the Australian College of Mental Health Nurses Inc.

YOU ARE NOT ALONE

RESULTS OF THE 2005 AUSTRALIAN CONSULTATION-LIAISON NURSES SURVEY

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EXECUTIVE SUMMARY

Mental health nursing roles in Consultation-Liaison (CL) Psychiatry and emergency departments are developing within Australia. Mental health / psychiatric nurses work in a range of environments including general hospitals, emergency departments and the community. Anecdotal evidence suggests that many of these positions have been initiated and developed in relative isolation and no formalised support framework. This was recognised by a collective of national CL nurses and subsequently three significant initiatives were established: (i) the organisation of a national annual conference (the first being held in 2003), (ii) the establishment of an e-mail network and (iii) the establishment of a professional group. The aim of these initiatives was to provide nurses with the opportunity to communicate with colleagues and enhance collegiate support within this developing specialty.

In order to improve the understanding of this specialty area, it was decided at the CL Nurses forum held Cairns, Queensland in June 2004 that it would be useful to gather information on CL Nurses in Australia through a national survey. The survey was aimed at CL nurses working in a range of settings and included questions relating to demographics, qualifications, experience, clinical practice, organisational structure, clinical supervision, education and training, and work satisfaction.

Key findings

CL nurses who responded to the survey:

- are experienced psychiatric / mental health nurses working primarily in general hospital wards and/or emergency departments
- work in a range of specialty areas including specialist medical and surgical units, emergency departments, rehabilitation, nursing homes, maternity services and paediatrics
- predominantly work on one or two sites
- receive requests for consultation from a range of health professionals but predominantly nurses
- provide mental health education and clinical supervision to a range of staff groups

- use a range of titles to identify their role
- predominantly report through mental health services
- identified a higher degree as the minimum educational requirement to work in the role
- overwhelmingly expressed satisfaction with their work

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1. INTRODUCTION

Mental health nursing roles in Consultation-Liaison (CL) Psychiatry and emergency departments have undergone significant development within Australia. Mental health / psychiatric nurses work in a range of environments including general hospitals assisting patients with physical and psychiatric co-morbidity (Sharrock *et al.* 2006), in emergency departments working particularly with people presenting with self harm and in psychiatric / psychosocial crisis (Fry & Brunero 2004, Wand & Fisher 2006) and in the community working with nursing homes (Harding 1999, 1998).

Anecdotal evidence suggests that many of these positions have been initiated and developed in relative isolation with no formal support framework. This was recognised by nurses within Australia and subsequently three significant initiatives emerged: the organisation of a national annual conference (the first being held in 2003), the establishment of an e-mail network and the establishment of a professional group. The aim of these initiatives was to provide nurses with the opportunity to communicate with colleagues and enhance collegiate support within this developing specialty.

At the second CL Nurses national conference held in Cairns, Queensland, Australia in June of 2004, the CL nurses group established that it would be useful to gather information through a survey in order to improve the understanding of this developing specialty. A survey of CL nurses was subsequently conducted and it included questions relating to demographics, qualifications, experience, clinical practice, organisational structure, education, clinical supervision, education and training, and work satisfaction. This report provides the background to and context within which this survey was conducted with reference to the local and international literature on CL nursing. The findings of this survey are also presented.

2. BACKGROUND

The first national conference for CL nurses was held in May 2003 in Melbourne, Australia. Fifty-five delegates from Australia and New Zealand attended. The feedback from participants was overwhelmingly positive and they identified that an annual conference would be a valuable addition to the professional calendar. Subsequent conferences were held in Cairns, Adelaide and Melbourne with the fifth conference planned for Sydney in 2007. The conferences aimed to reduce the isolation of CL nurses and create opportunities for networking, sharing ideas and education in a stimulating and supportive environment. These conferences also aimed to raise the profile and contribute to the development of the identity of CL nursing within the mental health / psychiatric nursing profession.

The Australian and New Zealand Mental Health Consultation Liaison Nurses e-mail network (ANZMHCLN 2007) was established in February 2002 as a mechanism for CL nurses to communicate with each other. This facilitated sharing of ideas and information on an ongoing basis.

The tone of the network is casual, generous and supportive, fostering active participation and some lively debates on practice issues. Since inception there have been over 2250 messages exchanged, at an average of 55 messages per month over the last two years. As of the end of November 2006 there were 180 bona fide subscribers to the network: the majority from Australia and New Zealand, with others from England, Scotland, Wales, Ireland, the United States, the Netherlands and Canada. This e-mail network appears to be the largest on-line community of CL Nurses in the world. The aim of the e-mail network is to link peers to enable exchange of information and ideas with a view to improving communication and support for CL Nurses. The e-mail network has been adopted as the preferred mode of communication for the newly formed Australian College of Mental Health Nurses CL Special Interest Group.

The group of nurses that came together at conferences and through the e-mail network were initially known as the CL Nurses Group. This group considered becoming formalised, again with the aim of raising the profile of CL nursing and contributing to

the development of the identity of CL nursing within the mental health / psychiatric nursing profession.

The Australian and New Zealand College of Mental Health Nurses (now known as the Australian College of Mental Health Nurses [ACMHN]) was considered as an appropriate body with which to explore this potential. The ACMHN "…is the peak professional body for mental health nurses in Australia. It is the only organisation that solely represents mental health nurses. The college engages with its' members and key stakeholders to advance mental health nursing across the country" (ACMHN 2007).

There was national consensus for creating a special interest group under the auspices of this organisation and the ACMHN executive was approached to ascertain their support for the development of this group as a professional body. The proposal was received positively by the ACMHN Council and subsequently proposed to the delegates at the 2005 CL nurses conference in Adelaide. The CL Special Interest Group was formalised at the 2006 conference in Melbourne and processes for the operation of this group are being developed (Appendix 1). This survey represents one of the major initial projects of this group.

At the CL Nurses conference held in Cairns in June 2004, it was decided that it would be useful to gather information from nurses working in this area in order to improve the understanding of this specialty. A survey was developed that was aimed at CL nurses working in a range of settings within Australia. A bi-national survey was not conducted because the resources required to undertake this were not available but it is hoped that any future survey will include New Zealand CL nurses.

3. CONTEXT: EXPLORING COMMONALITY

There has been debate (ANZMHCLN 2007) in relation to the terminology that best describes the group of nurses that have come together to form what is now known as the Australian College of Mental Health Nurses CL Special Interest Group (CL SIG). Whilst consultation-liaison is the current terminology, it is expected debate over the most appropriate language will continue as the group evolves. The CL SIG aims to support the body of knowledge and understanding that underpins the work of group members through discussion and debate, presentation and publication, and research and evaluation. It is evident that the conferences, the CL SIG and the e-mail network have evolved and are sustained from the need to connect with others who have some form of commonality. As a result it is significant to explore the nature of that commonality.

3.1. Common ground: to whom service is provided

The terminology of consultation-liaison arises historically from the work of CL psychiatry. This sub-specialty emerged in the United States through the liaison of psychiatrists working in general hospital psychiatric units with their medical-surgical colleagues in the general hospital. In particular, psychiatrists responded to requests for expert consultation from their colleagues on the mental health care of patients admitted for physical health problems (Lewis & Levy 1982, Lipsitt 2001). CL psychiatry defined itself on the characteristics of the patient population to whom it provided service. This population is one of people with physical and psychiatric co-morbidity. CL Psychiatry specialises in:

> "…the diagnosis, treatment, study and prevention of psychiatric morbidity in the physically ill, of somatoform and factitious disorders, and of psychological factors affecting physical conditions". (Lipowski 1981 p. 555).

