Reconciling the past, celebrating achievements and creating a positive future for mental health nursing

Lakeman, R. (2014 Oct 7-9). Reconciling the past, celebrating achievements and creating a positive future for mental health nursing (keynote). Paper presented at the 40th Annual Conference of the ACMHN: Honouring the Past, Shaping the Future. Sofitel Melbourne.

This presentation considered the current context of mental health nursing, and the challenges that lie ahead for the profession. It critically considered what may be needed to enable practitioners to look back on their professional lives with pride and few regrets knowing that they have made a positive and lasting difference to the mental health of individuals, families and communities.

In the not too distant past a psychiatric nurse was someone who trained, worked and often lived in a psychiatric hospital, kept order therein and assisted in delivering whatever the passing fashions of treatment for what counted as mental illness were in vogue at the time. This is still pretty much the case in much of the world but in contemporary Australia it is somewhat more complex than this, not least because those institutions that sustained the identity of generations of nurses, no longer exist.

Over the last twenty five years or more the occupation of mental health nursing has been undergoing a prolonged identity crisis. Fundamental questions about the nature of mental health nursing remain unresolved:

- Who are mental health nurses?
- How should they be prepared?
- Whom do they serve?
- What do they know and what ought they know?
- How ought they be employed or deployed?

No amount of pontificating by academics will satisfactorily resolve these questions as the specialty of mental health nursing is buffeted by currents quite beyond its control. Nursing has aspirations to be a profession, but it lacks many of the hallmarks:- a distinctive and well-articulated body of knowledge, autonomy of practice, and self-regulation mechanisms. To use a maritime metaphor, mental health nursing is not a sound vessel, doesn't have a functional tiller, nor a captain to guide it. The College has at best been something of a beacon over these last 40 years.

Mental health nursing is instrumental to medicine. That is mental health nurses are the eyes, ears and sometimes strong arm of medicine. This instrumental, and dependent relationship has rarely been acknowledged in academic circles or in nursing theory. The culture of health services are such that naïve bio-medical conceptions of illness, and treatment tend to predominate and are held and promulgated uncritically by doctors and nurses alike. Where medicine goes, nursing will follow. Nursing tends to adopt the predominant explanatory theories and frameworks of medicine. Thus Peplau, adapted psychoanalytical ideas, and latter nurse leaders have adapted contemporary explanatory models. However, it is unclear how these ideas are

enacted in practice. For many nurses who are still required to carry out 'doctors orders' or deliver treatments prescribed by others it might be an uncomfortable position to be in to challenge the dominant ideas about illness, treatment and so on, or even be somewhat ahead of ones time by adopting a more contemporary therapeutic approach not in accord with the dominant ideology. That said, much mental health care takes place in relatively small teams of which nurses are often a part and these can develop their own subcultures and be islands of good practice

Who is a mental health nurse?

In the absence of specific registration or statutory endorsement for mental health nurses in Australia it poses a problem differentiating the 'mental health nurse' from the wider pool of registered nurse. According to Health Workforce Australia (2013) in 2011, 13252 registered nurses identified that they worked in a mental health setting. That is roughly 6% of the working registered nurse work force[1]. Nurses accounted for 64% of those professionals who work in the mental health field (a figure which is diminishing as a percentage of the overall workforce). The majority of these nurses work in either hospitals (56%) or in state community mental health services (29%).

A serious problem and challenge for the very survival of the specialty is that merely working as a nurse in a mental health service setting is frequently conflated with being a mental health nurse. Presently the only formal recognition that someone has post registration training in mental health nursing and has sustained some degree of relevant professional development is the ACMHN's voluntary credential for practice programme. The number of credentialed mental health nurses presently stands at 1320[2]. While this understates the number of eligible people, only 1 in 10 of those who work in mental health settings and 0.6% of the registered nursing workforce are entitled to be called credentialed mental health nurses.

