Evaluation of the Ward 7 Patients' Group

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The Advocate/author wishes to thank Mrs Shirley Hancock, Clinical Nurse Consultant of Ward 7, Royal Derwent Hospital, New Norfolk, Tasmania. If it were not for the contribution of Mrs Hancock, in both the development and support of the Group, and the thought and writing of the Staff Perspective contained within this publication, the project may have achieved entirely different outcomes than those outlined below.

The Advocate wishes to thank all the patients and staff that have contributed to the growth of the Group and the changes it has made within the environment of Ward 7.

Thanks must go to the Advocates and staff of Advocacy Tasmania for their generous support and feedback on the project and report.

Language

The reader will note the use of the word "patient" throughout the document including in the title of the Ward 7 Patient's Group. Royal Derwent Hospital is exactly that, a hospital and as such, much of the language used at RDH is from the medical model.

With the closure of Royal Derwent Hospital, the shift away from the medical model of care for persons with a mental health illness, and the move towards community integration, the author has transposed where possible the more appropriate word "resident" of a mental health facility.

Foreword

The Royal Derwent Hospital Ward 7 Patient's Group was auspiced under the Redevelopment in March 1999 by the RDH Advocate, Valerie Williams. The initiative was to meet Standard 11.4.B.2 of the National Standards for Mental Health Services states;

> **Consumers and carers have the opportunity to be involved in the management and evaluation of the facility.**
>
> ***Notes and Examples: Residents' committee, Board of Management, participation in evaluation of accommodation programs.***

Consumer consultation and participation is a core element of the Royal Derwent Hospital Redevelopment, and integral to the provision of best practice standards in the new community facilities. The Redevelopment is not simply the replacement of the bricks and mortar of the historic institution but an altering of how services are to be delivered to residents into the future.

While the Ward 7 Patient's Group provided/s a forum for patients of that ward to make a contribution towards changes in their daily lives, it is also a pilot for the development of similar resident's committees to be formed in all supported accommodation mental health facilities in Tasmania in accordance with the requirements of the National Standards.

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Section 1

Rationale for Evaluation

1.1 Introduction

The group had been meeting for about eight months when the Advocate attended a meeting that had only three residents present. She facilitated the meeting but the residents were insistent that they had nothing to say, could offer no suggestions, and had no complaints. After about fifteen minutes, the shortest and least attended meeting that we had had to date was closed. The CNC did not attend this meeting.

The staff member who had been delegated to stand in for the CNC walked down the corridor with the Advocate, apologetic for the low attendance, the length of the meeting and the fact that nobody had said anything. He had viewed the meeting as a negative experience. She, on the other hand, had viewed it as a positive one.

She had been present at the very first meeting, and the ones following and had heard the resident's anger and had seen the distance between staff and patients on issues and in attitudes. Over time, she had watched the function of the group grow in acceptance by staff and residents and had viewed the significant changes that had been made to the environment of Ward 7 as a result to the group's voice.

It was at that point that the Advocate realised that the development and role of the needed to be documented, if not evaluated, simply because any single meeting could be judged negatively on the face of the proceedings. The value of the group could be too easily dismissed by those that had little insight into its accomplishments if there was not some type of identification and recording of that value.

1.2 Background

The Royal Derwent Hospital, as it is has been named since March, 1968, is the oldest mental health facility in Australia and has had a long and troubled history spanning the nearly one hundred and seventy years of its existence. The demolition of the old, and the construction of new wards during the late 1950's, and the advent of new drug treatments, saw a significantly altered role for the institution in Tasmanian society. While the number of accommodation and amenities buildings increased on the site, the numbers of patients residing at the

facility decreased. This was a consequence of the new phychotheraputic drugs and the process of deinstitutionalisation.

Deinstitutionalization was introduced into the American mental health system by the Democratic Government of President John F. Kennedy in the early 1960's. It was argued by the Government's fiscal advisors that it was far cheaper to treat and support mental health clients in the community than in institutions. A Government commitment was given to build over 1000 Community Treatment Centers across the United States but less than 400 were ever built. Commentators claim the failure of the Government to provide adequate community treatment and support was responsible for the statistics that support that up to 90% of any cities' homeless population consists of individuals who have a mental illness.

