



Canadian Federation of Mental Health Nurses

This special issue is a tribute to the victims, families, and all those impacted by the tragedies that took place on September 11th, 2001

Newsletter Fall 2001
Edition Number 33

Flag-raising was 'shot in the arm'

Friday, September 14, 2001

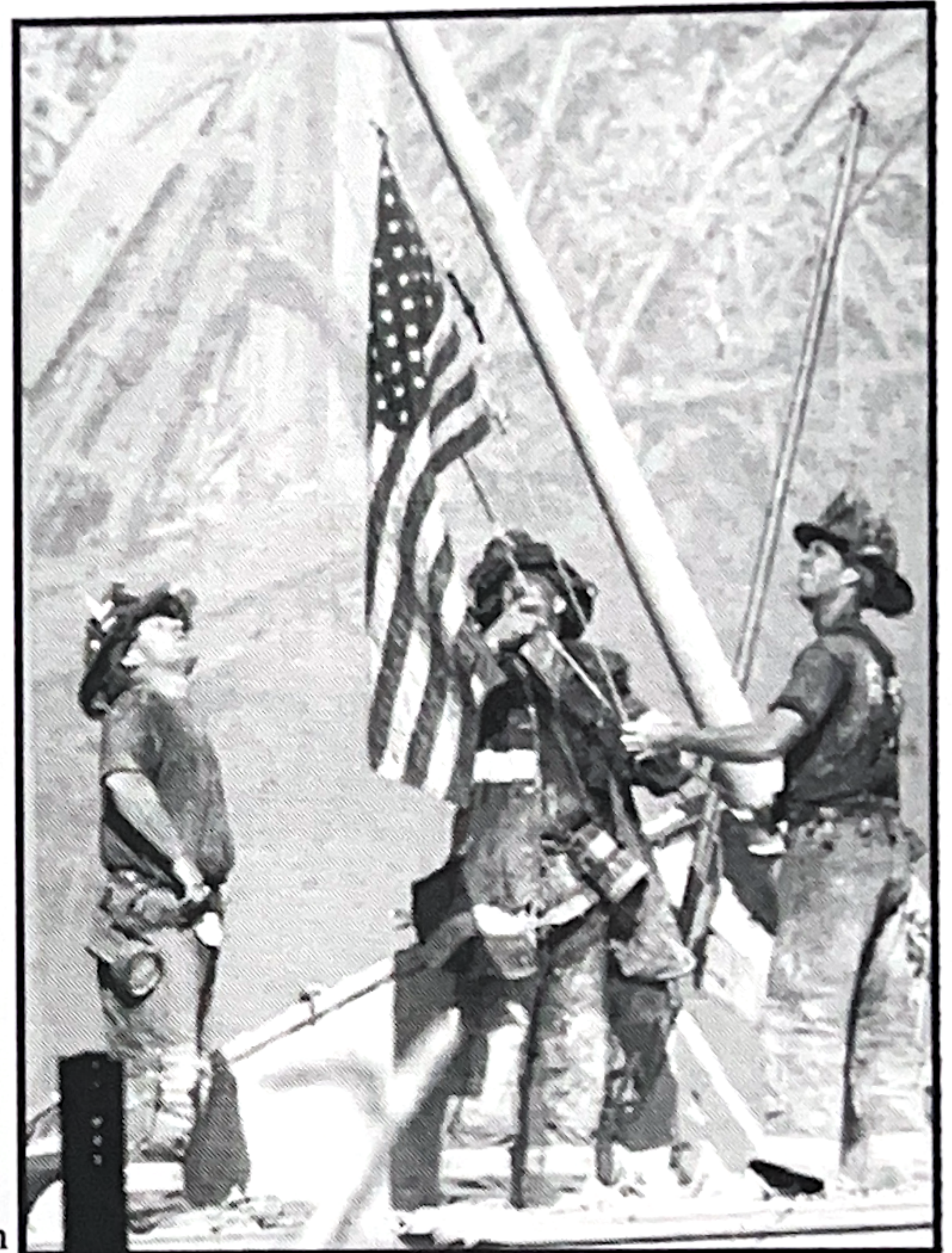
By JEANNINE CLEGG, Staff Writer, N.J. News

World Trade Center Building Seven was about to collapse on Tuesday. Firefighters from Engine 255 and Ladder 157 in Brooklyn had been digging in the rubble for survivors for six grueling hours, when they got the call to immediately evacuate.

Firefighter Dan McWilliams from Ladder 157 headed out with the rest of his crew. It was then that the 35-year-old firefighter spotted a flag flying from a yacht docked behind the World Financial Center. He made his way to the boat, rolled the flag up around its pole to be sure it didn't touch the ground, and carried the pole back to the evacuation area.

As McWilliams passed his buddy and fellow 157 firefighter George Johnson, he slapped him on the shoulder. "Gimme a hand, will ya, George?" "I knew exactly what he was doing," Johnson, 36, said. Then Billy Eisengrein of Rescue 2, another Brooklyn fire company, and McWilliams' childhood friend from Staten Island, jumped in, "You need a hand?"

The three firefighters quickly found a perfect spot -- a single flagpole anchored in the rubble about 20 feet off the ground on West Street. They climbed a makeshift ramp so they could easily raise the flag in its new home. It was at that moment that Record photographer Thomas E. Franklin spotted the three from a distance.



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Photo Credit: Thomas E. Franklin, Staff Photographer

Only two days had passed since that moment. The World Trade Center death and chaos were still fresh in the minds of McWilliams and Johnson as they sat in the noisy kitchen in the Flatbush firehouse recalling how the three firefighter friends -- Johnson from Rockaway Beach, McWilliams from Long Island, and Eisengrein from Staten Island -- acted as one.

"A big part of this is maintaining the unity of the whole team," McWilliams said. His eyes filled with tears as he remembered the hellish day New York's firefighters experienced right after the Twin Towers' collapse, and their lack of progress in finding survivors. "Everybody just needed a shot in the arm," he said, pausing to regain his composure.

The photo was the shot seen round the world. It has run on many American newspaper front pages, including the New York Post, the Baltimore Sun, and Providence Journal, and has been shown on network television. McWilliams and Johnson said they didn't raise the flag to solicit personal attention. They didn't expect to get any phone calls or comments from friends and family. They were unaware they were being photographed. It was a spur-of-the-moment decision that started with McWilliams. Though few firefighters remained in the evacuation area at that moment, Johnson said he recalls hearing comments after the flag went up. "A few guys yelled out 'good job' and 'way to go.' "

And although he hadn't given the hoisting much thought, McWilliams remembered, "Every pair of eyes that saw that flag got a little brighter."

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A very special thank you to Sharon MacLeod for her contribution as Nova Scotia rep and Treasurer, Judy Buchanan as Past President, Carol Ewashen as Alberta rep, Linda Humphreys as Manitoba rep, Karen Finestone as Quebec rep, Ann Greene as Newsletter Editor, and Nancy Johnston as President.
Welcome to Catherine Lucas, Manitoba, Geertje Boschma, Alberta, and Gloria McInnis, Prince Edward Island.

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President's Message

Nancy Johnston & Ann Greene

Turn, Turn, Turn

To everything there is a season, and a time to every purpose under heaven:

A time to be born; and a time to die

A time to plant, and a time to pluck up that which is planted

A time to kill, and a time to heal

A time to break down, and a time to build up;

A time to weep, and a time to laugh

A time to mourn, and a time to dance

A time to cast away stones, and

A time to gather stones together

A time to embrace and a time to refrain from embracing

A time to get and a time to lose

A time to keep, and a time to cast away

A time to rend and a time to sew

A time to keep silence and a time to speak

A time to love and a time to hate

A time of war and a time of peace

Ecclesiastes 3: 1-8

Some of you my colleagues of "vintage" will recognize these words and you will remember also them as they were set to music by The Byrds back in the 1960's as the US went to war with Vietnam. The Vietnam war raised deep questions back then just as the Terrorist Attacks on September 11th raise profound questions for all of us now. I wonder at how war, change, and poetry which has endured for thousands of years converged in my mind at this time? Could it be that we go back to that which endures when we are most threatened? Has this poetry been handed down through millenia because it unfolds a universal truth - that change is inevitable, cyclical and paradoxical?

This issue of the Newsletter is dedicated to thinking about our history, our accomplishments, our concerns, our practices and our future in the light of September 11th - an event that has jolted us and caused us to think deeply about all we may have taken for granted.

Do you agree that despite all of our plans and calculations, change comes upon us inevitably? Has it been your experience that in some cases change accosts us 'out of the blue' and is completely unforeseen? Has it also been your experience that upon deeper reflection we have sometimes understood that the seeds of so called "spontaneous" change actually could have been detected if we had been attentive enough?

Some authors including Freidman, Tofler & Tofler, and Hancock, for example have been warning about the inevitable consequences of technology and globalization for some time. These trends they argue, can (if not harnessed for the benefit of human-kind) widen the gap between rich and poor nations by putting more and more in the pockets of fewer and fewer people. It is this gap they posit, that in the long run, threatens the very survival of the planet.

What do reflections on change, the events of September 11th and the determinants of planetary health have to do with nursing? Kleffel (1991) suggests that the time has come to think and care more broadly. She asserts in the strongest of terms that nursing as a profession must look beyond downstream solutions and even expanded paradigms like "community health" to consider its role in helping to modify the economic, political and environmental factors that have been shown to be the precursors of poor health throughout the world. According to this view Society is the locus of change. She says:

Today the world is confronted with a global ecologic crisis that has placed humans' fulfillment and even survival in jeopardy. It now seems clear that nursing will have to move ahead as an integral part of the global ecologic and environmental movement or get left behind.