No one should be in a teaching or leadership position in mental health nursing without holding appropriate qualifications and presently the only reliable way of demonstrating this is through credentialing. I'd go further: no one should even hold the drug keys in a hospital or be employed at all, in any capacity in community mental health settings without being credentialed. Clearly we have a long way to go.

Presently, the media, our medical colleagues and the general public perceive that nurses who work in mental health are mental health nurses. For example, this story run in the AGE and by the ABC suggests that mental health nursing is the 'most dangerous profession' in Victoria[3]. I do not wish to minimise the real problem of managing aggression and violence in public mental health

[1] According to Health Workforce Australia (2013a) there were 219,354 registered nurses in paid employment as nurses in 2011.
[2] Personal Communication with Ellie Wilson (Credentialing Officer, ACMHN) on 31/7/2014.
[3] http://www.abc.net.au/news/2014-08-08/mental-health-nursing-the-27most-dangerous-profession27-in-vi/5657464

services, and the probable good intentions of releasing this story in an attempt to secure more resources. However, it is by no means clear that any inferences can be made about mental health nursing as a profession which arguably has a long pedigree in researching, theorising about and managing violent behaviour particularly in ward settings. Perhaps having a workforce in which only one in ten people are appropriately credentialed to do the job might be a major contributor to such problems?

We face a serious image problem as our medical colleagues, exposure to quality mental health nursing practice is limited. During their brief exposure to mental health settings as trainees and junior doctors they are unlikely to encounter many actual mental health nurses, and rather will base their impressions on their encounters with the sometimes servile, or coercive individuals who have a limited repertoire of skills to deal with people who have complex mental health needs beyond administering drugs. Thus we have an uphill PR battle to convince others of the value and unique contribution of mental health nursing. Indeed programmes such as the Mental Health Nurse Incentive Programme are based on a 'practice nurse model' in which the nurse is seen as enacting a medically formulated plan, rather than being treated as specialists or professionals (Lakeman, Cashin and Hurley, 2014).

The mental health nurse incentive programme might be small and poorly conceived in its design, nevertheless it is the only programme which is comprised entirely of a credentialed workforce and is thus particularly worthy of our critical gaze. From research on the MHNIP (Lakeman, 2013) we can extrapolate that mental health nurses in Australia are by and large highly experienced, qualified, with often multiple postgraduate qualifications with considerable expertise in one or more forms of psychotherapy. They are able to work flexibly and collaboratively to assist people with the most complex psychosocial needs and problems of living. Their pathway to becoming a mental health nurse is often long and torturous and few identify their basic training as particularly useful to their roles (Lakeman, 2013).

Training mental health nurses

The move to comprehensive nursing preparation and the loss of specialist endorsement for psychiatric or mental health nursing is widely recognised (at least within the small mental health nursing fraternity) as being to a large part responsible for the de-skilling of the mental health workforce. Hurley and Ramsay (2008) describe moves towards generic pre-registration courses in the UK as potentially sounding the death knell for the profession. In Australia generic comprehensive nursing programmes offer a dismal preparation for a career as a mental health professional. Research has consistently demonstrated that mental health nursing is one of the least preferred career directions of undergraduate students and positive attitudes tend to be correlated with more lengthy theoretical preparation and clinical placement (Happell and Gaskin, 2012). A survey by McCann et al (2009) found the average number of mental health and illness theory hours across comprehensive nursing programs was hugely variable with a mean of 106 hours (range 15 to 359) with clinical experience in mental health ranged from

0 to 352 hours. Most people who work in mental health services are a product of this system of training and despite being comprehensively trained it is not uncommon for nurses working in mental health to claim they can't nurse people with complex physical health problems. Also our medical, surgical and critical care colleagues often claim that they lack rudimentary skills to undertake basic care for people with complex psychosocial problems.

Training nurses in Australia is a production line process and uncapped preregistration courses are a cash cow for schools and departments. One is hard pressed to find any nursing school where expansion of student numbers or completions is not higher up the agenda than producing quality graduates let alone graduates fit to become mental health nurses. Within this context mental health and illness is a marginalised part of most curricula, and outnumbered mental health lecturers spend considerable energy resisting the encroachment of genericism and defending the paltry amount of mental health and illness content against competing claims from other branches of nursing.

