Issue 2 – December 2011

# Shared Learning in Clinical Practice

## Mental Health Practice Development Newsletter

The second "Shared Learning in Clinical Practice" Symposium was held at the UniSA Centre for Regional Engagement in Mount Gambier on Friday 11 November 2011, co-facilitated by Professor Nicholas Procter, Chair: Mental Health Nursing UniSA and Philip Galley, Clinical Mental Health Nursing Director CHSA. A total of sixty-six health professionals and support workers participated in the Symposium.

The "Shared Learning in Clinical Practice" is a partnership between the UniSA Mental Health and Substance Abuse Research Group and SA Health's "Acute Matters." The overarching aim of the partnership is to provide a safe environment for mental health practitioners to reflect and learn from one another in relation to the complexities of modern-day clinical practice and the implications of the various reform agendas on the way clinicians provide care and treatment. A particular focus of the Symposia relates to working with people in suicidal, self-harm crisis and other forms of risk. Feedback from the Mount Gambier Symposium has now been collated and will be used to plan future events both in metropolitan and regional South Australia.

These occasional newsletters are produced in response to feedback in order to share "practice tips" and recommendations from the Symposia; and to provide frontline teams and services with news of future events. The Shared Learning in Clinical Practice Team welcomes your comments and feedback on how the format and content of the newsletter can be improved. Please send your feedback via e-mail to Judy Stephenson, CHSA Mental Health Nursing Project Officer – judy.stephenson@health.sa.gov.au

### *Clinical Practice Tips*

The extended presentation by Dr Conrad Newman on the collaborative assessment and management of suicide risk was particularly well received by those attending the Symposium. Consistent feedback themes focused on the importance of ensuring that people presenting with suicidal risk are assessed with respect, empathy and an holistic approach, giving the person time to talk about their situation. A number of delegates also expressed appreciation for the information presented on the "Suicide Status Form" developed by David A Jobes. The practice tips below are therefore based on the principles of this tool and the "CAMS" model for working with suicide risk. They are particularly pertinent to the acute setting:

> Review all data sources – OACIS (summaries, encounters, scan pathology) + CBIS/CCC + Ambulance record + Police report
> The patient's perspective – **their** view of the stressor and precipitating factors. Encourage narrative
> Collateral must be sought before the patient can be discharged (partner, family, friend, neighbour, priest, employer, previous treating team, current treating team)
> Supports must be identified and engaged. Try to avoid discharge post suicide attempt to home alone
> Provide education to the person at risk and those supporting him/her (what to do, who to call, written information, explanation of acronyms)
> Wherever possible, provide for the person to meet a member of the follow-up team before leaving ED
> Communication with the GP to advise of presentation, for history and to determine their comfort level in being involved in follow-up
> Give serious consideration to pharmacotherapy to relieve anxiety / agitation and assist with sleep (benzodiazepine or atypical)
> No suicidal patient has been fully assessed until the safety of others has

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been established (children, parents, siblings, partners or ex-partners, employers, colleagues)
> If the person is paranoid about their partner or another family member, do not send them home alone with that person

**Other Practical Pointers:**

"*For a man to end up in ED after a suicide attempt is a big thing."* Male depression often goes unrecognised:

> "I'm not depressed"
> Poor performance at work, at home and in leisure activities
> Restlessness, awkwardness, feeling 'starved' emotionally, irritability, quarrelsome, lack of concentration and alcohol / drug use
> Difficult (not impossible) to motivate men to have treatment
> They will often try and bring about a rejection by clinician

The way that someone is treated in ED has a major impact on their subsequent engagement with services.

For more detailed Clinical Guidelines for working with people at risk of suicide, see "Meeting the Suicidal Person" on the Aeschi Workgroup website (cut and paste link into your web browser) http://www.aeschiconference.unibe.ch/Guidelines_for_clinicians.htm

**Key Learnings from other presentations:**

**Annette Jones** presented sobering statistics from a number of key reports on suicide and coronial inquests, including the 2009 report, *Retrospective Analysis of Coronial Cases of Suicide* by Ellen Rosenberg. A common phenomenon in this study was the "denial" of suicidal ideation when health practitioners inquired about people's thoughts, or wrote contracts with a person who stated they would not suicide, prior to their death.

