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IN THIS ISSUE

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Editorial Staff
Finbar Hopkins
Greg Mutter

Centre for Psychiatric Nursing
School of Health Sciences
Level 2, 757 Swanston St
Parkville Vic 3052

THE JOURNEY TO GENDER SENSITIVE CARE FOR WOMEN CONSUMERS OF MENTAL HEALTH SERVICES

Jayashri Kulkarni, Professor of Psychiatry, The Alfred and Monash University, Heather Clarke Chair Woman of the VWMHN,
Cheryl Sullivan Project Officer VWMHN

Overview

Over the past five years the focus of the work of the Victorian Women and Mental Health Network (VWMHN) has been to address the safety needs of women admitted to adult acute mental health units. As the Project Officer for VWMHN, I met with Penny Cutting, the Clinical Coordinator and Women's Lead for the South London and Maudsley National Health Service Foundation Trust of the Bethlem Royal Hospital London, during 2010, to discuss mental health services for women in the English context. This article outlines a brief history of the journey towards gender sensitive care provision in England and Wales, the response from one foundation trust and some issues for reflection as we in Australia continue to develop a service system which provides a safe and secure services and healing environment for women.

History

In England, the push for gender service change came from the results of a study on patient safety conducted by MIND during the 1980's. The study reported on some horrific experiences of women who were patients of the mental health system.

Several Government reviews have since been conducted such as the 2002 report *"into the mainstream"*. From this study arose a national strategy *Mainstreaming Gender and Women's Mental Health* recommending the establishment of women only areas in acute and secure settings and women's safety in residential settings.

In 1998 the Government set a target of 70% of all health authorities to provide single sex accommodation to 95% of women by 2002. This target has not been achieved as yet. The 2009 *"Women Detained in Hospital"* report found that while some services did provide care sensitive to the issues of privacy, dignity and safety for women, there were many services not meeting the needs of women. The 2009 *"Count me in"* report confirmed these findings stating that 76% of women were not in single sex wards at the time of the census.

Response to the need for Women in the South London and Maudsley National Health Service Foundation Trust

Penny Cutting, who has worked with the South London and Maudsley trust for over a decade spoke of how they have adapted their services in response to the call for gender sensitive environment for women.

Within their inpatient unit they now have separate male and female units, the female unit being 22 beds and the male unit providing 25 beds. They have 17 emergency and high dependency beds for males and one high dependency bed for a woman. One unit, which was previously an inpatient unit, has been converted to a day program, providing services to people with Borderline Personality Disorders.

From discussions with women Penny noted that what women, apart from wanting to be cared for in a safe and secure environment, requested the opportunity:

- to talk, be listed to and be provided with practical help
- to talk about the trauma they have experienced in a safe environment and be able to fit this into the context of their life
- to learn skills to assist them in the future
- to have creative opportunities eg guided creative writing, art.
- to be cared for in a "green space".

In an attempt to provide this model or care, in addition to the women's unit, the trust has developed an eight bed unit in one of the green, leafy suburbs called *"Foxley Lane"*. This is a unit run by women for women. It is led by nurses and set up in partnership with women, taking women's stated requirements into account. The length of admission to Foxley Lane unit is approximately 21 days.

Referral to the unit is multi-pronged and women can: self refer, be invited for assessment, voluntary patients can be transferred from the acute ward if assessed as suitable and if the woman is an involuntary patient this can be rescinded if Foxley Lane is seen as the most appropriate treatment environment.

Penny said that there are some other similar units in England offering an alternative model of care to hospital. One of these units offers accommodation to women with their children.

Penny noted that staff training is a major area of concern in the general units. While there was recognition of the need for gender sensitive care, there was no specific funding allocated for staff training. This has resulted in a structural change to the service system, but not a corresponding cultural change to meet the needs of women.

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THE SMOKE FREE POLICY: A SNAPSHOT IN VICTORIAN MENTAL HEALTH 3 YEARS ON

The smoke free policy introduced in Victorian Mental Health Units has been an emotive and divisive topic. To gain an overview, all Adult Mental Health Services (AMHS) in the state of Victoria were contacted. Each was able to verbalise what was happening at the local facility and express any problems occurring there. They were problems associated with patients smoking on hospital grounds, at the front of hospitals and in courtyards of mental health units. Risks of fires were highlighted. Smuggling of cigarettes was problematic. Of course, the heightened risk of aggression was of paramount concern.

