Action Research in Preventing Workplace Burnout in Rural Remote Community Mental Health Nursing

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Candidate's Certificate

I certify that the thesis entitled **"Action Research In Preventing Workplace Burnout In Rural Remote Community Mental Health Nursing"** and submitted for the degree of "DOCTOR OF PHILOSOPHY" is the result of my own research.

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IN LOVING MEMORY OF BEN

1974-2002

“Forever young”

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Table of Contents

LIST OF FIGURES 11

ABBREVIATIONS 12

DEFINITION OF TERMS 13

ABSTRACT 15

CHAPTER 1 18

1.1 General Introduction 18

1.2 Thesis structure 19

1.3.1 Models of health 20

1.3.2 The Initial concept for the study 22

1.3.3 Occupational Stress 23

1.3.4 Impacts of occupational stress 25

1.4 Context of the study 26

1.4.1 Factors impacting on rural and remote practice 26

1.4 2 Addressing workplace stress 30

1.4.3 Burnout 31

1.4.4 The person-environment congruency theory 33

1.4.5 Community mental heath teams and unique issues 34

1.4.6 The extent of rurality and its impact on nursing practice 36

1.4.7 The impact of the agricultural crisis 38

1.4.8 Educating the nursing workforce 39

1.4.9 The Action Research methodology 40

1.5 Research questions 40

1.6 Study aims and objectives 41

1.7 Theoretical contributions 42

1.8 Summary 42

1.9 Thesis outline 43

CHAPTER 2 Methodology 45

2.1 Introduction 45

2.2 Epistemology of research in health and social sciences 45

2.2.1 The birth of action research 48

2.2.2 The characteristics of action research 49
2.2.3 The cyclic nature of action research 51
2.3 Methods of nursing research 54
2.4 Study design 57
2.5 Researcher responsibility ensuring voice, identity and reflexivity 58
2.6 Selecting the appropriate methodology 60
2.7 Conclusion 61
CHAPTER 3 Method 64
3.1 Action Research Method 65
3.2 Thematic concern 66
3.2.1 Reconnaissance—a community perspective to mental health services 66
3.2.2 Developing interest 70
3.2.3 Study setting 72
3.3 Demographic and epidemiological profiles 74
3.4 Sampling 75
3.4.1 Sample population 75
3.4.2 Purposive sampling 76
3.4.3 Inclusion criteria 77
3.4.4 Limitations of sampling method 77
3.5 Rigour 77
3.6 Ethical Considerations 80
3.6.1 Informed consent 80
3.6.2 Right to withdraw 81
3.6.3 Autonomy in voice 81
3.6.4 Representation 81
3.6.5 Participant privacy 81
3.6.6 Participant sensitivity 82
3.6.7 Distress to participants 82
3.6.8 Educating the participants 82
3.6.9 Confidentiality 83
3.7 Ethical behaviour standards 83
3.8 Access to data 83

3.9 Storage of data 84
3.10 Data collection 84
3.11 Data analysis 86
3.12 Trustworthiness 87
3.13 Critique of the research study 88
3.14 Conclusion 90
CHAPTER 4 Stage 1 of Research Cycles 92
4.1 Development of a client infrastructure 92
4.1.1 Introduction 92
4.1.2 Contracting: A starting point prior to the development of a client infrastructure 92
4.2 Becoming change agents 93
4.3 Establishing contact 93
4.4 Meeting the participants 95
4.5 The critical group 95
4.6 An unforeseen occurrence 96
4.7 Stressful work environments 98
4.8 Unrelenting stress and burnout 99
4.9 The impact of stress 99
4.10 Preparing the nursing workforce 101
4.11 A paradoxical ethical issue 102
4.12 Conclusion 103
CHAPTER 5 Implementation of the first two action research cycles 105
5.1 Introduction 105
5.1.1 Diagnosing phase 105
5.1.2 Summary 143
5.1.3 The action planning stage 143
5.1.4 The action taking stage 152
5.1.5 The evaluation phase 154
5.1.6 Specify learning phase 155
5.2 A nursing model of practice 156
5.3 The second cycle 156
5.3.1 The diagnosing phase 157

5.3.2 Action planning phase 162
5.3.3 Action taking phase 165
5.3.4 Evaluation phase 179
5.3.5 Specify learning phase 180
5.4 Further development of a nursing model 180
5.5 Conclusion 181
CHAPTER 6 Implementation of the final two research cycles 183
6.1 Introduction 183
6.2 Diagnosing: Identifying/defining the problem. 183
6.1.2 Action planning phase 196
6.1.3 Action taking phase 204
6.1.4 The evaluation phase 214
6.1.5 Specify learning phase 217
6.2 The ongoing nursing model development 218
6.3 The final cycle 218
6.3.1 Diagnosing: Identifying/defining the problem. 218
6.3.2 Action planning stage 220
6.3.3 Action taking phase 222
6.3.4 Evaluation phase 227
6.3.5 Specify learning phase 228
6.3 The finalisation of a new nursing model 229
6.4 Conclusion 229
Participant's final comments: 230
CHAPTER 7 Discussion 232
7.1 Introduction 232
7.2 Reflection on the aims of the study 232
7.2.1 Reflection on action research methodology 233
7.2.2 Utilizing the action research methodology 236
7.3 Overarching themes 236
7.3.1 Staff safety 236
7.3.2 Education 238
7.4 Change 240

7.5 The development of tools 241
7.6 Empowerment 242
7.7 A collaborative process 244
7.8 Benefits of group formation 245
7.9 Developing theory 246
7.10 The development of a conceptual model 247
7.11 Conclusion 249
CHAPTER 8 Summary of the study 251
8.1 Introduction 251
8.2 General overview 251
8.3 Discussion of the theoretical significance of the findings 253
8.4 Wider theoretical implications 253
8.5 Limitations of the study and areas for further research 254
8.6 Practical implications and policy 255
Implication 1 256
Implication 2 256
Implication 3 256
Implication 4 257
Implication 5 257
Implication 6 257
Implication 7 257
Implication 8 258
8.7 Conclusion 258
Final remarks 258
REFERENCES 262
APPENDICES 288
Appendix 1 Ethics Approval 288
Appendix 2 Explanatory letter and information of consent from 289
Appendix 3 Plain Language Statement Lay Summary of Proposed Research 294
Appendix 4 Consent Form 295
Appendix 5 Right to withdraw: Withdrawal of Consent Form 296
Appendix 6 Declaration of Confidentiality by Transcribers of Taped Data 297

Appendix 7 (Area) H&CS Mental Health Triage Tool 298

Appendix 8 Triage Tool: Risk Factors Flow Chart 299

Appendix 9 RISK MONITORING CHART 303

LIST OF FIGURES

		Page
Figure 1	Difficult terrain contributing to isolation	28
Figure 2	Detailed Action Research model (from Susman, 1983, adapted by Pearson, 1989)	63
Figure 3	Aerial view of study area	73
Figure 4	Agricultural land surrounding study area	75
Figure 5	Conceptual model of praxis	248
Figure 6	Leaving the valley	261

ABBREVIATIONS

A & E	Accident and Emergency Department
ABS	Australian Bureau of Statistics
ACEM	Australasian College of Emergency Medicine
ATS	Australasian Triage Scale
BMSE	Brief Mental Status Examination
CEO	Chief Executive Officer
CMHST	Community Mental Health Support Team
CMHT	Community Mental Health Team
CNC	Clinical Nurse Consultant
ED	Emergency Department
GP	General Practitioner
MBI	Maslach Burnout Inventory
MHA	Mental Health Assessment
MO	Medical Officer
MPS	Multi-purpose Service
MSE	Mental Status Examination
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PCA	Personal Care Attendant
RN	Registered Nurse
RRMA	Rural, Remote and Metropolitan Areas
SCARC	Senate Community Affairs Reference Committee
SLA	Statistical Local Area
TAFE	Technical and Further Education

DEFINITION OF TERMS

Community Mental Health Team: a team of multidisciplinary health professionals in a field of nursing that is a blend of primary health care and mental health nursing practice within public health nursing (Treatment Protocol Project, 2003). These teams are comprised of psychiatrists, psychologists, social workers, occupational therapists, clinical nurse consultants, clinical nurse specialists, and registered nurses. Although not all centres have the full complement of staff, specialty fields covered in these teams include child and adolescence nurses and drug and alcohol counsellors (Treatment Protocol Project, 2003). The provision of service is preventative, curative and rehabilitative. The philosophy of care is based on the belief that care directed to the individual, the family, and the group contributes to the health care of the population as a whole (Treatment Protocol Project, 2003).

Critical Group: a practitioner group participating in collaborative discourse both theoretically and practically to build a language by which they may analyse and improve their understandings and actions in a given situation. The 'action research of the group is achieved through the critically examined action of individual group members' (Kemmis & McTaggart, 1988, p.5). For the purpose of this study, the participants will collectively be known as 'critical group'.

Emancipatory Action Research: a practitioner group that takes joint responsibility for the development of practice, understandings and situations. The role of an outside researcher is minimal. The role, even as a facilitator, would actually undermine the progress of the group in a collaborative response to the process (Owens, Stein & Chenoweth, 1999).

Reflectivity: a term used for introspection in the research setting whilst still engaged in the research, the aim of this introspection should be immediately employed to reflexively examine the data collected and the ways it is to be analysed (Willis, 2006).

Rural Remote: a distinctive characteristic relating to large distances (hundreds, up to thousands, of kilometres) from the greater populated metropolitan and regional settings. The Rural, Remote and Metropolitan Areas (RRMA) classification is a 'geographical classification based on statistical local areas (SLAs), and allocates each SLA in Australia to a category based on population numbers and an index of remoteness' (Clark et al., 2007, p. 443). The 'RRMA classification estimates seven RRMA categories: capital cities; other metropolitan centres (urban centre population > 100 000); large rural centres (population 25 000–99 000); small rural centres (population 10 000–24 999); other rural areas (population < 10 000); remote centres (population > 5000); and other remote areas (population < 5000)' (Clark et al., 2007, p.443). The area in this research has a population of less than 5000.

ABSTRACT

The social phenomenon of stress and workplace burnout has spanned over five decades. Despite a plethora of literature that exists, there still remain problematic issues that neither scientific investigation or government legislation have been able to resolve. The literature examined throughout this research is extensive and does reflect this 50-year period. It demonstrates that studies into this phenomenon have attempted to define stress, identify causal factors of workplace stress, workplace burnout and environmental congruence; and discusses strategies (focused on both the individual and organizational levels) that have been implemented to effect beneficial outcomes for individuals affected by any one of these. As this thesis continues, the more recent literature gives a greater recognition to violence in the workplace and legislative enactments as preventative measures to reduce the heavy burden of costs, both physical and financial, to organizations. This extensive literature review indicates no answer to the problem has been identified to date and that this phenomenon remains, giving a clear indication that further scientific investigation is required to find a solution to what was described as the most serious health issue of the 20th century. Based on the literature examined this health issue has now gone well beyond the 20th century, giving relevance to the research study described in this thesis. The investigation is validated as vital and should be used as a basis for further research.

This study undertook a collaborative social process, action research, empowering participants to identify and change stressful factors identified within their practice indicative to rural remote community mental health teams. A critical social theory arose out of the problems within the context of the research setting, based on the ideal that the significant issues for this group of individuals within this organization could be solved through the action research process. The group ‘existed’ within the issues indicative to this rural remote area, however these issues were outside their control. Through the

implementation of the action research process courses of actions were undertaken that provided enlightenment in self-knowledge with dialogue heightening collective empowerment to effect change within their practice.

The action research process, being a holistic process, facilitated this change in practice, developed and refined theory as it proceeded in a cyclic fashion within this local setting. It concerned actual not abstract practices in the social world in which these participants practice. This methodology facilitated examining the significant stressors identified by the Community Mental Health Support Team (CMHST) that caused distress, allowing them to implement changes in their practice. The forum provided an avenue that could reduce stressors significantly and prevent ongoing occupational stress that contributes to workplace burnout. It offered an opportunity to work with a group of participants in a non-hierarchical and non-exploitative manner and enabled members of this group to identify their roles as effective practitioners, empowering them to effect the changes they deemed as essential criteria to reduce the stress they were experiencing indicative to their remoteness.

Critical reviewing throughout the data collection attempted to understand and redefine these significant issues. It aimed to acknowledge the way things were relative to how things could be improved from organizational, personal and wider community perspectives. Simple principles and guidelines of action research were followed potentiating acceptance as a rigorous research approach from a positivist perspective whilst retaining the attributes that characterise action research.

There are solutions to the dilemma of the employee overcoming the debilitating effects of stress leading to workplace burnout. This includes the cooperation of managers, policy

makers, academic researchers and government officials working collaboratively to reduce the impact of occupational stress. Through this collaborative process, changes can be effected to ensure the health of the nation improves and that relevant recognition is given to the fact that there is a significant threat to a healthy workforce. Examining the nursing profession from a social perspective provides alternatives to medicalising workplace injuries and illnesses.

CHAPTER 1

1.1 General Introduction

The aim of this research was to identify factors that contributed to stress in a group of nurses practicing in a rural region in Australia, and implement strategies that could reduce significant stressors. The research was focused on nurses who treat people with mental health issues accessing an area health service. An action research process, informed by the work of Susman and Evered (1978), was used to work with a group of staff from a 46-bed rural hospital. Establishing contact with this critical group led to a collaborative relationship based on mutual trust. The critical group identified significant problems that they believed constituted major stress within their practice through group meetings. The group nominated issues that required intervention, developed and implemented the planned actions, and evaluated the extent to which these actions resolved the problems identified. During this process, I analysed data from transcripts of group meetings to specify learnings based on the critical paradigm. Theory was developed from this process with the group actively working in real time to change their work environment.

My interest in the impact of stress on workers within the health field spans a 20-year period. I identified this phenomenon through personal dealings within the helping professions in the late 1980s when health staff implemented abnormal coping mechanisms after dealing with stressful incidents at work. Some of these coping mechanisms included excessive drinking to unwind after a shift, the depersonalization of patients and co-workers, and a social withdrawal from friends and colleagues. Relationship difficulties, including increased divorce rates, seemed to stem from these unhealthy coping mechanisms. These issues of workplace stress became more evident as I progressed through my mental health nursing career and encountered high levels of stress or anxiety in

general nurses and other clinicians, untrained in mental health, who were required to care for people with mental health issues. In recent years, there has been a shift to providing support for these clinicians through the introduction of mental health nurses and other mental health professionals into general health care teams as supporters, educators and advisors. However, these initiatives are rarely feasible in rural and remote health care settings due to low staff numbers, large distances involved in accessing specialists, and the time taken to transfer patients from rural regions to regional centres. Therefore, nurses in the rural remote setting are more likely to be exposed to stress, as they may be required to work—without substantive education and training and with limited access to specialist services—with patients with mental health issues. The rural remote setting was targeted in this research study as most likely to provide insight into the issue of workplace stress and a useful contribution to addressing this problem.

1.2 Thesis structure

This thesis is made up of eight chapters. In writing this thesis, I have elected not to have a stand alone literature review chapter but to embed the relevant literature into each chapter. This variation in the presentation of a thesis from the more traditional thesis presentation dismisses the concept that all the literature had been examined prior to the commencement of the data collection. This concept is discussed by Fisher and Phelps (2006) in challenging the conventions for writing action research theses. It should be recognized that the action research process is dynamic and should allow for any relevant issue under investigation throughout the research process to be considered with literature support being accessed at that time. This means that the literature review is in constant flux and that relevant literature could not be predetermined, rather, literature was reviewed and is reported adjacent to the research findings, justifying and validating the study as it progressed (Kendall, 2005).

A second variation in the structure of the thesis involved the de-identification of the participants. The critical group discussions in the data collection spanned a 16-month period. In presenting the stages undertaken throughout the action research cycle a variety of participant input occurred. Due to the length and complexity of the transcripts, the comments by each participant are not singularly identified with a number or pseudonym but are presented as a collective. Participants' comments that are acknowledged in the thesis are identified as the 'participant' and include the transcript disk and line numbers. The researcher's input is identified as the 'researcher' and also includes the transcript disk and line numbers.

1.3 Background to the study

1.3.1 Models of health

Population models for mental health across Australia proposing links between population or public health and integration with personal health care have, to date, become the chief focus in many community mental health settings (Judd & Humphreys, 2001). One model proposes assessments, formulation of interventions from prevention to treatment and maintenance at both population and individual levels. It addresses the issues across the lifespan applying to special populations, culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander peoples. The model is conceptualized at different levels of care incorporating primary, secondary and tertiary mental health care, applying these across the population matrices of the various groups. Implementation of this model requires the identification of input outcomes (treatment outcome is the effect on a patient's health attributable to an intervention), data and information system infrastructure, workforce, education and training, research and development, quality processes, resource frameworks and review and change processes. This model serves to provide for a comprehensive, evidence based and cohesive approach toward the provision of optimum

mental health care, lessening the extent and burdens of mental disorders affecting populations (Bushy, 2004).

To achieve the improvement in mental health services that lessens the disease burden, proactive interventions must be implemented to impact effectively on relevant factors at both population and individual levels. These programmes open to the community total accountability in mental health service provision (Judd & Humphreys, 2001). However, in attempting to achieve this idealistic approach in maintaining mental health, a time constraint dilemma exists. It becomes imperative for members of community mental health teams to allocate a time frame to provide the mental health intervention while maintaining best practice (Pinikahana & Happell, 2004). The flow-on from this is seen in the detraction from face to face contact and implementation of strategies and interventions to the clients they serve. This has seen an over-extension of personal resources creating a state of constant and unresolved stress for these team members (Pinikahana & Happell, 2004).

Hegney et al. (1997) discuss the differences between metropolitan and rural health service delivery models. The authors recognize that the metropolitan models of health are not effective, with some models being inappropriate in rural regions particularly in relation to small rural communities. An alternative model of health service delivery discussed is the Multi-purpose Service (MPS). The MPS is a joint Australian Federal and State/Territory government initiative specifically designed for rural and regional areas (Commonwealth Department of Health and Aged Care, 2000). The aim of an MPS is to provide a coordinated and cost effective health service with funding flexibility across health and aged care sectors to overcome the restrictions of programme funding barriers by pooling funds from acute hospital, aged care, primary health and community support services thus enabling greater flexibility in meeting the needs of the community. It is anticipated this approach would provide more service choices specific to local community needs.

However, some of the barriers associated with this model include resistance to change within health professionals and a lack of educational and training opportunities for them (Hegney et al., 1997; Commonwealth Department of Health and Aged Care, 2000). This model of health is the model currently governing practice in this research study area.

1.3.2 The Initial concept for the study

The health care workplace today presents a very different profile to that of yesteryear. A range of changes, for example, best practice policies, litigation threats and loss of autonomy, have created a less predictable and, at times, hostile work environment for both genders (Gillespie & Melby, 2003). Expectations of better health outcomes and quality assurance from reduced funding and resources have led to dramatically increased stress levels for employees and an increase in suicidal behaviour of staff (Pompili et al., 2006).

Stress at work has become one of the greatest challenges facing employers, governments and trade unions as its impact extends not only into the personal aspect but also into the economic stability of individuals, organizations and nations (Duquette, Kerouac, Sandhu, & Beaudet, 1994; Hehir, 2006). The International Labour Organization (1993) nominated it as the most serious health issue of the 20th century. In the Australian setting, the Senate Community Affairs Reference Committee (SCARC) (2002) noted that the workplace is a major source of stress with dramatic changes in structure and organizational demands over the last three decades and should be identified as the target for change directed at individual and organizational levels (Snow, 2006). This indicates that, despite recognition and strategies to address stress in the workplace for more than a decade, it still continues to present concerns for governments, organizations and policy makers, therefore making it worthy of ongoing research investigation.

1.3.3 Occupational Stress

The issue of occupational stress has been discussed and researched increasingly over the last five decades. The General Adaptation Syndrome identified by Hans Seyle (1956) suggests the physiological reaction to stress. The body's response in an alarm reaction (a stressful situation) triggers an immediate physiological response increasing the activity within the autonomic nervous system and the adrenal glands. This stage is well documented as the 'fight and flight' response. Latent features of this response include fatigue, headaches, loss of appetite and fever. Coping mechanisms are employed by an individual in response to the stressor. Exhaustion may ensue if the individual is unable to resolve the stressor or adapt to the crisis, with extreme circumstances resulting in death (Dorrian et al., 2006; Duquette et al., 1994; Plaut & Friedman, 1981).

The literature covering occupational/workplace stress suggests that constant strain in the absence of adequate strategies for coping leads to disease (Hehir, 2006; Plaut & Friedman, 1981; Rose, 1986). Workplace stress has been linked to a decrease in the psychological wellbeing of individuals, resulting from a combination of low job control, high job demands and low work-related support. The work environment influences the 'burnout' syndrome with emotional exhaustion being highlighted as the most strongly affected component (Turnipseed, 1994). In the 1960s, references to the effects of long-term drug use and to chronic schizophrenia adopted the term 'burnout'. This was later used in socio-political contexts. Freuenberger was reported to have pioneered the use of the term 'burnout' in its current context, basing his model of burnout on the psychology of the individual (Maslach, 1976). Maslach (1976) extensively researched this topic, relating to it from the psychosocial perspective. Job-related demands identified as becoming excessive sources of 'burnout' include organizational, interpersonal and personal factors (Duquette et al., 1994; Maslach & Jackson, 1981a; 1985; Snow, 2006).

There are a large number of factors commonly associated with work-related stress including long working hours, heavy/unrealistic workloads, changes within the organization, tight deadlines, changes to duties, job insecurity, lack of autonomy, boring repetitive work, insufficient skills for the job, over-supervision, inadequate working environment, lack of proper resources, lack of equipment, few promotional opportunities, harassment and bullying, discrimination, poor relationships with colleagues or bosses, and crisis incidents not appropriately addressed (Caufield, Chang, Dollard & Elshaug, 2004; Constantini, Solano, DiNapoli & Bosco, 1997; Duquette et al., 1994; Johnson & Preston, 2001; Maslach & Jackson, 1981a; 1982; Perlman & Hartman, 1982; Pines & Maslach, 1978).

Changes within the workplace in modern society that have influenced the well-being of employees are commonly described as contributing to a "hostile" work environment. A comprehensive systematic review of evidence from both quantitative and qualitative paradigms on developing and sustaining nursing leadership that fostered a healthy work environment in health care was undertaken by Pearson et al. (2004). These authors identified that many organizations were in search of strategies that may create a healthy work environment as the depletion of the nursing workforce continued and access to resources was reduced. The implications for practice identified by Pearson et al. (2004) recognized that different leadership styles exist in nursing and these can create positive healthy work environments that may lead to positive outcomes for both staff and patients. A combination of leadership styles, attributes, characteristics and behaviours of nursing leaders and the empowerment of the nursing workforce were all cited as contributing to the possibility of creating a positive healthy work environment. The review was unable to identify recommendations on feasible, meaningful or effective organizational strategies to

create this (Pearson et al., 2004). The academic discussion of the hostile work environment identifies several factors relevant to the concern under investigation in this research. These factors include workplace stressors, the person-environment congruency theory, the burnout syndrome, rurality, the impact on nursing practice and unique issues associated with community mental health teams in rural remote regions in Australia (Pearson et al., 2004).

1.3.4 Impacts of occupational stress

The rapid advancement of the technological age has created a greater quality of life for humanity; however, this has occurred at a cost (Johnson & Preston, 2001). With dramatic changes in structure and organizational demands over the last three decades, the workplace is a major source of stress and should be identified as the target for change directed at both the individual and organizational levels (Snow, 2006). The restructuring of the nursing work environment in downsizing, staff restructuring and unrealistic workload has impeded nurses' maintenance of well-being and increasing occupational stress. Evidence suggests nursing has become a more stressful occupation, placing nurses at a 'greater risk' for illness (Dorrian et al., 2006; Jones, 1997). Occupational stress leading to burnout has become one of the greatest challenges facing employers, governments and trade unions as its impact extends not only into the personal aspect but also into the economic stability of nations (Hehir, 2006).

Some costs that should be considered when reviewing the impact of workplace stress include the financial costs to an organization and the health of the individual. Kenny (2000) purports the annual cost of such related illnesses to American employers was $150 billion, and expected possibly to exceed $300 billion in absenteeism, injury and accidents in the current climate. In Australia, work-related stress had a national estimate of $105.5 million in 2000–2001 (Caufield et al., 2004). Additional consequences for businesses

include a greater turnover of staff and a drop in productivity. The possible consequences of workplace stress for the employee include increased susceptibility to workplace accidents, deterioration of personal relationships and ill health such as an increased risk of cardiovascular disease and workplace aggression and violence (Caufield et al., 2004; Constantini et al., 1997; Duquette et al., 1994; Johnson & Preston, 2001; Maslach & Jackson, 1981a, 1982; Perlman & Hartman, 1982; Pines & Maslach, 1978). In Australia, the impact of burnout in the workplace and the associated reduction in work hours has been addressed through legislation. Over the last decade, various States across Australia have developed Occupational Health and Safety Acts. Sections of these Acts signify the responsibilities of employers to maintain not only the physical well-being of employees but also their psychological well-being.

The study of stress has become an important area of study, as suggested in literature, due to its heavy costs in terms of the damage it has caused within society; to individuals, to relationships and to organizations (Snow, 2006). For the individual physical symptoms associated with work-related stress can include depression, anxiety, feelings of being overwhelmed and inability to cope, decreased work performance, increased sick days and absenteeism, sleeping difficulties such as insomnia, cognitive difficulties such as reduced ability to concentrate or make decisions, fatigue, headaches, heart palpitations, gastrointestinal upsets, such as diarrhoea or constipation, and increased aggression (Caufield et al., 2004; Constantini et al. 1997; Duquette et al., 1994; Johnson & Preston, 2001).

1.4 Context of the study

1.4.1 Factors impacting on rural and remote practice

The impact of stress can not only be derived from organizational, societal, personal and professional sectors but also environmental impacts must be considered in regard to

maintaining employees' well-being. Workers at times may be in conflict with any or all of these factors in their work situation (Gillespie & Melby, 2003). There is vast literature on rural health with much focus being placed on the detrimental effects rural and remote areas exert on individuals (Halcomb et al., 2005). These areas face unique issues and constraints relating to distance, isolation (see Figure 4), poor technological support, population size and recruitment of appropriately experienced and skilled staff (Productivity Commission, 2005).

For rural Australia, access to and provision of health-related services have been continuing factors in poorer health outcomes and have been greatly influenced by the economic downturn and changing rural demographics (Mahnken, 2001). Rural communities now require health services involving a more diverse range of health promotion, preventive, chronic and social care. Shifts in health policies during the 1990s reflected this changing need. Hegney et al. (1997) identified the geographical implications for health care in rural Australia. These authors contended that rural areas in general had fewer facilities with shortages of health professionals. They identified significant inter- and intra-State differences in the availability of ease of access to health care services. Major rural towns and regional centres were well provided with primary and specialist services whilst many smaller and rural communities failed to attract the most basic of health care services. Attention was drawn to the fact that accessing basic health care services for many rural Australians presented a major difficulty due to reduced services associated with decreasing population and demographics.

Figure 1. Difficult terrain contributing to isolation

Humphreys and Rolley (1991) identified three themes that exist in any discussion of rural health care needs. The first of these was the specific difficulty associated with the provision of any health intervention, including staffing and hospital availability in remote and rural areas. The second of these themes identified the necessity for flexibility in the delivery of services, providing accessibility whilst considering the monetary cost involved to the health regions. The final theme these authors identified was related to the appropriateness of service models designed for metropolitan areas when utilized in rural regions. Many of these had proved to be unsuccessful in application. Referring to a study conducted in the Hunter Valley, NSW, the authors identified that rural residents expected complete competence from their health care provider, placing an additional stress on rural health personnel. Compounding this issue, and increasing the stress levels for the practitioner, was the considerable distance from acute care facilities, accompanied at times by 'fragile and erratic means of communication' (Humphreys and Rolley, 1991, p.69).

The Rural Remote Metropolitan Area (RRMA) classification system was developed in 1994. It is a classification system describing the areas of medical practice within Australia. The system identifies rural, remote and metropolitan areas according to city status, population, rurality and remoteness (Australian Institute of Health & Welfare, 2004; Commonwealth Department of Health & Ageing, 2005). The Statistical Local Area (SLA) system classifies zones according to population and locality. These include Metropolitan, Rural and Remote. Further subdivision of zones identifies seven classes and categorises them as capital cities (Category 1), other metropolitan centres (Category 2), large rural centres (Category 3), small rural centres (Category 4), other rural centres (Category 5), remote centres (Category 6) and other remote areas (Category 7) (Commonwealth Department of Health & Ageing, 2005). There is a distinction between five types of remote rural communities. These include company towns, Aboriginal communities, small, old and established rural towns and regional centres. The area involved in this study is in Category 5 of the RRMA.

Several reforms have occurred and have impacted strongly on the practice and working environments of many rural nurses. There has been a shift in small rural hospitals having reduced or closed their traditional bed-based services and encompassing health preventive, health promotional and community-based health programmes. This has seen a shift in the traditional role of the nurse to encompass first-line primary care, community health and emergency care (Mahnken, 2001). This change has occurred in services, which are often without medical practitioners. The change in health care models now seen in the provision of health care includes a range of restorative, rehabilitative, aged and respite care (Mahnken, 2001). Examining the role of the nurse working in expanded and advanced practices indicates this is not new for nurses working in areas of rural Australia. It has been the norm for rural nurses to provide comprehensive health care at advanced levels over the

past century without necessarily having the support of medical practitioners (Mahnken, 2001). This has been largely ignored and unreported particularly from a policy and legislative level until recent times.

> *"For many rural communities, nurses have been, and continue to be, the only regular health care professionals, maintaining a health service presence and working in de facto nurse practitioner roles to meet health needs. Previous health policies have not reflected the high level contribution of nursing care to rural health outcomes, nor has legislation upported the advanced role rural nurses play" (Mahnken, 2001).*

The shift in policy with regard to nurses in advanced practitioner roles has been seen through the training of nurses to this level in Australian universities. The national rural health policy acknowledges the role of rural nursing as 'crucial to the successful implementation of reforms and the improvement of health outcomes for rural people' (Mahnken, 2001).

1.4 2 Addressing workplace stress

Psychological models of stress argue that stress occurs when an individual of any age determines an external or internal demand exceeds their capability to adapt and cope (Caufield et al., 2004; Gillespie & Melby, 2003; Lazarus, 1995; Lunney, 2006; Power, 2004). Stress is not an inherent characteristic of either individual or environment, but is the interaction of the two (Heerwagen, Heubach, Montgomery & Weimer, 1995). Research into the physiology of stress indicates a correlation between stress and disease (Booth-Kewley & Friedman, 1987; Cohen, Tyrell & Smith, 1993; Holmes & Rahe, 1967). In an effort to overcome the effects of stress, employees will often utilize sick leave and workers' compensation prior to resorting to a change of employment (Beehr, 1985; Caufield et al., 2004; Cohen & Willis, 1985; Constantini et al., 1997; Duquette et al., 1994; Gillespie & Melby, 2003; Johnson & Preston, 2001; Sullivan & Bhagat, 1992).

There is a plethora of literature covering the effects of workplace stress. Prolonged stress may lead to a depletion of personal resources, including a withdrawal from work practice

(Caufield et al., 2004; Cohen & Willis, 1985; Constantini et al., 1997; Duquette et al., 1994; Gillespie & Melby, 2003; Johnson & Preston, 2001; Maslach & Jackson, 1981a, 1982; Perlman & Hartman, 1982; Pines & Maslach, 1978; Sullivan & Bhagat, 1992). Stress-related problems for employees have been clearly identified in literature as increasing and one of the most serious health issues of the 20th Century (International Labour Organization, 1993). It is paramount to promote a safe and healthy work environment that is adapted to meet people's physiological and psychological needs and protects them from injury and illness (Gillespie & Melby, 2003).

Extensive literature review suggests the importance of worker involvement in organizational change to address the increasing cost associated with staff resignation and recruitment that has had an enormous impact on organizations both financially and physically. Several factors identified within the workplace as impacting on these costs include high work demands, low autonomy, the threat of job insecurity, workplace unpredictability and lack of workplace control (Fletcher, 1998; Gillespie & Melby, 2003; Kahn & Byosiere, 1992; Karasek & Theorell, 1990; Levi, 1990; Sauter, Murphy & Hurrell, 1990). Recent research focuses on the increased complexity of the health care workplace environment that has led to an increase of occupational stress and workplace burnout (Caufield et al., 2004; Dorrian et al., 2006; Gillespie & Melby, 2003; Johnson and Preston, 2001).

1.4.3 Burnout

Over the last six decades, helping professions (e.g. nursing, occupational therapy, social work, psychology) and human services developed an interest in the subject of burnout. These include staff members, administrators, policy makers, researchers and students (Johnson & Lipscomb, 2006). Maslach (1976) and Maslach and Jackson (1981a) provide a widely used conceptualization of burnout as the complete emotional exhaustion, increased

depersonalization and decreased personal accomplishment resulting from the over-extension of the worker. Emotional exhaustion refers to feelings of physical and emotional depletion that leaves nothing to give to others at a psychological level. Depersonalization refers to the development of attitudes of cynicism and negativism. Personal accomplishment burnout involves a negative evaluation of one's personal accomplishments in working with people. The development of the Maslach Burnout Inventory (MBI) provided an instrument to measure varying degrees of burnout relevant to each of these three aspects (Maslach and Jackson, 1981a).

Repeated and unresolved stress leads to workplace burnout (Maslach and Jackson, 1981a). In defining burnout, Farber (1982) examined the works of Pines and Aronson (1981), Freudenberger and Richelson (1980), and Edelwich and Brodsky (1980) in an attempt to provide an accepted general consensus of symptoms relating to the syndrome. The general consensus was that the symptoms of burnout include attitudinal, emotional, and physical components. Maslach (as cited in Farber, 1982, p.3) noted that burnt out professionals "lose all concern, all emotional feelings for the persons they work with and come to treat them in detached or even dehumanized ways".

Evidence suggests nursing has become a more stressful occupation, placing nurses at a greater risk for illness (Johnson & Preston, 2001; Jones, 1997; Lunney, 2006; SCARC, 2002). Deinstitutionalization and the economic rationale to shift health costs have seen a significant health budget restructure. The financial cost effectiveness of this remains questionable, when the human costs implied on both the health professional and the consumer are considered (Richards, 2000). This restructuring of the nursing work environment in downsizing, staff restructuring and unrealistic workload has impeded nurses' maintenance of well-being and increased occupational stress (Richards, 2000). In

recent years, there has been an increase in the expectation of professionalism and specialist services within the health realm. This is evident particularly over the last two decades and has been demonstrated in increased coordination costs, inefficiency of services and the expectation of service providers to have an extensive information and communication knowledge base (Duckett, 2005).

Research has turned the focus towards the impact of the environment on workplace burnout. Although widely studied, the concept of burnout is controversial. Alturn (2002) contends burnout is a result of unmanaged work stress rather than being a symptom of work stress and is seen to be prevalent amongst the helping professions (Büssing and Glasser, 1999). Additionally, the term 'burnout' has become commonly used by lay people to describe work pressures that lead to an individual's inability to work with clients, organizations and their own expectations (Maslach & Jackson, 1982; 1984). It has been suggested the term 'stress' could be dismissed as a useful linguistic abbreviation society uses as a throwaway line if it were not for the numerous claims that have been made about the effects of stress (Gillespie & Melby, 2003). This trivialized use of the term detracts from the seriousness of the burnout syndrome.

1.4.4 The person-environment congruency theory

Environmental psychology has studied stress from the perspective of congruence between the person and the environment. The person-environment congruency theory suggests that cognitive compatibility with the environment is a fundamental need (Heerwagen et al., 1995; Mor-Barak, 1988; Sarason & Sarason, 1987; Pompili et al., 2006). Two aspects viewed in this congruence theory are the functional and psychological components of the work setting (Pompili et al., 2006; Shirey, 2006). Congruency is achieved if both functional and psychosocial aspects meet the basic needs of social cohesion, and cultural and collective meaning. MacDonald (1984) postulated that stress is not a characteristic of either environment or individual but is the outcome of the interaction of the two. Research

indicates that certain actions by individuals and by the organization can significantly decrease stress and burnout (Shirey, 2006). Ideally, change should be directed at both individual and organizational levels.

The combination of the working environment (i.e. organizational cultures and values) and organizational structure has been identified as a major cause of workplace stressors and the psycho-physiological well-being of employees (Donnelly, 2004). For example, Carlin and Farnell (1985) identify stressors that stem from ineffective organizational systems and poor physical working environments. Individual solutions may alleviate the symptoms of stress but do not address the source (Cooper & Cartwright, 1997) with literature suggesting the importance of worker involvement in organizational change efforts. According to the 'self-care' concept the input by the worker should include how the intervention is developed and the content of such interventions (Dochterman & Bulechek, 2004; Lunney, 2006; McKivergin, Wimberly, Loversidge & Fortman, 1996). The match between stressful events and the controllability of such stressors should also be considered (Cutrona, 1990; Cutrona & Russell, 1990; Lunney, 2006).

1.4.5 Community mental heath teams and unique issues

Health professionals working in the health sector make up 6.7% of the employed workforce in Australia (Duckett, 2005). Community mental health teams providing illness treatment/rehabilitation based on the recovery model and preventative services of education, health promotion and prevention programmes are part of this cohort. The expectation placed upon this service is proving to be an increasingly difficult, if not near impossible, task to achieve and maintain in light of the socio-economic situation of rural communities (Bushy, 2004; Fraser et al., 2002). Effective delivery of health care in community nursing practice within rural areas encounters a range of barriers, such as the

remoteness of some communities and the vast distances of travel required, and the isolation and fragmentation of supportive health service providers (Hays & Beaton, 2004).

Since deinstitutionalization, mental health care in the community is now provided through collaboration between representatives from several disciplines (Cook & Fontaine, 1991; Gibb, 2003; King, 2001; Murray & Huelskoetter, 1991). The role of psychiatric nurses is significantly different to that of their equally qualified and skilled counterparts in other specialty areas of nursing. Cutcliffe and Goward (2000) contend that psychiatric nurses have a relationship with their clients that is qualitatively different to their counterparts in other disciplines. In psychiatric nursing, the role is based on the development of a mutually influenced relationship between the mental health consumer and the nurse. Pivotal to this relationship are the use of the self as a tool by the nurse and the closeness of the relationship that is formed. A significant amount of trust in oneself is required by the psychiatric nurse, as this relationship can be problematic or unpredictable. The nature of mental illness does not lend itself to conformity to rules and regulations set by society and often requires extreme tolerance of what would normally constitute unacceptable behaviour by a health consumer. Ambiguity can exist for the nurse as he/she practices in an unclear arena with much of the nursing practice involving situations that are uncertain (Cutcliffe & Goward, 2000; King, 2001). It is within this context the psychiatric nurse lends their skills attempting to normalize the world for a person who has lost the ability to make sense of their environment. The nurse must ‘exist’ within this world with the consumer to deepen the relationship and become therapeutic with the use of the self. Cutcliffe and Goward (2000) suggest that the psychiatric nurse is a ‘human amphibian’ who simultaneously inhabits two worlds—the world of the patient and their own world. The consequences of this form of nursing can result in chaos with many nurses experiencing stress and considering leaving (Cutcliffe & Goward 2000).

Community mental health teams in rural and remote areas face issues and constraints specific to their locations relating to distance, population size and recruitment and retention of appropriately experienced and skilled staff (Bushy, 2004; Gibb, 2003). The rural remote community mental health nurse's work is influenced not only by the reduced resources but by the diverse and demanding role of first line managers of care for mental health consumers in the geographically challenging setting (Francis & Chapman, 2008). Further contributing to their workloads, the community mental health teams extend their case management by maintaining mental health services to the general community. These teams are required to provide flexible and innovative programme development in preventing illnesses and planning of treatment approaches for a comprehensive network of services to meet the ever-changing needs of the general population (Croll, 1997; Gibb, 2003; King, 2001). Lack of resources requires the community nurse to become extremely innovative and creative, with improvisation an important learned skill (Lauder, Reynolds, Reilly & Angus, 2001). These issues are coupled with an increased demand for their services due to an agricultural crisis that, according to some researchers, Australia has been facing for some decades (Bryant, 1992; Fraser at al., 2002). This agricultural crisis has resulted from the decline in wealth in the agricultural sector (following several years of low rainfall and declining produce and stock prices), and the rationalization of government and private sector services that has led to a decline in the financial well-being of rural towns.

1.4.6 The extent of rurality and its impact on nursing practice

Whilst there are several definitions and classifications given to 'rural' and 'remote,' the consensus is that there is a vast difference in the culture, norms, values, populace and needs associated with rurality. Francis and Chapman (2008, p.149) define rural and remote health professionals' practice as being "characterised by diversity in roles, employers, settings and types of communities". The authors purport professional and social isolation differentiates the practice of these health professionals from that of their urban and

metropolitan counterparts. There has been a substantial change in the demographic and social profile of rural communities in Australia in the last two decades. The inception of health services restructuring into regional centres has had dramatic implications for rural areas. This restructuring has led to a consolidated health care workforce across Australia in the later part of the 20th century (Duckett, 2005). Therefore, transport services between small rural towns and regional centres are pivotal in ensuring equity of access, particularly to quality health and aged care services (Strong, Trickett, Titulaer & Bhatia, 1998). However, there is no one 'homogeneous' rural community due to the differences in demographics of each community (Hegney, Pearson & McCarthy, 1997). The changes in demography have led to changes in the way health care is funded and delivered, and this is particularly evident in the smaller communities. Strong et al. (1998) identified barriers contributing to slow adherence to State changes in service provision, including dysfunctional facilities, absence/lack of public transport, poor coordination/planning between service providers, recruitment and retention issues and poor communication between government, management, health professionals and community representatives.

Strong et al. (1998) suggest that the major challenges facing health service provision in rural Australia can be identified according to four categories. These are:

- Health status: (generally lower in the rural sector), a rapidly ageing population (with a higher rate of illness chronicity), and higher incidence of lifestyle related diseases;
- Community expectations: self sufficiency in health, and skewed perceptions of government agendas to reduce costs and services;
- Infrastructure: logistical considerations in accessing specialist health services, poor transport between services with many consumers requiring escorting, disparity in the physical condition of the infrastructure of health facilities with many lacking

appropriate security, and difficulty in the recruitment and retention of appropriately qualified staff;

- Service delivery: areas of low population fall below the level required to maintain a viable and quality service, service duplication in an adjoining community, and the unsuitability/rigidity of Commonwealth and State funding for the specific requirements of each community.

1.4.7 The impact of the agricultural crisis

The Australian 'agricultural crisis' is a term used to describe the economic changes in evidence in rural areas. This crisis has lead to a continual population decline in rural towns with the closure of many agriculture-dependent businesses (McLaren, Jude, Hopes & Sherritt, 2001). Associated with this is the loss of community support systems such as community centres and schools, all of which have been moved to larger, more distant regional centres (Drury, Francis & Dulhunty, 2005; McLaren et al., 2001; Quevillon & Trenerry, 1983; Stewart, McKenery, Rudd, & Gavazzi, 1994; Borland, 2000). Due to demographic changes in the rural sector, there is a decreased sense of belonging together with a reduction in satisfaction with community life (Lawrence, 1987) that has led to a rural crisis (Drury et al., 2005; McLaren et al., 2001; Vanclay, 1994). Economic hardships related to on-farm costs have been associated with increased psychological distress and dysfunction (Armstrong & Schulman, 1990; Beeson & Johnson, 1987; McLaren et al., 2001). Added to this dilemma there has been a reduction of health services in rural, remote and isolated communities across the nation with limited inducement for clinicians to relocate to these areas. The withdrawal of health professionals from these regions has created an enormous gap in services (Falk-Rafael, 2005) that would otherwise be provided as primary health care. This increases the difficulty of recruiting and retaining new staff to fill these vacancies to ensure equity of health service provision is afforded to the population residing outside metropolitan areas (Lindsey, Stajduhar & McGuinness, 2001).

With the reduction in resources, difficulties in attracting and maintaining qualified professionals to rural districts and increasing workloads, employees are finding themselves over-extending their own personal resources and working in increasingly stressful, if not at times hostile, work environments.

1.4.8 Educating the nursing workforce

Many community mental health workers in Australia were practitioners in the psychiatric realm prior to the various Mental Health Acts (e.g. Victoria 1986 and New South Wales [NSW] 1990) and were required to undertake service provision for consumers of mental health services at a time when limited rehabilitative education had been afforded to the clinician. Prior to deinstitutionalization in Australia in the early 1990s it was recognized that custodial care was no longer an acceptable practice; however, there was only a decade or so (1985–1994) where rehabilitative care education was afforded to psychiatric nurses. This has meant that many of nursing staff who had been educated in psychiatric nursing practice under custodial care practices left the stand-alone institutions ill-prepared to work in the community or general hospital psychiatric wards (Clinton & Hazelton, 2000; Croll, 1997; Glasson, 1996; Kenny & Duckett, 2003). Their primary role had been to address and care for patients who had a diagnosis of mental illness with the necessary support and safety from within an institution. The new concept from a community mental health focus saw the nurse having to deal with the needs and requirements of clients from a primary care perspective within community settings. This may have occurred without the consumer necessarily having a formal diagnosis of a mental illness.

Concurrent with the shifting of education from hospital training (an apprenticeship model) to university training in a comprehensive nursing degree (an academic model) there was a significant depletion of the workforce within the psychiatric nursing industry. In one Australian State, the nursing workforce recruitment in rural regions is predominantly from

nursing students graduating from regional universities (Kenny & Duckett, 2003). Preference for nursing students wanting to pursue career paths in the more glamorous areas of nursing creates a deficit in the potential recruitment pool. This has led to a history of poor recruitment and retention in the psychiatric nursing workforce, particularly evident in rural and remote contexts (Gibb, 2003).

1.4.9 The Action Research methodology

By adopting scientific investigations to answer questions endemic to nursing practice, researchers contribute to the accountability and social relevance of nursing and the identification of further research questions. This allows an opportunity for the expansion of the nursing knowledge base and, with implementation, bridging of the theory–practice gap (Baskerville & Lee, 1999; Burns & Grove, 1993; Cronenwett & Redman, 2003; Seng, 1998). Action research is a form of research that empowers participants to change their practice and gives ownership of this change to participants. It is designed to create change in practice, and to develop and refine theory within its local setting. Theory is developed from the bottom up and is generated by an interactive process within the cycles of the research (Kemmis & McTaggart, 1988). Participatory action research facilitates implementation of research findings by empowering the individual with autonomy, decision-making processes, and programme design. Implementation of the findings is built into the research itself, thus circumventing the situation of research findings not being put into practice (Wadsworth, 1997; Whitehead, 2007a).

1.5 Research questions

The questions to be addressed in this thesis are ‘What stressor(s) does a community mental health team in a rural and remote region identify as critical in the creation of occupational stress that may lead to workplace burnout, and how can the team overcome these particular issue/s in their setting?’ These types of questions are ideally suited to the Participatory Action Research methodology because it allows a group to be involved in the diagnosis of

a problem and permits action to be taken that is conducive to establishing solutions that best suit the group's area of practice.