**Leigh Peterson -** Mental Health Nurse Practitioner Candidate in Mount Gambier Hospital Emergency Department – presented a lively and engaging session on her own journey in making use of brief Solution-Focussed Therapy with people presenting with risk issues in the acute setting.

The afternoon sessions focused more on actual service delivery models and their relevance for Shared Learning in Clinical Practice. The South East of the State was heavily represented here: **Paul Prentice** and **Ann McElroy** talked about the Regional Hospital Consultation Liaison Service (CLS) which has developed over several years. The presentation was rich in data demonstrating the impact of a CLS model on hospital stays and consumer outcomes.

**Linda Galley** and **Lynda Dyson** discussed how the development of Intermediate Care in the South East in 2011 has enabled a truly biopsychosocial service which aims to strengthen partnerships between CHSA and NGO services to promote and support recovery and wellness pathways.

**Dr Dan Mosler** summarised key changes to South Australian Mental Health legislation with the 2009 Mental Health Act, as well as highlighting how responsiveness and service capacity has grown in the South East over the last twelve months.

**Dr Andrea Gordon**, Research Fellow at UniSA, presented a comprehensive summary of research for managing risk in the context of co-morbid substance use and mental health care. Andrea's conclusions focused on the importance of co-morbidity screening – risk management starts with risk identification.

**Jean Kerslake,** DASSA Clinical Nurse based with the South East Regional MH team, centred on the need to apply what we already know about Screening, Assessment and Collaborative Intervention Planning in everyday practice.

Aboriginal community perspectives were provided by **Karen Glover** (CEO) and **Sarah Bates** (Program Manager) from Pangula Mannamurna, in a presentation entitled *Staying in Balance*. Images of pinky grass weaving and the trauma history of the Black Fellows Caves near Carpenter Rocks were used as a poignant back-drop to the mental health needs of Aboriginal people in the South East.

The theme of 'connectedness' was also highlighted in terms of people developing shared understanding of life experiences.

**Philip Galley** presented the work and outcomes of the Eyre Mental Health Service based in Port Lincoln and Ceduna. The "C-PEOPLe" presentation included five key principles for practice development:

1. Mental Health Services aren't only delivered by mental health services
2. Different disciplines see different disciplines differently
3. Telemed has a major bearing on least restrictive outcomes
4. Incremental Service Development makes most sense
5. An integrated IT based "case note" system is a key enabler for effective service delivery. Where such systems don't yet exist, CCC and provider relationship building are pivotal

The final presentation of the day was delivered by **Dr Jon Jureidini**, Clinical Director of the CYWHS CAMHS service. Jon suggested that in mental health service delivery, "Harm-Benefits Analysis" is potentially a more useful paradigm than "Risk." In any therapeutic encounter, it is at least as important to explore the person's predicament as it is their diagnosis: Not "what is wrong," but "what is bugging [them]." This leads to the need to work therapeutically with people's anger, as well as with fear or sadness.

SA Health employees can access all of the presentation power-points by cutting and pasting the following links into their web browser:
http://wiki.health.sa.gov.au/Country/3-Whole_of_Country_Services/Mental_Health/Clinical_Resources/Internal_Initiatives/Practice_Development_Initiatives/Shared_Learning_in_Clinical_Practice%3a__Practice_Development_Symposiums/South_East_Acute_Mental_Health_Care_and_Risk_Symposium
Further information can also be found on the UniSA Mental Health Research Group website:
http://www.unisa.edu.au/sansominstitute/mentalhealth/default.asp

**Panel Discussions:**

A popular component of Shared Learning in Clinical Practice Symposia is the Expert Panel Discussion.

