

ISPN Poster Presentations

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Poster 1

MENTAL HEALTH PERCEPTIONS AND BARRIERS TO CARE: A SURVEY STUDY OF DEPLOYED SOLDIERS IN IRAQ

Rosanne Visco, PhD, MSN, RN-BC

Purpose: This study explores soldier perceptions about mental health services and whether they are amenable to seeking treatment if experiencing problems. The research questions that will be evaluated address two categories common in surveys: questions about behaviors (treatment seeking) and questions regarding attitudes, beliefs or opinions (stigma, mental health perceptions).

Design and Methods: This retrospective study will review 1,150 UBHNA (Unit Behavioral Health Needs Assessment Surveys) taken by soldiers assigned to Camp Adder, Iraq, using descriptive statistics. Chi-square analysis will examine the significance between mental health perceptions (stigma) and access to care (barriers) and will also look at the relationship between current mental health status and interest in receiving help.

Findings: The outcome will determine if there is perceived stigma and barriers to behavioral healthcare in the deployed setting and if there are particular factors that make it difficult for soldiers to seek or obtain behavioral healthcare.

Practice Implications: According to the Joining Forces America report (2008) almost two-thirds of service members believe that their peers are very or somewhat unlikely to ask for professional help if they are dealing with issues like depression, post-combat stress, or family adjustment. Since military and civilian advanced practice psychiatric nurses will come into contact with active duty and/or veteran combat warriors, it is important to understand perceptions and the types of barriers soldiers face when accessing behavioral health.

Poster 2

ROOTED AND GROUNDED: HORTICULTURE AND WORSHIP COMPLIMENT CARE IN AN ADOLESCENT RESIDENTIAL PSYCHIATRIC SETTING

Kristin M. Moore, MDiv, and Tyra Warner, CTRS

Members of a multi-disciplinary staff at an adolescent residential psychiatric treatment program share two experientially based complimentary care programs, which have been highly successful in contributing to treatment goals.

Horticulture: Getting their hands dirty in both greenhouse and garden, youth learn first-hand the cycle of life and what living beings need to survive. Under the supervision of a horticulturist, youth plant and sow, prepare and tend. Youth flourish and grow alongside the flowers, fruit, herbs and vegetables. Rewards are both tangible: selling plants and eating the harvest, and intangible: satisfaction, accomplishment, discovery and growth. In this presentation staff share key elements of the program and its successes.

Worship: Youth engaged in a yearlong grant-funded worship renewal project using the expressive arts of music, movement, expressive writing and art therapy to create non-traditional worship opportunities. Highlights of that program will be presented, along with insights on how to positively engage youth 8-17 in spiritual development and worship using the expressive arts.

Both programs use kinesthetic, experiential activities to address:

- self-discovery
- disciplined creativity
- skill development through experimentation and positive reinforcement
- cooperative interaction with peers
- collaboration
- belonging
- positive accomplishment
- valuing inherent worth of self, others, nature
- fostering awe and wonder
- delayed gratification
- impulse control
- behavioral consequences
- stewardship of the earth
- respect for self, others, diversity
- trying new and unfamiliar tasks
- hopeful possibilities for the future

Benefits of Worship and Horticulture include: physical, intellectual, emotional, psychological, spiritual and social benefits; learning to take responsibility and ownership; building healthy relationships; sense of belonging; improved decision-making; self-confidence; self-control; and metaphorical learning.

Horticulture Targeted Activities include: plant sales; outings to conservatory; planting and transplanting; plant care - watering, weeding, harvesting; delivery to kitchen; cooking with crops; and composting.

In both worship and horticulture the words of Dr. Albert Schweitzer are an encouragement to staff and a lesson shared with youth, "No ray of sunshine is ever lost, but the green which it awakens into existence needs time to sprout, and it is not always granted for the sower to see the harvest. All work worth anything is done in faith."

Poster 3

DEVELOPMENT OF A DEPRESSION-RELAPSE PREVENTION PROGRAM USING A DIALECTICAL APPROACH

Yasuko Koyano, PhD (Japan)

In Japan, the number of patients visiting mental clinics for the treatment of mood disorders, compulsive disorders, and stress-related disorders is increasing. The suicide rate in Japan is 24 people per 10 million. This number is the highest among the seven most-advanced countries and is 9th in the world overall. In April 2010, the Japanese government established measures for the treatment of patients with depression in an effort to reduce the number of suicides in Japan, which presently totals more than 30,000 annually. However, as the number of patients who develop new types of depression is increasing, the number of patients who do not recover after conventional treatment is also increasing. Thus, a diversification of therapy to include social psychological treatment, rather than just drug therapy for depression, is required as part of attentive interventions. Also, the increasing prevalence of depression is associated with a high relapse rate. Therefore, social psychological treatment for patients with expected relapse should be included in preventative maintenance programs.