With the momentum of fiscal rationalization and the civil libertarian movement, western countries accepted the policy of deinstitutionalisation and large numbers of patients were discharged into the community. It soon became obvious however, that while 90% of consumers were in the community, Governments were required to spend 90% of their mental health budgets on operating and maintaining the institutions that still provided inpatient treatment for the remaining 10% of consumers. Hence the complete dismantling of the institutional setting as an option for patient care and treatment became a financial necessity for governments.

Tasmania began the process of the downsizing and redevelopment of the Royal Derwent Hospital when Cabinet gave its approval on 11th August, 1997 to the recommendations of the Derwent Valley Taskforce. Tenders for the construction of the new buildings were sought in early 1999, and the closure of the hospital is timelined for December, 2000.

1.3 Psychiatric Disability/Intellectual Disability

The development of the Ward 7 Group Meeting was a learning process for the Advocate and for the staff of Ward 7. There was no literature found which dealt specifically with the establishment and running of resident groups for persons with a mental illness although there was information on groups and intellectual disability. This material was not appropriate to the needs of the target group.

Generally, persons who have a mental illness can be highly intelligent persons with well-developed life skills. They can be well educated. They may experience episodes of mental unwellness during periods of their lives while at other times, their symptoms are controlled by treatment or they are illness free. They have spouses and children, homes, employment and social and community networks. When they are hospitalised, they are most often at the most serious level of their illness and their minds and bodies most affected by the drug therapy that they are receiving.

This is in contrast to persons with an intellectual disability who have a low level of intelligence and who benefit from skill development through both tried and innovative education methods, and whose state of mental capacity remains static. Through training over long periods, persons with an intellectual disability can raise their skill levels and improve their quality of life.

Yet there is a tendency to lump all persons with a disability together particularly those persons with intellectual and psychiatric disabilities. Simplistically, this is a chalk and cheese combination as the intelligence levels, skill levels and needs of the two groups are poles apart. This is apparent in the area of group work where a number of opposite factors, including the following, can distinguish the two groups.

- Low intelligence/impaired judgement
- Lower skill level/higher skill level
- Long term accommodation/temporary accommodation
- Home environment/clinical environment
- Well/unwell
- Unrestrained/legally detained
- Unmedicated or less medicated/highly medicated
- Desire to stay/desire to leave
- Acceptance of the system/anger at the system
- Permanence/transience
- Non-changeable prognosis/positive prognosis
- Staff-support workers/staff- nurses

1.4 Other Group Meetings

Over the years, wards of RDH have held group meetings. These meetings have been held daily, usually first thing in the morning. One such meeting was jointly evaluated over the period of a month by the Advocate and the RDH Chaplain.

The results showed that the meeting was staff and facility focused. The intention was for staff to advise residents of daily happenings such as times that Doctors

would be calling into the ward, and to organize washing up rosters etc. Residents notified staff of broken equipment or minor ward problems.

Staff controlled the meetings and though they were not compulsory, residents were punished if they did not attend eg: If a resident who had not attended the morning meeting asked what time the Social Worker was arriving, they were not given the information, instead they were told "Maybe you will know now to attend the morning meeting in future".

Each resident was given an allotted time to speak up until the turn passed to the next resident. Discussion and complaint, specifically service delivery complaint, were not encouraged.

There is a need to ensure that resident's meetings achieve the intended outcomes of the National Standards, and that a forum is provided in which residents with a mental illness participate in the process of quality improvement of the services they are provided, and the environment in which they live.

1.5 Method

It had always been the Advocate's intention to have the group evaluated. She investigated different options regarding how this might be done. But for reasons detailed below, considered that she was unable to achieve a proper independent evaluation of the group.

The group was functioning well and successful outcomes were being achieved. Positive changes were being effected within the ward in the areas of environment and service delivery. Attitudes of both residents and staff were changing to more rights focused so she determined not to concern herself with evaluation and allow the group to continue as it had begun which to all appearances seemed successful.

This paper is a reflective personal perspective of the group given by the Advocate and the CNC of Ward 7, Mrs Shirley Hancock who had been willing to work with the Advocate and support the establishment of a resident's group in the secured ward environment.

Section 2

Advocate's Perspective

2.1 Goals

The intention of the Advocate in the establishing of the group was to:

- satisfy the following Mental Health Standards

  11.4.B.2 Consumers and carers have the opportunity to be involved in the management and evaluation of the facility eg. Resident's Committees.

  11.4.B.7 Consumers living in the accommodation are offered maximum opportunity to participate in decision making with regard to the degree of supervision in the facility, décor, visitors, potential residents and house rules.

