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CLINICAL RESEARCH FELLOWSHIP PROGRAM 2008: AN OVERVIEW

The existence of gaps between theory and practice and between research evidence and evidence utilisation has been well documented in the academic literature. One way in which the Centre for Psychiatric Nursing is trying to address these gaps is through educating clinicians about research. The Clinical Research Fellowship (CRF) program aims to develop clinician's confidence and skills in the critical consumption of research, and in designing and conducting studies, the findings of which can be used to inform their practice. At the end of March, seven psychiatric nurses from Victorian Mental Health Services began the 10-week Clinical Research Fellowship program (please see Table on psge 3 for the list of fellows).

The Centre for Psychiatric Nursing funds each fellow to work in the program for two days per week during the 10 weeks. Each fellow spends one day per week at the Centre for Psychiatric Nursing where they are receiving tuition on various aspects of the research process. This education is supplemented with access to course materials from an online postgraduate nursing research course that is being run at The University of Melbourne. Fellows spend the other day each week working on individual research projects that are to be conducted in their own organisations.

Back Row L- R: Amanda Heib, Russell James, Karen Robb and Gillian Kerr **Front Row L – R:** Barbara Burriss, Tracey Harmer and Katherine Fairest

Centre staff have taught the fellows a wide range of research skills. The material in the program has been directed towards locating and examining published research, designing and conducting research projects, and using and disseminating research in practice.

Continued on page 3

IN THIS ISSUE

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INTRODUCING TRACY BEATON

VICTORIA'S SENIOR NURSE ADVISOR, MENTAL HEALTH

Tracy Beaton

I have worked in health services for approximately 24 years with the majority of that time being in mental health. I commenced a nursing career as an Enrolled Nurse and following graduation I went to work in a large psychiatric institution called Cherry Farm Hospital on the outskirts of Dunedin, New Zealand. Shortly after commencing at Cherry Farm Hospital, I completed a Psychiatric Nurse training programme and commenced as a Registered Psychiatric Nurse in an acute admission ward in 1988. I later went on to complete my General and Obstetric Nurse registration and returned to the mental health practice setting.

My clinical experience has included working as a clinician and operational manager in a variety of settings including acute inpatient services that included forensic assessment, psychiatric district nursing, mental health emergency services, a therapeutic community and private psychiatric hospital, triage and crisis settings, clinical lecturing and supervision of postgraduate students academic work in mental health, private consultancy, child and youth settings, rural and remote mental health services and community health services.

During my time in a private psychiatric hospital I completed studies in psychotherapy and commenced a Bachelor of Nursing. I later completed a Master of Arts (Applied in Nursing) through the Victoria University of Wellington focused on women's experiences of care from a mental health nurse for postnatal depression. My research and academic interests have been focused in maternal and child mental health; however, I have enjoyed the opportunity to learn much from working with registered nurses as an academic supervisor. I am currently working towards a Master of Business Administration which I hope to complete early next year.

The primary role of the Senior Nurse Advisor, Mental Health is to ensure nursing leadership and further development of collaboration between the Department of Human Services and the mental health nursing profession within Victoria. There is an expectation that the role provides expert advice to the department and government. The position has a focus on contributing to mental health nursing through education and training initiatives, promoting best practice standards, workforce planning and development and professional leadership.

I look forward to this opportunity within Victoria.

Tracy Beaton
Senior Nurse Advisor, Mental Health

THE PHENOMENON OF FEELING SOCIALLY SAFE AS A MUSLIM IN VICTORIA, AUSTRALIA

Globally, the perception of Islam and the adherents of the Islamic faith namely, Muslims has vacillated over time. The changing patterns in the way Islam has been perceived has been significantly influenced by two major factors - global migration of Muslims and the recent terrorist attacks on Western countries.

