carillon
representing progress & communication over distance

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IN THIS ISSUE

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Editorial Staff
Finbar Hopkins
Greg Mutter

Centre for Psychiatric Nursing
School of Health Sciences
University of Melbourne
Level 6 Alan Gilbert Building
161 Barry Street
Carlton Vic 3053

2013 THE YEAR IN REVIEW

December is typically a time for us to reflect on the successes and failures of the past year and to contemplate the challenges of the new year ahead. For the Centre for Psychiatric Nursing, 2013 has been both challenging and exciting, as it has for many mental health professionals and service providers.

One of the major issues we and other mental health training providers have faced this year is the continually shrinking availability of resources to support clinicians to undertake professional development, with many Victorian services unable to support any form of external training. This has been reflected in lower rates of registration and some cancellations of CPN training activities.

In response, our practice development coordinator, Finbar Hopkins, has been working closely with CPN staff and others to redevelop our workshop program. Elsewhere in this issue of Carillon you will find information regarding our new approach to practice development including new, industry-based workshops and the training calendar for the first half of 2014.

The CPN's research program continues to grow, albeit in an increasingly tight funding environment. Our year began with the submission in February of our first ever application for an Australian Research Council (ARC) discovery project grant, the culmination of around two years of preparation including pilot research, funded by the Telematics Trust.

After receiving very favourable reviews in June, we were disappointed that our ARC application was unsuccessful. In fact less than 20% of applications to this scheme were successful and even the projects that were funded received only two thirds of the requested project budget. It is also noteworthy that there were no nursing projects at all amongst those that received funding in this round.

Despite this and the ongoing challenges of the competitive grant environment, the commitment of many mental health nurses to the evidence-based improvement of their practice is inspirational. One notable example from 2013 has been the completion of a large-scale project in partnership with mental health nurses from Northwestern Mental Health as part of our medication safety research program. The medication safety vest protocol was implemented and evaluated across 21 inpatient units and we have clear evidence that the project was successful in reducing distractions during medication administration, one of the known factors in medication errors. First manuscripts describing the findings of this project have been written and we anticipate publishing early in 2014.

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IMPLEMENTATION OF RECOVERY PARTNERS AT ST VINCENT'S MENTAL HEALTH

The implementation of a recovery model at St Vincent's Hospital has been based on the Strength's Model developed by Charles Rapp and Richard Goscha. The Strengths principle of consumers directing their own care, and the primacy of the helping relationship in recovery has formed the foundation upon which Recovery Partnership has been built.

In the Acute inpatient service we are using the Wellness Recovery Action Plan (WRAP®). The WRAP® was developed by Mary Ellen Copeland PhD, whose work is based on the study of the coping and wellness strategies of people who have experienced mental health challenges. WRAP® becomes the basis for consumer care and it has replaced nursing care plans as a collaborative document so that clinicians and consumers can tread the path to recovery together. The Recovery Partnership model was introduced to replace Primary Nursing in the inpatient setting; it resembles case management because social workers and occupational therapists also become primary contacts for consumers.

Derek McCue PDN & Terri Hunt CNE, St Vincent's Mental Health

Education

The Recovery Partnership model is informed by training modules. Module training was developed by a multidisciplinary working party who established which skills and tasks were to become shared and which were to remain discipline specific. From this modules were developed to provide education sessions and resources to ensure the sustainability of the model. Along with module training, the staff are provided with a hard copy of a comprehensive manual outlining the role expectations of a Recovery Partner as well as intranet access to a digital copy of the manual and all the resources including the module training Power Point presentations.

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2013 THE YEAR IN REVIEW

Continued from Page 1

Many Carillon readers will be aware that the CPN has been commissioned by the Mental Health Drugs and Regions Division of the Victorian Department of Health to undertake three major workforce development projects in alignment with recent policy developments. These projects are designed to support individual clinicians and services to implement recovery-oriented practice, gender safety and sensitivity, and to ensure competent, evidence-based practice in child and youth inpatient settings. We look forward to working with many of you over the coming year as these projects unfold.

