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IN REVIEW:

THE 15TH COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE – 7 & 8 AUGUST 2014

The 15th Collaborative Psychiatric Nurses Conference was held on the 7 & 8 of August at Moonee Valley Racecourse.

185 registrants attended the conference this year, with 8 mental health and related organisations having trade display tables.

The conference consisted of four keynote presentations, thirty six individual presentations and three 90 minute workshops.

This year's keynote presenters were: **Ms Liz Carr**, Acting Director, Victorian Mental Illness Awareness Council, who presented on the impact of recovery orientated practice and reform, **Ms Lynne Coulson Barr**, Mental Health Complaints Commissioner for Victoria, who presented on her new role with the Mental Health Complaints Commission and the operations of the new commission to date, **Ms Bronwyn Tarrant**, Lecturer in Mental Health at University of Melbourne who presented on using technology in teaching and identified and demonstrated various e-learning applications that can be used. The final keynote presentation was delivered by three keynote presenters **Ms Tracy Beaton**, Chief Mental Health Nurse, Victoria, **Ms Pip Carew**, State Undersecretary, ANMF (Vic Branch) and **Mr Paul Healey**, State Undersecretary, HACSU who all presented on mental health nurses being at the forefront of mental health reforms in Victoria.

The keynote speaker's presentations were again, all of the highest quality with feedback from the conference delegates showing that the keynote presentations were very relevant, as well as having an impact upon delegates by both stimulating thought and discussion or having personal impact upon clinicians practice.

This year the three workshops were presented to provide participants with more interactive and experiential understanding of how theory can inform practice.

The three workshop topics were "Brainstorming – an effective form of supervision" presented by Prue Shanahan & Alex Smith from St Vincent's Mental Health Service, "AOD e-learning package for mental health in-patient service" presented by Christine Rampling & Terri Hunt from St Vincent's Mental Health and "Smoking in mental health services – new solutions for an old problem" presented by Amanda Haslam from Monash Health - Mental Health Program.

The conference has always been an environment that welcomes and supports "first time mental health nursing presenters" to assist them through what some feel are the rigors of their first conference presentation.

Next year conference registrations will again only be available on-line on the conference website. You can register for the full two days or register for a one day registration selection the day you want to attend.

Early Bird registrations closing date will be Friday 29 May 2015, so if you wish to take advantage of the discounted early bird registration you will need to diarise 29 May 2015.

Final registrations close on Friday 24 July 2015, so if you are intending registering for next year's conference you will need to diarise 24 July 2015.

Feedback from the conference delegates this year indicated continued satisfaction with all aspects of the conference.

The collaborative parties; Centre for Psychiatric Nursing, Australian College of Mental Health Nurses (Vic Branch), Australian Nursing & Midwifery Federation (Vic Branch) and the Health & Community Services Union would like to thank all delegates, presenters, major sponsors and trade display sponsors for their assistance in making this another successful conference and look forward to the 16th Victorian Collaborative Psychiatric Nursing Conference in 2015.

The Call for Abstracts will open in December 2014 for the 16th Victorian Collaborative Psychiatric Nursing Conference that will be held on the 6th & 7th August 2015.

So if you know of anyone who wants to present or is a first time presenter please ask them to contact us at the Centre for Psychiatric Nursing by email at **cpn-info@unimelb.edu.au** or **Ph: 8344 9626**.

Information on and details of lodging an abstract can be found on the conference website in early December 2014. Conference website can be found at **http://cpn.unimelb.edu.au/conferences/vcpnc**

MENTAL HEALTH NURSING IN VICTORIA

The Office of the Chief Mental Health Nurse (OCMHN) is part of the Regulation, Health Protection and Regions division of the Department of Health in Victoria. The role of the office is to provide mental health nursing leadership and advice to government, the public and private health sector and the education sector, as well as to support clinical quality and safety within Victoria's funded mental health services. The goal of the office is to improve the experience of care for consumers and their family and carers by supporting quality improvement and encouraging the uptake of best practice approaches to care in services.

The activities of the OCMHN support a range of mental health reform initiatives in Victoria, including the introduction of the new Mental Health Act (2014), and Victorian Government priorities around recovery-oriented practice, safety and reducing restrictive practices.

The office undertakes initiatives that support and enhance mental health nursing practice, such as the development of the Framework for recovery-oriented practice and the Framework for reducing restrictive interventions, as well as guidelines on a range of practice areas such as nursing observations, the nursing role in ECT, working with the suicidal person, and gender sensitivity and safety. Implementation activities are also undertaken by the OCMHN to support services in the development of local strategies in response to reform priorities.