Taking up Kleffel's challenge we are challenged as psychiatric and mental health nurses to wonder "How can there be mental health where there is no gender equality, no peace, no clean water, rampant disease, meaninglessness and no hope for a better future?" As nurses, and as North American citizens, are we willing to have less, and to take less for ourselves? Are we willing

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professionally to look more beyond our provincial and national borders to lend support in tangible ways to worthwhile grass-roots and international causes? Are we willing to put our individual goals into perspective so that we can build sense of belonging and community in the places where we live and work?

Alternatively, will we see our best interests served by putting up higher fences, barricading ourselves behind locked doors and hoarding more for ourselves? Are recent events a "wake up call" to reassess our priorities, to choose more wisely, to live differently?

As I consider the cyclical, seasonal and paradoxical nature of change, I am reminded that saying that "the more things change the more they remain the same" and my thoughts move closer to home and to what I see happening in the health care system and in nursing particularly.

By now all of us will have been "treated" to the rhetoric on "transformational leadership". We will have been told that we don't really need Nurse Managers, we need "transformational leaders" who can inspire us. But what, we ask has this really meant? Has it been a cover to downsize management to the point where staff-nurses are so "empowered" that they can now do everything for themselves without support? Has Shared-Governance really given stronger "voice" to staff nurses? Leaving the rhetoric aside, we can observe the cycles of thought and response by asking whether nurses trust organizations to support them appropriately. If nurses do trust their organizations, recruitment and retention issues will be solved. To the extent organizations fail to address these problems and destroy the sense of participation and community in work-life, they will be forced by chronic shortages to address these issues. One way or the other, meaningful work, trust-worthy management, visionary leadership and the willingness to commit to causes greater than oneself are all inextricably linked (Secretan, 1999). Fashions and seasons change, truths remain.

Finally, my thoughts on change turn to my experience as your President as I to hand over responsibility to Ann Greene your incoming President; (Ann's installation is yet to be formalized in the spring at our upcoming Annual General Meeting but she has kindly agreed to assume responsibility as Acting President in the interim).

"To everything there is a season and a purpose..." My season as President has drawn to a close and I wonder what purposes have been addressed? There are so many significant experiences but among the most important to me personally are the friendships I have made. Some friendships, because they have been forged in the oven of adversity, will last a lifetime. In addition, I have never been associated with a Board who have worked harder and accomplished more. Your commitment has been a source of encouragement and inspiration. I have learned so much and appreciate more deeply than would ever have been possible, outside of this role, just how creative and dedicated and resilient psychiatric nurses in Canada really are...Thank you all.

A few additional highlights - the Saskatoon Millennial Conference last year was a time of learning, connecting and celebrating; the shared-membership with RNAO/MHNIG was a time of vision building and practical action, the Mount Royale Institute was a time of appreciating the institution building efforts of our colleagues in Calgary and the small gathering on Best Practices in Vancouver was a time of exploring and wondering about future possibilities.

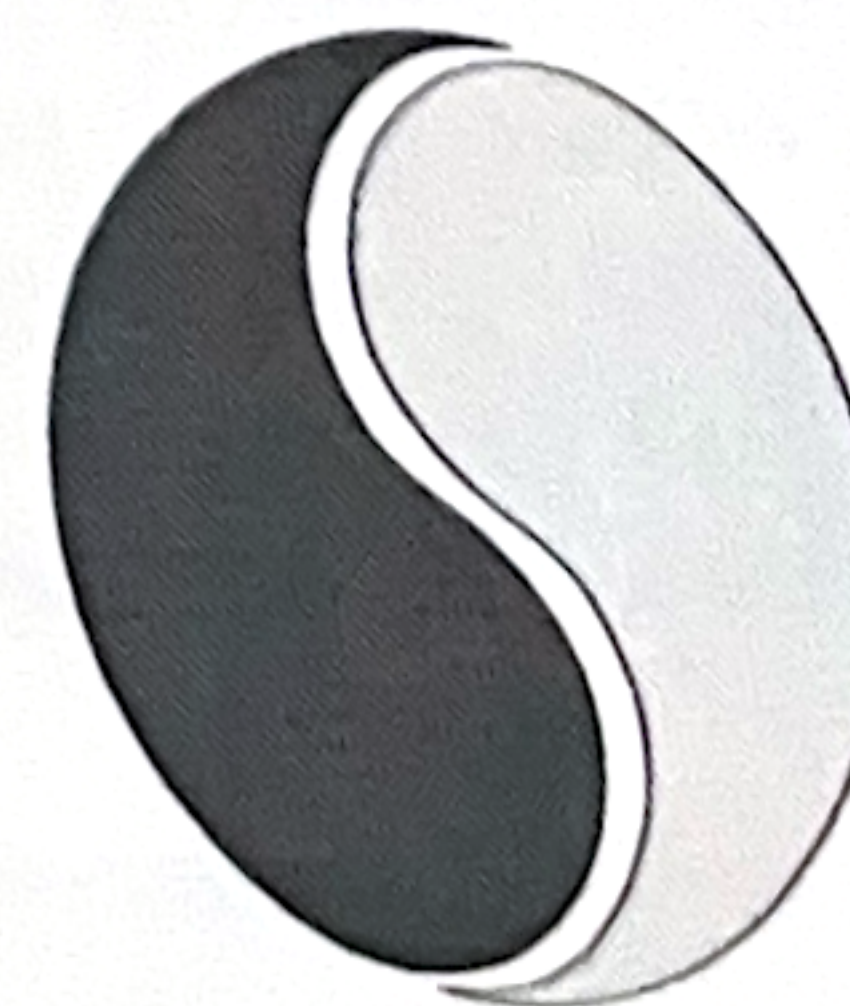
As I look toward the future and Ann Greene's time as President and the myriad talents and potential contributions of continuing and new Board Members, I feel certain that the next few years will be a time of clarity, consolidation and building better infrastructure to grow a strong national voice for Psychiatric and Mental Health Nursing in Canada. These are important goals and the Board has the talent and commitment to actualize them but I would like to encourage you as members to actively support the Board through volunteering to serve on committees. Thanks again for the privilege of serving you.

Yours sincerely

Nancy Johnston

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Baby Steps of cha

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Baby Steps of change

On an unusually balmy weekend in mid October, a group of seven (and then eight) psychiatric mental health nurses came together to plan the work of the Federation for the next two years. This was the Board of Directors first full planning retreat since 1995, and two days was dedicated to the process. I want to thank Sharon MacLeod, Susan Ray, Cathy Lucas, Alice Chan, Sean Hopkins, Judy Buchanan, and Nancy Johnston, for the incredible contribution and success of the retreat.

Through the provincial representatives we identified areas of expertise and key provincial issues that either support or are recognized in the objectives of the CFMHN. In keeping with previous reports of planning sessions, I will centre this report on those main objectives of the CFMHN:

1. To provide leadership in the development and application of standards of practice in psychiatric and mental health nursing:
 - To meet this objective we have identified an education portfolio that Alice Chan will lead. Once the committee is identified they will commence to address the following:
 - i. Review and revision of the Canadian Standards of Psychiatric and Mental Health Nursing Practice (2nd ed.) in preparation for reprinting in 2003.
 - ii. Identify the application of the standards across the country
 - iii. Review the use of standards as the basis of the certification exam
 - iv. Continue with the process of implementing the position paper on education
2. To examine and influence government policy and to respond to national and international issues related to psychiatric and mental health care:
 - This objective will be met through the continuation of the Policy and Development committee chaired by Ann Greene. This committee will also be responsible for media watch to ensure that the CFMHN is responsive to related national and international issues.
3. To liaise and collaborate with national and international groups with related interests in psychiatric and mental health care:
 - This objective is met largely through the International Affairs committee and we have approached Gloria McInnis to chair this committee.
 - The CFMHN has renewed its membership with the World Federation for Mental Health.
4. To facilitate excellence in psychiatric and mental health nursing through the provision of educational and networking resources.
 - This objective is likely the most comprehensive and the one on which the Federation focuses most of its resources.
 - i. Susan Ray will review the status of awards and reinvestigate a collaborative relationship with consumer groups.
 - ii. Nancy Johnston will lead conference planning. Toronto will host the Regional Conference in Spring 2002 and the International in 2003. Manitoba will host the International in 2005.
 - iii. The website will be developed under the leadership of Susan Ray.
 - iv. Judy Buchanan, with support from Gwen Van Schaik, will edit the newsletter.
 - v. The brochure will be updated immediately and reprinted following the AGM in spring 2002.

The provincial representatives role, along with the role and function of various committees were clearly identified and developed during the retreat, empowering representatives and committee chairs to a more active and accountable position to the membership and the Board of Directors.

These are the baby steps of change, that have been in place and now are clarified and revised to meet the current and future needs of psychiatric mental health nurses in Canada. To quote Anthony Robbins, "things don't get better by chance-they get better by change", and that is what we have accomplished in this last planning session. We have put a plan in place to move the activities of the Federation forward and created and revised avenues for the membership to meet the objectives of the Federation.

You will be hearing more on this notion of change as we move through the next two years and I look forward to working and collaborating with members of the CFMHN on this journey. I am saving a very special thanks to Nancy Johnston to the end. Nancy has mentored me over the past two years in preparation for the role of president. Nancy's vision of nursing in the global arena of healthcare, her astute understanding of systems and marketing, her knowledge of evidence based practice and her personal magnetism has been a benefit and an inspiration both personally and to the CFMHN. Under Nancy's guidance the Federation has increased its membership threefold, held two international conferences and expanded its bank account significantly.

Thanks Nancy....and all the best!

Ann Greene

Acting President

British Columbia

Alice Chan

The health care mood in this province is grim. The Liberal government, who was voted in by a landslide victory in May of this year, has no official Opposition party in the Legislature in Victoria (there are 2 members of the New Democratic Party sitting in the Legislature). The Liberal government is very much oriented toward private sector and running this province like a business.