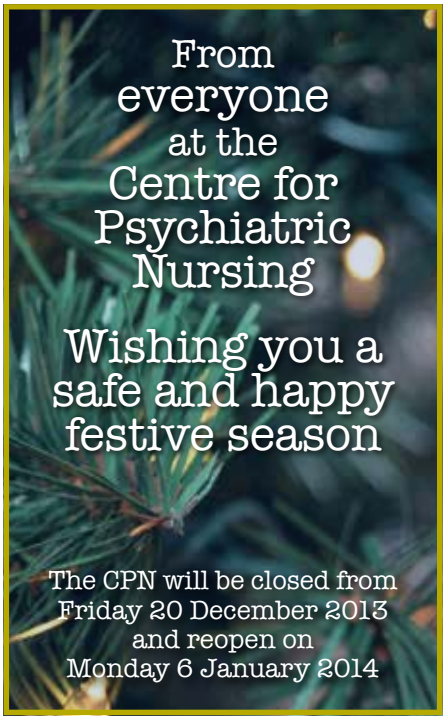
For me personally, 2013 marked my 35th anniversary as a mental health nurse and was cause for reflection upon the many changes that I have witnessed over the course of my career. When I started in 1978, Alzheimers disease was regarded as a relatively rare form of pre-senile dementia, affecting only those under the age of 65, and we had never heard of borderline personality disorder!

On a related note (ahem!) the CPN's psychiatric nursing history archive is now live on our website and open for contributions. The archive is curated by Natisha Sands and John Vokoun, who many of you will be aware, produced the documentary film, "Round the Bend: A History of Psychiatric Nursing in Victoria". We are very grateful to Natisha and John for the investment of their time and enthusiasm in ensuring that we capture as much as possible of the history of our profession.

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



LOOK AT WHAT WE CAN DO FOR YOU

Are you looking to enhance your existing educational opportunities with training sessions that contain the latest knowledge and skills on how to enhance your professional practice.

CPN Centre for Psychiatric Nursing
advancing mental health practice

The Centre for Psychiatric Nursing (CPN) is changing the way it offers its training so that it will also include a the opportunity for public mental Health services to choose on a monthly basis from cutting edge training opportunities that the CPN will deliver in the mental health service free of charge.

So the CPN will still continue to offer monthly fee based workshop opportunities that will be based at the University of Melbourne. The CPN training calendar will list these fee based workshops along with the cutting edge training opportunities that will be delivered in your workplace, free of charge to your mental health service.

How can you take advantage of this opportunity?

Have a look at the CPN training calendar and identify which of the three industry based workshops that you feel would be of the most benefit to your role and your organisation .

You will then need to contact your education team to get them to work with the Centre for Psychiatric Nursing to organise a suitable date to have the workshop delivered in your service.

Please refer to the Centre for Psychiatric Nursing website for the CPN Training Calendar – Jan to Jun 2014 at: **http://cpn.unimelb.edu.au/education_and_practice_development/training_calendar**, which will have updated details of the all CPN workshops including the no cost industry based workshops.

In 2014, staff at the Centre for Psychiatric Nursing look forward meeting you at the no cost industry based workshops being held in your workplace.

"IT'S NOT REAL WORK!" THE CONUNDRUM OF NURSES AND CLINICAL SUPERVISION

As the clinical healthcare environment becomes increasingly challenged by the acuity and complexity of the consumer group it serves, there is a growing argument that clinical supervision (CS) may provide the balance between what is expected from management and what is realistically achievable (Australian Resource Centre for Healthcare Innovations [ARCHI], 2012). However, a review of the literature suggests that there are (at least) two major critical themes which become apparent.