The purpose of the present study was to develop a depression-relapse prevention program using mindfulness, which is the key skill of dialectical behavior therapy techniques. Dialectical behavior therapy has begun to be applied to the treatment of borderline personality disorder and has recently begun to be used for adjustment disorders and eating disorders/traumatic stress disorders. I have been conducting an Emotional Literacy Program at a mental clinic day care center. This program is based on emotional intelligence theory (Salovey & Mayer, 1990). However, the program emphasizes the control of negative emotions. The present study examined the application of a depression recurrence prevention framework using a dialectical approach focused on "change" and "acceptance."

Poster 5

ALCOHOL SCREENING, BRIEF INTERVENTION, TREATMENT AND REFERRAL: AN INTERDISCIPLINARY EFFORT TO COMBINE THE ART AND SCIENCE OF PSYCHIATRIC NURSING TO IMPROVE PATIENT SAFETY, OUTCOMES, AND ACCESS TO CARE IN THE COMMUNITY FOR PATIENTS AT RISK FOR ALCOHOL-RELATED ISSUES

Lynnda L. Zibell Milsap, BSN, MS, CNS-BC, and Andrea Williams, PhD, RN+

A systematic approach for alcohol screening, brief intervention, referral and treatment for patients demonstrating at risk behaviors for alcohol use has been found to decrease Emergency Department recidivism, morbidity, mortality, and health care costs across the continuum of care.

According to state statistics in 2009, 238 people died from alcohol-related motor vehicle crashes, ~4000 were injured with 44,000 drunk driving convictions. In addition, 40% of 12-20 year olds in the state reported drinking in the past month, the highest nationwide rate. The statewide cost in 2007 was \$935 million. The NIAAA, SAMHSA, ACS-COT, CDC, DOT, Emergency Medicine Physicians groups, and the ENA recommended/mandated changes in alcohol screening, referral and treatment for patients demonstrating at risk/hazardous alcohol behaviors.

Based on a recommendation by Nursing Council, the Psychiatric Liaison CNS, Trauma Program Specialist, and advanced practice nurses collaborated with interdisciplinary groups and implemented hospital-wide changes for alcohol screening, treatment, referral, and brief intervention. Changes included CAGE + Consumption Screening of Adults; CRAFFT Screening of Adolescents 10 years of age and older; age appropriate referral to the adult and children, CIWA-AR use for symptom triggered treatment and age appropriate brief interventions using Health Link the newly initiated electronic medical record for documentation.

At three years post implementation, with the spring 2010 passage of the Mental Health Parity Law and Addiction Equity Act, the adult and children's hospital nursing leadership staff, Psychiatric Liaisons, advanced practice nurses and the Nursing Councils have collaborated with interdisciplinary groups to streamline and modify the ARI practices. Revisions to the standing order sets; Alcohol Related Issues Nursing Practice Guideline update; re-evaluation of the ARI screening tools; modification of the symptom triggered withdrawal process; along with initiation of follow-up calls to determine behavior change have been introduced to improve patient outcomes.

Poster 6

RECOVERY-INSPIRED ASSAULT PREVENTION: DECREASING VIOLENCE THROUGH CULTURE CHANGE

Sabrina Cito, RN, MSN, and Erin Schmidt, RN, BSN+

Aggressive behavior continues to be a significant issue in psychiatric settings, particularly inpatient units. It is interesting to note that inpatient units have been most reluctant to embrace the shift to a recovery culture and remain entrenched in provider-centered models of care. Recovery is embedded in relationships and to decrease violence and aggression, we must create environments that foster relationships built on an understanding of power, hope and respect. A Recovery-Inspiring Environment is built on a culture of mutual respect and partnering to foster the individual's recovery journey. This type of environment and philosophy result in a decrease in the power struggles, which abound on an inpatient unit. By increasing our understanding of recovery and creating a recovery-inspired culture, inpatient units can move from places where aggression and violence are the norm to practically eliminating these experiences from treatment settings.

