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A SMOKE FREE MENTAL HEALTH SERVICE – CAN IT HAPPEN?

On July 1st 2007, the Frankland Centre, inpatient unit of the Western Australian State Forensic Mental Health Service, went totally smoke free in all indoor and outdoor areas. Despite detractors and foretellers of chaos and mayhem, the introduction has proven to be very successful with positive consequences.

Frankland Centre is a maximum secure 30-bed unit with several courtyards, oval, gymnasium and workshops, on several acres, within a secure perimeter. There are 350, generally high acuity, high-risk admissions per year with average 90% smokers.

Smoking is considered to be the single greatest preventable cause of death in society. Indirect exposure or passive smoking is also a considerable health problem. Many studies recognise persons with psychiatric illness smoke excessively, with some as high as 94%. Links between smoking and higher premature death rates for such persons has also been noted, compared to the general population. Smoking was a long established culture within mental health facilities including Western Australian settings. None more so than the Frankland Centre, where use of cigarettes was not only covertly, but overtly used for developing rapport or for clinical management of patients.

Public health and social attitudes have influenced smoking in the general population, however this has been belated in transferring to mental health facilities. Within Frankland Centre there has been increased focus on patient and staff health, however little was done in relation to smoking. Occupational Safety and Health concerns in mid 2006, related to second hand smoke, provided the catalyst for introducing change. Cleaners refused to enter the ubiquitous 'smokers rooms' to clean them. Actions were taken to make it safe by closing the rooms two hours prior to cleaning. Then quite rightly, nursing staff asked 'what about them'. It was made safe for one group of staff but nurses were still expected to enter these rooms.

A working party was established to examine all aspects of smoking. Considerable literature reviewed and expertise accessed, concluded that the only safe action was to go totally smoke free. A project officer was appointed in November 2006 and an implementation plan was developed with four main phases:

- Planning, scope, timeline, raising awareness, seeking support.
- Education to staff, assisting staff to quit, gaining support.
- Assessment, education, policy, procedures and interventions for patients.
- Evaluation.

Many barriers were encountered in the early phases of the process. Working party membership was increased with many smokers included. However some had their own agendas or intent to stop the process. Staff and consumer groups raised many concerns, the majority related to fears of increasing aggression, exacerbation of symptomatology, effects on medication, increased boredom, staff moral and attrition. Claims were made that patient's rights would be infringed. The most frustrating barriers were bureaucratic issues external to the service. Pharmacy delays regarding ease of access to nicotine replacement therapy for patients' only days before implementation lead to unnecessary concern. Despite our service agreeing to provide free NRT to staff, area health budget holders overrode this.

Considerable effort was put in to turning this around mainly through the hard work of the project officer. Issues raised through staff forums and meetings, were addressed and worked through. Legal and Human Rights opinion sought concluded that there was no 'right to smoke', and services have 'duty of care' to prevent contact with anything that causes harm. Management then gave clear direction that the service would go smoke free and a new implementation group was established. Among the main turning points was a teleconference for staff with a similar Canadian service that had gone smoke free, as well as a visit by Dr Charl Els from the same service.

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VICTORIAN MENTAL HEALTH NURSE PRACTICE FELLOWSHIPS

The Centre for Psychiatric Nursing is pleased to announce the launch of the Victorian Mental Health Nurse Practice Fellowships. The Fellowships, valued at up to $1,000 each, will be awarded annually to Victorian nurses to enable them to undertake various activities designed to improve the care of mental health consumers. This may include support to attend conferences, short courses, or other projects.

