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DIRECTOR'S END OF YEAR WRAP

With some mixed emotions I sit at my desk to write my final article for the Carillon. This will be the final issue of Carillon in its current newsletter format. Early in the New Year we will be launching our new CPN blog with links to our Facebook and Twitter accounts (see Larissa's article in this issue for more details of this exciting new development).

IN THIS ISSUE

Stephen Elsom

2015 has been a year of big changes for the Centre in the wake of the University of Melbourne's Business Improvement Program and the investment logic mapping exercise that the CPN and the Department of Health and Human Services completed last year. The Centre's long term administration manager, Greg Mutter, moved on from the CPN in March this year and we welcomed Larissa Limberis to the team as our new Programs Officer. We were also very pleased to welcome back to the CPN, James Houghton, on secondment from NorthWestern Mental Health.

The Centre's operational plan, agreed under our funding contract with the Department of Human Services, included several major projects for 2015. These included: the evaluation of the Therapeutic Foundations in Mental Health Nursing pilot program developed by Robert Trett and the team at SPECTRUM, the evaluation of the Victorian Safewards trial, led by Dr Bridget Hamilton, the promotion of mental health nursing as a career of choice, and the further development of coproduction in our practice development program.

The 16th Victorian Collaborative Psychiatric Nursing Conference this year saw the launch of the Recovery Library (http://recoverylibrary.unimelb.edu.au) and the premiere screening of the film documentary, Mental Health Nursing: This is Our Story (https://vimeopro.com/lightcityfilms/mental-health-nursing-films).

Our research program in mental health triage, in collaboration with A/Prof Natisha Sands at Deakin University and researchers from Wales and England, gained momentum this year. Our new UK Mental Health Triage Scale yielded very high rates of inter-rater reliability and has already been adopted by two services in the UK and will soon be in routine clinical use in services in Queensland and New Zealand. Our manuscript reporting on the development and testing of the new scale has been accepted for publication and will appear in an upcoming issue of the International Journal of Mental Health Nursing. At the time of writing, we are in the final stages of preparing an application for funding from the NIHR (UK) to further progress this work.

I am very pleased to report that the MHTT-CAT (Mental Health Telephone Triage Competency Assessment Tool) has been completed. This evidence-based, interactive professional development and evaluation tool is the end product of a 4-year program of research and development. The MHTT-CAT is now available for licensing to mental health services and we have already received inquiries from several services in Victoria, interstate and overseas.

The Centre's practice development program has been comprehensively reviewed and redeveloped over the past year with many of our workshops now being delivered onsite at no cost to Victorian mental health services. A key feature of this work has been further development of coproduction in the conception, design and delivery of our professional development activities. With supported decision-making now enshrined in legislation (Mental Health Act, Victoria, 2014) the Centre's coproduced professional development activities have become increasingly popular with demand particularly strong for our supported decision-making and co-production workshops. Our capacity to keep up with this demand is a limiting factor and we are in the process of investigating strategies to build consumer academic capacity in the CPN.

Demand remains strong for our Best Practice in the Administration of Intramuscular Injections training with workshops being offered on a monthly basis at the CPN and also offered onsite and free-of-charge for Victorian mental health services. The hands-on nature of these workshops means that only small groups can be accommodated and that our capacity to meet the increasing demand is limited. We expect to offer a train-the-trainer workshop with supporting multimedia materials in 2016.

The success of our practice development, research and engagement work relies heavily on the involvement and commitment of many mental health nurses and others who support our work. On behalf of the CPN team, Finbar, Cath, Roshani, James and Larissa, I would like to thank the many people who have worked with us over the past year and to wish you all a very happy, safe and reinvigorating Christmas and New Year break. We look forward to working with you again in 2016 to shape the future direction of mental health nursing in Victoria.

Stephen Elsom
Director, Centre for Psychiatric Nursing

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Carillon has been published quarterly by the CPN since 2000. This is the final edition. As of 2016 the CPN's news will be published online.

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THE COUNTDOWN IS ON…

Larissa Limberis

That's right! It's almost time to say *"goodbye newsletter, hello blog"*.

For a lot of people this may be a terrifying shift. Many in the Victorian Mental Health nursing community that I spoke to about it went blank when I told them and claimed that they had no idea about how social media works. I guess for many (myself included!) computers, technology, and the internet often bring to mind negative connotations. They can be difficult to use, they seem to malfunction all the time, and they seem to require technical knowledge that only rocket scientists are privy to. Social Media only adds another layer of confusion into the mix with all of its bizarre codes, both civil and technical… But I hope that the CPN's blog will change your mind a bit. Rest assured that you will not need to be a tech-head to get good use out of it because it will be simple and easy to operate, and will deliver easily digestible, weekly news about Mental Health nursing practice and policy.