Poster 7

PSYCHOMETRIC PROPERTIES OF THE ARABIC VERSION OF THE DEPRESSIVE COGNITION SCALE

Abir Bekhet, PhD, RN, HSMI, and Jaclene A. Zauszniewski, PhD, RN-BC, FAAN+

Background: Suicide is one of three leading causes of death worldwide among persons aged 15 to 34 years and its prevalence is increasing significantly among adolescents. Recent data collected in Alexandria, Egypt, showed that 30% of high school students had a strong death wish. In fact, depression is a strong predictor to suicide. The evidence has also shown that adolescents not only experience the whole spectrum of mood disorders but also suffer from significant associated morbidity and mortality. Though frequently unrecognized, depression is common. Identifying depressive cognitions in adolescent nursing students can be an important step in preventing the development of clinical depression, which is directly associated with suicide. There are many instruments that measure the presence and severity of depression including the Beck Depression Inventory, the Hamilton Rating Scale for depression, the Center for Epidemiologic Studies Depression Scale, and the Zung Self-Rating Depression Scale. All these instruments are useful in measuring the affective, cognitive, behavioral, and physiological symptoms of depression. However, these instruments do not focus on specific cognitions that may precede the development of clinical depression. In response to this need, Zauszniewski developed the Depressive Cognition Scale (DCS), which focuses specifically on the measurement of cognitive symptoms that precede the development of clinical depression.

Purpose: This study focused on the psychometric testing of the Arabic version of the Depressive Cognition Scale (A-DCS) among 170 first-year, adolescent Egyptian nursing students.

Methods: The questionnaire was examined for internal consistency, homogeneity, and construct validity using factor analysis and convergent validity.

Results: Cronbach's alpha for the A-DCS was 0.86. The homogeneity of the instrument was supported by item-to-total correlations between 0.30 and 0.70. Factor extraction generated only one factor with an eigenvalue greater than 1, which is consistent with the English version. The A-DCS total score had a strong significant correlation with the Alienation Scale scores ($r=.51, p<.01$), indicating convergent validity.

Conclusion: The A-DCS scale has the potential to become a useful screening measure for depressive cognitions among Egyptian nursing students. Early identification and treatment of depressive cognitions can prevent serious depressive illness that may lead to suicide.

Poster 8

IMPROVING THERAPEUTIC COMMUNICATION THROUGH PRE-CLINICAL SIMULATION

Janine Graf-Kirk, MA, RN, BC, CNE, and Teresita Proctor, MS, RN, ACNS-BC, CNE

The transition from classroom to clinical is frequently one of fear and uncertainty among nursing students (Ham & O'Rourke, 2004, p. 139). This is certainly true when students first venture into the mental health setting. Psychiatric nursing is an area of specialization emphasizing knowledge and utilization of communication skills (Kameg et al., 2009, p. 503). Pre-clinical simulation is one way to prepare students anticipate possible situations they may encounter and how to better communicate therapeutically.

The purpose of this abstract is to describe the integration of pre-clinical simulation, video recording, and debriefing as a way of introducing students to psychiatric nursing. This multifaceted process begins with distributing to students a case study, developing a concept care map, and nursing care plan prior to their interaction with the human patient simulator. The "on the fly" approach by faculty (sight unseen) allows for instantaneous feedback based on the student's verbal and non-verbal communication. As each student enters the patient's room the simulation begins. When the interaction is finished, they return to a designated room to write up their process recording. During debriefing each student's video recording is played back to the clinical group and faculty for discussion. Immediately after the first clinical day, students are asked to complete a brief Likert survey identifying their perception about simulation and to reflectively write how this experience helped with their actual patient interaction. Excerpts include: "watching myself on the video helped me not to wave my hands so much"; "my patient in clinical had her head covered with a blanket and I knew from simulation not just to pull it away"; "in simulation I heard how loud I spoke, like I was yelling at the patient, with my real patient I talked in a more calm, soothing voice." This presentation will show how pre-clinical simulation has become an invaluable teaching tool to help students "break the ice," and be more aware of their communication. For faculty, it allows an opportunity to assess communication styles, to provide support and constructive feedback. Examples of case studies and results of evaluation surveys will be shared.

Poster 9

VITAMIN D AND PSYCHIATRIC DISORDERS

Margaret Rafferty, DNP, RN, MPH, and Dorothy Grasso, MS, FNP, CCRN

Recent epidemiological studies have found that inadequate levels of Vitamin D, the sunshine vitamin, increase the risk of cancer, cardiovascular disease, infectious disease, diabetes, multiple sclerosis, rheumatoid arthritis, and bone disorders. Experts estimate that one billion people around the globe have Vitamin D deficiency or insufficiency. Currently, there is keen interest in the scientific community in investigating the role of Vitamin D in the etiology of Schizophrenia, Mood Disorders, Dementia, and Autism. This poster will summarize the literature on Vitamin D's role in the prevention and treatment of these psychiatric disorders. The poster will also provide guidelines for the diagnosis and treatment of Vitamin D deficiency so that psychiatric nurses can help spread the news about this important public health message.

