line modes of delivery with in-built clinical supervision and mentoring programs, similar to the UK Thorn training program or its successor.
k. Assign to a new National Institute for Mental Health Nursing Practice (strategy 4), one of whose key charters would be to develop a course and sub-specialty programs (such as in strategy 12j), provide workforce education needs analysis and reviews, monitor progress and implementation of any of the above strategies (12a-j), accredit postgraduate courses from a professional perspective etc (A comprehensive proposal was developed and submitted to the Mental health Branch of the Commonwealth Department of Health and Ageing in 1999). There is a greater imperative for this strategy today than in 1999, although we could have been experiencing the benefits today of such a project.
l. Review case and enhancement funding for development of multi-disciplinary postgraduate mental health programs, where RN's, psychologists, social workers and OT's can all undertake common and shared core curricula components in evidence based interventions, with financial incentives/quotas for nurses to complete an agreed number of mental health nursing specific units. This approach would engender multi-disciplinary collaboration in training from the outset, add value/recognition to the final qualification, and get round the numbers game that universities are struggling with at the moment. This strategy

may be articulated in conjunction with all of the previous strategies 9a-k. Such a course could be provided by universities or in combination with an Institute of Psychiatry and the new Institute for Mental Health Nursing Practice (strategy 4/12k). Note: it would not be acceptable from the perspective of the nursing profession, for this to be solely provided by an Institute of Psychiatry.

m. Provide mental health services and professional bodies with enhancement funding to ensure a percentage of health funding is spent on the continuing educational needs of the mental health nursing workforce. Many courses can be fee paying and fully or partially self-funding, but base funding is required for program development and maintenance, highly specialist and skills based educational programs which cost more to run with smaller markets, but primarily to replace nursing staff on rostered shifts in critical areas such as inpatient units. The most significant barrier to attendance of ongoing education programs is the lack of funding in health service budgets to replace essential staff, followed by availability of staff for replacement from casual and part time pools due to workforce shortages, and unreasonable workloads. This phenomenon is almost exclusive to nursing and needs to be recognised and progressively and systematically addressed.
n. All educational programs, whether initial, specialty or continuing education, need to be evidence based, focus on scientific evidence based practices, and impart or develop humanistic, empathic and compassionate skills in caring and psychosocial interventions.
o. Plan and conduct a strategic combination of any of the above to meet the agreed educational needs of the mental health and nursing workforce. No single strategy will have sufficient impact or succeed, a multi-pronged or integrative approach is needed.

13. Earmark special research funds for practice development, clinical effectiveness and service outcomes research into mental health nursing practice, and to strengthen nursing sector involvement in collaborative multi-disciplinary, inter-sectoral and international research.

Key strategies for reform at broader mental health sector level

1. Reform of the management of refugees in Australian detention centres to make them at least a humane holding environment under our international obligations under Human rights; reduce toxic environment and practices; promote mental health well-being and resilience consistent with National Mental Health Strategy; improve access to mental services/health care professionals, health assessment, risk management, early intervention, treatment, counseling and support, establish quality improvement programs, and funding of/access to facilities to conduct ethical mental health research to guide practices, service provision and policy.
2. Increase focus and funding of research into respite care and support for families and carers affected by mental illness.
3. Increase and target funding to build capacity and resources for respite care and support for families and carers affected by mental illness.

