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Nurse faculty perceptions regarding psychiatric-mental health nursing behavioral interventions: A cross-cultural comparison

ABSTRACT

Mental disorders are internationally responsible for significant disease burden and disability. However, limited cross-culturally comparisons, related to psychiatric-mental health nurses and the care they deliver, have been conducted. Therefore, the purpose of this article is to present information obtained from nurse faculty from Australia, Hong Kong, Japan, South Korea, Thailand and the USA (State of Hawaii) about: a) titles and educational preparation of the psychiatric-mental health nurses; b) the role and perception of others about the psychiatric-mental health nurses; c) nursing behavioral interventions, including medications; d) length of stay of hospitalized psychiatric patients; e) leading mental health problems; and, f) the profile of the population with a mental illness. The findings reflect diversity in the role and educational preparation of psychiatric-mental health nurses, as well as how psychiatric-mental health patients are treated.

KEY WORDS

nurse faculty perceptions; psychiatric-mental health nursing; nursing behavioral interventions; cross-cultural comparisons

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Introduction

Mental health has been defined as "a state of successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to change and cope with adversity" (Department of Health and Human Services, 2000: 37). Individuals that do not possess these characteristics are perceived at risk for developing a mental disorder. From a nursing perspective, such people may be identified as being in need of psychiatric-mental health nursing care. The Global Burden of Disease study found mental disorders to be the fourth leading cause of burden, in the world, and one of the leading

causes of disability (Murray & Lopez, 1997). In light of this and the global significance of mental health, one may question whether the quality of psychiatric-mental health nursing care is the same from one health care facility to another, from one state or province to another or even from one country to another. An increasing emphasis, on benchmarking and governance structures, underscores the importance of making valid and accurate comparisons in health care delivery (Swage, 2000; Porter & O'Grady, 1995, 2001).

In the United States of America (USA), the quality of psychiatric-mental health nursing care has been perceived as being dependent on the educational preparation and clinical experience of those providing care, the types and effectiveness of the nursing behavioral interventions (i.e. activities existing and carried out within the scope of nursing practice that promote and maintain good mental health), provided and whether the care was helpful to those receiving it (American Nurses' Association, 2000). Does this same perception exist among nurse faculty within Asia and Oceania?

In an attempt to answer this question a review of the literature, using the key search terms "psychiatric nursing behavioral interventions," revealed 25 articles published between 1984 and 2001 in English language journals and listed in Pub Med. These publications addressed psychiatric-mental health nursing behavioral interventions throughout the USA, including: recent developments in psychosocial interventions for people with psychosis (McCann, 2001), utilization of seclusion and restraints (Allen, 2000), appropriately timed interventions with families and adolescents (Kalinyak, & Jones, 1999), cognitive behavioral therapies within the biological paradigm (Blair,1996), strategies used by women recovering from depression (Peden,1994), cognitive nursing interventions with long-term care residents (Abraham, & Reel,1992), and mental health nursing in the 21st century (Flaskerud, & Wuerker,1999). However, no articles, written in English and published in English language health care journals, could be found that addressed cross-cultural aspects of psychiatric-mental health nursing or made a cross-cultural comparison of nursing behavioral interventions. Thus, the lead author decided it would be of value to do a cross-cultural comparison of: a) the characteristics of psychiatric-mental health nurses, b) medications used in psychiatric-mental health treatment, c) the length of hospital stays, d) the prevalence of mental illness, e) the leading mental health problems, and f) nursing behavioral interventions. Nurse faculty colleagues (n = 9) of the lead author, attending the international conference, "Quality of Psychiatric Mental Health Care: Nurses Making a Difference," in Bangkok, Thailand in January, 2003, were asked to take part in comparing psychiatric-mental health nursing behavioral interventions among the countries of Australia, Japan, China, Thailand, South Korea and the USA. These individuals were selected since they have been identified as nurse leaders and experts on psychiatric-mental health nursing within their respective countries and had experience teaching psychiatric-mental health nursing concepts.

An open-ended 18 item questionnaire, developed by the lead author, was disseminated, via e-mail, among the group. This approach was used since informants can assist in the methods identification of contextual variables that have the potential of contributing to the explanation of phenomenon (Hughes & Preski, 1997). It must be kept in mind that this activity was not a research study, but a means for nurse colleagues to begin to identify and compare cross-cultural aspects of nursing behavioral interventions. It is the purpose of this article to present the results of the questionnaire.

