carillon
representing progress & communication over distance

Volume 13 Issue 42
September 2010

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carillon
Is published quarterly by the CPN.
For more information or contribution details please contact the CPN on the details below.

Editorial Staff
Finbar Hopkins
Greg Mutter

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

11TH VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE – AND YET ANOTHER SUCCES

On the 12th & 13th of August 2010, 330 delegates attended the 11th Victorian Collaborative Psychiatric Nursing Conference at the Moonee Valley Racecourse in Moonee Ponds, Victoria.

Delegates came from various private and public Victorian Mental Health Services, South Australian and Queensland public Area Mental Health Services and Victorian, South Australian and Queensland academic institutions.

Delegates chose between three consecutive sessions over the two days, with a choice of 37 presentations, 3 workshops and 4 keynote presentations.

Keynote presenters were: Ms Felicity Grey from Our Consumer Place who spoke of a consumer's perspective of recovery; Associate Professor Stephen Elsom, Director Centre for Psychiatric Nursing whose presentation discussed the issues of current intramuscular injection technique and the need to review current intramuscular injection practice; Professor Edward White whose presentation focused on clinical supervision; and Magistrate John Lesser who presented on the new mental health court of Victoria and the implications for nursing practice and care delivery as a result of the new court.

This years conference presentations provided a balance between consumer focused and clinical and research focused presentations.

Sessions right across the program were well attended at this year's collaborative conference

This year, the Department of Health sponsored three 1st Time Presenter Awards, each to the value of $250.

The awards were for the categories of:

- Best Consumer Perspective or Focused Presentation
- Best Recovery Focused Presentation
- Best Presentation on Innovation in Nursing Practice

We had the pleasure of announcing the award winners at the conference closing ceremony.

This is a very positive incentive to engage clinicians and consumers who might otherwise not have considered presenting at a conference, to participate and gain experience with public speaking in a supportive environment amongst peers.

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FIRST TIME PRESENTER WINNERS AT THE 11TH VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

The Mental Health Drugs and Regions Division of the Department of Health, a major sponsor for this year's Victorian Collaborative Psychiatric Nursing Conference, also provided three 1st Time Presenter Awards to the value of $250 each.

Winners of each category were announced at the closing ceremony of the conference.

Best Recovery Focused Presentation Category
Ms Carlene Hurst
(Monash University - Postgraduate Student)

Carlene's presentation was titled *"Mental illness in rural communities addressing perceived gaps in care"*

Best Consumer Perspective or Focused Presentation
Faith Field & Joanne Webb
(Southern Health – Mental Health Clinicians)

Faith and Joanne's presentation was titled *"The contribution of psychiatric nursing to an eating disorder recovery orientated group therapy program"*

Best Presentation on Innovation in Nursing Practice
Ms Merrilyn Bergbauer
(Bendigo Health – Clinical Nurse Educator)

Merrilyn's presentation was titled *"Advanced suicide assessment & planning – responding to the training needs of experienced mental health clinicians"*

We would like to thank all 1st time presenters for their valuable contribution to the conference. It was a difficult decision to pick each award as all 1st time presentations were of a high standard.

We encourage clinicians who have never presented at a conference to consider the opportunity to present at next years conference.

This conference is known as a grass-roots clinician conference and 1st time presenters are encouraged, mentored and supported in what can be a stressful experience.

Copies of the three award winner's presentations will be available on the Centre for Psychiatric Nursing Conference website:
www.cpn.unimelb.edu.au/conferences/vcpnc

TOWARDS 'CULTURAL COMPETENCE': IMPLICATIONS FOR NURSING PRACTICE IN MENTAL HEALTH SETTINGS

With about a quarter of the Australian population born overseas and 16% of Australians speaking a language other than English at home, cultural sensitivity is critical to serving our diverse community. The nature of mental disorders and the difficulties associated with accurate assessment and treatment, means that more than any other discipline, mental health practitioners require adequate knowledge and sensitivity to different cultural contexts if their services are to be effective.

There are a number of definitions of cultural competence, but one of the most comprehensive is that provided by Betancourt:

"Cultural competence in healthcare entails; understanding the importance of social and cultural influences on patients' health beliefs and behaviours, considering how these behaviours interact and multiple layers of the healthcare system and devising interventions that take these issues into account to assure quality healthcare delivery to diverse patient populations"

Betancourt argues that in view of the Sociocultural barriers to care, and the different levels in which healthcare delivery occurs, a holistic framework for cultural competence should include organisational, structural and clinical interventions (Betancourt, Green et al. 2003).