Here is the great thing about online media: it is literally designed to provide stacks of information in a way that requires as little time an effort on the readers' and viewers' behalves as possible. Google and other sources show that people rarely spend more than a few seconds on any given webpage. And that's why communications have recently evolved around the idea of an "attention economy." Believe it or not that's actually a real concept these days! According to Wikipedia it is "An approach to the management of information that treats human attention as a scarce commodity." "As content has grown increasingly abundant and immediately available, attention has become a limiting factor in the consumption of information." In other words if organisations want to reach their audiences via online channels they need to take a rapid fire approach, otherwise they will probably end up unnoticed. For busy and time-poor MH nursing practitioners, it should be pleasing to know that good online content is produced with this in mind!

So what exactly can you expect from the blog? I guess one way of looking at it is as a live and interactive newsletter. Each week we will post a couple of news items such as articles, short videos, podcasts, or recorded interviews relating to you and your colleagues, your services, clinical practice, research, and issues in policy development and implementation. You will be able to open up the blog on your computers and smartphones at any time to stay attuned with the latest news in the field. And you'll have the opportunity to interact and engage in live discussions. So whether you want to keep up-to-date with current affairs in MH nursing, stay in touch with colleagues, network, or find out about exciting career opportunities, the CPN's blog will be your one stop shop. Keep your eye out for the launch in 2016!

Wishing you all a fun and safe Christmas and New Year.

Larissa Limberis
Programs Officer, Centre for Psychiatric Nursing

PROFESSIONAL DEVELOPMENT WORKSHOPS 2016

The Centre for Psychiatric Nursing offers on-site professional development activities to each Victorian Area Mental Health Service.

These on-site workshops are delivered at your workplace at no cost to your service (NB minimum and maximum participant numbers apply to some workshop topics).

The CPN's workshops are designed to upskill the mental health nursing workforce in alignment with contemporary policy directions and legislation.

WORKSHOPS AVAILABLE IN 2016:

SUPPORTED DECISION MAKING

This workshop will introduce participants to the principles, practices and tools of supported decision making (enshrined in the Victorian Mental Health Act, 2014) with a focus on how they can powerfully change the role of the mental health practitioner and their relationships with service users.

EVERY MOMENT COUNTS

Wards and residential settings can be very busy and it often feels like there isn't enough time for therapeutic interactions with consumers. This workshop is about making full and effective use of the very little time that clinicians have with consumers, exploring the challenges and barriers to quality interactions, making new meanings and working through to effective solutions.

FACILITATING THERAPEUTIC GROUPS

The ability to facilitate a therapeutic group is an important skill for mental health nurses. This workshop explores the role of the nurse as group leader and the types of groups that nurses lead in health care contexts. Group psycho-education will be explored as a practice example of group work applicable to contemporary mental health settings.

ACTION LEARNING SETS

Action learning is a structured group approach to addressing complex issues in clinical practice. This workshop provides psychiatric nurses with an opportunity to develop their problem-solving, questioning, listening and facilitation skills.

CO-PRODUCTION

This one day workshop raises the bar for working with consumers, from seeking involvement/ participation after an agenda has already been set, to seeking consumer leadership from the outset. In line with co-production principles, participation from all disciplines including the consumer workforce and interested service users is encouraged.

BEST PRACTICE IN THE ADMINISTRATION OF INTRAMUSCULAR INJECTIONS

Using the latest available evidence, this workshop is designed to equip clinicians with the skills and knowledge to safely and effectively administer intramuscular injections to any patient in any setting.

Please speak with the RPN 4-5 or RPN 6-7 at your MH service about scheduling in sessions, and contact Larissa Limberis for further details and bookings.

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SERVICE USERS IN ACADEMIA CONFERENCE 2015, AUCKLAND

The annual Service Users in Academia conference was held in Auckland, New Zealand on Monday December 1st and Tuesday December 2nd. This year's theme was: 'Creating Connections & Building Bridges Together: One Step Closer'. I had the opportunity to present and to hear about some excellent work being done throughout New Zealand and Australia.