QUESTIONNAIRE

The 18 items in the questionnaire requested information about: a) titles and educational preparation of the psychiatric-mental health

nurse providers; b) role and perception of others about the psychiatric mental health (PMH) providers; c) nursing behavioral interventions, including medications; d) length of stay of hospitalized psychiatric patients; e) leading mental health problems; and, f) the profile of the population with a mental illness. Examples of some of the questions were: "What are the titles and educational preparation of nurses who provide psychiatric-mental health nursing care in your country?" "What types of nursing behavioral interventions do nurses provide in your country?" "What perceptions do people in your country have of psychiatric-mental health nurses?"

Results

The responses of the nurse educators were compiled, by country, and are presented in Tables 1 through 4. Information related to: a) titles and educational perspectives; b) role and perception of others about the psychiatric-mental health providers; c) nursing behavioral interventions; and d) medications, hospitalization and mental illness are discussed, in further detail, below.

Titles and educational perspectives

The titles of those providing psychiatric-mental health nursing care (See Table 1 in the Appendix) were found to include: a) psychiatric technicians (Psych Techs), b) enrolled nurses (EN), c) psychiatric-mental health nurses (PMHN), d) clinical psychiatric nurse specialists (Psych CNS), e) clinical nurse consultants (CNC), and f) psychiatric-mental health nurse practitioners (PMHNP). Although each respondent indicated that his/her country had educationally prepared psychiatric-mental health nurses (See Table 4), both the educational level and clinical preparation of the providers of psychiatric-mental health nursing care were found to vary (See Table 1).

The educational programs (See Table 1) were found to include: a) high school nursing programs, b) 1 year nurse training programs, c) hospital-based nursing diploma programs, d) baccalaureate degree nursing programs, e) 2 year Masters' degree programs in psychiatric-mental health nursing, f) post-graduate specialty training and, g) one to 5 years of post-graduate study and work experience in psychiatric-mental health nursing. No attempt was made, however, to determine whether the course content presented and the quality of the educational programs were comparable.

Role and perception of others about the PMH provider

The role of the psychiatric-mental health nurse (See Table 4) was found to be varied and diverse, from providing for basic activities of daily living (Japan) to addressing all aspects of psychiatric-mental health nursing care (Australia and USA). Such role diversity may be attributed to the varying educational experiences and knowledge base of psychiatric-mental health nurses across countries. Undoubtedly, prevailing cultural perceptions of mental health influence the activities and roles of psychiatric-mental health nurses and contribute to variations in roles and functions. For example, in certain Asian countries where mental illness is considered an "embarrassment" to the culture, the provision of high quality educational preparation of nurses, who deliver psychiatric-mental health care, is not likely to occur. This, in turn, contributes to the inability of nurses to deliver adequate psychiatric-mental health care.

Overall, psychiatric-mental health nurse providers were perceived as being "respected more than the general registered nurse" (See Table 4). Australia, Japan and the USA were found to have psychiatric-mental health nurses in private practice. In addition, certified psychiatric clinical nurse specialists in the USA were able to receive reimbursement for services rendered from "third party payers" (i.e. government agencies and insurance companies), as well as clients.

Nursing behavioral interventions

Nursing behavioral interventions (i.e. activities existing and carried out within the scope of nursing practice that promote and maintain good mental health) carried out by psychiatric-mental health nurses (See Table 2) were found to include, but were not limited to: a) continuous and comprehensive primary mental health care services that facilitate the promotion of optimal mental health, b) prevention of mental illness, c) rehabilitation from mental disorders, and d) maintenance of good mental health. The nursing behavioral interventions involved any number of activities done in response to or because of one's behavior. As one would expect, the intervention implemented most often was dependent upon the patient's/client's behavior and/or the outcome desired by a health care provider.

Nursing behavioral interventions were found to include a variety of activities from assisting with activities of daily living to performing cognitive-behavioral therapy, family education and group therapy. Not every country was found to implement the same interventions, nor did the same titled or educationally prepared individuals deliver the interventions. Psychiatric-mental health nurses appeared to be involved, either directly (Australia, Hong Kong, South Korea, Thailand, and the USA) or in addition to other health care providers (Japan, South Korea and the USA), in implementing behavioral nursing interventions.

It was interesting to discover, in addition to psychiatric-mental health nurses, advanced practice registered nurses, mental health nurse practitioners, certified mental health nurse practitioners and registered nurses, that non-nurse members of the multi-disciplinary health care team also implemented some nursing behavioral interventions (i.e. activities existing and carried out within the scope of nursing practice that promote and maintain good mental health). These non-nurse providers included: Occupational Therapists (OT), Psychologists, Psychiatric Social Workers (PSW), and Psychiatrists.