In the psychiatric literature, CL Psychiatry has been used synonymously with psychosomatic medicine as is demonstrated in the mission of the Academy of Psychosomatic Medicine that states that it:

> "…represents psychiatrists dedicated to the advancement of medical science, education, and healthcare for persons with comorbid psychiatric and general medical conditions and provides national and international leadership in the furtherance of those goals". (APM 2006)

The American Psychiatric Association formally recognised CL Psychiatry as a sub-specialty in 2004, and settled on the term Psychosomatic Medicine to define it (Wikipedia 2007). However, this is not a consensus view. In contrast, the American Psychosomatic Academy has a broader definition: "…the scientific understanding of the interaction of the mind, brain, body and social context in promoting health and contributing to the pathogenesis, course and treatment of disease" (APA 2006). It is argued that whilst CL Psychiatry and Psychosomatic Medicine can be considered to have 'common roots', they are different bodies of knowledge with a 'long-noted kinship' (Lipsitt 2001 p. 896). It is concluded that the CL SIG is not alone with the debate of terminology and definition.

The role of the Psychiatric Consultation-Liaison Nurse (PCLN) developed in the United States during the 1960s out of the work of CL psychiatry "…in response to recognition of the importance of psychophysiological interrelationships and their impact on wellness, physical illness, and recovery" (Minarik & Neese 2006 p. 3). The International Society of Mental Health Nurses (ISPCLN 2007) and the American Nurses Association have defined the work of a PCLN on the basis of the clinical characteristics of the patients to whom they provide service. This is reflected in standards for CL nursing practice as follows:

> The focus of this subspecialty is on the emotional, spiritual, developmental, cognitive, and behavioural responses of clients/families who enter the health care system with actual or potential physical dysfunction" (ANA 1990 p. 1).

Internationally, CL nurses whose role development has been informed by the American experience identify this group of patients as their clientele. Examples of this arise from the United Kingdom (Edwards 1999, Roberts 1997, Tunmore 1989), Canada (Newton & Wilson 1990), Taiwan (Chiu 1999) and Europe (Kocaman 2005, Priami 1997, Dutch PCLN Society 2007), as well as Australia (Hicks 1989, Meredith & Weatherhead 1980, Sharrock *et al.* 2006, Sharrock & Happell 2001a) and New Zealand (Chiplin & Geraghty 1990, Pointon & Hancock 1998).

Paralleling the development of CL nursing in the United States was that of Psychiatric Emergency Services. These services are predominantly based in emergency departments and attend to patients that present to the emergency department primarily for psychiatric

reasons (Borges *et al*. 1995, Callaghan *et al*. 2001, Curry 1993, Robinson 1982, Severin & Becker 1974, Stutesman & Yohanna 1994, Yoder & Jones 1982). These services tend to focus primarily on the evaluation and disposition of patients presenting to the emergency department for psychiatric reasons and not necessarily with physical co-morbidity. Robinson (1982) differentiated this role from a "classic liaison role". The recognition that emergency departments require expert assistance to meet the mental health and psychiatric needs of their patients, contributed to the development of CL services locally and internationally (for example Clarke *et al*. 2005, McEvoy 1998, McIndoe *et al.* 1994, Roberts & Whitehead 2002) and in Australia (Fry & Brunero 2004, McDonough *et al*. 2004, Summers & Happell 2001, Wand & Fisher 2006).

Comparative to the international experience, Australian services provide assessment and management of mental health-related presentations to the emergency department and facilitation of access to medical treatment for people with mental health problems (Wand 2004b).

The CL SIG has identified that it has members who work primarily in the general ward setting with patients with psychiatric and physical comorbidity, some who work primarily with emergency department patients and some who work with patients in both these settings. As a result, members of the CL SIG have similar interests, for example working with deliberate self-harm. However, the needs of group members also vary, for example, medical-surgical based CL nurses might be more interested in co-morbidity issues where emergency department based nurses more interested in psychiatric crisis. The aim of the CL SIG is to support both the commonality and difference for members working in these areas.

3.2. Common ground: how service is provided

Consultation-liaison can also be considered as a model of service delivery (Roberts 2002, Sharrock *et al.* 2006). This is based on the mental health consultation model as developed by Caplan (1970) and as applied to CL nursing practice (ANA 1990, Gillette *et al.* 1996, Hicks 1989, Lewis & Levy 1982, Roberts 2002, Sharrock & Happell 2000a, Tunmore & Thomas 1992). This is a collaborative model that provides a framework for

the provision of specialist consultation to non-specialist clinicians (ANA 1990, ISPCLN 2007, Lewis & Levy 1982, Roberts 2002, Sharrock *et al.* 2006).

Using this framework, a CL nurse is a specialist mental health nurse who consults to nurses and other health care professionals (consultees) within a non-psychiatric setting (Sharrock & Happell 2001a). The CL nursing role is a means of making mental health nursing expertise available to the client, his or her relatives and the staff within a health care setting not primarily focussed on psychiatric care (Roberts 1998). The CL model provides a framework for this goal to be achieved.

A clinical *consultation* includes working directly with the patient and with his or her relatives. It also includes working indirectly by collaborating with the staff in the development of a plan of care for the patient. Staff are provided with assistance, guidance, support and education in relation to the mental health care of referred patients. At an organisational level, the CL nurse acts as a resource on mental health issues and as a link between general and psychiatric services. An organisational consultation involves consulting to the broader organisation on mental health related projects, education and policy development (Sharrock *et al.* 2006).

The term *liaison* is used in a number of ways to depict a process of facilitation of relationships. It refers to linking the knowledge base of psychiatric/mental health nursing to the care of patients with actual and potential physical health problems (ANA 1990). Liaison also represents a process of facilitation of the relationship between the patient, his or her adjustment to illness, the consultee(s) and the hospital / ward milieu (Lewis & Levy 1982 p. 20). Lewis and Levy argue "…that patients' psychological symptoms can be fully understood only as related to their medical illness, their environment, and their care providers" (p. 97). Facilitation of the relationship between the consultant and the consultee is also an important focus of liaison work. Regular contact is made through various formal and informal channels such as meetings, clinical reviews, informal discussions and formal or informal educational activities (Roberts 2002). This contact aims to provide assistance to staff in the recognition, management and prevention of psychosocial and psychiatric problems in general hospital patients (Tunmore & Thomas 1992).

The establishment of CL as a model of service delivery does not confine its application to consultation in mental health / psychiatry, but allows for its use by other specialists who provide consultation, for example, an addiction medicine nurse providing consultation to a general hospital (Leiker 1989) or a community aged psychiatry service to a nursing home (Harding 1999). From this perspective, CL describes how a specialist does his or her job.

To varying degrees, members of the CL SIG identify with and utilise a CL model of service delivery. Some suggest the term 'liaison' nurse adequately describes their role whereas others have indicated that 'consultation' is an important inclusion. It is also debated that using the terms 'consultation' and 'liaison' is cumbersome. It has little meaning for other health professionals and is a model not confined to mental health clinicians working with general hospitals and emergency departments. Again, the aim for the CL SIG is to support these aspects of commonality and difference.

3.3. Common ground: where service is provided

The commonality of the environment in which service is provided, that is, the general hospital setting is another feature that has brought members of the CL SIG together. There are many challenges that present to the mental health nurse placed in a general hospital and / or an emergency department. Working with clinicians not specifically educated in mental health and working in the non-psychiatric acute health system can place the mental health nurse, who frequently works in isolation or a small team, in the minority. These nurses face an environment where clinicians lack mental health knowledge, skills and confidence to attend to the mental health needs of their patients within a system of care that emphasises physical care and tasks (Bailey 1998 1994, Gillette *et al.* 1986, Sharrock & Happell 2006, Wand & Happell 2001, Wynaden *et al*. 2000).

It is therefore not surprising that mental health nurses working in general hospitals have come together in the form of the CL SIG to draw collegiate support and gather ideas for practice from each other. However, it has also been explicated through debate within the group that mental health nurses in these settings work within differing roles, expectations and organisational structures. They use different models of service delivery

and work with different patient populations. The differences are evident with members of the CL SIG that work in other environments such as community settings for example, with nursing homes. This aspect has supported the notion that there are areas of commonality and difference that attract members to the group. However, this also complicates efforts to develop a consensus for describing or naming the work of members of the CL SIG.