Poster 10

EFFECTIVE REDUCTION OF RESTRAINT AND SECLUSION IN THE PSYCHIATRIC EMERGENCY DEPARTMENT WHILE MAINTAINING A SAFE MILIEU

Lisa Gilley, RN, BSN, and Katherine Holland Pontone, RN, BSN, MSN

Restraint and seclusion in the psychiatric emergency department have been a standard practice for many years. Complications associated with their use have prompted great concern. Reduction in the use of restraint and seclusion while maintaining a safe milieu presents a unique challenge on many levels. The treatment area is not conducive to comfort or privacy and it is difficult to meet the basic needs of patients with regard to rest, nutrition, and hygiene. The square footage is small and restrictive. The patient population presents with extreme states of agitation, psychosis, delirium, depression, mania, and intoxication, as well as sociopathy, malingering, and borderline behavior. Their presentation and treatment is further complicated by untreated medical conditions, patterns of non-compliance and substance abuse, history of violent behavior and ineffective coping, involuntary status and lack of social supports. Using a Quality Improvement process, restraint and seclusion data was tracked and trends were used to direct practice. Working from a primary prevention model, patient expectations, triggers, external signs of anger and personal safety plans were assessed and implemented. The treatment process was reviewed with individual patients and realistic expectations defined. Hourly assessments of patient status and comfort needs were performed. Staff partnered with patients and advocated to meet their needs for comfort and safety. Increasing the staff-to-patient ratio was offered as an intervention prior to a loss of behavioral control. When indicated, debriefing was conducted to provide the patient with an understanding of incidents and to allow for staff processing. QI indicators utilized to track aggressive patient management demonstrated a reduction in restraint and seclusion from 392 total hours to 159 total hours in a 12-month time frame. A key concern was an increase in assaults on staff from 5 to 12 in that same time period. Considering environmental limitations and the acuity of the population, restraint and seclusion are necessary at times to protect patients and staff. However, the use can be reduced, patient care and satisfaction improved and a safe milieu maintained when alternative strategies are effectively implemented.

Poster 11

THE RELATIONSHIP BETWEEN CONTEXTUAL FACTORS AND MENTAL HEALTH HELP-SEEKING PRACTICES OF AFRICAN-AMERICAN ADOLESCENTS AND THEIR PARENTS

Halima Al-Khattab, RN, BSN, Marion E. Broome, PhD, RN, FAAN+, and Michael T. Weaver, RN PhD, FAAN+

The prevalence of mental illness among African-American adolescents, 13 to 16.7%, is similar to that of Caucasians. Up to two-thirds of African-American adolescents with significant impaired functioning, receive no treatment and are more likely than Caucasian adolescents with similar problems to end up in the juvenile justice system. African-American parents are only 37% as likely as Caucasian parents to contact a professional as their first step of help seeking. Although it is likely that many reasons account for this difference, one underlying factor reported in previous research is the attitudes and beliefs of African-American adolescents and their parents about mental health help seeking, which differ from other races. African-American parents are twice as likely as Caucasian parents to expect disapproval from family members, to be concerned about others knowing, and to be embarrassed in general about seeking professional mental health treatment for their adolescent. They are also twice as likely to expect providers to lack knowledge of treatment methods and for providers to be untrustworthy and disrespectful. Yet, few studies have focused on how mental help-seeking practices are influenced by culture and other contextual factors that often characterize the lives of African-American adolescents. This knowledge will generate a better understanding of the mental help-seeking practices of African-American adolescents and their parents, as well as assist in the development of tailored interventions designed to change help-seeking practices. The purpose of this study is to examine the influence of various factors (e.g., personality, religiosity, relationships, household, and neighborhood characteristics) that influence help seeking in this population. A secondary analysis of data from the National Longitudinal Study of Adolescent Health (Add Health-R. Udry, PI), is in progress. Add Health is a study of a nationally representative sample of approximately 90,000 students in grades 7 -12 from 154 schools around the United States. The underlying assumption of this NIH funded study is that social context influences health related behaviors of young people, and understanding that context is essential to guide efforts to modify health behaviors.

Poster 13

PSYCHIATRIC-MENTAL HEALTH NURSE PRACTITIONERS AND SCHOOL-BASED HEALTH CENTERS: A MATCH MADE IN HEAVEN

Dawn Boyd, MSN/PMHNP

School-Based Health Centers (SBHCs) are an innovative delivery model to engage adolescents, a hard to reach population who often demonstrate risk-taking behaviors that lead to future preventable health problems. SBHCs are an ideal setting in which to design services to meet the objectives for Healthy People 2020 in adolescent care and mental health, because they can tailor services to the unique needs of adolescents and address health disparities. Evaluations of SBHCs show improved access and utilization when compared with other settings that serve adolescents. For example, the presence of a SBHC in a high school is associated with increased utilization of services such as family planning, screening and counseling for sexually transmitted infections, mental health and substance abuse services (National Assembly on School Based Health Care, 2008).