James Houghton, NorthWestern Mental Health

Firstly, by nature CS is very complex. There are so many variations of the settings and the contexts in which CS could be implemented, that it is not surprising there's great confusion regarding its role and structure. Secondly, there is the organisational resistance to CS, which seems to emanate from a strong cultural suspicion of change and poorly defined parameters of performance. In this context, staffing shortages and budget restraints are primary excuses for not maintaining a commitment to support this intervention (White & Winstanley, 2009). For nurses, it seems this translates to an attitude of… "If we can't prove it works, why waste our precious time and energy chasing it?" And Sloan & Fleming, (2011) suggest that this situation is further complicated by the scarcity of any professionally recognised qualifications to become a clinical supervisor. Having said this, the Australian College of Mental Health Nurses (ACMHN) has committed to support the use of CS and has a number of resources available on its website.

Anecdotally, this attitude appears to be less prevalent in other professions (psychologists, social workers and occupational therapists), who generally appear to value their CS – which even includes sometimes paying for it themselves.

When consideration is given to who benefits from supervision and how, the conundrum deepens. Koivu, Saarinen & Hyrkas (2011) contend that the outcome of nurses feeling good about their work is both an antecedent and a consequence of efficient CS. They found that nurses who actively sought CS also reported more job and personal resources as well as more job engagement and less burnout than nurses who did not. This then raises another conundrum – the 'teach or treat' issue, which appears to be well documented by generations of clinical supervisors. They suggest that avoidance of burnout, particularly in professionals with traits predisposing them to it, may be achieved through psychotherapy.

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COGNITIVE BEHAVIOURAL THERAPY SKILLS FOR NURSES AND ALLIED HEALTH PROFESSIONALS

For the past three years Barwon Health Mental Health Drug & Alcohol Education Team has been offering a series of one day workshops on CBT for nurses and other professionals.

The aim of these workshops is to teach specific skills and interventions which can be used in conjunction with other therapeutic interventions, and to introduce some of the theory behind the interventions and CBT in general.

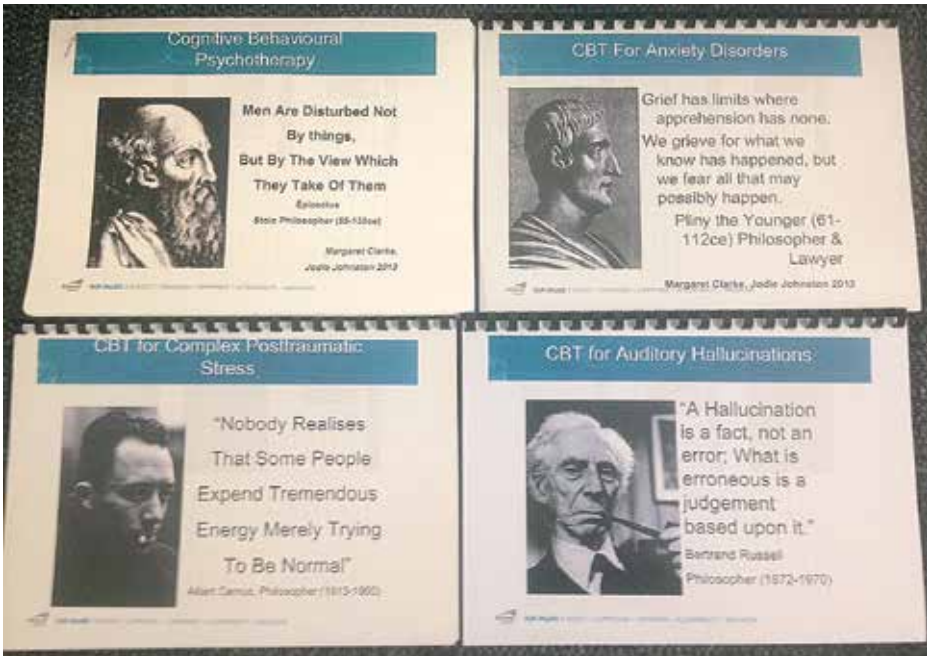
The workshops have been arranged so that they can stand alone or be taken as a course over the year. In the first year most people attended workshops specific to their area or interests, but in the two subsequent years the majority of attendees have booked the whole course or a substantial proportion thereof.