There is an anticipated series of funding cuts to health care, social services, and education. The figures speculated range anywhere from 20% to 50% from health care, social services, and education budgets, specifically to be reduced.

There is already much public discussion regarding Pharmacare. That seniors may have to bear the costs of a large number of their medication expenses, rather than be given their current government subsidies; that expensive psychoactive medications used to treat chronic mental illnesses such as Schizophrenia and Mood Disorders, may come under more scrutiny as people who cannot afford to pay for them are impacted by the reductions in social services.

The Ministry of Health has just hired this province's first Chief Nurse Executive whose primary mandate will be to address recruitment, retention, and education issues specific to the nursing profession. The Ministry of Health is also in the process of restructuring the entire profile of health regions in this province. The existing Community Health Councils and Community Health Service Societies will cease to be. They will be replaced by more Regional Health Boards with enormous geographic jurisdictions.

The threat by the Registered Nurses in this province to resign en masse if their labour negotiations with the Liberal government did not go in their favour during their 3 month long job action in the Spring and Summer of this year did not materialize. Just as well, as BC remains in dire shortage of nurses. Other health care professionals are in just as much demand. The wait lists for tests, elective procedures, cancer treatments, etc. remain high.

The psychiatric mental health landscape is but a reflection of what is currently going on in British Columbia.

Alberta

Carol Ewashen

The Alberta Mental Health scene is rapidly changing and with the influx of additional monies, a number of new initiatives are proceeding. More recently, there has been a renewed effort to contain costs however generally the mood remains upbeat with excitement generated through increased job availability and the emergence of some exciting new job possibilities for nurses.

Just this past week, along with the civic elections, members for the Regional Health Boards were elected in each of the Alberta health regions. This is the first time that regional health boards consist of elected members as well as appointed members. One third of the seats on the boards remain appointed. For example, in the Calgary region, a 15-member board (10 of whom are newly elected) will oversee a \$1.2 billion dollar budget - at a time when the region has a \$38 million dollar deficit. Constant challenges that remain include increasing access to the system and reducing waiting lists. The contracting out of medical procedures to private operators and the resulting controversies around privatization have already surfaced for discussion.

According to Beth Evans, Director of Corporate Planning for the Alberta Mental Health Board, there is a new culture emerging in the organization. The AMHB continues to focus on the coordination and delivery of provincial programs of psychiatric and mental health care while attempting to meet the diverse needs of particular communities. Evidence based models of practice and of community service are being developed with identification of measurements of effectiveness. I refer you to the Research section of this newsletter for one example of a current research project being conducted in Alberta: the Continuity of Mental Health Services (COMHS) Study of Alberta. This three-phase study includes both subjective and objective measurements as a way of designing an instrument to measure continuity of care.

Another shift in mental health service involves concerted efforts toward protection, promotion and prevention in partnership with other stakeholders. Additionally, public awareness campaigns will be continuing. The Alberta Mental Health website includes some very valuable resources for public education and awareness. As part of Mental Health Week (October 7-13, 2001) a number of brochures providing information on mental health and mental illness are included for downloading if desired.

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Ontario

Susan Ray

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With the disbanding of the Alberta Mental Health Nurses Interest Group, there seems a gap in ways and means for Alberta Psychiatric/Mental Health Nurses to network and to be responsive to the variety of issues facing practice and service delivery. I will be contacting each of you over the next few months to generate ideas on how best to proceed. I will be especially interested in assessing if there is interest in more formal organizing for ongoing discussion. If any of the membership wish to contact me to provide feedback regarding this issue, please feel free to do so.

Ontario

Susan Ray

Health care in Ontario continues to be in and on going state of change with hospital amalgamations; divestment of the provincial psychiatric hospitals to the private sector; recruitment and retention issues and the impending nursing shortage.

The recent resignation of Progressive Conservative Premier, Mike Harris, may offer a ray of hope. His Common Sense Revolution resulted in an era of downsizing, lay-offs, cutbacks, hospital closures and privatization. It remains to be seen how the closure of some of the provincial psychiatric hospitals and the reduction in beds to community based services will effect the mentally ill, in the future.

Ontario, like the rest of the country, is dealing with the major issue of the nursing shortage in all specialty areas. Universities and Colleges have been working with their local hospitals to develop strategies for recruitment into the profession and the retention of nursing personnel.

On a positive note, the collaborative B.Sc.N. Program between Universities and Colleges across the province was implemented in September. The first B.Sc.N. collaborative program students will graduate in 2005.

ADVERTISING RATES FOR CFMHN NEWSLETTER

The advertising rates for the Newsletter are as follows (Cdn. funds):

Full page \$250 Half page \$150
Quarter page \$100

These charges are on a cost recovery basis only so that we don't incur tax implications.

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Membership Notice

Canadian Federation of Mental Health Nurses

Please check your mailing label. The month specified after your name denotes when your renewal month is.

If there is no month listed, you are overdue.

Thank you for your assistance. If you have any further questions about membership do not hesitate to contact me.

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Editorial

Ann Greene

Preparing for this edition has been a roller coaster of emotion that is reflective of the one the world has been on since September 11th. As you have witnessed, the newsletter has taken off in new directions over the last several issues. There are nurses featured from the perspective of leadership in the Canadian Nurse Leaders piece, and, innovation in the very new "Dare to tell" interview. The feedback on these additions has been great. It would seem that our readers want to know more about who one another is, what we do and what keeps us doing it. Other areas that are continually being developed are the Research section and the latest Internet Café. There has been a spark smouldering within this newsletter for some time and there is a sense that it has been ignited.

Readers viewed the last edition featuring Gwen Van Schaik's artwork, as a leap into a new arena of communication with members. This current edition is dedicated to the victims of trauma that we work with, and most specifically, to those of the September 11th World Trade Centre disaster. Which brings me to the roller coaster I've been riding. Using our feature articles for format, I focussed on nurses involved in trauma work from varying perspectives. I discovered I didn't have to look far. Throughout Canada, there is a host of psychiatric mental health nurses that are skilled specialists in trauma work. Ruth Gallop is Canada's most noted nurse leader for her research, academic and clinical work with victims of trauma, and has kindly agreed to be featured as the Canadian Nurse Leader in this edition. Leigh Blaney has quietly developed and managed Critical Incident Stress Management teams over the past decade on the west coast and shares highlights of her work in the "Dare to Tell" interview. Compassion Fatigue is recognized as a real concern for anyone working with victims of trauma and Canada has key nurses working in this area as well. None were available to submit an article for this edition, however there is some information excerpted from *Creating Sanctuary: Toward the Evolution of Sane Societies* by Sandra Bloom. Our Internet Café and Research sections also focus on trauma, and Kathleen Whipp, a professional colleague from Social Work has kindly submitted a book review on the subject.

I hope you enjoy this "special focus" edition. The idea of a dedicated edition came while I was driving on Canada's Highway 1 the day the country stopped for 3 minutes of silence in respect of the victims lost on September 11th. I pulled my car to the side of the freeway, along with many others, and while I sat, the words of Dr. Martin Luther King, repeated by Jean Cretien moments before, echoed. "In the end it is not the words of our enemies that you remember, but the silence of our friends". These words of inspiration suggested to me the importance of taking opportunities, such as the publication of this newsletter, to give voice to the many 'friends' working alongside victims of trauma.

As a final note, I will be assuming the role of President of the CFMHN and passing along the editorship to Judy Buchanan. This position has been a surprising opportunity to gather nurses stories and nursing information from across the country and I will miss it greatly.

MEET THE NEW EDITOR

Judy Buchanan is well known to Federation members. A member since 1988, she has held key executive positions of treasurer, secretary, president and past president. Judy has sat on the PMHN Exam Committee; chaired the 2nd Standards committee; and participated in the development of the position paper 'Essential Psychiatric/Mental Health Nursing Education for Entry Level Nursing Programs in Canada'. Judy asked me specifically to mention her naturally blonde hair. (With this in mind, I have no doubt the editor will be looking at ways to print colour photos in future editions.)

Congratulations Judy and welcome to the world of publishing.

New Executive Board (Left to Right)

*Sharon MacLeod, Cathy Lucas,
Alice Chan, Sean Hopkins, Susan Ray,
Judy Buchanan, Ann Greene,
Nancy Johnson.*

*Missing: Geertje Boschma, Val Hartley,
Kelly Sterling-Edgers, Gloria McInnis*



Number 33, Fall 2001

CFMHN

Canadian Nurse Leader

Ruth Gallop

Ruth Gallop is Professor and Associate Dean in the Faculty of Nursing Science and cross-appointed to the Department of Psychiatry, Faculty of Medicine at the University of Toronto. She is a senior researcher in the Division of Society, Women and Health in the Department of Psychiatry. Ruth's research, clinical and consultation interests have focussed on the clinician - patient relationship with a particular emphasis on clients' perceived as difficult to manage and treat. These clients often receive a diagnosis of borderline personality disorders; have histories of severe early trauma and current self-harm behaviors. She has over 60 peer-reviewed publications.

Ruth frequently provides expert opinions in cases involving the role of the psychiatric nurse, the limits of the professional role, and sexual abuse violations by health professionals. She is invited to speak in many countries. During 2000-2001 speaking engagements include conferences and workshops in England, the United States of America, and Australia as well as Canada.

Ruth Gallop completed a B.Sc.N. and M.Sc.N. from the University of Toronto and a Ph.D. at the Institute of Medical Science University of Toronto. Her achievements are many and her academic work and research in the area of trauma and abuse is world-renowned. Ruth's CV is comprehensive and we are unable to publish it in its entirety. Following are highlights from this impressive nurse leaders profile.