3.4. Psychiatric / mental health nursing

There has also been debate within the CL SIG of the use of 'psychiatric' or 'mental health' to identify the nursing specialty of the group. Given the ACMHN has already used the term mental health nurse in its title, subsequently, this term was used. However, some members identify more closely with 'psychiatric' and the focus of working with people with psychiatric illness or crisis, and the associated body of knowledge and specialisation. The debate included that the specialist skills obtained through psychiatric nursing education might be eroded or diluted by using the term mental health, a more generic term that can be applied to a less specific body of knowledge and used by a range of practitioners. In contrast, some members identified with, the term mental health and the focus it provides to their specialist body of knowledge. The term mental health defined their capacity to contribute to a range of mental health related issues (not necessarily psychiatric illness) experienced by the client group they work with and the setting in which they work. As Barker states:

> The liaison mental health nurse appears to be trying to produce a form of care that is informed by certain skills, knowledge and values that belong within the mental health arena (the art and science of mental health care). At the same time they need to transform this art and science into a product that might meaningfully be used by a patient who stands outside the mental health setting (2002 p. 13).

A more detailed discussion of this debate is reflected in the literature (Barker 2002, Roberts 2002, Wand & Fisher 2006), hence will not be discussed in any further detail here.

4. CONTEXT: THE LITERATURE

The first documentation of psychiatric nurse consultation in the Australian literature was a description of the PCLN role as it developed at the Royal Prince Alfred Hospital in Sydney (Meredith & Weatherhead 1980). Later, Anderson and Hicks (1986) outlined the psychiatric nurse specialist role at the Westmead Hospital in Sydney. Since these early papers, there has been sporadic documentation in the Australian nursing literature (Hicks 1989, Sharrock 1989). However, this has increased in the last decade, with documentation by nurses of models of practice, service description and evaluation, theoretical discussion, specialist practice and clinical issues (Brunero *et al.* 2006, Brunero & Cowan 1997, Carter *et al.* 2006 2005 2002, de Crespigny *et al.* 2002, Fry & Brunero 2004, Gillette *et al.* 1996, Happell & Sharrock 2002, Harding 2005 1999 1998, McDonough *et al.* 2004 2003, Pollard 1996, Sharrock 2006, Sharrock *et al.* 2006, Sharrock & Happell 2006 2002a 2002b 2001a 2001b 2000a 2000b, Sharrock & Rickard 2002, Smart *et al.* 1999, Summers & Happell 2002, Usher *et al.* 2005, Wand 2005 2004a 2004b, Wand & Chiarella 2006, Wand & Fisher 2006, Wand & Happell 2001, Wand & Schaecken 2006).

The first CL nursing role in New Zealand was developed at Auckland Hospital in 1982. This role was not documented within the nursing literature but was presented to colleagues at a conference in 1984 (O'Brien A, communication on ANZMHCLN email network, 2005). To date, documentation within the New Zealand literature has been scant (Chiplin & Geraghty 1990, Pointon & Hancock 1998).

4.1. Contemporary influences on development

Mental health services to general hospitals are essentially developing in response to the recognition that:

- physical and psychological states are interdependent and both need to be attended to for optimal patient care;
- there is a higher incidence of mental health problems in the medically ill, particularly depression, anxiety and organic mental disorders, than in the general population;

- people who require attention post deliberate self-harm frequently present for care to emergency departments and may require ongoing care in the general wards;
- emergency departments are now the key access point for health emergencies of all types, including psychiatric emergencies; and
- health professionals not specifically educated in mental health / psychiatric care cannot adequately care for people with mental illness / psychiatric disturbance.

Political decisions on the direction of mental health care have also influenced service delivery models and precipitated the development of services, particularly to emergency departments. In Australia, many of the stand-alone psychiatric services have closed since the National Mental Health Policy (Australian Health Ministers 1992) set the direction for mental health reform. There has been a reduction of institutional models of care with an emphasis on mainstreaming. 'Mainstreaming' refers to the integration and co-location of psychiatric services into the general health system. This has influenced the provision of CL psychiatry services in general hospitals and emergency departments. In particular there has been an increase in the range and volume of mental health care issues within general hospital patients and systems (Hundertmark 2002, Stuhlmiller *et al*. 2004). It is also evident that clients of psychiatric services have shown increased rates of infectious disease such as hepatitis C, there have been increased vascular, respiratory and gastrointestinal disorders, and increased rates of injuries (Lawrence *et al.* 2001). Since mainstreaming, this client group is more likely to access general health services for care.

The impact of these reforms is that general hospital staff are having increased contact with people with mental health problems and subsequent need for skills to address mental health care issues within non-psychiatric settings. However, nurses working in non-psychiatric settings of general hospitals do not believe that they are adequately prepared to meet the mental health needs of patients (Bailey 1998 1994, Brinn 2000, Gillette *et al.* 1996, Happell & Sharrock 2002, Muirhead & Tilley 1995, Nurse Recruitment & Retention Committee 2001, Roberts 1998, Sharrock & Happell 2006, Wynaden *et al.* 2000). Nurses report a lack of knowledge, skills and confidence in the assessment and management of mental health problems in their patients (Brinn 2000, Bailey 1998, Edwards 1999, Fleming & Szmukler 1992, Gillette *et al.*, 1996, Roberts 1998, Sharrock & Happell 2006 2002, Wand & Happell 2001, Wand & Schaecken

2006). Evidence indicates that nurses in the general health setting find it particularly difficult when patient behaviour is perceived as difficult, threatening or disruptive (Happell & Sharrock 2006 2002, Heslop *et al.* 2000, Pollard & Hazelton 1999). Lack of resources, expert assistance and workplace policy in relation to people with mental health problems exacerbate these difficulties (Bailey 1998, Gillette *et al*. 1996, Wand & Happell 2001, Wand & Schaecken 2006).

In response to the direction set by National Mental Health Policy (Australian Health Ministers 1992), many of the state health departments have created initiatives to improve mental health support and services to emergency departments. Services arising from these initiatives have aimed to improve the response to the increased number of people that present to emergency departments requiring psychiatric assistance by increasing the presence of mental health clinicians in emergency departments. In Victoria, there was specific funding and policy direction for the prevention of suicide (Mental Health Branch, 1999). In South Australia, there has been a project looking at emergency demand management (Department of Human Services 2003). In New South Wales there has been an initiative that placed mental health Clinical Nurse Consultants into emergency departments (NSW Centre for Mental Health 1998, Wand & Fisher 2006). Similarly, the Western Australia mental health strategy included a key initiative aimed at increasing the number of specialist mental health nurses within emergency departments (Department of Health Office of Mental Health 2004). As a result, a number of psychiatric nursing roles are being introduced into emergency departments in Australia.

In contrast, the National Mental Health Plan (Australian Health Ministers 2003) recognised the interdependence between physical and mental health, that people with physical health problems have poorer mental health (pp. 9, 3 & 18) and set key directions in relation to service delivery (pp. 21-23). However, this has not translated to improvements in service delivery to this group of patients. State governments have not yet responded with initiatives for the improvement of mental health services to general hospital patients through policy direction and funding.

The result of this lack of attention to the development of CL Psychiatry in Australian hospitals is limited consistency in service delivery within the states and across the

country. CL psychiatry has historically provided psychiatric services to general hospitals but these services have not been systematically developed and have predominantly consisted of medical staff. The roles of other health professionals, particularly nurses, have been poorly developed (Smith *et al.* 1994) and like most states, psychiatric registrars have formed the "back-bone" of services in Victoria (Psychiatric Services Division 1996).