1.6 Study aims and objectives

Broadly, the objectives of the study were to work collaboratively with a community mental health team practising in the rural setting to examine the issue of workplace stress and address issues specified by the group. The specific aims of the study were:

a) To identify distinctive factors that impact on occupational stress associated with workplace burnout;

b) To identify what processes are currently utilized by the team to minimize occupational stress and the potential for workplace burnout;

c) To identify problems that lead to occupational stress and the potential for workplace burnout and strategies to overcome these problems;

d) To develop an Action Plan to address the problems identified;

e) To implement the Action Plan;

f) To evaluate the impact, if any, of the engagement of Action Research;

g) To evaluate and specify learnings from the implemented Action Plan and develop a theoretical basis for understanding the issue of workplace stress and burnout in community mental health teams in rural remote Australia.

This study aimed to provide clear benefits to those involved. For example, it was anticipated that participants would develop a sense of autonomy and empowerment through their involvement in the project and that factors contributing to workplace stress could be addressed to prevent burnout. Further, it was hoped that participants would be provided with skills and experience suited to implementing this process again should the need arise. The benefits to the organization in which this study was conducted were anticipated to include the long-term retention of qualified staff functioning at optimum levels.

1.7 Theoretical contributions

Nursing literature has previously examined occupational stressors and burnout as separate identities but has not considered these factors jointly in relation to the impact of a hostile work environment within rural, remote and isolated community mental health teams. The contribution of this study to the nursing profession is demonstrated through its potential to enhance community nursing practice to deliver effective holistic nursing care to consumers with mental health issues whilst maintaining their own psychological and physical wellness. The specified learnings from this research were envisaged to be processes and strategies for employees to overcome the debilitating effects of stress leading to workplace burnout. Examining the nursing profession from a social perspective provides alternatives to medicalising workplace injuries and illnesses. The concerns for staff safety and wellness remain paramount as the States across Australia continue to amend legislation and develop best practice policies and procedures to safeguard employees. The study results will contribute to the knowledge base of the mental health discipline and extend the scientific body of nursing and midwifery knowledge. It will also inform future research priorities regarding mental health care provision utilizing an action research methodology.

1.8 Summary

Occupational stress and workplace burnout are significant issues affecting modern day workplaces. Occupational stress has been linked to a decrease in physiological well-being of individuals. This results from a combination of low job control, high job demands and low work-related support. It is apparent that the helping professions have endured a significant shift in praxis with the changing profile of the health system, cost-control measures, working conditions and societal expectations, and that these changes have likely added to stresses experienced by health practitioners, particularly in the rural remote setting.

1.9 Thesis outline

Chapter 2 provides a detailed discussion of methodology and illustrates the decision to use action research methodology to answer the research questions previously posed. An overview of the action research methodology is presented and different models of action research are reviewed and discussed.

Chapter 3 summarizes the methods used in the study. This chapter reflects on the process undertaken when conducting the research through a summary of the appropriate literature.

Chapter 4 introduces the first stages of the first research cycle and is concerned with entry into the field, contracting, and developing the client infrastructure. It describes how objectives were established and outlines the roles and responsibilities of the researcher and the participants.

Chapter 5 discusses the further development of the first research cycle in diagnosing and identifying the problem, action planning, action taking, evaluating and the specify learning. The critical group identified significant stressful issues within aspects of their work practices allowing consideration of which interventions they believed would reduce stress.

Chapter 6 examines the subsequent cycles and considers alternative courses of actions that were undertaken in the belief that the problematic situation could be altered to produce a desired outcome. These cycles remained subject to the preceding cycles and facilitated the implementation of a hypothesized change by redefining and reconceptualizing an existing problem.

Chapter 7 is the discussion chapter and involves a review of the previous chapters in light of the purpose of the research study and other research in the field. It discusses the learnings from the study and how those learnings brought about change.

Chapter 8 the concluding chapter, briefly discusses the implications of the research and the utilization of the action research process for this study. It reviews the experiences shared by the researcher and the co-participants and the theoretical constructs developed

within this research. It refers to making progress in the development of clinical excellence and policy design and changing practice through evidence, and conducting research to effect change by reassigning new paradigms for changing praxis.

CHAPTER 2

Methodology

2.1 Introduction

This chapter provides a detailed discussion of the rationale for choosing action research as a research methodology. The chapter commences with an overview of the epistemology of nursing research. The origin of action research in the work of the German psychologist Kurt Lewin (1890–1947) is discussed. The characteristics of action research are explored giving the subtle differences from other qualitative research methods. The cyclic nature of action research is discussed initially following the steps of the Kemmis and McTaggart (1982) model as an approach for investigating the interpretive paradigm of a social phenomenon. Secondly, the Susman and Evered (1978) Model is discussed, outlining a workable concept for use in this study. The responsibilities of a researcher to represent adequately the participants of a research study are examined. Accountability and the reflective process are proposed as an alternative to validity of traditional research. The rationale for implementing an action research methodology in this study is identified through a deductive process. An outline of the proposed model used in this research is provided allowing the reader to examine the cyclic process.

2.2 Epistemology of research in health and social sciences

The nature of research facilitates inquiry into problems requiring solutions, new knowledge and the generation of theories in sound acceptable methods (Axford, Minichiello, Coulston, & O'Brien, 1999; Sheehan, 1996; Whitehead, 2007a). Hypothetical deductive reasoning is systematic, controlled and empirical, forming the basis of propositions and causal relationships (Gerber, 1999; Sheehan, 1986; Whitehead, 2007a). Applied research is described as focusing on discovering solutions to immediate problems, in direct contrast to the positivist approach of systematically collecting data and testing hypotheses (Gerber, 1999; Whitehead, 2007a). While positivist science emphasizes control, applied research is

required to study social or psychological functioning in the natural setting in which the concept of control is redundant.

Although there have been attempts to investigate nursing science through the reductionist approach invented in a laboratory, it is not always possible to apply such approaches to nursing research or practice (Gerber, 1999; Whitehead, 2007a; Tolley, 1995). Consequently, much nursing research has moved away from the traditional medical science model to the social science model of investigation grounded in the qualitative research paradigm (Ezzy, 2006; Owens et al., 1999; Walter, 2006a; Wright, 1991). Qualitative methodologies involve exploring participants' perspectives and experiences and locating these within a wider social context. Data collection, which involves the interactions of the researcher and respondents, is recognized as being based on a subjective process (Simmons, 1995). Qualitative research permits data analysis within the research as it progresses in the identification of patterns of meanings and interpretations. The aim of this is to develop sociological theory that contributes to the understanding of the social world (Willis, 2006). New knowledge that is socially constructed must be understood in its political and cultural context (Taylor, 1993) expanding nursing knowledge with the developed new theories to be applied in practice.

From a theoretical viewpoint action research can be deemed to be both action learning theory and critical social theory (Carr & Kemmis, 1990; Owens et al., 1999). Critical social theory allows for a collective inquiry into social reality with the potential for change in practice through collective analysis and action. This theory emerged after shortcomings were identified in both positivist and interpretive approaches to social science (Carr & Kemmis, 1990; Owens et al., 1999). A direct correlation between knowledge and practice forms critical social theory, which results from the 'outcome of human activity' (Tolley,

1995, p.185). The separation of the ideal world from the real world may contribute to the theory–practice gap (Tolley, 1995; Owens et al., 1999). Action research is a methodology that facilitates a greater union between researchers and clinicians and thus is in a better position to address the theory–practice gap (Owens et al., 1999; Whitehead & Elliott, 2007). It provides an ecological perspective in viewing social problems and individuals' behaviours, encompassing a focus on organizational, community, and cultural factors. In collaboration with participants, this form of research develops natural helping resources in communities rather than limiting the focus to professional resources only. This includes the change and development of new social policies and work environments. Action research can be described as a holistic social process facilitating change; organizational change is effected as this methodology marries the change process to the research findings (Owens et al, 1999; Whitehead & Elliott, 2007). It provides a way to work with people in the research field in a non-hierarchical and non-exploitative manner, enabling participants to reclaim the authority to identify their own roles and to establish conditions within their work practices (Kemmis & McTaggart, 1982).

Observation is a technique that facilitates description of actions, behaviours and interactions. It allows for individuals to be observed utilizing all their senses, including their verbal and non-verbal communication. Their perceptions, beliefs and assumptions can also be noted. The researcher examines within the practice context while not being dependent on categories of established theory and techniques, and constructs new theories defining means and ends interactively (Rolfe, 1996; Whitehead & Elliott, 2007). Reason (1988) viewed expression as a mode that allowed the meaning of experience to be verbalized and to take form. This requires the use of a creative medium. Human inquiry facilitates this medium. Language is expressed in various forms and can be identified through words, actions, art forms and silence, and can be 'analogical and symbolic' (p.82).

Reason postulates that the expression of experience, the inquiry into meaning, has been largely ignored in orthodox science and that it should be recognized as an important aspect of research. Reason (1988) cites Wilber (1981a) in support of this argument:

> *... for no amount of analytical-scientific data, no matter how complete, can totally establish meaning ... Rather, meaning is established, not only by sensory data, but by unrestrained communicative inquiry and interpretation [Wilber, 1981a, p32] (Reason, 1988, p82).*

2.2.1 The birth of action research

Kurt Lewin (1890–1947) is generally considered the 'father' of action research. A German social and experimental psychologist, and one of the founders of the Gestalt school, Lewin was concerned with social problems and was engaged in a project for the American Jewish Congress in New York—the Commission of Community Interrelations. This organization made use of Lewin's model of action research involving a number of significant studies into religious and racial prejudice. The focus was to improve conditions and inter-group relations, to examine the effects of conditions under which persons/groups made contact and what influenced an increase in sense of belonging within this cohort (Greathouse, 1997). Lewin's action research denoted a pioneering approach to social research by combining theory generation with change to the social system. Lewin's initial article, containing the term action research (Susman & Evered, 1978), highlighted his passion to transform social problems through a collaborative process so as to identify ways to initiate required changes, particularly in areas where traditional scientific research had failed. The benefits of this approach were seen in its ability to make social science relevant to the needs of policy makers, planners and community leaders (Susman & Evered, 1978). The approach was initially adopted by the business sector and, later, education (Hart & Cert, 1995; Meyer, 1993). Despite an apparent congruence between the aims of action research and much of the research conducted in the discipline of nursing, the uptake of action research by nurse researchers was surprisingly slow (Meyer, 1993).

Action research had gained acceptance in the new paradigm of research that was based on a collaborative approach (Reason, 1988; Reason & Rowan, 1981; Whitehead & Elliott, 2007). The emphasis on practitioners becoming co-researchers, through systematic reflection on their daily practice to effect changes within their practice, closely followed the concept of the action research process (Carr & Kemmis, 1986). This approach was subjective, varying greatly from the objective approach of quantitative methodologies and it called for critical self-reflection that then generated theory dependent on the meanings and interpretations of each participant (Carr & Kemmis, 1986; Meyer, 1993; Whitehead, 2007a).

2.2.2 The characteristics of action research

As in all social research, action research involves people as key stakeholders/co-researchers who determine the appropriateness of both the action and the research. Wallis (1998) and Owens et al. (1999) identify that the collaboration and participation processes of action research are essential to facilitate the knowledge, skills and confidence needed to change practice and to maximize the link between research and practice. Participants in the research are known as the critical group and they work collaboratively with the researcher as co-researchers (Whitehead & Elliott, 2007). Participation by all members of the critical group is the predominant factor giving rise to the emancipatory process, by allowing each member to become a co-researcher and to be given a voice (Whitehead & Elliott, 2007). Collaborative reflection and action among those with shared concerns can implement social change through this method of research, which is conceptualized as a spiral of collective, self-reflective inquiry (Kemmis and McTaggart, 1988; Whitehead & Elliott, 2007).

Susman and Evered (1978, p.587) describe the characteristics of action research as providing a ‘corrective to the deficiencies’ of positivist science. These characteristics are

explained by these authors as being ‘future orientated’ by creating a more desirable future for people when dealing with their practical concerns. The authors describe an interdependent relationship involving collaboration between the researcher and the participant. These authors (1978) cite Rapport (1970) in defining action research:

> *Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework (Susman and Evered, 1978, p.587).*

By implying a system development, action research facilitates the maintenance and regulation of a cyclic process of diagnosing, action planning and taking, evaluating and learning generating theory. Theory grounded in action provides a guide for diagnosing problems and evaluating their consequences. The generation of theory is a deliberate process in action research. Theory generation provides for emancipation of practitioners from constraints and ideal practices, providing the means to create democratic conditions through collaborative practical discourse (Carr & Kemmis, 1994; Whitehead & Elliott, 2007). Implementation of the findings is built into the research process circumventing the possible situation of research findings not being put into practice, which may occur when using other research methodologies (Annells & Whitehead, 2007; Carr & Kemmis, 1994). Action research can provide both the flexibility and responsiveness required for effective change and a check on the adequacy of data and conclusions (Adami & Kiger, 2005; Whitehead & Elliot, 2007).

One of the main characteristics separating action research from other forms of research is that researchers have limited control over the environment in which it is conducted. Although traditional scientific approaches seek to produce an objective body of knowledge that can be generalized to a larger population, action research collaboratively constructs a descriptive and interpretive brief of events that facilitates a mutually accepted resolution to

a problem identified by a group of people. Stringer (1996) refers to Foucault (1972) when discussing such postmodern research perspectives:

> *He is concerned that people should cultivate and enhance planning and decision making at local level, resisting techniques and practices that are oppressive in one way or another (Stringer, 1996, p.152).*

Action research is used in real time as opposed to a contrived, experimental study, and its primary focus is on solving real problems. It can be used for preliminary or pilot research if the situation is too ambiguous to formulate a precise research question. It is chosen particularly when circumstances require flexibility, the involvement of the people in the research, or change that must take place quickly or holistically. However, one of the hallmarks of action research is that analysis occurs in practice during each phase of the research cycle. Hypotheses are not formulated at the start of the action research; instead, hypotheses are suggested as a tentative prediction of an expected outcome and the identification of the most appropriate research question, problem, statement or idea becomes an integral part of the research (Greenwood, 1984; Whitehead, 2007a; Whitehead & Elliott, 2007). One of the distinguishing hallmarks of action research is that it seeks to create change, and develop and refine theory within its local setting (Polit & Hungler, 1991; Whitehead, 2007a). A thematic concern (i.e. the phenomenon of interest) exists with both action and research, underpinned by critical social theory, leading to intended outcomes and contributing both to knowledge and successful change in practice (Whitehead, 2007a).

2.2.3 The cyclic nature of action research

The action research method includes a wide range of variations on a theme, including participatory research, collaborative inquiry, emancipatory research, action learning and contextual action research (Sheehan, 1996; Susman & Evered, 1978; Whitehead & Elliott, 2007). The cyclic or spiral process first introduced in the previous section involves the four steps of planning, acting, observing and reflecting (Kemmis & McTaggart, 1982). The aim

of the planning phase is to develop an exact description of what changes should be implemented into practice (Kemmis & McTaggart, 1982). The critical group involved in the research carefully considers what is believed to be the most effective intervention to effect change of practice in order to resolve an identified problem (Kemmis & McTaggart, 1982). Critical communication practice (the formation of abstract generalizations and concepts then testing and applying these in a new situation) facilitates a reflection-in-action and a reflection-on-action and provides the basis for subsequent cycles. It is designed to create change in practice and develop and refine theory within its local setting (Kemmis & McTaggart, 1982; Owens et al., 1999).

The action step provides a rationale for strategic interventions aimed at an improvement in practice and greater understanding of the practice situation (Kemmis & McTaggart, 1982; Owens et al., 1999; Whitehead & Elliot, 2007). The second step, the planning step, is deliberate where controlled variations are implemented into practice and used as a platform for further actions in subsequent cycles. This step is guided by the critical group and takes place in real time. It may encounter variables and constraints such as the political climate and availability of resources (Kemmis & McTaggart, 1982; Whitehead & Elliot, 2007). It is described as fluid and dynamic, which requires instant decision-making by the critical group and the exercise of practical judgment (Kemmis & McTaggart, 1982; Whitehead & Elliot, 2007). The third step of action research, observation, serves to document and reflect on the effects of the action step, providing reflection for possible changes and thus being prospective to future cycles. With actions having constraints of reality, the observation step must be carefully reviewed, allowing for responsive and expanded views on the subject under consideration. Observing and reflecting on the action process allows identification of the implementation's constraints and benefits and any changes to circumstances, and provides a basis for subsequent reflection (Kemmis & McTaggart, 1982; Owens et al.,

1999; Whitehead & Elliot, 2007). The final step, reflection, is retrospective, recalling action previously recorded in the observation step (Kemmis & McTaggart, 1982; Owens et al., 1999; Whitehead & Elliot, 2007). All of the identified material relevant to the action process is assimilated and related to the varying perspectives and circumstances observed. This step involves discussion amongst the critical group leading to evaluation of data and reconstruction of a subsequent action. Evaluation is an integral part of this step, assessing the effects of the action in terms of its impact on the thematic concern and the potential theoretical implications arising from the action research cycles (McCaugherty, 1991; Rolfe, 1996; Owens et al., 1999; Whitehead & Elliot, 2007). The reflective step is descriptive, identifying progress for proceeding into any subsequent cycles, eventually establishing a final outcome to the research while allowing for reflection on what has happened and providing a basis for future planning (Kemmis & McTaggart, 1982; McCaugherty, 1991; Rolfe, 1996; Owens et al., 1999; Whitehead & Elliot, 2007).

Carr and Kemmis' (1986) model of action research includes an additional step to the typical model outlined above, reconnaissance, at the commencement of the first cycle. The reconnaissance step gives the researcher a framework to establish the circumstances of the setting under study. Once established, the researcher moves through the steps of planning, acting, observing and reflecting, as outlined above. A reconnaissance step was undertaken in this research and provided an overview of the community and the health area under study. This informed me of the demographics and established cultures within this community. This prior knowledge allowed for ease of acceptance as a researcher into the community and provided me with greater understanding of what the critical group may wish to achieve.

2.3 Methods of nursing research

Polit and Hungler (1991) refer to methods of nursing research as being quite diverse. The authors contend that there is no single correct way to discover knowledge and understanding of our complex world and that knowledge would be inadequate if there was not such a rich array of approaches to utilize. These authors express the view that the selection of an appropriate method depends to some degree not only on the researcher's personal taste and philosophy, but also largely on the nature of the research question. There is a range of research methodologies used in different disciplines to answer different types of questions. In experimental research, the researcher has strong control over the environment under study. Variables can be manipulated over time, numeric data is collected and, through statistical analysis, hypotheses are tested. Survey research, for example sampling opinion, intentions or beliefs with questionnaires or interviews, is commonly used in the work of economists and sociologists. Data are tested to validate models or hypotheses. Case research is used in business studies, where cases are analysed to build up or validate models or theories. Textual data are collected through interviews for analysis (Polit & Hungler, 1991).

Qualitative research methodologies are also appropriate to gain a better understanding of phenomena and can be particularly pertinent in nursing research. A phenomenological framework for research inquiry develops an understanding of a phenomenon through a specific human experience of that phenomenon. This methodology explores the person's experience rather than explaining a causal relationship for that experience (Hansen, 2006). For example, Heideggerian phenomenology seeks to understand the practical 'situatedness' of a person's experience and the relevance to that person's existence within their world (Whitehead, 2007b, p.109).

Grounded theory is an entire philosophy about how to conduct research. A fundamental feature of this research method is that data collection and analysis are conducted simultaneously; meaning is derived through constant comparison of the research findings (Jackson & Borbasi, 2008; Polit & Hungler, 1991; Whitehead, 2007b). This approach requires total data saturation and is concerned with the generation of categories, properties and hypotheses rather than the testing of them. This methodology is prescriptive in data collection and analysis and is aimed at producing a theory explaining the phenomenon under study (Hansen, 2006).

Habermas (1973) and Carr and Kemmis (1986) divide action research into technical, practical and emancipatory. (1) Technical: the co-researchers within an organization work collaboratively with an outside expert to improve the efficiency of the organization. (2) Practical: the outsider adopts a facilitation role with the co-researchers adopting a more active role in the research process; and (3) Emancipatory: there is a shared responsibility between the outsider and the co-researchers for the research process and outcomes of the research (Owens et al., 1999; Street, 2004). Emancipatory action research allows the critical group to take joint responsibility for the development of the research in a collaborative process generating theory and change. The shift from the traditional researcher-subject paradigm becomes imperative in this form of research and it provides a venue for participants to become partners and researchers in their practice in critical reflection. Habermas (1987) describes self-reflection as being determined by an 'emancipatory cognitive interest' (p. 310). Through critical reflection, the outcome of actions becomes an integral part of human reasoning and challenges beliefs and theories (Habermas, 1987; Owens et al., 1999; Rolfe, 1996; Schön, 1987; Street, 2004; Whitehead & Elliot, 2007). Habermas contends that critical social theory must provide objective explanations of social reality.

Action research involves the use of change in an experimental format involving people within their own social context. This methodology is embedded in socio-political studies of social and work life issues (Kemmis & McTaggart, 1982; Owens et al., 1999; Street, 2004; Whitehead & Elliot, 2007). Problematic issues within this social context are diagnosed as clinical problems, thus lending themselves to research studies. By actively engaging the participants in a democratic and reformatory social inquiry, critical social theory and emancipatory research is demonstrated (Grbich, 1999; Hansen, 2006; Whitehead, 2007b). A critical understanding of human action can be developed through the hermeneutic process of language, empowering individuals and emancipating them (Hart & Bond 1995; Owens et al., 1999; Whitehead & Elliot, 2007).

An approach to the acquisition of scientific knowledge can be simplified into a two-stage process. First, the diagnostic stage involves a collaborative analysis of the social situation by the researcher and the participants involved in the research to provide a basis for a research study. The research question and aims are established concerning the nature of the research domain. Second, the implementation stage involves collaborative change experiments. In this stage, changes are introduced and the effects are studied where theory can be generated (Owens et al., 1999; Whitehead & Elliot, 2007). The Susman and Evered (1978) Model of Change provides this simplified method of inquiry that involves a five-phase cyclical process of the original formulation of action research. The variation of this approach first requires the establishment of a client-system infrastructure or research environment. Then, five identifiable phases are iterated: (1) diagnosing (2) action planning (3) action taking (4) evaluating and (5) specifying learning. Figure 1 outlines this action research structural cycle. After careful consideration of the information discussed above,

this model by Susman and Evered was the preferred methodology that was adopted for this study.

2.4 Study design

One significant variation in adopting this model was with Pearson's (1989) adaptation that included an initial phase of 'Contracting'. This phase provides the researcher with the opportunity to define more clearly group interaction where contracts can be discussed and agreed upon prior to entering any research spiral. It also allows the researcher and the group to determine what roles and expectations will be required of all who undertake the research. Following the Susman and Evered (1978) model with the Pearson (1989) adaptation, the critical group in this study was selected in the contracting stage (see Figure 1). Similar to other action research approaches previously identified, this model involves a cyclic process.

The Development Phase provides for the client-system infrastructure to be established. This client-system infrastructure is the social system under study in which the participant members exist. In this phase, understanding and general consensus is developed between all parties. Each participant is given a speaker position, thus addressing the issue of participant bias agenda. Common power comes from a shared understanding permitting democratic contribution to the critical group and providing respect to each contributor without judgment.

The Diagnosing Phase involves problem identification and determines what is happening within the setting. It involves the collaborative analysis of the social situation by the researcher and the participants of the research. Theories are formulated concerning the nature of the research domain. A collective postulation of several possible solutions is examined from which a single plan of action emerges and is implemented. In this phase, a problem is identified and data is collected for a more detailed diagnosis.

The Action Planning Phase gives an exact description of what changes will be implemented into practice. Through a collaborative process, the researcher and the co-participants collate the information discussed in the previous phase and determine an appropriate action towards resolving the identified problem.

The Action Taking Phase implements mutually agreed changes in practice. A defined course of action is undertaken, directed at an area of practice perceived in previous phases to warrant amending. Deliberate and controlled variations are implemented into practice and used as a platform for further action in subsequent cycles.

The Evaluation Phase reports the findings and data generated by the action taken. Data analysis is undertaken based on the results of the interventions and the findings are interpreted to determine how successful the action has been. This phase serves as documentation of the effects of action, providing reflection, and thus being prospective to future cycles.

The Learning Phase provides critical reflection, theorizing and analysis of identified themes. Retrospectively it recalls previously recorded actions, reviewing the effectiveness of any actions taken guided by the evaluation phase. The emergence of new knowledge is identified taking the research to a new level. Gaps in knowledge can be identified and theories can be deduced with the potential aim of informing new policies.

2.5 Researcher responsibility ensuring voice, identity and reflexivity

A praxis model of research ensures that researchers remain accountable to the needs of the group(s) they study (Seng, 1998). When utilizing participatory research, researchers are confronted with a higher degree of accountability to the group that they are working with because participants are deemed to be partners, not subjects. In recognizing the subjectivity within action research the researcher is required to adopt an assessment of quality and accountability as an alternative to the traditional notions of validity and reliability from quantitative research. This is identified through the participants monitoring the researcher's

bias and their conducting and disseminating the working component of the research (Street, 2004; Waterman, 1995; Whitehead & Elliot, 2007).

Owens et al. (1999) and Whitehead and Elliot (2007) recognized the reflective process (a critical analysis of the results to determine whether they genuinely represent the solution to meet the group's needs) in addressing validity, where a holistic flexible approach to knowledge (both inductive and deductive) is viewed purposefully. These authors describe a quality process that adopts a deliberative approach. This involves identifying, describing and solving practical problems where omissions and errors are said to be identified, providing accurate conclusions drawn from experience. In recognizing the subjectivity of action research and the loss of the traditional scientific method attending to validity and reliability as traditional criteria, researchers are required to adopt an alternative assessment of quality and accountability. The theoretical underpinning for this exists in the concepts of emancipation and empowerment. Pearson (1992) discusses conflict theories identifying change as fundamental to social groups, where change depends on power. This author purports that within groups where consensus exists, power is authority.

A participatory approach recognizes that all members of a group bring useful knowledge and skills to the consultation and decision-making process. Local knowledge is particularly valued in consultation because of its socially democratic nature. The interests of each individual and group are acknowledged, facilitating cooperation in effecting resolve (Owens et al., 1999; Street, 2004; Wheeler and Chin, 1991; Whitehead & Elliot, 2007). A group's commitment to decision making by consensus as growing from defined 'Principles of Unity', each individual's viewpoint is valued equally throughout the decision-making process, moving away from any action which may exert power over other individuals. Consensus emanates from a full integration of all perceptions that influence a particular

concern, issue or decision. A participant in an action research project may become a facilitator or collaborator, empowering others to work for change. When discussing participatory action research Pearson (1992) associates a change agent with the concept of consultancy, acting specifically as a consultant in a collaborative process to effect change. It is emphasized by this author that this change should be 'mutual and dynamic' (p.26). In this approach all group members are supported to learn new knowledge and skills and to contribute to the best of their ability in an ongoing process of planning, taking action, reviewing what has resulted, and moving on to further planning and action to effect change within that community. The key responsibility of the researcher is to reflect accurately this process (Hansen, 2006; Kemmis & McTaggart, 1983; Owens et al., 1999; Street, 2004; Whitehead & Elliot, 2007).

2.6 Selecting the appropriate methodology

It is important to consider an appropriate research methodology that matches the research question being asked (Sheehan, 1986). To meet the aims of the research, a design and method that provides the opportunity for inquiry into a social phenomenon should be employed (Whitehead & Elliot, 2007). My research question was "What stressors does a community mental health team in a rural and remote region identify as critical in the creation of occupational stress and workplace burnout and how can they overcome these particular issues in their setting?" In addressing this, it was evident that a research method was required which would not incur additional workplace stress for the participants; rather, it should provide the means to explore the basis of, and alleviate, problematic issues contributing to workplace stress. In selecting the research methodology for this research, the emancipatory process of the action research design provided the desired outcome of empowerment, meeting the aims of the research (Owens et al., 1999; Simmons, 1995; Whitehead & Elliot, 2007). An empowering approach based on the concept of occupational and environmental stress associated with a variety of psychological, physiological and

behavioural outcomes would facilitate participants to examine the issues without duress (Hansen, 2006; Owens et al., 1999; Simmons, 1995; Whitehead & Elliot, 2007). This approach allowed the establishment of collaborative working relationships providing understanding, defining and shifting of parameters, and data generation (Annells & Whitehead, 2007; Webb, 1989; Whitehead & Elliott, 2007). Further, as the research aimed to overcome the theory–practice gap by initiating changes to work practices in the community mental health team and the hospital staff, it was research carried out in practice, offering the opportunity for the participants to take responsibility for change and to give them ownership of the project (Street, 1995; 2004). Hence, this study was an emancipatory form of action research. Those selecting action research seek different means to approach problems and change than those who conduct traditional intervention programmes (Owens et al., 1999; Street, 1995; 2004; Hansen, 2006; Whitehead & Elliot, 2007). Although alternative methodologies are available to implement research, action research provided the optimal conceptual framework for resolving the thematic concern of this study.

2.7 Conclusion

This chapter has outlined the methodology of this research with the view of informing the reader why the action research method was selected. It has discussed the birth of action research in the work of the German psychologist Kurt Lewin. The characteristics distinctive to action research were examined, primarily participation and collaboration between the researcher and the research participants in a reflexive praxis throughout each phase of the research. The hallmarks of action research include that analysis occurs in real time in each of these phases with the generation of theory being developed through collaborative discourse. Methodological comparisons highlighted the search for knowledge following the scientific paradigms to establish a suitable mode to be adopted for the research that would adequately address the research question. The emancipatory process of

action research was identified as having the required characteristics to be most suitable for the research study. The dialogue generated on methodologies gave validity to the Susman and Evered (1978) model of action research as the underpinning model for this study. The phases of this model were discussed providing the opportunity for the reader to become familiar with the cyclic process of action research. Details about how the research was undertaken during each of the action research phases are presented in the next chapter on methods.

THE CYCLIC PROCESS OF ACTION RESEARCH

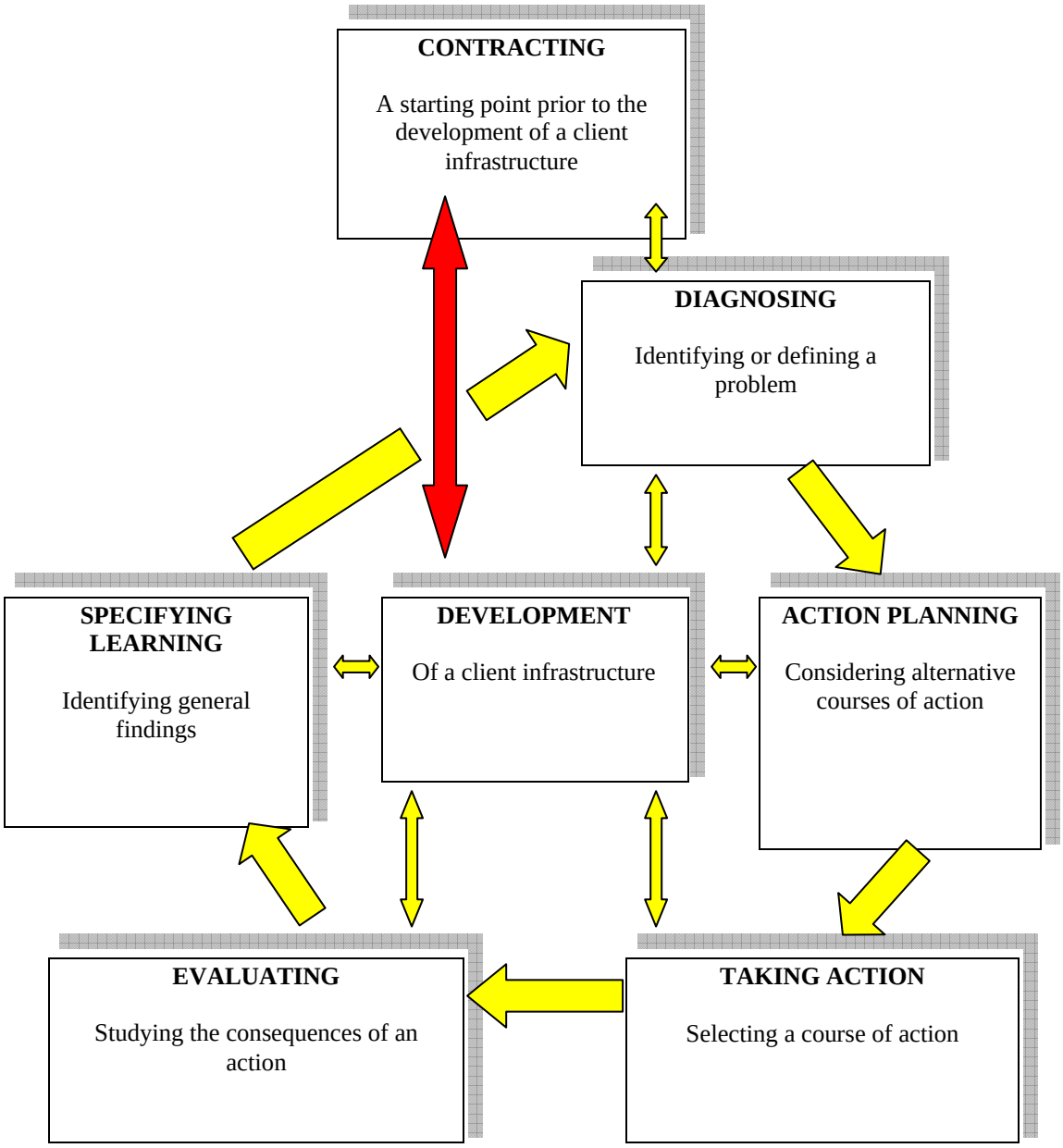

Figure 2. Detailed Action Research model (from Susman, 1983, adapted by Pearson, 1989)

CHAPTER 3

Method

Whereas the previous chapter examined methodology, the present chapter describes the action research method undertaken in this research study and the steps undertaken to ensure the rigour of the research study. The method is discussed identifying the formal application of systematic, logical procedures that guided the investigation. The conceptual idea or thematic concern is addressed giving recognition as to how this study was initiated. A reconnaissance phase is discussed in detail outlining the basis for the thematic concern. An expansion of this is discussed in the developing interest paragraph, which then describes the decision to implement an action research approach to the phenomenon to be studied. The study setting is described giving the reader an insight into the location of the health service and the difficulties associated with the geographical proximity. Demographic and epidemiological profiles are examined recognizing that data collected in an area of low population may be reflective of community-level needs. Purposive sampling is identified as the selected preference for this study in the belief that the sample would provide the key informant approach. The inclusion criteria are discussed giving credibility to purposive sampling. The limitation of the sampling method identifies the difficulties involving researcher bias and objective assessment of representativeness. A detailed discussion of rigour is undertaken highlighting that the data collected is appropriately represented for balance. Ethical consideration is reviewed giving acknowledgement to the protection of participants. This is achieved through providing informed consent, the right to withdraw, autonomy in voice, accuracy in representation, participant privacy and sensitivity, educating the participants, acknowledging any distress to the participants, ensuring confidentiality, acknowledging unethical behaviour, limiting access to data, and the storage of collected data. Data collection clearly describes the method implemented in this phase of the research. The formal interpretation of data is described emphasizing this

process in action research. Transparent data analysis ensuring validity and reliability through respondent validation are discussed in trustworthiness. A critique of the research study examines both the strengths and limitations that have impacted on the research.

3.1 Action Research Method

Qualitative research is essentially an inductive approach that values the holistic perspective and experience of individuals. Findings and conclusions are determined from collected data that describe and enunciate these perspectives and experiences. The balance between researcher creativity and rigour demands continuing close monitoring and self scrutiny by researchers (Owens et al., 1999; Whitehead & Elliot, 2007).

For the purpose of this study the following formal data collection methods were used: anecdotal records, field notes, informal conversations and tape recorded meetings with the critical group. Additionally, throughout the fieldwork there were occasions when informal conversations occurred, allowing the researcher to evaluate the level of commitment that each participant maintained. Data analysis was conducted alongside data collection. In data analysis theories were articulated and explored and these directed changes from the status quo affecting desired outcomes and creating greater understanding of practice (Owens et al., 1999; Whitehead & Annells, 2007; Whitehead & Elliot, 2007).

Reflecting on data collected within the group served as a form of validation upon which the research could proceed and this was aimed to sustain participants' confidence to continue without prejudice. Good questioning techniques provided the basis for reliability, using open-ended questions that fully covered all aspects of the situation and clarified any ambiguity (Owens et al., 1999; Whitehead & Elliot, 2007; Whitehead & Annells, 2007). Giving feedback to each participant to confirm that the researcher had interpreted his/her information correctly ensured validity of data submitted by the participant.

3.2 Thematic concern

Action research begins with a general idea that a concern of practice exists and improvement or change is desirable. A group is formed and works collaboratively in developing improvement strategies focused on the 'thematic concern' (Hart & Bond, 1995, p.54; Kemmis & McTaggart, 1988, p.8–9; Street, 2004). A research question identified in an action research study could be different to the 'thematic concern' (Kemmis & McTaggart, 1988, p.9; Street, 2004). The thematic concern is less restrictive. The original premise of this research was that occupational stressors exist in the workplace. A primary stressor that may influence this is practising in the rural, remote and isolated regions of an Area Health Service. The conceptual issue or thematic concern for this research was that the impact occupational stressors have on nursing practice in community mental health teams may lead to workplace burnout. It was believed this major stressor could be examined through action research, allowing consideration of its impact on the work environment. Accordingly the research question posed in this study refers to a group of nurses practising in a rural remote community mental health setting and what unique stressor(s) they saw as 'critical' in the creation of occupational stress that may lead to workplace burnout. This perspective was useful in developing programmes aimed at changing and improving the quality of work life and of the work environment itself.

3.2.1 Reconnaissance—a community perspective to mental health services

'Mental hospitals' of yesteryear provided patients with security and protection. This has been acknowledged for centuries, and, in Victorian times, the approach of housing these sufferers in institutions afforded total care. Scull (1984) purported that industrial and technological change in the 1800s, along with increasing urbanisation, brought decreasing tolerance of the often 'bizarre and disruptive behaviour exhibited by people with mental illnesses' (p.22). This behaviour was unacceptable within the social structure of the day. Before the 1950s, the dominant philosophy of care within most mental hospitals was

custodialism. Patients were generally regarded as ‘incurable fools’, and the hospital simply provided them with a minimum level of custodial care. There was little concern with patients’ human rights or feelings of self-worth. Therapeutic interaction aimed at rehabilitation was minimal or non-existent. Pioneering work in the 1950s by Caudill and associates and also by Stanton and Schwartz exposed the dehumanizing and depersonalizing atmosphere of overcrowded and derelict State mental hospitals. This gave rise to a worldwide trend to introduce rehabilitation and deinstitutionalization programmes in State-run facilities. Deinstitutionalization involved the move away from a physical structure towards a social structure that requires a comprehensive, coordinated service for the provision of care to discharged patients. The advent of psychotropic medication facilitated the already rapid changes in mental health service provision and meant that chemical restraint could be used rather than mechanical restraint, allowing patients to be managed in a less restrictive environment facilitating the move to deinstitutionalization (Wilson & Kneisl, 1992). More specifically the introduction of phenothiazines, chlorpromazine (Largactil) and the use of fluphenazine decanoate in depot injections for treatment of schizophrenia revolutionized the management of psychiatric patients and provided an avenue for the discharge of many long-term psychiatric patients into the community (Scull, 1984). This lent support to the medical model. The most strident advocates for deinstitutionalization argued that phenothiazines did not cure patients but merely provided symptomatic relief (Scull 1984). The philosophy upon which community mental health teams were to function involved collaboration across several disciplines, each discipline providing separate but not always distinctive services to mental health consumers (Cook & Fontaine, 1991). Community-based programmes would focus on prevention and utilize a total and comprehensive approach. Primary, secondary and tertiary interventions were to be established in delivery modalities; crisis intervention, partial

hospitalization and day treatment programmes would allow flexibility of cover in total care.

The delivery of community mental health has been strongly influenced by political and economic trends (Murray & Huelskoetter, 1991). As humanistic concerns were articulated, politicians and bureaucrats identified this as an area of health service provision that would allow cost savings. Thus, the mental health reforms reflected social, political and economic characteristics of the time (Wilson & Kneisl, 1979). This rehabilitation and cure of 'madmen', the reformation of criminals and the salvation of delinquent children saw the rebirth of humanism during the 1950s. The mental hospital was redefined as a 'community of persons' until deinstitutionalization. This was in preference to a 'rigid institution of incarceration' (Scull, 1984, p.30). Dramatic changes in the provision of psychiatric services within this period in Australia led to the development of legislation such as the Mental Health Act (1986) in Victoria, providing for voluntary admissions into mental hospitals in States across Australia. Bates (1977) described this as 'legal preparation for the open door policy' (p3). However, opponents of this reform argued that family and community settings were unsuitable for the care of the insane, thus breaching the traditional realms of health care. Chapman (1997, p.149) contends that home-based care being 'best and cheapest' failed to consider the costs both financially and otherwise to all concerned in the provision of mental health services.

The changes to the provision of psychiatric care have occurred on a global scale, with many countries trialling various models of care. Sedgwick (1982) and Scull (1984) discuss the parallels between the British and the American experiences of deinstitutionalization. For example, in both countries, advocates of deinstitutionalization gained political support by using financial issues to support their argument. In Italy, Hicks (1984) describes a

radical movement initially trialled in an industrial city in which changes to the Italian Mental Health Act (1978) led to a veto on the building of new psychiatric facilities and the banning of new admissions to existing facilities. Similarly, Kwakwa (1995) supported the approach of not building new facilities when reviewing the alternatives to hospital-based mental health care introduced in Cornwell, England. This extended study revealed that several districts had developed services that aimed to provide acute home-based mental health care as an alternative to hospital-based care.

Australia adopted the policy of deinstitutionalization later than some Western countries, with South Australia as the forerunner of the movement. In New South Wales, the Richmond Report (1983) proposed community-based forms of treatment with financial support coming from the closure of psychiatric hospitals. There was considerable aversion to change and industrial unrest amongst mental health professionals occurred during the move to deinstitutionalize. A change in government led to a reversal in policies and another report was commissioned. The Barclay Report (1988) recommended the integration of community mental health services into the general hospital system. This ideology, however, followed the medical model as opposed to the socio-cultural model of the Richmond Report (1983). Despite the resistance towards the provision of new services, Victoria followed NSW in the deinstitutionalization process.

The continued push to complete deinstitutionalization in Australia revealed several shortcomings in the process. There was a consensus amongst health professionals involved in deinstitutionalization that these shortcomings could be attributed to the lack of adequate funding from governments for the establishment of community mental health centres to provide acceptable care to mental health consumers. In Victoria, the deinstitutionalization policy incorporated mainstreaming, which placed psychiatric services within general

medical services. Croll (1997) identified that although support for this move was based on cost savings, there were still deficits in its funding by government. Fragmentation of funding reflected problems in the transfer of care for the mentally ill, and as a result, the quality of life of many patients with chronic mental illness who were now living in the community became severely compromised.

Provision of appropriate mental health services is hindered considerably in rural and remote regions. Resource levels for community-based programmes may not always provide appropriate levels of service. Additionally, isolation is a major factor contributing to poor recruitment and retention of qualified staff (Kenny & Duckett, 2003; SCARC, 2002). Remaining health staff are faced with the burden of attempting to provide an adequate mental health service to mental health consumers. At times, such services have to be provided by health professionals without mental health qualifications, working with limited or no access to local mental health services together with scarce and scattered resources.

3.2.2 Developing interest

Journal documentation for this research commenced in May 2000. Consultation with the Director of Psychiatric Services and a psychiatric Visiting Medical Officer at two Base Hospitals (large acute and emergency hospitals in regional centres) confirmed that a study into the stressors affecting community mental health teams in rural remote regions would be of real interest. Regional and rural remote areas were both considered as potential sites as they experience similar dilemmas. Although regional centres should have a round-the-clock on call service (where the clinician is called to the hospital to assess the patient) for the provision of essential care, it has become increasingly difficult to maintain this due to costs and the intrusion into the private lives of practitioners, causing them to seek employment elsewhere (personal observation). This has resulted in on call services being

decommissioned, leaving only a telephone counselling service (crisis line) for contact located in the regional centre. As a consequence, service provision in regional centres is at a similar level to that in remote regions.

An action research process was discussed as part of the consultation as being a suitable methodology to address occupational stress and the prevention of workplace burnout in rural remote regions, and also to effect change and view the problem from a social perspective. Through this approach, it was believed individuals would be empowered to resolve the distress without medicalising the problem, through participants harnessing their own desire to relieve the anxiety associated with stress. The concept was also discussed with work colleagues, who gave encouraging support. Sources of literature on workplace burnout and issues surrounding community mental teams were sought. An application to the University was made to undertake this research and a principal supervisor and co-supervisor were appointed.

Further discussion with supervisors led to the formulation of the concept and the proposal began to develop. Throughout this phase, I became more aware of problems caused by State border anomalies. In Australia, most health care is provided by the various State governments and is funded by the Medicare system providing subsidized health services to the population. It was decided that this research would be conducted within the public health sector in a rural remote region straddling the border between two Australian States. The setting of the thesis is one ‘community of interest’ that is divided geographically by the State border, meaning that the specific population in this study draws its clients from both States and at times must consider cross-border anomalies when initiating care. The laws under which a facility must practise are identified in the Mental Health Acts specific to each State, leading practitioners at all levels within the multidisciplinary teams

expressing concerns about the difficulties in service provision. The researcher felt that these cross-border anomalies compounded the stress practitioners were exposed to in an already difficult and demanding work environment. A cross-border agreement between the two States involved in this research was introduced in 2002 to provide continuity of care for health consumers and eliminate the duplication of services located within a few kilometres of each other. With the implementation of this agreement, it was proposed that variations in the two States' Mental Health Acts could be overcome through the implementation of restrictions and guidelines. This agreement was to be another consideration for the community mental health teams to focus on in the provision of services, potentially compounding the stress levels of community health teams. The underpinning concept of this research was considered that some of these stressors might be resolved through this research process.

3.2.3 Study setting

The study area is a geographically isolated health service existing in a rural remote health care group set in mountainous terrain (see Figure 2) approximately six hours' drive from a capital city and two hours from a small regional city. Health and community services in this Health Area are delivered through a Multi-purpose Service (MPS). This method of health service delivery has been identified as an alternative model to that used in metropolitan areas, where each type of service is funded separately (Commonwealth Department of Health and Aged Care, 2000). The MPS model was designed and implemented to allow collaboration and networking between multidisciplinary teams within the health sector resulting in a cost-effective service. There is acknowledgement that the area under study had an obligation to the Commonwealth and State governments to ensure that the people of this community received the best value care from the funding that was provided.

Figure 3. Aerial view of study area

Psychiatric service provision caters for all age groups with an extensive network of community mental health teams and psychiatric inpatient units throughout the region, supporting patients, carers and families. However, there is an identified constraint on the provision of adequate mental health services, with very limited resources available to service the outlying parts of the catchment area within this study. As part of the redevelopment of programmes, a comprehensive needs assessment was undertaken by this health service in 2002 to identify the underpinning health care plan for the community through to 2005. An unusual approach was adopted for the study in that it combined epidemiological and evidence-based approaches with a high level of community participation. There is an argument that maximizing health gains or achieving allocative efficiency is impossible within a framework of community-determined priorities. One reason for this is the possibility that the community is unlikely to have the specialist knowledge required to know what services, treatments or interventions are the most affordable and effective (Anderson & McFarland, 2006).

