Working with consumers who hear voices: the experience of early career nurses in mental health services in Australia

Short title: Nursing the consumers who hear voices

ABSTRACT:

Mental health consumers who hear voices frequently experience distress and express a desire to discuss their voice-hearing experience. Nurses do not regularly demonstrate a willingness to engage in such discussions. With the introduction of educational strategies that develop empathy and an understanding of voice-hearing experiences, it is anticipated that early career nurses will be able to translate such understanding into their professional nursing practice. To explore early career nurses' understanding of providing care to mental health consumers who hear voices, a qualitative exploratory descriptive study was conducted in which nine early career registered nurses were interviewed regarding their experiences of caring for people who hear voices. Thematic analysis was employed to analyse the data and generate themes. Participants reported difficulty in developing relationships with consumers who hear voices, due to a workplace culture that was focussed on risk and lacking professional support. Nurses need specific education to develop the skills necessary to respond to consumers who hear voices and engage in dialogue that assists consumers to relate to the voices in a meaningful way. However, for this to succeed in practice, changes need to be supported by addressing the cultural barriers, such as risk-focussed environments, that prevent nurses implementing best practice.

INTRODUCTION

Distress related to hearing voices increases the anguish that consumers experience in mental health services and adds substantially to the cost of managing consumer distress for society (McCarthy-Jones, 2012; Morgan et al., 2011). Nurses are at the frontline in caring for people experiencing mental health issues, including those consumers who experience distress in response to hearing voices and consequently they can play an important role in promoting recovery. While it is recognised that a variety of terms are used for people seeking mental health care, the term consumer is used here in order to respect the rights for self-determination, choice and empowerment rightfully claimed by people who seek mental health services (McLaughlin, 2009).

Health professionals' understanding of the phenomenon of voice-hearing is changing. The predominant biomedical view of twentieth century psychiatry has been that voice-hearing, (termed auditory hallucinations), is a meaningless manifestation of mental illness (Moskowitz & Corstens, 2008). Studies have revealed links between childhood adversity and voice-hearing (Andrew, Gray, & Snowden, 2008; McCarthy-Jones et al., 2015; Rosen, McCarthy-Jones, Jones, Chase, & Sharma, 2018), with evidence that voices are a meaningful defensive response to adversity (Longden, 2017), and likely to be reflective of past negative experiences (Rosen et al., 2018). People who hear voices develop a relationship with their voices: the nature of both the relationship (Beavan, 2011; Romme & Escher, 2012) and the content of the voices determines whether or not distress is experienced (McCarthy-Jones et al., 2015; Rosen et al., 2018).

The nursing model of care for voice-hearing in the latter half of the 20th century was based on the biomedical understanding of voices as a symptom of a perceptual disorder that should be eradicated or reduced by administration of neuroleptic medication

(Hoffmann, 2012; Martindale, 2012). Nurses were expected to divert the consumers' attention away from the voices so as not to reinforce psychotic behaviour. In stark contrast, current understanding indicates that consumers who hear voices benefit from being assisted to relate to and cope with the voices in an adaptive way, based on a personal recovery philosophy (Slade, 2009). Consequently, nurses need to update their practice and develop the skills to engage with consumers in dialogue about the voices However, research indicates that engaging with consumers who hear voices is not regularly occurring in mental health nursing practice (Coffey, Higgon, & Kinnear, 2004; Harrison, Newell, & Small, 2008). The establishment of a good working relationship between consumer and nurse, that provides a safe place for the consumer to relate their experience and find meaning in a shared understanding, can be therapeutic and result in a better outcome for the consumer (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014).

In Australia, following a government-funded task force that investigated undergraduate mental health nursing preparation during 2006-2007, 58% of university programs undertook a review that led to the revision of nursing mental health curricula. Changes were enacted requiring all nursing graduates be competent at mental health assessments and "establish professional therapeutic relationships with people with mental health issues and their carers" (Mental Health Workforce Advisory Committee, 2010, p. 2). While there was wide variation in content (Wynaden, 2010) nearly all nursing schools reported using resources that reflected the lived experience of mental illness. Two universities have reported using activities specifically aimed at helping students understand the lived experience of hearing voices (Mawson, 2014; Orr, Kellehear, Armari, Pearson, & Holmes, 2013). Consequently, it was anticipated that nurses

entering mental health settings after these changes were implemented would be better prepared to respond to the distress experienced by consumers who hear voices in mental health settings. While there is an expectation that students will transfer new skills into their professional nursing practice, there are no studies investigating how newly-qualified nurses have applied this learning in health care settings. Studies have also revealed that newly graduated nurses adopt the values of the existing mental health care system (Cleary, Horsfall, Mannix, O'Hara-Aarons, & Jackson, 2011; Hazelton, Morrall, Rossiter, & Sinclair, 2011; Wright, Lavoie-Tremblay, Drevniok, Racine, & Savignac, 2011).

