MHNIG NEWSLETTER

Spring 2011

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UPFRONT Report from the President

Welcome all old and new members!

This is an election year. Ontario will see the Liberals go to the polls on October 6, 2011 in the hope of retaining the provincial Parliament for another term. The Progressive Conservatives and the New Democrat Party are contesting the election on many issues. For details of the RNAO platform, see the document Creating Vibrant Communities at http://www.rnao.org/Page.asp?PageID=924&ContentID=3176. See also the Nurses Vote bookmark on the RNAO website.

The MHNIG had been alerted to issues in the province in 2010. In May a private member's bill made first reading. This bill aimed to end funding for Electroconvulsive Therapy in Ontario. Reaction quickly focussed on the benefit of ECT to a client population that couldn't afford the intervention. At this time, a response is being formulated to address the issues related to ECT as a treatment.

In October 2010, the MHNIG learned from colleagues, (registered nurses and mental health consumers), of a number of Halloween Charity Haunt events taking place in the Greater Toronto Area that portrayed people living with mental illness with negative stereotypes. The MHNIG contacted RNAO for support regarding addressing these stigmatizing and distasteful events. A meeting was held in December to discuss strategies for a response to this type of event, and to look at ways to educate the community about mental health and stigma.

In September, Interest Group presidents were challenged to choose a Best Practice Guideline to roll out with members. A short article in this newsletter updates the reader on how MHNIG selected the first BPG to be selected for this support.

This year's Day at Queen's Park on February 3rd provided many nurses and nursing students the opportunity to meet with MPPs or their parliamentary assistants to discuss pressing issues about nursing in Ontario. Among the concerns have been the hiring of more nurses while the ratio of nurses to population (72 per 10,000 people) trails the national average (83 per 10,000), and the employment challenges across the province. For more information, see the reports on the RNAO website.

Planning continues with the CFMHN for the national conference on October 26 – 28, 2011. Abstracts have been reviewed and the program is being formulated. We anticipate many nurses attending from across Canada and elsewhere.

We intend to hold our Annual General Meeting on the Friday morning of the conference. The next newsletter will include the minutes of the 2010 AGM, business notices, and the slate of nominations for anticipated vacancies.

Thanks to the many members who have contributed to the activities of the MHNIG in the past year. We look at new ways to connect with members. We invite your input, questions, and participation in any way you can to promote the practice of mental health nursing.

Thank you.
Steven Holbert

Ontario Shores Begins Electronic Health Record

**By Joanne Jones RN BScN CPMHN (C), Clinical Education Leader,
Ontario Shores Centre for Mental Health Sciences**

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is the first hospital in Canada to go live with Meditech 6.0 Advanced Clinical System (ACS), a fully integrated Electronic Health Record (EHR). Ontario Shores' highly specialized Health Informatics and Professional Practice teams created an electronic health record based on best practice guidelines, and interprofessional and recovery philosophies to support patient outcomes and reflect the specialized needs of a tertiary mental health facility.

Our inpatient implementation occurred through several phases. In the readiness and pre-work phase a thorough understanding of "current" process was mapped throughout the organization through order audits, policy review, standards of care, and subject matter expert engagement. In the planning phase, high level committees allocated resources and developed a project charter. In the technical infrastructure and devices phase, the hospital's wireless and hardware strategies were established. And finally in the application design build and testing phase, each module of the ACS had its own design team and working group. The design team built and tested the content of their specific module, ensuring integration between the modules. During our end user education, all Ontario Shores clinical staff, including more than 800 nursing, physician and allied health staff were trained concurrently in less than 10 weeks. Training was provided by our Informatics team, Professional Practice team and a highly engaged group of frontline clinicians who became invaluable Super Users.

Project success is currently being measured by support metrics and medication/chart audits. Early findings suggest an improvement in process and practice, reduced risk, and increased decision support. The patient experience is improved through accurate information sharing and streamlined team communication.

Our next phase of implementation of an electronic health record will be coming in 2011 to our diverse outpatient programs. Utilizing technology has supported Ontario Shores in being a leader in mental health care, providing a spectrum of specialized assessment and treatment services for people living with complex mental illness.