The effects of displacement, resettlement, and the migration process on the mental wellbeing of refugees is poorly understood

Peter Browne's book *"The longest journey: Resettling refugees from Africa"* opens with a chilling account of a Rwandese mother of four who runs to the Kenyan capital Nairobi after an attack on her family left two of her children dead. While waiting to be processed by the United High Commission for Refugees (UNHCR) for Humanitarian resettlement to Australia, she is attacked again in Nairobi and two of her remaining children are killed, she is seriously injured and is hospitalised with multiple stab wounds. There is no evidence from Peter's book on how these experiences affected the mental wellbeing of the Rwandese woman (who was eventually resettled in Australia) featured in his book, however, it is increasingly clear that many refugees from similar backgrounds are treated in Victorian mental health services.

Australia has continued to receive an increasing number of displaced persons from various parts of the world, more recently from Afghanistan, Iraq and Sudan as part of its global commitment to providing assistance to refugees, and this is set to continue, with the reported number of people seeking refugee status globally topping 14 million (Burgess 2004). The Australian Mental Health system is designed to cater for the needs of Australians, but there is scarce data on the exact mental health needs of the people that Australia accepts through its humanitarian resettlement programs. The effects of displacement, resettlement, and the migration process on the mental wellbeing of refugees is poorly understood (Burgess 2004).

In advancing the cultural competence agenda at both the policy and service level, there is need to be aware of the inherent danger of stereotyping. Mental health practitioners need to abstain from many 'dos' and 'don'ts' of how to treat a patient of a given ethnic background or culture that is often equated to cultural competence (Kleinman and Benson 2006). The example from Peter Browne's book helps to underline the importance of looking at each case on its merits and not to let cultural assumptions hinder objective understanding of individual issues and experiences. Cultural stereotyping has the potential to make the client's 'Longest Journey' even longer.

The unique work of the Multicultural Mental Health Australia (MMHA) and the Victorian Transcultural Psychiatric unit (VTPU) helps to prepare clinicians and health services to work with people from diverse backgrounds by enhancing capacity for cultural competence (MMHA 2007). For clinicians wishing to access more information on cultural care, more information can be obtained from these websites;

MMHA: www.dhi.gov.au/Multicultural-Mental-Health-Australia/
VTPU: www.vtpu.org.au

Elijah Marangu
Deakin University, School of Nursing and Midwifery

CARILLON: CALL FOR ARTICLES

Do you have some news you would like to share with the mental nursing community or has some one in your service done something you believe should be recognised?

Then make a submission to be published in the Carillon.

Articles should be between 500-1000 words and submitted by the 15th day of the month before Carillon is issued. Carillon is published in March, June, September and December each year.

Contributions can be emailed to **cpn@nursing.unimelb.edu.au**

COLLABORATIVE CONFERENCE ANOTHER SUCCESS

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This is a very positive incentive to engage clinicians and consumers who might otherwise not have considered presenting at a conference, to participate and gain experience with public speaking in a supportive environment amongst peers.

Stephen Elstom opening the 2010 conference

The Early Bird Registration refund prize was also drawn at the conference closing ceremony and the winner was Ms Bronwyn Cole from Southern Health. Bronwyn will have her conference registration fee refunded. To participate in this draw for next year's conference, you will need to register by 27th May 2011.

Unfortunately, as has been the case for the past two years, we had many people trying to register after the registration closing date. Again this year we were unable to accept these registrations due to venue size and catering close off requirements.

We wish to remind future conference delegates that if they wish to attend the conference next year, they need to note that the registration closing date will be 15th July 2011 and they will need to diarise that date now to avoid disappointment.

Feedback from the delegates that attended this year's conference indicated that clinicians are happy with the format of conference and that it provides them with the opportunity to find out what is happening in other services and also provide the opportunity to network with other mental health professionals.

The collaborative parties, Centre for Psychiatric Nursing, Australian College of Mental Health Nurses (Vic Branch), Australian Nursing Federation (Vic Branch) and the Health & Community Services Union would like to thank all delegates, presenters, major sponsors and trade display sponsors for their assistance in making this another successful conference and look forward to the 12th Victorian Collaborative Psychiatric Nursing Conference in 2011.