This has led to a richer experience for attendees as we have been able to build up knowledge as the course has progressed, and it has allowed for discussion and peer supervision whereby clinicians can feed back how they have used the techniques between sessions, and what they have found useful or otherwise.

The one day workshop consists of seven sessions:

- Introduction to CBT
- CBT for Anxiety Disorders
- CBT for Depression
- CBT for Adult Trauma
- CBT for Complex Trauma
- CBT for Auditory Hallucinations
- Advanced CBT Skills Workshop

The format of the day remains consistent for each workshop delivered.



Examples of Workbooks from Barwon Health Cognitive Behavioural Psychotherapy Workshop, 2013.

The morning is allocated to looking at the theoretical models of the disorder.

This usually involves examining Beck's Schema models and looking at maintenance factors and formulation. Participants are asked to practice formulation using both schema – based and maintenance models.

In the afternoon we look at specific techniques and practise their application.

Some of these techniques are familiar to participants, but we often find that they are used inconsistently or with a poor understanding of implementation.

Feedback we have received suggests that often the rationale and theory behind the interventions is poorly understood, and that examining the theory in the morning and then applying it to treatment models enhances participants' understanding and ability to apply the techniques effectively.

We also find that participants' confidence grows and that they are better able to communicate the purpose of the interventions to consumers and encourage persistence.

Each workshop is accompanied by a Workbook (pictured) which consists of copies of the presentation, large diagrams of any models or charts used (for example diary sheets), and one or more pieces of literature relevant to the subject.

Throughout the day participants are encouraged to bring examples from their own practice (or, as occasionally happens, their own lives), and we have had much lively discussion within professional boundaries.

Margaret Clarke – Nurse Educator, MHDAS
Jodie Johnston – Manager,MHDAS Education Team
Barwon Health

IMPLEMENTATION OF RECOVERY PARTNERS AT ST VINCENT'S MENTAL HEALTH

Continued from Page 1

There are 5 self-contained modules that can be undertaken in any order. This was to enable flexibility to accommodate rosters and maximise attendance at each session.

The topics include:

- Why are we doing what we are doing?
- Occupational therapy and social work task sharing
- Admission, discharge and documentation
- ECT and risk assessment
- Metabolic monitoring and early psychosis

The 1 hour modules were initially rolled out weekly over a two month period to prepare clinicians prior to the official commencement of the model. This was followed up by regular scheduling of module sessions to get new staff and staff that had missed the earlier sessions. Further to this there have been additional sessions of WRAP® refresher training to consolidate the change in practice.

What is in it for Recovery Partners?

Having allied health as Recovery Partners increases the amount of time available to nurses to spend with individual consumers. It increases collegial respect through fostering a greater understanding of each other's disciplines thereby enhancing interpersonal relationships amongst staff. Allied health staff now receives an opportunity to widen their skill base and to develop a primary relationship with consumers by working with them holistically.

What is in it for Consumers?

Hopefully the consumer's experience under the Recovery Partnership Model will be more collaborative. The model will provide a "one stop shop" for consumers to realise their goals and have their needs met, whilst avoiding repetition through eliminating demarcation. It should engender a greater continuity of care and a more meaningful relationship with their Recovery Partner on their personal recovery journey.

Conclusion

The implementation has established the groundwork for a sustainable framework for recovery based practice, the manual and the module training allows for the continuation of the Recovery Partnership Model through the future scheduling of education sessions for new staff, graduates and refreshers for all staff.