SBHCs also offer unique opportunities for interdisciplinary mental health care. Since employees of SBHCs often have access to the school, it is easier to observe students in the context of the school, obtain data from teachers, reduce stigma about mental health, and collaborate with the school to provide school-wide preventive programs. Psychiatric-Mental Health Nurse Practitioners (PMHNPs) are trained to provide primary, secondary and tertiary psychiatric and mental health care in a variety of settings. Because mental health is integrated into the primary care setting at SBHCs, high-risk adolescents can not only be identified but also treated early. Treatment may include individual or group psychotherapy and/or pharmacotherapy. PMHNPs in SBHCs provide access to various modalities of mental health interventions, thus improving quality and continuity of care. This presentation will explore a variety of approaches to School-Based Mental Health and models in which PMHNPs can effectively practice and expand their role.

Poster 14

STRENGTHENING THE CARE GIVER - MENTORING PROGRAM FOR PARENTS AND CAREGIVERS OF CHILD AND ADOLESCENTS IN INPATIENT AND RESIDENTIAL SETTINGS

Yvetta M. Collins

Parents helplessly watch their child suffer in a reality, which sets them apart from other children. Parents, who are unable to find solace or make sense of what is happening in their lives, detach themselves from the outside world. Feeling alone, without an avenue to grieve the child that was and make sense of the world where the child is, they question themselves, their ability to be parents, dissolving into the tides of despair as they see no hope for their child. Living the feeling of inadequacies, appointments, diagnosis, doctors, medicines, and explosive crisis, hands reach out to lift them into a place where help exists, where they're able to see beyond and to learn how to care for their child. These hands are those parents who are traveling the same road of dual realities but who have learned how to ride those waves of uncertainty, despair and darkness on the surfboard of hope and strength. These parents use their experiences wrapped in the folds of compassion to help other parents to be able to endure the journey. From parent to parent is an invisible thread of strength where experiences are told, tips are revealed, skills are offered, tears are shed, emotions are vented and help is given. This parent-to-parent program provides the bridge between socially accepted norms and the reality of voices, anger, depression, darkness and stigma. They are experienced, seasoned and keepers of the storm.

Poster 16

EVALUATION OF THE REVISED EUROPEAN QUALITY OF LIFE SCALE (EQ-5D)

Susan McCrone, PhD, PMHCNS, BC, and Yea-Jyh Chen, PhD+

Introduction: The European Quality of Life Scale (EQ-5D) is a simple, valid, multidimensional outcome measure of health related quality of life used worldwide. Its reading level (11th grade) is a concern and limits its use. The purpose of this pilot was to assess the feasibility and validity/reliability of the revised EQ-5D for patients with low literacy.

Methods: The revised EQ-5D (index and visual analog scale [VAS]) was compared to the original version. The EQ-5D was modified by a literacy expert from an 11th grade reading level to a 4th grade level. Expert validity was established by an expert panel. A convenience sample of 41 patients from a university clinic was enrolled. Most participants were White (100%), female (54%), adult (mean age 53.1 \pm 16.9 years), with an average of 12.6 years of education (70.7% \leq 12.5 years), with 2.3 chronic conditions. Proportions of item agreement (%) of same responses in each of five dimensions (mobility, self-care, usual activity, pain, anxiety/depression) and VAS score (worst to best health status) were calculated. Similarities in responses to individual items (mean differences) were evaluated by subgroups using univariate analyses. Content validity (correlation r) and internal consistency (Cronbach's alpha) for the revised EQ-5D were determined.

Results: Agreements on item response were high (97.6%-82.9%) and 78% for EQ-VAS scores. Mean scores were very similar with no significant differences (EQ-5D: 0.72 \pm 0.2 vs. 0.74 \pm 0.2; median: 0.80, $p=0.30$; EQ-VAS: 70.6 vs. 71.4, median: 70.0, $p=0.15$) The majority of respondents had no problems with walking (58.5% vs. 61%), self-care (90.2% vs. 95%), or performing usual activities (61% vs. 63.4%), except having pain/discomfort (68.3% vs. 70.7%) and anxiety/depression (46.3% vs. 48.8%). Content validity was supported by strong correlations between each original and revised item ($r=0.81-0.95$, $p<0.001$). The internal consistency for the revised EQ-5D was 0.75. Mean scores for measuring quality of life were not significantly different by age, gender, education or number of chronic conditions.

Conclusions: The revised EQ-5D with a lower literacy level demonstrated similar results to the original version in evaluating health related quality of life. Further testing using larger and more diverse samples is warranted.