RNAO Granted Standing at Ashley Smith inquiry

By Lee Minty, Administrator, Legal Assistance Program

On October 19, 2007, guards at the Grand Valley Institution for Women watched as nineteen year old Ashley Smith choked herself with a piece of cloth. The guards had been ordered to not intervene. Ashley had been in the Federal prison system for 11 1/2 months and had been transferred 17 times through this period. Much of this time was in an environment of isolation where she had become increasingly desperate and depressed and was known for self harm.

Initially, the inquest was to review only the period Ashley spent in Ontario, from May to October 2007. However, in November 2010, the Coroner, Dr Bonita Porter, expanded the scope of the inquest to also look into the full 11 ½ months leading up to Ashley's death and to consider how her state of mind may have contributed to her death.

In December, 2010, RNAO was granted standing at this inquest. The scope of our standing is to address nursing practice issues, and specifically the role of registered nurses from both a practical and policy perspective in the care of incarcerated clients with mental health needs and incarcerated clients who present with a risk of self-harm.

Originally the inquest was estimated to last 3-4 months and was put on hold in November pending the Coroner's decision on the question of expanded scope raised by the Smith family. It is estimated that the inquest will now be more than six months long and will include approximately 100 witnesses. The inquest is scheduled to begin on April 4, 2011. ***(N.B. The inquest has been delay until May or June)***

The Impact of Childhood Lead Exposure on Mental Health

By Shelly Archibald, RN BScN, Public Health, Sioux Lookout Zone, Ontario Region FNIH, Health Canada

Lead is an inexpensive metal that occurs naturally in the environment and has innumerable industrial uses. Trace amounts are present in the air, soil, food, drinking water and a wide variety of consumer products. Yet a growing body of researchers now suggest that the harmful human health effects associated with lead exposure occur at blood lead levels below 10 mcg/dL, the level of concern established by both the US Centers of Disease Control (CDC) and the World Health Organization (WHO) (Agency for Toxic Substances and Disease Registry [ATSDR], 2007; Canadian Partnership for Children's Health & Environment [CPCHE], 2008; Health Canada, 2009a). Although there are differences in individual sensitivity and environmental influences, this paper will discuss the most common mental health symptoms associated with childhood lead exposure at blood levels above and below the CDC and WHO defined threshold of concern.

Prenatal Period

The complex changes underlying brain growth and development during pregnancy expose the developing fetus to neurotoxins such as lead (Wigle et al., 2008) for which a substantial transplacental passage has been established (Winneke, 2007; ATSDR, 2007). Current research suggests that prenatal lead exposure is linked to the development of mental health symptoms associated with conduct disorder and criminal behaviour (Learning and Developmental Disabilities Initiative [LDDI], 2008; Carpenter & Nevin, 2009), in addition to attention deficit hyperactivity disorder (Winneke, 2007), schizophrenia (Opler et al., 2008) and Alzheimer's disease (LDDI, 2008).

Early Infancy to Toddlers (Birth-2 years of age)

Postnatal environmental exposure to lead is thought to exert neurobehavioral adversity as well, given that brain development is a continuum extending into this period and beyond (Winneke, 2007). Children`s bodies take up lead more readily than adults (CPCHE, 2008) and they experience greater lead exposure due to hand-to-mouth activity and pica behaviour (Health Canada, 2009b). As a result, children have a longer period of susceptibility to damage from environmental toxicants such as lead (CPCHE, 2008). Indeed, the biological plausibility of lead-induced impacts has been demonstrated by extensive animal and human testing (Carpenter & Nevin, 2009).

Early Childhood (2-6 years of age)

Recent epidemiologic reviews and longitudinal studies demonstrate an inverse dose-response relationship between cognitive function scores and blood lead concentrations below 10 mcg/dL in school age children (Bellinger, 2008; Wigle et al., 2008). Such deficits result in lower IQ scores (Binns et al., 2007) as well as a host of behavioural changes including reduced attention span, hyperactivity (American Academy of Pediatrics [AAP], 2005), impulsivity, an inability to follow simple directions and to deal with frustration (Carpenter & Nevin, 2009). A number of studies also link low level lead exposure with attention deficit hyperactivity disorder (Nigg et al., 2010) andantisocial behaviour (Bellinger, 2008). Greater lead burden has been shown to increase the risk of behaviours linked to the inattentive subtype of ADHD (such as distractibility and disorganization) as well as aggressiveness (Bellinger, 2008).