Medications, hospitalization and mental illness

With the vast majority of patients, in all countries, receiving psychotropic medications, one may question the effectiveness of the medications in relationship to the length of hospitalization (See Table 3). Although 100 % of the psychiatric patients in both Japan and Thailand receive psychotropic medications, Japan's average length of stay is significantly longer than any other country (344 days). On the other hand, Australia and the USA were found to have less usage of psychotropic medications, with length of stays of one week or less.

The majority of the countries appear to be attempting to decrease hospitalization rates of those with mental health illnesses (See Table 3). Thus, individuals experiencing schizophrenia, other psychoses, substance abuse and depression (the identified leading mental health problems) may, in the future, be treated in a community setting. The movement toward decreased hospitalization was noted to be greater in Australia, Hong Kong, Thailand and the USA than in South Korea and Japan. This may be due to cultural differences regarding the meaning of mental illness within the respective countries. These trends are likely to be driven by fiscal and policy agendas, but may not necessarily show better outcomes for patients and their families.

While over 20 % of all Americans, 18 yrs. of age and older, in any given year experience some form of mental illness during their lifetime, 5.4 % of this population suffer from a serious and persistent mental illness (See Table 3) (National Alliance of the Mentally Ill, 2002). The reported percentage of the population, within other countries, with a mental illness varied. It has been estimated that 17% of Australians suffer from anxiety, depression and substance abuse disor-

ders over any given 12 month period, with approximately 3% of the population experiencing psychotic disorders (Andrews, Hall, Teeson & Henderson, 1999). On the other hand, Thailand identified only 0.4% of the population as having a mental illness. One has to wonder, with such variation across countries in reporting the prevalence of mental illness, if the manner of calculating these percentages and the criteria used to diagnose mental illness are the same. Thus, while schizophrenia and other psychoses, drug addiction and depression appear to be the leading mental health problems within all countries, the percent of the population perceived to have a mental illness was found to be relatively low when compared to the percentage of other health care problems, such as cardiac disorders and cancer.

Discussion

These findings seem to help explain why psychiatric-mental health nursing in the USA has been recognized as "a specialized area of nursing practice that employs theories of human behavior as its science and the purposeful use of 'self' as its art" (American Nurses Association, 2000: 55). A nurse cannot provide effective and meaningful psychiatric-mental health care without a sufficient level of knowledge regarding human growth and development, behavioral expectations, societal/cultural norms and environmental factors. In addition, the nurse must be able to critically think, so as to appropriately determine whether a behavioral change needs to occur. In the USA, the practice of psychiatric-mental health nursing has been perceived as requiring diagnosis and treatment (from a nursing perspective) of human responses to actual or potential mental disorders and their long-term effects. While change, in regards to the perception of nursing and the treatment of mental illness has been perceived to be occurring throughout the world, the practice of psychiatric-mental health nursing does not appear to be the same throughout Asia, Oceania and the USA.

The information provided by the nurse faculty from Australia, Hong Kong, Japan, South Korea, Thailand and the USA has allowed for a better understanding of the similarities and differences in the roles and in the development and practice of psychiatric-mental health nurses within each country. Not only are the titles of those delivering nursing behavioral interventions diverse, but also the educational requirements differ from country to country, even when the same title is awarded. These findings potentially create dilemmas for conducting cross-cultural comparison of nursing behavioral interventions delivered by psychiatric-mental health nurses. Until there are global standards regarding knowledge and preparation of psychiatric-mental health nurses, the cross-cultural comparison of nursing behavioral interventions delivered will continue to be difficult.

Throughout the world, the nurse's level of knowledge is dependent both upon his/her level of education and clinical experience. As shown by the nurse educators' responses, not all nurses who work in psychiatric-mental health nursing have been educated, certified or credentialed as psychiatric-mental health nurses. This appears to be especially true in certain Asian countries where there is a pervasive cultural sense of shame among the populace about needing psychiatric mental health care and where the status of those who provide care to the mentally ill is considered to be very low. This obviously has implications for the type and quality of care the mentally ill receive.

In Japan, stigmatization regarding any kind of mental illness has lead to an environment whereby "no one wants to think they have a mental problem and most doctors say they just don't know anything about that area" (French, 2002; Fuji et al., 1993). It is not surprising that Anders, et.al. (1999), when comparing the use of nursing diagnoses among long-term psychiatric patients in Japan, noted that "discrepancies

may exist because of inconsistent interpretations of the nursing diagnosis by the primary nurses" (p. 41). It is possible that the occurrence of inconsistent interpretations of nursing diagnoses is a result of the effect of the pervasive cultural stigma associated with mental illness (i.e. not wanting to acknowledge the presence of a long-term mental health problem).