This has changed over the last ten years with nursing roles developing from locally generated needs and activity. For example, the position introduced at St. Vincent's in Melbourne was partly in response to the recognition that the medically focussed psychiatric consultation did not adequately address the needs of nurses when caring for general hospital patients with mental health problems (Sharrock *et al.* 2006). Additionally, increased costs and resources associated with nurse specialling (1:1 nursing observation of patients considered at risk) has led to PCLNs being introduced to a number of Melbourne major teaching hospitals. Evidence is accumulating that PCLNs can be effective in improving care and reducing associated costs of patients with mental state disturbance admitted to a general hospital setting. (Cross & Moore 2006, Forster J personal communication February 2007, North Western Mental Health 2006, McMillan 2005). Local evidence also supports the development of the PCLN role within Australia. This includes that the role contributes to improved patient care through improved access for staff to mental health resources, especially nursing expertise in the delivery of nursing care. The role provides education, input into organisational issues and policy development. It also facilitates links between acute and mental health services. Nurses report that the PCLN position offers a number of benefits including:

- improvement in their ability to deliver nursing care to patients;
- increased understanding of mental health issues;
- increased confidence and a sense of support in knowing there are resources available to assist;
- increased knowledge and skill;
- increased ability to recognise mental health issues in their patients; and
- demystification, de-stigmatisation and decreased fear of mental illness (Gillette *et al.* 1996, Happell & Sharrock 2002, Sharrock & Happell 2002a 2001b, Sharrock *et al.*, 2006).

In addition, local evaluation of nursing roles in emergency departments has demonstrated:

- considerable satisfaction with service delivery from staff and patients;
- improved waiting times and decreased length of stay;
- increased awareness and confidence of staff in relation to mental health issues;
- improved support and standard of care for patients;
- improved support and education for staff; and
- improved liaison with mental health services (Gillette *et al.* 1996, McDonough *et al.* 2004, Summers & Happell 2002, Wand 2004b, Wand & Schaecken 2006).

4.2. Profile of CL nursing

It is not possible to accurately determine how many nurses are working in PCLN positions or the current profile of CL psychiatry services in Australia. Smith *et al.* published a survey in 1994, but it is clear that PCLN roles have developed considerably since that time. The survey undertaken in this project was in part, an attempt to capture a current understanding about the role of this evolving sub-specialty of psychiatric / mental health nursing.

A literature review identified that only two surveys relating specifically to CL nursing have been conducted. These were both from the United Kingdom. The first was undertaken by Tunmore (1994) and reported briefly in a journal article on CL nursing. This survey of 35 liaison mental health nurses (LMHNs) was accessed through the Royal College of Nursing LMHN special interest group. There were 32 respondents. Areas surveyed included work setting, specialist practice, consultation and liaison work, educational preparation and research activity. This survey highlighted that LMHNs in the United Kingdom were employed at senior levels and worked with a range of patients including those experiencing mental health problems associated with physical illness as well as those attending emergency departments. The majority worked within some form of psychiatric service or department. Position titles varied with ‘liaison’ included in the titles of 14 respondents. Uncertainty in relation to the adequacy of educational preparation was expressed by 14 of the respondents, 14 were satisfied with

their preparation for the role, nine reported having no specific training and 15 reported that the role developed out of 'trial and error'.

Roberts and Whitehead (2002) conducted a second survey of the CL nursing position and explored similar areas in relation to practice. There was an increased response with 78 returns reflecting the growth in this specialty area within the intervening years. This survey also highlighted that the respondents were experienced nurses with 97% having more than six years experience post qualification and over 50% having more than 11 years experience. Sixteen respondents held a Masters degree and three held a PhD. Job tiles varied but the word 'liaison' was included in the majority of titles. The majority of LMHNs worked with deliberate self-harm, 53 included the emergency department in their area of practice and 33 stated they worked specifically in emergency departments. Crisis intervention was the most commonly utilised therapeutic model (75% of respondents). The authors suggested this was consistent with the high proportion of respondents working with deliberate self-harm. Forty-seven nurses were involved with ward consultations. This finding highlighted that liaison nursing development in the United Kingdom has been focussed on deliberate self-harm and emergency department work which as the authors state is consistent with government health policies targeting suicide reduction. Referrals were most commonly received from medical (61) and general nursing (41) staff with 28 receiving referrals from psychiatrists. 61% were actively involved in the education of staff within the general hospital. The majority (44%) were employed by mental health services and 22% were employed by the acute health sector. The authors concluded that whilst LMHN had seen a period of rapid growth it had primarily been in the area of deliberate self-harm. LMHNs worked in small teams, in relative isolation and experienced difficulty introducing and establishing these new roles. Despite this, the authors believed that the role was likely to continue to develop.

Scott (1999) undertook a postal survey of self identified clinical nurse specialists working in a range of nursing specialties in the United States. Eighty-four of the 724 respondents were mental health / psychiatric nurses and it is likely that a number of these nurses worked in CL nursing roles. It was noted that the clinical nurse specialists that responded to the survey identified five characteristics of a specialist role: expert practitioner, educator, consultant, administrator and researcher, all aspects of the CL

nursing positions. The limitation of this survey was the mental health nurse sub-group was not reported on separately, thereby providing minimal information that was relevant to the survey of Australian CL nurses.

5. METHODOLOGY

An exploratory design was selected for this study. The researchers developed a survey that consisted of two main parts. Firstly to collect general demographic data and secondly to collect information related to qualifications and experience, clinical practice, organisational structure, clinical supervision, education and training and work satisfaction (Appendix 2). The content of the survey was informed by the previously cited surveys from the United Kingdom (Roberts & Whitehead 2002, Tunmore 1994). The survey included questions exploring the respondents wish to join a special interest group. Data collected from this question was used by the developing CL SIG to begin its establishment and therefore is not included in the findings.

No definition of CL nursing was provided within the survey because it was thought that 'consultation-liaison' was a generally understood term in which there was some degree of consensus as to its meaning. That is, mental health nurse experts who provide expert consultation to health professionals in a non-psychiatric setting.
However, the debate that ensued on the email network (ANZMHCLN 2007) described earlier in this report, highlighted that this was not the case. Those who responded to the survey presumably identified themselves in some way as CL nurses or with the group and in reviewing the responses to the survey, it could be argued that only two responses were not describing CL nursing roles (see findings).

The surveys were distributed between May and October 2005 via e-mail networks including the Australian and New Zealand Consultation-Liaison Nurses e-mail discussion group, the Australian and New Zealand College of Mental Health Nurses and the Royal Australian and New Zealand College of Psychiatrists. The surveys were also distributed to attendees at the 2005 CL Nurses conference in Adelaide.

Surveys were returned to the research assistant and subsequently entered into an electronic spreadsheet. In order to maintain confidentiality, the identifying demographic information collected for the CL SIG was removed by the research assistant and forwarded to the secretary of the group. Data from the survey was handled in a manner

consistent with the Australian National Privacy Principles (National Health & Medical Research Council 1999, Office of the Privacy Commissioner 2000).

The design of the survey yielded both quantitative and qualitative data. Quantitative data were entered into a database using the package Statistical Package for the Social Science (SPSS) format. Qualitative data were coded according to commonalities for use within the SPSS format by the researchers in a face-to-face meeting. A qualified statistician using the SPSS program then undertook statistical analysis of this data. As an exploratory, descriptive study, this analysis was essentially identification of frequency of responses. The final question related to work satisfaction and revealed a depth of qualitative responses. The researchers therefore, undertook thematic analysis of the written responses to this question. The transcripts were reviewed by each of the researchers independently, initially breaking the transcripts into words of phrases that held a concept. The researchers grouped words and phrases with similar meaning. The final step was to collaboratively identify the major themes. The findings are presented in the next section of this report.

6. FINDINGS

Fifty-six nurses responded to the survey. Due to the method of distribution, a response rate could be determined. The majority of the respondents worked within general hospital wards, emergency departments and the community. One respondent worked in justice health (court liaison) and one in GP (General Practitioner) liaison. It could be argued that these two positions were not CL nursing roles but given there was no definition included in the survey that excluded these roles, these two surveys have been included in the findings.

Each state of Australia was represented: New South Wales (20), Victorian (16), South Australia (10), Queensland (5), Western Australia (3), Tasmania (1) and Australian Capital Territory (1).

6.1. Qualifications and Experience

Forty-two respondents held a hospital certificate, 34 held a bachelor degree, 20 held a post graduate certificate and 26 held a post graduate diploma. Six had completed a Masters degree, three by research and three by coursework. No respondent held a Doctoral degree.