Therefore, an exploration of the experiences of more recently qualified nurses working in the mental health setting provides insight into whether they have translated the knowledge and skills gained from changes in undergraduate mental health nursing education into the workplace. More specifically, it is essential to understand whether they have been able to implement skills when responding to the distress experienced by consumers who hear voices. This study aimed to address this gap through an exploration of experiences of nurses in their first 5 years of experience as a Registered Nurse when working with mental health consumers who hear voices.

METHODS

A qualitative exploratory descriptive design was chosen to provide a general understanding of a topic with limited evidence, while keeping interpretation close to the description of the participants (Sandelowski, 2000, 2010). This method of investigation was deemed as most suitable to generate data that would closely reflect the experience of the participants without being impacted by a particular theoretical view (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

For the purposes of this study, an early career nurse was defined as a Registered Nurse (RN) with less than five years' experience. The inclusion criteria for participants were that they be an early career RN, employed in a mental health care service, and within the last three months had cared for a consumer who hears voices.

A purposive selection strategy was undertaken to recruit participants from a range of mental health services to allow for diverse variation in experience (Creswell, 2007) and to meet the time constraints of the project. Participants were recruited from clinical work areas in two public health services of NSW, incorporating both metropolitan and regional mental health services. An information sheet about the study was distributed. Those who were interested made contact via email. Those who expressed interest were then emailed an information pack that outlined the purpose of the study. A returned signed consent form indicated consent to participate in the study. Once recruited, the participants chose either a convenient location that provided relaxed surroundings and enough privacy so as not to be overheard, or a room at the university for a one-to-one interview. Prior to the start of the interview, a verbal explanation of the study was offered and the participant's consent was confirmed. Participants were asked not to use real names during the interview. It was anticipated that ten participants would be sufficient to reach data saturation (Tuckett, 2004).

Ethics approval was obtained from the University of Technology Sydney Human Research Ethics Committee (UTS HREC Ref no. 2012000112). Steps were taken to assure confidentiality for all participants. One participant knew the interviewer as a teacher at a university but the others had no prior relationship. All participants were informed that the study was being conducted by the interviewer (MW) as an Honours project for a Bachelor of Nursing (Hons). Due to the small pool of early career nurses in

mental health services from which the participants were recruited, data that could identify participants were altered to protect confidentiality. This included using non-gender specific language, using non-gender identifying pseudonyms, and correcting language without changing meaning where the participant spoke English as a second language.

Each participant was interviewed once over a period of two months in 2014. The length of the interviews ranged from 40 to 75 minutes with an average of 55 minutes. A semi-structured interview guide (Table 1) was used and oral interviews were digitally recorded and transcribed verbatim. The transcription was sent to participants for verification and as an opportunity to add further comments. No feedback was offered by the participants. Data collection ceased after nine interviews when no new themes were emerging and within the time limits of the study.

Data analysis

A thematic analysis was performed by the first author (MW) using a general inductive approach (Thomas, 2006) with themes generated from the data rather than a predetermined format. Interview recordings and transcripts were reviewed 5-7 times each to gain a sense of the whole. Data were coded by labelling segments of text that had meaning in relation to how newly graduated nurses perceived nursing care of consumers who hear voices and then each segment was grouped and given a code that summarised its meaning (Sandelowski, 2006). The codes were then interrogated for links, both similarities and differences, and then grouped into meaningful units that became categories. Once all categories were identified they were sorted into themes and arranged into a cohesive narrative. The categories and themes were scrutinised by all authors until consensus was reached. An example of this was using whiteboards for

brainstorming the themes and their connections. In one session the first author argued that a theme of 'hopelessness and helplessness' was predominant but as all authors tested the connections it was became apparent that these views had been expressed only by nurses working in inpatient settings. As a result this became a sub-theme under 'role and context'.

Rigor and Reflexivity

Several strategies were employed during data collection and analysis to ensure rigor. Each interview started with informal chat to allow the participant to become familiar with the interviewer to increase trust and facilitate the interviewee relating their experiences, thereby providing rich data (Morse, 2015). The findings were reported in narrative format with interpretations supported by direct quotes thereby allowing readers to judge for themselves whether the findings have relevance to their settings (Sandelowski, 2000).