Moderate lead exposure can produce specific deficits in attention, visual-spatial skills, fine motor coordination, balance and social-behavioural modulation (AAP, 2005). Exposures of this magnitude have been reliably associated with attention deficit hyperactivity disorder (Nigg et al., 2010). Children with blood lead levels between 20-44 mcg/dL can suffer cognitive, behavioural or neuropsychologic impairment even with appropriate intervention and management (AAP, 2005). High level lead exposure (greater than 60 mcg/dL) results in a host of neurologic abnormalities, including headaches, clumsiness, agitation, decreased activity, somnolence (Binns et al., 2007) as well as hyperirritability and is associated with lasting neurological and behavioural damage (ATSDR, 2007).

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Childhood (7 to 12 years of age)

Early childhood lead exposure continues to have adverse effects well into this period and beyond (Gould, 2009). Low blood lead levels ranging between 0.3-2.20 mcg/dL have been associated with hyperactivity in children ages 6-17 years of age using DSM-IV ratings (Nigg et al., 2010).

Those diagnosed with lead poisoning early in life were also found to have worsening behaviour patterns as they aged and had higher rates of arrest, particularly for violent crimes (Gould, 2009). These findings support the theorized link between lead exposure and antisocial or destructive behaviour in both human and animal studies (Gould, 2009).

References

Agency for Toxic Substances and Disease Registry. (2007, August 20). *Case studies in environmental medicine: Lead toxicity*. Retrieved March 18, 2010, from http://www.atsdr.cdc.gov/csem/lead/docs/lead.pdf.

American Academy of Pediatrics. (2005). Lead exposure in children: Prevention, detection, and management [Electronic version]. *Pediatrics*, *116*(4), 1036-1046.

Bellinger, D.C. (2008). Very low lead exposures and children's neurodevelopment [Electronic version]. *Current Opinion in Pediatrics*, *20*, 172-177.

Binns, H.J., Campbell, C., & Brown, M.J. (2007). Interpreting and managing blood lead levels of less than 10 ug/dL in children and reducing childhood exposure to lead: Recommendations of the Centers for Disease Control and Prevention Advisory Committee on Childhood Lead Poisoning Prevention [Special Article] [Electronic version]. *Pediatrics*, *120*(5), e1285-e1298.

Canadian Partnership for Children's Health and Environment. (2008, May). Report of the national policy consultation on children's health and environment. Retrieved March 31, 2010, from http://www.healthyenvironmentforkids.ca/sites/healthyenvironment forkids.ca/files/cpcheresources/ NPCWorkshopSeriesFinalReport.pdf.

Carpenter, D.O., & Nevin, R. (in press). Environmental causes of violence. *Physiology & Behavior*.

Centers for Disease Control and Prevention. (2009). *Managing elevated blood lead levels among young children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention*. Retrieved March 23, 2010, from http://www.cdc.gov/nceh/ lead/CaseManagement/ caseManagechap3.htm.

Gould, E. (2009). Childhood lead poisoning: Conservative estimates of the social and economic benefits of lead hazard control [Electronic version]. *Environmental Health Perspectives*, *117*(7), 1162-1167.

Health Canada. (2009a). *Lead and health*. Retrieved March 18, 2010, from http://www.hc-sc.gc.ca/ewh-semt/alt_formats/hecs- sesc/pdf/pubs/contaminants/lead-plomb-eng.pdf.

Health Canada. (2009b). *Lead information package*. Retrieved March 31, 2010, from http://www.hc-sc.gc.ca/ewh-semt/contaminants/lead- plomb/exposure-exposition-eng.php.

Learning and Developmental Disabilities Initiative. (2008, November). *Mental health and environmental exposures*. Bolinas, CA: Institute for Children's Environmental Health.

Nigg, J.T., Nikolas, M., Knottnerus, G.M., Cavanagh, K., & Friderici, K. (2010). Confirmation and extension of association of blood lead level with attention-deficit/hyperactivity disorder (adhd) and adhd symptom domains at population-typical exposure levels [Electronic version]. *Journal of Child Psychology and Psychiatry*, *51*(1), 58-65.