The respondents were an experienced group of nurses with 5-36 years as a registered nurse (mean 19.5 years), 1-31 years in mental health nursing (mean 16.5 years) and 0-11 years in CL nursing (mean 4.1 years). There were 1073 collective years of experience in nursing within the respondents

6.2. Scope of clinical practice

The survey asked the nurses to identify their area of practice. Forty-three worked in general medical / surgical wards, 40 worked in emergency departments and 32 identified both areas of practice. Twenty-seven respondents identified the care of older persons as their area of practice with four respondents specifying working with nursing homes. Seventeen respondents worked in maternity services, 16 with rehabilitation

services and ten in paediatrics. Seven respondents specified working with specialist medical units such as haematology, oncology, nephrology, palliative care and cardiology. Four respondents specified working with specialist surgical units such as burns, orthopaedic and plastics units and four specified the intensive care unit. Other areas of practice identified included community agencies such as non-government organisations; the police; the Criminal Justice System; community workers and groups; Veterans Health services and general practitioners.

When asked to identify their primary area of practice, 19 identified the emergency department, seven general wards, three identified both the emergency department and general wards and three older persons. Fourteen respondents identified no primary area of responsibility.

The majority of majority of CL Nurses responding to the survey (50) provided assessment and treatment services to inpatients and a significant number worked with outpatients (32) and day patients (19). Twenty-three respondents worked with the families and other carers of patients. Staff with mental health problems constituted the clientele of 23 respondents and three did not answer this question.

The respondents provided education to a range of staff including: 54 to nurses, 46 to other health professionals, 44 students, 36 mental health workers, 32 patients and families and 24 community groups. One did not answer this question.

6.3. Hospital / department size

Most (33) respondents worked on 1 site, seven worked across 2 sites, one across 3 sites, two across 4 sites and two across 5 sites. There were six respondents who worked at multiple sites (range between 6-27 sites). These nurses tended to work in rural and community settings and had contact with multiple services of similar type such as aged care facilities, emergency departments and rural hospitals. Five did not answer this question.

Respondents were asked to estimate the number of beds in the department or hospital in which they worked. There were 55 responses to this question. Bed numbers ranged from

14 to 700. Eighteen respondents worked in settings with less than 200 beds and 18 worked in settings with 200-400 beds. Ten respondents worked in large hospitals with greater than 400 beds.

In addition, respondents were asked to estimate the number of nurses employed in the department or hospital in which they worked. There were 34 responses to this question and nursing staff numbers ranged from 14 to 7200. Fifteen identified 14-150 nurses, nine identified 300-1000 nurses and ten greater than 1000 nurses.

6.4. Requests for consultation

The respondents received requests for consultation from a range of staff within their respective services. The vast majority received requests from nurses (54), other health professionals (54), mental health workers (46) and other members of the CL team (40). Other sources included community services (35) and patients and carers (25).
The survey asked the respondents to "Describe the patient referral process to you and/or your team". Analysis of the responses indicated that an informal process dominated with 39 respondents describing accepting verbal referrals. Referrals were predominantly (41) direct to the CL nurse or team. Twelve respondents indicated that referrals came via a triage function with only 20 indicating that they received written referrals. Six respondents did not answer this question.

6.5. Organisational structures

Position titles varied enormously. Forty-six titles included the word *nurse*, 23 included the word *consultant*, 16 included the words *consultation liaison*, 11 included *liaison* only and one used *nurse practitioner*. One respondent did not answer this question. Sixteen respondents indicated that managerial responsibilities were part of their position. 39 did not have these responsibilities. One respondent did not answer this question.

Salaries also varied from $54214 to $78588 (Australian dollars) per annum. The average wage was $69674. One respondent did not answer this question.

The wage breakdown per state is provided below:

State	Salary range	Base level salary	Date of award
Queensland	$54214-$68117	$37595	25/12/05
Tasmania	$68451	$38048	1/12/05
Victoria	$64132-$78588	$38386	1/10/05
South Australia	$57756-$70589	$40413	1/10/05
Western Australia	$71710	$40842	1/7/05
New South Wales	$59259-$77912	$42193	1/7/05
Australian Capital Territory	$76543	$42308	8/9/05

Respondents were asked to provide detail about the reporting processes for their position. Thirty-five respondents identified that they reported to mental health services, 16 reported to non-mental health services, three were not clear and three did not answer. The profession of the direct line managers of the respondents were as follows: mental health nurse (29), psychiatrist (7), nurse - not specified (5), director of nursing (4), manager - not specified (3), non-mental health nurse (2), medical practitioner - not specified (2), occupational therapist (1), social worker (1) and one reported to a mental health nurse and a psychiatrist. One respondent did not answer the question.

Thirty-four respondents were part of a CL team. These respondents provided the following information about team structure. The team size ranged from 0.7 – 12 full time equivalents (FTE) (four did not answer). The nursing FTE ranged from 0.5 – 7.5 (four did not answer). In addition to nurses, the teams consisted of psychiatrists (22), psychiatric registrars (15), psychologists (13) and medical staff not specified (10). One team included a social worker, one a drug and alcohol nurse and one included caseworkers.

There was no statistically significant difference between the pay rates of nurses with managerial responsibilities and those without, working within a CL team or not, or working in smaller or larger teams.

6.6. Clinical supervision

Forty respondents received clinical supervision and the majority (28) of their supervisors were nurses (18 not specified, seven mental health nurses and three CL nurses). Nine supervisors were psychiatrists, one was a psychiatric registrar and one was a psychologist. One identified having a psychiatrist or psychiatric registrar as supervisor and another had two supervisors, a psychiatrist and mental health nurse. Fifteen CL nurses did not receive clinical supervision and one did not answer this question.

Thirty-five CL nurses provided clinical supervision. The supervisees were primarily nurses with 16 supervising non-mental health nurses, 14 mental health nurses and 12 CL nurses. Other groups receiving supervision form CL nurses included students (3), others (4) and one did not answer this question. Six respondents who provided supervision did not receive their own clinical supervision.

6.7. Educational preparation

The question "What do you believe should be the minimum educational requirements to work as a CL nurse?" resulted in a range of responses. The majority proposed higher degrees such as a post graduate qualification in mental health nursing or equivalent (22), masters (10) or working toward a masters (4). One respondent believed a hospital certificate was adequate and four proposed a bachelor degree was required. Twelve respondents were unsure and three did not answer this question.

Of the 56 respondents, nine indicated that qualifications higher than they held were required for the role. That is, they were currently under-prepared for the role but had sufficient educational backgrounds to be pursuing the qualifications that they thought were required for the position. Twenty-three respondents held the same level of qualifications that they believed were required for the role and nine had qualifications that were higher than they believed were required for the position.

The respondents were asked to specify if they had undertaken education specifically to enhance their ability to work as a CL nurse. Twenty-nine indicated they had, 16 had not,

two planned to and six did not answer. Three identified informal education as their only source of education. Seven indicated they were undertaking postgraduate studies to assist in their practice and six were undertaking a masters program.

The survey asked "Are there education programs that you would like to see available for CL nurses?" Seven indicated the need for postgraduate certificate / diploma level of academic programs and five wanted programs at masters level. Respondents indicated that programs should be "easily accessible for rural and remote areas", that there is a "need to bear in mind that the role is different across organisations" and "that support to attend ongoing education should be provided".