In a qualitative study the lens of the researcher influences the construction of knowledge (Norum, 2008) and this subjectivity is best managed through a process of reflexivity (Malterud, 2001). Throughout the interview process the first author (MW) kept a reflective diary to challenge assumptions and prejudices that may have influenced the process. For example, when MW began the interviews she questioned her interview technique because she noted that the participants did not "stay on track". Challenging this assumption meant accepting that the participants were reflecting their experience and it was MW's role to listen and understand this. During the analysis, a process of discussion and acknowledgement of potentially influencing views and biases along with questioning the findings assisted in avoiding erroneous assumptions (Newell & Burnard, 2011). For example, the lead author had the preconceived notion that the

participants would use and understand the language and terminology of mental health nursing in the same way as the research team. This was not the case so care was taken to use the participants' own words and descriptions. Nevertheless, the process and findings of this study were informed by the collective and creative imagination and experience of the authors (Gabriel, 2015).

FINDINGS

Nine early career nurses were interviewed for the study. One was in the first year of working as a Registered Nurse (RN1) and was participating in a New Graduate Transition program. Three participants were in their second year (RN2), three were in their third year (RN3), and one each in their fourth (RN4) and fifth year (RN5) of working in mental health nursing. Three participants worked in a community setting, while the remaining six participants worked in hospital inpatient settings. These demographics have been indicated alongside the participant's name for each quote.

Four overarching themes were identified: responding to consumers who hear voices, developing knowledge and skills, viewing the role of the mental health nurse, and the impact of the practice context. To indicate the issues of greatest importance to the participants the themes are presented in the order of frequency of response. For the first theme, responding to consumers who hear voices, participants' responses were grouped into four sub-themes.

Responding to consumers who hear voices

Administering medication: *'I think the medication is […] the goal'*

The administration of medication was the initial nursing action reported by 5 of the 6 participants working in inpatient settings when asked about nursing care for consumers who hear voices, and all participants considered this a priority in inpatient settings:

> *Largely, I think the medication is the treatment, the goal... My only understanding (of treatment for consumers who hear voices) is that medication will help with the voices, and, or distraction* - Pat, RN2, inpatient nurse.

> *Like for example, Clozapine, like understanding the way that works and the protocol around administering that for the first time.* – Dana, RN2, inpatient nurse.

> *Generally, it was medication. If you saw someone becoming distressed you would give them PRN medication to try and manoeuvre that distress* –Val, RN4, community nurse.

However, this wasn't without concerns:

> *If that's the only thing you've given a person who hears voices is medication, that's the only kind of defence mechanism that they've got, if they stop taking it then they're screwed. I think the most poignant thing was hearing about the old fellow- he was about 60, who committed suicide after he got treatment... he couldn't live his life without his two best friends [the voices].* - Taylor, RN3, community nurse.

> *Anti-psychotic medication is quite harsh. So I think in regards to over medicating, people end up quite sedated. Sort of docile and you don't want to do that to someone. There's no point in living life like that.* –Dana, RN2, inpatient nurse.

Reducing distress associated with the voices*: 'She was just... too frightened'*

All participants agreed that managing distress was important as it could be a precursor for self-harm. Offering PRN medication was the most common response cited for reducing consumer distress:

> *But in terms of doing anything with the voices, all they've being doing is, if she gets acutely distressed, are giving her some loraz (Lorazepam) to help her just be calm.* -Pat, RN2, inpatient nurse*.*

> *In regards to patients hearing voices, I suppose they can be different because they can be agitated by something they can't control and we can't control, apart from anti-psychotic medication.* –Bailey, RN2, inpatient nurse*.*

> *Medication helps lots of the time, I mean not always, you can just tell, medication is just the magic, but sometimes even with the medication patients are carrying on.* –Morgan, RN3, inpatient nurse*.*

The participants reported that talking to the consumer, or being with the consumer, was also a way to reduce distress. One participant described this as an interim measure that allowed time for the medication to take effect:

> *You need to make the environment they're in safe and comfortable to then let the medication work* –Pat, RN2, inpatient nurse.