The title of mental health nurse appears to be used interchangeably with the title of psychiatric nurse. Either title reflects that the psychiatric-mental health nurse is the provider of nursing care to people experiencing a mental illness and contending with its related treatment. Generally, no distinction is made regarding whether the nurse works in a hospital or community setting, nor is there a clear delineation of title based upon the type of care provided. Rather, the psychiatric-mental health nurse, regardless of title, is perceived as performing a range of services in a variety of settings with people experiencing a diverse set of psychiatric illnesses and/or mental health difficulties. In addition, the psychiatric-mental health nurse provides consultation and educational services to others about psychiatric-mental health issues. It is not unusual for a psychiatric-mental health nurse to be involved (as a team member) in, but not limited to: acute and rehabilitative psychiatric nursing care, community mental health, early psychosis intervention, child and adolescent mental health, child protective services, juvenile justice services, law-court services assessing the mental competence of an accused, violence prevention and intervention, abuse and neglect services, prisons, liaison services in general hospitals providing consultation to emergency and inpatient care providers, and educational and organizational programs.

The psychiatric-mental health nurse usually chooses to work as a provider of psychiatric-mental health care, rather than being directed to do so. This is one of the reasons psychiatric-mental health nurses, in some countries, may be perceived as being "respected more than the general registered nurse". Not every nurse wants to provide care to the mentally ill. Nor does every nurse have the knowledge or ability to provide care to those with mental health difficulties or to assist patients' families as a caregiver, health care coordinator, case manager, health teacher, change agent, counselor, client advocate, and/or supervisor.

In some countries, there is no special educational requirement to perform psychiatric-mental health nursing care. Thus, any licensed registered nurse may work and be identified as a psychiatric-mental health nurse. In an attempt to prevent secondary co-morbid conditions and disabilities, it appears that nurses who work with the mentally ill try to assist the person by addressing support system needs and by seeking adequate community resources to enhance daily functioning (Magyary, 2002).

In the USA, all nursing curricula for registered nurses must include content related to the practice of psychiatric-mental health nursing. Registered nurses, in the USA, who meet the basic practice experience requirements, can take a Generalist Certification examination in psychiatric mental health nursing. In addition, master's prepared psychiatric mental health nurses, with advanced knowledge and skills are encouraged to seek national certification so as to be eligible for reimbursement for their services from government agencies and insurance companies.

A designated organization or official government body provides both the Generalist and the Clinical Specialist certification examinations, in the USA, South Korea and Japan. The American Nurses Credentialing Center has been recognized as the official certification entity for nurses in the USA. In South Korea, certification for both the Generalist and the Specialist in psychiatric and mental health nursing can be achieved from the Ministry of Health and Welfare, after successful completion of an examination administered via the Association of Psychiatric

and Mental Health Practitioners. On the other hand, the Japanese Nursing Association (JNA) has become the recognized certifying body for nurses seeking certification as either liaison psychiatric nurses or mental health psychiatric nurses.

Certification and credentialing of psychiatric-mental health nurses appears to be of increasing importance to the Nursing Council of Thailand. During January 2003, the Council offered, for the first time, a national certification examination for advanced psychiatric-mental health nursing practice. However, at this time, other countries in Asia and Oceania do not appear to have such a credentialing or certification mechanism for nurses delivering psychiatric-mental health care. Rather, throughout Asia and Oceania, there appears to be an ever-increasing number of non-credentialed, non-certified, and educationally and clinically unprepared non-nurse health care workers. These non-nurse health care workers are increasing in number and are attempting to implement behavioral nursing interventions that focus on mental health care within community settings. This is of grave concern given the fact that community settings, when compared to acute care settings (i.e. hospitals), provide little, if any, supervision by more experienced, educated health care providers.

Nursing behavioral interventions implemented throughout Asia, Oceania and the USA cannot be examined without taking into account the cultural meaning of the interventions being delivered. For example, the reason Japanese psychiatric patients are hospitalized for over 344 days may be due to the societal pressures that discourage placement of patients into community settings (Anders et. al., 1999). Countries, that have significantly shorter lengths of hospital stay (Australia and the USA) base their actions on the fact that societal expectations and cultural norms require an individual to be responsible, within the context of the community, for his/her own behavior. Length of hospital stays, regardless of country, may also be driven by economic agendas, as well as by the power and influence of governmental lobby groups.