Awards

- ◆ Dorothy M. Pringle Research Award, Lambda Pi Chapter, Sigma Theta Tau, 1999
- ◆ Career Scientist Award, Ministry of Health, Ontario, 1988-93
- ◆ Various national and international Fellowships and Visiting Professorships

Funded Research Activities

- ◆ Effects of Childhood Trauma on HPA Activity in Women with Major Depression. Hegadoren, K., Gallop, R., & Le Melledo, J-M. Medical Research Council of Canada \$210,000.
- ◆ The relationship between abuse during pregnancy and postpartum depression (LEAP study) Cohen, M., Sher, B., Gallop, R., Stewart, D. Centre for Research in Women's Health (\$25,000).
- ◆ The development of guidelines for a safe, containing and empowering environment in psychiatric settings for women who have a history of abuse. R. Gallop, S. Engels, B. Dorian, R. DiNunzio, N. Stuckless & K. Hegadoren. Women's Health Bureau, Ontario Ministry of Health \$6,000.00
- ◆ Knowledge, Competencies and Beliefs of Community Based Nurses Working with Women Survivors/Victims of Violence. M. Harris, D. Anderson, R. Gallop. School of Nursing, Seeding Grant Scheme, Queensland University of Technology. \$10,800 (Australian)
- ◆ Education and Training of Front-Line Professionals in Assessment and Treatment of Women Who are Victims of Violence. H. Barbaree, B. Dorian, R. Gallop, B. Toner (alphabetical order). Ontario Women's Health Bureau. \$58,928.00 Publications

Ruth's publications in peer-reviewed journals and published abstracts/summaries are extensive. A history of abuse and self-harm, understanding of childhood trauma, history of childhood sexual abuse and history of sexual abuse are among the many topics explored. Of particular note is her recently published book: Everett, B. & Gallop, R. (2001) The link between childhood trauma and mental illness: Effective interventions for mental health professionals. California: Sage Publications. (See Book Review, page 24)

Ruth is a sought after presenter and has a vast portfolio of invited papers and presentations on the national and international scene. She is regularly invited to provide consultations and seminars to nurses and other health professionals in clinical settings. She has consulted to both Federal and Provincial governments and has been an expert witness in civil, criminal and grievance hearings as an expert on psychiatric nursing and on the scope of professional practice and the nature and limits of the nurse-patient relationship. Her accomplishments are outstanding for academic achievement, mentoring, supervision and committee work.

The CFMHN applauds Dr. Ruth Gallop's contribution to psychiatric mental health nursing in Canada.



Ruth Gallop

Dare to tell

.....a glimpse into the lives of **Real Nurses**
an interview by Ann Greene and featuring Leigh Blaney

This second instalment in our series of "Nurses to know" features a nurse who has literally taken the notion of caring for the whole client to its broadest interpretation. Leigh Blaney balances her hectic life of work as a team leader in psychiatric mental health, play of training and competing in triathlons and volunteerism creating, teaching and providing Critical Incident Stress Management services in BC, Canada and Internationally. Her sense of community and the role and function of nursing within this context exemplifies the principles of caring and commitment.

This interview took place in Leigh's home on Vancouver Island in British Columbia at the end of a weekend, at the end of a sunny, autumn day and, for Leigh, at the end of a marathon of writing reports for the MA program she attends.

Leigh, will you tell us a bit about what you do, why you do it, how you got to where you are, what you like about it, what inspires you?

The Critical Incident Stress Management stuff started a number of years ago when I was working in the community as a counsellor at a crisis centre. We had a number of Vietnam Vets visiting the centre and there was some triggering event that brought to our attention that these vets were having severe PTSD symptoms. It was very difficult at that time to find out how to help and manage these extreme reactions. For example, waking up in the middle of the night and putting knives to their partners throats thinking they were back in Vietnam dealing with the enemy.

I got in touch with the Veterans Administration in Washington DC and Washington State. They sent me information on treatment modalities for PTSD and some cognitive behavioural techniques, some of which we implemented into practice with favourable results.

I began to ask questions, as any good nurse will, about; is there a way to prevent these extreme reactions from happening and started to investigate PTSD. I couldn't really find anything around prevention and very little on treatment. I finally came across some stuff by Jeff Mitchell in Baltimore who developed a model of management using critical incident stress debriefings and other group modalities to help emergency service providers who were experiencing extreme reactions to incidents they had been involved in. He had also been doing some work with Vietnam vets as a number of the vets were involved as emergency service workers such as paramedics. I got involved in studying with Mitchell around his CIS stuff and concurrently was talking with some local fire chiefs who identified that nothing was in place locally to deal with CIS. From there I got together with some local people, got some

training and formed some intervention teams that started working on the north end of Vancouver Island as a non-profit society. The interventions were mostly for emergency providers but the military base was located in our home town so we worked with the military as well.

What inspires you to this work?

I think because this is a series of simple processes that we can do to immediately impact the effect and reactions to incidences. We can sit down and by virtue of a therapeutic or para-therapeutic relationship provide a framework to people to talk about their reactions. That verbal ventilation mitigates the effects of those reactions. It is immediate and it is not long lasting and it is simple. It lends itself to the use of volunteers and peer support. It is not a medicalized issue. It is a peer support process using the expertise of mental health nurses (and other professionals) to provide the guidance for the peers.

So do you see yourself doing this as a nurse, or peer support. What is your role?

My expertise is in the assessment of the crisis and helping manage the process for the peers. I see my role as the mental health professional. CIS interventions are team interventions using the mental health professional guiding the process, and the peers providing the 'in' to whatever emergency service or community service is being intervened with.

You do a lot of teaching as well. How did you get into that end of it?

We were bringing in some pretty high priced experts to provide team training, locally and nationally. Sometimes these trainers were missing the boat on the rural experience and perspective of CISM. So we had a chance to send me to Baltimore to the inaugural Train the Trainer for the international CIS Foundation and then we adapted the training to the rural setting and the rural incidents that occur. The training is actually a big part of the whole CIS process. It is a combination of the prevention which is pre incident education, intervention which is the debriefings and defusings and postvention which is the community follow up with therapists or EAP programs or whatever. After the CIS interventions are over with. Educating people to what common stress reactions are, normalizing those reactions, helping to develop strategies for managing those and making sure they know what networks are available to them if they need intervention services.

I've taken this course from you and you put a lot of fun into it. Do you want to talk about how you have fun in your work.
Well PTSD and CIS and general stress are pretty intense topics and people who come to these trainings are usually intense

Continued on page 11

Continued from page 10

people with high pressure jobs. The professionals, emergency service professionals, technicians. To come on their days and listen to someone blither on is a good

interest and commitment. Whatever and more interesting for them and so information is personally what I like topics and incidents and you need to silliness, without denigrating the incident

As far as your work as a professional how do you think this CIS work has
I think it has made me more aware of awareness with colleagues about the need for having stress management life. We are not taught stress management this CIS process has shown me that that it is simple to walk the walk. It our lifestyles to something more healthy our general stress and therefore make CIS when it occurs.

Tell our readers how you walk the walk
You and I make wine together and the need to be aware of our general lifestyle day for ourselves. We need to develop away from our work. General, broad Have some fun. Get some exercise. be like some of us running marathons your dog. Be willing to talk about your life meaningful in simple ways.

Is CISM something that you see as a
I think it is. I have been involved with Board (in BC) to develop legislation legislation. A big component of that is the development of CISM programs being available incidents of violence. These programs programs, but they do have to be available within their community. I think any for violence. Recent events in the US that it doesn't matter where you work CIS and PTSD and death by terrorism things. I think the implications of that are very troubling for people and so the we develop to, first off, open up discussion of issues, not so much the right and will react to it and they will react over Especially when they see it on television reactions will occur and what will be reactions. Sometimes it's as simple as

Have you been involved in the recent
I'm part of 2 networks. The International Stress Foundation and the Canadian

Continued from page 10

people with high pressure jobs. They are healthcare professionals, emergency service providers, search and rescue technicians. To come on their days off, to sit for 2 days and listen to someone blither on is a good indication of their

interest and commitment. Whatever I can do to make it easier and more interesting for them and still provide the requisite information is personally what I like to do. It is pretty intense topics and incidents and you need to balance that with some silliness, without denigrating the incidents or the reactions.

As far as your work as a professional nurse with a "day job", how do you think this CIS work has influenced that?

I think it has made me more aware and made me share that awareness with colleagues about common stressors and the need for having stress management strategies in our day to day life. We are not taught stress management in our schooling and this CIS process has shown me that we need to walk the walk, that it is simple to walk the walk. It doesn't take much to shift our lifestyles to something more healthy that will help decrease our general stress and therefore making us less vulnerable to CIS when it occurs.

Tell our readers how you walk the walk.

You and I make wine together and that's a great hobby. We need to be aware of our general lifestyles and make time each day for ourselves. We need to develop supportive relationships away from our work. General, broad supportive relationships. Have some fun. Get some exercise. And that doesn't have to be like some of us running marathons, but a daily walk with your dog. Be willing to talk about what it is that makes your life meaningful in simple ways.

Is CISM something that you see as useful at all worksites?

I think it is. I have been involved with Workers Compensation Board (in BC) to develop legislation around workplace violence legislation. A big component of that legislation is the requirement of CISM programs being available to all workers after incidents of violence. These programs don't have to be on site programs, but they do have to be available for staff to access within their community. I think any worksite holds potential for violence. Recent events in the US certainly have shown that it doesn't matter where you work, you could be at risk for CIS and PTSD and death by terrorist attacks and all sorts of things. I think the implications of that in day to day life can be very troubling for people and so the more strategies and skill we develop to, first off, open up discussion around these types of issues, not so much the right and wrong of it, but that people will react to it and they will react over and over again. Especially when they see it on television over and over. These reactions will occur and what will we do about those stress reactions. Sometimes it's as simple as turning the television off.