3.3 Demographic and epidemiological profiles

Demographic data was obtained through the Australian Bureau of Statistics (ABS) for the purpose of this study. The shire where this Area Health Service is located encompasses 6,673 square kilometres and has a population of 6,311 (ABS, 2001). The area is traditionally known for agricultural activities, beef and dairy production and supports a strong timber industry (see Figure 3). The fastest growing industry is the tourism industry with seasonal festivals highlighting this population influx. The town in which this study is located has a population of approximately 1200 people. Medical resources include an aged care facility, a district hospital with limited acute care facilities and a range of community and home based support programmes. There are three General Practitioners (GPs) who service the town and a local ambulance station with two ambulance officers. Accessing and developing an epidemiological profile for a small rural community represents a significant challenge. Some Australian States (such as NSW) have, for many years, provided high quality epidemiological data to health services through their public health centres. It is important to point out that epidemiological information relating to small populations has many limitations. Some may argue that regional data is adequate for community-level needs assessment. Rural health issues differ from those in more populous areas (Strong et al., 1998). These often reflect work-related morbidity and mortality. There are common issues for rural communities across Australia. These include appropriate models of service delivery, recruitment and retention of health professionals, equitable access to health care and appropriate education and training for rural health workers (Strong et al., 1998).

Figure 4. Agricultural land surrounding study area

3.4 Sampling

As sampling is an integral part of qualitative research it becomes imperative the researcher selects the appropriate examples of the population within a study. It is the process used to select the sample (Jackson & Borbasi, 2008). Qualitative research uses human subjects to examine human experiences who then become known as participants. It is a non-statistical approach in understanding the depth and subtleties of the human experience (Jackson & Borbasi, 2008; Llewellyn, Sullivan & Minichiello, 2004; Whitehead & Annells, 2007). Tending to be small in sample size, qualitative research uses various sampling techniques that result in the selected sample being 'information rich or experienced in the phenomenon of interest' (Jackson & Borbasi, 2008, p. 167). This study adopted the purposive sampling technique.

3.4.1 Sample population

The population of interest in this study refers to the health care workers working within this health area (Llewellyn, Sullivan & Minichiello, 1999). The selection of participants in the sample population for this research study reflected the key characteristics of a representative sample (Whitehead & Annells, 2007). These included Community Mental

Health Team (CMHT) members, Registered Nurses registered with the State nurses' registration body, Clinical Nurse Specialists, Clinical Nurse Consultants, Health Promotion Officers, social workers, occupational therapists and psychologists.

3.4.2 Purposive sampling

Based on the limited number of staff within this specific isolated CMHT this sampling technique was deemed to be the most suitable for this study. This form of sampling (deemed to be judgmental sampling) enabled the researcher to select participants best suited to address the issue under study and to target a representative selection of participants (Jackson & Borbasi, 2008; Mugo, 2003; Patton, 1990; Walter, 2006b; Whitehead & Annells, 2007). Experts in this specialty field of mental health service provision were selected on this basis. Despite the sample size being limited, Jones (2002) argues that the focus of qualitative research is on the depth and richness of text rather than on participant numbers.

The leader of this CMHT (known as the Community Mental Health Support Team [CMHST] due to regional funding) indicated that it was also necessary to invite staff of the emergency department (ED) of the hospital to participate in the research. These staff were the first point of contact for consumers with mental health issues accessing the service and it was believed that their needs were not being met. It was identified that this created a significant amount of stress for nursing staff when working in the ED, and also for the CMHST who were frequently required to attend to the dilemmas experienced by staff in this section of the hospital. Due to the size of the town, the ED is not permanently staffed and staff work there only when needed. Invitations to participate were therefore extended to all Registered Nurses in the hospital who may be required to attend the ED. Recognition was given that a collaborative team of multidisciplinary stakeholders should be sought to establish the best available evidence for the specific thematic concern underpinning this

research in an attempt to develop clinical guidelines and practice. Therefore, invitations were also sent to all allied health staff (health staff involved in other aspects of a patient's well-being, e.g. occupational therapists, social workers, etc), and the GPs in the town who serviced the hospital. The Chief Executive Officer (CEO) who was a Registered Nurse was also invited to participate.

3.4.3 Inclusion criteria

Suitability for participant inclusion in this study required characteristics that represent health staff that have sufficient experience in the phenomena under examination. It was determined that staff with a minimal work history in a rural remote region would not have had sufficient exposure to this and therefore health staff who have practised nursing and health care in a rural remote area for a period of not less than twelve (12) months would be accepted into the study. These also ensured participants were selected to give a cross-section of years of experience.

3.4.4 Limitations of sampling method

The limitations of this method of sampling must be identified. Through the sampling method the researcher attempted to achieve a representative cross-section of the target population in order to increase the efficiency of the research study (Jackson & Borbasi, 2008; Whitehead & Annells, 2007), despite the fact that the Area Health Service was quite small. The risk of conscious sampling bias may exist and this method did not allow for the precision of the researcher's judgment to be measurable. It did not provide any external objective method for assessing the representativeness of the selected group. Despite these limitations, the majority of nursing researchers and qualitative researchers use non-probability sampling (Polit & Hungler, 1991; Whitehead & Annells, 2007).

3.5 Rigour

The reliability and validity of research findings contribute to the rigour of both quantitative and qualitative research. This research study employed the framework identified by

Creswell and Miller (2000) that is governed by a two-dimensional approach: “the lens researchers use to validate their research and researchers’ paradigm assumption” (p.124). The ‘lens’ refers to a viewpoint used by the inquirer for establishing validity. Validity as reflexive accounting allows the researcher, the topic, and the sense-making process to interact (Creswell & Miller, 2000; Owens et al., 1999; Street, 2004). Creswell and Miller suggest that the paradigm allows the researcher a critical approach to engage in validity procedures through ‘self-disclosure and collaboration with participants in the study and permits researchers to be situated in a study’ (Creswell & Miller, 2000, p.126; Jackson & Borbasi, 2008). In action research the loop module provides a reasoning process for critical groups to initiate a productive knowledge base (Whitehead & Elliot, 2007). This allows for the probability outcome of actions and causes. Each innovation in action research cycles is introduced and examined with a specific intention. Evaluating this and refining the effective action with strategic modification produces the desired consequence and provides a domain for questioning goals and testing validity (Hansen, 2006). Consciously choosing the values one wants to enact becomes the personal responsibility of each participant. The success of satisfactory interaction within the group depends on each individual taking deliberate responsibility to ‘enact the values within her/his own behaviour’ (Wheeler & Chin, 1991, p.13). Peer group questioning of each participant’s input into its probable causality gives credibility to their ideas allowing actions to be tested, generating theory and bridging the theory–practice gap as the theory is implemented into practice (Annells & Whitehead, 2007; Hansen, 2006).

Steps were taken throughout the research study to ensure scientific rigour was maintained to demonstrate dependability and truthfulness (Annells & Whitehead, 2007; Newman, 2000). Reliability and validity were also reflected in this methodology through member checking (Creswell & Miller, 2000; Silverman, 2006) which involved dissemination and

analysis of data amongst the participants for verification. Verification of data and its implementation into subsequent cycles ensured the usefulness of the data by identifying convergent and counter patterns (Whitehead & Annells, 2007). This is supported by Hansen (2006) who contends the data is reviewed by the research participants 'member checking' (p.56) for accuracy allowing the incorporation of study findings into a second round of analysis. The principle underpinning this method establishes the 'degree of correspondence' between researcher and participant view (Hansen, 2006, p.56). The reflective stage of each cycle indicated the value of the results through construct validity. This is based on systematic reflection revealing differences in prior thinking altered by the current data (Owens et al., 1999; Silverman, 2006). Participants aided in determining the direction of research to ensure applicability and relevance of face validity. Gaining the impressions of the participants about descriptions, thematic analyses and conclusions permitted the group to move through the cycles. Data were deemed relevant and carried from cycle to cycle only if there was consensus among participants. Wheeler and Chin (1991) provide a clear definition of consensus:

> *Consensus is not totalitarian 'group think'. Unquestioning agreement to a party line is not a consensus. The group's Principles of Unity provide a common focus for examining diverse views, but are a guide, not dogma. A new viewpoint on an issue can challenge the group to re-examine their Principles of Unity, resulting in healthy growth and change. Individuals usually maintain diverse ideas about an issue, while at the same time taking into account the views of others and the overall sense of the group. Out of this balance grows an ability to willingly move towards a decision that is best for the group (Wheeler & Chin, 1991, p.48).*

Stringer (1996) relates community-based action research, or participatory approaches to inquiry, to a collaborative approach. A group, community or organization engaged in a democratic, equitable, liberating, and life-enhancing manner in this research process would provide an opportunity of ownership for such groups. Those affected by the problem under study are included in the process of investigation. Stringer identifies the research process

as a rigorous inquiry transforming investigation and theorising, which in turn, tests hypotheses.

3.6 Ethical Considerations

Ethical and legal issues were given the utmost consideration and the researcher adhered to the National Health and Medical Research Council (NHMRC) guidelines for ethical research upon humans (NHMRC, 2007).

Approval for this study was sought and obtained from the University of Adelaide Human Ethics Committee and the health service ethics committee where this research study was conducted (Appendix 1). The research did not commence until ethics approval was gained from both ethics committees, with the research following all human research ethics guidelines. Each letter of approval was provided to the other ethics committee. Once completed, the CEO of the Area Health Service received an explanatory letter detailing the proposed research (Appendix 2). From the outset, issues of ethical concern were identified (Coup & Schneider, 2007) and are detailed in the following section.

3.6.1 Informed consent

The invitation to participate was contained in a Letter of Information & Invitation to Participate (Plain Language Statement, Appendix 3) that clarified the aim and process of the study. Invited participants were provided with a copy of the Consent Form (Appendix 4). The researcher ensured that the Letter of Information & Invitation to Participate (Plain Language Statement) was discussed at the ‘Contracting’ stage to facilitate participants’ understanding of the content and to encourage them to ask questions about the research in order for them to make an informed decision. The contact details of the researcher and principal supervisor were clearly identified in the Letter of Information & Invitation to Participate (Plain Language Statement).

3.6.2 Right to withdraw

Each participant had the right to withdraw without prejudice. This statement was acknowledged in the consent forms signed by participants and respected by the researcher throughout the research study (Appendix 5).

3.6.3 Autonomy in voice

Participants and the researcher all have voices in qualitative research. The question that arises is what value is accorded to these different voices? Collaboratively the power of these voices may be extended by the exploration of stories as the researcher becomes the agent seeking to represent participants with accuracy and to serve them well. When the researcher illuminates these stories it is essential that the expressed aspirations and constraints of the participants be considered, as well as those of the researcher. Each participant in this study was given the right to have a voice and that each voice was respected.

3.6.4 Representation

Multiple perspectives can be expressed and must be reflected adequately. The researcher must acknowledge this responsibility as potentially harm may eventuate from insensitive or inaccurate representation of participants' stories, exposing them to a violation of their privacy. The critical group acknowledged their stories would be reflected in this study and encouraged the researcher to undertake this, placing trust in the reflective process.

3.6.5 Participant privacy

Privacy is protected through anonymity, even if self-incriminating statements are made in discourse. However, this warrants the utmost care as privacy is situational, with changing parameters at any given time. Should a private matter arise the researcher should not exploit the situation but, by preventing elaboration of the topic, the participant can be protected. It was agreed by all participants that the researcher would not assign

pseudonyms to each member of the critical group and would only refer to them as participants throughout the thesis.

3.6.6 Participant sensitivity

The researcher must adhere to and maintain the rules of ethical consideration to protect participants, thereby providing them with empathy and respect (NHMRC, 2007). Boundaries must never be exceeded or blurred for the sake of the research, and procedures must reflect ethical consideration, so as to acknowledge the sensitivity of human subjects (Stake, 2005). Throughout this study, all care was taken to ensure all aspects of the ethical considerations outlined were adhered to and that all persons involved in the study recognized their responsibility.

3.6.7 Distress to participants

The researcher identified that this research topic may create distress for the participants. In light of this, a social worker from outside of the Area Health Service was contacted and given a verbal explanation of the proposed research. The social worker gave a formal undertaking to provide psychological support for participants who deemed it necessary for defusing and/or debriefing. It was clearly explained to all concerned that participants would initiate this request for intervention, with full confidentiality maintained and without the knowledge of the researcher. Participants were advised that this service was freely available to them and informed that at no time were they required to divulge any information relating to use of this service to the researcher or the critical group.

3.6.8 Educating the participants

Invited participants met as a group with the researcher to discuss the thematic concern. Those who wished to continue were provided with Consent Forms (Appendix 4). This group identified that they were very familiar with the action research process and had undertaken several projects within their organization using this methodology. Therefore, there was no need to undertake education in action research.

3.6.9 Confidentiality

Confidentiality was a crucial element within this research. Due to the sensitive nature of some elements of the thematic concern and the small size of the town, it was a firm agreement among all persons that if any matter was to be discussed with the health service the identity of the participant who raised the issue was not revealed. This allowed participants to feel confident in contributing to the discussions throughout the data collection with the knowledge that any sensitive information would remain within the critical group.

3.7 Ethical behaviour standards

Unethical and illegal conduct was considered and discussed. Prior acknowledgement was given that any unethical behaviour by the participants or colleagues and the researcher at any time throughout this research would need to be reported to the relevant manager or university supervisor.

3.8 Access to data

Apart from the critical group members, only the researcher and the transcriber had access to data during the study. All members of the critical group were given access to the transcribed information for verification of accuracy. Confidentiality was maintained through various measures.

The person transcribing the audio-recordings of the focus group was required to sign a confidentiality agreement (Appendix 6).

Critical group members who heard data from other critical group members during meetings were provided with clear guidance as to how confidentiality was to be maintained by members of the group during and following the critical group meetings.

Staff members and medical officers involved during input from within the health service did not have access to raw data but did see and hear analysis and comments about the clinical tools under development. These tools contained no identifiers that could lead to the identification of any members of the critical group. Therefore, confidentiality of participants was not at risk.

The researcher's nominated supervisors were given access to any of the data that they required to monitor the progress of the research. This was provided on a need to know basis, however there was no identifiable data provided to negate anonymity.

3.9 Storage of data

All tape recordings of the critical group were retained in a locked filing cabinet in the researcher's office, Room 6123, Building 6, La Trobe University, Wodonga, Victoria. The University has security measures in place to exclude unauthorised persons from accessing buildings after hours. Staff offices remain locked when not in use by the staff member. The keys to the researcher's office and filing cabinet were retained by the researcher at all times. The transcriptions were typed onto a password-protected computer located in the researcher's office. The researcher maintained all information in confidence and no disclosure of taped or written material was made. On completion of the research all data will be stored for a period of five years in a secure location within the Discipline of Nursing, University of Adelaide, Adelaide, after which time all data collected and stored in any form will be destroyed.

3.10 Data collection

The researcher conducted fortnightly meetings with the critical group over a 16-month period. These meetings took place in the health care setting, ensuring the cultural environment of the selected centre was maintained. The meetings were conducted in a non-directed, relaxed atmosphere allowing the participants to direct the course of the research

cycles and the determination for the subsequent cycles. This was based on the evaluation of each previous cycle. It was presumed there would be a substantial amount of data generated, therefore to ensure accuracy the critical group meetings were tape recorded. This information was transcribed into hard copy and provided to each group member for review to verify the content at the subsequent meeting. From this, exceptions and explanations were generated for review and were tested within the subsequent cycle. Data and interpretations were checked against relevant literature with reflection again implemented into the next cycle. The very nature of action research allows for data collection at different times in successive iterations that also provide a long-term assessment of effects observed in earlier cycles of the study, generating relevance and valid knowledge (Kock, McQueen & Scott, 2000; Street, 2004; Willis, 2006).

It is important to note here that this form of data collection was utilized to prevent contamination by researcher and participant bias and to maintain scientific integrity. Data were collected as accurately as possible ensuring that the data remained unbiased, relevant and useful to the research. The validity of comments from the researcher and participants with biased agendas was acknowledged through recognizing that each person had the right to have a speaker position. Common power came from a shared understanding permitting democratic contribution to the critical group and providing respect to each contributor without judgment. It is essential that the potential for domination of the research agenda does not lie with the researcher but with an equal, mutually empowering relationship established between participants (Annells & Whitehead, 2007; Owens et al., 1999), allowing them an equal say in the direction taken by the research. The advantages in recording the data and the identification of themes are that different perspectives lessen the likelihood of strong individual bias. At all stages, the researcher attempted to find exceptions to the data collected to disconfirm any emerging interpretations.

Reflection on the data was maintained over the period of the research cycles whilst the researcher maintained a journal noting both formal and informal communication within the group. This provided an opportunity to observe each participant in naturalistic settings and identify relevant issues for each of them. Initially, the primary objective of this form of data collection was to obtain a broad view of the situation for the group, and then as the research progressed the focus shifted to identify the reactions of individuals to their experiences and behaviour. To minimize observer-imposed meanings and structures, the recorded notes were verified at the time of entry by asking group members for their true meaning. This journal provided another form of checking data. The storage of this journal remained with the tapes in the researcher's locked filing cabinet.

3.11 Data analysis

Data analysis is built into action research. During the reflective phases, the group critically appraised, revised and evaluated new information. Once subsequent cycles were identified, the revised plans were implemented in actions and the effectiveness of these actions observed, again entering the reflective phases for evaluation. Each completed cycle initiated changes into the workplace and the critical group monitored the effectiveness of these changes. With progression though the action research cycles, the changes to practice were refined until the group considered their thematic concern resolved.

The 'circling and parking' style of data analysis was adopted in this study. This form of analysis provides the opportunity for the data set to be treated as a mass that is best understood by not 'fracturing' it into small abstract sections (Annells & Whitehead, 2007). Data analysis involved the exploration of themes, thematic analysis, and became an overarching guide as to how the research developed. Connection of issues by thematic analysis provided the identification of related issues, giving language to themes. The discourse around each issue was facilitated through clear definition of terminology and

identification of the theoretical perspective governing the discussion. Common power came from a shared understanding that permitted democratic contributions to the critical group. Power was not linear and came from all levels within the research process. Participants were permitted to explore their opinions and develop knowledge from change. This facilitated their ability to change from this interpretive process and prevented any misrepresentation of corrections in validation (Hansen, 2006).

Communication varied from individual to individual and the stories people told influenced their participation in the research. The more value they believed their stories held also influenced their contributions. Acceptance of the variety of communication skills within the group promoted engagement in the research by all participants. Subjectivity held great power for the individual, reflecting cultures, values, judgments and morals. Promotion of learning from one another was an integral part of the critical group. A pivotal point was for the researcher to bracket herself to ensure personal bias did not prevent this. Clear documentation of the data collected provided validity to the research.

3.12 Trustworthiness

The concept of data analysis in qualitative research means to interpret it with analysis serving to portray complexities and variations within a study. From this, reports are constructed from participants' stories that have been told in dynamic interactions throughout the data collection and trusted by the participants to be reflected accurately by the researcher (Browne, 2004). The final account is an abstract report of the original information that must remain 'faithful' to the data obtained (Browne, 2004, p.627). Trustworthiness is represented 'when it accurately represents the experience of the study participants' (Gerber & Moyle, 2004, p. 43).

The parallel relationship with traditional methodological criteria for trustworthiness in this study was established by the following four criteria (Guba and Lincoln, 1989). These criteria are:

- Credibility—the truth of the findings was continually assessed by the participants throughout the data collection period
- Auditability—accountability of adequacy of information available to the reader from the raw data throughout the various steps of analysis within the action research cycles to interpret findings
- Fittingness—the findings faithfully reflect participants' everyday reality in adequate detail and provide autonomy for all participants to have a voice, allowing others to evaluate the importance of their own practice, research and theoretical development
- Confirmability—progress through the action research cycles provided transparency to facilitate recognition of credibility, auditability and fittingness standards (Whitehead & Annells, 2007).

3.13 Critique of the research study

A researcher strives to do justice to the research being undertaken without subjective dogmatic theoretical viewpoints. Openness in a research methodology permits the researcher to appreciate biases and perspectives that may influence the interpretation of data (Gerber & Moyle, 2004; Silverman, 2008; Willis, 2006). Qualitative research methodologies provide the opportunity to undertake research within the social context and allow the researcher to become closer to the study (Whitehead & Elliot, 2007). The reciprocal relationship between the researcher and the participant facilitates recognition of backgrounds that may influence how the research is conducted (Gerber & Moyle, 2004). In doing this, there are certain strengths and limitations whatever methodology is adopted. For this study, both the strengths and limitations of action research are listed as key points.

Strengths

The strengths of this study must be acknowledged as contributing to the success of the research. These are identified as:

i) It was focused on a specific problem in a defined context, not on obtaining generalized information

ii) the application of fact finding to practical problem solving

iii) generation and validation of theories through practice

iv) individual input guided the course of the research

v) participants were empowered to shift the parameters in which they practised

vii) participants had ownership of the project

viii) individuals took responsibility for change within the organization and,

ix) enhancement of practice skills flowed through to patient care (Greenwood, 1994; Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993; Whitehead & Elliot, 2007).

Limitations

Equally as important to be recognized in this study are the limitations that may have impacted and/or influenced the outcome of the research. These are listed as:

i) Research conducted within the scientific realm must conform to the canons of the scientific method to be granted legitimacy. It is questionable whether this qualitative research method could generate evidence that is recognized as truly scientific

ii) qualitative forms of research reflect the humanistic perspective thus this study required a different type of study design

iii) underlying democratic and civil discourses guided the process of investigation that then provided a greater chance of researcher bias

iv) action research may have facilitated a forum that allowed the researcher and participants to have an agenda that gave priority to meeting their own goals. It did however facilitate social change

v) the method of sampling did not allow for the evaluation of the precision of the researcher's judgment

vi) difficulties and dilemmas arose over the availability of persons within the group to attend critical group meetings. This was due to demands such as shift work and patient emergencies and the remoteness of the setting, and

vii) co-workers' acceptance of the research process in the local environment may have had an impact on the expected workload of those not involved in the research (Greenwood, 1994; Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993; Whitehead & Elliot, 2007).

3.14 Conclusion

This chapter has presented the methods employed during the research study. Discussion is given to method, thematic concern, reconnaissance, developing interest, study setting, demographic and epidemiological profile, sampling, rigour, ethical considerations, data collection and analysis, trustworthiness and a critique of the study. The data analysis method was summarized providing a rationale for its adoption in this study. Thematic analysis was facilitated through 'circling and parking' in which words are assumed to have multiple meanings and are open to loose interpretation. Rigorous examination and interpretation of data is critical if the research is to have scientific integrity.

The action research process facilitated openness and empowerment. This strengthened the validity and reliability of the research. The protection of anonymity through the use of 'participant' recognition provided individuality allowing free articulation. Natural behaviours occurred once the critical group was established. Allowing respect to open

dialogue empowered and encouraged participants to express frankly issues of concern that caused them stress. It became evident that several of these issues were shared by other members of the critical group.

The next chapter will examine the movement through the action research cycles.

CHAPTER 4

Stage 1 of Research Cycles

4.1 Development of a client infrastructure

4.1.1 Introduction

This chapter examines the process of entry into the field and formation of a collaborative partnership with the participants involved in this study. This was achieved by adopting the Susman and Evered (1978) model in the initial phase of developing a client infrastructure. The process of establishing contact with the participants, the processes that led to the final composition the group and the roles of participants within the organization are examined at length. The chapter includes a discussion of the process through which participants adopted the role of co-researchers and became change agents. The emphasis of this involvement and collaboration is a central characteristic of the action research process. There is discussion of the underpinning thematic concerns identified by the group that would direct the research cycles. Literature was examined with relevance to these concerns.

4.1.2 Contracting: A starting point prior to the development of a client infrastructure

According to the Susman and Evered (1978) model of action research, the contracting phase is important because it provides the required access to the field, sets the socio-cultural context for the research and establishes the framework needed to address the research question. This model is more of a holistic approach to problem-solving rather than a single method for collecting and analysing data, and it allows several different research tools to be used in a change process (Holter & Schwartz-Barcott, 1993; Whitehead & Elliott, 2007).

Contracting is crucial to empowering all participants and allows the opportunity for relationships to be formed between the researcher and participants. Every participant enters

into a contract with the researcher and is informed of the nature and extent of the research, the proposed direction of the investigation, the roles and responsibilities of both researcher and participants and the expected duration of the research (Pearson, 1992). An expected outcome from this stage is a general consensus as to how the research will progress, noting the strengths and limitations of the participants and researcher together with the organizational influences identified at that time.

4.2 Becoming change agents

The concept of a change agent can be related to those within an organization who provide 'technical, specialised or consulting assistance in the management of a change effort' (Pearson, 1992, p.25). The deliberate process to change the status quo and reduce the stressors experienced in the Area Health Service under study required a deliberative and collaborative partnership between this client system and the researcher (Holter & Schwartz-Barcott, 1993; Whitehead & Elliott, 2007). The participants, who were eager to bring about change, turned actions within their practice into research strategies (Bond, Barker, Pearson & Proctor, 1996) by adopting the role of co-researchers. This process of becoming change agents can be said to be a characteristic of action research (Baskerville, 1999; Holter & Schwartz-Barcott, 1993; Street, 2004).

4.3 Establishing contact

After the research question had been posed, a six-month negotiation process was undertaken between the researcher and the team leader, a Clinical Nurse Consultant (CNC) who had completed a Master of Mental Health Nursing. The team considered for this research was comprised of the CNC, three Registered Nurses (RNs), a RN (Child and Maternal Health) who held a Postgraduate Diploma of Mental Health Nursing, and a RN undertaking a Postgraduate Diploma of Child and Adolescent Mental Health. This team is employed as the Mental Health Support Team and it receives services from the Community Mental Health Team located in the regional centre of the Area Health Service.

This regional centre is located approximately 150 kilometres from the site and provides limited visits once a fortnight to the site if the regional team deems there is a client need. All mental health consumer consultations are carried out by the MHST at the site, with a variety of interventions undertaken by this team to address any specific needs. Consultations and assessments are undertaken by the CNC, who is frequently called at any time and regardless of whether or not she is on duty. She is also responsible for assisting GPs who have patients with mental health issues/referrals; providing outreach for Aged Psychiatric services, Adult Mental Health services and Child and Adolescent Mental Health services; supporting clients and carers; assessment and early intervention in mental health; mental health promotion and generalist counselling. The team leader described her role as being on call for 24 hours every day, with the hospital nursing staff calling her for consultations when they were faced with difficult situations involving mental health issues. Despite the fact that she was happy to help out in all situations, it was evident that this was becoming stressful for her. She mentioned that there were times when she dreaded the phone ringing in her off-duty time for fear of another call back to the hospital. She identified that this arrangement was not sustainable and was becoming more stressful as she progressed towards retirement age and she identified a need for separation of work from her personal life. Compounding her role in health promotion and job responsibilities, the team leader stated that she saw many staff in the ED who, at times, required some level of debriefing after an exceptionally difficult patient contact that involved convoluted mental health issues. She had implemented several education sessions in an effort to assist the general nursing staff to deal with these consumers, particularly those with increasing suicidality. The team leader believed that this intervention had not been totally adequate as it did not identify the real issues or concerns the nursing staff were actually experiencing in this department. There was, however, a noticeable cohesiveness between the staff and a desire to rectify a difficult situation that was potentially worsening through increased

community demand, especially during seasonal and festive occasions. The team leader expressed interest in developing a research group that might be able to address these issues of mental health care delivery in this setting.

4.4 Meeting the participants

Following these initial meetings, the team leader lodged a proposal to the CEO of the hospital for an action research project to address the significant issues of concern she had identified existed within the health service. Due to the fact that the majority of initial contact for mental health services is through the ED at the hospital, the team leader requested 'buy in' (input) from the general hospital staff in order to support the changes to the team's practices that may impact on service provision and reduce some of the stressors associated with these contacts. An invitation to express interest in supporting the research project was extended by the researcher to all RNs, the three GPs, allied health staff and the CEO in an attempt to elicit a cross-section of representatives from key stakeholders. This meeting also provided the opportunity for the researcher to meet staff who were interested in participating in the study. It was anticipated that this meeting would allow the researcher to gain informed consent from the persons who were intending to participate and who would form the critical group. A clear and concise overview of the specific details of the research was given, indicating that the research was to be directed by the critical group and that the researcher would facilitate the process. The meeting also provided an opportunity for the group to discuss their level of interest and the commitment the research would require. It was hoped that the critical group would become a cohesive working group that could discuss and work through the impact significant stressors had on their work practices and possibly on their personal lives.

4.5 The critical group

The final critical group was comprised mostly of RNs. It included the two RNs with postgraduate mental health qualifications, one RN working towards a mental health

qualification, the Assistant Director of Nursing (Quality and Safety Manager and manager of the low-acuity residential facility), one Nurse Unit Manager, an After Hours Manager who was also a Nurse Educator (at the time of the project), a Health Promotion/Community Development Team Leader and a psychologist who was planning to retire from practice in the near future. Other invited key stakeholders did not respond to the invitation. There are 30 RNs in this district hospital, thus nearly a quarter of them (23%) were involved in this project. The majority of the RNs participating in this study had contact with consumers with mental health issues accessing the health service and therefore there was a significant representation of those staff who were involved with mental health care interventions.

4.6 An unforeseen occurrence

Gaining informed consent from participants was a priority during this initial meeting, however, an unforeseen occurrence prevented this. The meeting generated a great deal of animated discussion and became a cathartic process. All attendees provided lively input, detailing their experiences involving significant stress over years of practice as nurses. The level of adaptation to these stressors varied with each person and the perceived levels of support they had at the time. This session indicated the richness of text the researcher could expect from this small group and it underscored the relevance of the research question as each member related their stories of stressors impacting on their practice. This meeting was thus very encouraging in terms of indicating the severity of the problem and the willingness of the participants to contribute.

While not all participants had continuous practice in the region under study, each individual had experienced the stressors found in rural regions. Several similarities and themes became obvious during these discussions, including:

- isolation from regional support services during critical incidents;

- very poor access to a contact person for debriefing after a critical incident;
- absence of technological support (no mobile phone service or pager system was operational in the region);
- long distances involving extensive travel when accessing clients;
- the remote location of farm properties, each with several closed gates that visitors had to pass through to gain access (the golden rule of farmers—each closed gate must be closed again after passing through it);
- seasonal climatic conditions producing ice and snow on roads, hampering access to clients;
- political dilemmas when involved in interdisciplinary discussions;
- difficulties with anomalies associated with different Mental Health Acts and hospitalisation procedures between the two States;
- the delay in accessing specialist care/interventions (lengthy periods of up to eleven hours);
- difficulties with transporting clients after hours due to the challenges of driving large distances (for example, a two-hour delay on the road after hitting a kangaroo);
- poor access to emergency transport resulting in excessive delays for client assessment/hospitalization (the ambulance may not be available for a number of reasons);
- limited professional supervision;
- limits to assistance from the police when they were required elsewhere.

There is vast literature that supports the notion that the health workplace can be a very stressful situation, particularly in the rural sector of the nursing field (Bushy, 2004; Gibb, 2003; Hugo, 2001; Melamed, Shirom, Toker, Berliner & Shapira, 2006; Scopelliti et al., 2004). Rural and remote areas face unique issues and constraints relating to distances,

population sizes and recruitment of appropriately experienced and skilled staff especially within community mental health teams. Many of these areas have seen significant withdrawal of resources with government economic rationalisation across all Australian States (Bushy, 2004; Carlin and Farnell 1985; Gibb, 2003; Hugo, 2001; Melamed et al., 2006; Pompili et al., 2006; Scopelliti et al., 2004).

4.7 Stressful work environments

The workplace has a profound impact on employees' morale, physical and mental health, and personal identity. Many work demands create stress simply because they do not satisfy basic human needs. The intense nature of nurse–patient interactions and the stress associated with confronting difficult and challenging patient behaviours on a regular basis compound the physical and psychological demands on nurses in an already hostile work environment (Pompili et al., 2006). The working environment and the effectiveness of organizational structure were examined by Carlin and Farnell (1985) with organizational structures being identified as a major origin of workplace stressors, along with poor physical working environments. Lambert (1995) described unhealthy workplaces and work habits as causing stress, lowering productivity and creating physical and psychological difficulties for individuals. Workers suffering prolonged stress and ill-feeling towards their employing organization are more likely to suffer from poor self-esteem, burnout and violent outbursts (Lambert, 1995). Work environment evaluations and changes can minimize these problems and promote health and safety for employees. Workplaces and work habits that fail to allow for periodic unwinding create stress, erode physical and mental health and lower productivity. Lambert discusses the growing concern in Japan about work-related deaths. Karoshi, 'death from overwork', is a major occupational health problem and involves too many hours on the job, producing high blood pressure and high stress levels (Melamed et al. 2006). It is the second highest cause of death after cancer amongst workers in Japan.

4.8 Unrelenting stress and burnout

Melamed et al. (2006) present evidence to suggest that the literature regards burnout as continuous and prolonged exposure to stress, particularly related to the workplace. The authors acknowledge that there are facets in the coping process such as psychological withdrawal and that there is the concept of a recovery from this state of fatigue that passes after a resting period. Burnout, however, is conceptually distinct from Melamed's concept. The burnout phenomenon is multidimensional in construct, consisting of emotional exhaustion, physical fatigue and cognitive weariness. The authors review the studies of Schaufeli and Buunk (2003) and Shirom (2003) that purport that these represent the core components of burnout. In a study undertaken by Melamed et al (2006), the results suggested there was a remarkable stability of the burnout syndrome regardless of the sample composition, attesting to chronicity. This study also revealed that a job environment in which there is chronic workload stress was more strongly related than personality factors and age. The authors report that this has led to an increase in workers' compensation claims across the United States of America, United Kingdom and the Netherlands, with Sweden having burnout as a diagnosis on medical certificates. Branco, Chambers, Fallon, Fraser and Howlett (1981) identify burnout as being a common experience in practitioners of the helping professions, regardless of the time spent working within their profession. The authors recognize the physical manifestations of burnout, with symptomatology occurring in the physical, cognitive, attitudinal, affective and social levels of functioning. Branco et al. (1981) recommend that professional training within the helping professions should include education about the signs and symptoms of burnout and its management.

4.9 The impact of stress

Stress exists in all human beings and is evident in all human beings in varying degrees. Thought to be a strong motivating force, stress is required to produce optimum functioning

levels. It stimulates individuals into a response to define and cope with any given situation or problem (stressor) (Lazarus & Folkman, 1984). This is known as eustress (healthy stress). Excessive and unrelenting stress becomes distress (unhealthy stress) impacting on and reducing work performances. The level of stress felt by an individual is determined by his/her response to a particular situation. If an individual recognizes that he/she is vulnerable when faced with situations perceived to be stressful, the basic human instinct is fight or flight (Seyle, 1956; 1974; 1976). The effects of stress may vary from one individual to another with different degrees of intensity. This will impact on the homeostasis of each individual, and the adaptation to this stress will be determined by the effectiveness of his/her own coping mechanisms. Distress results when the demands of the situation exceed the person's ability to cope, or become an unconscious threat to his/her psyche. This phenomenon has been the subject of scrutiny for several decades, with Selye (1956) first proposing a link between stress and health problems in his General Adaptation Syndrome (Kenny, 2000). At times, stressors may become excessive and effective coping mechanisms that may have previously worked are no longer adequate to reduce the stress experienced (Bushy, 2004; Gibb, 2003; Hugo, 2001; Melamed et al., 2006; Scopelliti et al., 2004). Relating this to the psychosocial perspective, job-related demands identified as being excessive can lead to burnout (Maslach, 1976; Cherniss, 1982).

The change in eustress to distress is very individualistic and may impact on the person's interpersonal skills, contributing to the reduction of self-esteem and outwardly affecting his/her relationships with work colleagues and family (Melamed et al., 2006). This deterioration can be insidious; individuals may not recognize when a fatigue factor originates, nor may they identify that there is a gradual deterioration within their own psychological wellness. It may take only a simple trigger to cause a downward spiralling of functioning and stress management, leading to the inability to cope with the simplest of

tasks within the workplace. This poor interaction can lead to resentment from social networks and co-workers, without recognition from anyone that the individual is actually experiencing a decline in functioning (Melamed et al., 2006). It can be considered at this point that workplace burnout is being experienced. Subject to the severity of this deterioration, this may indicate the need for employees to move away from their chosen profession or take extensive leave in an attempt to come to terms with their inability to cope with the stress of the workplace (Heard & Harris, 2004; Malach-Pines, 2000). Lachman (1996), in her discussion on stress and self-care, describes cognitive control strategies by which changing individual perceptions of an environment from an uncontrollable threat to a controllable challenge, the individual's attitudes would be affected.

> *The ability to cope effectively is generally viewed as the major determinant of stress outcome. During the coping process, the individual attempts to achieve balance or restore his or her equilibrium in the face of potential adversity (Lachman, 1996, p.8).*

Cohen, McGowen, Fookskas and Rose (1984) contend that it is the notion that others will be available to provide support when needed that acts as a stress-buffering agent. The authors suggest different studies indicating that if there is a perceived support available for the health professional, it is negligible as to whether this support is received or not. The fact remains that it is this belief that support is available which impacts on the health and adjustment of the staff member and the eventual outcome for the individual.

4.10 Preparing the nursing workforce

In the last 20 years, there has been a marked change in the education of nurses, from the apprenticeship model to the academic model. It is argued that a section of this workforce from either model do not have the comprehensiveness in education when entering the workplace to meet adequately the needs associated with the various cultures and values of today's Australian society and the radically changing requirements of the Australian health system beyond 2000 (Clinton & Hazelton, 2000; Happell & Platania-Phung, 2005). This

deficit is significant in the specialty field of mental health nursing. The impact of the change from psychiatric deinstitutionalization to community-based care has required implementation of a diverse community care framework, providing a range of community and hospital-based services. Sharrock and Happell (2002) purport there is increasing evidence to suggest nurses working in general hospital settings consider themselves as inadequately prepared, skilled or experienced to care for consumers with mental health issues. Campbell (1985) contended that the changes in work practices have led to decreases in job satisfaction. Stresses within the work environment, along with personal stresses, have contributed to feelings of the job becoming increasingly undesirable. Current literature suggests this argument is supported and continues to apply in current practice (Clinton & Hazelton, 2000; Happell & Platania-Phung, 2005).

4.11 A paradoxical ethical issue

When applying for ethics approval it was identified that the very nature of the research topic may elicit some degree of psychological distress for the participants and that measures would be put into place to support the participants. An unexpected outcome from the initial contact with the participants was that the researcher experienced a degree of psychological distress from the graphic accounts in the discussions of the difficulties these nurses had experienced. The researcher had not considered that she would experience any psychological distress from this research and this issue had not been addressed in the application for ethics approval. As a consequence the researcher was unable to gain informed consent from the participants at this time as planned. The researcher was guided by her supervisors to have counselling following this meeting. They advised that ongoing pre-arranged counselling sessions should be organized for the day following each research meeting in the event any further distress to the researcher should occur. A subsequent meeting was required to obtain the participants consent and was without incident. This occurred within a fortnight of the original meeting.

4.12 Conclusion

Discussion in this chapter has centred on the importance of the contracting stage as described by Susman and Evered (1978). Effective contracting establishes clear guidelines and provides pathways for all involved to give open feedback throughout the research. This establishes a rigorous methodological approach to ensure biases are openly identified and permitted with the group's awareness of how these may impact on the data. It becomes imperative that all participants have an equal voice that is recognized as contributing to the value of the research. This is to be reflected accurately by all without judgment and facilitates exploration rather than constraint. Contracting provides for ownership of the research with each individual having the responsibility for their own contributions within a collaborative process towards solving practice-based issues. This stage also provides the researcher with an opportunity for external validation of the research and verification of representation of input through the contractual agreement with academic supervisors.

The concept of participants becoming co-researchers and change agents indicates a sense of ownership of the research through the forming of the deliberative and collaborative partnerships. In establishing the initial contact, the CNC heading the MHST described the complexities associated with providing pseudo-support in a rural remote health service. Added to this situation the MHST was described as very much reliant on the sporadic support of the CMHT from the Area Health Service located some 150 kilometres away. This placed an increasing demand on this team leader who is seen to be accessed constantly despite being supposedly off duty.

A cathartic process occurred when the prospective participants first met and the critical group was formed. The group related several stressful incidents related to the rural and remote sector. Several themes were identified from the similarity of reports, supporting the

findings of literature that indicate both internal and external environmental factors should be considered when reviewing the impact of workplace stress.

An oversight in the ethics application by the researcher is discussed identifying that the researcher may also experience psychological distress. Concern was initially given to how such a research study may impact on any participant's well-being with no thought to the psychological impact on the listener. Despite having studied stress for several years, this researcher was totally unprepared for the reaction that occurred.

The next chapter will discuss the diagnosing stage that led the research in the examination of the thematic concern, the research question and aims of the study.

CHAPTER 5

Implementation of the first two action research cycles

5.1 Introduction

This chapter examines the progress of the first two cycles of the research study, following the Susman and Evered (1978) model. Each of the cycles contains the four distinct phases as discussed in Chapter 3. There was a significant amount of data collected in these phases as several participants' related repeated unresolved stressful issues. This data is largely transcribed as opposed to being paraphrased to reflect the true meanings and emphasis the participants attempted to portray in their contributions to the research. In so doing it is the intention of the researcher to avoid any possible researcher bias in interpretation and reflection or loss of integrity of this data. The chapter identifies the dominant themes that the critical group believed to be of most concern and causing the greatest amount of stress within this health service. The themes are discussed in light of a literature review that offers support for the issues raised. Based on this theory is generated and discussed. The development of a nursing model is begun with the concept of staff safety being a predominant theme. In this chapter, there is a variation to the terminology that is used in the participants' transcripts that is not consistent throughout the thesis. The participants refer to the Emergency Department (ED) as the Accident and Emergency Department (A&E). The current terminology according to literature for this department is the Emergency Department (ED) and as such is referred to as this in other chapters of the thesis.

5.1.1 Diagnosing phase

This phase of the research provided the opportunity for the critical group to speak openly about issues that caused the greatest amount of stress for each of them. The enormity of the issues that concerned them was notable. On several occasions, these clinicians had limited support and recognized that the geographical isolation factor contributed to feelings of

uncertainty and doubt in the provision of effective and safe practice. Lengthy discourse occurred within the critical group and it was decided preference should be given to a few significant issues then narrowed down to reflect the most imperative stressors to be addressed, rather than attempting to address all stressors. It became evident there was consensus that the danger of being alone or with limited support presented the most concern for all participants, particularly with the unpredictability of consumers with mental health issues. There was a level of despair amongst the members of the group as to how big this issue was, with no idea as to how it could be resolved. After careful consideration, staff safety became a predominant theme that the group decided should be considered in the first instance. There was a degree of relief when this was proposed despite the fact that no decision had been made as to how it would be addressed.

Participant:

Disk 1 Lines 11–40

> *You know, isolation is a factor so maybe we are talking about lots of things like, when I was working and I found one crisis that you have to justify and so you have to narrow it down like. If you are going to be mental health, day to day or crisis intervention or particular crisis I found things like difficulty with the powerlessness of the whole thing. Like you come in, and you go oh there's this client in the ward down here and there is two nurses on who have a hell of a lot of work to do and this person is either going to have to have, you know, someone from the community supervise them, sit with them because there is just not a person, a staff member available to supervise someone who is suicidal.*
>
> *And then, you might ring medical staff who is very powerful because they have the right to admit or not admit and it's no easy matter for them either because it is such a serious thing to deprive someone from their liberty and commit them and you don't start doing that unless you really honestly think that someone is either going to be a harm to themselves or to you know, we're not building detention centres here. ……They are the kind of things that I can recall feeling very frustrated and concerned and go home and lay awake looking at the ceiling…. There is only one of you in the surrounds, and you know the team (Regional Community Mental Health Team that supports this area health service by a monthly visit) won't be there for another fortnight and so there is the kind of things that you are dealing with – that's how I see it and at the moment I haven't got a real feel for what examining we are going to do.*

The mere fact that a nurse may be frequently exposed to stressors does not indicate that he/she will necessarily be distressed by them (Glasberg, Eriksson & Norberg, 2007; Wheeler, 1997). Coping and adaptation are explicit parts of a transactional definition associated with a stressful experience (Dewe, 1989). Payne (2001) purports that a transactional approach focuses on an individual's perception of the stressor and the resources available as being important factors that determine well-being. This approach asserts that individuals continually appraise their environment; the individual's perception of the demands within this environment and the ability to cope with these demands constitute stress. Lazarus (1995) suggests there is limited usefulness in identifying conditions of work that may adversely affect most workers due to stress being ultimately an individual phenomenon. For the participant in the present study, the level of stress she experienced was directly related to the work demands and the amount of support she perceived she had in the workplace. Due to the limited number of trained mental health professionals working within this Area Health Service a great proportion of initial contact by mental health consumers is with the nursing staff in the ED and this participant recognized her own deficits in knowledge and skills to be able to cater adequately for the consumer's needs whilst remaining safe in her own workplace.

There was significant discussion amongst the group that their levels of distress were not necessarily debilitating as a direct result of the contact with consumers in crisis, but they agreed that such incidents did cause them concern due to their uncertainty of practice and knowledge in these matters. There is a widely held belief that the nursing profession is inherently one of the most stressful occupations within the workplace (Rees & Cooper, 1992). Some of these stressors include dealing with death and dying, severe and emergency illnesses, aggressive and abusive patients and relatives, long working hours, shift and weekend work (Descamp & Thomas, 1993; Kennedy & Grey, 1997; Schaefer &

Moos, 1996). The nature of mental health nursing, in which emotional clients seek help by imparting information to nurses (Gladding, 1992; Maslach, 1982), can lead to the phenomenon of workplace burnout (Freudenberger, 1989; Maslach, 1986). Patients expressing very strong, direct and negative emotions to the health professional during the course of therapy can at times direct this towards the health professional (transference). Maslach and Jackson (1981a) identified that mental health professionals scored lowest on personal accomplishment and highest on emotional exhaustion on the Maslach Burnout Inventory when compared with other professionals. For the critical group the combination of insufficient education in mental health nursing and the nursing skills required to deal with the demands of such intensity proved to be of significant concern. Greater expansion of their concerns led the group to the impact of the unrelenting stressors particularly experienced by the MHST leader.

Participant:

Disk 1 lines 43–57

> *Well to me the most at-risk person of burnout would be (nurse named),… like you've got a lot of younger people who may, not saying they have mental health problems, they are wobbly, so yeh, that sort of person (MHST leader indicated) is the one that is being constantly bombarded. The rest of us, we're seeing more crises at the you know, coal front, downstairs, (ED indicated) or there might be a few people coming in with the depression and we just wondering whether we are managing them the right way, but we have the luxury of that's not happening every week, that's not happening every day, whereas for (nurse named), she is you know, managing this workload that doesn't go away, it is more or less every day that is the constant management of the mental health side of it, plus you have the thrown in crisis, you know, on quite a regular basis, I think there seems be, you know something come up and she's off on a mission somewhere else, so in keeping with (participant named), yeh, where do we narrow it down? Who are we trying to help or what's the biggest problem that we are really looking to solve here? Who is stressed most?*

Prolonged stress causes depletion of personal resources and may lead to physical illness, irritability, cynicism, fatigue and a withdrawal from work practice (Schaefer & Moos, 1996). Role conflict and ambiguity in the workplace, variations in workload, lack of

autonomy and under-utilization of skills contributes to stressors for the worker. Job stressors respect no boundaries and the potential for exposure to this class of health risks is ubiquitous (Lusk, 1997). The critical group acknowledged that the leader of the MHST is in contact with people in crisis more often than hospital staff, which validated the concerns expressed at times by this leader about the unrelenting demand for her input. The group believed this unrelenting stress and demand could lead to workplace burnout for this team leader.