Magyary (2002) reminds us that mental health nursing interventions have "primarily focused on the treatment of mental disorders and the prevention of associated comorbid conditions, disabilities, and negative consequences for individuals and their families" (p. 343). It is not surprising, therefore, to find that many of the nursing behavioral interventions being used in the respective countries are directly related to the treatment of mental disorders (cognitive-behavioral therapy, behavior analysis and modification, self-control and modeling, and group therapy). Other nursing behavioral interventions are directed more toward prevention of comorbid conditions (assistance with ADLs, symptom management, recreational therapy, relaxation and supportive therapy) and negative consequences of mental illness (family education, drug education, stress coping, and vocational training).

There seems to be an attempt throughout Asia, Oceania and the USA to develop and implement a continuum of nursing behavioral interventions. Such a continuum, hopefully, will provide cross-cultural guidelines for behavioral nursing interventions that can facilitate nurses' decision-making regarding appropriate responses and reactions toward specific behaviors (Kozub & Skidmore, 2001). In other words, the continuum needs to be designed to provide nurses with choices based on the particular behavior assessed and requiring change. For example, patient behavior problems could be addressed through a variety of interventions, including attentive listening, empathic responses and support of existing ego strengths (Sayre, 1990), as well as through effective medication dosing and/or teaching families meaningful behavior management techniques (Saunders, 1999). Implementing such interventions, within countries that tend not to use them, may

facilitate a decrease in the amount of psychotropic medications used and the length of hospital stays, while maximizing recovery, reintegration, and the quality of life for the mentally-ill individuals and their families.

Australia has developed psychiatric mental health care clinical guidelines, such as the Australian Clinical Guidelines for Early Psychosis (Commonwealth of Australia, 1998), that provide models for understanding early psychosis and early interventions. Due to increased pressure from Health Maintenance Organizations (HMOs), insurance companies and government agencies that provide reimbursement for psychiatric-mental health services, the USA has developed a variety of guidelines for psychiatric-mental health nursing practice. It is unclear, however, if psychiatric-mental health nursing clinical guidelines have been developed in other countries.

Limitation of the results

In reviewing the responses of the nurse faculty members from Australia, Hong Kong, Japan, South Korea, Thailand and the USA, one must be cognizant of the limitation of the findings. The data were obtained from a limited number (9) nurse faculty identified as leaders within their respective countries.

Implications

The findings have generated a number of unanswered questions related to nursing curricula, didactic and clinical experiences of nursing students, and the purpose and meaning of behavioral nursing interventions within each respective country. The diversity in approach and methods, in spite of the global burden of disease, reflects a need for cross-cultural investigations into models of care, nursing interventions and methods of professional practice.

There appears to be a need for cross-cultural studies on nurses' level of knowledge of human growth and development, behavioral expectations, societal and cultural norms and environmental factors within Asia, Oceania and the USA. In addition, there is a need to determine nurses' ability to critically think and implement appropriate nursing behavioral interventions. The increasing emphasis on the contribution of mental health care to the progression of physical illness, such as cardiovascular disease, underscores the importance of psychiatric-mental health nurse education (Schulz, Beach & Ives, 2000; Vaccarino, Karl, Abramson et al., 2001).

References

Abraham, I.L. & Reel, S.J. (1992). Cognitive nursing interventions with long-term care residents: effects on neurocognitive dimensions. *Archives of Psychiatric Nursing*, 6(6), 356–365.

Allen, J.J. (2000). Seclusion and restraint of children: a literature review. *Journal of Child and Adolescent Psychiatric Nursing*, 13(4), 159–167.

Anders, R.L., Kawano, M., Mori, C., Kokusho, H., & Tomai, J. (1999). Cross-cultural comparison of long-term psychiatric patients hospitalized in Tokyo, Japan and Honolulu, Hawaii. *Nursing & Health Sciences*, 1(1), 35–44.

Andrews, G., Hall, W., Teeson, M., & Henderson, S. (1999). *The mental health of Australians*. Mental Health Branch. Commonwealth Department of Health and Aged Care, Australia.

American Nurses' Association (2000). *Scope and standards of psychiatric-mental health nursing practice*. Washington, DC: The Association.

Blair, D.T. (1996). Integration and synthesis: Cognitive behavioral therapies within the biological paradigm. *Journal of Psychosocial Nursing and Mental Health Services*, 34(12), 26–31.

Commonwealth of Australia (1998). *Australian Clinical Guidelines for Early Psychosis*. Commonwealth Department of Health and Aged Care, Australia.

Department of Health and Human Services. (2000). *Healthy People 2010: Conference Editions* Volume I and II. Washington, DC.

