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# 2014 – THE DIRECTOR'S WRAP

As I contemplate the past year, as seems to be the case every year, many superlatives spring to mind to describe the roller-coaster ride we have experienced in 2014. Along with the usual mix of successes and disappointments, this year we have also faced extra challenges in the form of major reforms within the University of Melbourne and within Victorian mental health services.

One of our major programs of work this year has been the Workforce Development Projects funded by the Victorian Department of Health through the office of the Chief Mental Health Nurse. Many Victorian mental health nurses have participated in training and implementation planning for the Gender Safety and Sensitivity, Recovery Library and CAMHS training initiatives. We were most fortunate to have been able to extend the contract of our Project Manager, Imogen Edeson, to complete these projects in early 2015.

Many readers will be aware that Finbar Hopkins, our professional development coordinator, has been away for the second half of this year. We are very pleased to have been able to negotiate the secondment of James Houghton from NorthWest Mental Health to replace Finbar since August. James has slipped easily into this role and has been actively engaged in the delivery of various training activities, most notably clinical supervision training for a large cohort of advanced practice nurses from the Royal Children's Hospital.

Our "best practice in the administration of intramuscular injections" program continues to gain momentum with numerous presentations to mental health services and workshops delivered both at the Centre and to small teams of clinicians in mental health services. With the increasing demand for these workshops, which are free of charge for nurses employed by Victorian mental health services, priority is being given to those services that have developed (or wish to) implementation plans at the organisational level to manage the transition to best practice. While evidence-based training is a critical component of this work, it is doomed to failure unless such issues as continuity across services (e.g. primary care, GP care), consumer preferences, pharmaceutical product information, organisational policies, and risk management are all addressed. Mental health services interested in developing a change management plan to introduce best practice in IMIs are invited to contact me directly.

One of the major contextual developments of 2014, and one that has had significant impact on the Centre's work, has been the University of Melbourne's Business Improvement Program (BIP). The BIP aims to (1) enable academic performance, (2) improve student experience, (3) enable professional excellence, and (4) increase efficiency. Overall the BIP has meant a reduction of over 500 professional staff positions across the University and one of the positions affected is that currently held by the CPN's administration manager, Greg Mutter. Greg will continue to work in the CPN until late March 2015. As many regular Carillon readers know, Greg has been a tremendous asset to the Centre for the past decade and he will be sadly missed. Watch out for details of an event to farewell Greg and to celebrate his contribution to the CPN and to mental health nursing in Victoria.

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# WHAT'S DRIVING THE FUTURE?

## CONSUMER LEADERSHIP AND CO-PRODUCTION IS SHIFTING THE GEARS IN THE TRAINING OF MENTAL HEALTH CLINICIANS

**What is co-production?**

According to Boyle and Harris (2009), co-production occurs in the context of public services when they are developed and delivered through equal and reciprocal relationships between professionals, people using services and their families and communities. The CPN recently adopted an industry based approach to the delivery of some of our training and it was agreed that we would use co-production as our preferred methodology. This decision meant we needed to examine what co-production might mean in our context and which areas lent themselves to this approach. Because the Victorian Mental Health Act 2014 identifies supported decision-making as an integral part of and essential to the delivery of contemporary mental health care we decided to apply the principles of co-production and specifically, consumer led co-production to the development and delivery of this part of our training curricula.

**Why use co-production?**

For people who are governed by mental health legislation and the clinicians working alongside them the interference with a person's autonomy and rights to self-determination are critical issues. Under a supported decision-making model the focus of clinical care shifts to facilitating the retaining or regaining of a person's self-determination. Thus, co-production is a good fit with supported decision-making because both require a paradigm shift in power relations between consumers and mental health service providers.

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## 2014 – THE DIRECTOR'S WRAP

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Over the past 6 months the CPN has been engaged with the Victorian Department of Health in a strategic planning and investment logic mapping exercise designed to clarify expectations of our key stakeholders and to ensure that the CPN's work delivers the benefits expected by our primary funding body. At the time of writing, the Centre's new strategic plan is close to finalisation and our work plan and key performance indicators for the next review period is being developed.