In defining burnout, Farber (1982) examined the works of Pines and Aronson (1981), Freudenberger and Richelson (1980), and Edelwich and Brodsky (1980) in an attempt to provide a consensus of symptoms relating to the syndrome. The consensus was that the symptoms of burnout include attitudinal, emotional, and physical components. Maslach (as cited in Farber, 1982, p.3) noted that in burnout professionals "lose all concern, all emotional feelings for the persons they work with and come to treat them in detached or even dehumanized ways". Stuart and Sundeen (1987) support this argument; describing burnout as a syndrome of physical and emotional exhaustion involving the development of negative self-concept, negative job attitudes, with a loss for concern and feelings for clients. By making excessive demands on energy, strength and resources, an individual may fail, wear out and become exhausted (Snook, 1984). Stress can be caused within the workplace in any circumstance where an individual is unable to cope with a demand. When considering stress in terms of the fit or congruence between individuals and their work environment, the relevance of their ability to adjust to new circumstances must be examined. The group was concerned that this discussion may evolve into a single focus on this MHST leader but acknowledged that by initiating a change in practice this would reduce the impact of stress in her workload.

Participant:

Disk 1 lines 70–72

> *I'm not saying she is at burnout but how do we ever know, and I agree with you, she is a remarkable person who has huge capacity and energy, but who are we to judge when she is actually going to reach burnout point?*

The term burnout has become widely and frequently used to describe work pressures an individual perceives to exceed an acceptable level of comfort. It has become popularized, diminishing the seriousness of the syndrome (Gillespie & Melby, 2003). It has been used interchangeably with describing excessive stress due to workplace pressure, throwing even more doubt on the existence of the problem (Sarros & Sarros, 1987; 1990), with the term stress used in everyday language, often as a throwaway line. These authors disprove the use of the term as a useful linguistic abbreviation.

It is necessary to acknowledge and differentiate between occupational stress and workplace burnout. Burnout occurs as a consequence of job stress that is repeated and unresolved (McFarland & Thomas, 1991). Occupational stress, however, is described as the sum total of factors experienced in relation to work, which affect the psychosocial and physiological homeostasis of the worker (Grosser, 1985). The workplace has a profound impact on employees' morale, physical and mental health, and personal identity. Many work demands create stress because they do not satisfy basic human needs (Hover-Kramer, Mabbett & Shames, 1996). The worker at times may experience any or all of these factors in their work situation. Occupations having a high potential for burnout involve workers dealing directly with people whose problematic issues are highlighted during intervention. This may elicit strong emotional feelings within the workplace causing continual distress for the worker. This type of chronic emotional stress is believed to induce burnout (Maslach & Jackson, 1981a).

If the relationship between individuals and their environment is appraised by them as taxing or exceeding their resources it produces stress within the individual. This stress becomes an internal response to an unsatisfactory situation, thus stimulating biochemical responses by the body when reacting to what is perceived as a threat (Otto, 1983). Occupational stress has been linked to a decrease in psychological well-being of individuals and increased emotional exhaustion (Dear, 1995; Jones, 1997; Lachman, 1996; Lusk, 1997; Turnipseed, 1994). In turn, these effects flow on to, and impair, the performance of workers. For example, a stressed worker may become callous or derogatory to client and co-workers (Gillespie & Melby, 2003).

Blair and Ramones (1996) discuss the concepts of burnout and vicarious traumatization and the implications of these for health professionals. The authors explore the continued exposure to the depth of human despair which can produce similar symptoms for the health professional, leading to severe intrusive and disruptive behaviours lasting from short periods to months or even years. They describe vicarious traumatization as contagious and malignant, with severe consequences for the health professional. Counter transference is examined by these authors who suggest the professional may become prone to these intrusive thoughts and disturbing behaviours eliciting intense emotional reactions despite any evidence of personal abuse or trauma. This phenomena is discussed by Mandaglio (1984), referring to the work of Maslach (1982), when reviewing occupational hazards in the helping professions. The chronic emotional strain of dealing extensively with other human beings, particularly those troubled or having problems, can lead to patterns of emotional overload for the health professional and this is said to be at the heart of the burnout syndrome. The author acknowledges overload as a common dimension of job settings, with the danger of the health professional changing his or her attitude in the provision of patient care. Mandaglio continues and refers to the work of Cherniss (1980)

emphasising that attitude is a crucial element within the helping professions. Changes to this attitude in negative terms leads to professionals disengaging from their work as a defensive coping mechanism in response to the stress and strain of the job.

The critical group reviewed the positions held by the MHST members and discussed the expanded roles they adopted in their work practices. The responsibility of this team to ensure access to care and optimal treatment subjects the team to demand and criticism if these are not provided. The workplace today has experienced a range of changes creating a less predictable work environment for both genders and there are significant differences in work practices to those found previously in Western industrial societies. The expectations of employers that staff do more with less in terms of staffing levels, financial support and equipment has placed increasingly unrealistic expectations upon employees (Bushy, 2002; Duquette et al., 1994;). Many of these changes have the potential to threaten the health of the worker (Stansfield, Fuhrer, Head, Ferrie & Shipley, 1997). Additional responsibilities without the appropriate support for individuals have created a significant impact on the emotional and physical well-being within this workforce (Bushy, 2002; Duquette et al., 1994). A balance is required between occupational demands and personal characteristics, requiring work to be challenging but not causing under- or over-load (Leppanen & Olkinuora, 1987).

Participant:

Disk 1 line 83–100

> *Because really (nurse named) role came out of the situation you were describing before and when you were here (participant named), I mean really, I think the isolation even for you as a worker, was phenomenal, wasn't it? Because of the confidentiality and the fact that (participant named) was the only person dealing with anybody with mental health – we were not thinking about mental health emotion and not thinking about the well-being of the whole community – we still had a very strong illness focus and (participant named) was there, you know, in a little box, basically and it was very hard. I think we learnt a lot, from that time, because it was terrible, wasn't it? I mean it was probably action research and*

> *management – (laughter) no it was fine, it was fine, there were a whole lot of things that we didn't think about – about we approached even mental health – we didn't see mental health as part of the well-being of the whole community. Really, we were only looking on the outskirts of what was happening and then everyone had to deal with crisis. So the crisis, I mean we can just deal with the crisis, we can restrict this piece of research as to how we deal with crisis and thereby include everybody generally, but the crisis could be medical and they are all very confident with that and they are probably not at the risk of burnout in those medical ones because they are all, you know, highly competent. We just need to deal with mental health crisis and how that is managed and obviously (nurse named) does that.*

The work environment is an area that has been under study for many years. Sources of burnout have been identified as including organizational, interpersonal and personal factors (Maslach & Jackson 1982; 1984). There is a direct correlation to workplace injuries with job stress highlighted as being associated with burnout within work practices (Bushy, 2004; Gibb, 2003; Hugo, 2001; Melamed et al., 2006; Scopelliti et al., 2004). Work group support, role ambiguity and work-related stress exert a direct influence on job satisfaction (Bushy, 2004; Gibb, 2003; Hugo, 2001; Melamed et al., 2006; Scopelliti et al., 2004). Role ambiguity is a significant factor both as an influence on work-related stress and as a direct influence on psychological distress and work dissatisfaction (Melamed et al., 2006; Scopelliti et al., 2004). The Work Environment Scale is a widely used instrument developed by Moos (1986). This scale measures three dimensions of the work environment; relationship, personal growth and system maintenance. It is imperative that the work environment is considered with the actual milieu in which the person works and not the overall organization.

Schaefer and Moos (1996) discuss the relationship between work stressors and work climate, and between job morale and functioning. From their literature review, these authors suggest that specific work stressors and a negative work climate have a negative impact on health. Associated with this are lower job satisfaction, decreased job performance and mental health problems amongst staff. Lack of support, cohesion,

autonomy and clarity were described as being associated with job dissatisfaction. The authors recognize the importance of support from supervisors. They suggest that further review of the literature indicated that this support had been linked to greater job satisfaction, and less emotional exhaustion and depersonalization. Cohesiveness and supportive relationships, with good leadership from supervisors, promote positive interpersonal work environments. Challenging job tasks become rewarding as staff are empowered to act autonomously in resolving issues that may otherwise be negative stressors (Cherniss, 1982). Prolonged work stressors and a negative work environment erode staff's job morale and functioning. The experience of fatigue and frustration resulting from ongoing input, without noticeable recognition or reward, leads to gradual erosion of emotional and physical reserves. The progressive disillusionment and idealism within the workplace may result in decreasing workplace effectiveness and detachment (Cherniss, 1982). The theme of inadequate training and knowledge levels for all staff led the discussion with expansive thoughts on how this may be resolved through this research study.

Participant:

Disk 1 line 118–124

> *No, I think that is actually a really good point and a very valid one because the fact that it is a sort of a bit hit and miss down there (ED indicated) and you haven't got absolute continuity of someone working exactly the same shift and getting exactly the same exposure to problems, you know, in a consistent fashion, then they don't necessarily, they are not equipped, you know, to always deal with mental health crises. And you know, it happens out of hours, and on the weekend, middle of the night, evening when the least amount of resources are around.*

The critical group felt that patients frequently accessed the ED with mental health issues under the guise of general health concerns, leading ED staff to feel that they lacked the skills and knowledge to assess and treat these consumers appropriately. The ramifications of this are twofold. First, the consumer may have the appropriate treatment withheld, as statistics show waiting times for treatment in EDs have been problematic for many years.

Secondly, the professional and personal safety of nursing staff may be compromised. A major responsibility of the employer is to ensure the well-being of the employee (NSW Occupational Health and Safety Act, 2004; Victoria Occupational Health and Safety Act, 2004). These laws provide for a general duty of care by employers to provide a safe and healthy workplace and one that is free from psychological and physical hazards. Occupational health and safety legislation throughout Australia has now been implemented in an attempt to reduce workplace injuries and reduce workers' compensation claims.

Fulde (1995) discussed stress from an ED perspective and attempted to define it. He postulated that there is no universal definition despite 50 years of scientific work undertaken on the topic. He does note, however, that definitions developed to date depended on the researcher's field of study and discipline. In his discussion, Fulde cites Seyle (1975), identifying stress as the non-specific response by the body to any demands made upon it. The crucial question remains, when does this response become detrimental to the well-being of an individual?

The helplessness of the situation in the ED as perceived by one group member was clearly articulated. This group member felt that despite several strategies having been implemented to provide nursing care to these clients in an effective and positive manner, there was little support within the health sector, including the emergency services.

Participant:

Disk1 line 127–133

> *Everyone seems to not want to help us, you know the doctors don't want to help us, because they don't want to be involved unless they are going to be certain, the ambulance don't want to take any people who are way out – everybody it seems to me – you know you have those poor people who are like "nobody wants to help me – I've got all this trouble and nobody wants to know about, doctors don't want to know about it, ambulance don't want to know about it, police don't want to know about it". They must be going like, "I can't stand this".*

Because of the emphasis in mental health legislation across Australian States on nursing people in the least restrictive environment, a wide range of crisis intervention models is being developed that incorporate a multidisciplinary approach to the management of people with a mental illness. These were discussed at length by the critical group. These models provide interventions as a solution to treating the exacerbation of psychiatric symptoms that may have resulted from poor medication compliance, physical illness and exposure to environmental stressors. In a relapse into a psychotic episode, sufferers may experience symptoms resulting in disturbed and difficult behaviour. This may be exhibited in aggressive and threatening outbursts either vented towards themselves or others. Crisis intervention at this stage becomes imperative to prevent further deterioration of an uncontrolled situation. The flow-on effects of continuing this type of management of mental illness, however, become time-consuming and stressful to implement for community mental health teams, with staff burnout becoming an increasing concern (Joy, Adams & Rice, 1999).

Staff safety became a central focus during these discussions. Complacency due to the location of the town led some critical group members to admit that they had not, at times, considered safety factors when dealing with unknown clients. Others acknowledged that, due to a transient population, they had been concerned about unknown persons accessing the health service regardless of the nature of their illnesses.

Participant:

Disk 1 line 142–156

> *I think it has improved. I think that (nurse named) has certainly put some processes in place to help staff down there (ED indicated) and there is that luxury of being able to contact her and I think people probably feel a little bit more confident but I know there is still a lot of angst around and frustration around particularly in dealing with mental health crises, because as (participant named) says the ambulance don't want to take them, the police don't want to know about it, it is really hard to find someone further down the line that will take them. No-one wants to know about it. Even the mental health nurses are arguing with the doctors about whether they should be what should happen (sic). They are saying well,*

you listen – they are saying well we don't do that once you do that. You know you're sitting there saying ummmm. Then you start thinking I'll just get out of here. I'll tie them down and come back tomorrow. Well, it's a long way from (regional centre named) to start with. You can't just say that, well we don't have staff here, how about this person does not need to be committed but they might need to go to another hospital where they can at least have someone looking after them in an admission type situation.

Participant:

Disk 4 line 173–179

And we are vulnerable. And I think that fear comes to a lot of the staff because they don't understand mental illness or you know, the level of agitation that they're seeing very much presses the fear button in them and they think , am I safe? And of course, we need to jump to that first. And you think what do I do? Who have I got? There's nobody else here. You know, the only thing that we have got is that locked door between us and them at night and the fact that the policy says you do not go to the door alone.

Participant:

Disk 4 line 187–188

I think my personal thing is safety first. Am I safe? Are they safe? Are the people around me safe?

Participant:

Disk 4 line 190–191

Do you think that comes from thinking that because we're in (town named), this is not going to happen?

Participant:

Disk 4 line 193–195

No, because it did happen to (staff member named) when a patient smashed the front door because she (nurse indicated) waited for somebody and he thought she was refusing care, and he just shoved something through the door.

Participant:

Disk 4 line 197–200

But I am sure there is a school of thought. You know, sleepy little (town named) you know everybody, but it's actually quite frightening, because there are lots of people coming and going that we don't know about and

> *they could be having a mental crisis of some description and you think you know (staff member named) – you know well, she's calm.*

Benveniste, Hibbert and Runciman (2005) discuss the issue of critical incidents in Australia involving mental health patients. In reports from twelve EDs, 16 per cent of all reported incidents (190 of 1214 incidents) involved violence (p.348). Mental health problems were patient-related contributing factors for over half of the violent incidents, with alcohol or drug intoxication contributing to more than 25 per cent of violent outbursts. The Australian Patient Safety Foundation has developed systems to collect, aggregate, monitor and analyse incidents related to patient safety since its formation in 1988. The Foundation created a taxonomy and software which became the Australian Incident Monitoring System to re-analyse data from the Quality in Australian Health Care Study in 1998. A classification of health care incidents including adverse events and near misses was developed. The classification of an incident as "any event or circumstance which could have led, or did lead, to damage, loss or harm" was initiated (Benveniste et al., 2005, p.348). The authors identified the most common staff-related contributing factors were communication problems and insufficient or inadequate numbers of staff. Precipitating factors included dissatisfaction with staff decisions to admit or discharge a patient from hospital, lack of support on discharge, or non-prescription of patient-requested medication. Benveniste et al. described weapons used in incidents, including hospital equipment, razor blades, scissors and blood-filled syringes. They reviewed reports from ten mental health services, which indicated 28 per cent of all incidents reported (1467 of 5326 reports) involved violence (Benveniste et al., p.348). The violence seen in the Area Health Service in this study can be said to be consistent with societal changes and is also affected by the changes in mental health service provision throughout Australia.

There are major implications for risk management and injury litigation in all acute health services with the rationalization of health services. There is an increasing need for health professionals working in psychiatry, emergency medicine, general practice or rural and

remote health to develop protective behaviours, for both their own safety and that of their patients. For example, in South Australia the last public psychiatric hospital was scheduled for closure in 2007, and patients with acute psychiatric conditions were directed to general hospitals. This State has had two workplace deaths of psychiatrists associated with patient violence since 1992 (Benveniste et al., 2005). This signifies the importance of staff access to duress alarms, escape routes and back-up support, giving credibility to the critical group's concerns.

Participant:

Disk 5 line 226–232

> *… they're the kind of things you need, like staff education, so that you always need to know your access points to remove yourself to safety because often you might get into, say into Room 1 and they've got the door in front of you, but you've got the patient between you, where you need to always have the door at your back so that you can remove yourself safely from that environment and still keep them in their area, but I mean we've always been taught that because I've done quite a bit of mental health….*

Participant:

Disk 5 line 234–241

> *There are a lot of people who have no regard – there was a course that I did a couple of years ago about managing clients with potentially dangerous behaviour – and it was really good – there was a bit of self-defence and different things in it, and we may need that to help staff feel safe when they're doing, you know, - a lot of staff come here with their own experiences, you know with a gun, and we're so old, they come with a bit of baggage already. And there are people who just can't handle it at all – that is right. And I think that if they really feel very strongly about that then somebody else has to get in and do that assessment.*

Discussion amongst the critical group concerning the workload within the ED elicited a significant amount of information about issues affecting them and their future wellness. Staffing ratios, shift work and the pressures of trying to earn an appropriate income saw some members stating they had had some tough years. Indications were that some members had attempted several different strategies to get some stress management going, e.g. getting more exercise. They saw this as:

Participant:

Disk 1 line 261–264

> *... a bigger bag of goodies to draw on under stress, but I really have to say that there is still really you know barriers with people saying, "well I'm on top of it and I make myself stay on top of it because I've got these things that I do and things are working for me".*

There is a plethora of literature examining the problem of occupational stress and workplace burnout. Critical analysis is given in the literature over the decades on stress, occupational stress, stress-related illnesses, studies examining this phenomena and the development of a measuring tool that was adopted in the determination of workplace burnout. This literature contends that job environment features are more strongly related to burnout than are personality factors. Johnson and Lipscomb (2006) discuss a report from the National Institute of Occupational Safety and Health which recognized that occupational health research has not maintained pace with workplace changes in understanding the implications for work-life quality, safety and health. These effects relate both to the individual and organizations, as described by Maslach and Jackson (1981a), particularly amongst 'helping professionals'. Wilson and Kneisl (1992) refer to burnout impacting on legal, social work, psychology, prison and health professionals.

The following entry indicated that members of the critical group did recognize that the work-life balance needed to be in harmony and reviewed if they were to remain well and continue into an expanded working career span. If restructuring and alternative work arrangements could address the root problems of deskilling and unrealistic job demands, the work environment would become less hostile and less of a threat to individuals' well-being. The experience of fatigue and frustration resulting from ongoing input without noticeable recognition or reward leads to the gradual erosion of emotional and physical reserves. It then becomes essential that this problem is addressed, allowing employees to gain a sense of worth and value to the organization. It is important to recognize that safety is not limited to the physical health and well-being of employees but also their mental

health and well-being (NSW Occupational Health and Safety Act, 2000 Sec.3c; Victoria Occupational Health and Safety Act, 2004, Sec.21). The incidence of psychological and psychiatric work-related injuries tends to indicate that employers may not have taken reasonable care of employees. The progressive disillusionment and loss of idealism within the workplace is deemed to result in detachment and decreased workplace effectiveness with increased absenteeism. Stress injuries are as liable as any other injury to lead to prosecution of employers under the law (NSW Occupational Health and Safety Act, 2000, Sec.3c; Victoria Occupational Health and Safety Act, 2004, Sec. 21).

Participant:

Disk 1 line 276–283

> *Yeh, don't retire well, and some even younger nursing staff are having some real issues about how they get on with other people and how they are looking after themselves in their own general health and it's really reflecting on their work and they way they practice their job and the way they communicate with other people and not necessarily in a very positive way. Like—I can think of three people easily without necessarily thinking about it. I know there have been loads and loads of resources and brain power and different strategies. I know you've really, really tried, and it is, there are so many barriers.*

A British longitudinal study, the Whitehall II study (Head et al., 2006) examined the influence of change in psychosocial work characteristics on sickness absence. The authors reported results from previous studies that indicated a stressful working environment was recognized as a workplace hazard, prompting the United Kingdom Health and Safety Executive to introduce management standards in 2004 for work-related stress that included demands, control, and work support within the workplace. Head et al. found an association between the levels of work characteristics and subsequent sickness absence. Improvements in work social supports were associated with reduced sick leave and adverse changes in decision latitude (autonomy) and job demands were related to increased sick leave. In their study, the authors contend their findings correlate with a cross-sectional Swedish study showing that psychosocial working conditions impacted on personal wellness and sick

leave absence. Workers with a higher level of job control showed lower levels of absenteeism, and changes in working conditions were associated with 'long spells of sickness absenteeism' (p.60). The limitations of cross sectional and cohort studies to prove causation from correlation must be considered here; however, the authors recognized that the methodology for randomized studies is problematic in this field and recommended further study of systematic 'natural' experiments (p.60) investigating employers who begin implementing public health policies on work-related stress.

Stansfield et al. (1997), in their examination of the Whitehall II study, support the argument proposed by Head et al. (2006) when addressing the level of wellness and absenteeism in the workplace. Stansfield et al. (1997) clearly identify the implications for management and organizations giving support to employees to improve the mental health of workers, reducing sick leave and short spell absenteeism. The authors contend that social support by supervisors has a 'consistently protective effect' (p.78). Stock (2000) reviewed a four-year Harvard University study of more than 21,000 nurses in the United States. This study addressed women's physical functioning, limitations due to physical and emotional problems, bodily pain, vitality, social functioning and mental health. It linked job strain to hypertension, cardiovascular disease, smoking and depression. In their discussion of the coping measures used by Intensive Care Unit nurses, Lewis and Robinson (1992) based their studies on Seyle's (1974) General Adaptation Model and Lazarus' (1981) cognitive appraisal theories of stress to develop a Stress Management Process Model as a conceptual framework. The authors postulate that work-related stressors may be internally or externally mediated, and may or may not be controlled by the individual. Nurses implement a variety of coping measures, either adaptive or maladaptive. Two participants recalled:

Participant:

Disk 1 line 285–288

> *I do hit a lot of barriers by working shift work, you know you are tired. I don't know about you but I am not a night person. I was talking to a nurse the other night who was saying, you know the shift work throws out her eating and she can't look after herself and that topples you over.*

Participant:

Disk 1 line 292–298

> *One of the reasons that I've moved from being in a clinical area to get more into an administrative managerial role is to get out of shift work and to try and get a normal family life so it was either, OK do you leave the workforce and go for the complete change or do you try and work within what you've got and take it somewhere. So I'm trying to take it somewhere, but that's to get away from shift work. You know, all the drama, and the… I'm just so sick of all that sort of stuff that goes on down there.*

Johnson and Lipscomb (2006) argue that there has been and continues to be a concern in health related issues with regard to employees working long hours. The impact of this is seen in epidemiological evidence showing an increase in acute and chronic health outcomes for such workers. The length and structure of working hours are discussed, viewing the nursing profession as an important population to study due to the effects of the exhaustion and fatigue they experience. Otto (1983) refers to stress as an internal response to a situation that is not conducive. In its reaction to threats from the social environment, Otto purports the human organism will generate energy to prepare the body for the fight or flight response. In a prolonged stress-producing situation, there is an increased risk of ill health from a variety of sources. These sources are the biochemical responses implemented by the body as a direct response to what it perceives to be the threat (Johnson & Lipscomb, 2006). The impact of this can be seen when one critical group member reported that she had implemented different strategies in an attempt to relieve her stress level within the workplace, restoring 'a normal family lifestyle'. The ensuing discussion indicated she was not alone in recognizing the impact of shift work and extended shifts. The personal degree of effectiveness of specific coping measures used previously in reducing stress will

determine their usage in similar current experiences. This is reflected by the critical group member stating:

Participant:

Disk 1 line 308–309

> *I remember what it was like 20 years ago, when I was thinking oh dear, I can't wait to give this shift work up.*

It became evident that the group members' work lives were becoming more difficult to separate from their personal lives, adding to the stress this group experienced. The impact of both became evident as stories within their personal lives flowed into discussions. The Australian agricultural crisis, described by Vanclay (1994), is the result of declining wealth in agriculture, with government and private sector service rationalisation. This has led to a decline in the financial well-being of rural towns (Humphreys, Mathews-Cowey & Rolley, 1996), and has contributed to the rural crisis. The reduction of casual labour used on properties means that more demands have been placed on farming families to undertake physical tasks on properties. The loss of employment for casual and itinerant workers in rural communities has caused financial difficulties that have seen an increase in the use of social services with a flow-on effect on businesses.

Over this period there has been a total shift in funding and resource models by health departments in an attempt to meet the population's needs whilst remaining economically viable (Humphreys et al., 1996; SCARC, 2002). A result of this shift of service provision has been a marked reduction in health services in smaller rural towns, with consolidation of resources in regional centres in an attempt to reduce duplication. There has been little consideration given to access to these services by residents of communities in rural and remote regions which is generally poorer than that for the metropolitan populace (Humphreys et al., 1996; Productivity Commission, 2005). Logistically this is fraught with difficulties due to a lack of public transport in many rural areas, with isolation being a

barrier in accessing appropriate health services (Humphreys et al., 1996) for the ageing population in rural Australia. Government schemes such as the Isolated Country Patients' Travel Allowance have been developed to assist with travel expense costs, however, initially this is of little value when the cash flow is limited within the rural sector and expenses must be incurred before a rebate can be claimed. Ongoing droughts, fires, floods and falling produce prices have created a new dilemma, bringing with it an increased psychological despair that has not been seen previously in Australia (Australian Institute of Health & Welfare, 2002). The changes to the health care system and the skills nurses now require to practise within this system have had a significant impact on the nursing workforce, their approaches to the workplace, and to the health consumer particularly in rural and remote locations (Fuller, Edwards, Proctor & Moss, 2000; Johnson & Lipscomb, 2006). Bryant (1992) discusses social influences on health issues in terms of the farming financial crisis. This dilemma is not recent; Bryant refers to the farming communities on the Eyre Peninsula, South Australia in the late 1980s to early 1990s and the poor solution to the economic problems within Australian agriculture. Bryant identified the consequences of these economic pressures as the loss of independence and self-reliance in individuals. In response to this, the social cost to rural communities has been impacted greatly by this crisis, with the withdrawal of existing health, welfare and agricultural services in country areas by State and Federal governments. Over the years, youth, women and many farmers themselves have sought alternative employment off farm. Bryant (1992) argued these drastic trends were consistent with national results. The impact of this is reflected in the significance for one participant who related:

Participant:

Disk 1 line 311–329

> *It affects your family, you wanting to be there for your children, and you wanting to go to the school things and do this and do that and try as you might, and I've found, particularly in this environment, in a small organization, you don't actually have some of the luxuries that you have in*

> *the bigger hospitals because you would say, well I'm available for these shifts and these days and that's what I'm going to work and they go yeh, that's great, whatever. You know there are so many more options to have a manageable regular life so that you could get it ordered and be on top of things whereas, you know, there's someone off sick so you do an extra shift, and then you are constantly changing your whole routine, and that's probably it, there is no real routine, there's no, you know, getting yourself into an organized sort of, routine and I guess that is fine if you don't want to be organized in routine, but for me that was a really important thing to try and establish some routine and organization in what I was doing so I could achieve certain goals and certain health factors for myself, because I knew that if I was working, you know, a couple of nights, and then having one day off, and then doing an early and you know, I was just a wreck, and there was no regular exercise, and it all circles, because we do need regular exercise, for your own mental health as well as how you operate.*

Lawrence and Williams (1990) also discuss the dynamics of decline in rural Australia due to the agricultural downturn. In establishing why the population is reducing, they identify that smaller rural centres are adjusting accordingly. This is to say, businesses close, people become unemployed and are forced to seek education and employment elsewhere. With this continued decline in the local economy, government services and agencies are withdrawn from the sector. The authors postulate that political and economic disadvantages are evident, rendering these communities powerless and less self-determining. In continuing their argument, Lawrence and Williams (1990) examine the sizes of rural towns and the availability and access to services. They reveal people residing in towns with fewer than 10,000 persons experience 'considerable disadvantage' (p.41), and people residing in towns with fewer than 5,000 persons face 'extreme disadvantages' (p.41). These authors suggest that issues of declining resources and difficulties in recruiting, attracting and retaining appropriately qualified personnel in rural regions might well be attributed to the gross inequalities and inadequacies in health care provision throughout regional Australia. This may be seen in the deficiency of qualified staff available within the locality and the fact they can be neither 'attracted nor retained' (Lawrence and Williams, 1990, p.49).

Despite arguments presented in the literature, the group reflected that the workforce in the Area Health Service in this study had remained stable. People who live in rural and remote regions cannot just resign from their positions and leave the area to relieve stressful work practices. Consideration must be given to the fact that their roots are here. They have other commitments such as partners working on large rural properties. Another factor is that their families may have been established in these regions for many years, with family properties being passed down from generation to generation. With the downturn in the rural sector from the agricultural crisis in Australia, it is very difficult even to place properties on the market for sale, with the last ten-year drought adding complexity to the situation. It is not a matter of just moving to the next hospital or another position. Resulting from the continued high levels of stress associated with the rural crisis is an increase in stress-related illnesses for the population. Variations in nursing work practices are required to relieve stressful situations within the organization to maintain the level of retention and minimize the impact of stressful events experienced in small communities. One participant reflected:

Participant:

Disk 2 line 92–104

> *Eileen when we did our last consultation …. In 2001 – I know it's been a long time but …I just heard about our consultation where we asked people about the broader view of health views – the social model of health and really tried to get them to not think doctors and nurses and stuff, and asked people what was getting in the way of how healthy they'd like to be. That was the first question, and overwhelmingly it was stress. So there must be stress for all of us, I mean we're all part of the community too, that causes high levels of stress in all sectors so that could be related to not enough money, not enough - you know the isolation, the distances, the lack of public transport, the petrol prices, the border issues – all sorts of things, with reason. But it all came out as high levels of stress – so we might even be kidding ourselves saying we're not terribly stressed. It might be just – that we're beginning to 'crack up'.*

The impact of stress can be derived from organizational, societal, personal and professional sectors. The worker at times may be in conflict with any or all of these factors in their

work situation (Seago & Faucett, 1997). The way stress affects one individual may vary to another with much lesser or greater intensity. This will vary the homeostasis of each individual and adaptation will be determined by the effectiveness of their own coping mechanisms. In attempting to meet the ever-increasing demands of the health consumer individuals may at times lack the resilience and emotional resources to sustain the chronic stressful situations in which they work. Energy, vigour, emotional vitality and cognitive liveliness are rapidly consumed during the coping process when attempting to deal with stressful work situations that progressively deplete coping resources. Cumulatively this leads to a state of psychological strain leading to physiological illness and exhaustion, potentiating the possibility of workplace burnout (Seago & Faucett, 1997).

Perkin, Young, Freier, Allen and Orr (1997) identify burnout as being frequently interpreted as a situationally induced stress reaction that may also reflect personal values. The authors view personality hardiness as being related to stress among nurses, with groups of attitudes, beliefs and behavioural tendencies existing that insulate individuals from high degrees and ill effects of life stress. The authors postulate that burnout may be more frequent in those health professionals who do not possess these personality traits. Participants' reflections moved towards how the community existed within the stressful environment and the impact this had on them, not only as health professionals within this community but also as community members themselves.

Participant:

Disk 2 line 105–107

> *We definitely have high levels of alcohol consumption, there is lots of underage drinking – we have lots of ODs and smoking and alcohol….*

Participant:

Disk 2 line 110–113

> *How can we not be stressed if we live in a community that lives with a high level of stress, and … reported it – we didn't have to go looking for it, so if you're dealing with people that are stressed – I guess one of the things that happens from time to time, is that ……..*

Participant:

Disk 2 line 114–115

> *Yeh, it teaches very badly and I know it happens to the nursing staff quite often – yeh even some of the staff.*

Participant:

Disk 2 line 116–126

> *Yeh – I'm working with this person so that kind of conflicts and you try to get your message across and for some people that would go from nought to one hundred with them roaring at you with problems that have been put on the table, and suddenly you're getting hammered at and ……. Not very good skills at conflict resolution! We have done some work around that and had (guest speaker named) here, was great, and really everybody speaks highly of her – the other thing we've got is a lot of staff who are around menopause age so there's lots – you know, people really want information, so I think we can try and get (guest speaker named) back again – we had a very good speaker on that, yeh, but I'll say there's really a kind of, ……. I might be underestimating the levels of stress. This week is good, but it's only Monday – so by Friday she'll be more stressed.*

Nursing literature consistently reveals a multitude of job-specific stressors that have been found to be associated with burnout. Although the role of a nurse may be clearly defined, there are considerable differences between the expectations of nurses in metropolitan areas and those of rural nurses. Role ambiguity and conflict may function as variable between environmental and workplace conditions causing role stressors with potential negative consequences. The philosophy of the nursing profession is that of nurturing and caring (Duquette et al., 1994). Nurses are constantly exposed to stressful situations that are repeated and lead to the depletion of resourcefulness and energy that can result in burnout (DeRijk, LeBlanc, Schaufeli & De Jonge, 1998). Burnout is purported to originate from not only nursing work itself but also with characteristics of both the worker and the work

environment, with the latter being particularly significant (Schaufeli & Janczur, 1994). Simoni and Paterson (1997) discuss the relationship between the personality construct of hardiness, coping behaviours and burnout. In their study, the authors reviewed the literature on hardiness, which is reported as having a role as a buffer between stressors and burnout in nursing. In describing hardiness, the authors recognize three components; openness to change and problem solving (challenge), a feeling of involvement (commitment), and a sense of personal influence (control). Direct active coping strategies orientated towards the source of a stressor are reported by the authors to decrease the negative effect this stressor may have. They refer to Pines and Aronson (1981) suggesting that this form of strategy has been reported to account for lowered levels of burnout among nurses. In comparison, inactive coping strategies that avoid or deny the source of stress are reported by the authors as increasing the levels of burnout among service professionals. The authors found that greater hardiness and adaptive coping were independently associated with decreased measures of burnout among nurses (Simoni and Paterson, 1997). Literature supported the theory of decreased negative influence on psychological functioning and low levels of burnout among nurses. Direct coping approaches are applied outwardly to the environmental stressors, whilst indirect coping approaches are applied inwardly to one's own attitudes, emotions and behaviours. These are problem-focused and support-seeking behaviours. Due to inconsistencies in research, it has not been possible to determine conclusively how various work-related factors exert influence across the dimensions of burnout described by Maslach (1976).

Having allowed a free-flowing discussion among the participants, the researcher proposed a summary of the content. Verification of the common themes was discussed in a reflective process that generated thought and discussion amongst the participants as to where this session may lead them. It became evident that a few issues needed highlighting as they had

the potential to drive ongoing cycles. One participant questioned how they managed crisis situations, all too frequently they just happen and everything else ‘went one side, went on the back burner’. It would seem that work was completed still but it could not be done at that particular time. Playing ‘catch up’ with the required duties, fitting in shift work and everything else that may have come in as extras for that shift saw the staff having to become ‘creative’ in their time management.

The second point in the discussion addressed the issue of personal wellness being a serious point in their lives. Some participants agreed that some of them could sustain ongoing work life and manage this around their own social life, identifying they had the space to be able to do this whilst remaining well. An opposing viewpoint was that there were clinicians coming into work ‘exhausted, they’ve had enough, they’re stressed’, with a physical display that these stressors were impacting on their physical wellness, their attitudes, their approaches, certainly their interaction with their patients and co-workers. The group had now identified two themes for consideration as the overarching themes; the question was put to them as to which path this research should take.

Participant:

Disk 2 line 379–380

> *So it’s that loss of control – is that what we’re really going to be what we’re titled ….*

Participant:

Disk 2 line 385–386

> *Is the loss of control is the identified factor as the major stressor of this occupation?*

Participant:

Disk 2 line 387–388

> *The fact that you know, you can’t determine what happens – you know you’re running around.*

Researcher:

Disk 2 line 389–394

> *And long term over a period of time it can be identified the clinician hasn't got time to address their own wellness – they go from one crisis situation to the next – from one shift to the next, to the next and they haven't got time to regroup – when they have got their days off they are just exhausted and as you said, you end up coming in on an extra shift to cover someone's sick leave or yeh – so you're not able to maintain your own wellness.*

Participant:

Disk 2 line 404–408

> *That kind of talk …is that in the nurses we are actually taking specific action towards avoiding a crisis so we expect that in some ways we can actually help them be – there is a prevention strategy as well as a management of the difficult situations and that you expect that the more success you are going to have less crisis come in and that would be good.*

The impact of a lack, or loss, of control over situations in the workplace for these participants was vigorously argued and identified as one cause of increased stress for them. This may have resulted from the loss of idealism of the professionalism and expectations that the nurses held for themselves. The belief that nurses are able to manage complex patient needs is dispelled when they are unable to deal appropriately with a situation in which there is the loss of control or uncertainty of practice. Cognitive constructs (Piaget, 1971, as cited in Blair & Ramones, 1996) that provide basic schemes of identity, values, causality, self-concept and trustworthiness of perception (p.26) are challenging for nursing professionals if there is a sense that they are unable to maintain this idealism of practice due to the loss of control within their practice. Decision making and autonomy in providing therapeutic interventions for clients are integral components of the nursing role in rural and remote communities. The discussions by the critical group indicated there was an increase in their stress levels when they were unable to incorporate these elements in their practice, particularly in high demand job situations.

The expanded discussion by the critical group required some guidance to enable them to regain focus on how this research study could assist them in meeting the aims of the research by addressing the identified stressors. At this point, the researcher intervened, giving recognition to the value of the previous discussions. The question posed at this point by the researcher was whether running with the two themes was an acceptable option to the group. There was significant discussion by the group as to whether the development of a tool or a guided intervention might relieve some of the stressors.

Researcher:

Disk 1 line 330–353

> *When you spoke about, so many times trying to make sure everybody is well, that you've got a lot of support; there seemed to be quite a lot of reflection of autonomy, that you seem to have quite a reasonable amount of autonomy within this area to be able to implement strategies or undertake new initiatives. So, it doesn't sound like the lack of autonomy is holding you back, it's actually that whole work environment seems to be creating some of the problems?*

Salter (1991) attempts to define stress and refers to research literature offering a bewildering variety of approaches to the subject. Much of the confusion surrounding the concept of stress, Salter suggests, originates from the poor fit between human characteristics and the physics of inanimate materials. The analogy used is a beam under load, producing stress (force per unit area) and strain (extension per unit). In his paper, Salter referred to the term stress as meaning agonistic stress. The person in an agonistic state has been psychologically aroused by an aggressive interaction or a form of threat of physical injury or reduced status. In response to this, the body initiates the fight or flight response. Evers, Frese and Cooper (2000) discuss four studies undertaken by Cooper, Sloan and Williams (1988) using the Occupational Stress Indicator. This tool is founded on the notion that not all individuals react to stress in the same way, with stress being a lack of fit between the person and the environment. Evers et al. (2000) purport this is a valuable tool in the diagnosis of stress in organizations, allowing for the assessment of many

different aspects of the stress process. The group concurred that there was a level of autonomy within the organization and staff were openly encouraged to participate in change in the promotion of a more effective workplace.

Participant:

Disk 1 line 355–367

> *We were asked regularly, did you have the resources you need to do your job you're here for, and if you don't let's get them into the plan and let's work out how we can get them. So we don't have a mantra for this oppressive (sic) from authority even. We are all encouraged to be autonomous, to be independent self starters, to get cracking and our reporting is minimal. You know, adequate but minimal. We're not burdened with onerous reporting, probably in the clinical setting though, (participant named), you would remember having to keep records and how stressful that can be. Some of us have actually found that difficult. One thing that I should add about this organization is probably one of the hardest things for me, and I don't know how other people feel, is the reality is that we can't keep growing and we can't keep responding to every single need and that we do have to prioritize and we do have to say no from time to time.*

The group continued discussion around the increasing demand on the health service and, at times, the unreal expectations some clients have of the nursing staff. Despite the resources available to the nursing staff there were dramatic limitations on the adequate and appropriate interventions that were available to be implemented for the client, adding to the stress for nurses. This has increased the stress on health professionals from both an individual and professional perspective.

Participant:

Disk 1 line 369

> *It is hard to say no, just say no at time when I have to.*

Participant:

Disk 1 line 371–384

> *It's worth it. I guess that would have to be one of the stressors for me and I guess that it would be hard for recognizing that we have limitations. I have limitations and I want to retire well. That is one of my goals and it breaks my heart to see terrific women, my age really, retiring very unwell, so seriously we need to think about that. That is very disappointing, for an*

> *organization without a sense of valuing the whole workforce, everyone is valued, so I don't want to leave like that either. So that might be another theme as how we create all these expectations and certainly if you talk to some of the older ones they'd know they are in a good paddock, they've got good access to services, they've got good access to home care, they are well managed, their transition between critical episodes and recovery are well managed, but if we had a change of government and a change of whatever, we might have to live in an environment where we can't respond so effectively. We might have to work under a different model. I'd be out of here.*

There was a level of agreement among other participants on this point. When discussing sources of stress in the workplace, Otto (1983) recognizes the distinction between experiences that are challenging and ongoing problems that cause distress. In both cases, the body's initial response is alarm reactive. In a challenging situation, the reaction is transitory and can lead to a sense of satisfaction as a feasible solution results. In direct contrast to this, Otto suggests the distress-producing problems present a sense of feeling trapped. There is no perception of resolution to the antagonist and the situation is viewed as beyond one's control. The body's mobilization of energy resources towards an environmental threat is not harmful if the threat is of short duration and is resolvable. Should this not occur and the problem persists over an extended period of time harmful consequences ensue. Psychological effects include anxiety, depression and irritability. Within the work setting, stress has been associated with reduced productivity, staff turnover, absenteeism, accidents, injuries and substance abuse (North, Syme, Feeny, Shipley & Marmot, 1996).

McMillan (1986) contends that an individual's resources to withstand prolonged and repetitive stress provide the individual with ongoing job satisfaction functioning at optimum levels. In supporting this argument, Lachman (1996) discusses stress and self-care, describing cognitive control strategies. Changing an individual's perception of their environment from an uncontrolled threat to a controllable challenge affects his or her attitude. In investigating the potential for psychosocial interventions to modify individual's

perceptions, Cahill (1996) contends that person-based coping enhancement programmes are ineffective in achieving work environment changes. Cahill believes that healthy organizational change could include changes that would increase and create employee autonomy, give a sense of job security, increase skill levels, promote workplace social support, encourage the use of technology, attempt to balance job demands and improve personal coping mechanisms, and thus would cause no harm (Cahill, 1996).

Foster and Tomkins (1997) differentiate between eustress and distress. In their discussion the authors recognize the benefits of increased eustress in task completion; however, they also acknowledge the deterioration in performance should the stimuli be increased excessively, leading to distress. When viewed from an organizational perspective, distress is seen to be a common occurrence, as many health service organizations, in particular, set unachievable objectives. This creates disillusionment, as support and resources are unavailable to complement the required targets.

Participant:

Disk 1 line 401–407

> *From the point of view when I'm talking to colleagues, or CEO or department head or something like that then the hierarchical side of nursing can restrict some people who have grown up in that area who cannot speak openly on a one to one basis with superiors or whatever, but I fully take on board what (participant named) was saying over here, because she is quite right that someone presents at A & E or any door in the whole organization and you cannot say no, sorry, the shop's shut, fully booked. We can't do anything for you. You are always totally committed. I mean it's rare when you've got a situation where there is nothing to do. If that happens great – not very often – we always run it as win at all cost - everybody has to.*

This statement indicated the nursing staff at this Area Health Service were willing to exceed expectations to ensure all health consumers receive the highest priority regardless of the circumstances within the organization. Each staff member held a sense of personal responsibility to provide an exceptional level of health service to the community regardless

of any other demand on that nursing staff member. Some stress levels within the workplace are acceptable as part of everyday work demands and may be therapeutic and challenging. Increases in workload that may cause unwanted stress to one person may well offer another a welcomed extra stimulus. Sarros and Sarros (1987) suggest stress may be salutary and therapeutic if an individual feels challenged and stimulated by work demands. A job with high demands may not necessarily produce stress, particularly if there is adequate support from co-workers. If, however, an individual perceives him/herself as failing to cope with prolonged stress, burnout may result. Kenny (2000) describes the inner resource purports one must use to reach harmony and balance in dealing with stress. This harmony and balance exists between three contexts, oneself, others and the environment. When experiencing an overload of stressors this balance is in disequilibrium and contributes to immunosuppression and stress-related illnesses (Head et al., 2006).

Despite the discourse that had been summarized some members of the group continued to discuss strongly concerns that they felt had overriding implications for them and presented significant stress. The main issue discussed at length led to a general consensus pointing to a lack of perceived control over situations that arose when the ED was accessed by a consumer with mental health needs. This was a frequent occurrence. The group saw staff safety being compromised by inadequate resources and lack of education about assessing these clients. The uncertainty and the unpredictability associated with mental health caused many participants to reflect on their own inadequacies in knowledge about how to deal with situations arising from this cohort of health consumers. These consumers may or may not have been seen previously by the MHST. Participants were not only saying that this team should develop specific strategies to be implemented by staff should a known client access the hospital for assistance, but the group argued that the more pressing need was for the regaining of control over what seemed to be unpredictable events within the ED to maintain their own safety.

Participant:

Disk 1 line 416–417

> *But I think it is a loss of control. It's all that work practice when you haven't got control and when you haven't got control the stress levels are way out.*

Participant:

Disk 1 line 419–422

> *And when you go completely out of control when you've got the suicide patient and you know the medication round is due and you've got somebody starting a round and you've got somebody else ……to turn down in nursing time and if you've got someone in A & E can you send –*

Participant:

Disk 1 line 424–425

> *The phone's ringing – you know someone's ringing up with some bizarre enquiry and you know god knows what comes in on the phone.*

It is recognized that stress is an inherent feature within the work of nurses, with evidence suggesting it to be increasing in severity. The ED does have highly stressful events that at times have certain elements that are beyond an individual's control. For the critical group many situations originating in the ED were perceived by nursing staff as stressful, including critical emergencies, motor vehicle accidents, cardiac arrests and deaths, serious injuries, uncooperative patients, psychiatric emergencies and abusive or demanding patients and relatives exhibiting crisis behaviour. Nurses may at times be unsure as to the level of involvement required with their patients and feel uncertain about how to deal with various patient needs (Buunk & Shaufeli, 1993). Role ambiguity and role conflict within the work environment may elicit a variety of behavioural and affective responses predictive of occupational stress and burnout (Pearce, 1981). McGowen (1995) discusses organizational stress from the feminist perspective. She describes how working women commonly experience organizational stress as role conflict and role ambiguity. This author goes on to describe the psychological symptoms of workplace stress. Job-related tension and negative impact, nervousness, increased anxiety and insomnia are present when

women report how work-related issues impact on the core functioning of their lives. Somatic conditions and general fatigue are inherent in these reports of deteriorating physical health. The solution women seek to resolve this dilemma is job promotion. There is variation in the importance of role stressors (Boyd & Pasley, 1989) with further research being required as to which role stressors are linked to negative consequences (Jackson & Schuler, 1985).