Opler, M.G.A., Buka, S.L., Groeger, J., McKeague, I., Wei, C., Factor-Litvak, P., et al. (2008). Prenatal exposure to lead, delta-aminolevulinic acid, and schizophrenia: Further evidence [Electronic version]. *Environmental Health Perspectives*, *116*(11), 1586-1590.

Wigle, D.T., Arbuckle, T.E., Turner, M.C., Berube, A., Yang, Q., Liu, S., et al. (2008). Epidemiologic evidence of relationships between reproductive and child health outcomes and environmental contaminants [Electronic version]. *Journal of Toxicology and Environmental Health*, *11*, 373-517.

Winneke, G. (2007). Appraisal of neurobehavioral methods in environmental health research: The developing brain as a target for neurotoxic chemicals [Electronic version]. *International Journal of Hygiene and Environmental Health*, *210*, 601-609.

Best Practice Guideline selected by MHNIG Members
By Steven Holbert

At September's Assembly meeting, Doris Grinspun challenged Interest Group chairs to pick a Best Practice Guideline to champion. The Mental Health Nursing Interest Group determined to get members' input on the choice. A question was formulated on which BPG would fit our focus on mental health. An email "blast" about selecting a BPG to support and roll out by MHNIG was sent out to membership in November 2010 with a cut-off date of December 15th. Response was very good, and many votes came in; several indicated support for more than one BPG. The final result was the selection of the BPG, "Caregiving Strategies for Older Adults with Delirium, Dementia and Depression".

After the selection was announced in December, a message was posted on the website and sent by email "blast", asking members to let us know how or what they were doing to support a roll-out of the particular BPG. In February, we received two updates from nurses using the BPG to enhance their practice in geriatric services. We are formulating a way to post the discussion on the website so members can share their stories.

Thanks to the many who contributed to this first effort to focus on and support the roll out of a Best Practice Guideline.

A Letter From the Canadian Nursing Students' Association

10 March 2011

Re: Canadian Nursing Students Association – National Conference – Exhibitor Fair

Dear Steven Holbert,

On behalf of the 2011 CNSA National Conference Planning Committee, it was with great pleasure to work with MHNIG in planning the 2011 CNSA National Conference. Together we have helped guide the future of Canada's next generation of Registered Nurses, Practical Nurses and Psychiatric Nurses.

Held in Hamilton, ON at the Hamilton Convention Centre this past January, MHNIG and CNSA were both provided with the ability to lead, engage and inspire 800+ nursing students from around Canada. MHNIG helped these students in identifying the needs of mental health consumers in our province and country. This has been greatly appreciated and very well received by myself and my fellow nursing students.

As the older generation of nurses retire, CNSA and MHNIG have a great opportunity in addressing the concerns of mental health nursing in Ontario. Together, we have the ability to reach out to passionate students in shedding light on a field of nursing that has been so covered in darkness for far too long.

It has been a great honour to work with MHNIG, and I hope to establish a working relationship between MHNIG in attending the 2011 CNSA Ontario Regional Conference in Toronto, ON in October.

Sincerely,

Matthew Smith
National Conference Director
Canadian Nursing Students' Association
HYPERLINK "mailto:conference@cnsa.ca" conference@cnsa.ca
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Vision & Objectives

MNHIG is an interest group of RNAO and an affiliate of the Canadian Federation of Mental Health Nurses (CFMHN).

1. To provide a forum for communication and the exchange of ideas.
2. a) To promote the health and well-being of people who are at risk of experiencing mental illness and/or emotional distress.
   b) To promote the development of mental health services that are responsive to the needs and wishes of consumers and the community.
3. a) To collaborate with consumers/survivors and family groups.
   b) To collaborate and clarify our roles with mental health professionals.
4. To lobby on behalf of mental health nursing for the recognition of, and positive image of mental health nursing.
5. a) To promote the awareness of the practice of mental health nursing.
   b) To serve as liaison with the RNAO and CNA and certification of mental health nurses.
6. To promote professional growth and best practices in changing mental health care trends.
7. To support participation of mental health nurses in education and research

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SUBMISSIONS TO THE NEWSLETTER ARE WELCOME!

This newsletter can be your voice. Please share your stories, ideas and thoughts. Due date for articles for the next newsletter is August 15, 2011. Submit items to Newsletter Coordinator via e-mail above or mail to:

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