The morning discussion, facilitated by **Dr Andrea Gordon** (below), looked at *Managing Risk – Whose Responsibility?*

**Philip Galley** facilitated a Panel Discussion at the conclusion of the afternoon session, exploring the concept, *Picking up the Practice Threads – what might today mean for the future?*

**Future Symposia**

The next Shared Learning in Clinical Practice Symposium will be held at UniSA Hawke Building, North Terrace, Adelaide on **Thursday 22 March 2012.**

Some 150 people have already registered for the event, which will include:

- "composite client" film footage to illustrate interview principles for working with people at risk of suicide
- Expert panel discussions on the issues raised by the film will then be used as a foundation for better understanding client pathways and clinical decision-making

This approach has been incorporated into the March 2012 Symposium in response to feedback from the Mount Gambier event for future practice development forums to include interactive workshops focused on skills acquisition.

To register for the event, please e-mail your details to mentalhealth@unisa.edu.au

## SUMMARY OF RESPONSES FROM THE EVALUATION FORMS

Number of Participants: 66
Number of Responses: 42

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| The Symposium was relevant to my role | 29 | 13 | - | - |
| The Symposium has made a positive contribution to my professional Development | 30 | 11 | 1 | - |
| The Symposium Program held my interest | 28 | 14 | - | - |
| The Symposium was of a good standard | 30 | 12 | - | - |

## A SELECTION OF COMMENTS FROM EVALUATION FORMS

**What is the important take home message about Risk Assessment and Risk Management that you have gleaned from today?**

- Future skills training for other professionals, not just mental health nurses. This is paramount in a rural area as there are certainly gaps in this area
- The focus of the 'at risk' group of males was particularly positive and will inform practice from here
- The value of professional networking at an event like this and the ability to discuss clinical practice issues with other professionals is invaluable
- Mental health services are improving in CHSA
- Collaborative assessment and care processes – being with the consumer; working with, not at
- Never become unchallenged by the suicidal potential; there's so much more we can do
- More investigation into risk, especially through the ED
- General nursing staff needs the tools/skills and confidence to support/manage/assess people presenting with all but specifically suicidal intent
- Mental Health/Drug & Alcohol training should become a mandatory training session
- Better understanding of mental health services in rural setting
- Many take home messages and good to see the support network for mental health get together
- In particular, the address by the NPC for Mount Gambier about her role in ED – and being "solutions-focused" and the risk assessment/management strategies
- Suicidality is not necessarily a symptom of an illness, more so a mental health problem which requires some intervention
- UniSA and SA Health, through the Acute Unit Matters Group and Mental Health and Substance Use Research Group, are really making a difference
- Take care to avoid "compassion fatigue" in practice. Focus on self-care; avoid the risk to self of vicarious trauma and include debriefing in practice
- Instead of risk management, consider CHOICE Management. After all, if you always make the same choice, nothing will change
- Informative, validating own practice
- To promote holistic approach to people with suicidal risks

**What was most beneficial to you about today's Symposium?**

- The presentation by Dr Conrad Newman was excellent, as were all the presentations
- Reinforcement of expert clinical knowledge and evidence for practice or highlights to the required improvements to our practice or attitudes
- The concept of suicide rehearsal and ambivalence – this changed my thinking
- Majority of the suicide status form, particularly front page
- Success of the Eyre Mental Health Service (fabulous)
- Increased confidence in supporting mental health clients who present to A&E or on the Ward within the general setting. The morning program on suicide/suicidal ideation of clients will be invaluable to my future practice
- Hearing from a mixture of country and metro based experts. The synergy was very powerful
- Speakers – questions and answers; pushing being connected
- Panel discussions
- Confirmation of my desire to pursue/further a career in mental health nursing
- Learning about how to change my practice
- This was a vital day of learning for everyone
- Connected with consumers, rather than focusing on models
- The benefits of other alternate therapies used in ED