4. Increase and target funding including recurrent funding for key program areas under the National Mental Health Strategy within the Non-government sector (NGO's).
5. Reform and increase of National and State budgets and funding (recurrent, capital and human resource investment) for public mental health services in Australia as one of the principle strategies under the 3rd National Mental Health Plan.
6. National review of conditions in Justice/Corrective Services and prisons to make them humane and socially just environments; reduce toxic environment and practices; promote mental health, well-being and resilience consistent with National Mental Health Strategy; improve access to mental services/health care professionals, health assessment, risk management, early intervention, treatment, counseling and support, increase focus on psychiatric rehabilitation and recovery including vocational training and support to re-enter the community and workforce prior to and after release, establish quality improvement programs, and funding of/access to facilities to conduct ethical mental health research to guide practices, service provision and policy.
7. Increased emphasis in the 3rd National Mental Health Plan in the provision of mental health services to people with co-morbidity, including adoption of dual diagnosis approaches and increase of capital/human resource funding for dual diagnosis units.
8. Review of funding, bed numbers staffing levels per population need, practices and evidence based approaches in acute inpatient facilities to ensure consumers receive better treatment and care, choice, mental health outcomes, and reduce recidivism and re-admissions.
9. Review and develop national guidelines on the use of seclusion, restraint, locking of psychiatric units, and restrictive practices; appropriate utilization of acute psychiatric care environments; resourcing/access to secure facilities and psychiatric intensive care units; and training and use of psychosocial interventions and risk management to improve therapeutic milieu, patient and staff safety, reduce absconding, aggression, violence, non-compliance and their sequelae.
10. Develop national guidelines on architecture and design of psychiatric inpatient facilities, including appropriate allocation and effective utilisation of space, observation and monitoring of patients, environmental safety from a psychiatric perspective, privacy and confidentiality, interview and consulting rooms for patients, family and *all* staff (not just medical), reception areas, comfortable and aesthetic surroundings, consistent with health service philosophy and provision (as opposed to bare minimum associated with custodial environments). Ensure proper consultation on plans with all staff including nursing and medical and/or contracting services of a nursing consultant. Budgets must not be the *only* bottom-line, and guidelines should allow for and offer incentives for sponsors from the corporate/private sector as a means of enhancing properly appropriated budgets from public funds (not deficient public funds/budgets with gaps or shortfalls).
11. Increase funding for mental health research, not just causative and curative, but into clinical practice, effectiveness, treatment options, care and resilience.

12. Establish and fund a sustainable national de-stigmatising public awareness and mental health promotion campaign engaging all significant media outlets with measurement of impact factor. Include focal points for consumer (consumer vignettes and stories), family and carers, health care professionals and their practices (best practice vignettes and stories, with particular emphasis on nursing/mental health nursing and practice), mental health services, program and facilities (inside view of facilities to re-frame public perceptions and images constantly re-inforced in the media), and education of health/mental health professionals as a pre-requisite to recruitment and career planning, especially school leavers. Engage/partner/consult with and feature relevant professional and key stakeholder groups in campaign components and public exposure to demonstrate or promote partnership, collaboration, transparency and public confidence in mental health care.
13. Commonwealth and State politicians must refrain from the frequent 'bagging and bullying of mental health services', it is inappropriate, political, destructive, frequently erroneous, demonstrates civic and social irresponsibility, ignorance and incompetence. It is a significant driver influencing public perception and stigma. The media are well known to capitalize and sensationalise every word said, creating stories out of here-say and anecdotes for their own ratings and public voyeurism. It drives down morale within our public mental health services, the self-esteem of mental health care professionals, and most importantly the confidence of consumers and family carers in our health care system.
14. Establish an independent public 'mental health watchdog' **or** department/division of a mainstream public 'watchdog' **or** responsibility with funding allocation to the Mental Health Council of Australia. Sane, MHCA and a few other NGO's do a very good job with limited scope and resources, and all too often we simply leap from one public inquiry into another both at National and State levels. Government reports and literature are replete with them over the past two decades, and little is achieved from them other than re-inforcing social stigma and band-aid solutions. Accreditation of Health Services and health services themselves are able to or gloss over critical issues and Official Visitors have insufficient resources and powers. We need a responsible public 'watchdog' which will look over matters that are brought to their attention with respect to practices, service delivery, public attitudes, media, politicians, governments and other Australian institutions, so that problems and complaints can be identified and corrected early with minimal bureaucracy-head hunting-protectionism, best practice can be showcased, and the public interest served in an accountable and appropriate manner. Such a 'watchdog' should include constitution from or contribution by all key sector stakeholders within mental health and draw from our community.

Conclusion

These are the strategies and recommendations I would like to put before the Senate Select Committee, arising out of the analysis and issues I have attempted to present. I respectfully present them, without prejudice and with honest intention, even though I am conscious that some of the issues raised may be viewed as controversial, and the implementation of some strategies will require considerable political disquiet, commitment and public spending. This is deliberate and not mere ideology, since the

problems have lingered for far too many years, and far too little has been done about them. The significance and cost of the strategies proposed are consistent with the gravity of the problems and the measures required to resolve them. During the next 10-20 years the social problems that are likely to continue to develop unabated, will likely outweigh any commitment to action now. I commend this response to the inquiry to the judgment and wisdom of the Senate Select Committee and Senate, in the hope that significant and timely progress may be made in unity with the concerns and submissions, no doubt, of many others. References and selective bibliography follow.