Flaskerud, J.H. & Wuerker, A.K. (1999). Mental health nursing in the 21st century. *Issues in Mental Health Nursing*, 20(1), 5–17.

French, H.W. (2002). Depression simmers in Japan's culture of stoicism. *The New York Times* (www.nytimes.com). August 10, 2002.

Fujii, J., Fukshima, S. & Yamamoto, J. (1993). Psychiatric care of Japanese Americans. In Caw, E. (ed.) *Culture, Ethnicity and Mental Illness*. American Psychiatric Press, Washington, DC, 305–345.

Hughes, L.C.,& Preski, S. (1997). Focus on quantitative methods. Using key informant Methods in organizational survey research: Assessing for informant bias. *Research in Nursing & Health*, 2 (1), 81–92.

Kalinyak, C.M. & Jones, S.L. (1999). Appropriately timed interventions with the family And the adolescent: the role of the therapist. *Issues in Mental Health Nursing*, 20(5), 459–472.

Kim, S. et al (1998). *Community-based Mental Health Nursing Programme for Koreans*. UNDP project, final report. ROK/96/004.

Kim, Y. et al (2002). *Psychiatric Nursing*. (4th ed.). Soomoonsa, Seoul.

Kozub, M.L., & Skidmore, R., (2001). Least to most restrictive interventions: A continuum for mental health care facilities. *Journal of Psychosocial Nursing*, 39, (3), 32–38.

Lee, S., (1996). *Effectiveness of the community psychiatric nursing programs in Korea. Unpublished doctoral dissertation*. The Ewha Womans University of Korea, Seoul.

Lee, S.W., (2001). Perspectives on the 21st century Korean psychiatric and mental health. *Journal of Korean Academy of Psychiatric and Mental Health Nursing*, 10 (1), 5–11.

Magyary, D., (2002). Positive mental health: A turn of the century perspective. *Issues in Mental Health Nursing*, 23, 331–349.

McCann, E. (2001). Recent developments in psychosocial interventions for people with psychosis. *Issues in Mental Health Nursing*, 22(1), 99–107.

Murray, C.J.L. & Lopez, A.D. (1997). Global mobility, disability and the contribution of Risk factors: Global burden of disease study. *Lancet*, 349, 1436–1442.

Nam J., (1994). Evaluation of mental health facilities and incidence rate of. *Seminar for mental health policy and community mental health development*. Seoul National University, Ajou University and KIHASA.

Park, E.S., Yang, S.O., Kim, S.O., Yang, S., Park, Y.J., Ha, N.S., & Kim, K.H. (2002). Analysis of the Nursing Curricula in Graduate Programs in Korea. *Journal of Korean Academy of Nursing*, 32 (1), 100–113.

Peden, A.R. (1994). Up from depression: strategies used by women recovering from depression. *Journal of Psychiatric Mental Health Nursing*, 1(2), 77–83.

Porter-O'Grady, T. (1995). From principle to practice: whole systems shared governance. *Journal of Shared Governance*, 1(3), 21–26.

Porter-O'Grady, T. (2001). Is shared governance still relevant? *Journal of Nursing Administration*, 31(10), 468–473.

Saunders, J.C., (1999). Family functioning in families providing care for a family member with schizophrenia. *Issues in Mental Health Nursing*, 20, 95–113.

Sayre, J., (1990). Psychodynamics revisited: an object-relations framework for psychiatric nursing. *Perspectives in Psychiatric Care*, 26(1), 7–12.

Schulz, R, Beach, S., Ives, D., Martire, L., Ariyo, A., Kop, W. (2000). Association between depression and mortality in older adults. *Archives of Internal Medicine*, 160, 1761–1768.

Suh, D., (2002). *2001 Community mental health supporting committee workshop*. KIHASA (Korea Institute for Health & Social Affairs).

Swage, T., (2000). *Clinical Governance in Health Care Practice*. Butterworth Heineman Oxford.

Usher, K., & Lindsay, D. (2001). Mental health nurses' PRN psychotropic medication Administration practices. *Journal of Psychiatric and Mental Health Nursing*, 8, 383–390.

Vaccarino, V., Kasl, S., Abramson, J., Krumholz, H. (2001). Depressive symptoms and Risk of functional decline and death in patients with heart failure. *Journal of the American College of Cardiology*, 38(1): 199–205.

Won, J.S., (1997). A preparation process and counteract of psychiatric mental health nurse practitioner for the applications community-based mental health law. *Journal of Korean Academy of Psychiatric and Mental Health Nursing*, 6 (1), 20–43.