Poster 17

SPIRITUALITY IN NURSING PRACTICE WITH THOSE WHO EXPERIENCE SERIOUS AND PERSISTENT MENTAL ILLNESS

Linda O'Dell, BSN, MSN, DNP(c), and Carol Sharpe, BSN+

It is easy to recognize that holistic nursing care includes both physical and mental components. In the practice of holistic nursing care it is important to recognize the aspect of spirituality. Spirituality is not same thing as religiosity, although in some situations they may overlap. Those who experience serious and persistent mental illness often have poor, ineffectual coping skills. It is a challenge for them to meet their needs, including spiritual needs. Nurses who work with those who experience serious and persistent mental illness may be hesitant to discuss spiritual needs of their clients because of personal discomfort with the subject, concern about crossing an invisible line between personal and professional roles, and lack of knowledge about spirituality in general. There are a variety of methods that nurses can utilize to apply the principles of holistic nursing care (including spirituality) when working in the area of psychiatric mental health nursing.

Poster 20

SUICIDE PREVENTION POST-INPATIENT DISCHARGE

Grace Serafini, RN, MSN, APRN-BC

Suicide prevention, a TJC National Patient Safety Goal since 2006, was developed in an effort to make suicide a "never event" in the hospital setting or shortly after discharge. A suicide risk assessment and subsequent plan of care has been put into place to address suicide prevention in our institution. A standard screening for suicide risk, SAD PERSONAS, is conducted on all behavioral health patients at emergency department (ED) triage within 5 minutes of arrival. If the risk assessment is high the patient's acuity level is elevated and the patient is moved to a safe ED location. The SAD PERSONAS risk assessment is then 'migrated' to the inpatient medical record and a thorough suicide risk assessment is performed.

Within the SAD PERSONAS screening tool there is an element evaluating access to means to kill oneself. Trained staff identify valid access to means to kill oneself, and obtain patient consent and family agreement to remove the means to kill oneself from the home. If the patient refuses, a protocol is followed that helps maintain the patient's safety.

In addition to SAD PERSONAS screening, a root cause analysis on near misses and completed suicides reveals the following inpatient behaviors are useful to consider in identifying patients at risk for future suicide attempts immediately after discharge: serious suicide attempt precipitating admission with verbalized regret of attempt being unsuccessful, subsequent denial of this statement, male gender, patient disengaged in the milieu and therapeutic program, and ambivalence about discharge. When these behaviors as well as other risk factors identified through literature review (e.g., chronic & acute stressors, family history of successful suicide, financial crisis, history of impulsivity and plans kept secret) are present, a vigorous interventional approach is taken toward identifying subsequent risk for suicide, and the family is actively incorporated into the treatment in addressing subsequent risk.

Incorporating this plan into practice has led to a significant decrease in suicide after discharge. The suicide intervention has also engaged the staff in identifying patients at risk and challenged staff in managing this high-risk behavior.

Poster 21

INTRODUCING PRECEPTOR TRAINING IN AN RN-BS PROGRAM

Candy Dato, PhD, RN, CNE, Patricia Maher-Brisen, MS, RN+, and Margaret Rafferty, DNP, RN, MPH, PMHCNS-BC

As part of a grant-funded expansion of an RN-BS program, qualified preceptors were needed to meet the needs of major program growth. Preceptors are expected to perform their important role based on their education and experience as master clinicians but few have had formal evidence based preceptor/clinical coaching training. More recently, the importance of this training has been linked to positive outcomes such as increased retention. Our students report that teamwork and collaboration in large urban hospitals are at an all time low and that not much has changed since Kramer's legendary book, *Reality Shock*. Many of our students were introduced to the profession in the "eat-our-young cycle of violence" that has so traumatized neophyte nurses for generations. We found that although our students were inexperienced nurses, many were already veteran preceptors without the benefit of any formal training and/or support. We integrated the training into the curriculum to prepare students for this expected nursing role. Students reported that the preceptor/clinical coaching training was also an invaluable resource that helped them cope with workplace environments that are often inhospitable and stressful. In this presentation we will discuss the response of both preceptors and students to the Vermont Nurses in Partnership (VNIP) training program, which is an evidence-based clinical coaching model. We will also present implications for practice and education.