Of the 21 AMHS in Victoria 17 implemented the Smoke Free Policy. Of the four who did not implement the policy, one created a designated smoking area, two never implemented the policy and one implemented the policy on two occasions without success. In one mental health facility which has two wards, one ward had an exemption, the other not. At one unit an application for an exemption has been made and at two others, the policy is under review. Of those with exemptions, all without exception stated they had no problems. The focus of this discussion is the 17 which do not have an exemption.

The majority of people interviewed were all willing to talk and freely described what was happening at their AMHS, with the exception of one NUM who was somewhat dismissive. All wished to receive feedback on the findings of this study, and indeed felt that something needed to be done about this issue and a State-wide snapshot was desirable.

All without exception stated the Smoke Free Policy was not working. Some of the descriptive language included: *"An uphill battle"; "It's three years on and we still have the same problems"; "It's an infringement on their (patients) rights"; "It's a disaster"; "It's an issue for mental health patients. The hospital board is to be involved"; "It's a burden for the patients"; "The patients still smoke"*. All stated that doctors did not "prescribe cigarettes" and pressured nurses to accommodate patients with cigarettes who in turn pressured social workers to buy cigarettes for patients. All without exception offered NRT and had quit educators to assist patients to quit. The majority of these reported that patients often flatly refused NRT, preferring to smoke. All stated that the policy is difficult to enforce and that nurses do not feel they should act as police. All stated that patients still smoke.

Half of the AMHS reported that patients were smoking in the courtyard. The other half had patients smoking at the front of the hospital or on hospital grounds. For the latter some reported that: *"There's no dignity for the patient"; "We have a beautiful courtyard that is totally empty"; "There have been punch ups from patients from different units"*. Some units are situated near business or residential areas and all of these had received complaints from local businesses or residents. The majority of AMHS who have patients smoking outside have had leave policies changed, with the majority making changes to leave forms and altering risk assessments. In other units, patients are escorted outside the grounds to smoke by nursing staff. The majority of respondents say: *"It is not a good look"; "The general ward patient's are out there smoking with drips hanging from their arms."*

The majority of units had noted an increase in aggressive or threatening behaviour directly linked to smoking; *"I don't want my staff bashed"; "A patient had to be secluded because he wanted a cigarette."* In one unit a patient smashed the window between the High Dependency Unit (HDU) and was secluded; because the smoking issue dominated his care, he had to be transferred to another facility where smoking was permitted. The majority of those units reporting increased incidents of aggression are in locked units or HDU.

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GENDER SENSITIVE CARE

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Gender Sensitive Care in Victoria

When Penny was speaking I was struck by the similarity in the responses of the needs of women in England to those frequently articulated by women in Victoria. As documented in the VWMHN *"Nowhere to be Safe Report"*, after wanting a safe and secure environment, women identified the focus on medication was too narrow and they wanted increased opportunities to talk with staff about ways of soothing themselves and managing emotional distress. They also wanted more activities. During other forums with women, I recalled how they spoke of the need for *"green spaces"* and that this was one of the downfalls of moving from the previous "institution" model of care.

The VWMHN developed a 5 point action pan prior to the last Victorian state election. We called for the government to:

- Ensure a policy of providing choice of single sex treatment environments be incorporated into the design guidelines for adult acute inpatient units.
- Ensure any new units being built provided a separate women's area comprising an adequate number's of designated female rooms, women's lounge, bathroom facilities and outdoor recreation area,
- Restore funding for women's mental health consultants to all Area Mental Health Services and establish a State wide Women's Mental Health Coordinator position.
- Support training for mental health staff in the implementation of relevant Chief Psychiatrist and Service guidelines to ensure a culture of gender sensitive practice becomes embedded in acute community mental health services.

In Victoria we have certainly started the journey with the publication of the *"Gender sensitivity and safety in adult acute inpatient units project report"* in 2008 and the Chief Psychiatrist's Guideline *"Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units"* in 2009. Several units have developed women only spaces.

The new Victorian Government, in their pre-election policies committed to:

- The development of a Prevention and Recovery Care (PARC) Facility for women
- The establishment of three new mother and baby units in regional Victoria
- Investing $4 million to establish gender-separated areas in existing facilities and committing to gender-separated environments in new facilities

Some of the next steps

It is recognised that training and induction for staff is a vital requirement to bring about the cultural change required in the provision of gender sensitive care for all those who access our mental health services.