Other suggested techniques for reducing distress included diverting the consumer's attention away from the voices and reality testing. A description of this suggested that they sometimes using cognitive-behavioural approaches to gently challenge beliefs about the voices:

> *She spoke about how she liked playing the piano and then she said "the voices said that if I didn't stop they'd kill my parents, so I stopped". … I said, "What do you think would have happened if you had kept playing?" … that's reality testing…* -Dana, RN2, inpatient nurse.

One participant suggested the use of earphones while listening to music as a response to distress from the voices:

> *Sometimes people find music very good. So listening to earphones especially because it's in the ear, they find that that can help drown out the voices* –Jordan, RN5, inpatient nurse.

However, another participant noted that these techniques were not particularly successful:

> *So when I started even just a few years ago a lot of it was just ignore, distract… which doesn't work. Or doesn't work for everyone.* –Taylor, RN3, Community Nurse.

A developing awareness into the relationship between consumer distress and the perceived power and control of the voices was very aptly described by one participant illustrating the feeling of helplessness to reduce the distress that was expressed by many participants:

> *But she was just… too frightened… like that it's absolutely their reality… that if she continued to play the piano her parents would die. It sucks.* -Dana, RN2, inpatient nurse.

Reducing risk and promoting safety: *'If I feel so scared […] how am I supposed to be helping this person?'*

The participants placed a high priority on risk reduction and promotion of safety, not just for the consumer but also for the staff and other patients on the ward. Distress and agitation engendered anxiety and fear as participants had experienced violence in the workplace:

> *We did have lots of patients who got injured, and the staff were injured as well because of the hallucinations and auditory hallucination and command*

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hallucinations as well. … They start being abusive, physically aggressive, verbally aggressive or trying to push, trying to kick, trying to punch the wall or breaking things, throwing chairs, things like that. –Morgan, RN3, inpatient nurse.

You can be a bit worried about what's going on in their head, so like command hallucinations … that could be quite dangerous. That's worrying. - Dana, RN2, inpatient nurse.

Expressions of personal fear and not knowing what to do were also commonly reported accompanied by a sense of powerlessness:

Uncomfortable. Like I didn't know what I was doing. Unsure of how to respond when she was really distressed. - Alex, RN1, inpatient nurse.

Sometimes patients with command hallucinations … can be really dangerous and they do things, which has happened a lot in this ward. … We can just offer different things to de-escalate the patient especially if they are hearing voices and they can't control the voices. -Morgan, RN3, inpatient nurse.

When consumer distress was perceived as being out of their control, participants focused on external control and talked about the use of force, or restraint to restore order:

When someone did become highly distressed… that's when, in an inpatient unit, you would look at things like, does this person need to be secluded at the moment, do they need to be restrained. -Val, RN4, community nurse.

Building rapport and a relationship: *'If somebody has a good rapport with you, […] they're much more willing to share their vulnerabilities'*

All participants expressed awareness of the importance of developing rapport and gaining trust to establish a relationship with consumers who hear voices. However, they

reported obstacles in achieving this, sometimes due to the consumer's behaviour and sometimes due to fear of criticism as expressed by one participant:

> *The other nurses criticized me for what I was doing because… we're not paid to do that… I guess they thought I was just having a good time… had they have actually come out and seen that it was therapeutic for him, that maybe they wouldn't have criticized me so much for doing that.* -Alex, RN1, inpatient nurse.

One participant described the technique used to determine if a consumer was hearing voices when unable to gain the consumer's trust:

> *They will see you coming, and zip up, and they don't want you to know what's going on. But if you can just observe them from another room and they're feeling a bit more relaxed like they're not being all out watched, then you can see them responding. And hear them responding.* – Dana, RN2, inpatient nurse.

One exception was a participant who attributed participating in a Hearing Voices simulation as part of undergraduate education to the ability to better develop rapport:

> *I feel I'm able to build a better rapport with consumers who hear voices than some of my colleagues that haven't had that experience.* –Chris, RN3, community nurse.

This participant felt that this experience had played a large part in the choice to work with consumers who hear voices as well as enhancing the ability to develop a therapeutic relationship.

Developing knowledge and skills: *'We have to do a lot of training ourselves'*.

The participants spoke with a mix of admiration and disappointment about their more experienced colleagues and the value they placed in learning from them. However, only

one participant gave an example of a more experienced colleague specifically interacting with a consumer who hears voices:

> *I have one colleague who is very vocal and she will just yell at a particular consumer until they get what she's talking about and doesn't recognise what's going on for the consumer is that they don't comprehend what you're saying at that time, that they're distracted by the voices.* – Chris, RN3, community nurse.