- provide a forum whereby consumers were empowered to effect influence on their daily lives.

- build partnerships between staff and residents

- improve service delivery

- educate residents and staff as to the rights and obligations of residents and staff

2.2 Composition of the Group

Meetings are voluntary and open to any resident who wishes to attend regardless of the present phase of their illness. The meetings are held in the dining room and residents are free to join and leave the meeting as they please. Some residents do not wish to be seen as a part of the group and will loiter around the periphery of the group interjecting with comments while refusing all invitations to sit down.

Ward staff members are encouraged to attend. There is always at least one staff member, usually the CNC who writes an action list during the proceedings. Staff members do not generally contribute to the meeting other than to offer information and explanation when requested to do so by residents, or by the facilitator, in response to a resident's question or statement.

The Advocate attends most meetings. The Social Worker and the Chaplain have also attended meetings.

2.3 Scope of the Group

The group has the role of initiating changes in the resident's living environment. The only matters not discussed by the group are clinical issues. While resident's

concerns about their medication, doctors visits, treatment Orders etc are listened to, the resident is encouraged to speak with nursing staff on the matter after the meeting. During the past year, residents have come to understand that the meeting is not the forum to deal with these issues so they arise far less frequently than they did initially.

Issues which are discussed and reported on, are systems failures, attitudinal problems and environmental design and functioning. Individual issues range across inappropriate behaviours by staff members, residents not being given enough time to eat meals before staff remove plates, to no shelf in the ladies shower on which to hang clothes and place towels to keep them off the floor.

While residents are encouraged to self advocate and speak with staff individually, some residents prefer to have their say from within a group environment. In this type of group atmosphere, residents are able to see that what they believed was universally acceptable, and therefore should be tolerated, is in reality, not acceptable to others, both residents and staff.

The group provides a forum for sharing information which allows for better, more informed choices, including the choice to complain.

2.4 Difficulty in evaluating the Group

The group's establishment had been a change initiative. It was considered of essential importance to evaluate the progress of the group both as an internal mechanism of system efficacy and dynamics, and as an external influencer of environmental and system modification.

However, there were a number of contributing factors that made evaluation difficult.

Ø 2.4.1 Transience

Many participants spent no longer than two weeks on the ward. A few stayed a week or less. Some participants including the longer stay residents, attended more than two meetings but could not remember attending previously. Some patients were discharged directly from Ward 7 while most were transferred to Ward 12.

Some of the longer term patients resided in the Group Homes or Millbrook Rise but would be sent to Ward 7 during times of high stress and periods of acute unwellness. These stays could range from two nights to weeks.

The composition of the group was always different with rarely more than two of the participating residents having had attended the previous meeting although, the majority of patients had attended a meeting previously.

Ø 2.4.2 Health

Often, during their first few days of hospitalisation, residents were heavily medicated or were in extreme psychotic states. This usually resulted in attendance at a later meeting rather than at an earlier one with some residents being admitted and transferred/discharged having not had the opportunity to attend a meeting at all.

Longer stay residents had differing periods of wellness that impaired their memory and understanding of the group's role and/or their participation in the Group.

Residents, both long stay and short stay, were sometimes too sleepy to attend or if they did, could not focus their attention on the group's purpose.

Ø 2.4.3 Voluntariness

As attendance in the group is voluntary, numbers swayed from week to week, the smallest number attending being three and the largest being ten. Even during the meeting, attendance levels vacillated as residents left and returned.

Ø 2.4.4 Fear

For some residents, there is a "them and us" attitude learned from having spent many years within the mental health system. Many of these residents carried emotional traumas of a historical Royal Derwent Hospital where residents were subjected to abuses and reprisal by staff if they complained.

The short length of stay of some of theses residents in Ward 7 was often not sufficient to build a conduit of trust where they did not fear, or at least were not suspicious of this new forum in which they were actively encouraged to speak without fear of retribution. This meant that residents did not attend meetings, or did not speak at meetings, or were hostile at meetings.

Ø 2.4.5 Game playing

Again, residents who game played did not trust the forum sufficiently to speak honestly. Their agenda was to be released as soon as possible and to not make waves which would delay that outcome. As a consequence, their comments to the meeting were that the system in the ward was perfect and the staff members were perfect, and that they had no reason to complain, only compliment.

A subset of game playing is that group of residents who have a false consciousness.