Terri Hunt, CNE & Derek McCue PDN
St Vincent's Mental Health

INTRODUCTION OF TRAUMA INFORMED CARE TO A MALE ACUTE FORENSIC MENTAL HEALTH UNIT

Trauma Informed Care (TIC) is an all-encompassing term that involves the provision of care for patients who have experienced trauma. Many patients who receive mental health care have a history of trauma and forensic patients in particular represent a severely traumatised population, with many experiencing childhood maltreatment including physical, sexual and emotional abuse as well as physical and emotional neglect. Trauma can overwhelm people's capacity to cope, and some patients will experience a range of symptoms associated with trauma.

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The Victorian Institute of Forensic Mental Health, known as Forensicare, is responsible for providing adult forensic mental health services in Victoria. Forensicare has a 116-bed secure hospital, Thomas Embling Hospital in addition to Community and prison based programs. The TIC project is currently being piloted at Thomas Embling Hospital on Atherton Unit, a 15 bed male acute unit.

As described in the Forensic Mental Health Nursing Standards (2012), forensic patients may experience trauma as a result of:

- exposure to a traumatic experience
- trauma related to committing the index offence
- trauma related to detention
- trauma related to experiencing coercion in secure settings
- trauma related to the impact of the secure environment.

Currently TIC is introduced in the management of aggression workshop and is discussed in refresher training; however the application of a TIC approach to practice remains fragmented across the hospital. Some organisational factors are also at odds with several of the principles of TIC. This project aims to introduce a co-ordinated TIC approach to Atherton Unit by:

- providing and supporting patient and staff collaboration
- enhancing sensory modulation interventions
- providing a model of assessment and treatment that is patient centred and trauma informed.

Project to date

The project on Atherton began when a group of enthusiastic staff met and started to discuss how a model of TIC could benefit the patients and staff alike. A project steering committee was formed and the committee membership includes two current consumers. The Trauma Informed ToolKit (from SAMHSA) was chosen to be the roadmap for the project.

The first part of the implementation involved providing preliminary education about trauma, its impact, the relationship between mental illness, trauma and offending, and concepts of TIC. To date 65 staff (including senior management, nursing, social work, medical, maintenance, cleaning and catering staff) have attended the training.

Thomas Embling Hospital grounds

This painting was designed by one of the Atherton patients for the TIC project. The painting represents two people walking and working together, and is the official logo for the TIC project

At present staff and patients are filling out a trauma informed organisational self-assessment as a guiding tool to help Atherton to become more trauma informed. Results from this self-assessment will be analysed and this information will be used to guide goal setting for the rest of the project.

The steering committee have been overwhelmed by the support this project has received. Every group that we have delivered the training to has been extremely receptive and positive about the project aims. When we have discussed the project with current Atherton consumers they have also been enthusiastic about the project. The following are comments that have been made to us over the course of the project.

"You mean like when I'm talking to one of the nurses and I get angry? I'm not really angry at them but about something that happened in the past and it still makes me angry now."
(Patient on Atherton during presentation at community meeting)

"It's making a difference already, the other day I heard someone in the nurses' station say 'you can't do that it's not trauma informed'
(nurse on Atherton)

In the coming weeks there will be some exciting changes on Atherton unit, such as modifications to the activities room, more sensory items, more training on trauma and assessment, and additions to the personal safety plan, to name a few. To date this has been a very rewarding project and has been greatly enhanced with consumer participation.

This painting was designed by one of the Atherton patients for the TIC project. The painting represents two people walking and working together, and is the official logo for the TIC project

Tessa Maguire
Clinical Nurse Consultant/M4 Co-ordinator
Forensicare

THE CONUNDRUM OF NURSES AND CLINICAL SUPERVISION

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In their 2013 review of the literature surrounding the CS debate, Dilworth et al, (2013) argued that for CS to be successfully established in practice, negotiations would need to take place at a local level so that it meets the needs of those staff engaged in it. Ross (2012) supports this from her study of the efficacy and effectiveness of cognitive therapy supervision which was provided to a team of community mental health rehabilitation staff. Given all this, perhaps one option is to consider delivering supervision from a grounding in another form of psychotherapy?