Arguably too, the nursing academy and mental health nursing struggles to realise the more noble of the multifarious purposes of the university… to be creative, critical, innovative, generate new knowledge and act to some degree as the secular conscience of the profession and society. As Happell (2014) recently noted in an editorial in the College Journal, respectful debate and disagreement is a rarity in nursing and mental health nurse academics are more likely to be conservative apologists rather than critical commentators or innovators. If that isn't enough Mental health nursing lecturers also often struggle with issues of credibility given that career academics rarely engage in mental health nursing practice and often have limited (if any) direct relationship with mental health services.

Such is the perilous state of undergraduate preparation and problems recruiting nurses into mental health nursing that Collin Holmes (2006) in a paper entitled "The slow death of psychiatric nursing: what next?" suggested that we ought to cut traditional disciplinary ties and embrace the development of a mental health workforce trained as graduate specialists outside of existing disciplinary identities. To some extent this is already happening at a post graduate level as many credentialed mental health nurses hold qualifications in the trans-disciplinary field of psychotherapy. However, such is the power of the professions, that it is unlikely that any will yield space for another type of generic worker, especially when even the qualified psychotherapist is not recognised or regulated in Australia.

Happell and others (Happell and Cutcliffe, 2011; Cleary and Happell, 2005; Happell et al, 2008) have also been longstanding critics of the comprehensive education approach but have otherwise sought to research options or tweak the existing system to address skills shortfalls and improve student attitudes. These initiatives have included facilitating a mental health nursing major in undergraduate degrees, improving access to people with lived experience of mental health problems and recovery and including people with lived experience as part of academic teams.

Supporting graduates through entry to practice programmes, clinical supervision and graduate courses have all been proposed and evaluated with varying degrees of rigor and with equivocal results. With a few outstanding exceptions the post-graduate options on offer in mental health nursing across 24 training institutions (Gendek, 2012) at least on the face of it appear bland and undifferentiated. It is unclear how some of them can be offered at all given the paucity of specialty expertise in some schools. Given the rapid shift towards distance and mixed mode teaching and learning it is likely and desirable that fewer universities will offer such courses. Our collective challenge will be to work cooperatively, drawing on our strengths to develop credible post graduate course options, perhaps accredited by only a few universities but drawing on the talent of experts from wherever they are across Australia. The College already has had its first forays into providing e-learning modules. However, a fruitful role will also be to act as a course accrediting body and perhaps a facilitator of a national consortium to develop and deliver credible post graduate education and training for mental health nursing.

What does it mean to offer mental health nursing?

This of course begs the question what does it mean to be a mental health nurse? What particular skills should they possess? A post graduate qualification in mental health nursing is presently poorly defined and at the very least using the vernacular of the time a credentialed mental health nurse ought to be able to provide 'focused psychological strategies' but presently they are not recognised as possessing these basic skills despite sometimes decades of practice and multiple post graduate qualifications. Nurses in Australia were early adopters of the mantle 'mental health' nurse and this has been rather uncritically adopted, whereas in other jurisdictions nurses have tenaciously held onto the title 'psychiatric nurse. I and colleagues have argued that the distinction is or ought to be more than semantics.

The Australian Standards of Practice for Mental Health Nurses (ACMHN, 2010) has some quite explicit and unambiguous statements about what it means to provide mental health nursing:

> *A Mental Health nurse is a registered nurse who holds a recognised specialist qualification in mental health. taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual* (ACMHN, p.5)

As Barker and Buchanan-Barker (2011, p.342), note the Standards give value and prima-facie significance to partnerships, personalised notions of recovery and respect for human rights but they "…might fly in the face of contemporary forms of evidence-based practice', which remain 'patient focused' and paternalistic, where they are not actually coercive and dehumanising".