Yours respectfully

Jon Chesterson
RN, MHN, DipCPN, DipAppSc (Nsg), BAppSc (Nsg), MRCNA, FANZCMHN

Promotion and Prevention, Hunter New England Mental Health, NSW
Conjoint Lecturer, University of Newcastle, NSW
Board Director, Psychiatric Rehabilitation Association, NSW
Board Director, Lifeline (Newcastle and Hunter), NSW
NSW Branch & Hunter Sub-Branch Executive, ANZCMHN
Convenor, Hunter Mental Health Conference
Project Consultant (Credentialing), ANZCMHN
ICN Expert (Mental Health Australia, RCNA) International Council of Nurses, Geneva
Convenor, MHN-Leadership Network (International)

3 Canopus Close
Marmong Point
NSW 2284 Australia
Ph +61 2 49595967 (H)
Mb +61 (0)408251146
Email jonc@idl.net.au

References

Australian & New Zealand College of Mental Health Nurses, 1999 – *Proposal to Establish An Institute for Mental Health Nursing*, Submission to Mental Health Branch, Commonwealth Department of Health & Aged Care, January 1999, Canberra.

Australian and New Zealand College of Mental Health Nurses, 1995 - *Standards of Practice for Mental Health Nursing in Australia*, PO Box 126, Greenacres, SA 5086, www.anzcmhn.org.

Australian and New Zealand College of Mental Health Nurses, 1999 - *Setting the Standard: A History of the Australian and New Zealand College of Mental Health Nurses*, PO Box 126, Greenacres, SA 5086, www.anzcmhn.org.

Australian and New Zealand College of Mental Health Nurses, 2004 – Credential for Practice Program & CPP News Bulletins, *www.anzcmhn.org*, *Credentialing Pages*.

Australian and New Zealand College of Mental Health Nurses, 2005 - Letter to Senator Amanda Vanstone, Minister for Immigration & Multicultural Affairs, February 2005.

Australian and New Zealand College of Mental Health Nurses, 2005 - Mandatory Detention of Australian Citizen and Mental Health of Refugees in Immigration Detention Centres: Press Release, 8 February 2005.

Australian Health Ministers, 1995 - *National Mental Health Policy,* 4th reprint, first published 1992, Commonwealth Department of Human Services and Health, Australian Government Publishing Service, Canberra.

Australian Health Ministers, 2003 - *National Mental Health Plan 2003-2008*, Australian Government, Canberra.

Australian Health Workforce Advisory Committee, 2003 – *Australian Mental Health Nurse Supply, Recruitment & Retention*, AHWAC Report, 2003.2, Sydney, http://www.health.nsw.gov.au/amwac/pdf/menhealth_20032.pdf.

Australian Medical Association, 2005 – *General Practice Nurses Make Perfect Sense But Independent Nurse Practitioners Don't: Media release*, 4 April 2005, ACT.

Barker P & Buchanan-Barker P, 2005 – Still Invisible After All These Years: Mental Health Nursing on the Margins: Commentary, *Journal of Psychiatric and Mental Health Nursing, **12***:252-256, Blackwell UK.

Bland R, 1996 – Episodic Care of People with a Mental Illness, *In Towards A National Agenda for Carers: Workshop Papers*, Australian Government Publishing Service, Aged & Community Care Division, DHSH, Canberra.

Broe G, Jorm A, Creasy H, Casey B, Bennett H, Cullen J, Edelbrock, D, Waite L & Grayson D, 1999 – Carer Distress in the General Population: Results from the Sydney Older Persons Study, *Age and Ageing, **28**, 307-311.*

Chesterson J & Clinton M, 2000 - Scoping the Present and Planning the Future: Mental Health Nursing in Australia and New Zealand, *Journal of the American Psychiatric Nurses Association*, ***6**(5):165-169*, Mosby.

Chesterson J & Hazelton M, 2003 – The Australian and New Zealand Context: Prospects for Mental Health Nursing Down Under, In *Barker P (ed), Psychiatric and Mental Health Nursing: The Craft of Caring*, Arnold (Hodder Headline), London, ch 71, pp 597-606.

Chesterson J, 2002 - *Credential for Practice Program (CPP): Report to Council* (Unpublished), Australian & New Zealand College of Mental Health Nurses, PO Box 126, Greenacres, SA 5086, April 2002, www.anzcmhn.org Credentialing Pages.