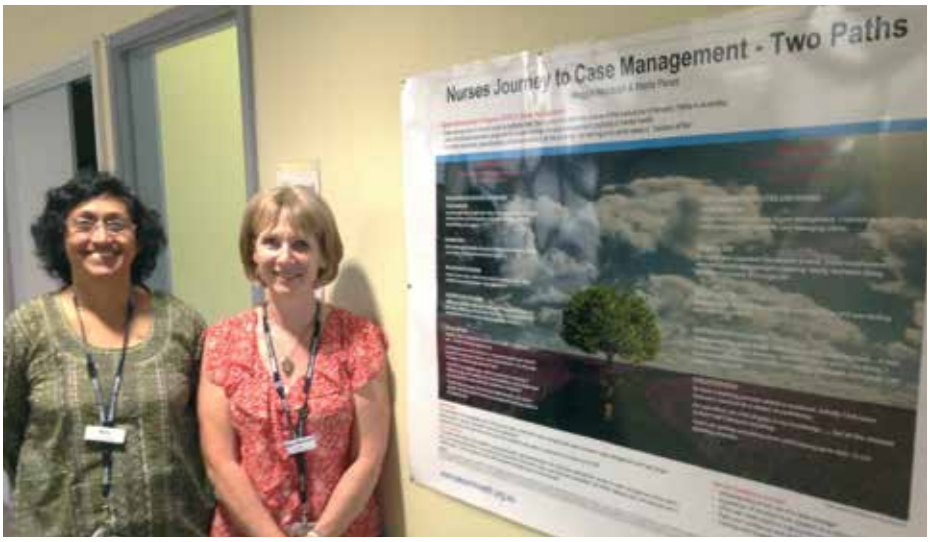
A basic literature search shows that Acceptance & Commitment Therapy (known as ACT) appears to have gained a sound reputation for improving outcomes for mental health consumers. ACT has been utilised in a number of studies and achieved positive outcomes across various clinical situations, including stuttering, anxiety disorders and deliberate self harm in episodes of psychosis. Therefore, it's reasonable to consider that ACT could have similar successful outcomes when used as a framework for CS.

If CS is delivered using ACT and gives clinicians a chance to clarify their values and connect with a sense of meaning or purpose; if it allows them to be present, conscious, aware, open and connected to their experiences; if it helps them set goals and break them down into committed actions; if it supports an increase in self-awareness around the short and long term effects of their behaviour; if it allows them to be aware of and validates their thoughts and feelings, whilst at the same time allowing them to choose to just accept them; if CS allows them to be more compassionate and accepting towards themselves and others – surely then, there's a possibility that CS could be seen by nurses as "real work"?

James Houghton
Nurse Educator, NorthWestern Mental Health

TRANSITION TO SPECIALTY PRACTICE PROGRAM

The Transition to Specialty Practice (TSP) program at Eastern Health was initiated in 2011 with the development of a six month program for registered DIV 1 nurses.



Maria Peres & Maggie McIntosh from Eastern Health

The aim was to provide opportunities for general nurses to gain experience in working in mental health acute inpatient units. The structured program was supported through on line learning via MHPOD, formal study days, competency assessment, mentoring and clinical supervision. Four positions were identified within the adult and aged inpatient units and eight participants undertook the program during 2012.

Following success with the initial program, discussions occurred between the Practice Development Team and Community Mental Health managers in the Continuing Care Team (CCT), Community Care Units (CCU) and Mobile Support Team (MSTS).

The aim was to develop entry level programs to the community areas using a similar format to the entry level positions described above; however, positions were for a 12month period.

Providing a structured program enabled novice nurses gain entry to a community position in a supported way with graded learning tasks and increased autonomy and responsibility, rather than through ad hoc on the job training. All programs are based on the Framework for Recovery Oriented Practice and the National Standards for the Mental Health Workforce, 2002.

The main aim of the TSP training programs is to provide selected participants a range of theoretical, practical, supportive and reflective opportunities to enhance both knowledge and skills in a specialized area within mental health.