In my own more inductive attempts at attempting to define what is 'good mental health nursing' (Lakeman, 2012) I have similarly been left wondering if

coercive practices are at all compatible with good mental health nursing, or how one can reconcile acute crisis intervention or containment responses to aggression and violence with good mental health nursing. Incidentally the use of seclusion has shown a linear decline and reduced by a third (as a proportion of patient bed days) since 2008 (Australian Institute of Health and Welfare, 2013). However, Barker and Buchannan-Barker (2011, p.342) go further and ask whether a mental health nurse is meeting the standards if they are involved in encouraging individuals and their families to adopt a psychiatric view of their 'symptoms' of 'mental illness', rather than assisting people to develop their own understanding of their problems in living?

There is not a singular and uncontested psychiatric view of anything but it is clear that a naive biomedical pharmaco-centric orthodoxy prevails at the present time (Cutcliffe and Lakeman, 2010) and this poses a substantial threat to not only mental health nursing, but also the credibility of psychiatry and the wellbeing of the nation. The orthodox view that Barker and Buchannan-Barker allude to is the simplistic notion that one has an illness resulting in an underlying biochemical imbalance that can and ought to be corrected by a drug. Nurses have been enthusiastic and largely uncritical proponents of this view and play a powerful role as the most trusted of the health professions (Roy Morgan, 2014) in promulgating a pharmaco-centric view of human distress (Lakeman and Cutcliffe, 2009; Cutcliffe and Lakeman, 2010). This has led to a large proportion of the population being medicated.

I believe we will look back on this era, particularly the last twenty years with a mixture of incredulity and shame. Insulin coma, lobotomy and unmodified ECT which we now view as crude and cruel treatments were confined to a small number of people relative to the extent that people are medicated today. Regardless of evidence of iatrogenic harm, or of evidence based guidelines which ought to have put a brake on prescribing, and regardless of scandals demonstrating the unscrupulous and sometimes criminal behaviour by pharmaceutical companies in their pursuit of extending markets, the increase in medicalization and medicating of distress has been exponential.

In Australia we now spend more on ''mental illness" treatment than at any time in history, that is over $6.9 billion or $309 per Australian. In the first 10 years of the national mental health strategy the Australian Government share of the increase in expenditure was almost entirely spent on psychiatric drugs (Department of Health and Ageing, 2013). The stigma associated with depression and suicide is now significantly reduced and a substantial number of Australians now seek help for problems of living which they construe as mental health problems through their GP (some 7.1% of the population in 2011-11). More people than ever are getting a mental health care plan and attendant psychological support but this almost invariably comes with a prescription. In 2012-13 There were 31.1 million prescriptions for mental health-related medications (subsidized and under co-payment), accounting for 11.4% of all prescriptions (Australian Institute of Health and Welfare, 2013a). Eighty six percent were provided by GPs. The Australian Government spent $788 million, or $34 per person in Australia, on subsidized prescriptions for

psychiatric drugs under the PBS/RPBS during 2012–13, equating to 8.3% of all PBS/RPBS subsidies (Australian Institute of Health and Welfare, 2013b).

In Australia nothing has made a difference to the trend to prescribe more antidepressants: Not widely reported concerns over SSRIs and increased suicide risk in young people in the earlier part of the century; Nor the NICE guidelines which mandating counseling and CBT in particular for mild to moderate depression; and not the widely publicised meta-analysis of data submitted to the US Food and Drug Administration which suggested that antidepressants don't work any better than a placebo in all but the most severe episodes of depression (and then the difference is not great and probably not clinically significant) (Kirsh et al, 2008). This was widely reported and discussed in the lay press in Australia with psychiatric Commentators largely telling people not to stop their meds and to see their doctors. Ironically the steepest increase in antidepressant prescription in 10 years occurred following the meta-analysis essentially saying that according to the best tools available in the evidence based toolbox the drugs don't work. Prescriptions increased by 2 million drug units!