THE PHYSICAL HEALTH SCREENING AND TREATMENT NEEDS OF PEOPLE WITH A MENTAL ILLNESS

People with mental illness have significantly worse general health and are at higher risk of physical health disease than the general population (Brunero and Lamont, 2010). Individuals with severe mental illness have 3 times the risk of premature death and a shortened life expectancy when compared to the normal population (Brown, Inskip & Barraclough 2000 and Rossler et al, 2000 as cited by Holt and Peveler 2010). Davidson (et al, 2000) reinforce this by indicating that even *"after controlling for unnatural causes for death (suicide & accidents) people with mental illness are still significantly more likely to die in larger numbers at younger ages…In particular, the mentally ill are more likely to die from cardiovascular and respiratory disease"* (p31). To complicate things further, mental disorders are more common in people with chronic physical conditions (diabetes, asthma, heart disease, stroke, cancer and arthritis) than for those without them (Australia's Health 2010). Crone, Tyson and Holly (2010) cite the UK Department of Health 'White Paper' (2006) which also found that people with mental health problems are more likely to have poorer health and an increased risk of life threatening conditions such as heart disease when compared to the general population.

The clinical needs for people with mental illness are diverse and complex, but what stands out in the literature is the definite need for physical health screening and education activities that can help improve the general wellbeing of mental health consumers. The rate of co-morbid substance use is also higher in people with mental illness, for example rates of smoking are 73.2% for men and 56.3% of women compared to 27.3% of men and 20.3% of women in the general population (Meadows, Singh and Grigg 2007).

Individuals with severe mental illness have 3 times the risk of premature death and a shortened life expectancy when compared to the normal population

Excessive body weight (obesity) is now a major health concern for the population of Australia and is set to worsen the morbidity and mortality from leading causes of death in Australia - ischaemic heart disease, stroke and obesity-related cancers (Aitken et al 2009). People with serious mental illness face additional challenges in maintaining healthy eating and an active lifestyle. Weight gain is a recognized side effect of a number of antipsychotic and other medications as the following quote indicates: *"There is growing concern that the newer atypical antipsychotic medications cause additional weight gain. If this concern is well founded we can expect the prevalence of obesity to rise as more patients are prescribed the newer medications (p31)"* (Davidson et al,2000). Holt and Peveler (2010) support this notion in their suggestion that antipsychotic medication have an adverse effect on cardiovascular risk factors. However, Holt and Peveler (2010) highlight the fact that people treated with antipsychotics for their mental illness had lower mortality than those with no treatment. Even though antipsychotic medications may increase health risk factors they decrease overall mortality rates when compared to non treated consumers with mental illness. The National Institute for Health and Clinical Excellence (NICE, 2010) recommends that people with schizophrenia undergo annual health screening for cardiovascular disease risk factors and diabetes, include monitoring of blood pressure, lipid levels, smoking and waist measurements. NICE (2010) also suggest that treatment is provided for any identified health problems. Along with the existing mental health education needs of people with mental illness, there is a need for physical health education and screening that focuses on preventative measures for behaviours that adversely affect the general health of people with mental illness. For example smoking, drug use, unprotected sex, and poor diet and nutrition are lifestyle based risk factors that can be addressed through educational measures.

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REFORM OF THE MENTAL HEALTH ACT 1986: APPLYING THE REFORM AGENDA

The CPN hosts regular meetings with the level 4/5 nurses from around the State. The main aim of this group is to bring together the collective experience, skills and strength of the Clinical Nurse Educators and Psychiatric Nurse Consultants to network and share information and ideas. The meetings are always well attended and take place every 6 weeks. At each meeting an invited guest speaker presents an issue or concern related to a pertinent professional or clinical domain.

At the August meeting, Cath Roper, Consumer Academic, and Finbar Hopkins, Lecturer, presented on the Review of the Mental Health Act of Victoria, 1986. The main aim of the presentation was to provide the group with an overview of some of the key issues for reform emerging from the government response to the Mental Health Act review consultations. A particular focus was on those reforms that impact on consumer decision making. Other aims included examining the reforms through the lens of current practice, values and beliefs associated with recovery practice and providing the group with a space to reflect on the challenges and enablers of meeting the reforms. The key areas covered in the presentation included; recovery, human rights, use of advance statements, increasing voluntary service use, supported decision making practices and informed consent.