APPENDIX: TABLE I: TITLE AND EDUCATIONAL PREPARATION OF PSYCHIATRIC-MENTAL HEALTH NURSES*

	Title	Educational Level	Special Education/Program
Australia	Psychiatric Technician	HS + 1 yr. post-HS	1 Yr. education – similar to LPN education
	Enrolled Nurse	EN course orTAFE course	MH specialization
	Psychiatric-Mental Health Nurse	BN or HB	5 Yrs. experience or BN or HB + PG education & 3 Yrs. experience
	Clinical Psychiatric Nurse Specialist	BN or HB + specialty education & experience	PG education + 5yrs. experience and successful application
	Clinical Nurse Consultant	BN or HB + specialty education & experience	PG education + evidence of achievement in clinical, research, professional and educational domain. Record of advanced practice.
	Nurse Practitioner	BN or HB + specialtyeducation\ experience + PG education and 5,000 hrs. advanced practice.	1 yr. specialty program, Masters' level entrygraduate diploma. Portfolio & Viva examination with NRB
Hong Kong	Psychiatric-Mental Health Nurse	Diploma in PN (HBqualification) + ULER before 2001 BN + PG diploma or MN in MHN + ULER	
	Psychiatric Enrolled Nurse	HB School of PN	
	Clinical Psychiatric Nurse Specialist	BN + PG diploma in MHN + ULER + specialty training + 5yr. post-registration experience	
Japan	Psychiatric-Mental Health Nurse	HS nursing diploma, or 2 yr. or 3 yr. Nursing Diploma, or 2 yr. Junior College Nursing Diploma, or 4 yr. College Nursing Degree	
	Certified Nurse Specialist in Liaison Psychiatric Nursing or Mental Health Psychiatric Nursing	Masters' education in Japanese Nursing Association certified 4 yr. nursing program	Certification by Japanese Nursing Association
South Korea	Community Mental Health Nurse	3 Yr. Junior College Nursing Diploma or 4 Yr. College Nursing Degree.	3 yr. exp. + 1 yr. spec. ed. + ULER for community psych. Specialist
	Psychiatric-Mental Health Nurse Practitioner	Masters in PN + 1 Yr. Specialty Education or CPS	Level II: 3 yr. exp. PMH + 1 yr. spec. ed. + ULER for community psych. specialist Level 1: 5 Yrs. Experienceas CPS
Thailand	Psychiatric-Mental Health Nurse	2 Yr. or 4 Yr. College Degree	3 Credits (2 Yr. College) or 6 Credits (4 Yr. College) of PMH + 3–4 Weeks of Clinical in PMH
United States (Hawaii)	Psychiatric-Mental Health Nurse	HB Diploma, or 2 Yr. or 4 Yr. College Nursing Degree	
	Clinical Psychiatric Nurse Specialist	Masters' in PN	Can become certified via ANCC

***Legend:**
ANCC = American Nurses' Credentialing Center
APN = Advanced Practice Nurse
BN = Bachelor of Nursing
CPS = Community psychiatric specialist
HB = Hospital-based qualification (pre-1985)
LPN = Licensed Practical Nurse
PG = Post-graduate specialty
PMHNP = Psychiatric-Mental Health Nurse Practitioner
PN = Psychiatric Nursing
TAFE = Technical and further education
ULER = Universal Licensing Examination for Registration

Appendix: Table 2: Nursing Behavioral Interventions

	Type	Directed By	Implemented By	Made by Nurses
Australia	Comprehensive assessment and treatment planning Problem-solving Managing positivesymptoms via medication titration and education Therapies: Cognitive-Behavioral, Counseling, Supportive, Psychotherapy, Psychoeducation, Family therapy	MultidisciplinaryTeam Member – Senior Psychiatric Nurse	Registered Psychiatric Nurse	Yes
Hong Kong	Systematic Desensitization Behavior Analysis and Modification Operant Conditioning Flooding Implosion Self-Control and Modeling	Clinical Psychologist	Psychiatric Nurse	Yes
	Behavior Analysis and Modification Family Education Therapies: Psychotherapy, Cognitive-Behavioral, Self-Control, Group, Supportive, Reality, Relaxation	Registered Psychiatric Nurse	Psychiatric Nurse	
Japan	Activities of Daily Living Therapies: Social Skills, Group Recreational Therapy: Karaoke, Picnic, Seasonal events	Psychiatrist Psychologist Clinical Nurse Specialist	Registered Nurse Occupational Therapist Psychologist Psychiatric Social Worker	Sometimes
South Korea	Activities of Daily Living Study Skills Vocational Training Family Education Symptom Management Drug education Recreational Therapy: Art, Karaoke, Videos, Book Reviews Therapies: Cognitive-Behavioral, Group, Social Skills	Psychiatrist Psychiatric-Mental Health Nurse Practitioner Psychiatric Social Worker	Psychiatrist Psychiatric-Mental Health Nurse Practitioner Child Mental Health Nurse Practitioner Psychiatric Social Worker Registered Nurse	Yes
Thailand	Interpersonal Relationships Counseling Limit setting Reinforcement Group interventions Behavior Modification Therapies: Family support, Group, Supportive	Registered Nurse Psychiatric-Mental Health Nurse or Masters' Prepared Psychiatric-Mental Health Nurse Clinical Psychologist (Depending on level of intervention)	Registered nurse Psychiatric-Mental Health Nurse	Yes
United States (Hawaii)	Cognitive-Behavioral therapy All Types of Behavioral Interventions Psychiatric-Mental Health Care	Masters' prepared Psychiatric-Mental Health Nurse Providers with Masters' or Higher Degrees in Psychiatric-Mental Health Disciplines	All members of the Psychiatric-Mental Health Care Team Under the Direction of the Responsible Discipline Team Member	Yes