A similar trend exists for neuroleptic prescriptions which were once dispensed rarely and with caution and are now prescribed off label for all manner of issues. These have brand specific trends in keeping with good marketing rather than good science and trends are quite unaffected by scandals associated with their marketing practices overseas. When I shared some of these slides with a psychiatric colleague her response was 'We really believe the drugs work!' We do, often despite the evidence of harm and despite their often crude non-specific effects. This would of course be fine if they were benign or even were effective in addressing most people's problems… but this naïve bio-pharmaco-centric approach to human distress hasn't been found to be helpful to most and often serves to obscure alternative ways of viewing and addressing problems.

One would for example, expect that the unprecedented expenditure on mental health promotion and treatment might be making a big difference. However an analysis of national surveys of adult psychological distress in 1995, 2003-4 and 2011 concluded that there was no improvement in adult mental health over this 16 year period in Australia (Jorm & Reavley, 2013). Some such as Robert Whitaker have argued (and I'm yet to hear a good rebuttal) that our over-reliance on taking pills has actually contributed to increased disability and chronicity. Even in the scientific press, sacred cows such as the idea of maintenance treatment for psychosis have been slaughtered with evidence that in the long run, those not receiving drugs relapse less than those on maintenance treatments (Wunderink, 2013).

Mental health nursing and mental health nursing needs to be seen to align itself with a more critical, sophisticated and pluralistic account of the human condition than the present naïve bio-medical orthodoxy presents. We need to be seen to keep our distance from the interest groups that serve to benefit from perpetuating the medication of everything and everyday life. Psychiatry itself is shifting and is rebranding itself neuro-psychiatry. The very categories

of mental illness have been described as ‘lacking validity’ by the National Institute of Health (Insel, 2013) and research by this prestigious organization will no longer address the familiar DSM categories. This is no anti-psychiatric plot but rather a recognition that research endeavors to date have not elucidated the psychopathology of or yielded any specific treatments for any of the amorphous groups of mental disorders as we understand them. Mental health nursing risks being an anachronism unless it positions itself at the forefront of psychotherapeutics rather than being naïve followers of outmoded fashions and it needs to align itself with service users rather than with pharmaceutical companies.

This is where there is considerable hope. Things have improved considerably for people living with psychosis in Australia over the last twenty years (Morgan et al, 2012) and these are the core group of people who community mental health services serve. The problems that these people are most concerned about are social rather than health related: finances, lack of employment and loneliness. Nearly 90% of people surveyed are reliant on government pensions. There are however, promising programmes such as ‘open dialogue’ which reflect different ways to respond to people in crisis and which appear to preserve and enhance social networks and occupational functioning in psychosis. In trials of open dialogue over 80% of people who experience their first episode of psychosis are employed or in study after two years and taking little if any medication (Lakeman, 2014). Nurses are in an ideal position to champion the development of these approaches.

There is growing insight into the role of different kinds of trauma in the aetiology of psychosis and rapidly evolving explanatory models and therapeutic approaches which take this knowledge into account. Australia’s youth mental health strategy, whilst under-resourced relative to other areas of mental health and largely funded through the flawed aforementioned MBS activity based funding model is at least emphasizing assisting young people remediate the damage associated with childhood trauma and attachment disruptions whilst providing a scaffolding to support them build healthy coping and relationships. Mental health nurses need to position themselves at the forefront of this new movement, notwithstanding that they lack eligibility to work under ‘better access’ the principle means of funding in primary care.

Communications technologies have vastly changed the dynamics between mental health service providers and service users as they have altered the dynamics of all human relations. We have high expectations of being able to contact people rapidly and we expect a near immediate response. Access to information means that service users can be better informed, closer to real consumers of services. Communication technologies have enabled the rapid evolution of international peer support and self-help movements such as the hearing voices network.