Participant:

Disk 1 line 427–429

> *Well I think your exercise is in control because we deny that this is how to make it work. It's just how to implement something that will give you some control, even if it's only in …….. control.*

Participant:

Disk 1 line 431–432

> *I don't know if it controls anything other than an illusion anyway. It's that feeling that you're in control, rather than being totally out of control.*

Participant:

Disk 1 line 436–437

> *You feel like you can manage something, even if you're not actually in control, you can't do it all, at least it's all realizing and feeling good.*

This discussion reflected a sense of pride and satisfaction the nurses gained when they were able to implement some strategies that produced a conducive work environment despite problematic events. It was clear there was no single example that any one of the group were able to provide but the mere fact that they were able to work within a professional scope allowed them to challenge the sense of feeling trapped in stressful situations. Rural nurses may be classified as being multi-skilled, often having to work in extended roles, however there is limited literature that has investigated the conditions of rural nursing practices (Drury et al., 2005). Pinikahana and Happell (2004) examined studies across Victoria (Australia) and Canada, indicating that rural nurses gained greater

job satisfaction than their metropolitan counterparts. Contributing factors associated with job satisfaction were community contact, job flexibility and autonomy; however, the authors identified that there is a paucity of research investigating rates of stress and burnout in rural nurses and rural psychiatric nurses. The findings of the study revealed that workload was the highest perceived stressor on the Nursing Stress Scale, closely resembling the findings of British and Australian studies. Expansion of research in this area is recommended by the authors in regards to the particular benefits their findings would have in recruitment strategies for rural and remote regions across Australia.

Otto (1983) contends that identifying a stressor as being transitory suggests it will have a resolution in sight, which can give a sense of task achievement. This intrinsic factor acts to protect against risk of ill health. Stressors perceived as unalterable are most likely to initiate defensive coping mechanisms aimed primarily at personal adjustment rather than that of situational changes. Briner (1997) describes stress management interventions as primary, secondary or tertiary interventions. Primary interventions are consistent with changing job conditions; secondary interventions are those that develop people's skills in effective coping mechanisms; and tertiary interventions treat those individuals experiencing distress or negative affects. The author explains that primary intervention may take many forms including increasing the level of control that employees have over their job. Stress management training is the major component in secondary intervention, with employee assistance programmes providing counselling. Financial and legal advice was identified as tertiary interventions (Briner 1997). The author postulates that only primary interventions are specific in addressing changes to the work environment that ultimately aim to reduce the presence of stressors.

This argument is supported by Cooper and Cartwright (1997), who also discuss types and levels of intervention in organizations seeking to establish and maintain the physiological, psychological and psychosocial well-being of their employees. Reference is made to the prevention of stress, also identifying primary, secondary and tertiary levels of stress management interventions. Primary prevention is concerned with stress reduction and is described as taking action by modification or elimination of the source of the stress. In other words, the environment is adapted to fit the individual. Secondary prevention essentially involves individuals themselves recognizing that they are experiencing stress resulting from workplace stressors. This type of intervention is achieved through training and educational activities aimed at improving stress management skills. The authors also recognize that there are individual stress thresholds that vary from one person to another. Key factors contributing to variables that influence an individual's vulnerability to stress include their psychological, psychosocial and physiological attributes, as well as the perceived degree of social support the individual has. Tertiary prevention is particularly concerned with the treatment, rehabilitation and recovery of individuals who have or who are suffering stress-related illnesses. Evidence suggests that counselling is the treatment of choice in effectively improving psychological well-being. Limitations to this intervention strategy are addressed by the authors, reflecting on research undertaken on the sustainability of the benefits. Murphy (1996) suggests that stress management interventions within the work environment will significantly impact on job and organizational outcomes. Many companies have responded to occupational health and safety programmes and have created safer work environments (Lachman, 1996). However, the attention given to the physical workplace as a contributor to stress and psychological dysfunction continues to gain interest from all quarters. Organizational cultures and values need to be continually reviewed as these contribute to workers' responses to the workplace environment.

The focus of discussion changed when the critical group recognized just how many persons who they knew were accessing the health service. The group identified this increase was due to local farming and townspeople who had started to acknowledge that they were not coping with their current social situations. The small size of the community leads to problems associated with maintaining the privacy of clients and client embarrassment at seeking support from the health service industry and having to consult a professional who is known to them socially. This results in the lack of privacy, further compounding the distress and self-esteem.

Participant:

Disk 1 line 447–451

> *Providing privacy in this area can be very challenging and I've had very challenging episodes of trying to afford privacy to that person who's having their crisis in a small town and there are all these people lined up waiting for pathology and outpatients. Yeh, it's all happening in there and you just know it can be heard in the corridor – so there's a whole lot of aspects.*

Elliot-Schmidt and Strong (1997) argue that attitudes to health and illness differ between rural and urban dwellers. The notion of exposing their private lives to acquaintances in local services impacts on rural people's mental health. The authors contend that the distance to seek alternative medical interventions in regional or metropolitan areas is prohibitive in travel costs, accommodation and time. There are ethical dilemmas involving boundaries for nurses working in small rural communities. Patient contact is very frequent in these localities from a social perspective when both patient and nurse may be involved in community activities, clubs, church, school functions and similar situations. The multiple relationships nurses may find themselves in may preclude developing a trusting therapeutic relationship with the patient and can potentially lead to impaired clinical judgment (Scopelliti et al., 2004). The critical group concurred that while this was a significant issue adding to their already stressful workplace, it did not pose the greatest concern, which was reserved for staff safety.

5.1.2 Summary

The first theme identified by the critical group was staff safety. After long deliberation the group arrived at the position that there were two definite problems within this theme that needed to be addressed: personal and professional safety of staff. Compromised personal safety of staff generated the most discussion. The group recognized that on several occasions staff were exposed to potentially threatening situations involving violence or the risk of violence to staff members. The group maintained that these situations involved degrees of control. This sense of control underpinned their capabilities of being able to deal with crisis situations leading to a sense of personal safety. Crisis situations were identified to be most prevalent during 'high risk times' including night shift with limited staff and resources available, and during peak seasonal activities such as festivals. Discussion was given to the group's ability to maintain professionalism when involvement with community events saw them associating with some of their clients. Recognition by the group was evident in the distinction in interactions they needed when a member of the public or of the nurse's social group attended the health service for assistance.

5.1.3 The action planning stage

This stage involved consideration of alternative courses of action to achieve improvement or resolve the problems identified by the critical group. Mental health treatment involves nursing staff interacting in many aspects of clients' lives. It is imperative that all interactions are well planned and have continuity across all staff members to ensure both clients and staff remain safe. Once the group had agreed that there was a clear need for interventions to overcome their safety need and the level of staffing in crisis periods, several action plans were discussed. This section outlines the development of these action plans, which would be later refined and implemented and adopted by the health service in providing an appropriate service. Discussion around these action plans centred on regaining control over the health care environment and maintaining staff safety. The

following examples indicate some of the ideas discussed by members of the critical group as the basis of action planning.

Participant:

Disk 1 line 489–493

> *Yeh, so you're starting to get control over what might be happening, but you need to know to kind of work out where that might come. It might be people waiting for physicians, maybe, there might be people interested in a little course and then a roster or something where they could be called. That might be your sense of control.*

Participant:

Disk 1 line 455–457

> *We've got a few good strategies happening down there now to try and provide privacy as one example, we'll remove some stimulants like not so many people coming in and different faces every time.*

Participant:

Disk 1 line 459–463

> *Maybe some form of ……maybe the carers or some untrained person could sit inside. I'm just trying to think of some intervention that would make you feel like, OK so I can get on with my work because I don't have to be checking and that would be something like maybe a roster in which volunteers – like it might be someone like a carer or ….*

Participant:

Disk 1 line 467–471

> *Maybe you could say well that room is for that and that room could be used for somewhere where they could sit quietly and they could be supervised by someone who may be able to explain things to like I don't know, teach them how to deal with a kind of calming thing and how to incorporate that if they need it.*

Participant:

Disk 1 line 473–474

> *Certainly some training like that would be good, maybe a three- day course or something like that.*

Participant:

Disk 1 line 478–487

> *Sort of like I think that's taking some strategies or strategy that has been kind of discussed a little bit but hasn't been truly developed and yeh, that's like a bit of light bulb going on going yeh, an untapped resource that really could be bought in, in that after hours or even during hours time when everyone tends to be, I mean if there is one thing going wrong there's three things going wrong, like the place is chockers (sic). There's ambulances arriving and you know someone's having their crisis and it is part of the illusion of managing would be to know that OK, at least I know that person is being supervised. I know they're safe, and I know the rest of the ward is safe because I've actually got enough people in with the right skills in the right areas.*

Participant:

Disk 1 line 489–493

> *Yeh, so you're starting to get control over what might be happening, but you need to know to kind of work out where that might come. It might be people waiting for positions maybe, there might be people interested in a little course and then a roster or something where they could be called. That might be your sense of control.*

Participant:

Disk 1 line 547–548

> *I think it might be quite an empowering thing for nursing staff to think that OK when and if this situation arises I know I've got the knowledge.*

Persistent discussions followed the theme around the need for extra personnel to support staff dealing with a mental health consumer until the MHST could assist or until the patient could be transferred to a regional centre two-and-a-half hours' drive from the town. This is the closest psychiatric inpatient unit to the area under study. The time and stress involved in this process was of great importance and became central to the development of an action plan and in justifying the need for change. While the group was mindful of minimizing additional costs to the health service of implementing change, these costs were balanced against the extra cost within the health service when a mental health consumer requires extra time and more personnel than are available. This was considered by one participant who related a history of having great difficulty in accessing the appropriate treatment for a

client and requiring an increase in staff input to affect a suitable resolution. This impacted greatly on the nursing staff and became an ongoing issue that underpinned many points considered throughout the discussions.

Participant:

Disk 2 line 10–14

> *One was probably for two days and the rest mainly a full day, like, something like 10–12 hours by the time that person had presented to the time they were actually shipped off to where they needed to be and the resources and energy that went into getting that person to the right place was phenomenal, like yeh, and really down to (nurse identified) just saying right this person deserves better.*

Participant:

Disk 2 line 17

> *Yeh, there was total exhaustion.*

Participant:

Disk 2 line 18–19

> *And it's gruelling – people saying you shouldn't have done that, that was my job.*

Participant:

Disk 2 line 20–25

> *Yeh, absolutely and the fallout, yeh that sort of fallout is so negative, especially in an area where you've got such a cohesive great group of people work together so well, and then there's a situation like this occurs and it causes real rifts because people take it so personally that their judgment, it was perceived to be the right one and you know, so and so should have done this and so and so should have done that, and that's all fine in retrospect.*

The group acknowledged that there is an ethos of mental health care that directs them to nurse people in the least restrictive environments. This has led to a wide range of crisis intervention models being developed which incorporate a multidisciplinary approach to management. These models provide interventions as a solution to treat exacerbation of psychiatric symptomatology, which may have resulted from poor medication compliance,

physical illness and exposure to environmental stressors. In a relapse into a psychotic episode, sufferers may experience symptoms such as delusions and/or hallucinations resulting in disturbed and difficult behaviour. This may be exhibited in aggressive and threatening behaviour vented towards themselves or others. Crisis intervention at this stage becomes imperative to prevent further deterioration. The flow-on effects in continuing this type of management of mental illness, however, become time-consuming and stressful to implement for the community mental health teams, with staff burnout becoming an increasing concern (Joy et al., 1999). Community mental health teams extend their case management to maintain mental health services to the general community and this contributes to their workloads. These teams are required to provide flexible and innovative programme development in the prevention and planning of treatment approaches for a comprehensive network of services to meet the needs of the general population. For the MHST this became an essential component for the community due to the limited staff numbers. Aware of added costs to the organization associated with change, a well-devised plan was established to be implemented should an after hours contact be made by that client. Despite the best laid plans, the group recognized limitations.

Participant:

Disk 2 line 26–27

> *And even sending people you know in the ambulance. That's also very time consuming, isn't it? But you need to have a carer to the hospital.*

Participant:

Disk 2 line 28–31

> *Well, it's just like any medical emergency, you can get them to stop - yeh not so long ago, someone was held for six hours before we could actually get them out, and it wasn't for want of trying by our medico that was on. You know, it was really frustrating.*

Participant:

Disk 2 line 32–35

> *So, it's a very expensive process, isn't it? The things that make it extra stressful is that we put all these resources into play everybody gets stressed out of their brains and it costs heaps and we have to be careful about calling more people in for a w*hile.

Participant:

Disk 2 line 36–43

> *Yeh, but even just like, even the fallout costs, OK two or three people are drawn from their job on that day to help manage this situation so what they should have been doing and what they were probably working towards a deadline for anyway so they're stressing out about the work that they should be doing and they've got the stress of the situation that they are currently dealing with. Then they come out of that quite exhausted then it's the next day, like I still haven't done such and such and I've got to go back and address that, so there is all those sort of things.*

Participant:

Disk 2 line 44–45

> *Then they debrief, and they say, well I have to debrief but I've still got five patients.*

Social support can provide relief for nurses in stressful work environments. This support is described by Holahan, Moos and Bonin (1997) as a resource people call upon when coping with stress. This resource can modify the impact of chronically stressful conditions (Sarason, Sarason & Pierce, 1992). Gottlieb (1985) describes social supports as "verbal and/or non-verbal advice" and having "emotional and behavioural effects on the recipient" (pp.28–29). Gore (1985) purports that the stress-buffering effect from social support is contingent upon the support being initiated rather than the perceived notion that it exists. Thoits (1985) supports this argument, suggesting that the received support is more powerful than the perceived support. This was discussed by the group to some degree, however a great deal of uncertainty existed among the group as to the effectiveness of utilizing debriefing as a form of social support.

Participant:

Disk 2 line 46–55

> *There's a few studies around that actually say that debriefing is not a very good idea, you know, some people love it and it works well for them, but there is a whole lot of people who just are much happier to just go right, I've compartmentalised that and I'm OK and I don't want to think about it again or talk about it ever again, it's done. So it teaches us that we do put a lot of effort, we've got our system and that's more people, usually two at a time which assists. Anybody can ask for help from them and they are very good but that's a whole lot of time when duties are done and then those debriefing significant episodes can take an hour or two, so yeh, it takes a lot of time – time that I'm probably always stressed about.*

In the work situation described by the critical group, the stressor can be deemed to be either resolvable (short duration) or prolonged according to how it is viewed and the context in which nurses may find themselves (Pines & Aronson, 1981; Pines & Maslach, 1978). Individuals have different responses to stressors, ranging from slight psychological arousal with minimal performance deterioration to an intense arousal with psychological distress (Lazarus & Folkman, 1984; Light, 1981; Turnipseed, 1994). When examining this situation, an initial distinction can be made between the problems that are experienced as challenges requiring innovative problem-solving ideas to bring about a resolution and ongoing problems causing distress. This could be due to personal needs not being met, with expectations or demands being beyond the control or exceeding the limitations of the nurses involved which requires extra energy resources when confronting the situation. Associated with stress from this level and linked to the burnout syndrome is reduced organizational efficiency and work-related problems such as staff turnover, low morale, poor quality of patient care, absenteeism and, interpersonal problems (Jackson and Maslach, 1982; Maslach, 1979; 1981; Turnipseed, 1988).

There was still a significant amount of concern by the critical group with regard to their ability to reduce their workload stress. The group identified a strong volunteer ethic in the community and an existing volunteer programme, a visiting programme that assists the

nursing staff in the nursing home section of the hospital. It was agreed this was a successful project and was still working well. Based on this community ethos it was suggested a roster of Personal Care Attendants (PCAs) could be enlisted for assistance as required. However, concern was again voiced as to the reception a similar programme would receive if it was implemented into the care of consumers accessing the service for mental health issues.

Participant:

Disk 2 line 147–148

> *First of all just to spread it around and see what they say (hospital staff indicated) – see what they come up with ideas – and give us some feedback as to whether it is feasible.*

Participant:

Disk 2 line 149–150

> *So really crisis at the coalface so to speak, whereas as crisis management, mental health crisis management.*

Participant:

Disk 2 line 154–160

> *It's probably a bit like, you know, if something comes in you're not on call as such but you might, you tell the staff, you know you can always ring me so if you had some PCAs or someone with some training or someone who's interested in that field and happy to be part of the volunteer programme so that they know. If they're home then that's a bonus. If they're not, they're not, so if you have a list and it's a bit like nursing staff. You hope like hell that someone's at home and available.*

Participant:

Disk 2 line 198–200

> *The first thing to do would be to see what the response would be for the acute nurses, you know, in a more serious way. Because what you don't want is another person as a patient.*

Various members of the group had many suggestions related to ad hoc strategies they had implemented to assist them in streamlining work practices. The ensuing discussion led the critical group to explore the possibility of having a list of volunteers from the community

to be on call and assist with ‘specialing’ (having a person stay in close proximity to a client) a patient with mental health issues accessing the ED. It was suggested that these volunteers could have Mental Health First Aid training to facilitate their level of ability to protect the patient and provide them with a level of confidence whilst under the supervision of qualified hospital staff. Consideration was given to the area within the ED so persons may be afforded privacy without compromising safety for volunteers, staff and patients, and the legal issues around having a band of volunteers assist with the care of patients. There was some discussion amongst the group that a family member may be able to assist with monitoring the safety of the patient whilst nursing staff made contact with the mental health team both locally and regionally. However, this caused some concern with negative experiences being related. Additionally, the transient nature of the population prevented family support in some cases.

Participant:

Disk 2 line 253–258

> *Well, one of them that has presented a few times didn’t actually have a family member to sit with him. And another one was certainly very physically threatening and there were Police there. So yeh, with the family, some of the more suicidal – not sure what they’re doing, depressed younger people – there have been people who have carers. Some of the really acute ones there just wasn’t anyone that they knew or had.*

Participant:

Disk 2 line 259

> *And sometimes the people just don’t come from here.*

Participant:

Disk 2 line 261

> *They’ve come here and have episodes so their support groups are elsewhere.*

Participant:

Disk 2 line 263–264

> *Yeh, during the Folk Festival, there's a few of those and the drug and alcohol that comes with that show.*

The group identified there were ongoing issues that caused great concern when dealing with clients who were not from the local area. Many problems arose when clients were required to be scheduled into hospital (detained in hospital against their will) under the governing Mental Health Act for the State and then attempting to return that client to their home State. Due to variation across Australia in legislation governing the detention of patients with mental health issues, there have been a number of agreements between NSW and adjacent Australian States with regard to the transfer of patients who have been placed under the respective Mental Health Acts of those States. These include agreements between NSW and Victoria, Queensland, and Australian Capital Territory (Department of Health NSW, 2005). These agreements permit the transfer of detained patients to be admitted or accepted into the receiving hospital under the respective jurisdiction giving recognition of interstate restrictive orders (Department of Health NSW, 2005). The Northern Territory of Australia Mental Health Review Tribunal Report (2006) identified there had been an improvement in corresponding law provisions to enable cross-border agreements and arrangements with other jurisdictions to facilitate the transfer of patients under detention across jurisdictional borders.

5.1.4 The action taking stage

This phase saw the course of action considered in the previous stage implemented into practice. The group proposed that the idea of a volunteer roster be implemented for use in times of need for clients with mental health issues accessing the service. This concept was to be circulated amongst staff within the hospital sector to gain feedback as it became apparent that it was the area of most concern. This responsibility was delegated to a specific critical group member (the Assistant Director of Nursing) to be undertaken prior to

the subsequent meeting. It was suggested all staff be contacted during the week at afternoon handover when there would be the greatest representation of staff involved in staffing the ED. This idea was also to be proposed to the CEO after input from all staff had been obtained.

Participant:

Disk 2 line 271–272

> *We're really widespread in consultation about the way we do things – we probably should even have a chat to (CEO named) as to how he would see the role.*

Participant:

Disk 2 line 273–277

> *You might get some other wave of people feeling like they've got control and they can keep control – however, it will mean that if you get into a situation that's difficult you've got options and choice. Like, you know I can manage this myself, I can get someone else in, I can you know – and we do work off different procedures.*

Hegney et al. (1997) found that the behaviours in social practices of metropolitan nurses and medical officers had changed over the past 20 years and had become more 'specialised and high technology focused' (p.123). These authors suggest, however, that rural health services had maintained a similar focus to that of 20 years previously. Change is embodied within the learning praxis and needs to be embraced with culturally specific recognition. Shifts in power relationships occur and are based on the acquisition of knowledge that may or may not be personally confronting. These shifts require changes in perspectives within the workplace and should accommodate other workers who are not wishing to make changes. Common values, along with common principles of nursing practice, allow the development of group cohesiveness in a period of change (Gibb, Anderson & Forsyth, 2004).

5.1.5 The evaluation phase

Following the completion of the action taking phase a collaborative approach was used to evaluate the outcomes. This phase determined whether the theoretical effects of the action were realized and whether these effects provided a suitable outcome. After discussion with the CEO, it was reported back by the Assistant Director of Nursing to the group that the suggestion of engaging a bank of trained volunteers was not a viable option. Financial constraints and the logistics of the proposal precluded the idea. This was not a suitable outcome but the group had considered alternatives over this period, with consideration given to a management tool. A framework for the next iteration of the action research cycle was established (Baskerville, 1999). One participant had investigated how other health areas managed clients with mental health issues. This proved to be useful as the findings revealed tools that had been developed could be an alternative to the rejected notion of having a bank of volunteers.

Participant:

Disk 2 line 283–299

> *Yeh, and seeing some of the episodes that have occurred down there (ED indicated) where I've been directly or indirectly involved in and then sort of moving across the field as I am and I do have something to do with policy and procedure and quality coordination here, when I'm out looking for other things mental health – like there's a wonderful (State named) mental health guidelines managing acute sort of phases – information that I've found which I've flicked around the agencies. Big documents that there are some good templates and strategies in there, but everyone is so overloaded and like oh yeh, that could be a useful tool but you know, when do we actually get to really discuss it. And I have downloaded and given a hard copy to (nurse named) and like she's the same, oh yeh, there are some good things in there and yes hopefully at some stage we'll get to look at those, but that maybe just as an example a sort of tried and tested document that we could look through now through this process, where we might be able to buy some flow charts – as to OK if this situation happens then these are good processes to have I place. So that means ……intervention is going to be a better outcome for the clients and for the organization. We would hope to find evidence in there.*

Participant:

Disk 2 line 302–303

> *Yeh, it's actually about rural health and it's trying to, I think, take into consideration…*

Participant:

Disk 2 line 371–373

> *Well, there is certainly a lot of cases with loss of control – you'd could argue that by gaining some control over a situation that people would be less stressed and therefore ……..…*

A study undertaken by Schmitz, Neumann and Oppermann (2000) to evaluate the effects of locus of control and work-related stress on burnout in hospital staff nurses revealed that greater work-related stress and burnout was associated with poorer locus of control in nurses. The authors contend that the perceived degree of control is instrumental in enabling nurses to cope with stress and burnout. Saines (1999) reported nursing as the most dangerous profession in the United Kingdom and that health service managers should make every attempt to reduce violence and aggression in the ED. The Health Services Advisory Committee (1997) found it was possible to reduce the risk of violence by proactive management at senior levels, which should be underpinned by positive commitment. This idea is supported by research that indicates managers' behaviour and support is significant as a buffering factor in the burnout syndrome (Glasberg, Norberg & Söderberg, 2007). Training for all senior managers must be an essential element and should include negotiation and communication skills, recognition of toxic behaviours (such as victimization and harassment), managing organizational changes, conflict resolution and grievance procedures, safe job and work design, and identification and control of occupational stress and early intervention.

5.1.6 Specify learning phase

This phase was undertaken as the last formal phase of this action cycle. The knowledge gained from the previous action research phases was used to resolve the staff safety issue

by restructuring organizational norms to reflect the new knowledge gained in the research. This additional knowledge provided the foundations for the critical group to maintain focus on the identified stressor leading to the diagnosing phase of the next action research cycle. The theoretical framework provided relevant knowledge for future research settings (Baskerville, 1999). In this study, the specific learning revealed that stress from the workplace impacted on the functioning levels of nursing staff. Despite a nurse's feeling of how he or she is able to cope, if there is a perceived loss of control in one's practice the stress levels increase. In general, it appeared that a simpler approach to reducing the stress within the ED and for the MHST leader should be adopted in keeping with organizational economic constraints. Having determined that the original action plan was not a suitable option for the organization, the critical group examined alternative strategies to change practice. Some of these alternatives were identified in feedback from hospital staff.

5.2 A nursing model of practice

From this initial theoretical concept the reduction of stress and an increase in occupational health safety and wellness has been well discussed. The critical group was able to assert their need to address such significant issues and design a change in praxis to reflect this. Several factors contributed to this requirement for a variation to practice norms. This became central to the new nursing model.

5.3 The second cycle

This section examines the second cycle that developed in the study. A large amount of data had been generated in the previous cycle that provided rich text for the critical group to determine an appropriate course of action based on the feedback the hospital staff had supplied. This next cycle proved to be as lengthy as the first cycle throughout its various phases.

5.3.1 The diagnosing phase

In continuing the examination of the initial diagnosis that the most significant stress in the ED was staff personal safety based on a sense of loss of control, the critical group adopted recommendations from hospital staff and sought alternatives from other Area Health Services across Australia in addressing this problem. Additionally, knowledge of how operational procedures are implemented in larger centres in crisis situations was conveyed by staff members who had experienced this when employed elsewhere. Throughout this period of interaction with the local hospital staff, some thought was given to the level of knowledge and skills possessed by the staff. It was determined that there was a significant educational deficit that posed serious consequences for all who would have contact with the mental health requirements of a client.

Participant:

Disk 3 line 3

> *The suggestion there of the management tool sounds pretty reasonable, particularly if we are going to look at end stage – where that goes back to you (MHST member indicated).*

Participant:

Disk 3 line 6–20

> *(Participant named) came to me and I said, "look I've been thinking a lot about the downstairs stuff and what is it that makes it so difficult down there and the first thing I came up with was lack of understanding and knowledge. The other thing, and in that I guess, lack of understanding and knowledge, is where do I go with this? How do I manage it? And I'm so busy, you know with all these other things, what's the easiest way to manage it? And when we had bit of chat around it I said, look I've got this stuff, this mental health for emergency departments guide from (State named). I said there's a flow chart in it and she went Oh, I found this other thing on the net that she sent me and she's printed it all off and said there's flowcharts and things in here. How about we get back to the start and say OK you have someone come through the door that is behaving what you consider to be a strange manner, where do you go with it? What's the first, like you do your assessment first, then that assessment say comes up with yes, we think there's a mental health injury there, issue here, it's perhaps not alcohol, you know they've ruled that out – you know it could be drugs, it could be you, their not sure. Where do they take it and how do they manage the behaviour I guess, or, I don't know. You'd have to go through*

> *it and because we don't have a proper triage system, it's that person who is dealing with the eight others in acute at the same time has to do the triage, has to decide where to go and if there was something like a flowchart there with some phone numbers or something on it, or even how deal with suicidal behaviour or risk assessment, and teach them in the steps on this is how you do with this kind of assessment, this is what you've found. I don't know. This flowchart was the thing that we most came up with, hey we have an emergency manual down there giving girls guidelines on basic things but there's not a mental health section to it. We need to put a mental health section into that manual.*

When reviewing triaging in EDs that may involve violence, Forster, Petty, Schleiger and Walters (2005) contend strategies to prevent and manage violence and aggression in the workplace have become a primary occupational health and safety issue. The authors refer to Austin Health, an 800-bed tertiary teaching hospital servicing the north eastern metropolitan region of Melbourne, Australia, where a multidisciplinary working group was formed. Since 2000, this committee has continued to review incidents involving violence in the hospital. Policies and procedures have been developed, with the development and implementation of an aggression risk management tool being a key factor in aggression management and prevention. One critical element of this tool provides for the early detection of a potentially violent situation and alerting staff. This allows proactive strategies to be implemented to ensure both staff and patients remain safe with optimal care being provided to the patient. This information suggested to the group that an alternative protocol could be developed for their organization.

Participant:

Disk 3 line 31–35

> *And have it reviewed, just something simple to start with and then it will be reviewed say every two years I think they review the manuals down there and then they've got, this one's the suicide one, isn't it? So suicide risk is chart to see and then you just do that and then care level 1 and care level 2 and then that was the dilemma was who's actually going to do the caring.*

Participant:

Disk 3 line 48–51

> *So, this is the action, but have we collected enough evidence first up, we're doing an action research, have you collected enough evidence from the team to say this is what we want to work on, do you think?*

At this point of the research, the discussion offered an opportunity for the researcher to suggest the group consider an appropriate strategy that might be implemented as another action cycle. The previous sessions had generated a substantial amount of data with the main focus on troubleshooting when a crisis situation involving mental health presented. The discourse had proceeded to a point where the group members were circling back to concepts that had been previously discussed in detail. This opportunity was met with a positive response, allowing the group to reflect on common themes. Discussions continued to be centred on the stress experienced when faced with mental health issues and the ongoing impact for the MHST.

Participant:

Disk 3 line 56–60

> *We're saying, (retired psychologist named) recalls in her role, when she's been working here, that was one of the things that caused her a great deal of stress when she had a client that she had needed to make an inpatient and that's when she had to go home, when her working day finished, she went home and she often felt nervous that those clients might not be in the best hands, that they could be ….*

Participant:

Disk 3 line 63–74

> *But that's how we got to this, we've started to say OK. We also talked a lot (participant named) about where the stress was in the organization and, it must have been a good day, because we were all saying that we weren't feeling very stressed. Famous last words! But that we found that a lot of the stress in the organization was in the nursing staff that when they had to handle physical ailments they were quite competent – they were stressed anyway – but to give them someone that they couldn't work out, someone with a mental health problem, they because extra stressed and then a combination of the amount of health worker not being a 9–5 job, more like 7–9 so not a day job and then the overnight observation of these clients was often critical to their well-being, they needed to be protected from*

> *themselves and given some peaceful space, and that (participant named) she often went home very distressed and didn't sleep all night worrying about her patient. So that was how we said….*

Various authors who have studied and written on stress and burnout have identified two distinct factors believed to be consequences of excessive job-related demands. These changes, which occur in attitudes and in behaviours, have led those leading the research into burnout to note them in the definition. Wilson and Kneisl (1992) refer to burnout impacting on professionals from various disciplines who struggle to retain both their objectivity and their empathic concern for the people with whom they work (Sarros & Friesen, 1987). Capacity building for nursing staff—by adding aids for working with clients with mental health issues—became central in ensuing critical group discussions. Specifically, a mental health triage tool was named as a high priority. Cooper and Cartwright (1997) acknowledge valid supporting strategies serve a useful function in assisting individuals to moderate and overcome personal stress. There are, however, limitations to these preventative strategies when stressors that are inherent in the work environment may not be able to be changed. The group emphasized that any strategy or tools that were designed elsewhere may need to geared to the needs of this organization and would not be a ready-made answer to this situation.

Participant:

Disk 3 line 76–80

> *OK. So let's focus on beefing up our capacity to support clients or manage mental health clients in their acute episodes as one of the strategies we might come up with to improve the mental health of the staff. But they've (hospital staff indicated) given us the answer themselves. They've said give us more knowledge and more information and tools to use when we know more. Does that sound like that to you?*

Participant:

Disk 3 line 82–83

> *Staff would find optimum benefit in a flowchart triage and first line management and assessment for presenting acute mental health clients.*

Participant:

Disk 3 line 101–103

> *We'd discuss this at the next team meeting the benefit of dealing with one management tool method for mental health clients.*

Participant:

Disk 3 line 107

> *Yeh, that we pick a tool and obviously someone delivers some training around it –*

Participant:

Disk 3 line 109–111

> *No No, We'd need to develop it first to suit our organization really. I mean this (State hospital identified) is a huge A & E department where you have to have a triage nurse and you have whatever.*

A mental health emergency care interface project undertaken by the National Institute of Clinical Studies (2006) incorporated emergency and mental health staff from different organizations with the aim of improving the care of mental health patients in EDs. A total of 41 hospitals participated in this project across Australia, from metropolitan, urban and rural settings, with 40,000 mental health presentations recorded over a twelve-month period. The focus of the project was to improve the processes of care from the first point of contact at the ED and planning discharge in collaboration with the community, primary care, mental health and tertiary care services. The study found that the ED is a common point of entry in accessing services for patients with mental health issues and there is significant anecdotal evidence suggesting much variation in practice for medical clearance in Australia for these patients. In identifying barriers to the project, several of the sites reported that inadequate understanding of mental health issues among ED staff had implications for effective care and appropriate referral for patients. The results from this project saw various resources submitted by project teams from each area to guide best practice.

Participant:

Disk 3 line 113–114

> *And you know, herein may lie our first little bit of action, getting people to do mental health assessments, briefly, not in depth, briefly.*

5.3.2 Action planning phase

This phase allowed the critical group to build on the feedback they had received from hospital staff during the diagnosing phase. The group felt confident in developing a suitable tool that would meet the needs of their organization within the constraints inherent to this rural remote location. Literature suggests interventions engaged in the past to address occupational stress have predominantly been focused on the individual. These interventions primarily addressed how the individual could become more resilient towards the stressors arising in the workplace (Lewis & Robinson, 1992; Murphy, 1996; Perkin et al., 1997; Simoni & Patterson, 1997). This approach marginalised workplace stress as an individual's issue and ignored the possibility of this being indicative of the workplace environment, thereby negating the relevance of the occupational health and safety responsibility of the employer (Cotton & Hart, 2003). There is increasing acknowledgment that an organizational approach to manage stress at work is imperative to minimize effectively the negative effects of workplace stress (Ellis, 1995), particularly when the stressor is not foreseeable or is unavoidable. Stress prevention policies developed in consultation with workers should identify stressors and ways to assess and control them (Hehir, 2006). This health and safety issue should be regarded as predictable and capable of remediation.

Although there is a tacit understanding that nurses have the knowledge to administer the appropriate intervention for a patient, some uncertainty exists for nurses in their roles as health care providers particularly for patients with mental health issues (Buunk & Schaufeli, 1993; Gillespie & Melby, 2003; Malach-Pines, 2000). This suggests there is role

ambiguity and role conflict that produce behavioural and affective responses within the work environment, precipitating workplace stress and burnout (Glasberg, Norberg & Söderberg, 2007; Pearce, 1981). One participant related a story of a personal situation involving a family member who had become extremely stressed and whilst under the influence of alcohol had expressed suicidality. The participant related her attempts to assess accurately the level of suicidality through questioning techniques.

Participant:

Disk 3 line 181–184

> *Yes, if you can attribute a figure, a number, to those questions, and then that can give you a scale you can work on and then determine the level of consciousness, and capabilities and cognition of that patient, so then if they fall below a certain level, then you've got problematic issues, obviously a form -….*

A review of literature (Francis, Bowman & Redgrave, 2001) suggested that health professionals practise in environments and manners that are reflective of contemporary thinking. This review cites Foucault (in Grbich, 1999) who argued knowledge and interpretations of the world are formulated on culturally associated discourses. This is to say that the way people view health and illness is determined by predominant discourses. The practice of nurses in rural communities is controlled by medicine both directly and indirectly, however it is based on a humanistic philosophy of care and not the medical model (Rural Doctors Association of Australia, 2007). Similar core skills are used across nursing; however professional roles or boundaries of practice are at times extended and are more generalist than specialist in nature. Common problems identified in this review included professional isolation, scarce resources, legal implication and a range of occupations within these communities that are associated with environmental and workplace health hazards. The range of skills required by the health professional to address these issues is said to indicate advanced nurse practitioner knowledge and skills.

Hegney et al. (1997) discussed the deskilling of nurses in rural practice. These authors stated that one result of downgrading rural hospitals has been nurses' inability to maintain skills due to the infrequency of having to treat certain illnesses that formerly would have been treated at the local hospital prior to the downgrade. They suggested that rural nurses experience difficulties in accessing adequate education and training to maintain their knowledge base and skill levels. In continuing the review, a study by Bell, Daly and Chang (1997) suggested rural practice has its own unique stressors without the provision of adequate training for rural area nursing practice that may extend the limitations of nurses to extremes in what is heralded as a stressful occupation. These authors continue to argue that authorities fail to provide cost effective education for rural health professionals. There is a need for multi-skilling of nurses in rural communities as each rural community is different, with issues related to the community that require different nursing practices (Bushy, 2004).

A study undertaken by Gibb et al. (2004) identified measures that had been implemented to address the critical shortage of nurses in rural areas of NSW by increasing educational opportunities. These educational opportunities were extended to remote communities by the formation of partnerships between rural health services, providers of technical and further education (TAFE) and the university sector. This pathway allowed local people to commence their training as Assistants in Nursing and then enrol in further nurse education programmes towards Registered Nurse qualifications. The study found there was a reticence to learn through self-directed learning and a profound sense of imposed change within small rural hospitals. The authors suggest complexity issues within the workplace require a clear definition of what constitutes a learning environment. Without a clear distinction, any imposed change within a work environment can be seen to contribute to stress (Gibb et al., 2004).

5.3.3 Action taking phase

The critical group continued to examine a range of emergency triage tools from various Australian States and develop ideas that could be useful to include in a tool specific to their organization. Limitations were identified in many tools but modifications were suggested that could be adopted. The mental health initiative undertaken by the Victorian Government involved 41 teams on a national basis and was the first major initiative of the Emergency Care Community of Practice (Department of Human Services, Victoria, 2007). Teams of mental health and ED clinicians collaborated to improve the care of mental health presentations to EDs. The focus of the project was on the ED triage and assessment of patients with mental health issues, and sedation of acute emergencies involving agitation or behavioural difficulties. A literature search undertaken by Broadbent, Jarman and Berk (2004) identified scant literature addressing the provision of triage and management guidelines to assist nurses in making objective clinical decisions to ensure appropriate care for clients with mental illness. The authors examined the need for such guidelines and reviewed several mental health triage scales that had been evaluated for use in EDs. The results indicated that the effective implementation of triage scales had seen improvements in staff confidence and attitudes when dealing with clients with mental health problems. This resulted in improved outcomes for clients.

The suggestion from various group members was that the identified existing triage tools be disseminated among hospital and community staff to gain feedback on what could be included into the tools to become locally relevant. The critical group recognized the value of the input from this staff which would give a cross representation of what the various needs would be from varying perspectives.

Participant:

Disk 3 line 261–264

> *Just get it out down there (participant indicating these documents should be disseminated to all hospital and community staff) and go which one, here you are, there's three that just as a team we've gone through and we've chosen three or four and then we put it out down there for have a look at this, how do you think this would work, leave it out for a couple of weeks for comments and pull it apart and say umm they like it –*

Participant:

Disk 3 line 291–295

> *(Participant named) hit the nail on the head, saying, you know, wasn't in their training, it's an – there's always been that unnatural separation between mental and physical – it's always been through my training and my practice – and other staff here are very highly skilled – they've already got their first line emergency and everything else – so why wouldn't they get mental health training?*

In Australia in 2003–2004, there were almost five million mental health service contacts in outpatient and community-based mental health services and 111,581 same day hospital separations (Australian Institute of Health and Welfare, 2005). Over the last 20 years there has been a significant change in the preparation of the nursing workforce. Until the early 1990s mental health nurses were trained via direct entry into psychiatric hospitals. The comprehensive nursing curriculum introduced in the 1990s saw minimal mental health nursing elements of theory content and clinical hours. There was a significant drop in hours dedicated to these theoretical and clinical hours in this specialty field compared to what had previously been provided in psychiatric nurse training. Although nurses entering the workforce are expected to be able to provide psychiatric assessment and care within general hospitals, in the recent past they have been far from workplace ready (Heath et al., 2002; Pante, 1999; SCARC, 2002; Wynaden, O'Connell, McGowan & Popescu, 2000). There is a growing body of evidence indicating that nurses working within general hospital settings are inadequately prepared to care for patients with mental health issues (Bailey,

1998; Sharrock & Happell, 2002). This has given rise to the role of the Psychiatric Consultation Liaison Nurse in EDs.

The ensuing discussion led the group to identify existing emergency triage tools that could be used as guidelines in developing a triage tool specific to the area under study. It was acknowledged that the existing tools were based on well-resourced medium-sized hospitals and did not adequately address the issues inherent in this region. The group recognized that it was not a matter of adopting a suitable tool but of creating tools that complemented each other and became user friendly. The Action Plan developed from this would involve input from all staff within the hospital for inclusion into the creation of these tools to ensure it would also be a suitable and workable solution for the MHST whilst remaining a workable document for hospital staff.

Ongoing discussions led the group to choose several aspects from a range of existing emergency triage tools from various Australian States. Although they did not cover the exact needs of the Area Health Service involved in the study, they provided a guide as to how the critical group could develop the tools needed for the specific needs of this organization. An investigation into triage tools by Hegney et al. (2003) found that there has been considerable variation in the application of the Australasian Triage Scale (ATS) since its introduction. The authors identified a need for improved uniformity in the application of the ATS by triage nurses. A reproducible, reliable and valid method to classify the illness acuity of ED patients is required regardless of which hospital is being accessed. Their impressions were that a standardized tool would be of considerable value to emergency nurses. It would support nurses working in this challenging area by promoting standardization and decreasing subjectivity in the triage process. A study undertaken by Shaban (2006) revealed that problems of routine mental status examinations (MSEs) and

mental health assessments (MHAs) by psychiatrists, physicians and nurses were well documented, however were too lengthy and complicated. This indicated such assessments were unsuitable for use in emergency situations. Shaban (2006) referred to an American study (Kaufman and Zun, 1995) which examined the use of a quantifiable Brief Mental Status Examination (BMSE) for emergency patients. The study comprised a six-item BMSE and was administered to 100 ED patients who warranted an assessment of their mental status. The results of this study indicated examiners rated the BMSE as useful in 98% of cases. The study concluded that the BMSE may prove to be a valid and useful tool for assessing the mental status of emergency patients in both pre-hospital and ED settings. This supported the critical group's decision to design a framework that was user friendly and simple to implement.

Participant:

Disk 3 line 323

> *This is how we want it done and this is pouring it down into simpler forms.*

Participant:

Disk 3 line 327–329

> *OK, so there's your local protocols and now they've just brought it down into a flowchart and a simple assessment tool, which is what we've got in our emergency plan except there's no …simple things that we come by.*

Participant:

Disk 3 line 331–335

And if you don't have a doctor you can do this – like there's some standard orders that doctors have actually signed off so long as we agree. If the whole three of us agree and you make that assessment and this is the outcome then you can do this and you can't get onto us then you can do this and all those girls are first line emergency care trained so that they can commence drugs and things.

Researcher:

Disk 3 line 367–369

> *I think too if your doctors get a hold of this and have a look at it and say if you sign off on the protocols, you say follow this flowchart where you*

want this to go with these protocols – I mean it then gives them (nursing staff indicated) a medical back up –

In an examination of the issue of clinical work practices where there are no on-site doctors, the Department of Health, NSW (2004a) recognized there is a heavy reliance on the assessment, skills, judgment and experience of on-site nursing staff. This report suggested some rural and remote EDs in exceptional circumstances have developed a practice of 'local standing orders' (p.7) of clinical guidelines for nurses. Discussions continued in regard to other external factors that possibly contribute to the staff's increased stress levels. These factors were outside the control of staff and at times were compounded by the ongoing negotiation process between doctors, hospitals, ambulance and police involved in the transfer of patients for a higher level of psychiatric care. Nurses employed in small country hospitals, regional EDs and wards frequently provide the initial care for patients with mental health issues before formal access to psychiatric services can be arranged. These nurses are often lacking in the skills, knowledge, awareness and confidence needed when dealing with mental health management and assessment regimes (Aoun & Johnson, 2002). Hawley (1992) examined sources of stress for emergency nurses in EDs from four urban Canadian hospitals, basing her research on the Ivancevich and Matheson (1980) model of organizational stress research. Hawley (1992) identified that nurses were stressed not only by continual confrontations with patients and families in crisis situations, but also by patient transfer problems that had considerable impact on their ability to provide quality patient care. It would seem this is consistent with Australian practices. The geographical isolation and resource constraints confronting health providers in rural Australia are not limited to the internal working environment for nurses.

Researcher:

Disk 3 line 478

So you'd have to say that as a rural and remote – you have major issues?

Participant:

Disk 3 line 480–486

> *We do have major issues and they're not addressed by the changes in the Mental Health Act or I don't believe they are. In fact, for the client, which is who they've changed it for, is disadvantaged because then they have to go to A & E, sit there for I don't know how many hours till somebody gets to do an assessment and then a doctor's already done the assessment (this health service indicated prior to transfer) and said they need admission but no he can't sign for admission, he has to sign for assessment and then they can choose to push him on, which they basically have to because the doctor has signed it, hasn't he?*

Participant:

Disk 3 line 490

> *It has made it harder – it's made it harder on clients and workers in ….*

General Practitioners in rural remote locations assessing and/or placing a person under the Mental Health Act may require a hospital admission for that patient at a mental health inpatient unit in the regional centre. These GPs do not necessarily have admission rights to these hospitals and therefore can only refer the patient to the ED of that hospital for further assessment and possible admission. This referral may either support the initial assessment and admit the patient or fail to uphold the assessment and refuse admission. A report released by the Commonwealth Department of Education, Science and Training (Francis et al., 2001) examined the literature on rural nurses and the skills they required to meet the challenges of nursing in the 21st century. This report identified the constraints of an ageing workforce and difficulties in recruitment and retention of nurses to the rural sector. A significant finding within this report was that rural health care was in crisis. The report identified additional disadvantages to health, specific to rural remote localities, which were "exacerbated by geographical isolation and problems of access to care, shortage of health care providers and health services, socioeconomic disparities, greater exposure to injury in farming and mining industries, lower road quality, small, sparsely distributed populations and Indigenous health needs" (p.1).

Participant:

Disk 3 line 492

> *And the ambulance is another independent factor.*

Researcher:

Disk 3 line 508–509

> *So when you're transporting a pysch (psychiatric) patient do the ambulance expect staff to escort or are they happy to take them?*

There has been a rapid change in paramedic practice and ambulance care over the last decade. This has precipitated a number of challenges to the ambulance profession to ensure accountability and transparency in professional practice standards, education and training programmes, clinical standards, and policy (Shaban, Wyatt-Smith & Cumming, 2004). Shaban et al. purport the level of existing qualifications held by ambulance staff does not adequately prepare paramedics for clinical judgments outside those they have learned, which are based on competencies that may be of limited relevance in complex or uncertain environments. The group identified that the process of organizing a transfer was tedious and cumbersome. It involved the necessary paperwork from the doctor faxed to the regional ambulance service (two-and-a-half hours' drive away) before the regional ambulance centre would even consider accepting the job. This request required information as to whether or not an escort was required or whether there would be a police escort particularly if the request involved a psychiatric patient.

Researcher:

Disk 3 line 517–518

> *But your local chap (ambulance officer) can't leave town? You have to get someone up from (Regional Centre) or somewhere.*

Participant:

Disk 3 line 520–523

> *No – these guys came from (Regional Centre named) the other day – depends on where they can get someone to come – the local ones are not*

> *supposed to leave town and leave the town uncovered so I don't know whether there's one ambulance or two ambulances here so it means it can never go anywhere.*

A report commissioned by the Queensland Government, Transport of Patients with a Mental Illness in Queensland (Queensland Emergency Medical System, 2003) proposed standardized and consistent protocols for the transport of mental health patients in Queensland. The report discussed patients in rural and remote locations who could not be managed locally and required transfer. The type of transport depended on distance, safety issues, level of care needed and the availability of resources. Road ambulance transfers at times required the use of locally based vehicles and nursing, medical and/or police escorts. Long-distance transfers left the community without ambulance cover for extended periods of time that may have exceeded 24 hours if the return trip was included. One practice in Queensland is the changing of vehicles and officers at district borders to offset demands on the respective services. This practice is also common in New South Wales and has been implemented in Victoria. The main difficulty arising from this practice is that patient escorts are left without transport to return to their local areas. Other factors given consideration in this report were lack of personnel to provide escort, limited personnel trained in managing patients with mental health issues and the clinical impact on patients requiring transfer. In many country areas of South Australia, one practice is the use of volunteer ambulance personnel for road ambulance transfers (Department of Human Services, South Australia, 2002). The relevance of this literature had an impact on the progress of the emergency flow chart and assessment tools. The critical group realized they needed to expand the directives contained in the charts to incorporate emergency services, both locally and regionally.