Cath Roper

My presentation examined co-production in the context of the Reducing and Eliminating Seclusion and Restraint Project commissioned by the National Mental Health Commission and conducted by the University of Melbourne Social Equity Institute. I talked about the structures that were built into the research design that helped to keep the consumer voice front and centre in all stages of the research. Two other presentations that challenged and inspired me were each by New Zealand PhD researchers. The first was the keynote speaker on day one, Jackie Liggins who was a researcher, psychiatrist and person with lived experience ('multivocality'). The topic of her keynote was: "Creating Space for Healing in Mental Health Care". Jackie interviewed people about their experiences of healing spaces and also included aspects of her own journaling as part of the data she looked at. Participants talked about belonging, a safe haven, reciprocity and the heartfelt quality of healing. People often used metaphors to describe healing spaces like: warmth, bandage, content, building anew, being on the journey, blooming. People talked about having a space that can hold us enough so that we can do the connecting, develop understanding and create. Walking, being in nature were often described as restorative.

The second presentation that struck me was from occupational scientist Daniel Sutton whose interests are about helping people to do things more meaningfully. Daniel's presentation looked at how we structure our lives to give them meaning. His view on recovery is that it happens in the interaction between self and world. Daniel also interviewed people about their experiences and they too spoke about healing. He based some of his analysis on Heidegger's ideas about knowing the world by doing, while thinking comes later. He described how when our 'doing' breaks down, our brain is also affected. However, through repetition our brain structure and its plasticity can be activated. An example is relationally, where repeated experiences with someone over time builds trust. An example of embodiment he gave was how grounding it is to be in the wind because it tells you where your body begins and ends. This is especially healing for people who dissociate or become numb. On the other side, disconnection can provide opportunities to discover what we care about and provide opportunities for meaning making. Daniel spoke about the importance of having time where we can tarry/linger/meander.

What I took from these encounters and from being on the Plenary panel at the close of the second day, was a renewed interest in the idea of healing as a concept that has powerful resonances and physicality. Wherever debates about recovery might take us, perhaps a focus on healing is where we need to be.

Cath Roper
Consumer Academic, Centre for Psychiatric Nursing

CLINICAL SUPERVISION FOR NURSES: IT REALLY IS ABOUT TIME!

The subject of Clinical Supervision (CS) for nurses has been dissected, discussed and debated in many forums, in many formats and for some years now (in fact, more than two decades). When the topic is raised in almost any nursing setting, the variety of responses that are likely to be encountered can be quite remarkable.

James Houghton

Some nurses will demonstrate a marked indifference, which one could easily interpret as dismissive of the subject. Others will respond by quietly stating that they are having CS. If they're encouraged these nurses will share their positive views of CS but they don't generally tend to bring the subject up. They know that whilst their personal experience of CS may be positive, some (many?) of their nurse colleagues don't share this view. Then there are the nurses who are champions of CS.

Champions of CS don't just believe that it is good for nurses, both personally and professionally. They don't just hope that eventually CS will be an acceptable and accepted form of a professional development framework for nurses. They talk about it with enthusiasm. They actively promote it. They participate in innovative CS training whenever they can. They energetically seek to be supervised and offer to supervise others. Interestingly (and anecdotally), the membership of this group of CS supporters and promoters seems to be quietly yet steadily growing.

Only this year at the Australian College of Mental Health Nurses (ACMHN) Pre-Conference Forum in Brisbane, October 2015, "Clinical Supervision: It's About Time" experienced clinicians from all around the country participated in a roundtable forum to "move beyond an introduction to clinical supervision and occupy a space where we, as mental health nurses, can celebrate supervision in its own right for our profession".

Most participants seemed to consider this to have been a very positive and productive experience. As one participant said in a special interest group email list "the forum enabled a renewed momentum, with mental health nurses across Australia feeling they have an active role in the ongoing recognition of this crucial element of their practice."

The literature shows us that the discussion and interest in CS isn't just a local phenomenon, it's international. Nurses from as far afield as the USA, the UK, Denmark, Japan and our more proximal neighbours in New Zealand are consistently examining the CS conundrum. Whether they work in mental health, emergency departments, paediatrics, plastics or medical/surgical wards, more and more nurses are looking for a way to reflect upon and improve their clinical skills. Increasing numbers of nurses are realising that if our allied health peers believe that CS is good for them, chances are that it has something of value to add to nursing practice. And the reality is that our allied health peers DO believe that CS is good for them. Our allied health peers all view supervision as an essential part of the clinical development. So much so that they will undertake it in their own time and at their own expense.

So if, as stated earlier, CS has been on the nursing agenda for more than two decades, why does it still create so much contradictory opinion? Why does it appear to be so hard for nurses to engage with and commit to participating in CS? As with any complex nursing practice issue, there's more than just one explanation.