We need strong and committed leadership to ensure that the provision of gender sensitive care is seen as a priority in the unit and that resources are committed to providing the support and training for staff.

All new facilities must be designed and built with the provision of separate women's areas and existing units modified to provide gender separate spaces.

We need to ensure that women using mental health services have the opportunity to talk and be listened to, that they are offered appropriate activities while inpatients and are supported with their concerns properly responded to and correctly reported if they have experienced harassment or assault.

The provision of Gender Sensitive Care is a journey we have commenced, like England, we still have a long way to go, but we are on the path.

Cheryl Sullivan
Project Officer
Victorian Women and Mental Health Network

INJECTING TRANSLATION INTO RESEARCH

One of the main research programs of the Centre for Psychiatric Nursing in the Melbourne School of Health Sciences is that of medication safety. A recent focus of this program has been on best practice in the administration of intramuscular injections. This work has resulted in numerous keynote and invited presentations and many requests for consultancy from health services seeking assistance with practice change.

In January this year, Associate Professor Stephen Elsom, Director of the Centre for Psychiatric Nursing, was engaged by the consulting and communications company, Lifeblood, working on behalf of Janssen-Cilag pharmaceutical company, to develop a training module on the use of long acting injectable antipsychotic (LAIA) medications. The package includes a PowerPoint presentation dealing with such issues as: the role of LAIA in the treatment of schizophrenia; engaging consumers; preconceptions and assumptions about LAIAs; and injection technique. It also includes a series of videos in which A/Prof Elsom demonstrates correct practice in the administration of intramuscular injections.

The training package, which is titled *"Long-acting injectable antipsychotic medications: A guide for mental health nurses"*, has been rolled out across Australia through Janssen's network of nurse advisors with very positive feedback received from clinicians and services. One example was received after an inservice that was conducted at Goulburn Gaol hospital in NSW:

"After the inservice the Acting Team leader who had originally escorted me in called me into her office. She commented that the presentation was amazing and commented that it was nice the presentation was not promotional and that Janssen was giving valuable education to nurses. The Acting Team Leader also commented that the presentation has shown them new practical methods to improve their practice and bring them out of the dark ages as she reported that the nurses there felt cut off from the outside world as they seldom received education."

A/Prof Elsom demonstrates correct practice in the administration of intramuscular injections

The success of the training package in Australia has prompted interest from the Asia-Pacific region with Janssen's Hong Kong team recently requesting permission to use the package for their training program.

The growing profile of the Centre's work on intramuscular injection practice has also resulted in several mental health services seeking to be involved in our research. We have recruited three Victorian services as part of a pilot study designed to investigate the pharmacokinetic and clinical effects of changing from the dorsogluteal to the ventrogluteal site for the administration long acting injectable antipsychotic medications. It is anticipated that this study will provide important data to inform the design of a more extensive investigation leading to the development of guidelines for the safe transition to best practice.

STATISTICS IN NURSING RESEARCH

Evidence based nursing is ideal for providing quality care to clients. Over the past decade, the use of evidence based practice has become the standard for optimal clinical decision making and provision of quality healthcare. Evidence based nursing involves application of quality evidence into nursing practice. Identifying quality evidence from empirical patient care research requires better understanding of statistics. As a discipline, statistics plays a vital role in the different components of quantitative research including research design, data collection, analysis, and interpretation of results. Statistics in nursing had been used since the beginning of modern nursing. Florence Nightingale, the founder of professional nursing, effectively used statistics as one key element to develop and inform best nursing practice. She analyzed data using descriptive statistics and radial graphs, showing statistics has been an integral part of nursing practice. However, the extent of statistics use in nursing has been challenged by lack of statistical skills among nurses.

With a shift of paradigm in nursing practice to evidence based nursing, in the recent past, it is imperative for nurses to improve their understanding of quantitative research approaches in order to be able to fully and critically evaluate empirical findings in pursuit of quality evidence. Such understanding is an absolute requirement for the clinical application of research evidence. A good knowledge of quantitative research provides a level of objectivity that increases our confidence in the conclusions we draw with regard to scientific facts and existing scientific principles. To use empirical data most effectively, a sound understanding of major research principles and statistical methods is required.