Have you been involved in the recent activities in the US?

I'm part of 2 networks. The International Critical Incident Stress Foundation and the Canadian Traumatic Stress Network.

Both of those organizations are actively involved in providing services to victims of the World Trade Centre, the Pennsylvania crash and the Pentagon Fires. The ICISF is taking a lead role with FIMA in the US, and a colleague and myself were asked to pull together a resource list here in BC of trained people who would be available to go to the US and provide services to the victims, so we've done that. A team has gone and just returned and we are prepared to send more when the request comes.

Do you have any words of wisdom for our readers regarding how this work has influenced you or how it could influence them?

It would be in the form of a cautionary note to begin with. CIS reactions are normal reactions and are to be expected after critical incidents. We tend to pathologize or medicalize a lot of these reactions and it is important to recognize that stress and grief reactions are very normal reactions. People need to experience those reactions. What they need is not to have that taken away or pacified. They need an opportunity to make some sense or some meaning of the incident and their reaction to it. PMH nurses in particular have a great opportunity with their ability to establish therapeutic and supportive relationships and to use their listening skills in particular to help people make some sense or some meaning of their reactions.

I'd like to say some more about what makes it fun and what inspires me. The people I have met over the 10 or 12 years that I have been doing this. The phenomenal people that really are interested, compassionate caring individuals. And the team that I have worked with over these 10 years on the North Island. We've had various personalities, various backgrounds, academic and professional backgrounds. People that have come together with a focus of providing a service to the community. It has been really interesting to see that any differences that we may have come in with or conflicts that may develop are put aside at the time that the work is being done. We all come together with a common purpose around a common model and that has been a great learning experience for me about the power of communication, of collegiality and collaboration and that fits in with my ideal of nursing. And I have found it in a broader community.

What I hear you saying is that you have taken nursing and applied it outside of a "work situation" to a broader situation. Definitely. A lot of the work that we do is around coordination or intervention that requires the nursing process; the assessment, the planning, the intervention of the plan and then evaluating the efficacy of that plan. A lot of nursing theory comes into the practice of CISM. It is also a richer experience because of other professionals and paraprofessionals that bring their own experience into this. So we end up with a really broad context of people, personalities and services that can be adapted to just about any situation in any community and that has been a really neat evolution for me.

The Psychological Impact of Terrorism

Leigh Blaney

Terrorism has the potential to create an unprecedented level of fear, panic and crisis throughout the affected nation and adjoining nations.

Currently there is no consensus among international policymakers as to how an incident will unfold, what measure should be taken to prevent or respond to an attack, and no real track record of previous incidents to analyse in preparing for an attack, or even to responding to an attack.

Because there is limited ability to prepare, there is also limited opportunity to save lives in the aftermath of a terrorist attack. In the aftermath of a chemical or biological attack, there is more opportunity to save lives by giving vaccines or providing protective gear. But as we have seen today, the mass destruction of property and ongoing loss of life is impossible to predict for, or even respond to a comprehensive way. There are too many incidents and too many victims in too many locations to respond in a planned proactive manner; it is react, react, react and save as many as possible. This is counter to any training of emergency and disaster responders, and leaves planner, managers, responders, and the public at large with a sense of futility, helplessness, and hopelessness about the job they are doing. This is the real power of terrorism - the ability to cripple a nation psychologically.

In an attempt to assist emergency and disaster planner to provide appropriate assistance, disaster victims are categorized as primary, secondary, or tertiary victims and, although their reactions may be similar, the way responders provide psychological support to each is quite different.

The primary victims are folks that are injured or directly bereaved. The priority in caring for them immediately post-incident is to ensure physical safety and survival, then look at specific and individual psychological needs.

The secondary victims are the response personnel; in this case the firefighters, police, paramedics, emergency managers, incident commanders, air traffic controllers, etc. They are the ones who have designated jobs in "response to" the incident. We see common reactions with this group of folks, and we have some specific support mechanisms we put into place - things like critical incident stress defusings and debriefings, demobilizations, etc.

The tertiary victims are all the rest of the folks who witness the incident or see it on T.V., but aren't directly involved. Tertiary victims are those of us who are sitting at home watching television, or hearing about it at work, or reading about it in magazines and newspapers. Tertiary victims are the ones whose kids are reacting to what they see and hear on the media, and are asking mom and dad what to do.

There are some common and expected responses for tertiary victims as well. But just because the reactions are common and expected, do not assume they are easy or comfortable. They are very uncomfortable and distressing for people, and folks often think they are going crazy or losing it, or they'll never be "normal" again. It's important to recognise that there are various symptoms that people may experience all at once, or in waves, or sometimes not at all. It is important to recognise that these are very normal people experiencing very normal reactions to an extremely abnormal situation.

Symptoms are physical, emotional, cognitive, and behavioural in nature.

PHYSICAL

Nausea, vomiting, tremors, increased heart rate and blood pressure, hyperventilation, chest pains, headaches, muscle soreness and twitches, loss of coordination, weakness.

EMOTIONAL

Anxiety, guilt, fear (it could happen here, it could happen to me, it could happen to my kids, there but for the grace of God go I), depression, anger, resentment, scapegoating, emotional numbing, shock, withdrawal, helplessness, loss, grief, abandonment.

COGNITIVE

Confusion, short attention span, poor memory, poor concentration, impaired thinking and decision-making, intrusive images, flashbacks.

Continued from page 12

Pacing, restlessness, erratic mo

DO:

- Expect t
- Maintair
- Take tim
- Spend ti
- Build in
- Talk abo
- Take tim
- Take a v
- Get extr

DON'T:

- Think y
- Drink a
- Withdra
- Look fo
- Have un

ADVICE

Don't b

Remember

If the described symptoms in
7 -10 days, or for more inform
stress, the following commun
help:

- your physician
- your clergy me
- Crisis Line
- Mental Health
- School counsel
- private counsel
- Employee Assi
- Other: _____

Sources: (citations available)
- International Critical Incide
- North Island Critical Incide
- Canadian Traumatic Stress
- American Psychiatric Asso

Continued on page 13

BEHAVIOURAL

Pacing, restlessness, erratic movements, changes in activity and speech pattern, emotional outbursts.

DO'S & DON'TS:

ADVICE FOR SURVIVORS OF CRITICAL INCIDENTS

DO:

- Expect the incident to bother you and remind yourself that post-trauma reactions are normal
- Maintain good diet & get some exercise
- Take time for yourself
- Spend time with family & friends
- Build in time for leisure and "fun" activities
- Talk about your reactions to supportive network (peers or family)
- Take time away from the TV, newspapers, and conversations about the event - tell people you need a break.
- Take a walk with a friend, your kids, a pet
- Get extra help, if necessary from clergy, crisis line, mental health, or counsellors.

DON'T:

- Think you are crazy
- Drink alcohol or use other substances to deal with reactions
- Withdraw from routines
- Look for easy answers or explanations for the incident
- Have unrealistic expectations for resolution.

ADVICE TO FAMILY & FRIENDS OF SURVIVORS OF CRITICAL INCIDENTS

Encourage them to talk about their reactions to the incident
Listen. Be willing to say nothing; just being there is often the best help

Don't reassure them that everything is okay

Don't tell them you know how they feel - you don't!

Don't attempt to impose on them your explanation of why this has happened

Don't be afraid to ask how they're doing - they'll tell you as much or as little as needed

Remind them that their feelings are normal

Remember that someone who cares for a survivor can also experience critical incident stress

Suggest counselling if symptoms are extreme or don't settle down

If the described symptoms increase, or do not decrease within 7-10 days, or for more information about critical incident stress, the following community resources may be able to help:

- your physician
- your clergy member
- Crisis Line
- Mental Health Centre
- School counsellors or
- private counsellors
- Employee Assistance Program
- Other: _____

Sources: (citations available on request)

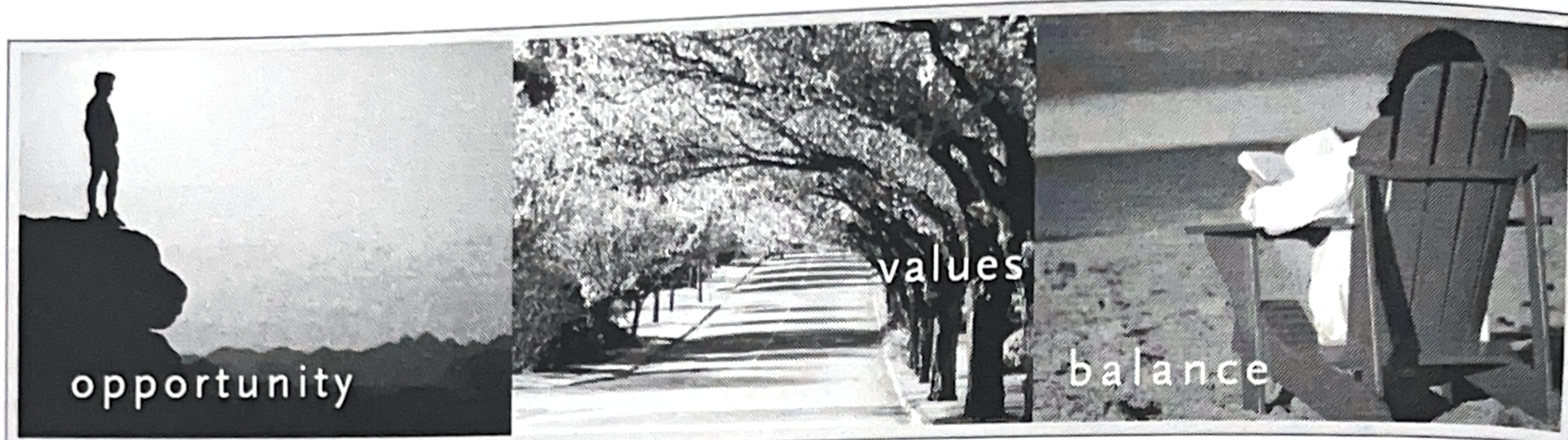
- International Critical Incident Stress Foundation
- North Island Critical Incident Stress Management Society
- Canadian Traumatic Stress Network
- American Psychiatric Association

Leigh Blaney

Leigh Blaney is a Registered Nurse, with a Bachelor of Science in Nursing and a MA candidate. Leigh works as the Team Leader Inpatient Psychiatric Acute Mental Health Services in the Central Vancouver Island health Region. She lives in Nanaimo and between work and study, trains for triathlons with her golden retriever "Rufus".