At this year's Victorian Collaborative Psychiatric Nursing Conference and again at the 40th International Conference of the Australian College of Mental Health Nurses we presented the findings of a survey of workplace violence in Victorian mental health services. This project, which was initiated by the Health and Community Services Union (HACSU), was conducted by the CPN in partnership with HACSU. Almost 400 HACSU members, the majority of whom were mental health nurses, completed the survey and reported a high incidence of verbal and physical aggression. Of particular concern was the finding that there was an increasing incidence of psychological distress among mental health nurses who had been victims of workplace violence. Although these findings were not unexpected, they have generated significant interest from the mass media with the ABC News, for example, reporting that mental health nursing is the most dangerous profession in Victoria. Although I'm sure that this was not the sort of 'impact' our Dean was demanding from University researchers, the media interest does serve to highlight that more work needs to be done to make our mental health services safer for all.

In the preceding paragraphs I have outlined just a few of the many interesting developments in which the CPN has been involved during 2014. This work is only possible with the support of dedicated people who share our commitment to shape the future direction of mental health nursing in Victoria. I would like to take this opportunity to thank the many mental health nurses, consumers and others who have contributed in so many different ways to the work of the CPN over the past year. I wish you a safe, peaceful and happy Christmas and look forward to working with you in the New Year.

**Stephen Elsom, Director, CPN**

## WORKFORCE DEVELOPMENT PROJECTS UPDATE

The Centre for Psychiatric Nursing's workforce development projects continue to progress. Following is a brief description of what has been happening with each of the projects to date.

### Recovery Library

The Recovery Library will be a web-based resource for the sharing of recovery-oriented resources, in alignment with the Victorian Framework for recovery-oriented practice (2011). The Library will support clinical and community managed mental health services to work in ways that support people in their recovery efforts. The library is intended to assist services to actively engage with the Framework, to share high-quality resources and to support a service culture of ongoing practice development around recovery values.

So far, a diverse range of resources has been gathered from clinical and non-clinical services that have been identified as innovators in relation to recovery-oriented practice. The CPN visited these services and engaged in an iterative and collaborative process of identifying resources that the services routinely use and regard highly, and which aligned with a set of criteria and values determined by the project team (including consumer involvement in the selection, adoption or use of the resource, self-determination, social and familial context, strengths-based language and perspective beyond a biomedical model).

The resources will be mapped against the nine domains of the Framework for recovery-oriented practice. An additional domain pertaining to Consumer Leadership is also in development.

The resources will be complemented by relevant links and multimedia resources.

The CPN project team is co-produced and includes consumer expertise, clinical experience and project management skill sets.

### Gender Sensitivity and Safety Project

Three rounds of Gender Sensitivity and Safety facilitator training were held in 2014 targeting Victorian adult inpatient services. Each adult service sent participants to be trained as facilitators of the Building Gender Sensitive Practice training package, which includes a range of resources such as video vignettes of personal stories of consumer experiences. Services have begun to roll out the training package locally to inpatient staff. A round of progress updates is underway. Services have reported a range of different approaches to roll out of the training, some as discrete training days, some as shorter sessions at handover, while others have integrated the package into existing and complementary training initiatives.

**Imogen Edeson, Workforce Development Project Manager, Centre for Psychiatric Nursing**

## CO-PRODUCED CONSULTANCY SERVICES

Over the past decade, recovery has become the driving force behind mental health policy, service and practice development internationally, nationally and state-wide. Victoria is in the process of adopting a new set of practices which represent a movement away from a deficit model towards a recovery-oriented approach. These principles also inform Victoria's Mental Health Act 2014.