For application forms and further details please refer to the CPN website: http://www.cpn.unimelb.edu.au

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Editorial Staff
Rosemary Charleston
Greg Mutter

Centre for Psychiatric Nursing
School of Nursing
The University of Melbourne
Level 5 / 234 Queensberry Street
Carlton VIC 3053

RIDERS ON THE STORM

REFLECTIONS ON A PRESENTATION AT THE ACMHN CONFERENCE 2007

It has been another hot summer for us in 2007/08. With the changing of seasons comes an increasing risk of bush fires, which have the potential to destroy property, uproot communities, and seriously affect people's lives. With this possibility in mind, I (first author) attended a presentation that Penny Ison and Clif Nelder, from Cairns and Hinterland Health Service District, gave on their Mental Heath Disaster Recovery Team's response to the aftermath of Tropical Cyclone Larry. In this article, we provide a summary of how the team responded to this natural disaster.

Underpinning their practice were the Zunin/Myers (in DeWolfe, 2000) phases of disaster. These phases include: warning, threat, impact, heroic, honeymoon, disillusionment, working through grief, and recovery. With this model in mind, we will now discuss what the Mental Health Disaster Recovery Team did during some of these stages.

Heroic Phase

In the immediate aftermath of a disaster, such as Cyclone Larry, relief activity primarily centred on the basics of human existence – safety, food, clothing, and shelter. In this phase, the Mental Heath Disaster Recovery Team focused on both the general population and existing consumers of mental health services. For people in the general population, the team undertook 'psychological first aid,' and, for existing consumers, they ensured continuity of care, especially with regard to medications. Home-based services were provided where appropriate.

Honeymoon Phase

This phase is characterised by community bonding and the availability of coordinated government and volunteer assistance for survivors. The survivors tend to be optimistic that this help will remedy the situation. During this phase, the emphasis of the Mental Heath Disaster Recovery Team was on widely disseminating information about normal stress reactions to disasters. Such messages reached members of the community through radio and print media, and through pamphlets distributed by general practitioners, news agents, and disaster recovery services. Multi-lingual pamphlets included information on helping children and young people through the disaster, how to cope with anxiety and stress, strategies to aid recovery, risk factors for future mental health issues. This information was constantly repeated, which acknowledged that survivors' receptivity to such messages changed over time.

Disillusionment Phase

In this phase, the withdrawal of government and volunteer assistance begins (often prematurely, in the eyes of survivors) and survivors gain a strong impression of their losses and the limited assistance available. Mental health staff screened and assessed people for unusually intense responses to the disaster. When appropriate, staff intervened with counselling and reassured people that their responses were normal. Staff educated people about remission and the effects of the anniversary of Cyclone Larry, and discouraged passivity and dependency. They also worked with survivors on reducing psychological arousal and anxiety, increasing coping abilities, and restoring social support systems.

Working through Grief Phase

In the working through grief phase, setbacks can occur in the disaster recovery, and people who were psychologically asymptomatic in earlier phases, sometimes show serious signs of anxiety and depression. Even though much of the assistance that is mobilised following a disaster is withdrawn in subsequent months, the Mental Heath Disaster Recovery Team kept a strong presence within the community. Mental health staff went door-to-door with workers from other agencies (e.g., Red Cross) to see what they could provide these people. They also spoke with, and provided education for, various groups, such as schools, the Country Women's Association, and Aboriginal organisations. Education focused on normal responses to an abnormal situation.

Recovery Phase

In this phase, survivors assume responsibility for rebuilding their lives. Recovery is seen when survivors see personal growth and opportunity from their experiences, rather than solely focusing on their losses. Here, the Mental Heath Disaster Recovery Team assisted with the transition of leadership from the organisations that had been prominent during the recovery to those services that been dominant in the community before Cyclone Larry. In their work, the team promoted cohesion and identity so that they could withdraw and let the pre-existing mental health services resume their work. To ensure continuity of care, the team provided a comprehensive handover to these services.