Leigh served as the Clinical Coordinator of the North Island Critical Incident Stress Management Society for over 10 years. She is currently a board member of the Canadian Traumatic Stress Network and active member and trainer for the International Critical Incident Stress Foundation.

Information Pamphlets *Psychological Reactions to Terrorism* and *Helping Children Cope After Disaster* are available by contacting Leigh Blaney at rufie@pacificcoast.net



Seven Oaks Program New Mental Health Facility Broadens Innovative Approach

On a 17-acre park-like setting, just 20 minutes from downtown Victoria BC, a new facility and program is taking shape that is poised to set new standards for the provision of care for the seriously mentally ill in the Capital Health Region.

The Seven Oaks psychiatric rehabilitation hospital, identified in 1997 by Health Canada as a 'best practices' site, is undergoing a major facelift and expansion with a new purpose-built facility comprising five resident houses and a rehabilitation and administration building.

When the new 38-bed facility opens in December this year, it will provide the highest quality of psychiatric treatment and rehabilitation in home-like cottages that allow residents to learn basic living skills and how to manage their illness and live with the neighbours in the community in order to move towards greater independence.

The tranquility of the surrounding park-like environment complements the emphasis on treatment and rehabilitation individualized to meet each resident's particular needs.

The Seven Oaks initiative reflects a commitment to provide residents with the best rehabilitation and treatment through a holistic approach rooted in the key values of openness, participation, quality and innovation.

"We believe in fostering an environment that encourages residents to reach the highest possible level of achievement and independence," comments Margaret McNeil, Regional Director for Mental Health for the Capital Health Region.

"Our goal is to become a centre of excellence by implementing and maintaining a policy of continuous quality improvement."

"Our innovative methods encourage care providers to share a diverse range of skills

such as anger management, assertiveness training, time and organizational management and every day living skills," said Tom Newton, the Program Coordinator for Seven Oaks.

The program fosters a multi-disciplinary approach working in partnership with residents, families and community health providers. Individualized health plans are developed for each resident with established goals evaluated on a quarterly basis. Staff use a combination of modelling, support, encouragement and education to ensure maximum independent functioning for each resident.

With expansion of the innovative new program and facility, the Capital Health Region has initiated recruitment of a number of key professional positions. In particular, a number of Registered Nurses and Registered Psychiatric Nurses are required for the planned opening in December 2001.

"We require experienced mental health professionals who enjoy working independently as well as in a multi-disciplinary team setting," says Ms. McNeil. (*The CHR was ranked sixth in health care regions in Canada in the Macleans' 2001 annual health report.*)

The Seven Oaks Program requires RNs and RPNs

If you are looking for the opportunity to:

- be a part of an organization recognized as a best practices site in tertiary psychiatric care by Health Canada and the focus of a national research study
- contribute to the provision of the best tertiary psychiatric care
- enrich and develop current skills with additional training
- work in a multi-disciplinary team system

- participate in and contribute to a program that is serving as a model for the development of tertiary mental health care in Canada...

...talk to us about Seven Oaks.

For more information on programs and job opportunities, please contact:

Eileen Coste
Recruitment Advisor
250.370.8981
Email: eileen.coste@caphealth.org

OR

Tom Newton
Coordinator – Seven Oaks
Seven Oaks: 250.952.5865
Office: 250.658.0784
Email: tnewton@caphealth.org

Please forward your résumé, quoting reference #1373/CFMHN, to:
Capital Health Region
HR – Recruitment Services
1900 Fort Street, Victoria, BC V8R 1J8
Toll-free tel: 1.888.296.3963
Fax: 250.370.8570
Email: jobs@caphealth.org

Seven Oaks, Victoria, British Columbia

www.caphealth.org/careers

Research Article

Synopsis by Susan Raye

Male Survivors' Perspectives of Incest/Sexual Abuse.

Published (2001) *Perspectives in Psychiatric Care: The Journal for Advanced Practice Psychiatric Nurses*, 37(2), 49-59.

Increasingly, nurses are coming in contact with male survivors of incest and other forms of sexual abuse. The purpose of this study was to understand the after effects of incest and other forms of sexual abuse as viewed from male survivors' perspectives. Themes of the after effects of incest and other forms of sexual abuse were identified which could help clinicians to explore with adult males the possibility of sexual abuse.

A convenience sample of 25 adult male survivors of incest and other forms of sexual abuse was recruited by means of referral by eight therapists for participation in the research. Audio taped interviews with 25 male survivors described the after effects in eight life areas. Data was analysed by the double-coding qualitative method.

The participants described the long-term aftereffects of their experience in the eight life areas: *social, psychological/emotional, physical, sexual, familial, sense of self, relation to men, and relation to women*. In all the eight life areas, the participants reported the long-term after effects as negative.

This study provided a rich description of the incest/sexual abuse experience as viewed from male survivors' perspectives.

The findings validated the previous qualitative studies, such as: difficulty forming sexual or non-sexual relationships; powerlessness, isolation, being alienated from others; depression, suicidal ideation and dissociative symptoms (Draucker & Petrovic, 1998; Etherington, 1995; Fater & Mullaney, 2000; Gill & Tutty, 1999). The all pervasive long-term after effects of incest/sexual abuse of male survivors were very similar to those of female survivors. Clinicians need to explore the possibility of a history of sexual abuse with males who seek treatment for addictions, suicidal ideation, depression, and chronic low self esteem.

References:

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- Etherington, K. (1995). *Adult male survivors of childhood sexual abuse*. *Counselling Psychology Quarterly*, 8(3), 233-241.
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- Gill, M., & Tutty, L.M., (1999). *Male survivors of childhood sexual abuse: A qualitative study and issues for clinical consideration*. *Journal of Child Sexual Abuse*, 7(3), 19-33.

Internet Cafe

Trauma Response Resources On-line

Canadian Traumatic Stress Network

Canadian Red Cross

Canadian Mental Health Network

Toronto Traumatology Institute

Green Cross Projects

International Critical Incident Stress Foundation

International Society for Traumatic Stress Studies

David Baldwin's Trauma Information Pages

Association for Traumatic Stress Specialists

Training Manual-U.S. Disaster Services

American Academy of Experts in Traumatic Stress

National Centre for PTSD

www.ctsn-rcst.ca

www.redcross.ca

www.cma.ca/cmhsn/

www.psychink.com

www.fsu.edu/~gcp/

www.icisf.org

www.istss.org

www.trauma-pages.com

www.atss-hq.com

www.mentalhealth.org/publications

www.aaets.org

www.ncptsd.org

L'Institut de la Santé des Femmes et des Hommes (ISFH)

Cher(ère) Monsieur/Madame,

Veuillez accepter notre sincère remerciement pour votre participation à la réunion tenue à Vancouver/Victoria.

L'Institut de la Santé des Femmes et des Hommes (IGH/ISFH), aussi bien que les autres instituts de L'Institut de Recherche en Santé du Canada (CIHR/IRSC), est en train d'établir un inventaire de la recherche entreprise sur une échelle nationale sur le sujet de la santé des femmes et des hommes. Cet inventaire indiquera les noms des chercheurs, leurs coordonnées, et leurs projets de recherche ayant un rapport avec les questions traitant de la santé des femmes et des hommes.

L'Inventaire sera accessible sur un site web et devra servir de ressource aux fins de:

- *Faciliter le réseautage parmi les chercheurs et les initiatives de collaboration dans la recherche sur la santé des femmes et des hommes;*
- *Render disponible toute information utile pour que l'ISFH puisse alerter les chercheurs sur les sources de financement à mesure qu'elles se présenteraient. Par exemple, pendant l'année 2001-2002, l'ISFH va créer plusieurs postes attrayants (consultez le document ci-joint) L'ISFH prévoit le lancement de cet inventaire au commencement de septembre 2001.*

Cela nous ferait grand plaisir si vous vouliez bien contribuer à la banque de données sur la santé des femmes et des hommes, en nous envoyant les renseignements suivants:

Votre nom;

Vos diplômes;

Prise de contact: (adresse, numéro de téléphone, télécopieur, courriel, site web

Les titres des projets de recherche, entrepris pendant les 5 dernières années, ayant trait aux questions de la santé des femmes et des hommes;

Les sources de financement de ces projets;

Durant les prochaines semaines, vous recevrez un rappel par courriel ou par téléphone, de Maria Tan ou de Jane Yi, toutes deux assistantes de recherche à L'ISFH. Estimez-vous libre d'inviter vos collègues, engagés eux aussi dans la recherche de la santé des femmes et des hommes, à participer à notre quête d'information. Vous êtes prié(e) de nous expédier vos renseignements par courriel, télécopieur, ou par la poste à:

CIHR Institute of Gender and Health

University of Alberta

5-22 UEC, 8303 -112th St

Edmonton, AB T6G 2T4

phone (780) 492-8031 fax (780) 492-8045

L'Institut de la santé des femmes et des hommes (ISFH) ainsi que ses instituts partenaires feront bientôt des appels de demandes liées à des projets stratégiques dans les domaines suivants :

1) Dans le cadre de l'initiative « **Nouvelles perspectives sur la santé des femmes et des hommes** », l'ISFH financera :

- jusqu'à douze **subventions d'occasion de recherche**, non renouvelables de 30 000 \$ (maximum) chacune, liées à neuf thèmes de recherche stratégique définis au cours de vastes consultations menées partout au pays. Ces thèmes sont les suivants : équité entre les femmes et les hommes en matière de santé; travail, loisirs et santé des femmes et des hommes; maladies/états chroniques chez les femmes et les hommes; vieillissement sain des femmes et des hommes; santé mentale des femmes et des hommes au cours de la vie; développement sain des filles et des garçons; promotion de comportements de santé positifs et prévention des accoutumances chez les femmes et les hommes; santé des femmes et des hommes en matière de sexualité et de reproduction; déterminants environnementaux de la santé chez les femmes et les hommes;
- jusqu'à deux **bourses de perfectionnement professionnel** (50 000 \$ chacune);
- jusqu'à dix **subventions de lancement** (10 000 \$ chacune) pour chaque thème prioritaire susmentionné.