GENDER SENSITIVITY AND SAFETY

In order to support the safety of women in mental health services, addressing challenges arising from mixed sex environments combined with limited physical space within facilities, and typically higher populations of males than females, the Building Gender Sensitive and Safe Practice Training Resource (2013) was developed. This 2 day train the trainer program has been implemented at adult inpatient services, with over 75 mental health practice leaders participating. Services have since been developing implementation plans outlining how gender sensitivity and safety training will be delivered within services and what actions will be taken to review policies, procedures and the physical environment in line with the principles of gender sensitivity.

RECOVERY

The notion of recovery, which emerged from and was conceptualised by the consumer movement, has become the dominant paradigm informing policy, service and practice development in Australia. Recovery-oriented service delivery is predicated on the principle that people should be supported to build and maintain a self-defined and self-determined satisfying life and personal identity, irrespective of the presence or not of ongoing symptoms of mental illness (paraphrased from Shepherd, Boardman & Slade 2008, cited in Victorian Department of Health, 2011). The Victorian Framework for recovery-oriented practice (2011) formalised the expectation that Victoria's mental health services would embed recovery approaches in service delivery. Although much work has been underway in services to facilitate the required culture change for adopting recovery principles, the OCMHN determined that more could be done to assist services. The Centre for Psychiatric Nursing (CPN) has been commissioned to develop a recovery library, the Tools for change: A recovery library website, drawing on nursing and consumer academic expertise in the design, development and implementation. The library will be an online repository of recovery-oriented references and resources intended to support the implementation of the recovery framework in policies, procedures and practice. The library is currently in the development phase with the intention that it will come online in mid-2015.

Whilst the awareness and understanding of nurses about recovery-based approaches to care is growing, providing recovery oriented care in acute settings can be complex and challenging. A project was established to try to address some of these challenges, looking at whether a partnership approach to service improvement with nurses, other health staff, consumers and carers can lead to a more recovery oriented experience of care in mental health inpatient settings. By seeking to strengthen the recovery orientation of nursing care it is intended that the quality of consumers' and their significant others' experience of nurse care in realising recovery goals will be improved.

The project, Recovery, Nursing and Advancing Practice (RNAP), brings nurses, other health staff, consumers and carers from an inpatient unit together, as equal partners, to identify aspects of service delivery that impact positively and negatively on people's recovery. Informed by the question of what would be most helpful to support consumers to lead a full life whilst staying on the unit, actions to enhance or address a small number of key aspects of service delivery are collaboratively determined by all participants and then implemented on the units.

The process has been undertaken on an adult acute unit at one service and has begun at the secure extended care unit of another service; a third service is setting up to commence with the process. Outcomes from the first service included identifying actions to enhance communication around admission and with family and carers. Actions have become embedded in the routine activities of the unit and have informed policy development.

REDUCING RESTRICTIVE PRACTICES

The OCMHN led the state-wide Reducing Restrictive Interventions (RRI) initiative to support Victorian mental health services to reduce and, where possible, eliminate the use of restrictive practices. The initiative was intended to support the implementation of the Victorian Mental Health Act 2014 and aligned with the state government's commitment to reducing restrictive practices.

The RRI initiative included a literature review, development of a framework and a state-wide program of work supporting services to develop and implement strategies, described in local action plans (LAPs), for reducing restrictive interventions. A state-wide RRI team was available to support services during the LAP development process. Funding was provided to services based on an assessment of their LAP.

Every Victorian mental health service participated in the initiative, with LAPs covering a range of strategies including workforce development, enhanced consumer and carer participation, strengthened clinical governance, innovative therapeutic interventions and sensory modulation. Several services opted to explore the reduction of restrictive practices in partnership with emergency departments. The state-wide team, in addition to supporting services, also developed and delivered train the trainer programs on sensory modulation and trauma-informed care, attended by practitioners from every area mental health service. Many of the services requested funding for sensory modulation equipment as part of their LAPs so a small grant was provided to all services to enable the purchase of equipment.

Underpinning the initiative was the need to strengthen the adoption of recovery-oriented practice and trauma-informed care. Consumer and carer participation was emphasised throughout the initiative, spanning the development of the framework and in services' LAP development. The value in undertaking a large scale initiative such as this is the opportunity it provides for the development of a broad range of local responses to addressing the use of restrictive practices and the potential for successful projects to be shared and implemented in other services.