Conclusion

The Cyclone Larry Mental Health Disaster Recovery Team found that the number of referrals to mental health services and requests for assistance increased in the aftermath of the cyclone. The number of referrals for moderate and severe psychological disorders, however, was less than could have been expected in such a disaster. Although this outcome may have been influenced by several factors (e.g., there were no fatalities, major flooding was feared but did not occur, strong social bonds between community members), the work of the Mental Heath Disaster Recovery Team must have had a positive impact on the mental health of survivors. We're sure mental health nurses in Victoria will be heartened by the positive impact members of their profession can have in such trying circumstances.

Dr Cadeyrn Gaskin
Research Fellow, Centre for Psychiatric Nursing

Penny Ison
Cairns and Hinterland Health Service District

Clif Nelder
Cairns and Hinterland Health Service District

"PSYCHO-GERRY STAFF A PLENTY"

Staff at Latrobe Regional Hospital's Macalister Unit presented at the 8th Collaborative Psychiatric Conference in Melbourne in 2007, detailing their plan to improve psychiatric geriatric staffing.

Macalister is a 20-bed unit with 10 psycho-geriatric nursing home beds and 10 acute assessment beds. The unit caters for clients over the age of 65 with a mental illness. The hospital's catchment area is 44,000 square kilometres.

The unit had in the past been chronically under staffed and morale had been extremely low. Staff embarked on a two-year journey to source staff and create an environment they wanted to work in, which eventually resulted in the unit becoming fully staffed.

Latrobe Regional Hospital's philosophy and practice as a team is best described by the acronym - WE CARE:

– **Wellbeing** – **Empathy** – **Compassion**

– **Accountability** – **Respect** – **Excellence**

We have fully embraced this philosophy, which is now what drives practice on our unit.

It was important for us to communicate our journey to others, especially the message that regardless of the challenges, positive change can, and does occur. Macalister staff decided that a video would be the best way to illustrate how they felt about the care provided and the team that provides it. Staff were asked to express their feelings both positive and negative about the unit they work on. In late 2007, two key staff members were selected to present our journey at the Collaborative Psychiatric Nursing Conference, held in Melbourne. This included a senior nurse of 10 years experience who had been through the good and bad times on Macalister and a newly qualified practitioner whose own personal experience had brought her to nursing later in life.

Christine Sexton and Nikki Bruce from the Macalister Unit

The result was a passionate presentation to the soundtrack of the children's films 'Toy Story' about this unique and challenging area of nursing.

The video was successful in portraying the intended message and feedback was positive. Macalister unit staff at Latrobe Regional Hospital are extremely pleased to assist other psycho-geriatric units to achieve a healthy staffing profile by sharing their long but worthwhile journey.

AUSTRALIAN COLLEGE OF MENTAL HEALTH NURSES RESEARCH GRANT 2007

Identifying the 'Right Patient': Nurse and Consumer Perspectives on How to Verify Patient Identity During Medication Administration

Medication safety has become a key issue in Victorian mental health services, and last year a Victorian Mental Health Nurses' Medication Safety Special Interest Group was established to develop and share innovations in this area. Here, at the Centre for Psychiatric Nursing, Teresa Kelly is leading a team that has been successful in obtaining the Australian College of Mental Health Nurses' Research Grant for 2007. The grant will be used to explore nurse and consumer perspectives on how to verify consumer identity during medication administration.

The one area in which mental health nurses' application of the five cardinal rules of medication administration (right dose, right medication, right patient, right route, right time) differs from nursing practice in non-mental health settings is in the ways of identifying 'right patient.' In most psychiatric inpatient units in Victoria, identification aids are not used. This creates a substantial risk that nurses will administer medications to the wrong consumers. In using unreliable methods of identifying consumers, nurses fail to fulfil their duty of care to prevent harm.

Anecdotal reports suggest that nurses perceive that consumers dislike some methods of patient identification, such as wearing wrist bands, and that some nurses perceive consumers rights are infringed through wearing such personal identifiers. The purpose of our study is to determine effective ways of identifying consumers during medication administration, which promote safety and are acceptable to mental health consumers and nurses.