None of the participants felt they currently had enough knowledge and skills. Only one participant could specify skills or knowledge required for working with consumers who hear voices, identifying the need for empathy and understanding in order to build a therapeutic relationship. During the interview she began to question her practice of talking with consumers about the meaning of the voices, identifying a learning need in the process:

> *Like I do know that voices have a background, so they do stem from somewhere. Quite often it might be a big meaning but it just hasn't been part of my practice. This is great. Good learning. It's so reflective, isn't it?* – Chris, RN3, community nurse.

The lack of structure or opportunity for learning on the job was elucidated by one participant:

> *When we have someone that presents hearing voices, there's no real structure in our role as to specifically what we do, and so we have to do a lot of our training for ourselves.* – Val, RN4, community nurse.

Thus, there was a relationship between their perceived lack of knowledge and skills and lack of a clear role in relation to caring for consumers who hear voices.

Viewing the role of the mental health nurse: '*There's not a clear understanding*'.

Despite the interview focus on the role of the nurse in caring for consumers who hear voices, most of the participants' responses concentrated on the general care for all consumers, such as empowering the consumer or being an advocate. The view that there was no difference between caring for consumers who hear voices and caring for all consumers was summed up by one participant:

> *The role is to support the patient, like any other time*. –Bailey, RN2, inpatient nurse.

To illustrate their role, participants were asked to describe interactions with consumers. However, they had difficulty in this, instead relating perceived lack of ability to help or lack of awareness that they could help:

> *If they have this fixed long-term chronic hallucinations I don't think that I can do that much for them to be honest. I can just make sure that they go back to the community and be able to look after themselves, with the help of case managers or other people around them.* -Morgan, RN3, inpatient nurse.

> *Apart from distracting them from the voices or letting them be able to live with the voices – I don't know what else, as a nurse I can do.* – Pat, RN2, inpatient nurse.

The only participants who did not express feelings of hopelessness and helplessness were two of the nurses working in the community setting.

Impact of the practice context: '*Won't be doing those therapeutic interventions*'

Inpatient work was less highly regarded and perceived as unskilled by some of the participants, while community work was not only seen as skilled but also as a role that

belonged to the advanced practice nurse, or a professional practicing beyond the usual scope of the mental health nurse. Inpatient work was described as:

> *…a babysitting exercise of sitting on a person till they're well enough that a community team can take over.* -Taylor, RN3, community nurse.

Some of the participants talked about their undergraduate nursing preparation and how they had believed the skills learned would be used in practice, with one stating they were only utilised in the community setting:

> *What's unclear (at university) is that a nurse won't be doing those therapeutic interventions with someone… that's hearing voices. (On the ward) we didn't look at the therapeutic side of things and communication with the family and stuff, like that was mostly done by doctors and psychologists.* – Val, RN4, community nurse.

DISCUSSION

The two most striking aspects of the analysis centred on the participants' challenges in responding to consumer distress and issues arising from the workplace culture. The difficulty in responding to distress was the result of a fear of the consequences of engaging in discussion about voices. The workplace culture impacted on their ability to fulfil their therapeutic role with consumers.

Many of the participants in this study were unable to distinguish between the specific care required for responding to consumer distress related to hearing voices and the nursing care important to all mental health consumers. Consumer needs are better served when response to their distress is aimed at the cause rather than at the distress itself (Cleary, Hunt, Horsfall, & Deacon, 2012; Harrison et al., 2008). Therefore, the ability to differentiate between consumer distress related to the voices, and that related to other causes is important.

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There was little evidence of nurses engaging in dialogue with consumers about the voices except for those participants who spoke about challenging the consumer's beliefs about what the voices said, and managing the voices in a way that helped them engage in activities with less presence of the voices. If consumers are to benefit from a therapeutic relationship with nurses (McAndrew et al., 2014) then nurses need to be able to engage with consumers in dialogue about the voices. Despite changes in content in undergraduate mental health nursing curricula, a focus on the consumers who experience distress related to hearing voices has not been universal. Even for the participant who had reported using knowledge gained from undergraduate curriculum when working with consumers who hear voices, there was recognition that more was needed.