In 2007, the Rural Doctors Association of Australia (2007) discussed the significant disadvantages faced by consumers with mental health issues in rural areas compared with

metropolitan areas. The report identified there may be a lesser degree of support and care due to limited numbers of mental health professionals available in rural and remote locations and difficulties in accessing specialist units. Invariably these consumers suffer poorer outcomes than those of their metropolitan and regional counterparts. The report argues that in rural and remote situations acute services should be well supported by ambulance and retrieval services, particularly when treating complex life-threatening cases. There is a noticeable lack of recognition in this report for psychiatric emergencies and support for specialist needs in psychiatric cases. This supports the critical group's concerns over lack of assistance and support when required for clients with mental health crises accessing the health area in this study.

A canvass of the rural hospital experience in Queensland indicated there was no rule or protocol that prescribed the transfer of clients with mental health issues from an ED via ambulance transfer (Queensland Emergency Medical System, 2003). There were significant difficulties with road ambulance transfers due to limited ambulance resources, distances involved in the transfer and limited mental health services. There was considerable concern if ambulances were to leave a community unattended in order to complete a lengthy transfer, because these communities would be left without any emergency cover (Queensland Emergency Medical System, 2003). In Victoria, the ambulance transport needs of people with a mental illness are identified under various categories. In the case of inter-hospital transfers, a routine code is applied for a response time for the dispatch of an ambulance. This response time is designated as "Code 3—routine transport" (Metropolitan Health and Aged Care Services, 2002, p.16). This routine response is applied if there is adequate care being provided, with the patient requiring transport to an approved mental health service. It is expected that other means of transport have already been considered but deemed to be unsuitable (Metropolitan Health and Aged

Care Services, 2002). The NSW Ambulance Service also has a response code that determines the priority for ambulance transport. Routine transport for inter-hospital transfer is deemed as R7 General Transport—COLD—discharge/inter-facility/convalescent/palliativecare/transfers etc (NSW Ambulance Service, n.d).

In an attempt to overcome the difficulties with the ambulance and other issues associated with assessing and transferring clients, the critical group continued to pursue protocols from all States across Australia. A telephone call to the Centre for Mental Health in one Australian State had revealed that their Psychiatric Emergency Manual had been taken out of publication and another manual was currently being developed to adhere to the national initiative. It was suggested to the group that they were probably approximately 12 months ahead of national planning; however, if an alternative was developed from this research it should be reasonably easy to align it with the national initiative once this had been released. Broadbent et al. (2004) examined ED mental health triage scales in the improvement of patient outcomes. The authors identified the importance of effective assessment and management of clients with mental health issues presenting to EDs for emergency care. In their discussion, Broadbent et al. (2004) identified a paucity of literature addressing the provision of triage and management guidelines to assist nursing staff in their clinical decision-making in the triage process. The authors' findings from their study not only indicated improved patient outcomes but also increased staff confidence and attitudes.

Comparison was made among the group as to just what resources were available locally and what was available in other areas, particularly metropolitan. This was spurred by the input from the staff who had examined the triage tools that had been disseminated for

comment. There was an acknowledgement that deficiencies existed in several areas of available resources in the local setting.

Participant:

Disk 4 line 142–154

> *I got the flowchart out and said why we would adapt it to suit our organization and most of the staff said that was good because a lot of them don't know, I don't know, each number - I don't know what the local numbers are – I come from big hospital where it's all there – like your mental health workers, your crisis health teams, and you just pick up a phone and people come down. You've got security, you've got your locked rooms, you've got your psych units just down the passage, you know what I mean? But here we've got nothing to support us as such so we have to depend on each other and have that information at our fingertips I think.*

Participant:

Disk 4 line 163–171

> *Yep, it's easy to put a phone number on the flowchart – and flowcharts seem to work for most people. I had a young girl come in at 4.00 am in the morning, threatening self-harm and she wouldn't give up her instrument that she was going to hurt herself with, and I just said to her, sure it's your choice, you either give it to me or I'll ring the police now and they will come and see you. And having not been back here long enough I didn't know what else to do, and she just handed it over. I mean it worked that time, it might not work next time. But, you know, when you start in a new organization you don't know what, unless you've got policies and information that are easy to access, you think well where do you go.*

Concerns began to grow as the critical group unveiled the current practices some staff implemented, particularly after hours. This was highlighted as the group worked through the recommended processes on the triage tools currently in use in other Area Health Services around Australia. Staff safety was the main theme the group had nominated as the primary concern to be addressed yet despite policies and protocols being in place there was still some staff who neglected the protocol of having a second person with them prior to permitting clients to enter the hospital, posing risk to their colleagues, themselves and their clients.

Participant:

Disk 4 line 181–185

But some people don't even wait for that now, like if they're up in acute and the buzzer rings and you're down there, by the time I've actually run straight away up because I know what the policy is and having worked in where you've been very vulnerable, they've already got the door open – like that could be anybody and I think we need to reinforce that policy.

Participant:

Disk 4 line 206–208

And really, we know our area, and no matter what they put out at government level, you have to bring it down to your local resources available because we won't have the same resources as (metropolitan area named) or (regional centre named).

Participant:

Disk 4 line 10–11

So it's a State government, but this (area named) one has come from that document – it's kind of brought down from a State level and put it into their work.

Researcher:

Disk 4 line 68–70

I certainly thought the Psychiatric Assessment Handbook – it could look at your brief rating scale that might, you know, sort of lay some foundations for some of you – that you might want to introduce to the staff that we were talking about.

Participant:

Disk 4 line 72–73

Yes, this would be ideal – so that they've (nursing staff) got a basic knowledge of all this sort of stuff – how do we assess this?

Participant:

Disk 4 line 83–84

Everybody needs to have the basic knowledge so that we can do the same assessment, you know what I mean, so that continuity in what we're doing.

Clark, Brown, Hughes and Motluk (2006) discuss education in improving triage of mental health patients in general hospital EDs. The authors contend there is a distinct lack of knowledge, expertise and confidence in undertaking psychiatric assessments by generalist nurses which leads to less accurate assessments for these patients. This is supported by Kerrison and Chapman (2007) who discuss what general emergency nurses want to know about mental health patients presenting to ED. In their investigation, set in a Western Australian hospital ED, the authors refer to non-mental health trained nurses as ill-equipped in psychiatric knowledge, assessment and communication skills.

Participant:

Disk 4 line 88–93

> *And we're trying to use the same language – that's what I found hard when I went into Mental Health was oh my god, I've nursed the first and I don't understand a word they're saying because I hadn't had a mental health grounding even in nursing. I came from the old hospital training – didn't have it – and that was huge – and there's a lot of nurses my age here who didn't have any mental health stuff in their basic training.*

Participant:

Disk 4 line 95

> *Well, half of my course was mental health training.*

Participant:

Disk 4 line 103–105

> *But hospital training – we had a psychiatric unit and we briefly touched on you know, stuff, and we worked in the psych unit at the (Hospital named) but you didn't really – it wasn't like Mental Health -*

Shaban (2006) examined an English study undertaken by Lynch, Simpson, Higson and Grout (2002) into medical professionals' knowledge of powers and provisions under the Mental Health Act. The results indicated that ED staff and police had poor knowledge of the legislation governing their practice in the care of individuals with acute mental illness and required formal education and training. Shaban surmised that the study not only reflected the poor levels of knowledge within these groups, but may also reflect the

differing perceptions of each group about their roles and duties under the legislation. There are similarities in the education of nurses in Australia and the United Kingdom. Australia adopted comprehensive degree-level education for all registered nurses in 1992 (Heath et al., 2002), but has continued to educate enrolled nurses through TAFE colleges. This is unlike the United Kingdom (Kenny & Duckett, 2005). There, students undertake a common foundation programme before specialising in one of four areas, i.e. adult, children's, mental health or learning disability nursing (Royal College of Nursing, 2007).

Participant:

Disk 4 line 111–115

> *Yeh, it is all on the holistic path – it's not a separate thing now and that's what we've got to introduce, that these people aren't separatists – mental health people – they are just people who are community members who are just accessing health care, yeh mental health care, as opposed to medical, surgical A & E – you know, yeh it happens in all aspects of the community.*

Participant:

Disk 4 line 124–132

> *At the moment we are typing up an assessment guide through the system so I can integrate this into a manual that's therefore, it was mainly looking at the enrolled nurses because they're having trouble doing an assessment, whether they use……., and whether they use the systems – this could be incorporated into this manual as well, so that it's actually like another system that they could look at as well, as you know, your gastrointestinal or your social aspect of care, so when they look at it they're going to look at the whole person, not just the physical side of the person – because it all impacts – you know if you've got a mental illness or your feeling depressed that day, it all impacts on your physical well-being, doesn't it?*

Participant:

Disk 4 line136–140

> *All right – there's a mountain of work to do isn't there, but what I thought was a good idea about a flow chart is you know the very simple, OK, well I've noticed this, then I do this, then I do this, then maybe I really do need to do – it will alert you to go and do a proper assessment – or there's a risk here – hang on – how do I do a suicide risk assessment and just that little…….*

The critical group concluded that the most appropriate course of action to undertake was the development of a flow chart that could be readily accessed by any staff member who might be required to attend the ED (Appendix 7). Several options were examined from various health departments of Australia States. Many of these had valuable information that the group believed could be amended and adapted for use within their service. It was obvious however, from the outset that these flow charts from various sources were designed to meet the needs of metropolitan areas and were not suitable for rural and remote communities. As the flow chart developed, the group stated that education for all staff should accompany each area addressed within the chart. Literature supported this argument, particularly in the appropriate assessment of clients with mental health issues accessing this service and the management of aggression and violence in the ED (Clark et al., 2006; Drury et al., 2005; Department of Health, NSW, 2004a). An action plan was set for the after-hours manager to access the hospital staff and gain feedback on the flow chart the critical group had developed by combining aspects of charts from various States. It was anticipated this manager would have better coverage of all staff than any other group member, as the group felt they needed feedback from the majority of staff to address adequately all needs.

5.3.4 Evaluation phase

The group developed a series of flowcharts based on the information gained from various State ED triage flowcharts. As planned in the previous phase, the after-hours manager disseminated the proposed charts to hospital staff for comment. The manager did not have written documentation about these flowcharts but did speak to a number of the staff at handover in one session. The consensus was that hospital staff thought the development and implementation of the flowchart was an excellent idea, as all information required would be kept together in a folder located in an accessible location in the ED. The feedback from hospital staff suggested they saw this as an area where they particularly felt

they had little confidence. This feedback provided easy discussion around the value of further development and implementation of this initiative and allowed a smooth transition into the next cycle.

5.3.5 Specify learning phase

The critical group was able to identify that there was a consensus that some form of remediation to practise in the ED was required to facilitate smoother and more effective assessments of clients with mental health issues. Nursing staff and GPs attached to the hospital suggested that any change to practice most importantly should protect nursing staff and ensure they remained safe. The acceptance of a flow chart provided the critical group with a base to develop a workable solution to put to the hospital administration.

There was a clearly identified second overarching theme in this cycle. This was the limited education of staff in assessing and managing clients with mental health issues accessing the hospital. Much discourse was given to the difficulties posed when an ineffective assessment occurred, posing greater risks for the staff involved and an unsuitable outcome for the client. The discussion highlighted that on occasions this may have led to an escalation of a violent outburst by the client with an undesirable outcome for all concerned. It was agreed that the group would seek input from all nursing personnel in determining the accuracy of this analysis and input into an effective resolve.

5.4 Further development of a nursing model

Added to the core of the nursing model described in the previous cycle, the critical group were able to identify there was a direct relationship to a reduction of stress and increased occupational health, safety and wellness and an improved positive patient outcome. Three further circles that overlapped in this model reflected the impact of rural remote nursing practice, education and upskilling in nursing knowledge and practice and organisational

support and resources were of a paramount need if there was to be any positive impact within the change in praxis.

5.5 Conclusion

There was a significant amount of rich data generated in these two action research cycles indicating a great level of interest throughout from the key stakeholders. This propelled the project throughout the various phases, giving it a sense of urgency and worth. The critical group found a remarkable level of support from hospital staff for the development of a flow chart. Based on the first two cycles the recommendations to address what was perceived to be problematic in the ED, that is the vulnerability of staff, supported the critical group's thematic concern of staff safety. Suggestions to alleviate this also included the impact any interventions may have on the MHST and patient outcomes. The critical group maintained the notion that having a set guideline for the assessment and transfer of clients would reduce stress levels in the ED and reduce the workload for the MHST. They recognized the benefits of accessing tools that had been utilized in other States with the view to combining and adjusting these to suit their region's specific needs. The second theme that was realized in this cycle was the need for education in assessing and managing consumers with mental health needs. The fact that there was limited immediate support available for staff to assist with the assessment and transfer of patients to the regional centre for more comprehensive assessment, prompted the realization that all staff should have the knowledge and professional skills to address the needs of these clients. It was thought educating nursing staff in the performance of MSEs and MHAs would increase staff safety.

The following chapter will discuss the subsequent two cycles of this study. These two cycles were concerned primarily with the ongoing development of the flow chart and triage tools and the proposal to the Clinical Aged Care Review Committee for ratification into

practice. This committee is part of the Quality Assurance team and reviews all changes or submission of forms utilized within the health service. Again, as demonstrated in the previous two cycles, there was a significant amount of rich data collected and reflected in the thesis to reflect the discussions and stories of the critical group.

CHAPTER 6

Implementation of the final two research cycles

6.1 Introduction

The previous chapter outlined the initial cycles undertaken by the critical group and highlighted the two overarching themes around staff safety and education. This chapter summarizes the next two completed cycles that resulted in an effective and acceptable resolution to the problem of workplace stressors for this Area Health Service. This resolution involved developing a flowchart and triage tools (Appendices 7 & 8) for use in the setting's ED. Based on these strengths the group worked together to develop the concept and actual draft versions of the emergency triage flowchart and triage tools. These were developed throughout each meeting as each issue of concern was discussed. The charts that had been accessed from other States were reviewed and consideration of the content was given as to the suitability for inclusion into the new flowchart and assessment tools being created. In the time between each meeting, all information generated on the new charts was entered into the researcher's computer and presented at the commencement of each meeting for verification of accuracy. The chapter will explore the details the critical group examined throughout the cyclic phases to reach a workable resolution to the themes identified in the previous chapter. Further development of the new nursing model is discussed with a final concept of how this model should be implemented to improve their practice and overcome the impact of significant stressors within their workplace.

6.2 Diagnosing: Identifying/defining the problem.

The richness of discussion generated in the previous cycle provided the critical group with the momentum to continue pursuing the two identified themes. Although communication varied from individual to individual, acceptance of participants' subjective opinion and stories enhanced their contribution to the research and enabled the participants to drive the research. Personal safety and isolation in practice were diagnosed by the group as being

issues of most concern. Determining a safe area for patient assessment was a concern for the staff; however, with limited secure areas within the hospital this presented a dilemma. The critical group indicated that, despite an 'Assist' button located in the ED, at times they still felt compromised in their safety. The physical layout of the ED contributed to this feeling of compromised safety and was deemed by the group as not conducive to a safe environment. There were lengthy discussions around how safe each individual felt with police resources and their availability to attend the ED on request.

Participant:

Disk 4 line 276–279

> *Start with the flowchart because that gives you a direction of where you're going – and that everything can come off the flowchart – the education of what we need – you know have some sort of charts pinpointing you know you go down the chart, x, y z.*

Participant:

Disk 4 line 283

> *And then we can write the policies or procedures or whatever.*

Researcher:

Disk 4 line 292–293

> *OK, so if we go back to your flowchart, what was the most common theme that they (hospital staff) identified?*

Participant:

Disk 4 line 301–305

> *We've got here that the rapid assessment was good, but you need a basic rapid assessment – yeh and that will just be education – and I put this one on this – if you were busy in A & E you need to call down and have an RN to do it, you need to have somebody to do it and just do it. You know, well they will say, maybe they're busy down there – well you'll have to stop them and tell them to actually come and do it.*

The role of appropriate triage, assessment and management of consumers with mental health issues in the ED has complexities that signify extensive workloads for the nurse. Contributing to these complex situations is the potential of violence by the consumer to

both staff and other patients (Kerrison and Chapman, 2006). Broadbent et al. (2004) suggest this assessment is usually conducted in Australian EDs by ill-prepared generalist nursing staff; in Victoria nurses registered in Division 1 of the Nurses Act (1994). Drury et al. (2005) contend clinicians working in rural and remote areas are expected to work at advanced levels. These clinicians do not have the experience or qualifications to work at these levels. A study examining the lived experience of rural mental health nurse by these authors revealed complexity in the role of the nurse that involved a need for the combination of local knowledge, awareness of community resources, therapeutic interventions and the support to other clinicians.

Participant:

Disk 4 line 307–309

> *So what's the first thing that you know happens when you actually have someone walk through the door who's agitated , anxious, what's the first thing you would think of? Where am I going to put this person?*

Participant:

Disk 4 line 313–314

> *They would need to go to a quiet place – I wouldn't want them to go into A & E where somewhere……*

Participant:

Disk 4 line 322–323

> *But it's only that you go there – and then you've left your whole ward – we would talk about the logistic.*

Participant:

Disk 4 line 325–327

> *What's the first thought that comes to your mind, the first thing you would do when somebody comes in who's, who used to be you know, anxious, agitated, you know, rrrrrrrrrrrrr – what's going on here.*

Schnieden and Marren-Bell (1995) discuss the prevalence, types and possible precipitating factors of violence perpetrated by the client within the health care workplace dividing this

behaviour into two categories: physical and verbal abuse. The authors contend verbal abuse is more frequent, however it is reported far less frequently than physical abuse. In their research, Schnieden and Marren-Bell identified a need for education in defusing violent situations. If this practice was implemented by staff the potential for escalation of violent incidents could be reduced. This knowledge and skill may enhance the well-being of the staff and reduce the stress associated with violent behaviour that was identified by the critical group.

Kennedy (2005) stated that workplace violence in the ED has reached a level that requires 'concerted action and shifts in attitudes" (p.362), citing Worksafe Victoria's definition of occupational violence as an "attack … experienced directly or indirectly and results at least in risk to well-being" (p.363). In accordance with Worksafe Victoria Kennedy explains three concepts of violence: occupational violence—the employee is physically attacked or threatened in the workplace; physical attack—the direct or indirect application of force to the body, clothing or equipment of the employee creating a risk to health and safety; and threat—a statement or behaviour causing the employee to believe he/she is in danger of being physically attacked (p.363). Kennedy reports the experience of violence is a universal issue for ED nurses, with approximately 90% experiencing some form of abuse over their career. In examining emerging strategies to curb the current level of violence in EDs Kennedy reviews the guidelines of the Australasian College for Emergency Medicine (ACEM) (2005), which states EDs require structural protection and security response systems including the presence of adequate security staff.

Mayhew (2003) contends health care workers are in the highest risk category of client-initiated violence. In reviewing strategies to prevent occupational violence, Mayhew claims the health industry is lacking in recognizing and embracing preventative strategies.

Mayhew suggested the adoption of the occupational health and safety 'hierarchy of control' (p.4) for occupational violence. The first stage of this is to eliminate risk of harm through design or engineering. This could include focusing on access to the room, the immediate surrounds within that room and the placement of furniture and fittings. Mayhew claims that, if adopted on a permanent basis, these changes are cost effective because any actual costs are balanced out by savings in the reduction of violence in the workplace.

One group member remained particularly concerned that organizational process was not followed when staff permitted entry to clients through the ED doors. Further to this concern was the hesitation of staff to access support through the emergency contact number. Mayhew (2003) examined the reduction of risk of occupational violence through administrative controls and discussed the use of a rapid emergency response plan with easy access to emergency support contact numbers. Staff education in this response is reiterated several times, highlighting the seriousness of a potential violent incident occurring and maintaining best practice in terms of violence prevention. Magarey and McCutcheon (2004) examined contemporary research in the management of violent incidents in the ED. The authors found that violence in the ED is a significant issue on a global scale that not only impacts on the nursing workforce but also directly and indirectly impacts on patient care and outcomes. Efforts in developing violence management strategies should have a long-term basis and include education on the theories and culture contributing to violent behaviours. Magarey and McCutcheon (2004) argued that a systematic review revealed many gaps in identifying the prediction of violent behaviour in the triaging process and questionable traditional violence management strategies.

Some members of the group had experienced unsafe practices within the work environment that may have led to an unacceptable outcome for both the staff and client.

Participant:

Disk 4 line 217–220

> *And we have huge time delays – like we know we've had situations where literally a whole day has passed before we've been able to get someone out of here to an appropriate, you know, hospital with the facilities for patients with mental health. That's happened quite often.*

A comparison was made by the group with community nursing, where there is still a certain amount of unpredictability in client behaviours. The group identified that community nurses have an understanding of the client's background, giving some alert to the fact that the potential for violence does exist. After reviewing input from the hospital staff, several suggestions were discussed in developing safety features to be contained in the flowchart. Kennedy (2005) reviewed strategies for prevention of violence in EDs and noted a key factor of identifying clients at higher risk of violent behaviour (clients with previous violent presentations, substance abuse and some mental health clients). This early recognition should then encourage the nursing staff to initiate proactive behaviour for self-protection. Kennedy (2005) also identified major strategic approaches that were being applied in Australasian EDs, including the presence of security staff as a deterrent to violent behaviour. In an examination of literature, Wand and Coulson (2006) contend aggression and violence in ED nursing is a common occurrence, with the State governments in Australia giving more recognition to this fact in recent times. A common theme the authors identified throughout the literature was that early recognition and de-escalation strategies were the preferred strategies in defusing a volatile situation. The authors recommended that practical policies, procedures and protocols should be in place within organizations to address this problem, with emphasis being placed on staff training and up-skilling in negotiation and communication strategies. The notion of the presence of a male staff member—as described by the participant below—is consistent with these strategic approaches described by Kennedy.

Participant:

Disk 5 line 29

> *Yeh, sometimes you just want that presence don't you, just so they (consumer indicated) know.*

The group continued to express concerns about the physical environment of the ED and the potential risk associated with a violent or suicidal client. They identified that the current layout was inappropriate if other staff and patients were to remain safe. Several options were discussed about where the client could be relocated to if isolation was warranted. Many suggested areas were not deemed as being suitable as there was poor access to other personnel for assistance, non-secure areas to keep clients safe and areas with excessive equipment such as the trauma room. This posed a difficulty for the group as they were acutely aware that there needed to be a safe area to move these clients to but there was no identifiable area that would be suitable in this hospital. There is the notion that in small rural and regional centres the physical layout of EDs can become problematic when attempting to facilitate private and safe settings for a conducive and therapeutic milieu for clients. This also applies to the normal operation of an ED (Australasian College of Emergency Medicine, 1998). For example, issues such as patient safety for potentially suicidal patients must be considered.

Participant:

Disk 5 line 58–60

> *We need to get back to this environment room. Which one is best – maybe we should decide that at the time – what is available? Do we need to nominate a room as a safe space?*

Participant:

Disk 5 line 75–76

> *Just doing the best you can – like that six hours of that guy in the high dependency unit, oh my god – how much stuff was there.*

Participant:

Disk 5 line 80–82

> *No – it comes back to an education thing – just being aware of what is a safe room - yes, and we'll make Room 1 as well – it's like next week we'll have to make Room 4 as one but we need to make it that night.*

Participant:

Disk 5 line 106–107

> *Well I had somebody in that room one night and he kept threatening to jump out the window.*

Participant:

Disk 5 line 109–111

> *And in that room it would be alright – all the other windows are several metres off the ground – and it's something you need to share or whatever, like you contact somebody to sit with somebody for so long they need to have regular breaks.*

The underpinning tone throughout this discussion, however, was simultaneously maintaining staff safety and the appropriate level of care for the client. The notion of the availability of medical support was met with some disdain by the participants, as there had been some previous negative experiences when medical assistance had been requested. The staff acknowledged that they actually filter a lot of presentations that do not warrant medical staff assessment and felt confident that these filtering decisions were correct. The group felt that they had a sound "judgment of character that we don't do it just off the back of our hats. You say I want you here, they should come" (Disk 5 line 131–135). In a review into the experience of new graduate nurses in rural practice in NSW, Lea and Cruickshank (2007) refer to the uniqueness of rural nursing. These authors discuss this role as a 'specialist-generalist role' (p.2) where nurses practice in areas with limited health services, medical practitioners and reduced health care facilities. It is a normal event in such cases to have the nurse working in all areas and assume extra responsibilities. This increase in role expectation can lead to 'role stress' (p.8). The notion of the assessment and referral process was discussed by the group to be included in the flowchart that would

direct the nursing staff to access the appropriate person/persons in the continuum of care for the client.

Participant:

Disk 5 line 145–147

> *Then – that's our physical problem, stabilising treatment, you can do that – mental health problem ensure safety – OK – we can put Care Level. And that comes down to term of observation level – care level to there I suppose…*

Participant:

Disk 5 line 162–164

> *Well a discharge thing – put down a GP follow-up or put a message or do the referral to me (MHST member) or whoever, admission to local hospital under care of GP, well that's where there needs to be a bit more education I guess around that sort of thing.*

McCann and Clark (2005) discuss the concept of adopting care provider-facilitator roles in nursing. These authors suggest that in developing linkages with others, the role of the nurse as a case manager is to facilitate a smooth transition back into society by enlisting the support of other agencies. Often the initial assessment has been undertaken by the case manager as the key worker with decisions being made for care on a 'tacit' (p.51) approval by the doctor.

Participant:

Disk 5 line 204–205

> *And transfers – we do need to get onto transfer and do our own flowcharts for transfer.*

Participant:

Disk 5 line 249–251

> *I think that's part of that education thing – you know who's best suited to do the exam – best suited at that time – you know if it happens at 10.00 am in the morning or if it happens at 10.00 pm at night – or 11.00 pm when I'm just ….*

Participant:

Disk 5 line 253–254

> *So it does come back to this, you know, presentation of a mental health patient, you've done that rapid assessment, OK so it does come down to the triage doesn't it?*

The progress towards achieving a workable and user-friendly flowchart continued under the guidance of the MHST members. Whilst it was acknowledged that the input from the hospital staff was invaluable it became evident the critical group looked towards the MHST leader to ratify suggestions for inclusions into the flowcharts and direct what should be addressed. However, there was never any formal process that a leader should be elected within this group. In attempting to refine the flowchart the group was able to identify specific needs for all staff in education deficits for examination and assessment of clients with mental health issues, the need for input from the medical staff and MHST and the need to determine if the presentation was a known client of the MHST. There was recognition given by the representatives of this team to the limitations on their availability, the sense of urgency of some presentations and the importance of risk assessment.

Participant:

Disk 5 line 343–346

> *But sometimes it's really hard to assess if it's a true mental health problem or if it's some other things…*

Participant:

Disk 5 line 350–353

> *And your triage – if your people have got the confidence or if they choose to get someone else to do it, someone else who is there or who has more confidence to do everything this kind of thing, this will give you a picture of whether you need to contact (MHST member identified).*

Participant:

Disk 5 line 355–361

> *I mean I don't want to be contacted just because it's in hours and there's someone who's crying and anxious – hang on – that's not necessary –*

> *there is a difference between actually needing mental health assistance – and the things like suicide risk – well any nurse should be able to do a suicide risk assessment. And that's just safety first, isn't it? So I kind of think this risk assessment is a good idea – violence, well you know if there is a sense of violence, you know a feeling that this person is violent, what do we do next?*

Mayhew (2003) discusses the severity of violence in the workplace and the impact on the recipient. She compares an unreported slap across the face by a patient with dementia to a violent incident perpetrated by a young male who is intoxicated. Mayhew suggests the level of reporting of occupational violence in Australia is skewed due to this phenomenon.

Participant:

Disk 5 line374–375

> *It's difficult – like the violence – if they're really super violent, yeh, we do get the police up, but what happens if they're just a potential and they're sitting there –*

Participant:

Disk 5 line 379

> *We don't have security – you know what I mean.*

The group concurred that there was a need for police presence at various times; however, there were certain times when this level of assistance was inappropriate despite the fact that the potential for violence existed. They agreed that the decision to call for police presence was at times difficult and that inexperienced staff would not be confident in making this determination.

Participant:

Disk 5 line 392–394

> *We do have a call system and I don't believe anyone would judge anyone badly if they felt there was a risk of violence or you know, physical harm to themselves or others you call that extra person.*

Participant:

Disk 5 line 396

> *And I was saying out of hours the police don't have the resources either.*

Participant:

Disk 5 line 398–399

> *No, I'm saying call whoever you have to come in – like another staff member or someone on call.*

Participant:

Disk 5 line 403–406

> *That night when we had the young girl that was threatening to kill somebody else late on night duty and I was actually up in acute and it was fine, she slept – but it was really reassuring when (MHST member named) actually rang and said, I'm just ringing to see how are things going – do not hesitate to ring her.*

Forster et al. (2005) discuss policy and strategy in developing programmes for managing the risk of aggression in the health care setting. These authors refer to a coordinated programme at a Victorian hospital, Austin Health, which has incorporated an approach for maintaining obligations to staff health and safety under occupational health and safety legislation and duty of care to the patient. The basis of this principle for reduction of aggression and violence in the workplace is systematic education and training for staff in identifying risk and management practices using patient/visitor contracts and policy development. This is supported by Chapman and Styles (2006) who examined nurses employed in Western Australia's health care system. These authors reported that a framework for future education programmes, policy and best practice should be established to ensure not only staff safety but also improved patient care. The critical group acknowledged that the format of several triage tools followed legislative requirements of the State involved and that any tool developed for this Area Health Service should also follow legislative requirements. However, within this context the group realized that there needed to be specific changes to suit their Area Health Service and that a well-developed education package would be required to facilitate any introduction of changes to practice that may result from this research. The perpetration of violence continued to be the

underpinning theme with concerns voiced about staff's inability to identify and/or address these situations adequately.

Participant:

Disk 5 line 312–313

> *So far the education we have identified is that we need to have a session on coping with clients with potentially dangerous behaviours.*

Participant:

Disk 5 line 427–429

> *Because there is a big difference between someone who is agitated and building up to that level of violence and there's a lot of ways that we can actually prevent that in the steps up to that – to prevent that.*

Participant:

Disk 5 line 554–573

> *But you do, you say, yeh, this person looks violent – the other person can go and call the police straight away – you don't have to wait until you've done that violence risk thing – like you're not going to sit down and say, well let me see, tell me are you homicidal or are you suicidal? You know when they've got the gun at your head – just let me tick the box first! …..… . You see I've had somebody come in here one day just to talk and they said they had a gun in the car and they were talking suicide when I did the assessment, I said well what would you use? And for a young female to have a gun in the car is not usual - Well, I think OK – now remember what I told you – I said if you've expressed any of these ideas of harming yourself or harming someone else then I have a duty of care to protect you and to protect me and I'm calling the police. Well they got the message that the girl had a gun on me – they raced around here – she was safe in here with me – the gun was out in the car – I just wanted them to take it away – because I can't touch it – I don't have a gun license – it's not my job – It was a bit scary – I thought oh my god what's going on…..They stormed the building – like a SWAT team –*

The group felt that clear guidelines needed to be established and fashioned into a flowing sequence through all ED assessments. The crucial factor that they all agreed upon was a strong educational package for all staff regardless of their level of experience and expertise to complement any format that was introduced. The design of a flowchart or assessment tool should be conducive to practice regardless of the situation in which staff found themselves. This meant that at any given time staff can be confident that they would

remain safe by following a set process and still have a positive therapeutic outcome for the client. Sands (2007) commented that early identification of the risk of violence at triage is an essential component of the triage process. Sands argued that early identification of the risk of violence determines urgency and should become a predictor in mental health triage.

Participant:

Disk 5 line 584–585

> *All assessments, like we've been saying you have to do simultaneously – you have to be making decisions about what you do next.*

Participant:

Disk 5 line 587–594

> *Just as I've been educating one on one it's time critical for any patient that you're calm – sitting down – just to have that piece of paper – because you do remember certain things – you initiate something so that person is being cared for – paperwork can always be done later – and it's a simple ticked box – I mean the simpler it is for people to just go and tick – it's when they have to write pages and pages of stuff because they are tired at the end of it - they're running out of time – the last thing they want to do is stay over just to write up paperwork – if they just have to do a brief report perhaps – we want to make it as simple as possible perhaps.*

Researcher:

Disk 5 line 596–610

> *… just writing them on a scoring scale and then people are OK they've got a score of 0 – 10 that's OK that's a low level – 11- 20 that's moderate so I need to implement some other strategy – and 20 – 40 – OK that's high acuity – let's look at something more. …… (A) and keeping it at the KISS principle. As you said earlier on too, new people coming into the organization – what is the protocol and procedure – they may not necessarily have a presentation for weeks and weeks and then all of a sudden something comes in.*

6.1.2 Action planning phase

The critical group had discussed their interventions at great length in attempting to determine best practice in developing the mental health triage tools and the emergency triage flowchart to assist all staff in maintaining safety when assessing a patient accessing the health service. It became apparent that there were further tools required to follow up

this emergency triage flowchart to allow a comprehensive assessment under each of the areas identified in the flowchart. These tools would allow nurses to establish the levels of violence, suicidality/homocidality and emotional distress and give them the direction to implement the required strategy for the presentation.

Participant:

Disk 5 line 629–632

> *Yeh, Determine observation level – well observation level here is – this one's got suicidal thoughts, attempts, bizarre behaviour bizarre thoughts, aggression, education, delusion – at risk – if you've ticked yes to them well they're a Care Level 1 or 2 observation and Care Level 1 means Nurse Special – call someone in –*

Participant:

Disk 5 line 656–657

> *I've actually rung (MHST member identified) out of hours about a patient that she's seen and she's said, oh do this and this, this person is dealt with. One phone call saves a lot of ….*

Participant:

Disk 5 line 664–667

> *Well, when I worked in (metropolitan city named) we were across from the medical centres, there used to be a flag and they used to have a pack – that would actually gauge that person, and it would tell you how to deal with that person. But I mean it was somebody who frequently ….*

Participant:

Disk 5 line 671–677

> *I put a warning – if I'm really concerned about somebody overnight or over a weekend I will go down and put a flag up and go you know – there's a little whiteboard in the drug room where I can write – you know just a little flag – if so and so presents, please call mental health number or call me so if I'm really concerned about them – like I've had one over the weekend – I've made all those safety check calls myself and actually put it onto them and said like you call me at such and such a time at home so that I've had two or three phone calls over the weekend –*

Researcher:

Disk 5 line 681

> *So one of the instructions in the flowchart would be check panel to identify…?*

Participant:

Disk 5 line 685

> *…you can put check panel – check whiteboard in the drug room where it is private…..…*

Lengthy discussion continued around the issue of when the assist buzzer would be activated, particularly during after-hours access. Due to the fact that this was a 24-hour service with limited staff, it was deemed that the flow chart should reflect what all staff were required to do when a client accessed the service through the ED. It was anticipated that the flowchart would facilitate a consistent adherence to the health service's policies to ensure staff safety. A second benefit would be to address the concerns of the staff that were on duty after hours who had limited access to resources and support from other staff.

Participant:

Disk 6 line 125–130

> *This is where the staff last month said to us – that's our biggest problem, is that we're alone – our biggest stress is that we are alone and suddenly you're confronted with somebody, so if you press for Assist and they come up and they go look, it's OK in the last 30 seconds or one minute I've done a better assessment, you know I'm happy, nobody's going to get angry about it.*

A link exists in Maslach's burnout theory between emotional exhaustion and the emotional disequilibrium created when an individual is exposed to unresolved crisis events. This response is individual and dependent on the individual's coping mechanisms. In adapting to stress, the General Adaptation Syndrome identified by Hans Seyle (1956) suggests a physiological reaction. The body's response in an alarm reaction (a stressful situation) triggers an immediate physiological response, increasing activity within the autonomic nervous system and adrenal glands. This stage is well documented as the 'fight or flight'

response. Latent features of this response include fatigue, headaches, loss of appetite and fever. Coping mechanisms are employed by an individual in response to the stressor in resistance. Exhaustion may ensue if the individual is unable to resolve the stressor or adapt to the crisis; the immune system becomes depleted with extreme circumstances resulting in death (Sdorow & Rickabaugh, 2002).

Participant:

Disk 6 line 132–137

> *At night time this is something that has not been done and a lot of the girls are saying some of them are going to the door, opening the door when they should press the buzzer before they actually do. So it's actually organizational behaviour that we want to enforce. Yes, we really do, delay that stress and know that you have permission. In fact you've been directed to call for assistance.*

Participant:

Disk 6 line 140–145

> *Yeh – there is black and white so people don't have to feel like…. I remember hearing Div 2s say that they didn't feel they had the right to call up people – I know we've had a few instances where we've had a situation and the Div 2 said, well I didn't think I was allowed to call people. That was someone else's job. Yeh, so that was some time ago though. So it needs to be very clear that you do call – whoever you are, you call.*

Researcher:

Disk 6 line 152

> *Reinforce safety ……. OK so you're happy with "Press Assist" to stay there – from "Press Assist" go to "Triage"? – and rapid assessment by the receiving nurse. …*

Participant:

Disk 6 line 162–164

> *Yeh because you're looking at the major risk first - no major risk, you do your medical review or medical assessment – they've presented for some reason. The next one, physical problems, whether you do your medical review or….*

The group worked through various strategies to determine the appropriate flow of information through the chart. They examined all aspects to ensure the dominant theme of staff safety was prioritized and supported with staff education; and to ensure that best patient outcomes could be achieved. Considerable discussion between all members was employed to reach general consensus about the final make-up of the flow chart whilst maintaining the dominance of the staff safety theme. Additional feedback from clinicians outside of the group was also sought.

Participant:

Disk 6 line 185–188

> *I guess the only other way of doing it is to actually put that back to the group – to the girls at the coalface to see what they would, how they perceive it – because we're perceiving it at a certain way and they're the ones that will be actually using it, so how – what's their perception on.*

Participant:

Disk 6 line 194–199

> *Yeh, I'm wondering whether you could have the two charts and say we could take it down to acute and at handover say, well if this was the triage …. Somewhere management chart you're using this chart – do you want the high risk on the left hand side reading across or do you want it as the lowest risk presenting first and then reading across? That's basically what we want to know. So what's happening in the triage?*

Participant:

Disk 6 line 243–246

> *I think so, we're really working on the stress levels of the staff and the greater things in place are going to reduce stress. Get help and get relief – we call (staff member named) just to be there, (staff member named), anyone – just a male presence, while you're actually then, then from here you can go down and do the chart if you want to.*

Participant:

Disk 6 line 263–264

> *As long as they're emotionally (client implied) – and both of you are physically safe – if you're physically safe is the most important thing!*

Lengthy consideration was given as to where to manage clients of concern identified through the appropriate section of the flowchart and triage tools. While it was acknowledged that the ED was not the best place to manage such clients, there were no other secure, isolated alternatives. An example was given of a night where a man had entered the ED with a gun. Several strategies had to be organized to have a secure area to nurse this patient. One group member related she had remained with the patient in the physiotherapy waiting area and talked there until other staff organized the secure area. Despite these efforts, the nurse deemed that this was not a safe situation. Further to these concerns of safety, the critical group acknowledged the extended time frame (11 hours) that was required before transport of this client to the regional centre for further assessment occurred. Throughout this cycle of the research it became evident there was an emotive undertone to the discussions. This was obvious as the group attempted to debrief about situations they had found themselves in at previous times in their careers.

Researcher:

Disk 6 line 579–582

> *So they (Nursing staff indicated) follow 2A – Chart 2A – which is rapid assessment of patient emotional and assess any level of care - again it goes back to moving a patient to, if it's a level 1 to the safe room – if it's care level 2, they make that determination of being able to stay here and level 3, regular obs, 30-minute intervals.*

Participant:

Disk 6 line 583–585

> *Yeh, and that could continue for say three or four hours – I mean intoxication alone, by three or four hours they might have slept it off – you really shouldn't turn people out on the street, just because you think – or they're just drunk.*

Participant:

Disk 6 line 632

> *Yeh, we need to get the level 2 onto a medical review*

A report commissioned by the NSW Rural Critical Care Committee (Department of Health, NSW, 2004a) into triage in rural and remote EDs with no doctors on site indicated that nurses experience 'challenging situations including lack of on-site specialist back-up' (p.4). It identified that a fundamental element of safety for the clinician was effective management of patients, particularly the triage process. Remote area nurses often act as sole providers of primary and urgent health care, and frequently extend their skills due to demand in the absence of any other form of support from health professionals.

Researcher:

Disk 6 line 633–634

> *And level 3, we're going to send them to? Because they're suicidal – we're going to send them to…? Do you want them medically reviewed as well?*

Participant:

Disk 6 line 635

> *Yeh – level 3 still has significant potential*

Researcher:

Disk 7 line 3–13

> *The flowcharts that I filled out and sent up were I think pretty consistent with what you were looking at so that was just the overview and then you had to scoot on down to the flowcharts and the other three flowcharts have got to be redeveloped but I wanted to get everybody's feedback on that. The thing that concerned me mostly about this flowchart is that I do recall you saying we wanted to move the person to a safer area, particularly a suicide risk – now that needs to be on that flowchart but I wanted to put it to the group today to see what you thought and obviously to have a look at what is your best option for that.*

Participant:

Disk 7 line 14–18

> *Yeh, now (nurse named) spoke to me about that – you rang her or emailed or something around that - um – so if we go yes, we probably need another little – I'm just thinking violence, potential violence, yes, call the police or male presence, so you're probably not going to be able to remove them to a safe area.*

Researcher:

Disk 7 line 20–24

> *And you want to be at a fairly sort of high profile area. So that if anything happens an easy access if you've got police coming in, where they've got quick access to - you're very visible right there?*

Participant:

Disk 7 line 27–30

> *Yeh, that looks good – I'm amazed that you got it on such a nice neat little bit, after all the chat we were doing the other day – I thought my God how is she ever going to get this organized. Maybe here we could put our yes up there and maybe another little box that says remove to safe area.*

According to Kennedy (2005), the ACEM guidelines released in 2005 clearly state that hospitals need to work with EDs to assess the risk of violence and to work proactively to reduce that risk. EDs need structural protection and security response systems, including the presence of adequate security staff. These can be seen to be characteristic of a safe environment. The physical environment is not the only contributing factor to safety. Better communication contributes to an improved experience for the mental health consumer, which can decrease the propensity for violence.

Participant:

Disk 7 line 38–47

> *Remove patient to safe area I guess, would be better than designated area because we can't actually designate the area – that needs to be something that's discussed at the time like you know, we thought that side of the building is probably safe because they can't get out on the roof – we've put them on the other side of the building they've got out onto the roof – but if you initiated your level 1 observations you've got somebody with them anyway pretty much the whole time, but you don't need to have sharps and all the other equipment around them.*

Participant:

Disk 7 line 61–70

> *They've got in those rooms, there's probably the least amount of equipment in one of those private rooms, or in the podiatry room - and I'm sure there's buzzers – I'm pretty sure there's buzzers because it's used as a recovery room on theatre day so there'd have to be the duress*

> *or a emergency buzzer there to press. This is the whole issue in rural health – that you are the one person on duty and that's about it – but you've also pressed here and you've got somebody else to come with you – so that's why we wanted that put in there – if we see someone is really… presents and we think oooh something's not right here – there's a mental health problem, or they're really emotionally distressed, and press the buzzer and you've got a second person.*

Strike et al. (2008) examined unintended impacts of psychiatric safe rooms in EDs and the experiences of suicidal males with substance use disorders. In their report, these authors revealed many of these patients presented to the ED alone and saw themselves as being punished when placed in single rooms. This tended to escalate behaviours, indicating isolation in the 'safe' room had an unintended negative impact on the patient. The authors report there is little attention in the literature about this phenomenon, which prompted a qualitative approach to their study. The results indicated that whilst staff believed this action was in the best interests of the patient, the reverse occurred and it was seen to be detrimental in establishing a therapeutic relationship and also limited effective interactions. The critical group agreed the best management for clients in the ED was to adapt an existing risk monitoring chart and implement this cover for at-risk clients (Appendix 9).

6.1.3 Action taking phase

The dissemination of the emergency triage flowchart and triage tools to the hospital staff for comment occurred in this phase, giving the critical group a greater awareness of the needs of all staff. The Clinical and Aged Care Review Committee in this Area Health Service met half-yearly to review any changes that were to be made and implemented into any area of practice. The feedback from hospital staff was an essential component at this point in the research, as it was apparent the committee required submission of a detailed package for ratification.

The group reviewed all comments and the work that had occurred in the previous phase and based further refinement of the flowchart and triage tools on this information. Burley

and Green (2007) described the significant demands on nurses in remote areas of Australia. These authors illustrated the context in which these nurses worked and the extended roles undertaken, such as nurse-led health services providing care across the lifespan. These roles cater for acute and chronic illnesses and preventative programmes across this population, which requires a high level of knowledge and skill. However, not all nurses working in rural and remote areas have the experience or training to undertake such levels of interventions and care (Drury et al., 2005). This is also true in this research study as there is a significant population of nurses who trained in the apprentice model and have not undertaken postgraduate studies into advanced nursing practice despite the fact that they are required at times to apply such skills.

Researcher:

Disk 7 line 80

> *Do you think it comes down to just specific education about that?*

Participant:

Disk 7 line 81–84

> *Yes, I do really – I think they need to be very aware of their own safety and the client safety and go, you need to make the decision at that time – where's the best place to put these people – and the education of actually managing somebody who's emotionally distressed – well you know.*

Participant:

Disk 7 line 113

> *Most of them are hospital trained – they haven't had any mental health training.*

Refinement of the charts continued on the basis of retaining a minimum of essential content, retaining clarity and maintaining user-friendliness. This was a difficult task as all input needed to be carefully scrutinized and modified only after consideration of the impact on the overall documents. Changes or deletions should not alter the integrity of the work provided by any contributor.

Participant:

Disk 7 line 241–242

> *Yeh, I am in, I'm rapt – I think it's really – the minimal information in a great useable format – like it's the real…*

Participant:

Disk 7 line244–246

> *Like it's not ambiguous – this – yes or no, this, this, or this – it's great – anyone – no matter what stress frame they are in should be able to navigate their way through that easily.*

Researcher:

Disk 7 line 247–251

> *There's a couple of things that I obviously haven't eliminated – you can see I've had boxes there – I've pulled those out – you don't see that – I didn't even see that till I looked at it then. Alright – so that's pretty reasonable…*

The issue of the lack of security and support continued to concern staff. Despite lengthy discussions of possible alternatives, it was apparent that the proposed resolution sought from this study may not be able to allay staff fears about personal safety. These fears are reflected in the literature. For example, Williamson (2001) identified that both rural and metropolitan hospital EDs in NSW had become areas of concern in regard to violent behaviour. Following the death of a junior doctor in the ED of Liverpool Hospital NSW, and the death of an elderly patient at the Kempsey Hospital NSW, Williamson proposed that the NSW health system must be supported with funding for on-site security, displaying a solid commitment to the safety and security of all associated with the public health sector. Williamson, who was representing the Health and Research Employees' Association, indicated that the Association required the introduction of security departments with sufficient numbers of trained staff throughout the public hospital sector. The level of security proposed by Williamson has not eventuated and this validates the concerns of the critical group in this research.