As we progress into a new reform era that has a significant impact on the mental health workforce and on the design and delivery of mental health services, it is timely for the CPN to address the question of how we can best contribute to sustained cultural change within mental health service provision and practice around a recovery approach.

The CPN is developing a new model of engagement with mental health specialist services that will engage service leaders, managers and practitioners across disciplines.

The purpose of this engagement is to offer tailored and site-specific support and assistance to self-selecting services and/or programs in the work of aligning local policies, practices, service development and culture with a recovery agenda.

The approach is based on a practice and culture change methodology. The aim of the methodology is for a CPN change management team to provide a structured, guided, process for change conducted on site within a mental health service or program. The facilitated process is based on observing current practice, consulting with people using and working in the service, identifying issues and impediments to change and collaboratively designing and delivering a tailored package of change management activities that are aligned with Victoria's Framework for recovery-oriented practice and broader reform agenda.

Partnerships between lived experience and clinical sets of expertise (co-production of knowledge) form the overarching principle of the methodology. The CPN change management team comprises consumer expertise, clinical experience and change management skill sets. The approach takes into account the realities of the context and environment in which work takes place as a critical starting point in assessing readiness for change, selection of priorities to work on and likelihood of success.

The change management approach recognises that people working within the sector already possess skills, capabilities and the capacity to find solutions to local problems. Facilitation is guided by the values of co-operative learning, mutual sharing and development of knowledge and expertise. Learning and outcomes are shared rather than working in isolation and the process is strengths-based in alignment with recovery principles.

**For further information on co-produced consultancy services you can contact the CPN at cpn-info@unimelb.edu.au**

**Cath Roper & Imogen Edeson, CPN**

# WHAT'S DRIVING THE FUTURE?

## CONSUMER LEADERSHIP AND CO-PRODUCTION

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In consumer led co-production and in supported decision-making, the agenda is set by the consumer; the process is determined by the consumer and supported by the clinician.

We firmly believe that Boyle and Harris' definition is missing at least one element – that being the identification of what the agenda should be in the first place and who gets to decide. For us, such fundamental questions speak to the integrity of both process and outcome. One of the outcomes of formulating and delivering this training is that it has re-affirmed our commitment to consumer-led co-production as a strategy to combat inequality and disempowerment.

**The paradigm shift that is supported decision-making**

Under a supported decision-making model, the consumer is presumed to be able to make decisions, and is provided with the means to maximise opportunities for maintaining decision-making authority. Such opportunities might be through accessing information, or individuals, specialists, or informal networks that help the person to decide. In contrast, under a substitute decision-making model clinicians take over treatment decision-making on behalf of consumers. With the emphasis on voluntary service use supported decision-making is intended to overtake substitute decision-making.

In supported decision-making, the clinical role changes from 'therapeutic helper' to facilitator of the person's own agency. While it may sound simple, this is a revolutionary step for many clinicians. Traditionally, care giving has focused on such considerations as organisational expectations; one's duty of care; what is perceived as being in the best interests of consumers; and anticipating risks in the workplace. The notable shift in gears involves a serious rethink and acknowledgment of the key principles of supported decision-making, that is, that all people are capable of making decisions about most areas of their lives; decision-making is relational in that we often discuss our decision-making with and seek advice from others; decision-making capacities can be developed, enhanced or even suppressed; and people have the right to make decisions others do not agree with and to make mistakes.

James Houghton & Catherine Roper

**Test driving the new model**

So far, we have provided five supported decision-making industry based training workshops. These were delivered as a one day program using both didactic and experiential sessions. It was considered important that the venue chosen was external to the ward setting to ensure maximum engagement and minimum disruptions. Participants included a diverse range of professional disciplines from a variety of clinical settings and programs. Several participants commented that they felt doctors should attend this training (only one medical officer has enrolled for the training but on the day was unable to attend). Other feedback included:

- Patients have the right to take risks in their lives
- Should be made mandatory for 'upper management'
- Opening my eyes and ears to the current practices, especially around enforcing the Charter of Human Rights
- Gave me skills to sit back and think rather than react to a patient's decision

Due to the enthusiastic response to and positive feedback from this training it will continue to be made available to services upon request throughout 2015.