2) En partenariat avec quatre autres instituts, l'ISFH accordera aussi au moins deux **bourses destinées à de nouvelles équipes** pouvant s'élever jusqu'à 250 000 \$ par année pour de la recherche effectuée dans le secteur stratégique de la violence et la santé des femmes et des hommes au cours de la vie.

3) En partenariat avec l'Institut des services et des politiques de la santé (ISPS) et l'Institut de la santé des Autochtones (ISA), l'ISFH contribuera jusqu'à 300 000 \$ par année à une initiative stratégique de trois ans axée sur l'**amélioration de l'accès aux services de santé chez les groupes marginaux**.

Veuillez visiter notre site Web (www.irsc.ca) au cours des prochaines semaines pour obtenir de plus amples renseignements sur les appels de demandes liées à ces bourses et subventions bientôt offertes par cet institut.

Canadian Institute for Health Research (CIHR) Institute

Thank you to all those who have contributed to the Canadian Institute for Health Research (CIHR), Institute for Gender and Health research inventory. This is just a reminder to those who have not yet had a chance to send us their information, to please take a moment to contribute to the database.

Dear Sir or Madam:

Thank you so much for participating in the Institute for Gender and Health meeting(s) in Calgary.

The Institute for Gender and Health (IGH), like other Institutes within the Canadian Institutes for Health Research (CIHR), is developing an inventory of gender and health related research being conducted nationally. This inventory will include researchers' names, their contact information, and their research projects that pertain to issues of gender and health.

The inventory will be accessible on the web and is intended as a resource:

1 to facilitate networking among researchers and collaborative efforts in gender and health research

1 to provide contact information so that IGH can alert researchers about funding opportunities as they arise. For example, in 2001-2002, the IGH will offer several exciting opportunities (see below). The IGH has targeted the beginning of September, 2001 as the launch of this inventory.

We would be delighted if you would contribute to the Gender and Health database by providing the following information:

Name,

Degree(s),

Contact information (address, phone, fax, email, web site),

Titles of gender and health related research projects conducted over the past 5 years,

Funding sources for these projects

Please feel free to share this request for information with colleagues whose research is also in the area of gender and health. You may email, fax or mail your information to:

CIHR Institute of Gender and Health

University of Alberta

5-22 UEC, 8303 -112th St.

Edmonton, AB T6G 2T4

phone (780) 492-8031 fax (780) 492-8045

Thank you for your contribution to this important database. We look forward to including you in this powerful collaboration and communication tool.

The Institute of Gender and Health, and its partner Institutes, will soon be making calls for applications for strategic initiatives in the following areas:

1) Under an initiative called "**New Perspectives on Gender and Health**", IGH will fund:

- up to 12 non-renewable **Opportunity Grants** of \$30,000 (maximum) each to nine priority research themes identified during extensive consultations across the country: gender and health equity; gender, work, leisure and health; gender and chronic diseases/conditions; gender and healthy aging; gender and mental health across the lifespan; gender and healthy child development; gender, promoting positive health behaviours, and preventing addictions; gender, reproductive and sexual health; gender and environmental determinants of health.;
- up to two **Retraining Awards** (\$50,000 each).
- up to ten **Seed Grants** (\$10,000 each) in any of the priority areas mentioned above.

2) The IGH will also offer at least two **New Emerging Team Awards** of up to \$250,000/year each in the priority area of **Violence, Gender and Health Across the Lifespan** in partnership with four other Institutes.

3) In partnership with the IHSPR and the IAPH, the IGH will contribute up to \$300,000 a year to a three-year strategic initiative focused on **Improving Access to Health Services for Marginalized Groups**.

Please check our website: www.cihr.ca over the next few weeks for information about the specific Requests For Applications related to these awards and grants, that will be forthcoming from this Institute.

Research Report

Carol Ewashen

This past year was dominated by a national health research agenda with the emergence of the Canadian Institutes of Health Research (CIHR) and, more specifically the Institute of Neurosciences, Mental Health and Addiction (INMHA). As of this month, the INMHA Strategic Plan 2001 is available through the website: www.cihr.ca.

The INMHA reflects the CIHR valuing of innovation as a means of new knowledge creation, capacity building and knowledge translation. The INMHA encompasses all aspects of Brain-Mind relationships including the four pillars of CIHR: biomedical, clinical, health services and population health research. The mission of INMHA is to "foster excellence in innovative research in Canada aimed at increasing knowledge of the functioning and disorders of the brain, spinal cord, the sensory and motor systems and the mind, as well as mental health, mental illness and all forms of addiction" (Strategic Plan, 2001). Additionally, it is hoped this new knowledge translates into improved health outcomes and health services.



As regards research priorities, five main areas are identified:

1. Building research capacity through funding for research training initiatives. Future generations of researchers will be encouraged through trans-disciplinary training grants programs. The BrainStar Award Program is one way of recognizing unique contributions of researchers. Recipients of this award are listed biweekly on the INMHA website.
2. Promoting major research initiatives to establish a leadership role at the international level. Criteria for innovative research the initial round of development, five broad research domains are identified: first episode in neurological and mental illnesses and in addiction., dual diagnosis/co-morbidity, brain repair/injuries, the senses including chronic pain, and tobacco use
3. Promoting New Emerging Team (NET) Programs on an annual basis. The main objective is to develop and sustain innovative research teams. See NET Program announcement on the website. The four themes identified for 2001-2002 include: discrimination and stigma, understanding the placebo effect, neurodevelopment and early life events, and computational neurosciences and artificial intelligence. Two very relevant themes for mental health/illness that are identified for partnership with other Institutes: Violence, Gender and Health Across the Lifespan, and Cognitive Impairment in Aging.
4. Building research capacity in the area of healthcare ethics, and
5. Promoting knowledge translation through such things as contributing to public policies and programs, engaging potential users of research results and potential decision-makers, developing INMHA indicators on research outcomes.

Other initiatives include ensuring access to relevant and reliable information through, for example, the development of a data bank on health and research information of interest to the INMHA. Also, initial steps are being taken to build international visibility of INMHA. This includes a series of workshops held between Japan and Canada in the field of Neuroscience.

Other Information of Interest:

1. A Request for Applications went out from the Institute of Health Services and Policy Research (IHSPR), the Institute of Gender and Health (IGH), and the Institute of Aboriginal People's Health (IAPH) for research proposals related to "improving access to appropriate health services for marginalized groups". Notification of successful applicants will be in January, 2002. Full proposals were due by October 12, 2001.

The specific objectives of this request are "to support innovative projects that will help inform policy, program and management decisions relating to improved access to appropriate health services for 'marginalized' people". For further detail, please refer to the CIHR website under funding opportunities.

2. CIHR Gender and Health Institute (IGH) Opportunity Grant. I wrote a letter of support for a proposed national symposium entitled Women and Mental Health: Creating a National Cross-Disciplinary Research Agenda and Strategy.

Continued on page 19

Continued from page 18

This proposal was original. Excellence for Women's mental health acknowledges the co

3. Newfoundland's Health October 9, 2001 Health Government of Canada the span of health re traumatic stress diso

This is just a very brief over the next year we c ing and our potential fo

The paradox of our tim buildings but shorter to viewpoints. We spend enjoy less. We have b conveniences, but less sense, more knowledge more problems, more

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These are the times and small character These are the days houses, but broken disposable diapers, overweight bodies,

Continued from page 18

This proposal was organized and submitted by Dr. Patricia Morrow, Research Associate/Post Doctoral Fellow, BC Centre of Excellence for Women's Health. This proposal recognizes the pressing need for a cross-disciplinary national symposium on women's mental health as a way of bringing together committed researchers to develop a national research agenda that acknowledges the complexity and particularity of mental health issues facing a diverse array of women.

3. Newfoundland's Health Research Community Receives \$5.1 million boost: Memorial Researchers to receive funding. On October 9, 2001 Health Minister Allan Rock, Industry Minister Brian Tobin, and CIHR delegate Dr. Sandra LeFort announced a Government of Canada grant of over \$5.1 million for health research initiatives. Five different projects were involved, covering the span of health research. Areas of interest for mental health include: stress and behaviour, Alzheimer's disease, and post-traumatic stress disorders.

This is just a very brief summary of a number of research initiatives. The research front continues to be very active and I hope that over the next year we can begin to identify projects specific to each of the member provinces as a way of increasing our networking and our potential for continued research development.