Using focus groups, our research team will ask mental health consumers and mental health nurses about their experiences of patient identification during routine psychiatric medication administration. We will also ask consumers and nurses of their preferences for, and different ways of verifying 'right patient' during medication administration. We will use the findings from this research to develop guidelines for the identification of 'right patient' during medication administration in psychiatric inpatient settings. These guidelines will help to ensure consumers receive the medication they have been prescribed.

Research team: A/Prof Stephen Elsom, Teresa Kelly, Cath Roper and Dr Cadeyrn Gaskin

Our research project is currently in the participant recruitment phase, in which we are openly inviting consumers and nurses from across Victoria to be involved in four focus groups. In future issues of the Carillon, we will provide updates on how the research is progressing.

If you would like to learn more about our work, please contact **Teresa Kelly on 8344 9626**.

AND ANOTHER THING … CARING FOR THE 'WHOLE' PERSON

This contribution to Carillon argues for adequate recognition and value of the whole needs of a person with mental illness. As with any specialisation, it is easy to become blinded to that main area of interest, and be less attentive to the additional health problems a person may have.

While this is necessary and critical in many acute situations in most specialties, it is unfortunate and can result in other health issues being neglected in relation to long-term management. Concomitant health needs that promote health and include the management of comorbid physical conditions are important considerations in the care of the person with mental illness.

Health promoting considerations include such basic health needs as nutrition, regular exercise, dental health, and smoking control. Comorbid physical conditions are an equally important consideration: after all, people with mental health problems have a similar prevalence of physical illnesses as the general population. Chronic physical conditions are frequently associated with depression which increases the experience of unpleasant symptoms such as pain, fatigue and insomnia. So, why is it that the broad divisions of mental and physical illness continue to be so disconnected that concomitant health issues can be neglected, even though we espouse the view that the person needs to be cared for as a whole?

This situation is due to a few key issues. Essentially, research examining combinations of mental and physical illness research remains uncommon, reflecting the Cartesian mind-body split. Researchers tend to confine comorbidities to their respective body system or sub-system of interest. In particular, the bulk of the literature relating to comorbidity concerns mental health or the epidemiology of comorbidity. This issue is compounded by the fact that comorbidity, or multimorbidity has no clear, universal definition.

The overspecialisation of health has limited the opportunity for integration within specialties. To illustrate this point, there are currently more than 2,000 categories of health professional in the USA, compared with 10 categories fifty years ago (Lawrence 2002). Australia is following a similar trend with currently more than 75 areas of defined nursing practice. The person with co-existing, chronic conditions is therefore required to interact with a variety of practitioners in multiple health care settings in an effort to manage complex treatments. This highlights the replication, fragmentation, and omissions in care.

For example, dual diagnosis or 'double trouble' illnesses often exacerbate each other and have overlapping symptoms, making treatment especially difficult. So too do combinations of mental illness and physical illness. For example, a person with mental health problems who requires acute care services for a physical illness may be at risk of inadequate care of their mental health during this time. When different body systems are diseased, there may be conflicting aims of treatment. This situation is made more complicated when the illness is stigmatised, as is the case in many chronic conditions of either mental or physical origins.

The socio-political implications of combining illnesses that receive negative press have important ramifications for the future development of integrated health care approaches. Staffing profiles are significantly different for each subspecialty, which complicate their integration. For example, consumers with dual diagnosis may receive treatment in either a mental health facility or a detoxification unit, placing them at increased risk of physical illness, social isolation, and self-harm.

Effective chronic illness management requires more than adding to a system focused on acute care, but attention to the design of the delivery system. A lack of time often prevents illnesses secondary to the presenting problem being assessed and appropriate management and follow-up being instigated during consultations. Referral systems are often ad hoc, and a revitalised supportive health care system that recognises and values the additional time that chronic illness management entails is critical. Such initiatives need to be appropriately funded. However, the added costs of attending to the person's overall health needs are contributing to the 'blow out' in healthcare expenditure not envisaged by healthcare planners. Yet people with complex health problems require long-term health promotion and illness management to control healthcare costs.