SAFEWARDS

Out of the 23 LAPs submitted by mental health services as part of the RRI initiative, seven of these outlined the intention to implement Safewards. In response to this interest, the Victorian Government committed $1 million to support a trial of Safewards at the seven services. Originating in the UK, the objective of the Safewards model is to reduce conflict within mental health services. The model attempts to identify and address the causes of behaviours in staff and consumers that may result in harm, such as violence, self-harm or absconding and reduce the likelihood of this occurring. The Safewards model describes how inherent features of mental health services create potential 'flashpoints', situations where conflict could arise. Safewards focuses on how staff can act to prevent flashpoints, and how to manage and influence conflict in instances where conflict does arise. A series of interventions have been developed by the Safewards team that can be used to prevent/address flashpoints.

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REDUCING RESTRICTIVE INTERVENTIONS ON INPATIENT UNITS: THE ACHILLES HEEL?

Mental health nursing is both an extremely challenging and exceptionally rewarding career. Daily, mental health nurses such as myself are faced with agitation, aggression, and threats to our safety. We can only begin to imagine how terrifying these experiences are for consumers of the service. Consumers do not have the privilege of de-escalation training or access to personal alarms, and lack the ability to simply swipe into an office should they feel the need to retreat away from threats to their safety.

Elyse Smith (RN)

The implementation of the reducing restrictive intervention (RRI) initiative is both a welcome and overdue operation in mental health services. Restrictive interventions such as seclusion and mechanical restraint are infamously punitive, and renowned for their traumatising consequences. The shift away from these interventions towards more holistic and humanitarian approach ensures mental health clinicians are adopting more therapeutic, holistic, and proactive method to care provision. This leads to improved relationships between consumers, clinicians, and the mental health system as a whole.

Having worked in the mental health setting for almost 4 years, predominantly on acute inpatient units, I have experienced a more-than-anticipated share of clinical aggression. Whilst feeling as competent as possible in my ability to manage such situations safely, no-one welcomes such occurrences. Unfortunately, aggressive instances appear to be becoming increasingly frequent on inpatient units, a major contributor seemingly due to increased use of the drug ice. Individuals who use this substance are often aggressive and agitated when on inpatient units. I have lost count of the number of holes punched in walls due to this aggression, with mental health clinicians regularly having their safety threatened. These situations evoke a fear for our own safety and the safety of all consumers on the unit. Often, we experience consumers expressing intense fear in relation to their acutely agitated peers. Surely this fear, in an environment that aims to be safe and nurturing, has no positive impact on anyone's mental health?

I believe it is important to consider both perspectives surrounding the implementation of RRI's. Whilst their positive impact is undeniable, they may also be considered to inadvertently limit intervention options. Consider the following example. Recently a gentleman was admitted to the intensive care area on our inpatient unit. He was extremely agitated, pacing the unit, abusing and threatening staff, and damaging property by punching holes in walls. He had his shirt off and he was displaying extremely threatening body language. His agitation was in the context of being admitted to a restrictive environment. Not only were clinicians fearful for their safety, but so were all other consumers in this area. They all retreated to their bedrooms. It is important to acknowledge that 'imminent risk to self or others' was arguably not present, as the gentleman did not attempt to assault anyone. Yet fear was instilled in everyone that witnessed this level of acute agitation. I ask how you would have intervened in this scenario? I am proud of the team that I work with, and in this example seclusion was not implemented. The situation was very safely managed by clinical staff. It is important to note, however, that the consumers in this area continued to express fear for their safety, and commented on their perceived lack of intervention by staff. Situations like this one, which happen so frequently, are always terrifying and upsetting. They leave their mark on consumers and staff alike.

Working for 8 hours a day with the heightened awareness required for the management of potential clinical aggression is extremely fatiguing. How amplified must this be for consumers who have to spend days, and sometimes weeks, in an environment in which they may feel unsafe? It is becoming clear that whilst we celebrate the new and more humane attitude to increasing safety on our inpatient units, potentially there is a gap which needs to be addressed. Surely interventions exist that ensure all consumers feel safe on our wards, even in the presence of clinical aggression? Good clinicians always consider the balance between beneficence and non-maleficence. Regarding RRI's, this leads us to consider that which is reducing harm to one individual may be indirectly imposing harm to others. Consider the previously identified example. While seclusion was avoided in this situation, it can be argued that vicarious ongoing harm was caused to all clinical staff and the 7 other consumers witness to it in the form of fear of a repeat incident.