A Wonderful Message

by George Carlin

The paradox of our time in history is that we have taller buildings but shorter tempers, wider freeways, but narrower viewpoints. We spend more, but have less. We buy more, but enjoy less. We have bigger houses and smaller families, more conveniences, but less time. We have more degrees but less sense, more knowledge, but less judgment, more experts, yet more problems, more medicine, but less wellness.

We drink too much, smoke too much, spend too recklessly, laugh too little, drive too fast, get too angry, stay up too late, get up too tired, read too little, watch TV too much, and pray too seldom.

We have multiplied our possessions, but reduced our values. We talk too much, love too seldom, and hate too often. We've learned how to make a living, but not a life. We've added years to life not life to years.

We've been all the way to the moon and back, but have trouble crossing the street to meet a new neighbor. We conquered outer space but not inner space. We've done larger things, but not better things. We've cleaned up the air, but polluted the soul. We've conquered the atom, but not our prejudice.

We write more, but learn less. We plan more, but accomplish less. We've learned to rush, but not to wait. We build more computers to hold more information, to produce more copies than ever, but we communicate less and less.

These are the times of fast foods and slow digestion, big men and small character, steep profits and shallow relationships. These are the days of two incomes but more divorce, fancier houses, but broken homes. These are days of quick trips, disposable diapers, throwaway morality, one night stands, overweight bodies, and pills that do everything from cheer, to

quiet, to kill. It is a time when there is much in the showroom window and nothing in the stockroom. A time when technology

can bring this letter to you, and a time when you can choose either to share this insight, or to just hit delete.

Remember, spend some time with your loved ones, because they are not going to be around forever.

Remember, say a kind word to someone who looks up to you in awe, because that little person soon will grow up and leave your side.

Remember, to give a warm hug to the one next to you, because that is the only treasure you can give with your heart and it doesn't cost a cent.

Remember, to say, "I love you" to your partner and your loved ones, but most of all mean it. A kiss and an embrace will mend hurt when it comes from deep inside of you.

Remember to hold hands and cherish the moment for someday that person will not be there again.

Give time to love, give time to speak and give time to share the precious thoughts in your mind.

Submitted by Melody Pierson



Letters to the Editor

Dear Ann Greene,

On behalf of Rodney Carson and Cathy McClain we would like to Thank You for the wonderful article written in your newsletter entitled Psychiatric Game Therapy. We have received requests for the educational program because of this article. The program has done well in the United States and it looks to have the same success in Canada. I cannot put into words the good this educational game brings to people taking psychotropic drugs.

I am thankful that you saw this and did this article. I play the game twice a week at my mental health facility and to see the response to the patients learning their medications, side-effects, drug interactions gives you a warm feeling in your heart. We are working on a new updated version featuring the new drug Geodon and soon to be releasing an adolescent-children edition. Thank you for sharing this wonderful game with your country. Oh yes, in reading your newsletter I notice conventions and workshops. Cathy and I would be honored to show our program to who ever is interested. If you have any in mind please let us know. Thank you again

Cathy McClain & Rodney Carson
The Psychotropic Med Game

To Ann Greene,

Great newsletter!

Gutsy, informative, varied...excellent effort, Nurse!

Website is great - please pass that on to whomever deserves credit.

Edie Pletzer

Dear Ann,

Ever since receiving your package with the summer issue of the Newsletter, I've been wanting to get in touch with you many times, but you know how that can go, the intent is there - but not the time. However, today is the day.

I feel extremely proud of the Summer 2001 issue of the Federation's newsletter. For many reasons. I'm proud to be part of a Federation that says: "We Psychiatric Nurses are meaning makers." I'm proud to have one of my creations function as a base and symbol to express a notion about transformative practices. Nancy explains it so very eloquently in her message. Reading the newsletter from cover to cover I was struck by an eery synergy of the stories that none of us could have known beforehand. Like Nancy's first words are about meaning and so are my last. We never discussed anything...you know what I mean.

Edition 32 is very innovative Ann, and you are to be congratulated!

I thought your pick of Linda Newton as a Canadian Nurse Leader profile was brilliant. My first thought was - why aren't there more Lindas?

We could do with more examples of nurses who apply psychiatric/mental health principles in settings other than the hospital.

Gwen Van Schaik

Compassion Fatigue

Except from *Creating Sanctuary Toward the Evolution of Sane Societies* by S. Bloom

Regardless of our professional training, nothing really prepared us to share the relentless and overwhelming nature of post-traumatic emotional states. The patients needed and deserved an empathic response. They needed other people to help them feel safe, to restore their sense of trust in others, to willingly help redirect their traumatic scenario. This is the social response that had failed them as children and could not fail them again. But there was an unending stream of them, and only a few of us. We found that the only real protection against this kind of toxic exposure was diffusion, spreading the overwhelming emotion over a group large enough to detoxify it. But we have all-patients and staff alike-been reared in a culture that shuns group approaches to anything. We have been taught since childhood to compete when we are in groups-that winning, and beating the other guy is all that is important. Even in team sports, individual achievement is the pinnacle of success. Nothing should interfere with our individuality. This philosophical paradigm put us at a distinct disadvantage when it came to working with these patients.

We had to learn new skills. Just as we encouraged our patients to lower their defences and trust other people, we had to do the same with each other. We were forced to recognize that we too brought our own unresolved conflicts and past traumas into every setting and that these conflicts could get in the way of good therapy. For our community to stay healthy, we had to expose ourselves to each other's criticism and judgement and hope that the other would be kind and compassionate. If we did not take care of each other, we could not take care of our patients.

Creating Sanctuary Toward the Evolution of Sane Societies; Sandra Bloom; 176-177



We need healthcare professionals who can work in a fast-paced environment and wear more than one hat.



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Greater Vancouver, BC

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Book Review

The Link Between Childhood Trauma and Mental Illness

Canadians Barbara Everett and Ruth Gallop have collaborated on a much-needed text in the field of mental health, *The Link Between Childhood Trauma and Mental Illness* (Sage 2001). Their combined experience in research, front line work, program management, and professional training enables them to speak to mental health professionals with compassion, hope and clarity. They challenge us to think critically about our work, as we take in the research and recommended practice guidelines coming from this rapidly developing field. Like most clinicians and trainers in traumatology, their knowledge is grounded in years of listening to both the experiences of survivors and the professionals who provide care.

Gallop and Everett straightforwardly follow their own advice to readers to strive for authenticity, by tackling such topics as "Why we often miss a history of childhood trauma", "The controversy surrounding traumatic memory" and "Understanding power".

Their chapters on "The healing and recovery process" and "promoting client safety" are both thorough and practical. The "Treatment models" section is unfortunately already

partially out of date, with promising new research and clinical practice developments coming out monthly. We are increasingly finding more empowering and contained techniques for supporting survivors of even severe abuse. For example, EMDR "resource installation" enables people who have histories of early deprivation and trauma to create their own inner resources. They can later process traumatic material without being retraumatized. Group work is also advancing with more design input from consumers, such as the "Atrium Model", the "Hope for Healing" manual from the US National Research and Training Center on Psychiatric Disability, and the work of "Community Connection" mental health centre in Washington DC.

"Personal and professional self care" are addressed throughout, in discussions of normal staff reactions and crucial supports that enable us to effectively meet the challenges of the work.

Kathleen Whipp MSW RSW is currently piloting a hospital-wide basic trauma curriculum co-created with staff at Riverview Hospital in BC.

Canadian Federation of Mental Health Nurses MEMBERSHIP APPLICATION

The Federation is an interest group of the Canadian Nurses Association (CNA) whose purpose is to further the standard of mental health nursing in Canada.

Please print the information on the application form in ink.

☐ New Membership ☐ Renewal ☐ R.N. ☐ Other (specify) ☐ Has address Changed ☐ CNA Member

Name: _____ Place of Employment: _____ Expiry Date: _____

Mailing Address: _____

Place of employment: _____ Postal Code: _____

Fax: (____) _____ Business Telephone: (____) _____

Internet Address: (if applicable) _____

Current Position - Please check one item from the list below:

- | | | |
|--|---|---|
| ☐ A: Staff Nurse | ☐ D: Clinical Nurse Specialist | ☐ G: Community Mental Health Nurse |
| ☐ B: Head Nurse | ☐ E: Educator | ☐ H: Independent Practitioner |
| ☐ C: Case Manager | ☐ F: Manager/Administrator | ☐ I: Other |

Areas of Expertise - Please check up to three items from the list below:

- | | | | | |
|---|--|---|--|-------------------------------------|
| ☐ AV: Abuse/Violence | ☐ GT: Group Therapy | ☐ AD: Administration | ☐ AL: Adolescence | ☐ AU: Adults |
| ☐ AG: Aged | ☐ AC: Alcoholism | ☐ CH: Children & Youth | ☐ CR: Cross Cultural Issues | |
| ☐ CS: Community | ☐ DA: Drug Abuse | ☐ DP: Developmentally Disabled | | |
| ☐ FT: Family Therapy | ☐ FI: Forensic Issues | ☐ IT: Individual Therapy | ☐ ME: Medication | |
| ☐ MC: Marriage Counselling | ☐ RE: Research | ☐ SC: School Health | ☐ SX: Sexuality | |
| ☐ WM: Women's Issues | ☐ OT: Other _____ | | | |

☐ Check here if you DO NOT want your name included in the Canadian Federation of Mental Health Nurse's Directory.

Remember to enclose \$30 application fee! Fee ensures membership a year from the date of application.

Please print out and mail completed form including cheque or money order payable to CFMHN to:
Sharon MacLeod, The Nova Scotia Hospital, Drawer 1004, Dartmouth, Nova Scotia B2Y 3Z3
Visit our web site at <http://www.cfmhn.org>