There was significant overlap in the content of the responses to the two questions relating to educational preparation (questions 3 and 7). Subsequently, these were analysed together. The responses generated a list of topics that could be considered as potential areas of self-education for CL nurses and also provide potentially useful content for a CL specific nursing program:

- Specialised training for the specialty area that covers issues faced by CL nurses and includes content related to general hospital / CL psychiatry
- Role definition and models of practice
- Development of skills when working within a system
- Input from experienced clinicians
- Interventions with anger
- Aggression management, including control and restraint training
- Alcohol and other drugs
- Advanced physical and mental health (including risk) assessment
- Psychopharmacology
- Suicide interventions
- Advanced communication and negotiation skills
- Interventions with clients commonly seen short term in CL nursing and ED: (interventions in depression, borderline personality disorder, anxiety and stress, adjustment to illness)
- Mental health issues specific to age range including adolescent, adult and older people

- Organic issues including biological aspects of illness, toxicology and delirium
- Medico-legal aspects including the mental health act and documentation
- Interventions with staff including clinical supervision, critical incident stress debriefing and adult education
- Evidence based practice and research

In addition, a range of psychotherapies were identified as useful learning topics:

- General psychotherapy and counselling
- Counselling specific to persons with physical illness
- Brief solution focused therapy
- Cognitive behavioural therapy
- Dialectical behaviour therapy
- Family therapy
- Gestalt therapy
- Grief and bereavement counselling
- Group therapy
- Trauma counselling

Art therapy, aromatherapy, massage therapy and personal construct psychology qualifications were held by respondents but were provided in response to question 3 (qualifications held). It was not clear if these qualifications were considered by the respondents to be useful for work in CL, or whether they were held incidentally whilst working in this role.

The respondents identified the importance of informal and self-directed learning. This included attending conferences, workshops, reading, on-the-job training and practical experience, networking with colleagues and attending inservice education programs.

6.8. Work satisfaction

The final question of the survey showed some of the most insightful results. It was an open-ended two-part question that asked: “Do you enjoy being a CL Nurse? (comments / explanations very welcome)”.

The first part of this question was quantitative. The responses are summarised as follows:

- Three did not respond to the question, one explained that they had been in the role, "for just a few weeks and it's too soon for me to tell yet";
- Two respondents answered in the negative, but qualified their answers. They described they had enjoyed being a CL Nurse previously, but their negative experience resulted from a changed workload and role expectations;
- Fifty-one answered positively about their experience in the CL Nurse role. This represented 96% of those who responded to this specific question.

The second part of the question captured information about the experience and work satisfaction of CL nurses. The responses were coded into major themes and are described in the following sections.

6.8.1 Enthusiastic positive comments and adjectives [n = 22]

This theme was the most common, with 39% of those surveyed describing that they enjoyed being a CL nurse. They used enthusiastic comments and adjectives including "Best job so far", Love it!, "I enjoy CL work tremendously", and "I thoroughly enjoy working in CL". The authors' favourite response within this theme was this one-word response to the question "Do you enjoy being a CL Nurse?" … "Indeedy!"

The remaining themes provide insight as to why the majority of responses were positive and enthusiastic.

6.8.2 Professional relationships / collaboration / education [n = 20]

This theme was the second most common theme to emerge from the survey. A third of those surveyed identified these aspects of CL Nursing as a positive experience of their role. The responses indicated that the duality of clinical and educational work within CL nursing was significant to work satisfaction:

> I gather most job satisfaction from impromptu spontaneous education sessions centred around a ward patient. Those situations where you 'just drop in' to check on a patient, quick entry in case notes, but ends up being given a few questions by a genuinely interested general nurse.

These responses indicated that mutually respectful, collaborative professional relationships are both achievable and desirable:

> I enjoy the education/training role both formal and informal. I have been part of this team for many years and have developed several strong working relationships [within the] mental health system as well as the general system.

and

> Working alongside staff in another specialised area in health - we can learn a lot from each other.

Other respondents shifted the focus from the process of collaboration to the outcome:

> [It's satisfying] supporting nursing staff to develop their skills in managing challenging patients.

The emphasis of professional relationships, collaboration and "networking with motivated CL nurses" was also considered important for satisfaction in this role. The significance of connection via a network that facilitated otherwise autonomous, often isolated, practitioners to collaborate with their peers was highlighted as follows:

> The 'cyberspace links' CL nurses and adds to the enjoyment of the role!

6.8.3. Autonomy / scope of practice [n = 16]

A sense of CL Nurses taking pride in their capacity to work more broadly across health systems was evident in many of the responses:

> Working outside the usual scope of nursing practice and in a non-traditional nursing environment has allowed me to broaden my professional outlook.

Unburdened by traditional hierarchal models of practice, the nursing skills and knowledge of the CL nurse were considered valuable and effective to the health system:

> Especially the autonomy…I particularly like the fact that I see patients and decide the appropriate referral required.

It was noted that CL nursing provided another career pathway for mental health nurses:

> I enjoy being able to still be a clinician at a senior level.

6.8.4. Challenging [n = 16]

This theme captured comments of the challenges experienced in CL nursing positions.

The presentations of acute hospital patients with psychiatric co-morbidities can be a:

> Complex clinical area, challenging assessment and care planning, busy, rapid work throughput.

and:

> Overwhelming…difficult keeping skills up to date.

Providing mental health education in an acute hospital setting was challenging in that:

> The stigma and lack of mental health knowledge of other staff gets wearing.

Respondents identified the diversity of the role and the opportunities to learn and apply a range of skills as a positive aspect of the position:

> It provides a great challenge to be a truly holistic nurse.

6.8.5. Variety / interesting / stimulating n = 13

Respondents described the diversity of the role and client presentations inherent in the CL model as an advantage:

> Very much enjoy this role. Diversity, challenging, contact with staff of various disciplines, contact with clients, families, community. Learn new things, information etc. Keeping abreast with current trends and planning for future policies etc.

This was identified in providing a service away from traditional mental health settings:

> It's stimulating with the focus on the patients and nursing staff in the general hospital.

One respondent identified both variety and repetition as enjoyable:

> I enjoy the variety from day-to-day, even allowing for the common themes of presentations (delirium, dementia, depression, deliberate self-harm).

6.8.6. Advocacy / promote mental health care / decrease stigma [n = 11]

Respondents identified their role in mental health promotion in terms of goals and outcomes of CL nursing:

> [The role serves] to improve the mental health care of general hospital patients, reduce stigma and to improve the skills of health professionals not specifically educated in mental health.

and:

> My particular niche enables me to work towards demystifying issues relating to mental illness.

It was important to many respondents that their role made a difference:

> The ability to advocate for clients in a system where their mental health would otherwise be overlooked.

and:

> One can make a real difference for patients with mental health needs in the ward setting, plus their families etc.

6.8.7 Using a range of skills [n = 9]

Respondents identified that the CL nurse role requires a breadth of skills:

> It provides me with an opportunity to utilise my clinical, educational and organisational skills.

and:

> [The role] combines problem solving, education and autonomy.

The most common response on this theme was of combining skills and knowledge:

> [I enjoy] being able to marry my general and mental health skills together.

6.8.8. Lack of resources / support [n = 9]

Respondents described the negative impact of this theme. Descriptions made by the two respondents who answered that they previously enjoyed CL Nursing before their workload and expectations of their role changed were noted.

High workload and minimal team / organisational support emerged as recurrent themes:

> Until this job 'yes', this position 'no'. It is too isolated. It has little to no support from the mental health team or psychiatrist.

and

> Used to. Workload now horrendous. Little medical cover. Expectations enormous…Clinical load greatly increased though explosion of presentations…with less time to deal with them though the clerical/paperwork aspect of the job.

Even though respondents enjoyed the work, there was a consensus with the difficulties associated with the lack of this support:

> [There is a] lack of managerial support, atrocious team dynamics with too many medical staff, on-going changes due to 'restructuring' of mental health service and planned relocation of hospital. Workload is very heavy with little time for developing education packages etc.

The final comment noted on this theme reflects a concern that the eclectic, yet specialised nature of CL nursing is not catered for by an existing learning path or within traditional nursing practice:

> It is hard to update personal practice when at this level there seems to be little supervision and education available from staff that have experience in CL. Some courses, especially on counselling, are too basic, so it's hard to advance personal knowledge.

6.8.9. Politics [n = 8]

Of those respondents who identified organisational politics as a negative part of the job, only two elaborated on this theme:

> However [I] hate [the] politics and red tape, especially information systems and data collection.

and:

> The Paediatric Unit is very unfamiliar with CL nursing and it is taking a long time for them to adapt. Not utilised to full position potential. Medical officers very much control the nursing work.