Since the 1950s there has been an increasing number of Muslims migrating to the West in search of further education and improved quality of life. Countries such as Great Britain, the United States of America (USA), Canada, France, Germany and Australia have been the recipients of increasing global Muslim migration. In recent years the initial trickle of Muslim immigrants to Australia has become a stream. Such an increase has been met with quiet yet pensive acceptance by the Australian community who, in the main, support the notion of multiculturalism as a cornerstone of Australian society. Prior to September 11, 2001 the Australian Muslim community lived in relative harmony with the general populace who held little interest in their religious practices and way of life. As Muslims they were effectively an invisible minority with no social identity attributed to them by the mainstream population as a result of their religion (Baker, 2006). However, on 9/11 the world witnessed a series of terrorist attacks launched against the USA by Muslim extremists who were believed to have links with al-Qaeda, a radical Islamic organisation. As a result of these attacks the world view of Muslims changed.

Psychological studies have shown that major world events can significantly alter previously held views and attitudes toward racially defined groups (Allen and Nielson, 2002; Bar-Tal and Labin, 2001). September 11, 2001 is no exception. As a consequence of this heinous act coupled with continued attacks and bombings in Indonesia, Turkey, Spain, and England, and the ongoing crisis in the Middle East a dramatic shift in the way Muslims are perceived in the West has taken place, creating a great deal of apprehension, tension and mistrust between Muslims who live in the West and the Western world. For example, Muslims living in the United Kingdom struggle

Most disconcerting of all to the participants was the inability to perform essential day to day tasks such as shopping for food, or taking the children to school, without receiving abuse from members of the public

with wanting to belong to Islam and Britain in an environment where less than 10% agree that neither the British Government nor the general community respect and support them (Sirin & Fahy, 2006). Baker (2007) conducted a study aimed at further understanding the notion of cultural safety by focusing on the social health of a small immigrant community of Muslims in a relatively homogeneous region of Canada following September 11(9/11). Twenty-six Muslims of Middle Eastern, Indian and Pakistani origin residing in Canada were interviewed. The participants reported that cultural risk stemmed from being in the spotlight of the international media and becoming a visible minority under suspicion (Baker, 2007).

Within the Australian context the Bali bombings were a further catalyst for a shift in community attitude toward Muslims although the mainstream Muslim community publicly condemned the atrocities (Sheridan and Gillett, 2005). Anti-Muslim sentiment characterised by antipathy, hate mail, verbal abuse, personal threats, exclusion and discriminatory behaviours emanating from apparent community fear and uncertainty became evident across the Australian social landscape. In light of this emerging pattern a group of nurse academics embarked on a qualitative descriptive study about the everyday experiences of Muslims

Ms Kana Intherarasa, Dr Karen leigh Edward, Mr Alan Robins

living in such a climate. The study involved both male and female Muslims over the age of 18 years. Ten participants took part in the study.

Analysis of the interview transcripts revealed a number of themes. Participants are in universal agreement that prior to the World Trade Centre and Bali bombings the general populace of Australia warmly embraced Muslims, however post these incidents participants perceived a marked change in their acceptance by the Australian community. Participants currently report being isolated, and living in an atmosphere of suspicion and fear. Some of the cited instances included difficulty in obtaining employment, and for those fortunate to have obtained a position a culture of abuse from work colleagues arose (including reports from within the nursing industry). Most disconcerting of all to the participants was the inability to perform essential day to day tasks such as shopping for food, or taking the children to school, without receiving abuse from members of the public.

As a result of a general community attitudinal change clinicians can now expect to encounter a parallel process within the Muslim community, and are likely to be met with suspicion and hostility. The class blind approach to treatment offers nurses a framework to assist in the development of therapeutic relationships.

Dr Anthony Welch (Chief Investigator) - RMIT/QUT
Dr Karen-Leigh Edward - Deakin
Alan Robins - Latrobe
Kana Intherarasa - RMIT
Gylo Hercelinskyj - Deakin/Charles Darwin

All investigators are affiliated with the Mental Health Interuniversity Research Group (MHIRG) available at: http://www.cpn.unimelb.edu.au/research/mhirg.html

ARTICLE REVIEW

The following review presents a 2003 study that compared staff and consumer perceptions of inpatient aggression within four NSW-based, inpatient psychiatric units. Through interviews conducted with staff and patients involved in aggressive incidents on these units, the authors revealed considerable differences in the way staff members and consumers perceived inpatient aggression.

Title: Differences between patient and staff perceptions of aggression in mental health units

Author: Ilkiw-Lavalle, O., & Grenyer, B. F. S.