Participant:

Disk 7 line 255

> *Contact – I'd put Police first – and then here again they (hospital staff indicated) have to decide.*

Participant:

Disk 7 line 269

> *The police might still be out on a call*

Participant:

Disk 7 line 271–272

> *So we probably, we still need to have someone else in here in place of security, don't we, such as… (male staff member named) or (second male staff member named) or one of the doctors.*

Researcher:

Disk 7 line 273

> *What if it's after hours?*

Participant:

Disk 7 line 274–275

> *Well that's where it becomes a problem, then you really are reliant on the police, hoping that they're actually….*

Participant:

Disk 7 line 278–282

> *'Cause I can think of one mental health situation that we had here when they were actually doing a drug raid or a big bust out at (town named) and it was very challenging because we actually needed some help here – they did come to the party but stretched their resources and were certainly stretching ours. Who else could you use out of hours? – and you can't ask the ambulance to come.*

The participants recognized that regardless of how much effort had been dedicated to the safety of staff and client there were inadequate resources to support their needs at the organizational and community level. The discussion led the group to attempt to implement strategies that would give them clear guidelines to follow if threats to their well-being

occurred, using available resources and setting alternative strategies when these resources were limited or non-existent.

Participant:

Disk 7 line 285

There's a gap there isn't there…?

Participant:

Disk 7 line 286–287

Well, what have we done in the past – I'm just trying to think, what have we done?

Participant:

Disk 7 line 288

I guess we just managed just with our staff.

Researcher:

Disk 7 line 289

Fly by the seat of your pants.

Participant:

Disk 7 line 290

Yeh, that's what you do – that's what we do here all the time.

Participant:

Disk 7 line 291

There's really no other resource….

Arising from this lack of resources, it became apparent that strategies had been developed by the MHST members out of necessity to accommodate crises as they unfolded. Throughout the data collection several instances were recalled where similar impromptu strategies had been developed to provide a safe milieu to both staff and clients, supporting the approach stated earlier of 'flying by the seat of their pants' and establishing care and trust. Recognizing that rural nursing is significantly different to that of urban nursing

practice, structures and solutions aimed at improving nursing standards and care in urban services do not necessarily work in rural communities. The contextual nature of nursing means that staff-patient relationships and working practices vary significantly between rural and urban settings. This can potentially limit the effectiveness of directly transposing initiatives from one setting to the other. The group continued to review the proposed documents that had evolved from the input of their colleagues and the requirements needed to suit their situation of isolation and limited resources. The charts had been developed using a colour coding system for ease of flow for the staff when implementing them. They were received with enthusiasm with regard to the progress that had been made over the short period of time, however, there was still an element of concern and the new charts were scrutinized more closely. The aim was to develop the charts to a suitable level for submission to the Clinical and Aged Review Committee where all new charts for the organization were reviewed by committee members for ratification into practice. The importance of having a document suitable for nurses to rely on as a comprehensive and accurate assessment tool was stated by the group.

Participant:

Disk 7 line 785–791

> *Yeh – at their fingertips that are easy to use if they wish to use them. We're not telling them they have to use them. They're there for you to give you a better picture and these are the things that you will be reporting to the doctor when you make the phone call. There are suicidal thoughts – there's bizarre behaviour and you've got it there – you don't have to remember it – you've ticked the box. It will make that assessment easier and that's what I like. That's what I want to achieve from this whole …….…*

Participant:

Disk 7 line 792–793

> *And it would make it more relevant too, to the nurse for whoever she's reporting it to – it's just like you know, these are the things that you look for.*

With the proposed flowchart and triage tools nearing finalization, the focus switched to how these would be introduced to staff and how education in conducting mental state examination and mental health assessment would be provided. The group indicated that many of the nursing staff were working on other projects across the hospital, limiting the opportunities for training. The introduction of an education programme needed careful consideration as to how the package should be designed and delivered in light of time constraints for the staff.

Researcher:

Disk 8 line 52–60

> *Well, we're developing up an education package as well as this, and then I've got the tool to support the education packages, that will follow up from the flowchart side of things. That was Theme 1. Theme 2 we might find that we need to, with looking at the organizational perspective and structural components and all the rest of it in the security of the staff….*

Participant:

Disk 8 line 75–81

> *That's right. And also that they can actually participate, that if they know something's happening and we give them an order to do something they understand well this is their role, like if it's CPR, or that you know, if they know that we need somebody and they're only one around to ring the doctor or get the rest of the nurses to push the emergency button, sound the alarm and then it all comes back – because I mean, it's so much important that everybody knows what a role is for a workplace and that minimizes things.*

The group had recognized the issue of the region's transient population, with various festivals, seasonal farming activities and the tourist industry drawing a variety of people to this area. The initiatives to be included in the flowcharts needed to reflect the needs of these clients whilst maintaining staff security in potential violent situations. The group had reviewed several charts from other health services that could be adapted to suit the needs of this health service. Once again, throughout the discussion the group identified the difficulties of not knowing the clients accessing the service or if any of them had a history

of violence. This meant that the clinicians would have to trust in their own abilities to assess if there could be a problem and feel confident in seeking assistance.

Researcher:

Disk 8 line 186–199

> *And that's something that you guys identified earlier on, wasn't it – because you've got a transient population with the various festivals that you have and the tourist industry …– so we need to put, Is this patient known to this health service? Is that what you want in there? Remember, we've adapted this from the (Area Health region named) and when we had a look at all the charts that were out there theirs seemed to be more consistent with this health service needs were so we adapted that.*

Participant:

Disk 8 line 190

> *And they could also come from another district – that's right.*

Participant:

Disk 8 line 309–324

> *I mean the problem is with working in rural settings like we have here, the exposure is not there all the time, it's different if you were a big facility – like it's a dime a dozen a day – like – and it used to be like Thursday, Friday, Saturday night – like the drinking and the partying – like now it's right across the whole working week – it makes no difference – you used to be able to identify certain days or certain things like whether it was a pay week – you know whether they've received their pension or whatever, we don't get it like – I mean we've had two in the last fortnight – but I mean if you go months again before you've got that exposure – like everything, your experience – comes with…you know what I mean –…I've tried to talk to the girls down there whether it's mental health or anything – as a team to bounce off each other – and it's better to have somebody come and say, well I don't know - and if you say well this is better – just look and make yourself familiar with it and everything because I think it just comes back to experience – but you just don't get that in the rural sector because…*

A report released by the Commonwealth Department of Education, Science and Training (Francis et al., 2001), examined the literature on rural nurses and the skills required to meet the challenges in the 21st century in the nursing environment. This report identified the constraints of an ageing workforce, the difficulties in recruiting and retaining nurses to the rural sector and concluded that rural health care was in crisis. The report identified poorer

health outcomes in rural remote localities that were exacerbated by geographical isolation and problems of access to care; shortage of health care providers and health services; socioeconomic disparities; greater exposure to injury in farming and mining industries; poorer road quality; small, sparsely distributed populations; and Indigenous health needs.

Participant:

Disk 8 line 336–351

> *Yeh – if you don't feel secure and it's always issues of safety – I mean the night after this guy appeared I was telling them I had a gentleman appear at the door at 2.00 o'clock (am) and I was at the desk working and I thought oh, somebody's there and I just had this feeling, somebody's at the glass door and I went straight into A & E and pushed the assist buzzer because at 2.00 am in the morning they think, oh there's something really happening because – and they come straight up in the matter – of not even like two minutes – and he'd disappeared – like really just like absolutely disappeared – and I said he was there – and I was doubting myself for a minute and then this guy – I mean he was a young fit male – late teenage – early 20s – with one of those cappy things on the ears – and there were footsteps there so we walked around and …. I checked that all the doors were locked and all that – but after that I was really quite jumpy – if there was some noise, because it's a very old hospital and it creaks – and I think well have they broken in through the kitchen, I mean you don't, you're kind of a bit on nerves then, because there's only us – and I'm in the upper end of the hospital by myself – you know – it does really.*

Participant:

Disk 8 line 366–387

> *That's right – in the city I was just working back down at the (metropolitan city named) …. But you're more aware of it down there because everybody has the potential down there because you don't know people and like you're more prepared for it – but you know you've got security down there, you've got doctors – and the psych triage is right there at your fingertips – yeh, here, we've just got to rely on ourselves and you know….and if you don't use it, you lose it – you think am I doing the right thing – should I do that – but I certainly quite comfortable sending that guy away the other day…*

An opportunity arose for one of the critical group members to implement the flowchart and triage tools that had been developed to date as a trial. The information fed back from this trial provided the group with valuable data that indicated strengths and weaknesses of the charts. This allowed the group to continue to refine the charts in preparation for

presentation to the Clinical and Aged Care Committee meeting. The concept behind the impromptu trial was to identify whether these charts could be of any use in practice, and what needed to be amended to enhance the practicality of the charts.

Participant:

Disk 9 line 538–542

> *You need to use it as soon as they come in because that would be a more effective outcome for the patient because you've already got your data there rather than on three separate things – you know what I mean?*

Participant:

Disk 9 line 543

> *She (client indicated) would have just gone into that Level 3?*

Participant:

Disk 9 line 548–549

> *But it was actually assessing both – with her because what she was saying and what actually happened after half an hour were different – which is….*

The concept worked in principle but required variation according to the situation. Much of the information gathered could be utilized in the assessment with the greatest benefit, being the prompts for staff that allowed them to undertake an effective MSE and MHA of the client. The most significant point identified was that staff would require a comprehensive education programme to complement the charts. If the staff did not feel confident in applying the MSE or the MHA, the charts would be of limited value.

Participant:

Disk 9 line 552–554

> *That's what we said you know, and that's where the education comes in – the education has to come – like there's a whole mental health assessment in here – 99% of people wouldn't know how to do a diagnosis of mental health.*
> *Further examination of other emergency triage tools available across all Australian States identified that there was a mental health triage chart being developed in the State where this research was based. This caused great angst amongst the critical group as many of them questioned the*

> *relevance of their work if it was to be negated with a State directive. Contact was made with an official from the State Department of Health concerned to determine if the State initiative would have an impact on this research. Reassurance was given that the work undertaken in this research was very close to what the State was developing, however the document was only a generic document and did not address issues that may occur in specific areas. This discussion determined that the work from this research would be consistent with the document to be released by the State and that it would only be a matter of adapting the charts to reflect the terminology contained in the State document. The benefit for this research of having the State document released was that the emergency triage flowchart and the triage tools, once adapted to reflect the State requirements, would follow best practice and remain within State legal guidelines. This proved to be of great reassurance to the critical group as they saw that the need for lengthy trials of their documents would be avoided, as they would only have to trial the draft documents, including the specific adaptations, for a short period of time.*

Having again circulated the documents to hospital staff for feedback prior to the submission to the Clinical and Aged Care Review Committee meeting, the critical group adopted all relevant feedback and finalized the development of the emergency triage flowchart, the triage tools and the risk monitoring chart. These were submitted to the committee meeting for consideration, anticipating that the documents would be ratified and permitting their implementation into practice.

Participant:

Disk 10 line 651–652

> It has to go but then we can trial it – we can send it out so that we can discuss it –

Participant:

Disk 10 line 654–658

> *And if there's any feedback before Clinical and Aged Care review all the better because that means they can take, or you can take that feedback to the meeting and you can say, well we've tried – and used it on two people and it's worked really well – because when we liaised with (regional centre named) and we put strategies in place.*

6.1.4 The evaluation phase

The outcome of the submission to the committee was unexpected and disheartening for the critical group. They had believed the documents were of an acceptable standard for use in

practice relevant to the needs of nursing staff. The GPs present at the meeting expressed concerns that they had had no involvement with the development of the charts. They related concerns that their involvement with the client was not indicated on the charts as being timely. The general consensus among the GPs was that they needed to be contacted earlier in the presentation. The only chart to be ratified at this meeting was the risk monitoring chart. The members of the critical group present at the meeting rebutted the initial concern that the doctors had no input into the development of the charts, as all key stakeholders had received invitations from the MHST to participate in the research and provide feedback. It was acknowledged that none of the GPs had accepted this offer. Despite this negative feedback, the group rallied quickly to begin the recommended amendments; however, a degree of disappointment, frustration and anger remained. The group identified that this attitude from the GPs was at times an on-going issue and added to their stress levels. Frustration in the relationship between GPs and nursing staff is reflected in the following comments from participants:

Participant:

Disk 11 line 558–564

> *Every single one says well do an assessment first and ring me back, so which is exactly what this says, "Assess by receiving Nurse and medical review". I would cut out, "if required".*

Participant:

Disk 11 line 566–567

> *Just get rid of the 'if required' cause they can wear it, they can have a phone call every time.*

The Department of Health, NSW (2004a) examined the incidence of presentations to rural and remote EDs with no on-site medical officers (MOs). In this examination, the Department recognized the unreasonable and unrealistic expectations on MOs to attend EDs. For example, it is neither achievable nor desirable that a solo rural MO should be expected to attend a patient presenting to a rural or remote ED at 3am with a minor

problem so that the assessment occurs within the two hours recommended in the Australasian Triage Scale. The report also recognized that it was acceptable if the on-call rural MO did not always physically see non-urgent patients. The alternative was to provide advice and suggest interventions by telephone (Department of Health, NSW, 2004a). Frustration continued to underpin the ongoing discussions about the amendment of the charts.

Participant:

Disk 11 line 596–597

> *So I think that's the only – you know, we can't put them up to the top of the ladder because they don't want to be at the bottom of the ladder.*

Participant:

Disk 11 line 864–873

> *Yeh, but the nurses have to bow – it's all about the hierarchical control stuff still here, it is very much so, we honestly still go by the old thing that um, aarh, well the doctor's the one who makes the call – even if we have good ideas we have to make them think it's their idea – we've got to very much like that. Make them think it's their idea and you'll get somewhere. I've been told straight to my face that I would be taking no notice of what a mental health nurse tells me about their patient. You know, they are way back, you know, they don't even give mental health nurses the credit of knowing their medications and I mean they're at the forefront of mental health treatment in the community, are they not?*

Organizational factors causing stress typically consist of poor positive feedback in reference to job performance, lack of autonomy and control, lack of participation in organizational decisions, ambiguity in job description, and conflicting role demands. Organizational factors that impact on individuals can cause frustration and disillusionment resulting from the differences between job realities and job expectations (Hover-Kramer et al., 1996). Other organizational constraints include communication problems within interdisciplinary teams, role ambiguity, conflicting goals of the clinical staff and administration and the perceived lack of institutional support. High job turnover and absenteeism are also evident (Hover-Kramer et al.). For the critical group the response

from the Aged Care Review Committee indicated to them that the expectation for nursing staff to be autonomous in their decision-making when assessing clients did not reflect true autonomy. The concern of the GPs about not being notified earlier with regard to the flowchart created disappointment among the critical group as it implied that there was a level of distrust in the ability of nursing staff to assess the appropriate level of intervention required for the client.

6.1.5 Specify learning phase

Personal safety and isolation in practice drove this cycle. The critical group came to understand that, despite attempts by the organization to ensure personal safety, staff were ill-prepared to undertake the complex task of adequately assessing and managing clients who presented with mental health issues. When faced with uncertain situations, at times staff remained very reliant on the local police in this matter. The unpredictable nature of psychiatric presentations had seen numerous unsafe practices evolve in attempts to manage the situation at hand. The need to have a trusting and honest relationship with other disciplines in the health sector is indicated in this cycle, with assumptions being highlighted as problematic between the critical group and the GPs. Literature indicated this is a common problem within the health industry; in an attempt to resolve some of the problems staff made determinations for patients that may not necessarily have involved the input of GPs.

To facilitate a smoother and more positive outcome for the consumer the critical group recognized the need to develop effective tools that all staff could readily access and implement. This would assist all members of the multidisciplinary team, providing continuity. After 12 months of progress, it came to light that the State government had commissioned a similar project that would generalize the triage process in EDs for mental

health consumers. The new knowledge gained from this reflects the need to maintain contact with government departments despite being isolated.

6.2 The ongoing nursing model development

Despite having included the concepts of personal safety, education and remediation of unsafe work practices in the initial circles of the model, there still existed a high degree of concern among the critical group that this model did not adequately represent all the needs for changing practice, a further circle to interact within the original three major themes was required. This would be reflected in developing a safe practice environment and support by management in decision making.

6.3 The final cycle

This section discusses the final cycle of this study. The cycle was the shortest cycle of the four due to the minimal input that was required to complete the actions addressing the thematic concerns.

6.3.1 Diagnosing: Identifying/defining the problem.

The feedback from the Clinical and Aged Review Committee in December 2006 required the critical group to develop a format for the emergency flowchart and triage tools that remained close to what nursing staff had requested while incorporating the recommended amendments from the Committee. There was particular attention given to the assimilation of the State directive whilst ensuring that no areas were compromised. This required minimal alterations.

Participant:

Disk 11 line 599

> *A really rapid flowchart – where do I go, how do I get some help?*

Participant:

Disk 11 line 623–624

> *Well, they're not to the end of the chart – but where can you put it – you can't until you've done an assessment.*

Participant:

Disk 11 line 627–630

> *They're (GPs indicated) notified every time we have a presentation, except at 2.00 o'clock in the morning if it's an emotional distress because their (mental health consumer indicated) cat's been killed, and we've got them at the top of the chart – well it would serve them right wouldn't it, at 2.00 o'clock in the morning to get 'my cat's dead'!*

Researcher:

Disk 11 line 663–664

> *Let's put them in here – notify Police or call Code Black – that went to Number 1 – let's put Number 2 notify Police and Medical Officer.*

Participant:

Disk 11 line 729–730

> *Well after that, we've got to have a medical – the medical officer decides on the CAT (Crisis Assessment Team) team.*

Participant:

Disk 11 line 99–1001

> *We'll get it done. It really wasn't an oversight. These are nurses' flowcharts. They are not for the doctor that's where they decided this was just a monitoring and stuff and then every chart was you know, contact the doctor…*

Participant:

Disk 12 line 16–17

> *So I guess when we're flicking this around for other stakeholder input we need to say – just …a little bit more?*

Participant:

Disk 12 line 19–20

> *Like, it doesn't have to be part of the chart, but we need a little bit of information when we send the emails.*

Jenkin and Little (1996) conducted a study on inter-rater reliability of triage by introducing scenario-based information. They found evidence supporting the provision of verbal and visual cues in the triage process. The authors reported that nurses in their study frequently

complained of difficulties experienced in categorizing patients with limited information, including a lack of visual and verbal cues. Rowe (1992) contends that in designing triage tools, the purpose is to focus the nurse on the specific data and the sequence required to enable a quality triage decision. This author emphasizes that the tool should not replace clinical judgement and experience but should act to enhance the decision-making skills of the triage nurse.

A mental health triage is a key component of the mental health service model (Department of Human Services, Victoria, 2003). There is a commitment to improving entry-point assessment in Area Mental Health Services across the State with the Mental Health Branch of the Department of Human Services working cooperatively with service providers to achieve the necessary policy and practice changes. The current mental health triage tool developed for this State is aligned to meet this directive. One directive in this framework is for mental health services to make every effort to ensure that triage clinicians are consistent in the way they conduct triage assessments. Mechanisms for ensuring consistency include the use of well-developed triage tools and triage training programmes. The critical group recognized the value of input into this tool from the key stakeholders who would be implementing it. Their experiences and clinical skills provided valuable information that should be considered in finalizing the development of the emergency flowchart and triage tools. It was imperative that the final product was user friendly and met the aims of the research.

6.3.2 Action planning stage

The critical group moved forward very quickly in this stage developing the triage tools and emergency flowchart to finalization so that all recommendations and feedback were implemented in readiness for the next Clinical and Aged Care Committee meeting in a few months. Additionally, the Christmas period was approaching and many of the group and

other staff would be away on leave until the end of January. Certain undertakings could occur during this time that did not require a formal meeting and those who were able to continue with the development kept in contact via email. Actions were undertaken by nominated individuals who would have the opportunity to continue with the project. This period involved a concerted effort by all to move the project to completion.

The need for uniformity and reproducibility of triage decision-making processes is well documented (FitzGerald, 1996). Adopting a consistent approach enables equity of access for patients whilst maintaining best practice (Monash Institute of Health Services Research, 2001). The Victorian government recognizes the need for consistency and equity across the State in the triage process for consumers accessing its mental health services. To facilitate equity of service provision the State recommend that mental health services work with ED staff in developing joint protocols for responding to mental health presentations to the ED (Department of Human Services, Victoria, 2003).

The group identified the significance of ensuring that the medical condition of a client is acknowledged and it may take precedence over the mental health emergency. The need for an urgent medical review was reflected on the flow chart. Guidelines set for the implementation of the ATS in EDs by the ACEM (2005) specify that the highest appropriate triage category be allocated, based on clinical and situational urgency. This is to reflect the combined presentation for clients with mental health issues and co-existing physical complaints. The ACEM suggests individual EDs may have a variety of procedures and assessment tools to assess the identification of mental health needs for clients, however these should be considered as supporting tools to the formal triage assessment using the ATS (ACEM, 2005).

Participant:

Disk 14 line 349–357

> *Self harm to themselves. And that's why this (chart indicated) came in because of that episode to have happened from here – that this guy wasn't treated for medical condition – ended up in jail – wasn't even brought here – the police bypassed us – I've got to have the meeting with adult mental health and (CEO named). They've been contacted because the Police bypassed us with what they thought was a mental health condition – took him to (Regional centre named) and he was jailed and like – two days later or something there was an officer – there's a police officer now who's a mental health liaison person picked them up and went up – well why wasn't this person taken to a hospital – he was diabetic – and he was in jail.*

Participant:

Disk 14 line 729–731

> *Really where Eileen's gone down this way following (State health department named), we just take out the bottom sections relating to suicide and bring it back over here, don't we, or do we just stick with our own tool?*

Participant:

Disk 14 line 732

> *Well – I think, we stick with our own tool.*

6.3.3 Action taking phase

The ongoing development of the emergency flowchart and triage tools had continued, to permit resubmission to the Clinical and Aged Care Review Committee meeting early in the next year (May 2007). The final product was circulated to the key stakeholders for any further comment with the view that what had been developed should not require any further amendments. The group felt confident that these documents had met all criteria set by all governing bodies and key stakeholders. There had been minimal adjustments to meet the State emergency triage requirements whilst remaining within the scope of the limited resources available to the Area Health Service. This meant that the State education package that accompanied the State triage tool could be adopted and this ensured that this Area Health Service involved in the study conformed to State requirements in education. The

team identified that the education package that they had developed to accompany the emergency flowchart and triage tools was not too dissimilar to the State's education package and could be mapped over very easily to incorporate the areas of need specific to rural and remote regions.

Participant:

Disk 15 line 265

> *We think we've got a tool that will be useable.*

Participant:

Disk 15 line 297

> *Great – I think the rest of the team is fine – we should be able to run with it.*

Participant:

Disk 15 line 312–313

> *Ok – so Clinical and Aged Care Review – so if it's accepted through there and then it's rolled out.*

Participant:

Disk 15 line 314–315

> *You probably will need to know – how are you going to roll it out to the Clinical and Aged Care.*

Researcher:

Disk 15 line 321–322

> *So initially – the Step 1 is to review – 2 – are we going to disseminate that across?*

Participant:

Disk 15 line 323

> *It will have – it will still have to go out into the ward within the acute and….*

The revised versions of the emergency flowchart and the triage tools were submitted to the Clinical and Aged Care Committee in May 2007 and were adopted with slight

modification to the colour coding for Triage Codes 4 and 5, Moderate Distress semi-urgent mental health problem. The group was elated to have their work recognized and their dedication to this project valued. They believed their efforts would enhance the skills of all nursing staff and secure the safety of both staff and clients. They saw this as a huge relief and were confident that this would have a major reduction on their stress levels. The greatest challenge the group now saw was the delivery of the education package and the logistics involved in ensuring all staff received it. Constraints for the group involved rosters and employment status, i.e. full-time and part-time employees having access to the education sessions. The group became creative in designing delivery modes to cater for all needs, including the financial impact to the organization.

Participant:

Disk 15 line 427–428

> *OK – so we're going to use the toolkit provided by (State government department named) that's online – so how do we actually roll it out into the unit?*

Participant:

Disk 15 line 470–472

> *Yeh – that's why I say they can load it on their flash drive and take it home if they want or they can have it here – but have a little package with their questions and answers.*

Participant:

Disk 16 line 103

> *So the next step is really getting the education roll out together – isn't it?*

There is a need for nursing to face a radical change in its employment characteristics if it is to continue to meet the health care needs of the population. This includes the upskilling of nurses in the workforce to advance their practice. A number of key reports provide extensive discussions on the issue of mental health nursing (National Health Workforce Taskforce, 2007). Currently in Australia the workforce includes nurses who hold

qualifications from the apprenticeship model of nursing, those with degrees (from the academic model) and those with postgraduate qualifications (SCARC, 2002). Concerns about competence and confidence exist for generalist nurses when assessing and caring for clients with mental health issues (Reed & Fitzgerald, 2005). To date, literature suggests there has been resistance to acceptance between the mental health and general health care sector since the mainstreaming of mental health services (Cleary, Freeman & Sharrock, 2005; Crowley, 2000). There is evidence supporting the lack of preparation of nurses who encounter and care for mental health clients in the general setting, both within Australian and overseas (Baston & Simms, 2002; Crowley, 2000; Happell & Platania-Phung, 2005; Happell, Summers, & Pinikahana, 2002; Hayes, 1999; Hsu, Moyle & Creedy, & Venturato, 2005; Lee, 2001; Mathers & Howard, 2000; Mavundla, 2000; Nash, 2002; Ramritu, Courtney, Stanley & Finlayson, 2002; Reed & Fitzgerald, 2005; Reed & Roskell Payton, 1997; Snowdon, 2001). In facilitating learning in the work environment recognition of existing history and experiences should be given.

Each individual brings an array of attributes with them that have been developed over various stages of their lives. They have developed strengths and learning experiences and should be encouraged to use these as a basis for ongoing education. Knowles (1990) refers to the theory and practice of the adult-centred, problem-posing approach to learning as andragogy. Some common features of adult learners include that they expect what they are learning can be applied immediately to practice, want to be actively involved in their learning, need to see the relevance and to feel confident in the learning environment (Rural Health Education Foundation, 2007).

Participant:

Disk 16 line 238–240

> *From your education point of view this is a major project but it's also investment in the future – like who's going to be rolling out this kind of thing every year and what's been done in mental health? Nothing!*

Participant:

Disk 16 line 241–253

> *Yeh – and if it's done well to start with then we can just make sure that some of this is on you know, for new staff coming in – it goes into orientation – they spend some time with me or they spend some time with someone doing – just looking at…. Well (CEO named) and I have had one discussion only – after the meeting and talked with (CEO named) about getting it out and he said we could do we like basically but when we looked at – when we looked at what it would cost to do a lot of face to face it really wasn't feasible. It was far too expensive I think - and hard to … about $29,000?*

Cleary and Walter (2006) review the education of nurses in clinical settings and contend this is complex to facilitate. The authors recognize several constraints with numerous factors impinging upon success. Staff participation and past experience, workplace flexibility in promoting education, opportunities to develop skills and expertise and positive role modelling become central to a successful educational programme. Further to this, Cleary and Walters suggest there is increased pressure on managers, resources and staff replacements to allow extra education in the workplace. Added to this impost is the mandatory educational requirement within organizations that must be facilitated. A practical way around the cost associated with ongoing education is suggested by Cleary and Walter (2006) to include flexible work hours as time in lieu. Since 2002–03, there has been an increase in funding to provide for health needs across Victoria. The Victorian government has been working to improve access to mental health services through a range of funding initiatives. In 2004–05 funding was dedicated for additional nursing staff in an attempt to improve acute care and discharge processes. In 2005–06, an additional $1.2m was allocated from the State government to enhance ED mental health services

(Department of Human Services, Victoria, 2007). It was anticipated this additional funding would have a significant impact on the health care provision for patients with mental health issues, prevent the need for acute beds and promote a positive outcome for patients.

Researcher:

Disk 17 line 330–332

> *Well the other thing is you've got the tool – so if we make this our information sessions up and give it to them as pre-reading – so that they've got these in front of them.*

Participant:

Disk 17 line 426–428

> *Yeh – roll it out – this is the first step because this is what – keep it going because this is what you are going to have to do if you want to stay in the business*.

6.3.4 Evaluation phase

The group received encouragement and positive feedback from the key stakeholders when the emergency flowchart and triage tools were ratified. Some members of the critical group had the opportunity to implement them into use and reported that they found them user-friendly. They indicated that they felt confident and safe in their practice and believed this would extend to the remainder of the staff once the education had been undertaken. The critical group recognized the importance of upskilling the nursing staff in the appropriate assessment and treatment of clients with mental health issues. They saw this education as an adjunct to the introduction and implementation of the emergency flow chart and triage tools. There was a notable change in the attitude of the critical group, with the realization that the research had permitted changes in practice reducing the identified major stressor. Excitement grew as the group could see ongoing benefits from this research to the organization and in personal development and networking through conference presentations.

Participant:

Disk 17 line 445

Yeh – I think this will be a great.

Participant:

Disk 17 line 447

A great tactic to help education as such.

Participant:

Disk 17 line 453

Yes – it matches the department tool.

Participant:

Disk 17 line 455–466

I might gather it all up and go to a conference and present it and say ohhh ohhhh.

Participant:

Disk 17 line 458

They've got the quality and excellence awards in there – you could go for that.

6.3.5 Specify learning phase

In this phase, the specific learning indicated that the group believed through the action research process they had implemented a strategy that would significantly reduce their workplace stress. It reflected the collaborative and cohesive process required to initiate new programmes into the workforce. The triage process is not necessarily intended to make a diagnosis but rather to facilitate resolution of the needs of a client. In this process, there must be a safe and non-threatening milieu in which the clinician can operate effectively. The critical group reflected that the use of the emergency flowchart and triage tools provided the user with a tool to facilitate a positive outcome and smooth transition for the consumer in accessing mental health services. These tools eliminated the guesswork in

assessing the client, reducing the stress they had felt when staff had no guide through this process. To maintain best practice there must be on-going research and education as a lifelong process. It becomes imperative that this education is delivered across all sectors of the nursing workforce to upskill nursing practitioners in the delivery of an adequate health service.

Staff and client safety should be a priority and staff should feel comfortable and supported in decision-making to determine clinical assessment and treatment without prejudice. The critical group had achieved this with the introduction of the emergency flowchart and triage tools.

6.3 The finalisation of a new nursing model

The theory generated from this cycle saw the critical group being enabled to add two final circles that overlapped with the original three allowing a complete interaction of all concepts whilst maintaining the core circle of reduced stress, increased occupational health, safety and wellness, and, improved positive patient outcomes. A change to a positive cultural influence within the workplace would provide the nurses with a relationship of mutual respect, support and acceptance of change between management and themselves. The amelioration of knowledge deficit through ongoing education to all nursing staff would provide the knowledge and skills required to effect a therapeutic practice when dealing with consumers with mental health issues.

6.4 Conclusion

This chapter has discussed the final two cycles of the four cycles undertaken in the action research model used in this research. These two cycles reflected the final development of the ‘Emergency Flowchart, Triage Tools and the Risk Monitoring Chart’ (Appendices 7, 8 & 9 respectively) based on the two overarching themes of staff safety and limited knowledge of mental health nursing. Personal safety was indicated as being crucial for

staff given the unpredictability of mental health consumers and the limited resources for assistance in violent situations. Literature reported violence in the workplace is often unreported with attempts by nursing staff to de-escalate a situation to preserve the safety of other staff and patients. Various occupational health and safety controls were considered in attempting to reduce the potential of violence and injuries. However, it was recognized that rural and remote areas presented unique situations where many of these controls could not be facilitated.

The notion of increased stress in nursing staff at rural and remote hospitals caused by greater expectations, often in the absence of appropriate training or medical support, is investigated in this chapter. In such hospitals, nursing staff are expected to assume the task of assessing clients presenting to EDs prior to calling for medical assistance. The initial presentation of the Emergency Flowchart, Triage Tools and the Risk Monitoring Chart to the Clinical and Aged Care Review Committee caused some frustration to the critical group. Spurred on by this and with support from their colleagues, the group rallied to produce a user-friendly package that met State government requirements and maintained relevance to issues of rural and remote communities. The second submission to the Review Committee saw acceptance with minimal amendments and the proposed upskilling of staff through the rolling out of education packages that would suit the budget available for such programmes. This indicated that the thematic concerns of the critical group had been addressed and that the nursing staff could anticipate reduced stress in the ED as a result of this action research.

Participant's final comments:

> *"You've actually given us the spark to get this and I think it will be very, very, very valuable here – it's up to us to now to get the education and to keep following it up and to keep doing the circle work to evaluate it (the product of the research indicated) and make sure it's OK."*

The following chapter will discuss the research findings and will review theories and concepts that have been developed from the cyclic process of the model used in this methodology. This theory generation is discussed demonstrating a direct impact on the development of the new nursing model.

CHAPTER 7

Discussion

7.1 Introduction

This chapter discusses the study as a whole by revisiting the initial aims and the methodology adopted for this study. The study methods are examined and the two overarching themes that evolved throughout the study are discussed. The change in practice identified as necessary by the critical group to reduce the significant stressors is discussed together with the development of the ED tools to assist in this process. Empowerment is examined and is featured to hold great significance in this research study. This is explored further to expose how this impacted on the progress of the research. The collaborative process is reviewed throughout the sixteen months of the research, demonstrating the commitment of the critical group to achieve the end goals. In examining the benefits of group formation peer support is highlighted as enabling a reduction in occupational stress. Theory development is discussed linking theory, education and practice and identifies how this research is embedded in social critical theory.

The development of a nursing model is shown and the relevance to the nursing profession is discussed.

7.2 Reflection on the aims of the study

The aim of the study was to work collaboratively with a community mental health team to identify the distinctive factors that increase and reduce occupational stress associated with workplace burnout. An examination of the processes that were currently utilized by the team to minimize occupational stress and workplace burnout was undertaken; and which of the problems that led to occupational stress and workplace burnout were to be explored. In exploring what strategies could be developed to overcome these problems, an Action Plan to address the problems identified would be introduced. The implementation of the Action Plan would: evaluate the impact, if any, of the engagement of action research and evaluate

and specify the learning from the implemented Action Plan. The underlying assumption in this study was that occupational stress could have deleterious consequences for employees and may lead to workplace burnout. This stress could be from any internal (within an organization) or external (from outside the organization) source. A combination of factors including the appraisal and interpretation of the situation, responses to stressors and coping mechanisms and appraisals of outcomes determine whether a potential stressor is perceived as a threat to the individual (Cox, 1978; Kasl, 1987; Lazarus & Folkman 1984). Lazarus and Folkman (1984) proposed a transactional model of coping. According to this model the individual will make a primary appraisal of the transaction between themselves and their environment determining whether or not there is an emotional reaction, positive or negative. If there is a potentially threatening situation the model predicts a secondary appraisal is made in which the magnitude and content of the threat is evaluated. Lazarus (1995) purports most coping strategies can be divided into two broad categories of problem-focused and emotion-focused coping. Problem-focused coping involves actions that "alter the person-environment relationship for the better" (p.7). This can be done by the adjustment of one's behaviour or by taking direct action to alter the problematic situation. A combination of factors, the appraisal and interpretation of the situation, responses to stressors and coping mechanisms and appraisals of outcomes determine whether a potential stressor is perceived as a threat to the individual (Cox, 1978; Kasl, 1987; Lazarus & Folkman 1984). Based on this assumption it was proposed that individuals working in a collaborative process could influence changes in their practice using an action research methodology to reduce the physical and psychological impact to the employee from a significant stressor.

7.2.1 Reflection on action research methodology

This study employed the Susman and Evered (1978) model of action research and the use of critical social theory based on Habermas' (1971) assumption that people have a basic

need to act independently and are capable of self-reflection. This study permitted the participants to effect change to their practice through embracing the research study with the belief they could contribute to the well-being of the organization and the body of nursing knowledge. The Susman and Evered (1978) model of action research proposes sequential phases of diagnosing, action planning, action taking, evaluation and specify learning. Within the diagnosing and action planning phases an opportunity existed for the participants to respond to an existing stressor, giving rise to rich data. An informal process was adopted to implement an action taking phase that had been designed to incorporate ideas from the expanded stakeholders and the critical group. Extensive evaluation of this action taking phase led the group to carry out a review of best practice in other Australian States. The purpose of this review was based on recommendations from the stakeholders and provided an opportunity for the group to meet the needs of the 'nurses at the coal face' in reducing a major stressor.

The prominent involvement of the critical group to examine the thematic concern and develop the tools to guide staff in clinical pathways in ED is characteristic of action research. Motivation by members of the critical group saw the participants as co-researchers and implementers of effective change generators, with the researcher adopting the role of a facilitator. This provided the opportunity to ensure accuracy of data through a collaborative process. Critical theory supports the liberation of individuals from constraints neutralizing the effects of dogma and ideology (Allen, 1990; Brent, 1993; Stevens, 1989). Critically questioning the assumed, reflective participatory dialogue and redressing power imbalances emphasizes consciousness-raising (Freire, 1990). Critical theory enables nurses to challenge traditional norms, uncover latent meaning and release constraining social-political barriers. Empowerment is gained through raising awareness of self, seeking change from existing constraints, and seeking alternatives. Actions are informed by our

knowledge and beliefs within our existence. Through reflection, we are permitted to change our world thus transforming reflection. Carr and Kemmis (1986) propose that a self-reflective spiral of action research empowers individuals through relating retrospective understanding to retrospective action. In this research study, critical theory was developed through the group's critique of their existing conditions with the purpose of enhancing their well-being within their workplace (Habermas, 1971). This process allowed unquestioned assumptions to be examined and challenged. Habermas (1984) contends it is the responsibility of researchers to identify constraining circumstances and assist in liberation from these oppressive constraints. This approach of critical examination of practice through self-reflection throughout this study involved the collaboration of this researcher and the critical group. Whilst the group valued the input from the expanded stakeholders, their autonomy to implement changes into practice was limited by admonishment from the medical staff and CEO. All proposed changes were submitted to the Aged Care Review Committee for ratification. Through reflection, the group acknowledged the difficulties faced in correcting dangerous practices by implementing change that may threaten some members of an establishment.

The premise that the purpose of action research is to solve practical problems through direct contact with practical problem situations (Lauri, 1982) was validated in this study. Throughout the research the critical group contributed by sharing, suggesting, advising, debating, accepting each others' ideas and recognizing and valuing experiences. Through this process the group effected changes within their practice by developing tools to assist nursing practice and reduce significant stress within the workplace. Responsibility was a shared role, with the group taking control of how the research progressed. This emancipatory process is characteristic of action research, allowing the group to address their own concerns relevant to the thematic concern. Participant validation provided a

process for checking accuracy and completeness of researcher interpretation. This reflection allowed each participant to ensure their voice was accurately reported without researcher bias tainting their perspectives (Titchen & Binnie, 1993). Limitations existed for this method of validity as not all participants were at every meeting to obtain consensus.

7.2.2 Utilizing the action research methodology

Participation by nurses in research is often as data collectors, for example Mental Health Outcome and Assessment Tools (Department of Health, NSW, 2004b) and Health of the Nation Outcome Scale (Department of Health, NSW, 2004c). The majorities of the participants in this study had completed, or were in the process of completing, tertiary education that involved research activities. The knowledge base about action research amongst this group, however, was extremely high as they had conducted several action research projects within their organization. The CEO of the health service in this study was an experienced action researcher and had promoted this form of research project over a number of years. I acknowledge that the participants' pre-existing knowledge of action research substantially contributed to the success of this action research project.

7.3 Overarching Themes

7.3.1 Staff Safety

The first overarching theme arising from this research was the safety of all staff. The MHST members had provided accounts of instances where they felt their safety had been compromised when a number of clients with mental health issues accessed the service. Once the remainder of the critical group felt comfortable with openly discussing their concerns in relation to this issue, several stories were related where the individual was confronted with a threat to their personal well-being. This was compounded by the fact that there is limited staff on shift, particularly night shift, and that it was not always possible to access police assistance when requested.

Benveniste et al. (2005) discuss violence in health care and examine the contribution of the Australian Patient Safety Foundation in monitoring and analysing incidents. This monitoring system, Australian Incident Monitoring System, is used across NSW, Western Australia, South Australia and the Northern Territory. The authors describe an increase in violence in the health sector and the need for secure rooms in public hospitals for patients presenting with violent behaviour to public hospital EDs post-deinstitutionalization. Strategies to prevent violence discussed by these authors include 'de-escalation training for staff and the introduction of violence management plans, improved building designs to enhance patient and staff safety, fast tracking triaging of patients with mental health problems and improved ED waiting times' (p. 351). The authors review the work of Fisher et al. (1996) who purport exposure to violence is particularly high for nurses in remote area nursing. In key findings identifying the most common contributing factors involving patient violence, Benveniste et al. (2005) suggest staff related factors such as "communication problems and insufficient or inadequate [numbers of] staff" (p.349). Inadequate knowledge or experience with system related security problems were also contributory factors.

The critical group generated much discussion throughout the data collection about the potential for workplace violence and the impact of this lack of personal security on their stress levels. Gillespie and Melby (2003) discuss factors that contribute to stress and burnout in nurses working in the ED. These authors contend individuals working in an environment with verbal and physical aggression are more likely to experience workplace burnout. The authors argue violence is an 'insidious' and 'pervasive' environmental stressor (p.844). It must be acknowledged that it may not be the stressor itself that presents as a crisis for an individual, rather the individual's perception and response to this situation that will determine the level of impact on them. A crisis presents a period of disequilibrium

leading to a threat to the individual's stability. The individual's effective mobilization of internal and external resources should be cognisant of the environmental variables, perceptions of the event and coping strategies that can be implemented. In many instances this awareness is failing, which can lead towards the burnout syndrome described by Maslach. The symptoms of burnout can include ambiguity, negativism, anxiety, cynicism, low morale, restlessness, frustration, anger, despair, depersonalization and irritability (Maslach and Jackson, 1981b; 1985). Sources of burnout have been identified to include interpersonal, personal and organizational factors (Maslach and Jackson, 1981b; 1985).

7.3.2 Education

The second overarching theme that arose from this research was the lack of education for generalist nurses in the field of mental health nursing. It became obvious that this lack of education underpinned a great deal of the anxiety felt by nursing staff, which in turn compromised their safety. Deinstitutionalization last century led to changes in the training and education needs of staff working in the mental health field. In the past, nurses employed in the mental health workforce were trained in direct entry mental health programmes as a specialty area in stand alone psychiatric hospitals. This specialist training was phased out over a period of years from the late 1980s through to early 1990s. Training entered an academic realm and entry for practice as a comprehensively trained nurse occurs at the end of a three year comprehensive Bachelor of Nursing degree (Heath et al., 2002).

A major discussion paper prepared by the Nurses Board of Victoria (2002) contends that despite a shift of psychiatric training from specialist institutions, the theoretical and clinical component of the undergraduate comprehensive programmes does not equip nurses to be competent in the assessment and care of mental health clients. Wand and White (2007) argue that educating nurses to work with consumers of mental health care at nurse

practitioner level is complex and involves both the imparting of knowledge and skills and the ability to develop a therapeutic nurse-patient relationship. Whilst this is straightforward, complexity arises with the breaking down of barriers, i.e. stigma and attitudes of the nurses. Despite comprehensive undergraduate nursing curricula facilitating mental health nursing education O'Brien (1994) purports mental health nursing is not perceived to be a glamorous area of nursing and is of less importance than general nursing.

A study undertaken by Wynaden et al. (2000) into the educational needs of nurses in the area of mental health revealed most nurses reported they were comfortable with attending to patients' emotional problems but felt under-confident, unskilled and lacking in knowledge when they were required to care for a person with a mental illness. The authors purport this study was very representative of nurses in health care practice settings across Western Australia and the results indicated a similarity of educational needs in mental health care across the State. However, the limitations to their study involved the reliability of the instrument developed to address the study's objectives. This may have skewed their findings.

In examining the education and training for non-mental health trained emergency nurses in Western Australia, Kerrison and Chapman (2007) determined this cohort of nurses was ill-equipped with knowledge, assessment, and communication skills to be able to provide an adequate level of care to patients with complex mental health issues accessing the ED. The authors contend triage nurses lack expertise and confidence in psychiatric assessment. The areas of knowledge deficit in psychiatric assessment formed a platform for further education and training in the ED. The critical group in the present study proposed the introduction of an education package for staff to complement the introduction of the triage tools and flow chart. This education would also include mental health assessments and

mental state examinations. It was agreed that this increase of knowledge and skills for the nursing staff would give confidence to undertake a comprehensive assessment of the patient and to apply appropriately the triage tools in making a determination of treatment. It is believed this new knowledge and confidence will increase the safety of staff as they would be skilled to determine the likelihood of aggressive and violent situations and to be able to de-escalate these situations.

Aoun and Johnson (2002) discuss how the delivery of a distance education programme for rural and remote mental health training across ten rural sites in Western Australia contributed to the capacity building of the nursing workforce. The evaluation of this programme revealed positive results, with reports of participants gaining knowledge of mental health management regimes and developing mental health assessment skills with enhanced clinical practice. It was identified that this programme promoted improved relationships with the mental health team. Gibb et al. (2004) investigated the cultural challenges of introducing workplace learning associated with a nursing educational pathway into small rural hospitals. These authors identified that support for remote nursing education through workplace cultures that valued learning required the development of locally tailored mentoring to meet the needs and expectations of nurses. This factor was crucial for advanced critical learning. The critical group recognized the constraints on educating all nursing staff within their organization and proposed alternative education packages be developed. This included the use of pre-recorded DVD presentations for self-directed learning by the staff in an attempt to overcome financial constraints associated with such a task to cover all nursing staff.

7.4 Change

The critical group worked well within this study to effect changes to their practice to eliminate the two significant stressors identified. Their development of clinical pathways

for managing clients in the ED and the acknowledgement of the need for education indicated the staff's commitment to shape and mould their nursing practice in an effort to strive for best practice and maintain their own wellness. Change and its effectiveness are difficult to measure and are not always apparent for some time (Meyer, 1995). The change proposed in this study aimed to solve problems associated with occupational stress. An understanding of the basic nature of change influences the effectiveness of change techniques (Lancaster, 1982) with success depending largely on organizational and individual qualities of participants (Lancaster and Lancaster, 1982). The qualities of a change agent include accessibility, trustworthiness, honesty, being goal focused while assisting others to do so, and facilitating openness in discussion and listening (Lancaster, 1982). Trust is the key element among participants involved in change (Lancaster, 1982) with change being effectively achieved by academically prepared, practising nurses introducing a systematic and reasoning approach to change (Pearson, 1992). The critical group members became change generators (leading conversion of issues into felt needs) and change implementers (agents implementing the change after the felt need was identified) (Pearson, 1992).

7.5 The development of tools

A nationally adopted five tier triage scale, the Australasian Triage Scale, was developed in Australia for the purpose of differentiating patient acuity levels for all patients that present to an ED, with the aim of promoting a standardized approach to triage. Numerous studies now suggest that the ATS has not been successful in achieving this intention (National Institute of Clinical Studies & Department of Human Services, Victoria, 2006). According to a report by the Department of Health, NSW (2004a) there are 153 EDs across the NSW health system with approximately 100 of these EDs having no on-site doctors. The implementation of this triage scale in rural and remote EDs was deemed to be inappropriate. Effective triage is fundamental to safe and effective management of patients

presenting to these EDs (p.3). A variation in triage practices between rural and metropolitan services was acknowledged and believed to be influenced by skill maintenance issues for RNs due to the decreased number of ED presentations in rural sites, and RNs working simultaneously in other parts of the hospital. The recommendation from this report in this situation is that standardized and simplified guidelines for triage and triage number allocation along with uniform and appropriate education be introduced to rural and remote EDs.