**Catherine Roper, Finbar Hopkins & James Houghton, CPN**

# EXCITING NEW PRACTICE DEVELOPMENT WORKSHOPS AT THE CPN IN 2015

The CPN 2015 Practice Development Calendar is now available on the CPN website at **http://cpn.unimelb.edu.au/education_and_practice_development/training_calendar**

As in prior years the 2015 Practice Development Calender details practice development workshops that will be delivered at the CPN and a range of the workshops can also be delivered in Victorian Public Mental Health Services.

This year there are several new exciting workshops available, including Co-production: Theory and Practice, Every Moment Counts and Creating Meaningful Communication with Consumers.

The 2015 Training Calendar identifies the workshops available at the CPN and also details the industry based workshops available.

Industry based training noted on the 2015 Training Calendar identifies workshops available in your workplace either in the first or the last 6 months of 2015.

To register for the workshops offered at the CPN you can follow the instructions noted on the CPN website at http://cpn.unimelb.edu.au/education_and_practice_development/practice_development_workshops

To organise an industry-based workshop, you can contact the staff at the CPN via email at **cpn-info@unimelb.edu.au**

# CLINICAL SUPERVISION – INNOVATION AT THE ROYAL CHILDREN'S HOSPITAL

A common theme in today's healthcare work environment is that, in large, busy organisations, there is little time for reflection and for managing the effects of anxiety and stress from a myriad of competing demands. Typically staff at almost all levels feel that in their day-to-day clinical practice, they encounter stressful and difficult problems.

The most common types of responses to these can include anger, frustration, tearfulness and a sense of not being heard. Often these levels of stress result in having to take sick leave, angry outbursts between colleagues, becoming cynical or burnt out, and for some it can result in leaving the organisation.

All of these responses are normal reactions to stress and anxiety. If these responses are not attended to, they can impact on the organisation through lost productivity, high levels of sick leave and increased turnover of staff. Experienced staff are often considered one of an organisations most valuable assets and every effort should be made for staff to feel supported within their current work place.

One way of addressing these commonplace concerns in the healthcare setting is through Clinical Supervision (CS). CS is a formal structured process of professional support and learning, where two or more nurses meet to reflect and review clinical situations. The use of CS is a way of supporting nurses to develop knowledge, skills, competence and capabilities, accept responsibility for their own practice, and enhance safe and effective person centred care in complex clinical situations.

Although there is some confusion, and anecdotally there are mixed responses to the possibility of the implementation of CS, in the literature there are also several reported benefits. The following studies found that there were:

- *Increased feelings of support and feeling of personal well-being* (Butterworth, et al., 1996; Hyrkas 2005).
- *Increased knowledge and awareness of possible solutions to clinical problems* (Arvidsson, et al., 2000).
- *Increased confidence, decreased incidence of emotional strain and burnout* (Hallberg & Norberg,1993; Berg & Hallberg, 1993).
- *Higher staff morale leading to decrease in staff sickness/absence and increased staff satisfaction* (Butterworth, et al., 1996; Begat et al., 2005).

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## CLINICAL SUPERVISION – INNOVATION AT THE ROYAL CHILDREN'S HOSPITAL

**Continued from page 3**

In March 2014, a CS working group was formed at the Royal Children's Hospital (RCH) to drive the implementation of CS for Advanced Practice Nurses (APN). Working group members included Bernadette Twomey, Executive Director of Nursing as the chair, and APN. The APN held roles as Clinical Nurse Consultants, Clinical Nurse Coordinators, Senior Psychiatric Nurse, Psychiatric Nurse Consultant and a Nurse Practitioner (from various nursing areas throughout the RCH, such as management, research, education, mental health, maternal/child health and care coordination). After identifying the APN group's needs in relation to CS, the working group then discussed accessing a suitable external CS training program. After a number of pre-planning meetings were held with Bernadette Twomey, Steve Elsom and Finbar Hopkins from the CPN, it was decided that the RCH would procure the services of the CPN to deliver the training.