In this presentation recovery was conceptualised in two distinct ways with a differentiation between what is commonly understood as 'clinical' recovery, and what can be characterized as 'personal recovery'. All psychiatric nurses are familiar with the concept of a medical recovery where the main aim is to reduce symptoms and stabilisation of treatment for the patient. Personal recovery is underpinned by very different principles in that it emphasizes self determination, empowerment and choice, and therefore needs to be self directed. Personal recovery was seen by this group as a more humanistic and emancipatory model that this entire group wanted to embed in their practice.

However, transforming service systems and care provision to a personal recovery approach is perceived as complex for a variety of reasons, not least of which is the Mental Health Act of Victoria 1986. An obvious example is around issues of medication and treatment where the jurisdictions of the MHA may allow the consumer's preferences to be overridden. A robust discussion around the concept of medical recovery and personal recovery took place. Personal recovery was valued highly by the group and it was seen as a model that would improve patient outcomes on many levels. As well, personal recovery was seen by the group as a good fit with nurse-centered care and they recognized that it would call for a change in the culture of nursing practice.

Some of this group discussed the difficulty they experienced when advocating for clients who wanted to discontinue their psychotropic medication to experience their life without prescribed medication and how difficult it was to hold the advocacy position when challenged about the risks of their support for this action by the patient's family, other colleagues and the patient's doctor.

Some group members discussed how to change care of people with mental illness from one of symptom reduction and treatment stabilization to balance with one of informed consent and supported decision making but felt that they needed much more support and leadership to effect this change in their care.

Finally, an interactive discussion took place in small groups focussing on what steps are needed to meet these reforms in their practice areas. The group finished with a commitment to explore how they can incorporate the ideas and the information about recovery into their practice.

Carillon - becomes an e-Newsletter

As a contribution to reducing 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: **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

CALL FOR ASTRACTS

11 & 12 August 2011

DEADLINE FOR ABSTRACT SUBMISSION

Friday 11 March 2011

Call for Abstracts

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.

Abstracts of no more than 200 words are invited for 30 minute paper, poster and 60 or 90 minute workshop presentations that focus on the practice of psychiatric nursing. All posters submitted for the conference will be entered into the Conference Poster Competition with a $100 Gift Voucher going to the winning entry.

Papers with a focus on recovery from mental health problems are particularly encouraged. Themes below are listed for your consideration but papers need not be restricted to only those shown.

Papers from practicing clinicians and post graduate students undertaking clinical projects are particularly encouraged. If you are interested in presenting a paper but would like more information, support or guidance please contact Steve Elsom at CPN:

T **8344 9460**
E **sjelsom@unimelb.edu.au**

Abstracts can be submitted electronically. The instructions and format for the submission of abstracts are located on the CPN website: **www.cpn.unimelb.edu.au**

If you are unable to submit an abstract electronically please contact the CPN:

T **(03) 8344 9626**
E **cpn@nursing.unimelb.edu.au**
F **(03) 9035 8519**

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

CPN Centre for Psychiatric Nursing advancing mental health practice
HACSU Health and Community Services Union
ANF Australian Nursing Federation
the Australian College of Mental Health Nurses Inc.

THE PHYSICAL HEALTH SCREENING AND TREATMENT NEEDS OF PEOPLE WITH A MENTAL ILLNESS

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Health and physical education activities for consumers with mental illness need to be incorporated into the treatment they receive from mental health services. Biddles & Faulkner (2002) quote the importance of physically activity in the treatment of the mentally ill: *"Evidence and recent policy initiatives support the promotion of physical activity and exercise within acute (psychiatric) inpatient settings. Mental health nurses may perform an important role in encouraging physical activity and legitimising its incorporation within care planning. The physical benefits alone from regular physical activity in reducing morbidity and mortality in clinical populations (of the mentally ill) are sufficient justification for the inclusion of exercise in programmes of rehabilitation"* (p660). These initiatives should be extended to the community and make up part of the treatment plans for mental health clients receiving care in the community. Crone (et al, 2010) cites a systemic review undertaken by Holley et al (2010) indicating that physical activity has the beneficial effect of reducing the occurrence of positive symptoms (such as hallucinations and delusions) whilst also alleviating negative symptoms and having a positive effect on wellbeing. There is justification for including both health and physical education activities in the care of people suffering mental illness. Mental health nurses and primary care clinicians in particular should seek professional development activities that focus on incorporating health and physical education into their clinical practice.

Nino Di Pasquale,
Lecturer, Deakin University

MAILING DETAILS HERE

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

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