Based on this, the critical group saw the need to develop a rapid triage tool for patients presenting with mental health issues that was consistent with the ATS and also met the needs of rural remote EDs. This involved researching several current tools that are in existence around various Australian States. Despite the fact that these tools were not suited for this particular health service, it gave the group a basis to format a template that could be adapted. By combining three charts on mental health guidelines of managing acute phases, the group were able to establish three tools that constituted the best templates and strategies. The group identified that the initiation of these triage tools would be a better outcome for the clients and for the organization. Input from the key stakeholders (general practitioners within the township and the hospital staff who would be implementing the tools) became a priority and all decisions were made in consultation. This promoted a community approach to the change process.

7.6 Empowerment

There is evidence to support the notion that there is a growing need for generalist nurses to gain more knowledge and skills in providing mental health care (Sharrock & Happell, 2001). Challenging and difficult behaviours in patients presenting to EDs at times cause alarm to generalist nurses who have limited knowledge and skills in mental health nursing (Sharrock & Happell, 2001). Empowerment in this study was represented by members of

the group identifying the most significant stressors within their workplace and developing strategies to reduce and/or eliminate them. The group's initiation of actions to address these concerns gave them a sense of control over their situation. Autonomy and responsibility in the development of the emergency flowchart, triage tools and risk monitoring chart gave the group the confidence to argue their case at the two Aged Care Review Committee meetings.

Work attitudes and behaviours can be influenced by the work environment. The group's recognition of the need for ongoing education to all generalist nurses about the introduction of these tools and the assessment and management of patients with mental health issues provided a supportive and safe work environment. Nurses report a higher level of work satisfaction and commitment to the job if their work environment is empowering, with a lower level of job strain and burnout (Laschinger, Finegan, Shamian & Wilk, 2003). These authors examine Kanter's Theory of Organizational Empowerment (1977; 1993). This theory argues that people react rationally whatever the situation is that they find themselves in. If situations are structured so that employees feel empowered, there is a greater likelihood that they will be satisfied with their work and feel that high-quality patient outcomes are achievable. Empowerment occurs when a work environment is structured so that it enables employees to do their work. This involves organizational structures particularly important in the growth of empowerment. These structures include having access to information, receiving support, having access to resources necessary to do the job and having the opportunity to learn and grow (Laschinger et al., 2003).

The acceptance of the Risk Management Chart at the first committee meeting highlighted the fact that medical officers saw this form as a nursing document only. It was apparent the GPs saw the emergency flowchart and triage tools as medical documents despite the

group's argument that they were nursing documents. The committee did not accept the tools without amending them to reflect a higher medical status on the charts. Once this had been accepted by the critical group, and with other amendments to reflect the needs of the nursing staff, the committee accepted all documents at a subsequent meeting. Harden (1996) contends one of the main obstacles to nurses' independence in hospital settings is the patriarchal and authoritarian leadership styles of head nurses and doctors.

7.7 A collaborative process

The commitment of the participants was active and successful throughout the sixteen months of data collection. Significant efforts by all to achieve the end goal were evidenced with active participation in all meetings. Through the group meetings participants exchanged and shared ideas, experiences, concepts, beliefs and behaviours. Discussions, dialogues, suggestions, comments and observations contributed to each individual's belief as to what would be the most appropriate actions to produce a suitable resolution. Voices are inextricable with a lifetime of experience. Concepts of life experience that can impact on all areas of life application can be analysed in terms of turning and shaping major transitions (Cleary & Walter, 2006). People may reconstruct or reinterpret the past, which forges the future. The richest resource of meaning we possess rests in what we have accumulated within us. The opportunity to link the past, present and future enriches life, valuing the wealth of each participant's input into research. This concept of respect for the attributes of one another was vital as the critical group worked in a cohesive manner towards changes within the workplace. The willingness to involve their colleagues, medical staff and CEO as valuable stakeholders, thereby enhancing the research, indicated the group's desire for the project to be a complete success. Karim (2001) purports that the success of a study by Webb (1989) into team nursing was due to the involvement not only of the nurses themselves but also the medical staff who did not object to the study.

7.8 Benefits of group formation

The formation of a multi-disciplinary group provided an opportunity for years of experience and models of health by cross-pollination of health professional expertise. Professional cohesiveness, a sense of belonging and the development of personal relationships provides personal development and self-confidence. The opportunity to share professional and personal feelings within this supportive environment creates peer support. The reduction of occupational stress experienced by nurses through peer support is extensively documented in literature (Gayor, Verdin, & Bucko, 1995; Kippling, 1998; Lees and Ellis, 1990). Involvement in a group offers an opportunity to increase awareness of traditionally accepted assumptions within practice (Greenwood, 1994). There are limitations to groups, however, where participants wish to appear socially acceptable and censor their responses striving for consensus rather than presenting valid argument (Brink, 1989). The initial group interaction provided an opportunity to examine how the group dynamics would eventuate, added dimensions to the existing thematic concern that had not been considered previously and demonstrated a level of validity as each participant checked each others' statements (Hansen, 2006). It was imperative that each member fully understood they had the right to have a voice and that all contributions were valued and respected regardless of the level of agreement with the remainder of the group. Habermas (1979) contends ideal speech situations provide participants with equal opportunity to utilize speech assuming dialogic roles without internal and external constraints and is orientated towards mutual understanding. Recognition of the collaborative communication process between participants enriched the data as it was reflected effectively and adequately. Subjectivity held great power for each individual reflecting culture, values, judgments and morals. An essential component of researcher responsibility is to evaluate this information and ensure the privacy zone of each individual is not breeched. The promotion of learning from one another was an integral part of the critical group. This

emphasized the importance of researcher bracketing to prevent personal bias influencing the discussion and learnings generated from the research.

7.9 Developing theory

The theoretical threads concerning the nature of the written work involve language, literacy, schooling, technologies, cross-cultural considerations and the historical and political conjuncture from a biopsychosocial perspective. The voice one can construct and the material one can use to develop argument is a mix of these threads. Communication varies from individual to individual; the life stories people hold influence their participation in research. The value the participant's believed their stories held influenced their contribution to the research and the development of theory.

The theory of communicative action, Habermas (1984) contends, is not necessarily the 'possession of knowledge' but the 'speaking and acting subjects acquire and use knowledge' (p.11). Such a theory provides rationality and practicality. Subjectivity holds great power for an individual reflecting culture, values, judgments and morals. Critical theory seeks human emancipation, liberating human beings from the circumstances that constrain them and providing an alternative to social and political philosophy. Acceptance of the varieties of communication skills within the critical group promoted engagement in the research by participants. Recognition of the collaborative communication process between participants enriched the data.

In this study, the specific learning phases of each research cycle permitted the development of refined theory. Initially, the data revealed that stress from the workplace impacted on the functioning levels of nursing staff. This was evidenced in a protracted reference to the potential for violence within the workplace that was the dominant theme that continued throughout each cycle of the research. The facilitation of an appropriate and acceptable resolution for the group was initiated in the triaging process; one that provided a safe and

workable non-threatening milieu in which the clinician could operate effectively. Throughout the cycles the group proposed ideas in the design of a flowchart suitable to meet their specific needs for staff safety. Contributions from hospital staff and key stakeholders provided the basis for the researcher to produce the final document.

Distressing examples were provided by each participant that led to unwanted and at times unrealistic stress highlighting underlying gaps and shortfalls that remain in mental health care. Careful examination of triaging tools from other States provided the group with Best Practice guidelines on which to develop an effective assessment guideline. The introduction of the triage tools facilitated a process that reduced the stress experienced by staff in the assessment process.

The concept of dangerousness for rural and remote nurses facing unique challenges when working with vulnerable people purported theory that the use of control measures in nursing consumers with mental health issues must be understood in the context of legislation and risk management. This implied a simple approach to reducing the stress within the ED and for the MHST in the emergence of the flow chart and triage tools.

Staff and client safety should be a priority and staff should feel comfortable and supported in decision-making to determine clinical assessment and treatment without prejudice. The critical group has achieved this with the introduction of these tools.

7.10 The development of a conceptual model

This research has led to the development of a new understanding of the phenomena of interest in this study. Dealing with people who have serious mental health issues and/or illnesses is difficult and stressful for those who have no experience or training in the process of developing a therapeutic relationship and adequate assessment. The resulting

stress may impact negatively on work satisfaction, perceptions of safety within the workplace and team functioning. Exploring the knowledge and skill deficits and other factors that contribute to the stress and identifying and implementing agreed actions helped to generate a “new” practice environment. The new model of praxis resultant from this study can now be applied by the nurses when nursing consumers with mental health issues (Figure 5). The interpretation reflects the three main circles to represent the critical group (top), the training and education provided (right) and the flowcharts accepted by the organization (left). At the core of the model, these shared domains contribute to a reduction on the stress of the nurse participants, improvements in the occupational health, safety and wellness of staff, and improved patient outcomes.

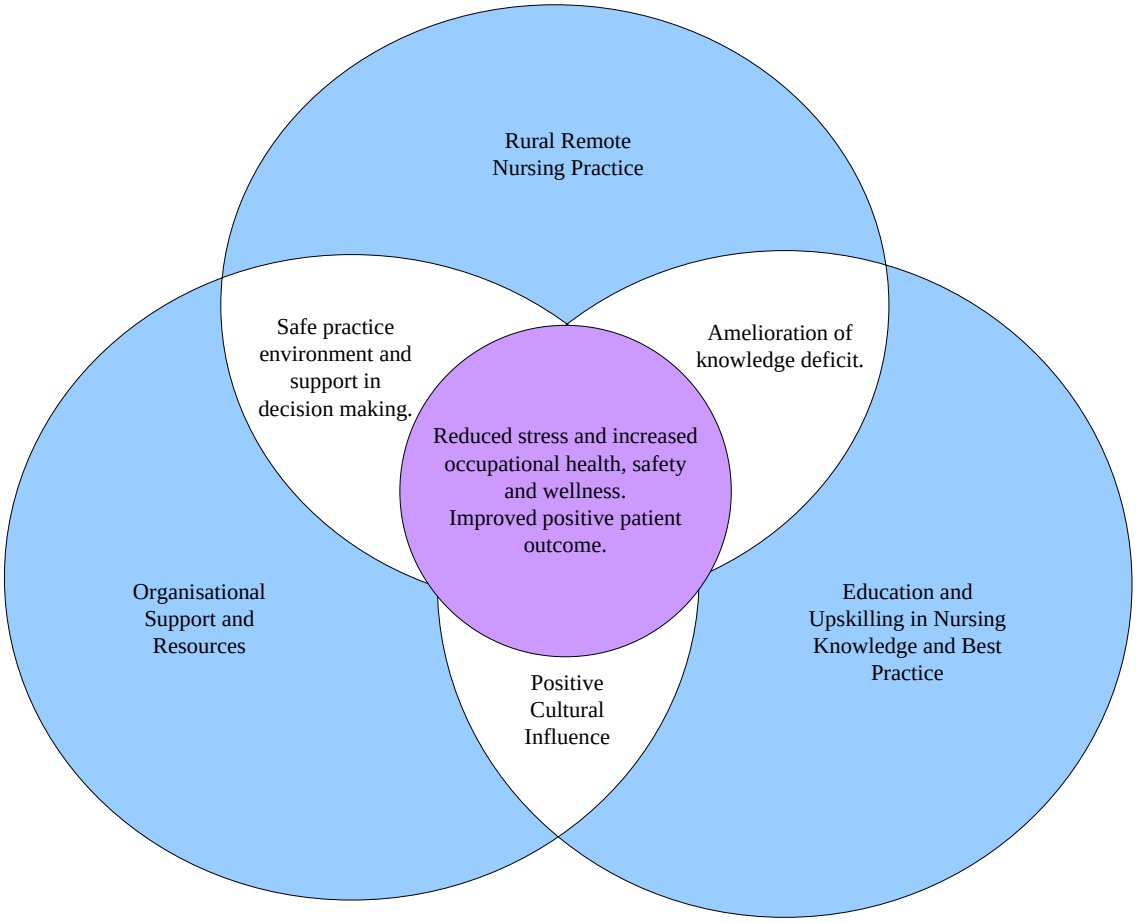

Figure 5. Conceptual model of praxis

The ‘amelioration of knowledge deficit’ is achieved through ongoing education to all nursing staff and is particularly reinforced by the MHST educating staff in dealing with clients with mental health issues. Knowledge in nursing is in constant flux and continues to grow in relation to the professional needs as demanded by the human and social welfare of society. Using substantive knowledge as a basis for theory-based learning is characteristic of nursing practice (Alligood & Tomey, 2002).

The ‘positive cultural influence’ section reflects the cultural shift of the workplace both at an organizational and individual staff level. Through mutual respect, support and acceptance of change, the cultural influence on practice becomes positive and enabling within a work environment. In nursing care this extends to patients maintaining or regaining their health/wellbeing (Welch, 2002).

The ‘safe practice environment and support in decision making’ section is influential in the nurse’s autonomy. The nursing profession holds a unique province. Societal expectations and demands are that the nurse will provide a unique service that addresses the biopsychosocial dimensions of an individual in restoring and maintaining health (Tomey, 2002). Whilst having this uniqueness, the nurse remains within practice guidelines and asserts himself/herself as a colleague of the other members of the health team. Continuing education is imperative to improve the knowledge base of the nurse, ensuring that he/she is aware of current best practice and at a level to undertake these responsibilities safely. Professional practice was changed through this research in the transmission and implementation of knowledge while theory was generated.

7.11 Conclusion

This chapter has reflected on the aims of the study and its findings, discussed the theoretical significance of the findings, examined its wider theoretical implications, reviewed the limitations and need for further research, and addressed the implications in

both the practical and political environments. The promotion of learning from one another was an integral part of the critical group requiring this researcher to bracket herself from dominance. This research has linked theory, education and practice. As a result of the action research cycles and through a collaborative process a critique of the existing social situation challenged current practices within the ED. The participants enhanced their knowledge and skills in undertaking this research and, through the logical evaluation of the findings and generating theory effected these changes.

The following chapter will conclude the thesis by paying attention to the theoretical significance of the study. It will marry the research question and aims to the findings and identify the significance of the research study to the body of nursing knowledge.

CHAPTER 8

Summary of the study

8.1 Introduction

This final chapter discusses the implications of the research and the utilization of the action research process for this study. The experiences shared by the researcher and the co-participants and the theoretical constructs developed within this research are summarized providing conclusion to the process. Reference is given to making progress in the development of clinical excellence and policy design by changing practice through evidence. Reassigning new paradigms for changing praxis is highlighted as vital in the provision of a safe and therapeutic environment to enhance a positive outcome for both staff and clients.

8.2 General overview

This study set out to examine which stressors a community mental health team in a rural and remote region identify as critical in the creation of occupational stress and, potentially, workplace burnout and how they can overcome these particular issues in their setting. Unrelenting exposure to workplace stress is suggested by literature as being significant in the burnout phenomenon that has seen an increase in workers' compensation claims around the world. Burnout, common among the helping professions, impacts across the biopsychosocial perspectives of peoples' lives.

The impact of stress can be both advantageous and detrimental to an individual depending on his or her vulnerability at any given time. The degree of intensity of stress impacts on homeostasis for the individual and the degree of effectiveness of that individual's coping mechanisms. This results in the level of wellness for the person and the ability to cope with workplace demands.

The preparation of the workforce in today's society, particularly in nursing, may have impacted on the individual in coping with workloads. The change in nurse education from exposure to the rigorous demands on nurses under the apprenticeship model to the academic model has seen the nursing students less workplace ready. This is particularly evident in the psychiatric nursing field.

Rural and remote nursing practice has stressors specific to that workforce. Not only have demographic constraints contributed to this but also the economic downturn associated with years of drought in Australia. This has led to a shift in health policies in an effort to make smaller rural and remote health service provision more economically viable.

Through an action research process using the Susman and Evered (1978) model, a multi-disciplinary critical group was formed in a remote area health service. The group involved key stakeholders in identifying the most significant stressors contributing to their occupational stress. The two key stressors were staff safety and the inadequate preparation of generalist nurses in assessing and managing clients with mental health issues accessing the health service.

As the separate chapters in this thesis have indicated, the cyclic process of the action research process provided the guiding process of diagnosing, action planning, action taking, evaluating, and specify learning. The data collection spanned a sixteen month period and there were four identifiable action cycles. The critical group developed three clinical nursing tools to address the diagnosed problems. These tools were (1) the Emergency Triage Flowchart, (2) the Mental Health Emergency Triage Tool, and (3) the Risk Monitoring Chart. Feedback and input from the key stakeholders and staff in the health service contributed to the development of these tools.

8.3 Discussion of the theoretical significance of the findings

In examining this component of the research the questioned asked is: Does my research make a difference to the theory on which it is based or that which it is related to? (Lewins, 1993, p.50). The simple answer to this is yes, this research does. Throughout the cyclic process of this action research study, theory was generated in the critical group identifying that the causal factors (Lewins, 1993) of their occupational stress were staff safety and inadequate education of nursing staff. This was grounded in the social reality of the participants' everyday lives. The work setting in the psychiatric nursing field has shifted focus from institutional care to rehabilitative care to managing people with serious mental illness in the least restrictive environments and is now based on the recovery model. The closure of psychiatric hospitals over the last three decades in the move toward deinstitutionalization has seen the number of people with serious mental illness being treated in community settings rise dramatically. The aim of mental health services in general is now to improve the mental health of the populations they serve. There is a definite lag in the education of nursing staff in current academic curricula across Australia to prepare nurses adequately for working in mental health nursing. With limited knowledge of this specialty in nurses who trained under the apprenticeship model and neophyte nurses graduating from university, the workplace remains problematic for clinicians faced with demands outside their scope of practice in this specialty area of nursing. This in itself remains a source of potential disaster as clinicians are left vulnerable to the unpredictability of psychiatric needs. The theory generated from this research can serve to direct the development of adequate curricular content in mental health nursing in comprehensive nursing degrees.

8.4 Wider theoretical implications

In addressing the problem identified in the research question, this research has illuminated more abstract areas of theory that were not initially of concern (Lewins, 1993). These

include deinstitutionalization and the impact on nursing care for mentally ill and mentally unwell clients, changes to educational preparedness for nurses, reconceptualizing nursing practice to reconfigure the nurse's role and the identification of occupational stressors as significant influences on the well-being of the employee. As previously discussed, there is much evidence suggesting that health, education and welfare organizations are impacted by the consequences of occupational stress. Resignations, absenteeism and sick leave have been associated with this problem. Burnout has become a loosely used term to validate this problem for staff within the helping professions. Organizational expectations of the worker demand professionalism at the same time as downsizing and budgetary constraints are implemented and workloads increase. Expectations of effective service delivery present a conflict for the worker who is attempting to work under a reduction in acceptable conditions. Disillusionment, frustration and despair will develop as the individual identifies their limited control over factors governing their work practice and the depletion of their own resources for coping. The study has highlighted the need for praxis between nursing education and clinical practice. Postgraduate programmes in mental health nursing are required if nurses are to expand their skills and knowledge base. This has significant implications under the occupational health and safety legislation of each State with organizations attempting to find suitable solutions to unpredictable violent incidents within the workplace.

8.5 Limitations of the study and areas for further research

The limitations of this study must be examined as they certainly will impact on its wider theoretical implications. As this was a qualitative study, the findings are influenced by the participants' subjectivity and their relatively low numbers. It may not be possible to generalize or apply the findings to other community or hospital settings due to the very specific nature of the stressors indicated by the study participants. Bracketing was undertaken by the researcher to minimize the impact of the researcher's experiences and

beliefs on the collection and interpretation of the data. However, human nature does not permit absolute detachment from influencing findings or outcomes. To support the bracketing, reflexivity provided the basis for validation allowing scrutiny by the participants.

Theories relating to social phenomena cannot be replicated, however they can be verified. What can be implemented across all areas of practice is the methodology to address such concerns as used in this research. The use of the action research process facilitates openness and empowerment that strengthens the validity and reliability of the research.

The findings of this research can provide an impetus for further qualitative and quantitative investigation. This further research can address some of the limitations listed above by using larger populations, a larger area of study and it could employ mixed methods, including quantitative methods to assess the statistical significance of the problem further contributing to the evidence base. More studies are required to refine the theory and to establish whether appropriate education will effectively meet the needs for nurses and increase their level of safety in the workplace when implementing mental health assessment and management.

8.6 Practical implications and policy.

Health care in Australia is provided through varying degrees of clinical and preventative services. Health issues must be addressed on a collaborative basis with government departments, organizations and communities. Identification of priority health issues and specific target groups for health interventions have determined that illness can be related to socio-economic status as well as geographical and economic environments. As discussed in previous chapters epidemiological studies indicate there are high levels of morbidity associated with mental health problems and depression, and an increase in mortality,

chiefly suicides, within the workplace. Staff members may be faced with violent or potentially violent situations in the course of their normal duties in the health care system (Wilson & Kneisl, 1992). Strategies to manage aggressive or potentially aggressive incidents effectively and ensure staff and client safety are vital to all facilities. This should alert managers, policy makers, and government officials that there is a significant threat to a healthy workforce. Despite amendments to the Occupational Health and Safety Acts of various States across Australia, the workplace can remain a hostile environment and a threat to the well-being of employees. This research can identify several implications for practice that should be scrutinized.

Implication 1

It is recognized that a great deal of current stress management practices are designed to assist employees in coping with work stress. Concerns are expressed by this author, however, as to the danger that these practices may pose. In attempting to help people to cope, these practices focus on the worker adjusting to their work situation. In order to be effective in helping most people, the work environment should be changed and not necessarily just the employee adjusting to the problem.

Implication 2

Stress management interventions should become more comprehensive in addressing the stressors within the work environment. Powerful stressors should be targeted, ideally including both organizational and individual factors. Burnout is a debilitating condition; however, it can be prevented.

Implication 3

A number of factors have been identified which, if implemented through policy changes within the workplace, can moderate or lessen the degree of stress experienced. A major component in this change is providing the employee with latitude in decision-making—that is, giving them ownership of the process.

Implication 4

Individuality dictates that responses to stressors in the form of coping mechanisms vary from person to person. It is purported contextual factors such as social support can intervene between the stressor and the outcome for the worker. Much of the literature supports the need for social support within the work environment to relieve stress experienced by any individual. Support measure (regardless of difficulty) should be examined and adopted within the constraints of the organization.

Implication 5

Organizational levels of intervention for job stress reduction must be specific to the relevant industry and directly related to the nature of the person's job. Professional development activities may be an effective modality in alleviating stress and enhancing the capacity and effectiveness of the individual. This may be as simple as ongoing staff education and promotion of industry conferences and journal subscriptions.

Implication 6

There is a need for a much greater awareness by managers in both the public and private sectors for job redesign in the promotion of employee health and well-being. It is also vital that employees incorporate self-care theories into their lives and work practices in order to maintain homeostasis within themselves. Employee wellness programmes should be encouraged; this may include self-rostering to be family friendly.

Implication 7

The changing face of nursing education since deinstitutionalization has not maintained industry standards that provide an adequately prepared mental health workforce to deliver the appropriate health care to this cohort of consumers. With an ageing workforce creative measures are required to address this concerning issue. By addressing the education deficits in mental health nursing, staff safety can be improved. This would require the bringing together of key stakeholders, that is, the university sector, government bodies,

industry partners, professional groups, industrial organizations and nursing students. Such an undertaking would provide students with the skills and knowledge necessary in the delivery of quality care to people facing mental health challenges in any setting whilst remaining safe in their practice. Ongoing professional development at postgraduate levels can provide the education for current nursing staff to implement new learning into future practice, particularly within the rural remote sectors.

Implication 8

A clear deficit in systematic and comprehensive accounts of rural health issues is evident despite an upsurge of interest in this field. Several key research questions remain, ranging from the health status of rural Australians, current funding to these regions and what mix of curative and preventative services is most appropriate to meet the specific needs of rural residents. There is limited research into the effects workplace burnout syndrome has on community mental health teams in rural and remote regions across Australia. Based on the data generated in this research, one implication for nursing would be to undertake a longitudinal study into continued high stress levels and the impact of them on the health, well-being and lifespan for rural and remote nurses (including the implications of environmental stress factors in the rural and remote regions as a variable) in comparison to their counterparts employed in other types of communities.

8.7 Conclusion

Final remarks

The workplace burnout syndrome may not be as prevalent as the loosely used term burnout may indicate. According to the Maslach Burnout Inventory, individuals who cease their employment due to burnout should not be able to function at any level in any employment due to the complete emotional exhaustion, increased depersonalization and decreased personal accomplishment. However, contrary to this some individuals are able to seek employment elsewhere, either in the same industry or an alternative, suggesting a different

form of acopia that may exist for that individual. This may be as simple as workplace fatigue resulting from a perception of little or no control over circumstances of the employee's work environment and own practice.

This study was grounded in critical theory. It provided legitimate evidence for professional practice. Evidence is not always quantifiable; it may be learned, experienced in practice, recorded or in testimony. What counts as evidence to clinicians must be feasible through critical inquiry, have appropriateness through philosophical inquiry, have meaningfulness through interpretive inquiry and have effectiveness through cause/effect inquiry (Jackson & Borbasi, 2008). Evidence is context bound; evidence knowledge transfer is through education, information dissemination and systems. Evidence utilization is managing change in organizations through the implementation of the evidence. Factors likely to influence the proposed change may be managed through diagnostic analysis, clinical audits and feedback (Axford et al., 2004). The notion that occupational stressors specific to rural remote community mental health teams do contribute to the level of stress experienced by the critical group was substantiated through openness in critical group discussion with participants deeming periods in their work life as excessively stressful.

This research has demonstrated the development of a new understanding/proposition of the phenomenon of interest in this study. Dealing with mentally ill people is difficult and stressful for those who have no experience or training in the processes of assessment and developing a therapeutic relationship. The resulting stress may impact negatively on work satisfaction, perceptions of safety within the workplace, team functioning etc; exploring the knowledge and skill deficits and other factors that lead to this being stressful and identifying and implementing agreed actions generates a "new" practice environment. This can thus be usefully applied to any similar situation. A new model of praxis has been

applied with the introduction of the clinical pathway nurses now implement when consumers with mental health issues access the health service in this study. Professional practice was changed through this research in the transmission and implementation of knowledge while theory was generated.

Further investigations into occupational stress and its deleterious effects on the individual working in health care would appear to be very valuable. Research into this should continue with studies including the Maslach Burnout Inventory to assist in identifying the level of burnout individuals may be experiencing. The theory of adopting scientific inquiry in promoting change in the workplace is presented as a possible guide for both community and hospital nurses in providing care for clients with mental health issues. The theory reflects a shift in paradigms; changing social systems, ideologies and communities by changing extrinsic fields.

> *"You cannot hope to build a better world without improving the individuals. To that end, each of us must work for our own improvement and, at the same time, share a general responsibility for all humanity, our particular duty being to aid those to whom we think we can be most useful".* *Marie Curie*

Figure 6. Leaving the valley

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APPENDICES

Appendix 1 Ethics Approval

Government of South Australia
Central Northern Adelaide Health Service

ROYAL ADELAIDE HOSPITAL
North Terrace,
Adelaide, SA 5000
Tel: +61 8 8222 4000
Fax: +61 8 8222 5939
ABN 80 230 154 545
www.rah.sa.gov.au
Research Ethics Committee
Level 3, Hanson Institute
Tel: (08) 8222 4139
Fax: (08) 8222 3035

24 January 2006

Eileen Petrie
School of Nursing
LaTrobe University
PO Box 821
University Drive
WODONGA VIC 3690

Dear Eileen,

Re: "Action Research in preventing workplace burnout in Rural Remote Community Mental Health Nursing." Version 2 (23 January 2006) Participant Information & Consent Form, Version 2 (23 January 2006).
RAH PROTOCOL NO: 060106.

I am writing to advise that Research Ethics Committee approval has been given to the above project.

Research Ethics Committee deliberations are guided by the NHMRC National Statement on Ethical Conduct in Research Involving Humans.

The general conditions of approval follow:

- Adequate record-keeping is important. If the project involves signed consent, you should retain the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them in the future if necessary. The duration of record retention for all research data is 15 years.
- You must notify the Research Ethics Committee of any events which might warrant review of the approval or which warrant new information being presented to research participants, including:
  (a) serious or unexpected adverse events which warrant protocol change or notification to research participants,
  (b) changes to the protocol,
  (c) premature termination of the study.
- The Committee must be notified within 72 hours of any serious adverse event occurring at this site.
- Approval is ongoing, subject to satisfactory annual review. An annual review form will be forwarded to you at the appropriate time.

If University of Adelaide personnel are involved in this project, you, as chief investigator, must submit a Human Research Approval Notification form (available at: http:www.adelaide.edu.au/research/ethics/human/guidelines/) within 14 days of receiving this ethical clearance to ensure compliance with University requirements and appropriate indemnification.

Yours sincerely,

Dr M James
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Appendix 2 Explanatory letter and information of consent from

To:

Chief Executive Officer/ Director of Nursing, (Study Area) Hospital
(Study Area) Health Service.
Community Mental Health Team Members
Chief Executive Director

Re: Research Project: Action Research Preventing Workplace Burnout

I am currently undertaking a Research Project as part of a PhD with the Clinical Division of Nursing, Adelaide University, SA.

You are invited to participate in this project by allowing me to approach staff from your department in my recruitment of research subjects.

I have received Ethical Approval from the Human Research Ethics Committee, and understand fully the responsibility of confidentiality towards the research participants.

Ethical consideration will be given to participants ensuring informed consent is obtained prior to commencement. This participant will be voluntary and each individual will have the right to withdraw without prejudice. Each participant being assigned a pseudonym will ensure anonymity.

A copy of the research Proposal and informed consent form are attached.

Thank you for your consideration.

Eileen Petrie. JP., M.N.S., Post Grad. Dip. In CPN. RN.
Lecturer
LaTrobe University
Wodonga. Vic. 3690

Incl. 7

This Participant Information and Consent Form is five (5) pages long. Please make sure you have all the pages.

Form of Disclosure and Informed Consent

Project Title
Action Research in Preventing Workplace Burnout in Rural Remote Community Mental Health Nursing.

Researcher
Mrs Eileen Petrie

Supervisor
Professor Alan Pearson.

I am Eileen Petrie enrolled in PhD studies at the University of Adelaide. As part of my studies, I am undertaking an Action Research project. This will involve the identification of an area of practice that could be improved, and the implementation of change using the processes of planning, acting, observing and reflecting. The area of concern I will study is workplace burnout and occupational stress.

I will form a participatory group from a Community Mental Health Centre.

The results will be utilized in my thesis to University of Adelaide, Adelaide, SA and will also be accessible to all participants. The results may also be presented at conferences or published in the professional literature.

This project has received approval from the Human Research Ethics Committee at the Royal Adelaide Hospital, Adelaide, SA.

If you have any complaints about the way you were treated during the study, or a query that I have not been able to satisfy, you may write to:

Executive Officer
Research Ethics
Ph: 8222 4139
Fax: 8222 3035
Level 3, Hanson Institute
Royal Adelaide Hospital
North Terrace
ADELAIDE SA 5000

Your Consent

You are invited to take part in this research project.

This Participant Information in this document describes the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or a co-health worker.
Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing this form, you indicate that you understand the information and that you give your consent to participate in the research project.
You will be given a copy of the Participant Information and Consent Form to take home with you and keep as a record.

Purpose and Background

The purpose of this project is to address the identified major stressors impacting on mental health workers in rural remote communities through an action research project which may contribute to workplace burnout. This can be achieved through education and management program using the action research process. The details of the program are described below in Section 3. Similar programs have proven to be of benefit to health care professionals and this project will undertake a similar process.
You are invited to participate in this research project because you are considered to meet the inclusion criteria of practicing in a rural remote locality.

Procedures

Participation in this
project will involve participant's involvement in discussion groups and to keep a professional journal. The time commitment will be negotiated with the groups and will include twice-monthly meetings of approximately 1½ hour's duration.

Possible Benefits

The benefit in participating in this project is that you will be given additional skills to assist you to manage significant stressors that are problematic in future and reduce time commitment in dealing with these issues by the application of an action research process. Participating in this project will help develop a model of care for all patients with a mental health issue which require an unusual amount of input from the community team. There is no guarantee or promise that you will receive any benefits from this project but it is presumed your understanding of the process will assist you in future practice.

Possible Risks

No risks or side effects should occur from participating in this project. However, there may be unforseen or unknown risks. It is recommended that should distress occur when participating in group discussions external counselling should be sought. This can be arranged for you should you choose by this researcher at no cost to you.

Alternatives to Participation

Should you decide not to participate or withdraw from this project, you are free to withdraw your consent at any time without prejudice or explanation.

7. Privacy, Confidentiality and Disclosure of Information

Individuals will not be identified in any way in this report, a pseudonym will be assigned to each participant and confidentiality will be maintained throughout the project. All data obtained during this project will be kept in a locked filing cabinet or under a password protected computer file. Following completion of this project, this computer Disk and data will be archived in a locked room in the School of Healthy Science LaTrobe University Bundoora, Victoria, for a period of five years. Data will be stored in a way that makes it impossible to identify you.
In any publication, information will be provided in such a way that you cannot be identified.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information. This new information may mean that you can no longer participate in this research. If this occurs, the person(s) supervising the research will stop your participation. In all cases, you will be offered all available care to suit your needs.

9. Results of Project

When the project has been completed all participants will receive a written summary of the overall results. The data collated in this research will be used in the publication of a PhD thesis and may be in part be used in publication for journal articles.

10. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. If you withdraw from the project we will still use the data we have collected in our research.

11. Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia (NHMRC). This statement has been written to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee, Royal Adelaide Hospital, Adelaide, SA.

12. Reimbursement for your costs

You will not be paid for your participation in this project.

13. Further Information or Any Problems

If you require further information or if you have any problems concerning this project (for example, any side effects), you can contact the Principal Researcher or the Associate Researcher (who is responsible for the day to day running of the project).

14. Other issues

Any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, may be directed to my supervisor, Professor Alan Pearson on 0883033595 or myself on 02 60432058 / 0260249719.

Appendix 3 Plain Language Statement Lay Summary of Proposed Research

This Action Research Study is part of a program of towards the award of a PhD in the Discipline of Nursing and Midwifery at Adelaide University. The Action Research process of inquiry involves talking with participants and working with them on managing change. Focus groups identify an area of practice causing concern and plan for change. The process of planning, acting, observing and reflecting forms the core of this research and continues in a cyclic way until an effective resolution has been established for the groups.

The area of concern I will study is workplace burnout and occupational stress. I will work with a critical group of three to four participants from a community mental health team (State identified). Participants will be asked to participate in discussion groups and maintain a professional journal. The time commitment will be negotiated with the group and include meeting twice monthly for an approximate time of one to two hours each meeting. These meeting will be audio-taped.

It is expected the data from these meetings will provide; a reconnaissance and diagnostic phase, description of the major stressor, exploration of the participants thoughts, collaborative exploration of what this research may achieve, a course of action, implementing the plan into practice, reflecting on, refining and evaluating the course of action thereby learning from and increasing knowledge. The participants will be enabled to identify the need for subsequent cycles should this information require further action to elicit a suitable outcome. Journaling will permit the acknowledgment of unforeseen and unexpected results. Opportunities will be provided during critical group meetings to discuss the participant's journals and issues of concern. The expected outcomes of this research will be the reduction of significant stress to the participants caused by the identified issues, and, the empowerment of each individual to implement the action research process in resolving future issues.

Appendix 4 Consent Form

I, (name), declare that;

I have read, or have had read to me in my first language, and I understand, the Participant Information Sheet.
I freely agree to participate in this project according to the conditions in the Participant Information form.
I will be given a copy of the Participant Information and Consent Form to keep.
The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.
A copy of this form has been provided to me.
Note: All parties signing the Consent Form must date their own signature.

Name of participant;
……..

Signature…….Date……..

Name of Researcher;
……..

Signature…….Date……..

Name of Witness;
……..

Signature…….Date……..

Name of Supervisor;
……..

Signature…….Date……..

Appendix 5 Right to withdraw: Withdrawal of Consent Form

Workplace Burnout Prevention in Rural Remote Community Mental Health Nursing.

WITHDRAWAL OF CONSENT FORM

Investigators:

Professor Alan Pearson — Supervisor. Principal Researcher, Johanna Briggs Institute, Margaret Graham Building, Royal Adelaide Hospital, Nth Terrace, S A.

Eileen Petrie — Associate Researcher, Lecturer, Nursing Studies Unit, Albury-Wodonga Campus, La Trobe University

I, ... (the participant), wish to WITHDRAW my consent in the participation of the Action Research Project. Data arising from my participation MAY be used in this research project as described in the Plain Language Statement and Consent Form. I understand that data arising from my participation will be used as part of the research to the date of my withdrawal. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Participant's Name: .....

Participant's Signature: .....

Date: / /

Appendix 6 Declaration of Confidentiality by Transcribers of Taped Data

Workplace Burnout Prevention in Rural Remote Community Mental Health Nursing.

DECLARATION OF CONFIDENTIALITY BY TRANSCRIBERS OF TAPED DATA

(This form will be completed as soon as the transcriber(s) are employed for the task)

Transcriber (please print details below)

I (full name)
……

Of (address)
……

……
……..

acknowledge that all information transcribed by me for the research project named above will be treated by me with the strictest confidence.

Further, I will ensure that all tapes while in my possession will be treated with the same level of confidentiality as the transcribed material and, together with the data, will be stored separately and securely, as stated in the research project application.

All material relating to the above project will, while in my possession, be accessible to the researcher(s) only.

Signature: ……

Date: ……..

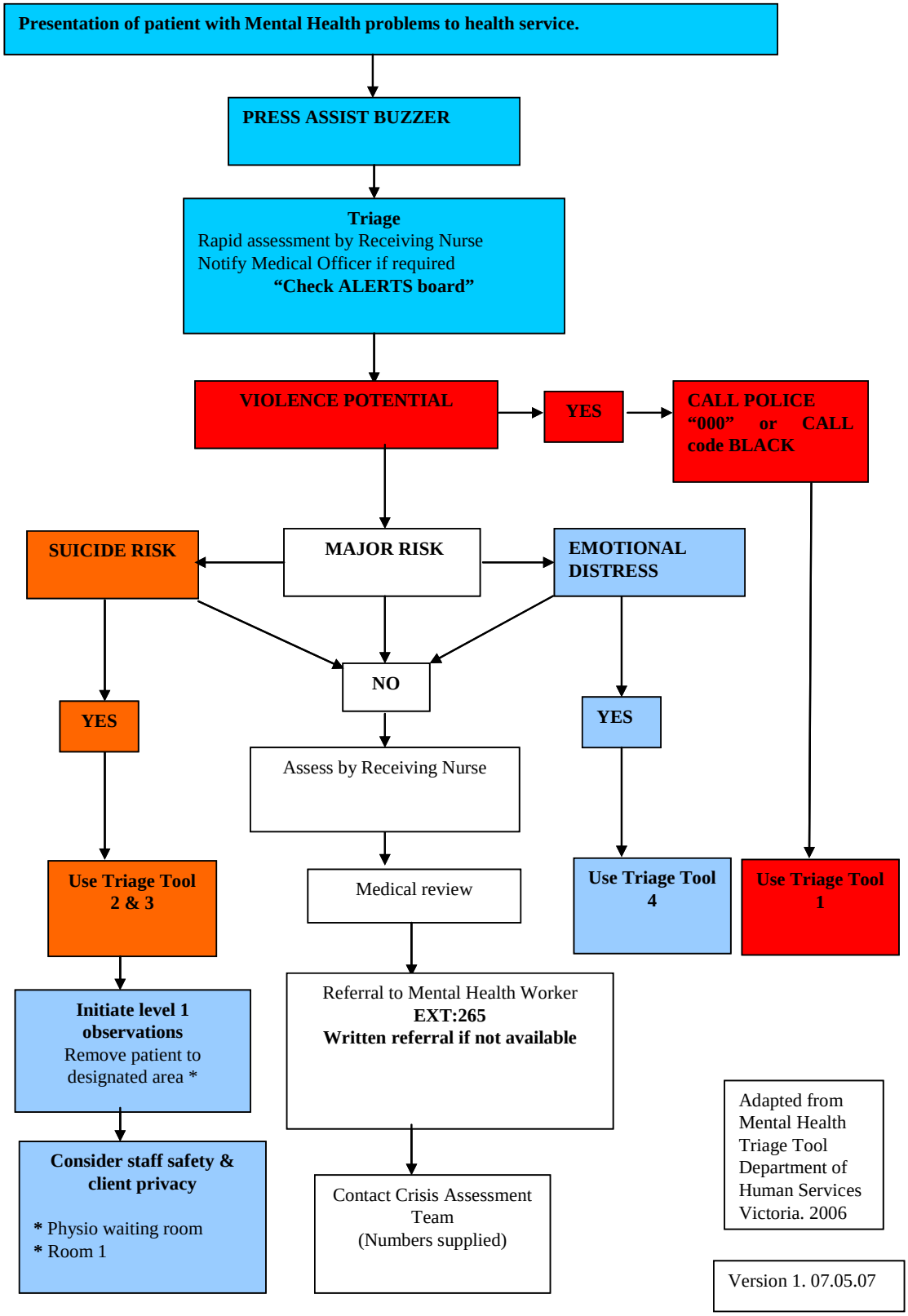
Witnessed by:

Name (print): ……..

Signature: …… **Date: / /**

Appendix 7

(Area) H&CS Mental Health Triage Tool



Appendix 8 Triage Tool: Risk Factors Flow Chart

Name: DOB: Date:

Triage Code 1 Assessing and Managing Aggressive Behaviour

RISK FACTORS
The following risk factors are linked to an increased risk of violence to others.
FUTURE VIOLENCE may be predicted by previous history of violence.

DEFINITE DANGER TO LIFE (SELF OR OTHERS)

	YES	NO
Does the patient have or said they possess a weapon? **(Notify police "000" immediately or call CODE BLACK)**	☐	☐
Is the patient expressing homicidal or violent ideas?	☐	☐
Self destructive behaviour?	☐	☐
Displays extreme agitation or restlessness?	☐	☐
Does the patient have bizarre behaviour delusions/hallucinations?	☐	☐
Does the patient have a known history of violence?	☐	☐

Action if any of the above "yes" **Level 1 observations**

- Maintain continuous visual observation – **never turn your back on the patient.**
- 2nd person Notify Police **"000"** or activate **CODE BLACK**.
- Notify **Medical Officer.**
- **Ring Ext: 205** to access extra personnel warning them of threat.
- Do not unlock the doors to a violent or threatening patient until the Police have arrived to assist.
- **Ensure you have a safe egress from this area.**
- Possession of a weapon is a police matter – **never try to disarm a patient carrying a weapon.**
- Attempt to maintain a safe environment for the patient and others.
- **Do NOT use emergency buzzer:**
  - Remove any person, including patients, members of the public and, if the person's behaviour is out-of control, all staff from the immediate vicinity.
  - Isolate the person within the Health Service facility
  - Await arrival of Police

PROBABLE RISK OF DANGER TO SELF OR OTHERS

	YES	NO
Is the patient known to this health service?	☐	☐
Extreme agitation/restlessness?	☐	☐
Physically/verbally aggressive to?	☐	☐
Confused/unable to co-operate?	☐	☐
Hallucinations/delusions/paranoia?	☐	☐
Requires restraint/containment?	☐	☐
High risk of absconding & not waiting for treatment?	☐	☐
Attempted or self-harm threat?	☐	☐
Threat of harm to others?	☐	☐

Action if any of the above "yes"
Level 1 observations

- Maintain continuous visual observation and note further escalation in behaviour to **DEFINITE DANGER.**
- Implement **Risk Monitoring Chart & notify Medical Officer.**
- Attempt to de-escalate patient's behaviour.
- Implement WRHS Adult Mental Health Risk Assessment tool
- Arrange transfer if required
- Plan for adequate personnel numbers to provide restraint if needed.
- Consider organic causes for behaviour (e.g. Diabetes/drug & Alcohol/head injury)
- Assess & treat physical conditions – stabilise.
- Relevant psychiatric numbers – Wodonga Regional Adult Mental Health **0260491500 (B/H), 24hr Crisis Line 1300881104, EXT 265 (B/H Local).**

Name: DOB: Date:

Triage Code 3

Possible danger to self or others. Consider is the patient

	YES	NO
- Verbalising suicidality?	☐	☐
-In a situational crisis?	☐	☐
- Agitated, restless?	☐	☐
- Displaying intrusive behaviour?	☐	☐
- Ambivalent about treatment?	☐	☐
-Not likely to wait for treatment?	☐	☐
-Displaying severe symptoms of depression, withdrawn, uncommunicative, anxious, elevated or irritable in mood?	☐	☐
- Displaying psychotic symptoms, thought disordered, hallucinating/delusional/paranoid ideas?	☐	☐
-Bizarre/agitated/confused behaviour	☐	☐

Action if any of the above "yes" **Level 2 observations**

- Close observation ***(see pg. 4)*** – **do not leave patient unattended.**
- Plan for adequate personnel numbers to provide support if needed.
- Implement **Risk Monitoring Chart & notify Medical Officer.**
- Ensure safe environment for patient and others.
- Note further escalation in behaviour to **DEFINITE DANGER.**
- Intoxication by D & A may cause escalation in behaviour.
- Discharge in. company of appropriate person ,
- Provide **24 hr crisis** number: **1300881104 OR 0260491500 (BH).**

Name: DOB: Date

Triage Code 4 & 5
Moderate Distress semi-urgent mental health problem
Under observation and/or no immediate risk to self or others.

yes/no	yes/no	yes/no
☐☐ Suicidal thought or previous attempt/s	☐☐ Known patient with chronic psychotic symptoms	☐☐ Depressed
☐☐ Self harming	☐☐ Known patient with chronic unexplained somatic symptoms	☐☐ Personal crisis
☐☐ Irritable without aggression	☐☐ Give coherent history	☐☐ Anxiety
☐☐ Aggression/agitation	☐☐ Drug &Alcohol and/or withdrawal effects	☐☐ Panic
☐☐ Pre-existing non-acute mental disorder	☐☐ Cooperative	☐☐ Compliant with instructions
☐☐ Willing to wait for treatment	☐☐ Able to discuss concerns	☐☐ Requesting medication
☐☐ 'At risk' if absconds		

Action if any of the above "yes" **Level 3 observations:** Monitor for any escalation in behaviour indicating reassessment of Level of Observation and intervention

Care Level Observation Categories. Implement 'Risk Monitoring Chart'
Care level one: Continuous visual surveillance = person is under direct visual observation at all times
Care level two: Close observation = regular observation at a maximum of 10 minute intervals
Care level three: Intermittent observation = Regular observation at a maximum of 30 minute intervals.

These recommended observation categories are a guide only and consideration should be given to patients level of distress and the likelihood that the situation could change.

Appendix 9

RISK MONITORING CHART

Name:
DOB:
Address:
(Client UR Label)

List Physical description/identifying features of client:

Anxious:
This is a subjective assessment by staff. Ask patient if his/her mind is racing.
Agitation:
This is an objective assessment. Observe the patient wringing of hands, pacing etc. Ask patient if they are experiencing butterflies in tummy.

Date/ Time	Location	Awake(A) Asleep (AS)	Anxious Y/N	Agitated Y/N	Thoughts of self harm (Describe)	Thoughts of harming others (Describe)	Action taken by staff (Comments)	Evaluation Effective (E) Non Effective (NE)