The first community position, based at the Koonung CCT in Box Hill, was recruited to in September 2012. Another novice case manager was employed to a direct case management position at the same time. This provided an opportunity to undertake a qualitative research study using semi-structured interviews with the two participants. Interviews were conducted at six monthly intervals. The two participants were similar in that they had worked in the same inpatient unit, held post graduate mental health qualifications, and worked in mental health for a similar period of time.

The results highlighted the TSP candidate gained knowledge and understanding of Recovery Focused Care. The candidate developed skill in working collaboratively with people and identified a shift in her practice. The candidate commented: "It has taken me 6 months to realise an Individual Recovery Plan is not mine" and "Looking back over the first 2 or 3 treatment plans and clinical reviews I've done for clients, I feel embarrassed… it's only now I'm aware of how inexperienced I was". The TSP candidate also highlighted that she benefited from the mentoring relationship "The TSP co-ordinator was able to assist me in looking at different ways of handling my responsibilities. I was challenged to approach the work from the consumer's viewpoint."

The nurse employed to a direct entry position did not develop a recovery focused approach to care, however there may be many variables that contributed to this such as the team culture in which the individual nurses worked, the mentorship relationship, and/or individual personality factors. Ongoing evaluation with future TSP candidates is recommended

The CCT staff and manager provided positive feedback and considered the TSP program was beneficial for novice case managers; therefore a second applicant has recently been employed to the position. A candidate has also commenced in the MSTS position. Future plans include extending TSP Programs to the Community Care Units and Aged and CYMHS settings.

On completion of the program the TSP candidate commented: *"I wish that every part of nursing could have this role where people can learn, and it's how we manage the learning within it - it's been terrific"*

Maggie McIntosh – Manager
Mental Health & Continuing Care Practice Development Teams, Eastern Health

Maria Peres – Nurse Educator
Mental Health, Practice Development Team, Eastern Health

WORKFORCE DEVELOPMENT PROJECTS

The Centre for Psychiatric Nursing (CPN) welcomes Imogen Edeson as the Project Manager tasked with leading a number of workforce development projects commissioned by the Department of Health, Victoria.

Imogen comes to the CPN from the Department of Health with considerable experience across gender sensitivity and recovery-oriented practice portfolio areas and is a fellow of the Victorian Travelling Fellowship Program 2011-12, in which she explored international approaches to recovery-oriented practice.

The workforce development projects that Imogen is leading are:

1 Gender Sensitivity and Safety Training
2 Nursing Leadership in Acute Adolescent and Youth Mental Health
3 Tools for Change: A Recovery Library
4 Nursing Expo

Gender Sensitivity and Safety Training

The CPN will deliver a train-the-trainer package to equip senior education staff from across adult

Imogen Edeson

clinical services with the skills and knowledge to deliver gender safety training within services. This training, based on a modularised package developed by the Women's Mental Health Network Victoria, will also workshop strategies for promoting practice change and service capability in line with the Service guideline on gender sensitivity and safety (Department of Health 2011).

Nursing Leadership in Acute Adolescent and Youth Mental Health

This project will re-engage nurse educators, senior nurses and nurse unit managers working in child, adolescent and youth mental health in an effort to roll-out a training program developed in 2012 to nursing staff employed in Victorian public CAMHS inpatient settings. The training package will also be mapped to a set of competencies for services wishing to use or adapt these in professional development and performance processes.

Tools for Change: A Recovery Library

The CPN will coordinate the development of a website that will provide high-quality recovery-oriented tools and resources to support Victorian mental health services in their implementation of the Framework for recovery-oriented practice. The project will draw on existing resources and seek to address identified resource gaps to support both service management and individual workers across the full spectrum of Victorian services to embed recovery principles in professional practice and service policies.

An exciting feature of the project is that it will privilege consumer knowledge and expertise throughout the thinking, planning, development and implementation stages. The project will be jointly managed by Ms Cath Roper, CPN's Consumer Academic and Ms Imogen Edeson, CPN's Project Manager, Workforce Development. In adopting a co-produced method of working, the project will model principles of recovery.