6.8.10. Recognition [n = 6]

This theme arose in the least number of responses, indicating that some CL Nurses receive positive feedback, whether implicit or explicit, in the course of the working day:

> liaison work is well appreciated.

and:

> I have found it a much needed and appreciated role by medical, nursing and allied health staff, but more importantly by the patients I have seen.

One respondent stated “I think they like me” suggesting that being a mental health clinician in a general health setting can contribute to personal insecurity.

6.8.11. Rewarding/fulfilling [n = 16]

The following statements summarise the rewarding and fulfilling experiences of the respondents in the CL nursing role and conclude this survey report:

> I've grown professionally and personally because of this. I understand my limitations better.

and:

> Very rewarding and extremely satisfying work – I enjoy bridging psychiatry and general medicine.

Finally:

> It’s the most satisfying position I’ve held.

7. LIMITATIONS

This survey was the first of its kind undertaken in Australia and the limitations have been identified.

The number of CL nurses working within Australia is not known and there is no well-established mechanism for accessing these nursing staff.

The SIG is developing as a robust network and professional association, but it has only been recently developed. Subsequently, it is likely that many nurses working in the CL role may not know about or have access to the group. Given the SIG was the primary means of alerting the profession to the survey, it is likely that many CL nurses were missed in this survey. No clear definition of what constitutes a CL nurse was provided with the survey. Hence, the self-identification of respondents with this terminology determined their participation. It is evident from the debate in relation to terminology that many potential respondents may not have participated in the survey because they did not relate to the terminology. Potential respondents may also have been influenced because of the inclusion of CL SIG section at the introduction to the survey. This made a clear statement of potential affiliation with the ACMHN and nurses who did not support this affiliation may have declined to participate in the survey.

The questions in relation to educational preparation and educational training programs (question 3 and 7) were poorly articulated leading to confusion in analysis of the responses. The material generated does provide guidance to developing CL nurses on educational programs or bodies of knowledge that might be helpful for self-education purposes. It also provides some ideas for potential curriculum development for CL nurse programs. However, it lacks specificity in terms of linking particular bodies of knowledge with the contribution that it makes to practice.

It would also have been useful to add medical staff as a specific category option for the questions relating to requests for consultation and provision of education (question 4). This may have provided useful evidence about the role of CL nurses in supporting and educating medical staff.

8. CONCLUSION

The Australian CL Nurses Survey was the first of its kind undertaken in Australia and was the first major project of the ACMHN CL SIG. This report provides the background to and context within which this survey was undertaken. Whilst the project had some limitations, it provided data on this developing specialty of mental health nursing. The findings demonstrated that CL nurses in Australia are an experienced group of nurses working in a range of clinical areas. They receive requests for consultation from a range of health professionals and also provide education and clinical supervision to a range of staff groups. Most respondents enthusiastically expressed satisfaction with their work.

There is no consistent use of titles to describe the role and the majority of CL nurses report to mental health services. The minimum educational requirement to work in the role was considered to be a higher degree. The survey indicated that there is a lack of education suitable for CL nurses and a clear request for a program from the respondents. This orientates us to a possible reason why the CL nurse conferences and e-mail network are so highly valued by participants.

The findings of this survey provide the profession with further understanding of the CL role and provide the CL SIG with information for further research and development of the role. It would be valuable to repeat the survey in the future as the CL SIG continues to develop and expand.

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APPENDIX 1: CONSULTATION LIAISON SIG RULES

STATEMENT OF PURPOSE

The primary purpose of the ANZCMHN Inc (The College) Consultation Liaison (CL) Special Interest Group (SIG) is to promote interest in and development of CL nursing. The CL SIG provides members of The College, who have a particular interest in CL, with a forum for exchanging news, views and ideas in this evolving/emerging sub-speciality in mental health nursing. The CL SIG promotes research endeavours and other matters of interest in CL by sponsoring an annual conference and via other means such as meetings or workshops that are considered timely and worthwhile. The CL SIG operates within the framework of The College's general guidelines for SIGs.

SPECIAL INTEREST GROUP EXECUTIVE COMMITTEE

1. The CL SIG Executive Committee shall consist of a Chairperson, Secretary, Finance Manager and an Education Officer. The executive committee provides general oversight for the operations of the CL SIG and recommends to the College, Board of Directors, policies and procedures for the formation, operation and dissolution of the SIG for The College review and approval.
2. Upon approval of these policies and procedures by the College, the SIG Executive Committee shall have responsibility for their implementation.
3. The CLSIG will operate under the Constitution of The College.
4. The CL SIG must consist of at least twenty five members. A quorum for annual general and extraordinary meetings will be half plus one.
5. The CL SIG Executive Committee may co-opt expertise from time to time as required to supplement the committee's expertise in dealing with particular issues.

FINANCIAL MANAGEMENT

1. The CL SIG shall manage all financial matters in accordance with the financial rules of The College.
2. All monies associated with the operations of the CL SIG shall be endorsed by the Finance Committee of The College, on consultation with the CL SIG.
3. The CL SIG will provide a projected budget to the finance committee before May of each year for consideration, after which an operating budget will be allocated.

4. The financial records of the CL SIG shall be included in the audit of The College accounts by a Certified Public Accountant appointed by The College, Board of Directors
5. The report of this audit shall be made available to The College membership in a College publication.

ELECTED OFFICERS

1. The elected officers of the CL SIG shall consist of a Chairperson, Secretary, Finance Manager and Education Officer. The term of office for these positions shall be for two years with an option of a second term.
2. These elected officers must be current financial members of The College.
3. These officers shall be elected by a vote of the membership of the CL SIG.
4. The voting process is within the Constitution of the College.

The duties of the Chairperson shall be:

1. To oversee the CL SIG and ensure it carries out its role effectively and efficiently.
2. To chair committee meetings/teleconferences.
3. To ensure the elected officers have the information they need to carry out their roles effectively.
4. To report to The College, Board of Directors, on CL SIG matters including recommendations that need to be approved via The College Executive Officer.
5. To prepare a written report on the activities of the CL SIG for the Board of Directors for presentation at The College AGM.
6. In the case of equality of voting the Chairperson shall have a second or casting vote.

The duties of the Secretary shall be:

1. To be primarily responsible of communication with members of the CL SIG
2. To maintain a membership list of the CL SIG and forward this to the Executive Officer of The College as determined by the Board of Directors
3. To ensure meeting agendas are prepared and distributed
4. To ensure meeting minutes are taken

The duties of the Finance Manager shall be:

1. To ensure the CL SIG complies with the financial rules of The College.

2. To ensure the finances of the CL SIG are managed in accordance with the statement of purpose of the CL SIG

The duties of the Education Officer/s shall be:

1. To co ordinate and facilitate the activities of the annual clinical conference
2. To disseminate information to the membership in relation to recent evidence based practices, research developments and other educational matters of interest to the CL SIG
3. To explore opportunities for collaboration between the CLSIG and other organisations or institutions as appropriate.
4. This position holds one vote

CONFLICT OF INTEREST

Any elected officer of the CL SIG must declare their conflict at the start of any discussion and request the time of departure from discussion be recorded in the minutes. If it is deemed that the officer needs to leave the meeting room the time of their departure and return be recorded in the minutes.

DISSOLUTION

1. Action to dissolve the CL SIG shall be by a meeting of the members of the CL SIG with a two third majority vote.
2. Written notice of the dissolution is to be forwarded to The College, Executive Officer as soon as practicable after the meeting.
3. The College, Board of Directors may dissolve the CL SIG for failure to comply with The College constitution and or rules.

REVIEW PROCESS

These rules will be reviewed yearly.

CHAIRPERSON PRESIDENT **CL SIG ANZCMHN**

Cecily Pollard May 2006

APPENDIX 2: CONSULTATION-LIAISON NURSES SURVEY 2005

Thank you for taking part in the Psychiatric Consultation-Liaison (CL) Nurses Survey. This survey has been developed as an initiative of the CL Nurses Group.