Chesterson J, 2004 – *Final Report to the Health Complaints Commission: Clinical Audit of Ward 1E, Launceston General Hospital*, Health Complaints Commission, Tasmania.

Chesterson J, 2003 – *Definition and Scope of Practice of the Mental Health Nurse in Australia: Draft Position Paper,* Board of Credentialing, Australian & New Zealand College of Mental Health Nurses, PO Box 126, Greenacres, SA 5086, November 2003.

Chesterson J, Clinton M & Muir-Cochrane E, 1999 - Cutting into the Challenges of Mental Health Nursing in the New Millennium: Mental Health Special Report. *Nursing Review October 1999; Sect 15-16*, Australia.

Clinton M & Nelson S, 1996 – *Mental Health & Nursing Practice*, Prentice Hall, Sydney.

Clinton M & Nelson S, 1999 – *Advanced Practice in Mental Health Nursing*, Blackwell, Oxford.

Clinton M, 2001 - *Scoping Study of the Australian Mental Health Nursing Workforce 1999*: Report from the Australian and New Zealand College of Mental Health Nurses & Curtin University WA, to the Mental Health and Specials Programs Branch of the Commonwealth Department of Health and Aged Care, Commonwealth Department of Health and Aged Care, Australian Government Publishing Service, May 2001, Canberra, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-ssamhnw.htm (Report not available on-line).

Clinton M, Hazelton M 2000 - Scoping the Prospects of Australian Mental Health Nursing, *Australian and New Zealand Journal of Mental Health Nursing, **9**(4):159-165,* Blackwell Asia.

Clinton M, Hazelton M, 2000 - Scoping Mental Health Nursing Education, *Australian and New Zealand Journal of Mental Health Nursing, **9**(1):2-10*, Blackwell Asia.

Clinton M, Hazelton M, 2000 - Scoping Practice Issues on the Australian Mental Health Nursing Workforce, *Australian and New Zealand Journal of Mental Health Nursing, **9**(3):100-109*, Blackwell Asia.

Clinton M, Hazelton M, 2002 - Towards a Foucauldian Reading of the Australian Mental Health Nursing Workforce, *International Journal of Mental Health Nursing **11**(1):18-23*, Blackwell Asia.

Clinton M, Hazelton M. 2000 - Scoping the Australian Mental Health Nursing Workforce, *Australian and New Zealand Journal of Mental Health Nursing, **9**(2):50-64*, Blackwell Asia.

Commonwealth Department of Health & Ageing, 2002 - *National Practice Standards for the Mental Health Workforce*, Canberra.

Council of Deans of Nursing & Midwifery, Australia & New Zealand (CDNMANZ), 2005 – *Nurses Are an Asset Not a Threat: Response to AMACGP Press Release Nurse Practitioners (media release)*, 13 April 2005.

Elder R, Evans K & Nizette D, 2004 – *Psychiatric & Mental Health Nursing*, Mosby-Elsevier, Sydney.

Farrell, G, 1997 - *Getting up to Speed with Evidence-Based Practice: Monograph,* PO Box 126, Greenacres, SA 5086, Australian and New Zealand College of Mental Health Nurses.

Freshwater D, 2005 – Developing a Visible Critical Mass: Editorial, *Journal of Psychiatric and Mental Health Nursing, **12**:129*, Blackwell UK.

Frost B, Carr V & Halpin S, 2002 – *Employment and Psychosis: Bulletin 3*, Commonwealth of Australia.

Harvey C, Evert H, Herrman H, Pinzone T & Gureje, 2002 – *Disability, Homelessness and Social Relationships Among People Living with Psychosis in Australia: Bulletin 5*, Commonwealth of Australia.

Hazelton M, Farrell G, Biro P, 1998 - *Self-Regulation and Credentialing in Mental Health Nursing: A Report to the Nursing Board of Tasmania*, PO Box 126, Greenacres, SA 5086, Steering Committee, Australian & New Zealand College of Mental Health Nurses, October 1998.

Hazelton, M. and G. Farrell, 1998 - *Evaluating the Outcomes of Mental Health Care: An Introduction, Monograph,* PO Box 126, Greenacres, SA 5086, Australian & New Zealand College of Mental Health Nurses.