Technology will also provide the means for rapid symptom amelioration for some people. Deep brain stimulation has already demonstrated clinical application to target neuronal circuits associated with problems of mood and anxiety (Ressler & Mayberg, 2007; Crowell et al, 2014). This provides the kind

of specific and immediate symptom relief that has proven impossible with drugs. It is unclear what if any implications this will have for mental health nurses. The prospect of being able to literally switch off anhedonia is exciting but the harder work may be to understand how an individual got to a particular state in the first place and helping them solve their problems. Neuroscience or genetics have to date provided no silver bullets. Mental health nursing remains largely high touch, low tech and this may be it's strength and saving grace.

Nurses can and do have a major influence on people's trajectories towards recovery and can play a major role in assisting people resolve crisis. One of the most robust findings is that the quality of the therapeutic alliance between therapist and client, or nurse and patient is one of the strongest predictors of recovery or good outcome. Indeed the contribution of therapeutic alliance is thought to be much higher than the intervention itself, or technique of the therapist (Martin et al, 2000; Bambling & King, 2001; Foster et al, 2014). Mental health nurses have a proven capacity to build alliances with people who seem to have the most complex of needs, often in psycho-noxious environments, and for long periods of time. Good mental health nursing is often unobtrusive if not invisible to those outside of the nurse-person relationship. These things are worthy of celebrating. Nurses need to reclaim and cultivate the idea of the 'therapeutic relationship' and research and highlight how they adapt principles and practices derived from psychotherapy in the practice of their craft for the service of the client. There are clearly synergies with nursing's philosophy and solution focused, narrative or dialogical methods but it is more important that nurses are passionate about developing their therapeutic potential in every way they can and expanding their repertoire of skills. Nurses then need to begin to articulate their skills base, and develop processes to teach others.

The final challenge for nurses is to integrate the ideas of evidence based practice with values based practice. To nurse in accord with the values they espouse. To borrow from Abraham Verghese speaking about medicine:

> *….the most important innovation, I think, in medicine to come in the next 10 years, and that is the power of the human hand -- to touch, to comfort, to diagnose and to bring about treatment*

Regardless of technological advances, new drugs or sophisticated assessment tools the fundamental values of mental health nursing - preserving dignity, holding hope, comforting, guiding, and assisting people in their recovery journeys are as salient today as ever.

References

Australian College of Mental Health Nurses. (2010). Standards of Practice for Mental Health Nurses. ACMHN: Canberra

Australian Institute of Health and Welfare (2013). Mental health services – in brief 2013. Cat. No. HSE 141. AIHW: Canberra.

Australian Institute of Health and Welfare (2013a). Mental Health related Prescriptions. http://mhsa.aihw.gov.au/resources/prescriptions/. Accessed 29/8/2014

Australian Institute of Health and Welfare (2013b). Expenditure on Mental Services. http://mhsa.aihw.gov.au/resources/expenditure/. Accessed 29/8/2014

Bambling, M. & King, R. (2001). Therapeutic alliance and clinical practice. *Psychotherapy in Australia*, *8*, 38–43.

Barker, P., & Buchanan-Barker, P. (2011) Myth of mental health nursing and the challenge of recovery. International Journal of Mental Health Nursing, 20 337-344.

Cleary, M., & Happell, B. (2005). Promoting a sustainable mental health nursing workforce: An evaluation of a transition mental health nursing programme. *International Journal of Mental Health Nursing*, *14*(2), 109-116.

Crowell, A. L., Riva-Posse, P., Garlow, S. J., & Mayberg, H. S. (2014). Toward an Understanding of the Neural Circuitry of Major Depressive Disorder Through the Clinical Response to Deep Brain Stimulation of Different Anatomical Targets. *Current Behavioral Neuroscience Reports*, *1*(2), 55-63.

Cutcliffe, J., & Lakeman, R. (2010). Challenging Normative Orthodoxies in Depression: Huxley's Utopia or Dante's Inferno? Archives of Psychiatric Nursing, 24(2), 114-124.

Department of Health and Ageing. (2013) *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011.* Commonwealth of Australia: Canberra. P.45

Forster, C., Berthollier, N., & Rawlinson, D. (2014). A Systematic Review of Potential Mechanisms of Change in Psychotherapeutic Interventions for Personality Disorder. *J Psychol Psychother*, *4*(133), 2161-0487.