The Psychiatric / Mental Health nursing role in CL Psychiatry has undergone significant development in recent years. CL nurses work in a range of environments including general hospitals, emergency departments and the community. The need to communicate with colleagues in this developing specialty has become increasingly apparent. To this end there have been a range of activities including the development of local networks, forums and an email discussion group. These networks are loosely known as the CL Nurses Group.

The 3rd CL Nurses Forum will be held in Adelaide May 13-14th 2005. Participants in past forums have travelled from within Australia and from New Zealand. The forum aims to reduce the isolation of CL Nurses and to create an opportunity for networking, sharing ideas and education in a stimulating and supportive environment. There is also a desire to raise the profile and establish and develop the identity of CL nursing.

In addition, the Australian and New Zealand Consultation-Liaison Nurses email list was established as a mechanism by which CL nurses can communicate with each other to share ideas and information. The tone of the list is casual, generous and supportive. Both the traffic on the list and the member numbers are increasing (the 100th member subscribed in November 2004).

At the June 2004 CL Nurses forum held in Cairns, Queensland, it was decided that in order to improve our understanding of this developing specialty, it would be useful to gather information on CL Nurses in Australia. The survey is aimed at CL nurses working in a range of settings and includes questions relating to demographics, qualifications, experience, clinical practice and organisational information. The information gathered from Sections 3-8 will be collated and made available to participating nurses and other interested parties through the Australian & New Zealand Consultation-Liaison Nurses email discussion group and the 2006 CL Nurses Forum. Consideration may also be given to publication of the findings. The data from Sections 1 and 2 will be separated from the remaining data and will be used for communication regarding the development of a CL specialty group. This development is consistent with discussion at the 2004 CL Nurses Forum held in Cairns. Please see next section for discussion of this development.

The development of a CL Specialty Group within the ANZCMHN

At the 2004 CL Nurses Forum, it was recognised that in order to develop a stronger identity and political voice, and to continue to organise the annual forum, the CL Nurses Group needed to become more formalised. The option of establishing a specialty group of the Australian & New Zealand College of Mental Health Nurses (ANZCMHN) was proposed and discussed. Mr Stephen Elsom, President of the ANZCMHN presented information on the College and is summarised as follows:

The Australian and New Zealand College of Mental Health Nurses provides professional leadership and encourages excellence in mental health nursing by:

–promoting a positive identity for the profession

–encouraging unity within the profession

–promoting best practice in mental health nursing education and training

–promoting the development of best practice in nursing care

–facilitating partnerships between mental health nurses and consumers, carers, indigenous people and other stakeholders in mental health

The College operates under a branch structure consisting of state based branches that are linked through a National Executive and Council. A paid Executive Officer has been appointed during 2004 to facilitate the operations of the ANZCMHN with the aim of improving service to members. The College is a professional body run by and for its members. Over recent years there has been a significant amount of effort put into the supporting the relationship with the New Zealand Branch. During 2004 the New Zealand Branch dissolved to establish its own national mental health nursing organisation.

There are no current specialty groups of the College so if the CL Nurses Group proceeds, it will be a first. There are no current constitutional guidelines for their function so these will need to be developed. A specialty group could be run as a national organisation with an allocated bank account organised through the national treasurer. Office bearers would need to be selected but there would not be an expectation to run the group as a branch. There is potential to utilise the website and the infrastructure support, for example in organising the forum. There is an opportunity to provide a voice for CL nurses at a national level, to support academic links and endeavours and contribute to the strengthening of CL nursing identity. There is interest from other specialist psychiatric nurses to form similar groups so this would add strength to the voice of the groups.

The decision was made at the 2004 Forum to further explore this option and it is hoped that establishment of the specialty group will progress at the 2005 Forum in Adelaide.

Use of information and privacy statement

The information gathered in this survey will be handled in a manner consistent with the Australian National Privacy Principles.

For further information go to http://www.privacy.gov.au/publications/npps01.html

Please return your completed survey to:

Catherine Roberts
Research Assistant
catherine.roberts@svhm.org.au or
C/O St. Vincent's Mental Health Service
PO Box 2900
Fitzroy 3065 Victoria

Thank you again for participating in this survey.

Jenni Bryant, John Forster, Paul McNamara and Julie Sharrock
on behalf of the CL Nurses Group
April 2005

Contact details:

Jenni Bryant, Newcastle Mater Misericordiae Hospital, Newcastle NSW, Jenni.Bryant@mater.health.nsw.gov.au
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Julie Sharrock, St. Vincent's Mental Health Service, Vic, julie.sharrock@svhm.org.au

1. DEMOGRAPHICS

Name: .....

Employer: .....

.....

Address: .....

.....

Phone: ..... **Pager:** .....

Fax: .....

Email: .....

Are you a member of the CL Nurses email list? Yes No

(more information go to:

http://groups.yahoo.com/group/AandNZConsultationLiaisonNurses)

Particular areas of interest: .....

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.....

2. CL SPECIALTY GROUP

Are you a member of the Australian and New Zealand College of Mental Health Nurses? Yes No

Would you like to be involved in a CL specialty group within the ANZCMHN?

Yes No

What activities would be the most useful? Mark in order of preference 1 (most)-5 (least):

Networking

Advocacy

Educational opportunities

Information sharing

Peer support

3. QUALIFICATIONS & EXPERIENCE

Qualifications (tick as many as are applicable& specify where asked)

Hospital certificate

Bachelor degree

Postgraduate certificate

Postgraduate diploma

Masters by coursework

Masters by research

PhD

Other (please specify): .....

Years of experience as a Registered Nurse? .....

Years of experience in Mental Health nursing? .....

Years of experience in CL nursing? .....

4. CLINICAL PRACTICE

Areas of practice (tick as many as are applicable & specify where asked):

Emergency department

General medical / surgical wards

Rehabilitation

Maternity

Paediatrics

Older persons

Nursing home

Other (please specify) .....

.....

.....

Is one of these areas your primary area of clinical practice? (if so, which one?).....

.....

Estimate the number of beds in the department/hospital .....

.....

How many sites do you need to visit? (ie hospitals or departments at different locations) .....

.....

Estimate the number of nurses employed in the department/hospital .....

Do you provide formal education to (tick as many as are applicable):

Nurses

Other Health professionals

Students

Mental health workers

Community groups

Patients and families

Do you provide assessment and treatment services for (tick as many as are applicable):

Inpatients

Outpatients

Day patients

Families and other carers

Staff with mental health problems

Do you accept requests for consultation from (tick as many as are applicable):

Nurses

Other health professionals

Mental health workers

Other members of the CL team

Patients or carers

Community services (eg NGO's GPs)

Describe the patient referral process to you and/ or your team: .....

.....

5. ORGANISATIONAL STRUCTURE

What is your position title? .....

What is your Grade? .....

In what state / territory do you practice? .....

Do you have managerial responsibilities? Yes No

What discipline is your direct line manager?

Mental health nurse

Psychiatrist

Medical practitioner

Other (please specify) .....

Is your position placed within a CL team? Yes No

Provide a brief description of your organisational structure: .....

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How many nurses are in your team? .....

What is the total nursing FTE? .....

What is the total FTE of your team? .....

What disciplines make up your team? .....

.....

.....

6. CLINICAL SUPERVISION

Do you receive clinical supervision? Yes No

If yes, what discipline is your clinical supervisor? (specify) .....

Do you provide clinical supervision? Yes No

If yes, to CL nurses? Yes No

Other (please specify) .....

.....

7. EDUCATION & TRAINING

Please specify if you have undertaken education specifically to enhance your ability to work as a CL nurse? .....

.....

.....

.....

What do you believe should be the minimum educational requirements to work as a CL nurse? .....

Are there education programs that you would like to see available for CL nurses? .....

.....

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8. WORK SATISFACTION

Do you enjoy being a CL Nurse? (comments/explanations very welcome).....

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