Poster 22

LEGAL AND ETHICAL IMPLICATIONS FOR ER NURSES: VOLUNTARY VS. INVOLUNTARY STATUS IN MENTAL HEALTH PATIENTS

Elizabeth Hiebert, RN (Canada), and Shannon Raitt, RN

In this oral presentation, we put forward a proposal for an educational program designed to enhance the knowledge base of emergency room (ER) nurses. The educational program focuses on the ethical and legal implications of allocating a voluntary vs. involuntary status to adults with mental health disorders (MHD) presenting in ERs. Background to this proposal is based upon our experiences as mental health nurses working both in a rural mental health facility and an urban ER. Many ER nurses identified that they were uncomfortable caring for patients with MHD. They lacked knowledge about the Mental Health Act and the ethical implications related to patient autonomy and patient safety in instances where the voluntary versus involuntary status of patients with MHD was questioned or implicated. The Mental Health Act (2005) was established as a means to establish safety for patients suffering from MHD. We want to construct a link in the minds of nurses, between nursing ethics and the use of Mental Health Act forms to institute involuntary status. We designed a highly interactive one-hour "Lunch & Learn" to assess ER nurses' knowledge base, teach key elements about the Mental Health Act and evaluate the effectiveness of the workshop. The assessment, educational, and evaluative tools will be described. This educational program can be adapted to any health care setting by mental health nurses as ethics, patient autonomy, and their safety are important components in the care of all patients experiencing MHD.

Poster 23

THE BENEFIT OF THERAPY DOGS WITH COMMUNITY MENTAL HEALTH CLIENTS

Elizabeth Ann Martin, MA, ARNP-BC

Elaine Smith was an American who worked as a registered nurse in England and is credited with the establishment of utilizing a systematic approach for the use of therapy dogs. In 1976 she started a program for training dogs to visit institutions. The demand for therapy dogs continues to grow as health care professionals have noticed the therapeutic effects of animal companionship. Therapy dogs have been shown to help decrease blood pressure, help rehab patients work harder at their exercises, raise spirits of the elderly, and help children overcome emotional problems. Therapy dogs also provide a sense of comfort, confidence, and companionship. A therapy dog is trained to provide affection and comfort and the primary job is to allow unfamiliar people to make physical contact. Children enjoy hugging while most adults enjoy petting the dog. Studies have shown that children found the non-judgmental ears of a therapy dog the perfect choice for talking about their problems, improving social skills, and improving reading skills. Therapy dogs make a difference. The therapy team consists of a certified therapy animal and a trained handler. Therapy dogs have to complete a training program and pass a skills test before they can become certified therapy dogs. Therapy dogs have been found to have a calming effect on doctors, nurses and other staff members working in high-stress environments.

Poster 25*

MOTHERING AND ILLICIT SUBSTANCE USE: A CRITICAL ANALYSIS OF THE IMPLICATIONS FOR NURSING AND HEALTH POLICY

Michelle Foulkes, RN, MSc, PhD(c)

The predominant construction of motherhood within the western world has generated a powerful binary representation of women as either “good” or “bad” mothers (Reid, Greaves, & Poole, 2008). There is no other collective of women who are more stigmatized than mothers who use substances during pregnancy (CAMH, 2007). This is because of the profound tension between the socially constructed image of the “good” mother and the actual mothering behaviour exemplified by this group of women through their substance use. The purpose of this work is to critically examine the socially constructed ideologies of mothering that have resulted in these paradoxical images to emerge while exploring the implications that these presuppositions may have for nursing and health policy development.

The current use of a punitive approach in the form of legal consequences, child protection involvement and stigmatization for deviant behaviour in the management of illicit drug use during pregnancy reduces the blame of the behaviour to the individual so that ownership of one’s moral failing falls securely on the “bad” mother alone (Weir, 2006). Such a reductionist stance denies the everyday reality of many drug-using pregnant women who are mostly poor, uneducated, minorities, and victims of profound violence and trauma (Greaves & Poole, 2007). It also ignores the social and distributive justice arrangements in our society that result in a political economy where healthcare, food, work opportunities and correctional measures are unequally distributed based on gender, sexual orientation, class and race (Sullivan & Tiff, 2008). Social and health policy as well as nursing practice can have a healing and restorative agenda rather than a punitive one that aims to correct socially constructed deviant behaviours.

Poster 26*

**INTEGRATING PHYSICAL AND MENTAL HEALTH ACROSS THE LIFESPAN
IN A NURSE MANAGED HEALTH CENTER: A PRACTIAL APPROACH AND
LESSONS LEARNED**

Keira Stevens, FNP-BC

In recent years there has been an increased interest in the integration of physical and mental health in one practice setting. Evidence has shown that many people will present to their primary care provider with a mental health complaint. Often these patients are not aware their symptoms may be related to a mental health disorder, they are uncomfortable with seeking help in a mental health setting, or they are afraid of the stigma of a mental health diagnosis. Thus the primary care provider is asked to treat complex psychological conditions or refer patients to an already encumbered mental health system with often long waits for care. On the flipside, mental health providers are evaluating patients for medical conditions and discovering untreated medical conditions that can affect mental health care. These patients are referred to primary care for follow-up and medical management. This poster will examine how integration of physical and mental health in a primary care setting at a nurse managed community health clinic on a major urban university campus was implemented. Day to day practicalities of operating a practice will be examined through the presentation of various real life patient examples. Lessons learned will be presented for the feasibility and practicality of integrating physical and mental healthcare in one setting.