Gendek, M. (2012). Scan of Postgraduate Mental Health Nursing Programs in Australia 2011. Australian College of Mental Health Nurses: Canberra.

Happell, B. (2014). Academic freedom: Alive and well or victim of the conservative creep?. *International journal of mental health nursing*, *23*(4), 285-286.

Happell, B., & Cutcliffe, J. R. (2011). A broken promise? Exploring the lack of evidence for the benefits of comprehensive nursing education. *International Journal of Mental Health Nursing*, *20*(5), 328-336.

Happell, B., & Gaskin, C.J. (2012). The attitudes of undergraduate nursing students towards mental health nursing: a systematic review. Journal of Clinical Nursing, 22, 148-158.

Happell, B., Robins, A., & Gough, K. (2008). Developing more positive attitudes towards mental health nursing in undergraduate students: part 2□the impact of theory and clinical experience. *Journal of psychiatric and mental health nursing*, *15*(7), 527-536.

Holmes, C.A. (2006). The slow death of psychiatric nursing: what next? Journal of Psychiatric and Mental Health Nursing, 13, 401-415.

Health Workforce Australia. (2013) *Mental Health Workforce Planning Data Inventory*. Health Workforce Australia: Adelaide

Health Workforce Australia (2013a) Australia's Health Workforce Series – Nurses in focus, Health Workforce Australia: Adelaide

Insel, T. (2013). Director's Blog: Transforming Diagnosis. National Institute of Mental Health. http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml. Accessed; 1/9/2014

Jorm, A. F., & Reavley, N. J. (2013). Changes in psychological distress in Australian adults between 1995 and 2011. *Australian and New Zealand Journal of Psychiatry, 46(4), 352-356.*

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS medicine*, *5*(2), e45.

Lakeman, R. (2014). The Finnish open dialogue approach to crisis intervention in psychosis: A review. *Psychotherapy in Australia, 20*(3), 26-33
Lakeman, R., Cashin, A., & Hurley, J. (2014). Values and valuing mental health nursing in primary care: what is wrong with the 'before and on behalf of' model? *Journal of Psychiatric and Mental Health Nursing, 21*(6), 526-535.

Lakeman, R. (2013). A Survey of Credentialed Mental Health Nurses working in the Mental Health Nursing Incentive Program: Who are they? How do they work? What have they achieved? Australian College of Mental Health Nurses: Canberra

Lakeman, R. (2012). What is Good Mental Health Nursing? A Survey of Irish Nurses. Archives of Psychiatric Nursing, 26(3), 225-231.

Lakeman, R., & Cutcliffe, J. (2009). Misplaced epistemological certainty and pharmaco-centrism in mental health nursing. Journal of Psychiatric and Mental Health Nursing, 16(2), 199-205.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, *68*(3), 438.

McCann, T., Moxham, L., Usher, K., Crookes, P.A., Farrell. (2009). Mental health content of comprehensive pre-registration nursing curricula in Australia. Journal of Research in Nursing, 14(6), 519-530

Morgan, V. A., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J. J., Carr, V., ... & Saw, S. (2012). People living with psychotic illness in 2010: The second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry*, *46*(8), 735-752.
Roy Morgan (2014). Roy Morgan Image of Professions Survey 2014 - Nurses still most highly regarded – followed by Doctors, Pharmacists & High Court Judges. Online: http://www.roymorgan.com/findings/5531-image-of-professions-2014-201404110537 Accessed 4/9/2014

Ressler, K. J., & Mayberg, H. S. (2007). Targeting abnormal neural circuits in mood and anxiety disorders: from the laboratory to the clinic. *Nature neuroscience*, *10*(9), 1116-1124.

Wunderink, L., Nieboer, R. M., Wiersma, D., Sytema, S., & Nienhuis, F. J. (2013) Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: Long-term follow-up of a 2-year randomized clinical trial. *JAMA Psychiatry, 70(9), 913-920.*