Horsfall, J., M. Cleary, Jordan R, 1999 - *Towards Ethical Mental Health Nursing Practice: Monograph,* PO Box 126, Greenacres, SA 5086, Australian and New Zealand College of Mental Health Nurses.

International Council of Nurses, 2001 – Mental Health: Stop Exclusion, Dare to Care, ICN, Geneva, http://www.icn.ch/matters_mentalhealth.htm.

International Council of Nurses, 2002 – Position Statement on Mental Health, ICN, Geneva, http://www.icn.ch/psmental.htm.

International Council of Nurses, 2004 - Fact Sheet: Developing Nursing Resources for Mental Health, ICN, Geneva, http://www.icn.ch/matter_mentalhealth04.htm.

Jeon Y & Madjar I, 1998 – Caring for a Family member with Chronic Mental Illness, *Qualitative Health Research **8**(5), 694-706.*

Jeon Y, Brodarty H & Chesterson J, 2005 – Respite Care for Caregivers and People with Severe Mental Illness: Literature Review (Integrative literature review & meta-analyses), *Journal of Advanced Nursing **49**(3),297-306*, Blackwell.

Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care, 2000 - *National Mental Health Report 2000, 6th Annual Report: Changes in Australia's Mental Health Services under the First National Mental Health Plan of the National Mental Health Strategy 1993-98,* Australian Government Publishing Service, Canberra.

Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care, 2000 - *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,* Australian Government Publishing Service, Canberra.

Morrall P & Hazelton (eds), 2004 – *Mental Health: Global Policies & Human Rights*, Whurr Publishers, London.

Project Consortium for the Mental Health Branch of the Commonwealth Department of Health and Family Services, 1996 - *National Standards for Mental Health Services,* Canberra, Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing.

Royal College of Nursing Australia, 1996 - *Credentialing Advanced Nursing Practice and Accreditation of Continuing Education Programs: An Exploration of Issues and Perspectives, Discussion Paper No. 4,* September 1996, Canberra, www.rcna.org.

Royal College of Nursing Australia, 2001 - *The Feasibility of a National Approach for the Credentialing of Advanced Practice Nurses and the Accreditation of Related Educational Programs: Final Report*, July 2001, Canberra, www.rcna.org.

SANE Australia, 1998 – *Planned Respite Care*, South Melbourne.

Schofield H, Block S, Hermann H, Murphy B, Nankervis J & Singh B, 1998 *Family Caregivers: Disability, Illness and Ageing*, Allen & Unwin, Sydney.

Teeson M & Burns L, 2001 – *National Comorbidity Project: National Drug Strategy and National Mental Health Strategy*, Commonwealth Department of Health & Aged Care.

Winstanley, J & White E, 2002 - *Clinical Supervision Models, Measures and Best Practice* (Monograph), PO Box 126, Greenacres, SA 5086, Australian & New Zealand College of Mental Health Nurses.

World Health Organisation, 2001 – *World Health Report; Mental Health, New Understanding, New Hope*, WHO, Geneva, http://www.who.int/whr/2001/en/index.html.

World Health Organization, 2003 – Fact Sheet: Mental Health Policies and Service Development, WHO, Geneva, http://www.who.int/mental_health/resources/publications/en/.

World Health Organization, 2003 - Investing in Mental Health, WHO, Geneva.

APPENDIX: Specialist Bibliography
Problems in Acute Psychiatric Inpatient Units

Bowers, L. (1998) Trends in the psychosocial problems of those with serious and enduring mental illness under the care programme approach: a three and a half year follow up. Psychiatric Care 5(1)6-11.

Bowers, L. (1999) A critical appraisal of violent incident measures. Journal of Mental Health 8(4)335-345.

Bowers, L. (2000) The Expression and Comparison of Ward Incident Rates. Issues in Mental Health Nursing 21(4)365-386.

Bowers, L. (2002) Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team. London: Routledge.

Bowers, L. (2003) Manipulation: description, identification and social ambiguity. Journal of Psychiatric and Mental Health Nursing 10:323-328.

Bowers, L. (2003) Manipulation: searching for an understanding. Journal of Psychiatric and Mental Health Nursing 10:329-334.

Bowers, L. Alexander, J., Callaghan, P., Eales, S., Guy, S., McCann, E. and Ryan, C. (2002) Safety and security policies on psychiatric acute admission wards: results from a London-wide survey. Journal of Psychiatric and Mental Health Nursing 9:427-433.