One of the more difficult barriers to overcome is the historical use of supervision as a means of implementing line-management. Some nurses half-jokingly refer to this as 'snoopervision'. In practice there's been an accepted application of line-management interventions to "manage" nurses who may have demonstrated that they are having some difficulties in clinical practice, and to call this supervision. Subsequently, being asked to participate in clinical supervision has come to be seen as an indication that the nurse is failing in their duty to provide care, that there are problems with the nurses clinical practice and/or that patients may be in some kind of imminent danger. Implementing this form of line management and claiming that it is 'supervision' only serves to complicate and cloud the issue and ultimately discourage nurses from seeing CS as something positive.

There are a wide variety of CS courses and training opportunities available for nurses who want to provide CS. Anything from NO training ("I have been nursing for a very long time and of course I can provide CS for more junior nurses") to more intense courses, some lasting up to 8 days at a cost of more than two thousand dollars.

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A LITTLE WALK DOWN MEMORY LANE...

SNIPPETS FROM THE FIRST EVER EDITION OF THE CARILLON

VOLUME 1, ISSUE 1, MAY 2000

Why 'CARILLON'? Carillon consists of a series of fixed bells which sound dramatically when struck. They are the largest musical instruments in existence and were first developed in the 14th century. The Carillon, which was originally associated with the town clock and chimed the advancement of time, can represent progress. The sheer magnitude and strength of its sound is representative of communication over distance.

A FOCUS FOR PSYCHIATRIC NURSING IN VICTORIA

Welcome to the first edition of the newsletter of the Centre for Psychiatric Nursing Research and Practice (CPNRP).

This inaugural issue will introduce you to some of the regular sections we hope you'll come to search out in the future– Practice Initiatives feature, in this edition, Dave Watkins and his role with the Victorian Dual Disability Service (see page 2).

The Good Practice Network feature will allow any reader to reap the rewards of sharing their ideas and experience.

Carillon bells, Peter & Paul Cathedral St Petersburg – Image from Wikipedia.org, permission granted for re-use

In our Who's Who at the Centre we introduce you to Brenda Happell, Acting Director, CPNRP; Brian Jackson, Senior Nurse Advisor, MHP/NWH; Judith Parker, Professor and Head, School of Postgraduate Nursing; Chris Gibbs, Chief of Mental Health, MHP/NWH and Allison Sidebotham, Administrative Officer, CPNRP.

The purpose of this newsletter is to provide a mechanism to inform psychiatric nurses of the Centre's activities/professional activities.

Furthermore, we believe strongly in the philosophy of inclusion whereby this newsletter is a nurse's newsletter. We therefore encourage you to help us to shape this communication tool through your contribution, ideas and vision for the Centre.

PRACTICE INITIATIVES: VICTORIAN DUAL DISABILITY SERVICE (EXCERPT FROM ORIGINAL ARTICLE)

DAVID WATKINS, SENIOR CLINICIAN, VICTORIAN DUAL DIAGNOSIS SERVICE

"To my way of thinking, a psychiatric nurse in a small team such as the VDDS needs to be four-eyed:

1. ***Innovative** – Original in their ideas and in their solutions*
2. ***Inventive** – Show creativity and resourcefulness in achieving objectives.*
3. ***Inspirational** – Help to provide leadership and direction.*
4. ***Instigative** – Be a self-starter who can prioritise and accomplish a range of tasks.*

CLINICAL SUPERVISION FOR NURSES: IT REALLY IS ABOUT TIME!

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Such a range of training opportunities, with no apparent formal regulatory body, can leave the potential supervision candidate confused and uncertain about the best way to develop new skills or enhance those they already have. And more often than not, this can lead to analysis paralysis (an unconscious decision to do nothing) which in turn compounds the clinician's general feeling that CS isn't really all that important in the classic 'chicken and egg' situation.

Add to this the fact that, in their search for a competent clinical supervisor many supervisees may have experienced AT LEAST ONE somewhat less than satisfactory encounter and things start to look at best, somewhat unpredictable when it comes to nurses engaging with the supervisory process.

New and challenging developments to the full and successful implementation of CS for nurses are arising all the time. Some are long standing and relate to the individual clinician's confidence in their own strength, resilience and ability to handle the current sense of isolation that staff are working in, especially related to the ever increasing demand for beds, short admissions and increasing presentations which involve some form of substance misuse. Others may be generationally specific – the potential influence of the digital media, netiquette, internet use and boundary issues pertaining to social media are now considered additional facets of clinical practice and would need to come into consideration, for instance when developing CS contracts.

Yet despite these significant barriers, CS for nurses has slowly but steadily been gaining support. And a growing number of organisations are starting to realise that it is an investment in the best, increasingly evidence-based outcomes for both consumers and clinicians when nurses are positively engaged in CS.

Several researchers have investigated the values frequently assigned to receiving effective CS, using various methodologies and there are a number of journal articles, which support the implementation of effective CS strategies, albeit with varying degrees of academic rigor. The most basic of literature searches will easily locate many of these articles.