The working group called for expressions of interest (EOI) from APN at the RCH to participate in a CS pilot. APN were asked to specify in their EOI if they were interested in participating as a supervisor, supervisee or either. A total of 34 EOI were received. From this 24 APN were selected to participate as supervisees and required to attend two days of training. Ten of the applicants were selected as supervisors and attended the initial two days training plus a master class. All participants were asked to complete a brief survey assessing their current understanding of CS and their belief in the likelihood of positive outcomes (the Elsom Therapeutic Optimism Scale ETOS). This survey will be repeated at the end of the pilot.

For training, the participants were split into two groups. Each group included a mix of supervisors and supervisees and each group attended two days of training a week apart. Day one of training included: a theoretical knowledge and practical application CS in the nursing context; an understanding of and the opportunity to practice skills relevant to various CS models; shown how to develop skills which maximize the clinical efficacy, critical reflective practice and professional development and support of the individual; being shown how to set up for CS; and discussed the ethical and practical issues related to writing up contracts, documentation, and various legal and ethical issues of concern. On the second day of training the participants were also introduced to and trained in the delivery of group supervision using the principles of Action Learning Sets (ALS). This involved completing practice sessions in which the participants used the newly acquired ALS skills.

The supervisors participated in a full day master class, in the week following the group training. The master class enabled a more detailed look at the supervisory relationships and more opportunities to practice skills in running ALS.

The groups commenced monthly supervision in mid-November and will continue until the end of April. Each group has two co-supervisors and four to five supervisees. At the conclusion of the pilot period the staff will be surveyed again using the ETOS and it is planned that the results will be published.

Upon evaluation, the training was described as a really positive experience by all of the participants. Almost all expressed the feeling that this was good investment of time and that they had developed new skills. Comments made by participants included the following:

*"I think it has already altered my work practice. The way I look at worries and concerns… Realising that I can't fix everything & that I'm not alone at this level."*

*"Feel more confident… Yearly updates please"*

*"Prepared me better for active involvement in clinical supervision"*

*"Practice has equipped me with the skill to trouble shoot & pre-empt problems"*

*"Feeling more confident to work through problems in a constructive manner"*

The Centre for Psychiatric Nursing will continue to provide this training upon request. Interested parties should contact the CPN to negotiate dates, trainers and fees etc.

**James Houghton, CPN &**
**Sally Lima, Royal Children's Hospital**

## PHYSICAL HEALTH MATTERS – ALFRED PSYCHIATRY SENIOR NURSES FORUM INITIATIVE

The physical health of people with a mental illness continues to be a major topic of discussion within mental health settings. We know that the mortality rate of people living with a mental illness is higher than that of the general population, it has been reported that people with a severe mental illness die at least 10-15 years earlier than the general population. Rather astonishing also is the fact that cardiovascular disease rather than suicide is the biggest cause of premature deaths in this population.

Several factors have been identified as barriers to the recognition and management of physical illness in people with a severe mental illness. These factors have been grouped into patient- and illness-related factors, treatment-related, service-related, health professional-related factors.

At Alfred Health, physical health monitoring has become one of the key priority areas within our service and this has been driven largely through the Senior Nurses Forum. We have developed a study day which we have called "Physical Health Matters". This study day brings together key health professionals to enhance the skills of our clinical staff in not only detecting but also provide where necessary interventions for our patients. The key professionals include; a sexual health nurse, dietician, pharmacist, acute medical registered nurse and psychiatric nurses.