Support in the workplace for implementing skills was also lacking. Newly graduated nurses look to their experienced colleagues to learn how to put their knowledge into practice and to fit in to the culture of the workplace (Cleary et al., 2011; Wright et al., 2011). None of the participants were able to identify examples of their experienced colleagues engaging in discussion with consumers about the voices. Previous studies have reported that nurses experience difficulty in managing distress with fear of causing further distress if they said the wrong thing (Coffey & Hewitt, 2008; England, Tripp-Reimer, & Rubenstein, 2004). Subsequently, they are hindered from engaging in dialogue with consumers and rendered unable to assist consumers in finding adaptive ways to relate to their voices (Harrison et al., 2008; Schnackenberg & Martin, 2014). While experienced nurses benefit from ongoing education in order to improve care to consumers and provide support to their newer colleagues, this alone will not result in change when the environment does not support this practice.

Of note were the beliefs expressed by the participants about the differences between working in the community and working in the inpatient environment. In particular, they were surprised to learn that the skills they learned at university were not used by nurses in inpatient environments. This is similar to research from other countries where studies have reported that nurses were found to be thwarted in their efforts to adopt therapies by a lack of confidence, poor educational opportunities, and conflicting demands in the workplace (Carlyle, Crowe, & Deering, 2012; Fisher, 2014; Wright et al., 2011). If the skills learned at university are not adopted in practice then nurses may lose these skills and further support a cycle of sub-optimal therapeutic care.

The participants working in inpatient settings reported that engaging in task-based nursing, such as conducting formal risk assessments, took priority over spending time developing therapeutic relationships with consumers. This resulted in internal dissonance for participants who wanted to develop therapeutic relationships with consumers yet felt unsupported in doing so. A working environment that is focussed on task-based nursing over therapeutic care is detrimental to nurses' abilities to implement the person-centred care they deem important (Rose, Evans, Laker, & Wykes, 2015; Wright et al., 2011). More importantly, focusing on potential risks posed by patients inherently erodes the formation of a therapeutic relationship, as patients who are viewed as risky are not trusted (Buckingham, Adams, & Mace, 2008; Clancy & Happell, 2014; Cleary, Walter, & Hunt, 2005; Lakeman, 2006; Rose et al., 2015; Stein-Parbury, Reid, Smith, Mouhanna, & Lamont, 2008; Wand, 2012) . Thus therapeutic engagement with consumers experiencing distress related to voices is thwarted. Such engagement is both the hallmark to good nursing practice (McAllister, Happell, & Bradshaw, 2013;

McAndrew et al., 2014) and a key to the recovery oriented approach preferred by consumers (de Jager et al., 2016; Holt & Tickle, 2014; Jones & Shattell, 2013).

STUDY LIMITATIONS

This was a small study using a self-selected sample. Initial recruitment strategies were unsuccessful, therefore limiting the number of sites for recruitment. This limited the reporting of participant characteristics information due to a risk of breach of confidentiality. Additionally, while the focus of the study was on the experience of early career nurses working with mental health consumers who hear voices, the participants had difficulty staying focused on the topic of voice-hearing as they were keen to discuss their experiences more generally. This may have skewed the findings away from the essential topic of responding to distress from consumers who hear voices.

CONCLUSION

While the findings of this study confirm what has been previously reported in the literature, this research adds insights on mental health care culture and nursing practice. There is now evidence that consumers want to have their voice-hearing experience acknowledged and understood, thus challenging the traditional view that doing so reinforces psychotic behaviour. Beliefs such as this are embedded in the culture of mental health nursing practice. Even when participants understood the importance of engaging with consumers in relation to their voice hearing, the perceived lack of knowledge and skills in more experienced colleagues hindered their ability to do so. Knowledge and skills alone are insufficient in supporting and sustaining changes in practice. The prevailing culture, and in particular the focus on risk, hinders

implementation of these skills. Consequently, changes to policies that focus on risk assessment and management are necessary in removing the barriers to implementing evidence-based knowledge and skills in practice.

This requires further investigation into the preparation of nurses at undergraduate level for working with mental health consumers who hear voices, as well as investigation into the support for implementing and developing the knowledge and skills in practice.

RELEVANCE FOR CLINICAL PRACTICE

This study identified that despite investment and changes made to mental health nursing curricula in Australia, further improvements are needed both in education and in the workplace, in order to better support nurses to improve the care of mental health consumers who hear voices. This should include educational activities that develop understanding of the lived experience of hearing voices as well as knowledge of support services and self-help groups, such as the Hearing Voices Network (Hearing Voices Network NSW).

Just as newly qualified nurses need education and skills specific to responding to consumer distress related to hearing voices, the findings also indicate that changes are needed in the prevailing culture to ensure that experienced nurses can also implement the skills required to respond to consumer distress related to voices and support their newer colleagues in developing these skills.

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