Both consumers and staff experience trauma and wounded mental states in relation to acutely agitated, aggressive, and threatening consumers. Whilst I by no means support the use of seclusion to manage such behaviours, I welcome a day when a safe alternative exists. Arguably, current strategies may not be enough. We need to armour this Achilles heel. Verbal and physical aggression is both destructive and traumatising for everyone exposed to it. Efforts and research should remain focused on looking for alternative interventions and support for clinicians and/or consumers being threatened and abused in their workplace or treatment setting.

The commitment and dedication of all mental health professionals to improving the experience and outcomes for consumers of mental health services is without doubt. RRI's have clearly brought a change and rethink for all of us, and from a consumer perspective this is surely welcomed. It is reassuring to know that restrictive interventions are increasingly being used as an absolute last resort in mental health care provision. And yet, I feel strongly that whilst it is easy to acknowledge the wealth of positive factors that have stemmed from these changes, perhaps we also need to develop further strategies and training that are cognisant to the negative impact these situations have on the mental health of both clinicians and consumers.

Elyse Smith (RN)

MENTAL HEALTH NURSING IN VICTORIA

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The Victorian trial will implement the model and ten Safewards interventions supported by the best evidence, based on the findings of a randomised controlled trial conducted by the UK Safewards team, seeking to determine the appropriateness of the Safewards model and interventions for the Victorian policy and service delivery context. The trial will be formally evaluated to identify the impact of the Safewards model on the use of restrictive practices, particularly on rates of seclusion and restraint, based on the hypothesis that decreases in rates of conflict in services will, in turn, reduce rates in the use of restrictive interventions. The outcomes of the evaluation will be used to inform any future implementation of Safewards more broadly across Victoria. It is intended that the trial will be underway in October 2014.

CONCLUSION

The work of the OCMHN plays a key role in translating the priorities of government into mental health service policy and delivery, working at both the state-wide policy development level and in partnership with services to support policy implementation. Impetus for the work comes from the sector, from consumers and carers, and from government policy and legislation. The development of practice guidelines on nursing observation and the role of nurses in ECT was undertaken in response to requests from practitioners to explicitly articulate the roles and responsibilities of nurses in relation to the these two areas of practice as guidance on these did not previously exist. The RRI initiative was driven by Mental Health Act reform and the Victorian Government commitment to reduce and, where possible, eliminate the use of restrictive interventions. Whilst all of the work of the OCMHN seeks to be inclusive of consumer and carer perspectives, the work around recovery, including the framework, the recovery library and the RNAP project, have been driven by the influence of the consumer-led recovery movement and intended to help services to create environments that support people's recovery efforts.

Tracy Beaton (Chief Mental Health Nurse) and Mark Davies (Senior Project Officer) Regulation, Health Protection and Regions Division, Department of Health, Victoria.

STATISTICS IN NURSING:

SURVEY RESEARCH

Survey research involves the collection of information from a sample of individuals using interviews or administering questionnaires. The information collected using surveys can be used to explore trends, attitudes and characteristics of a given population. Careful attention must be given to the survey design, measurement and sampling. When designing a survey, the goal of the research must be used to guide the questions that should be included in the questionnaire. There are four main types of survey designs: Mail Survey, Phone Survey, In-person Survey and Electronic Survey.

Mail surveys collect responses from participants by mailing out a questionnaire which the participant then completes and sends back to the researcher. Mail surveys are easier to conduct compared to the other methods. However, the response rate from a mail survey is generally much lower compared to a phone survey or an In-person survey. In order to achieve a reasonable response rate, it is important to send out reminders to those who have not responded. Other aspects such as sending out a notification to potential respondents before the questionnaire is sent out and a well written cover letter play a major role in achieving a good response rate.

In a phone survey, an interviewer contacts a participant via telephone and collects information. To get a representative sample of the population, it is common for the researcher to contact participants using random digit dialling to get a random sample. The response rate using a phone survey is much higher than a mail survey; but only those with a landline telephone service will be selected.

In-person interviews involve an interviewer interacting face-to-face with a respondent to obtain answers using a survey. Response rates are very high for in-person interviews when compared to other types of survey design and longer interviews can be tolerated better in person. Adequate training must be provided to each interviewer in order to minimise bias that could arise from using multiple interviewers.

Electronic surveys send out questionnaires to selected participants via e-mail and the respondent will complete the survey and send back to the investigator. Another type of an electronic survey is when the respondent is required to visit a website and then complete the survey online. Electronic surveys are relatively cheaper to carry out and provide much flexibility. A weakness in electronic surveys is that only those with access to internet will respond to the survey.

Research topic, characteristics of the sample and budget play a role in the choice of data collection mode. Each survey design has advantages and disadvantages and one should always assess the specific needs and employ the most appropriate design to achieve the goal of the survey.

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