Source: Psychiatric Services, 54: 389-393

Verbal and physical aggression from consumers on inpatient psychiatric units are issues of mutual concern for both clinicians and consumers. Ilkiw-Lavalle and Grenyer (2003) investigated staff and consumer perceptions surrounding aggressive incidents that occurred over a four-month period within four inpatient units in the Illawarra region south of Sydney. A total of 47 aggressive incidents occurred on these units during the study period. Twenty-nine staff members and 29 patients were interviewed shortly after each incident to identify the perceived cause of each incident and how future incidents could be avoided.

Despite their differences, both staff members and consumers generally agreed, however, that having a more flexible limit setting approach may be an effective way in reducing the amount of aggressive incidents

The study identified three main causal factors of consumer-aggression. Interviewees perceived consumer-aggression to be the result of patient illness, staff limit setting and interpersonal conflict with staff members or other consumers on the unit. Staff members tended to favour internal explanations for consumers' aggressive behaviour, whereas consumers put a greater emphasis on interpersonal and situational explanations.

CLINICAL RESEARCH FELLOWSHIP PROGRAM 2008: AN OVERVIEW

Continued from front page

Some of the topics in which fellows have received education include: searching the research literature, appraising research articles using a critical framework, developing research questions, using appropriate research designs, writing conference abstracts, developing conference posters, understanding basic statistics, presenting research to audiences, implementing research in practice.

Alongside the tuition that the fellows received in these topics, they have been working on their own research projects. As part of the application process for the CRF, nurses were asked to identify an issue in their practice that they sought to address through examining the literature and conducting their own studies. Staff from the Centre for Psychiatric Nursing mentored the fellows in the development of their research projects. The list of projects on which the fellows are working is presented in the table.

Centre staff have enjoyed working with the fellows to improve their research skills and to develop projects that will influence practice. In the coming months the fellows will be involved in carrying out these projects and implementing their findings into practice. Their research will be showcased at the 9th Victorian Collaborative Psychiatric Nursing Conference in August 2008. Centre staff are looking forward to mentoring the fellows through the remainder of their projects, and hope that the skills they have been taught and the relationships they have formed will have an enduring and positive impact on the nexus between research and practice.

CRF PROJECT LIST

Fellow	Research Question
Barbara Burriss	Does nursing education and the introduction of a screening tool impact the identification of elder abuse in an inpatient mental health facility?
Katherine Fairest	To what extent do psychiatric nurses educate consumers about their physical health?
Tracey Harmer	Do psychiatric nurses screen patients for metabolic syndrome within aged mental health settings?
Amanda Heib	How confident are nursing staff in managing medical co-morbidities on an aged in-patient psychiatric ward?
Russell James	How do nurses cope in the aftermath of serious incidents in the psychiatric inpatient setting?
Gillian Kerr	What are the experiences of general nurses in managing patients with mental illness in a rural general hospital?
Karen Robb	What are the attitudes of nurses within an Australian adolescent psychiatric inpatient unit towards adolescents who deliberately self-harm?

PSYCHIATRIC NURSE PROFILE: WARREN BARTLETT

Tell us about your professional history and background …

I am a registered nurse division one, having had a 'mid career' change and completing a Bachelor of Nursing degree at Monash University Gippsland Campus in 2002. It took me a little while to decide whether psychiatric nursing was for me, however during my general nursing graduate year I was amazed at how often I came across patients with co-occurring mental health issues. At the end of this time I found I could not ignore the interest I had in this area of nursing. In 2004 I undertook a graduate year in the psychiatric stream through Latrobe Regional Hospital and Monash University and completed a Graduate Diploma in Nursing (Mental Health).

Since completing my training, I have joined the Stepping Stones Recovery Program, which includes an outreach rehabilitation team utilising recovery-based rehabilitation with people in their own homes. This program was an interim program while our residential based facility was being built. It was very successful in combining a newly developed model, (The Collaborative Recovery Model) with evidence-based assessments for graphing the progress of clients in their journey of recovery.

Since graduating I have done some short courses in motivational interviewing, group work with people with psychosis and the Collaborative Recovery Model, which I implement in my every day practice.