Appendix: Table 3: Medications, Length of Hospital Stay, Prevalence of Mental Illness and Leading Mental Health Problems

	Receive Psychotropic Medications	Average Length of Stay (Days)	Trend to Decrease Hosp. Stay	Mental Illness Prevalence	Leading Mental Health Problems
Australia	60%	4 (public) 8 (private) 6 (total)	Yes	18.0%	Schizophrenia Affective Disorders Anxiety Disorders Substance Use Disorders
Hong Kong	Not Available	135	Yes	1.4%	Organic psychoses Schizophrenia and Schizophreniform Disorders Affective Disorders Child/Adolescent Psychiatric Disorders Neuroses
Japan	100%	345	Slight	1.0%	Schizophrenia
South Korea	70–80%	88 (males) 69 (females) 80 (total)	Slight	2.16%	Schizophrenia Affect Disorder Alcoholism Dementia Alzheimer's Disease
Thailand	100%	Plan to reduce to six weeks	Yes	0.4%	Schizophrenia Depression Suicide Stress Drug Addiction Dementia Alzheimer's Disease Mental Retardation Autism Conduct Disorders
United States (Hawaii)	Majority	7	Yes	5.4%	Psychoses Substance Abuse Depression

Appendix: Table 4: Role, Perception of Others, Preparation and Practice Regarding Psychiatric-Mental Health (PMH) Nurses

	Role	Perception of Others	Masters' Preparation	Engaged in Private Practice
Australia	Provider of all aspects of PMH nursing care, both with inpatient and community settings. Depends on educational qualifications and clinical certifications	Well respected within the nursing profession Considered a pivotal part of the multidisciplinary team	Yes, exact number not available	Yes, but without insurance reimbursement. Have to directly bill clients
Hong Kong	Promoter of well-being of the mentally ill Role of Caregiver, Coordinator, Teacher, Change agent, Counselor, Client advocate, Supervisor Assist with social readjustment	"Brave professionals" Willing to help the "mad" patients and manage violent behavior Respected more than general nurses	Less than 1% of nurses Only one masters program in psychiatric mental health nursing, started in 1999	No
Japan	Care for patient's activities of daily living Provide patient education and recreation (walks, TV, play games) Administer medications & take vital signs Manage patient's money Monitor seclusion room & provide restraint care	RN's who want to work with psychiatric patients	Yes, about 200	Yes, but only 11
South Korea	Advocator Educator Counselor Case Manager Provider of physical and supportive care	Diligent and Special Need endurance, character and preparation PMH nurse respected more than general nurse	Yes, there are 32 masters' level psychiatric/mental health nursing programs Less than 1 % of PMH nurses have a masters degree in psychiatric mental health nursing	No, although allowed by mental health act No reimbursement regulation
Thailand	Provide general nursing care Assist with Electo-Convulsive therapy Do therapeutic behavioral nursing interventions Provider of: Environmental Management, Milieu Therapy, Psychotherapy, Family therapy	First nurse specialty group in the country Smaller number than other nurses Very active through Psychiatric Nurses' Association of Thailand	Yes, 4 masters level psychiatric/mental health nursing programs in the country.	No
United States (Hawaii)	Depends upon educational and clinical knowledge Certification required for advanced practice Providers of all aspects of PMH care to all ages, in all settings	Positive, Active, Energetic and Outspoken	Yes.	Yes, with insurance State government reimbursement if certified.