Nursing Expo

The Australian College of Nursing's Nursing and Health Expo will take place in Melbourne on Saturday 12th April 2014. Under this project the CPN will be responsible for arranging a Mental Health Nursing Victoria booth on behalf of the Department of Health.

The CPN will be in touch over coming weeks to request support from Victorian mental health nurses in tending to the booth. Since 2009, this promotional activity has proven a valuable exercise for attracting prospective mental health nurses into Victorian graduate programs.

Further communication with services regarding these workforce development projects will occur in coming months.

STATISTICS IN NURSING RESEARCH: CORRELATION

Continued from last issue (#53)

Ordinal variables

A common test statistic used to examine the association between two ordinal variables is the Spearman's Rank-Order Correlation (rs), also known as Spearman's rho [ϱ]. For example, Spearman's correlation can be used to examine whether there is an association between students who enjoy chemistry and students who enjoy biology; where responses are given on a 7-point Likert Scale. Spearman's correlation uses rank order to determine the magnitude and direction of relationship between two sets of ranked data. Similar to the Pearson product-moment correlation coefficient, Values for Spearman's correlation coefficient vary between -1.00 and +1.00. A value less than zero indicates that as the rank of one variable increases the other one decreases, while a value greater than zero indicates that the ranks increase together. A coefficient of 0 indicates no association between ranks. The stronger the association between two variables, the closer the Spearman's correlation coefficient will be to either -1 or +1. Spearman's correlation can also be used when examining relationships between ordinal and interval variables.

Nominal variables

When two variables are measured at the nominal level, the association between those variables can be examined by cross-tabulating data in a contingency table and computing the Pearson's Chi-square statistic ($\chi 2$). For example, the association between the nominal variables gender and smoking status can be examined using the Pearson's Chi-square statistic. The strength of the association between two nominal level variables is measured using the Phi coefficient or Cramer's V. Phi coefficient is used when a contingency table has 2x2 cells and Cramer's V is used when a contingency table has more than 2x2 cells. The coefficient can range between 0.00 and +1.00. A strong association between variables is indicated by a value closer to one and a weak association is indicated by a value closer to zero. Pearson's Chi-square can also be used when examining relationships between nominal and ordinal variables.

Roshani Prematunga
Researcher
Centre for Psychiatric Nursing

15TH VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

CALL FOR ABSTRACTS

7 & 8 AUGUST 2014

As joint hosts the **Centre for Psychiatric Nursing, The Australian College of Mental Health Nurses (Vic Branch), The Health and Community Services Union** and the **Australian Nursing and Midwifery Federation (Victoria Branch)** invite you to attend this exciting conference.

The aim of this conference is to focus on the practice of psychiatric nursing and how this practice contributes to better health outcomes for the consumers of services.

Abstracts of no more than 200 words are invited for 30 minute paper, poster and 60 or 90 minute workshop presentations that focus on the practice of psychiatric nursing. All posters submitted for the conference will be entered into the Conference Poster Competition with a $100 Gift Voucher going to the winning entry.

DEADLINE FOR ABSTRACT SUBMISSION

FRIDAY 7 MARCH 2014

Papers with a focus on recovery from mental health problems are particularly encouraged. Themes below are listed for your consideration 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

THEMES

- Psychiatric nursing across the life-span
- Rural issues
- Cultural and indigenous issues
- Dual diagnosis
- Dual disability
- Recovery
- Trauma informed care
- Innovation in practice
- Sustainability of psychiatric nursing
- Consumer perspectives
- Carer perspectives
- Clinically-based research and evaluation

CPN Centre for Psychiatric Nursing
advancing mental health practice

HACSU Health and Community Services Union

ANMF Australian Nursing & Midwifery Federation Victorian Branch

the Australian College of Mental Health Nurses Inc.