Poster 27*

NARRATIVES OF CHILDHOOD BY MALE AND FEMALE PERPETRATORS OF CHILD SEXUAL ABUSE

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Knowledge about the childhood experiences of sex offenders is scant. It is believed that most offenders were themselves abused as children, but research shows that some were not (Craissati et al., 2002). Another common belief is that offenders against children are all pedophiles, but half are not (Seto, 1998). Furthermore, neither theory nor research provides sufficient guidance for effective treatment of offenders. The purpose of this study is to collect narratives of childhood from adults who have been convicted of sexually abusing a child. Participants are recruited directly from the offender registry of a southeastern state. They are not currently incarcerated or facing new criminal charges. The research methodology is a blend of phenomenology and narrative inquiry (Merleau-Ponty, 1962; Riessman, 2008). Private, in-depth, face-to-face audiotaped interviews are conducted according to the procedure specified by Thomas and Pollio (2002). To enhance rigor of the study, all research team members have participated in bracketing interviews and keep reflective journals. Interview transcripts are read aloud and thematized in an interdisciplinary interpretive group. Preliminary findings suggest considerable heterogeneity among childhood experiences; no one pattern or trajectory is evident. It is hoped that this project will provide some directions for future research, clinical interventions, and/or societal actions to prevent the crime of child sexual abuse.

Poster 28*

THE EFFECTS OF AN ANGER MANAGEMENT PROGRAM USING A COGNITIVE BEHAVIOR FRAMEWORK IN A VETERAN POPULATION

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Purpose: The purpose of this study is to assess the effectiveness of an anger management group on coping skills of participants using a cognitive behavioral framework.

Conclusions: Anger is an emotional state, defined by antagonism and physiologically negative behavior that may lead to aggression or hostility. Anger is a common manifest of military related trauma and is especially true among veterans diagnosed with Posttraumatic Stress Disorder (PTSD) and depression. PTSD rates are estimated to be 15-20 percent within the current returning veterans. Patients with PTSD and depression utilize frequent health care services, including mental health specialty services and outpatient appointments increasing the cost of mental health care and staff work load. A comparison of group therapy and individual therapy for substance use disorders revealed no sufficient difference in outcomes between the two.

Practice Implications: Advanced practice nurses are likely to use both individual and group therapy in practice. The significance was in the time difference between group and individual therapy. It took 41 percent less therapist time for the group. Improving coping skills of patients utilizing a six-week anger management group decreases the need for individual therapy. Group therapy improves patient care, decreases the cost for the institution, wait time for patient services, and improves the practitioner's availability for patient care.

Poster 29*

MEXICAN TRADITIONAL MEDICINE: A REVIEW OF MENTAL HEALTH HERBALS

Tanya R. Sorrell, NP-C, MSN, MS, RN

This poster summarizes findings of a systematic literature review of the research-based information available on Mexican herbal remedies deemed useful for mental health healing in Mexican-Americans. Scientific evidence for each herbal remedy is presented, along with warnings, cautions and possible interactions with other herbals or medications. Mexican herbal remedies are mainstream treatments in Mexican Traditional Medicine (MTM), an indigenous healing system that traces its roots to pre-Colombian Aztec, Mayan, and Incan healing traditions. The majority recent Mexican-Americans immigrants are primarily rural/border residents with traditional values and beliefs about health and illness, and traditional use of herbal/folk medicine (Escobar & Nervi, 2007).

While research shows that knowledge and use of culturally based care systems enhance minority utilization of health care services (Cabassa, 2008; Wintrob, 2009), United States mental health services remain dismissive of culturally meaningful treatments (Delgado, 2006). Consequently, Mexican-Americans reluctance to seek mental health services leads to disparities (Vega, 2009). When Mexican-Americans do seek treatment for mental health ailments, they prefer to initiate herbal remedies making Mexican herbal knowledge necessary for mental health practitioners (Zavaleta, 2009). In general, MTM herbal remedies are important in Mexican-American health care with over 90% of families aware of MTM services, and over 55-75% of families using these practices in the United States (Amerson, 2008; Padilla, 2001).

Using this information, mental health providers will not only be aware of potential MTM herbals their customers may use, but can also have a knowledge base from which to provide sound culturally based mental health care provision.