The inaugural study day was held recently and we were privileged to have A/Prof Roger Chen from the Concord Repatriation centre as a guest speaker. Roger talked a lot about metabolic monitoring of people taking psychotropic medications. We have now rolling out this study day 6 times a year. At the moment we are also embarking on a research project to measure outcomes. There has been various tools talked about in the literature and we are trialling a tool that can be utilised within our clinical areas. What we are hoping to achieve is to have;

- Create a culture/environment where physical health monitoring of our patients is seen as part of our nursing practice
- Build the skills and confidence of our clinical staff in detecting physical health issues of our clients and putting in place appropriate interventions
- Improve the physical health outcomes of our patients

We are very excited about this project and hope to report in the coming months some patient outcomes.

**Sandra Keppich-Arnold (Associate Director of Nursing & Operations Alfred Psychiatry)**
**Shelley Anderson (Manager of Alfred Psychiatry Workforce Development & Education)**
**Dr Michael Olasoji (Clinical Nurse Educator, Alfred Psychiatry Workforce Development & Education)**

*From everyone at the*
*Centre for Psychiatric Nursing*
*Wishing you a safe and happy festive season*

*The CPN will be closed from*
*Tuesday 23 December 2014*
*and reopen on*
*Monday 5 January 2015*

# STATISTICS IN NURSING

## EXPERIMENTAL RESEARCH

An experimental study is conducted to examine a cause and effect relationship between variables. A common experimental study design is the pre-post-test design. This design requires that data is collected from a group of participants both before and after an intervention has taken place.

For example, the effect of a new exercise programme on weight loss can be examined by employing this study design. In order to see the actual effect of the intervention, it is necessary to have two groups of participants where one group receives the intervention and the other group does not receive the intervention and acts as the control group. In all other respects, both groups are treated the same as well as include participants with similar backgrounds. To eliminate any differences between the two groups and to reduce selection bias, participants must be allocated to the intervention group and the control group randomly.

With this design, it is possible to compare the results of both the intervention group and the control group to examine whether there was a significant difference between the two groups. For example, it is possible to see how the weight of participants changed from pre-test to post-test. If an improvement in weight loss is observed in the intervention group compared to the control group and if nothing else changed between the pre-test and post-test; then it is likely that the weight loss experienced is the result of the new exercise programme. It could be investigated whether weight loss was observed for one group, both or neither.

When conducting experimental research, it is important to give consideration to ethical aspects of assigning participants to a particular group. In some situations it may not be ethical to allocate participants to a control group and the researcher may need to provide those participants the usual or standard care they would have received had they not taken part in the study. When randomisation is not practical, a quasi-experimental study design can be employed where assignment to the particular group is non-random.

**Roshani Prematunga**
**Researcher, Centre for Psychiatric Nursing**

Conference Dates: **06 & 07 August 2015**

CALL FOR ABSTRACTS

Abstracts of no more than 200 words are invited for 30 minute paper, poster or 90 minute workshop presentations that focus on the practice of psychiatric nursing.

Papers with a focus on recovery from mental health problems are particularly encouraged. Themes are listed for your consideration on the CPN website but papers need not be restricted to only those shown.

Papers from practicing clinicians and post graduate students undertaking clinical projects are particularly encouraged. If you are interested in presenting a paper but would like more information, support or guidance please contact Steve Elsom at CPN:

**T 8344 9460**
**E sjelsom@unimelb.edu.au**

Abstracts can be submitted electronically. The instructions and format for the submission of abstracts are located on the CPN website: **www.cpn.unimelb.edu.au**

If you are unable to submit an abstract electronically please contact the CPN:

**T (03) 8344 9626**
**E cpn-info@unimelb.edu.au**

DEADLINE FOR ABSTRACT SUBMISSION — FRIDAY 20 MARCH 2015

## HIGHER DEGREE STUDY OPPORTUNITIES AVAILABLE

### ARE YOU INTERESTED IN PURSUING A MASTERS OR PhD?

Exciting research opportunities exist for people interested in pursuing research higher degrees in mental health nursing practice.

**For further information contact:**

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