Bowers, L. and Park, A. (2001) Special Observation in the Care of Psychiatric In-patients: a literature review. Issues in Mental Health Nursing 22:769-786.

Bowers, L. Nijman, H., Palmstierna, T. and Crowhurst, N. (2002) Issues in the measurement of violent incidents and the introduction of a new scale: the Attacks (Attempted and Actual Assault Scale). Acta Psychiatrica Scandinavica 106 (Suppl. 412):106-109.

Bowers, L., Alexander, J. and Gaskell, C. (2003) A Controlled Trial Of An Intervention To Reduce Absconding From Acute Psychiatric Wards. Journal of Psychiatric and Mental Health Nursing 10:410–416.

Bowers, L., Callaghan, P., Clark, N. and Evers, C. (in press) Comparisons of psychotropic drug prescribing patterns in acute psychiatric wards across Europe. European Journal of Clinical Pharmacology.

Bowers, L., Clark, N. & Callaghan, P. (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33:961-968.

Bowers, L., Crowhurst, N., Alexander, J., Eales, S., Guy, S., and McCann, E. (2003) Psychiatric nurses' views on criteria for psychiatric intensive care: acute and intensive care staff compared. International Journal of Nursing Studies 40(2)145-152.

Bowers, L., Gournay, K. and Duffy, D. (2000) Suicide and self-harm in in-patient psychiatric units: a national survey of observation policies. Journal of Advanced Nursing 32(2)437-444.

Bowers, L., Jarrett, M. & Clark, N. (1998) Absconding: A Literature Review. Journal of Psychiatric and Mental Health Nursing 5:343-353.

Bowers, L., Jarrett, M. Clark, N., Kiyimba, F. & McFarlane, L. (1999) 3. Absconding: outcome and risk. Journal of Psychiatric and Mental Health Nursing 6(3)213-218.

Bowers, L., Jarrett, M. Clark, N., Kiyimba, F. & McFarlane, L. (1999) 2. Absconding: how and when patients leave the ward. Journal of Psychiatric and Mental Health Nursing 6(3)207-212.

Bowers, L., Jarrett, M. Clark, N., Kiyimba, F. & McFarlane, L. (1999) 1. Absconding: why patients leave. Journal of Psychiatric and Mental Health Nursing 6(3)199-206.

Bowers, L., Jarrett, M. Clark, N., Kiyimba, F. & McFarlane, L. (2000) Determinants of absconding by patients on acute psychiatric wards Journal of Advanced Nursing 32(3)644-649.

Bowers, L., Nijman, H. and Alexander, J. (2003) Managing violence in psychiatry: a European perspective. Rivista Sperimentale di Freniatria CXXVII, N.2, pp 143-154.

Bowers, L., Simpson, A. and Alexander, J. (2003) Patient-staff conflict: results of a survey on acute psychiatric wards. Social Psychiatry and Psychiatric Epidemiology 38:402-408.

Bowers, L., Whittington, R., Almvik, R., Bergman, B. Oud, N. & Savio, M. (1999) A European perspective on psychiatric nursing and violent incidents: management, education and service organisation. International Journal of Nursing Studies 36:217-222.

Carnwath, T., Jeacock, J., Huxley, P., Davies, A. & Bowers, L. (1998) Are all districts equally ready for "shared care" of drug misusers? Addiction Research 6(4)307-318.

Clark, N. & Bowers, L. (2000) Psychiatric nursing and compulsory psychiatric care. Journal of Advanced Nursing 31(2):389-394.

Clark, N., Kiyimba, F. Bowers, L., Jarrett, M. & McFarlane, L. (1999) 4. Absconding: nurses views and reactions. Journal of Psychiatric and Mental Health Nursing 6(3)219-224.

Crowhurst, N. and Bowers, L. (2002) Philosophy, care and treatment on the psychiatric intensive care unit: themes, trends and future practice. Journal of Psychiatric and Mental Health Nursing 9:689-695.

Gournay, K. & Bowers, L. (2000) Suicide and self harm in in-patient psychiatric units: a study of nursing issues in 31 cases. Journal of Advanced Nursing 32(1)124-131.

Nijman, H., Bowers, L., Oud, N. & Jansen, G. (in press) Psychiatric nurses' experiences with inpatient aggression. Aggressive Behaviour.