Tell us about your current role in the Community Care Unit …

Currently I am an Associate Unit Manager (AUM) at the Community Residential Care Unit in Traralgon, which was built in 2006. This is a different kind of position to that which you would find in an inpatient unit. In this position I find myself in a dual role of shift manager and case coordinator. In addition to the routine duties of the shift, each AUM has a daily-allocated client load as well as an ongoing caseload. This ensures the continued coordination of each resident's rehabilitation plan.

Warren Bartlett

What is the Collaborative Recovery Model? What are the strengths of the model and what are the challenges? How does this model inform your practice as a mental health nurse?

The Collaborative Recovery Model (CRM) is a model developed by the Australian Integrated Mental Health Initiative as part of a 5-year study by the Illawarra Institute for Mental Health. The CRM is a recovery-based model of psychosocial rehabilitation in which the emphasis is on a lived experience of the process of personal growth. Recovery is very much a personal process of change, often in attitudes, behaviours, values, skills and roles. The CRM has two guiding principles. Firstly that psychological recovery from mental illness is an individual process. Secondly that the recovery process is promoted by an effective working alliance between the person with a mental illness and the clinician so that they are not isolated in the process. While this is not that new, the CRM utilises a motivational interviewing approach with evidence-based assessments to assist consumers to set personal goals for themselves, as well as collaborative homework. This assists in breaking goals down further into weekly or fortnightly tasks towards achieving longer-term goals. It is a very important part of the process, as research suggests that goal monitoring through homework or regular follow-up gives the person the greatest chance of success.

From my perspective, the strength of the model lies in the emphasis of taking the consumer's perspective and promoting independence and autonomy for consumers. One thing that has been noticed by clinicians using this model is that you know when the model is working when consumers start self-initiating their own goals, and taking greater interest in this process. In so doing they become more autonomous in their everyday lives. The current challenges are around forming a new team from differing backgrounds and trying to transpose the model from an outreach team into a stand-alone unit with shiftwork arrangements. This includes balancing day-to-day shift responsibilities of AUM, while making 1:1 time available to pursue the CRM with residents. I have had some very rewarding experiences while utilising evidence-based practice to assist people with mental illness, to empower themselves to achieve their potential.

Where to from here?

From here? I find myself currently reviewing my own goals for the future. In the short term, I plan to attend and be a co-presenter at the 9th Victorian Collaborative Psychiatric Nursing Conference with a presentation on the challenges of transposing the Collaborative Recovery model from an outreach team to the Community Rehabilitation Care Unit. I am also considering furthering my education via undertaking a Masters program in mental health nursing as a possibility for next year. I have an interest in research and cognitive behaviour therapy and I am considering doing CBT and a thesis for the Masters Degree.

ARTICLE REVIEW

'DIFFERENCES BETWEEN PATIENT AND STAFF PERCEPTIONS OF AGGRESSION IN MENTAL HEALTH UNITS'

Continued from page 2

According to the authors, staff members overwhelmingly contended that patient illness factors, including psychiatric symptomatology or insufficient medication, were the prime causes of aggressive behaviour. Consumers, on the other hand, tended to attribute interpersonal conflict and communication difficulties with staff members or other consumers as the primary cause of aggressive behaviour. Staff and consumers both agreed, however, that limit setting could lead to aggressive incidents.

Staff and consumer perspectives surrounding the effectiveness of aggression management strategies used on the units, reflected the manner in which they attributed the causes of consumer-aggression to internal, or situational factors. The authors indicated that staff members favoured strategies that targeted consumers' internal characteristics, specifically, strategies that involved medication management and the reduction of consumers' psychiatric symptoms. Consumers, on the other hand, preferred approaches that emphasized effective interpersonal communication between staff members and consumers. Despite their differences, both staff members and consumers generally agreed, however, that having a more flexible limit setting approach may be an effective way in reducing the amount of aggressive incidents.

Ilkiw-Lavalle and Grenyer (2003) presented a thought-provoking article, relevant to the Australian context, which highlighted the difference in perspectives between staff and consumers regarding inpatient aggression. The authors raised important issues for both mental health clinicians and researchers with regards to how consumer preferences can inform healthcare practices.

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