The literature tells us that CS can have a positive effect on staff retention, staff job satisfaction and minimise the likelihood of staff burnout, as well as reducing its impact when it does occur. It is also believed that CS can encourage and support staff to develop their own plan for professional development which in turn allows them to feel less threatened both professionally and personally by the frequent occurrence of unavoidable organisational challenges. When group supervision is implemented, it is felt to be able to facilitate and enhance improved team communication and cohesive functioning. CS has also been described as having a positive effect on individual team member's accountability by increasing their frustration tolerance and reducing their reactivity to situations that might typically cause impulsive or risky decision making.

It is suggested that CS can support and expand the individual clinician's practice, increase their confidence and their competence and can allow them to develop new and complex skills by challenging their tolerance and acceptance of their current skill level. And again, anecdotally it's felt that these improvements in clinical practice ultimately lead to more positive outcomes for consumers.

There's also a growing belief that if clinical supervision is going to be implemented successfully and anchored within any framework of professional development for nurses, adopting a 'one-size fits all' approach is detrimental to the durability and sustainability of CS in practice. As with most changes introduced into clinical practice, staff need to feel that they have been part of identifying the problem, developing the solution and need to firmly believe that the individual and unique needs of their specific service have been considered and addressed. When clinicians feel they have ownership and have participated in the generation of a CS implementation strategy it is more likely to "have legs".

So, whilst it's clear that there are still many challenges ahead for nurses in the process of formally adopting an indissoluble relationship with CS, there also seems to be both strong evidence of its importance and a growing level of support for nurses to engage with CS positively. Developments such as the nascence of the Australian Clinical Supervisors Association, the development of the Bouverie Centre's Clinical Supervision web site and most significantly for mental health nurses, the recent ACMHN's roundtable forum, would all appear to clearly indicate that the nursing profession needs and intends to maintain the impetus towards adopting CS as part of its professional development. In the opinion of many nurses this can only be a good thing, because it really is about time.

James Houghton
Lecturer, Centre for Psychiatric Nursing

STATISTICS IN NURSING RESEARCH

SAMPLING METHODS

To answer a research question, data can be collected on an entire population or a subset of that population. Although it may be desirable to collect data from an entire population, this is not always possible for a number of factors such as budget and time available.

Roshani Prematunga

For a subset of the population, cost is always lower and data can be obtained in a shorter period of time. Therefore, a subset of the population is typically employed to make inferences about the entire population.

SIMPLE RANDOM SAMPLING

Simple random sampling is one of the most common types of sampling methods. This method involves the researcher assigning each case in the population a unique number and then randomly selecting the required number of cases from that population. With this method, each member of the population has an equal chance of being selected as a case in the sample. For example, if a researcher is interested in finding out the average amount of money spent on medical expenditure by households in a particular suburb, the required number of households can be drawn randomly from the list of all households in that suburb to generate the sample required.

SYSTEMATIC SAMPLING

Similar to simple random sampling, this technique requires the researcher to know the size of the entire population and assign each case in the population with a unique number. The researcher then selects every nth case from the population until the required sample is achieved. For example, if the researcher is interested in selecting a sample of 100 patients from a total of 1000 patients; the interval between each patient selected can be determined by using the ratio 1000/100=10. The first patient to be selected can be made at random, and from thereafter, every 10th case from the 1000 patients will be selected until the required sample size of 100 is achieved. One disadvantage of this method is that the existence of any type of pattern or arrangement could lead to a sample that may not be random or representative of the population.

STRATIFIED SAMPLING

Stratified sampling is a technique that involves the researcher forming subgroups from the population and then employing a sampling technique such as simple random sampling to obtain the required sample. This is typically done to make sure that the researcher does not miss out on any particular group and thus making the sample representative of the population. As an example, if the population contains 30% patients under the age of 50 and 70% patients over the age of 50; in order to make sure that the sample is representative, the population can be stratified based on the two age groups. If the required sample size is 100, then 30 patients under 50 years of age and 70 patients over 50 years of age can be obtained from the population using simple random sampling.

CLUSTER SAMPLING

In cluster sampling, the researcher divides the population into clusters and then a number of clusters are selected at random to be included in the sample. The researcher then includes all the cases from each of the selected clusters. For example, a researcher who is interested in studying aggression experienced by nurses working in hospitals in Victoria could divide the population into hospitals so that the hospitals become the clusters. The researcher could then randomly select a number of hospitals and include all nurses from the selected hospitals.

Roshani Prematunga
Researcher, Centre for Psychiatric Nursing