In this newsletter we will commence a stat corner column which will highlight basic concepts and issues in quantitative research. Most commonly used statistics in nursing literature will be briefly reviewed to assist readers develop ability to determine and interpret appropriate statistical measures within the context of the nursing literature. To provide a comprehensive overview of basic statistics, different types of variables and measures in the context of health research will be discussed. Principles employed in applying a range of statistical tests in nursing research, ranging from chi-square to t-test, will be underscored. Topics on research design, descriptive and inferential statistics will also be highlighted in subsequent series of this newsletter.

Zewdu Werata & Roshani Prematunga
Researchers
Centre for Psychiatric Nursing

THE SMOKE FREE POLICY

continued from page 2

There is evidence in a minority of units that underreporting of aggressive incidents is occurring. *"As you know there is always underreporting in these matters"; "We were told not to mention smoking because it's a smoke free environment."*

Other risk issues were also noted. In a minority there have been fires within the units. These included a laundry and storeroom. These were directly linked to the smoking policy and patients smoking clandestinely. There is evidence that nurses are tied up with performing visual observations and are constantly searching for patients off the hospital grounds. *"Before we had a designated smoking area, visual obs would take up to 15 minutes. Now they are done every three or four minutes."*

The majority of units said they would like to have a Designated Smoking Area (DSA). Further, in one unit, patients smoke near doorways and walkways used by patients, staff and visitors. At another unit, an Aboriginal Healing Centre has been erected on the hospital grounds. This is being used as a smoking area not only by psychiatric patients, but by patients from other wards; plans are under way to have a DSA so that the Healing Centre can be used for its original purpose.

In the majority of units that are locked and the HDUs of open wards, smuggling of cigarettes and lighters by visitors has occurred. Many respondents saw this as a safety issue. In one unit, a patient was found to be smoking in seclusion.

Mental health patients are often unwilling or unable to quit smoking and consequently, despite the smoke free policy, continue to smoke state wide. This is despite NRT being offered and quit educators on site at many mental health facilities. Nursing staff do not see it as their role to police the policy. It presents problems in duty of care and Occupational Health and safety. The smoke free policy is problematic for all facilities across the state, for patients and staff, for surrounding communities and family and friends of patients.

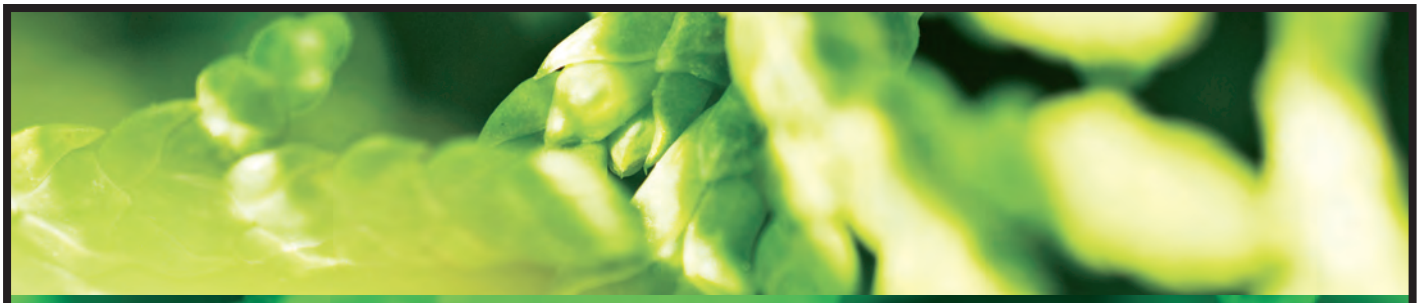
Matt Donato
Mental Health Nurse Researcher
St Vincent's Hospital Melbourne

CARILLON – now an eNewsletter

As a contribution to reduce our effect upon the environment, the Carillon will no longer be available in a hardcopy format from the beginning of 2011.

An e-copy Carillon will be available via email and can also be accessed via Centre for Psychiatric Nursing's website: **http://www.cpn.unimelb.edu.au/**

If you currently receive a hard copy of the Carillon and still want to receive an e-copy starting in 2011, please email us at **cpn@nursing.unimelb.edu.au** to provide us with your current email address.



12th VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

Thurs 11 & Fri 12 August 2011

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.

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

Registrations must close Friday 15 July

THEMES

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

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the Australian College of Mental Health Nurses Inc.