It is evident that a comprehensive, multidisciplinary approach to managing chronic illnesses with quality communication, supports and referral processes is needed in order to deliver co-ordinated continuity of care. The one-size-fits-all approach is not applicable or appropriate for the majority of people with chronic illnesses, and people most likely to suffer from failures in the healthcare system are those in the most need. Innovative models of healthcare that integrate disciplines are required with appropriate funding to ensure quality care of the chronically ill.

Allison Williams

ARC Research Fellow at afw@unimelb.edu.au

Lawrence, D. (2002) *Can the NHS learn from the USA?* The Kaiser Permanente experience of integrated care 9th Annual Office of Health Economics Lecture delivered by David Lawrence MD, Chairman and Chief Executive Officer of Kaiser Permanente.

NB: For related references please contact the author

9th VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

REGISTRATIONS

14 & 15 August 2008

As joint hosts the **Centre for Psychiatric Nursing, The Australian College of Mental Health Nurses (Vic Branch), The Health and Community Services Union** and the **Australian Nursing Federation** invite you to attend this exciting conference.

The aim of this conference is to focus on the practice of psychiatric nursing and how this practice contributes to better health outcomes for the consumers of services.

Registrations are now open

The registration form is available on the CPN website:
www.cpn.unimelb.edu.au

If you require further information please contact **Greg Mutter** at the CPN:

T: (03) 8344 9626
E: cpn@nursing.unimelb.edu.au
F: (03) 9347 4375

Be a winner!

Early Bird Registrations received at the CPN by the close of business on Friday, 30 May will be eligible to be placed in a draw. The winner of the draw will have their registration fees refunded.

REGISTRATIONS CLOSE: **Early Bird – 30 May 08**
All Others – 18 July 08

Themes

- Innovation in practice
- Sustainability of psychiatric nursing
- Consumer perspectives
- Carer perspectives
- Clinically-based research and evaluation
- Psychiatric nursing across the life-span
- Rural issues
- Cultural and indigenous issues
- Dual diagnosis
- Dual disability
- Recovery

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A SMOKE FREE MENTAL HEALTH SERVICE

The lead up to final stages saw significant increase in support by staff. Saturation of information and intensive advertising was undertaken with newsletters, posters and notices. Policies, NRT protocols, assessment and documentation forms were developed. Staff assisted with considerably increasing activities like art therapy, tai chi, sports, board games, magazines, cooking and music appreciation.

At implementation date stress-relieving strategies were introduced including supply of healthy snacks including microwave popcorn and large numbers of stress balls were distributed.

To date there has been no increase in aggression or any incidents directly related to smoking bans, and no concerns voiced by staff. Early data appears to show slight reduction in PRN medication and anecdotal reports indicate that patients sleep patterns have been improved.

In conclusion, Frankland Centre in now 5 months smoke free, and the predictions of chaos and mayhem have not occurred. No member of staff has left due to this. Instead we have noticed the subtle differences and clean air in our workplace. Staff were our greatest hurdle, but were also our greatest asset. Through strong leadership and support of staff, implementation went very smoothly. Smoke free is no longer the dreaded word it used to be and staff have not only accepted but have taken ownership of the process, ensuring patients are adequately supported during admission. NRT dispensing is now part of the daily routine, as is clean air and a healthier workplace for all.

Michael O'Kane
Nurse Director
State Forensic Mental Health Services
C/- Frankland Centre, Graylands Hospital Campus
Claremont
Western Australia

Breda Ryan, RMHN
Smokefree Project Officer, Frankland Centre
Breda.Ryan@health.wa.gov.au

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If undeliverable return to:
Centre for Psychiatric Nursing
School of Nursing The University of Melbourne
Level 5 234 Queensberry Street Carlton VIC 3053