- **2.4.5.1 False Consciousness**

  These residents were of the belief that the system and staff were perfect. The resident was the one who had acted inappropriately and had to be hospitalised and suffer the retributions for the actions of their mental ill health eg. loss of liberty, structured rules.

  Paternalism, patronisation, coercion, adherence to rules etc were viewed as necessary components of nursing care as the resident played out their "sick role" and adapted to institiutionalisation. They often would comment that the rules were tough but would justify them saying that they needed to be tough.

  They wanted to be well and ward 7 staff were there to ensure that they got well. They were hospitalised because of ill health and inappropriate behaviours. Complaining about the system or staff was just another manifesting of inappropriate behaviour because when one was ill, they became placed entirely within the hands of the professionals who had the skills to make them well.

2.5 Ownership

The Advocate attended nearly all the meetings in the initial six months but soon believed that the meeting was becoming known as the Advocate's meeting. The situation was, if the Advocate was unable to attend an occasional meeting, the meeting would often not go ahead. This was of concern as the meeting was intended to become staff and resident self reliant and the Advocate's role was one of a facilitator until such time as the group did become self reliant.

The Advocate spoke with staff on this issue. Procedures were put in place. The CNC spoke at a staff meeting about the issue and informed staff that the weekly meetings were to be included in staff daily plans and discussed at hand-overs.

The Advocate took the initiative to miss meetings, attending approximately one meeting every three weeks. The consequence of this action was that despite the efforts of the Advocate in trying to ensure that her role was not seen as fundamental to the meeting, meetings were rarely held if the Advocate did not attend.

The arrival of the Advocate triggers staff to begin arranging for the meeting to commence. If the Advocate arrives ten minutes late, the meeting commences ten minutes late. The presence of the Advocate definitely assures that the

meeting will go ahead but when she is not there, other staff priorities seem to come to the fore such as limited staffing, doctor's consultations etc.

This is the most disappointing outcome. If each facility, under the restructuring of Mental Health Services in meeting its obligations under the National Standards, is to hold resident's meetings, it is inappropriate and logistically impossible for the Advocate to facilitate each meeting. Residents and staff need to claim ownership of the group.

2.6 The Group's Role within the Routine of Ward 7

Longer stay residents seem to look forward to the meetings. It was mentioned to the Advocate by staff that certain patients would inquire during the week as to the day and time the meeting was to occur.

An intention, prior to the formation of the group, had been that the meeting should be a part of the living environment of the ward and central to the daily routine. The group meets in the dining room. Tables are pushed together, chairs gathered around. Doors are unlocked and resident's join and leave the meeting at choice. Sometimes it is noisy and other times its is quiet. But it is always as it is in Ward 7 and not an environment separate to the patient's day such as a Board Room or an office. I believe that this provides a comfort zone of familiarity for some of the residents.

Residents who don't wish to attend the meeting sometimes sit away from the group, listening. Often they will interject with comments of their own on issues while actively exercising their right not to participate within the meeting.

2.7 Staff Attitudes

Staff attitudes towards the group varied according to the individuals. Staff as a whole was extremely wary of the group and the Advocate initially. Staff members attending the meetings often felt it was their role to justify themselves, the hospital and even the mental health system when residents brought up an issue. On occasion, staff had to be reprimanded by senior staff.

Some staff have retained a "them and us" attitude exhibited through body language: sitting apart from the group, arms folded, even sniggering at resident's comments; their demeanor having the appearance of their perceived custodial/supervisory/protective role. Some staff would lock the dining room door to keep undesired residents from entering/disturbing the meeting.

Some staff speak for the clients. For example a staff member might say "You like such and such. You have never had any problems with that!" And the patient replies, "Yes, I do and no I don't." The staff use of imperative language is a tool that disempowers a patient.

Staff taking notes of the issues sometimes wrote their own interpretation of what a resident said. For example, one resident said that "there were intelligent people on the ward and yet when OT came, they got patients to colour in and that's all! There needs to be more focus on stimulating and educative activities by Occupational Therapists to help prepare residents for their return to the outside. Activities need to be less childish." The staff member wrote "OT is unsuitable."

2.8 Changes in Staff Attitudes

Staff attitudes to the meetings initially had ranged from apathy to hostility. There was a general belief amongst staff that the meetings were a way for patients to complain against individual staff members without the staff member being able to defend themselves.

It is the Advocate's belief that when staff began seeing change, often changes that they had been unsuccessfully lobbying for some time, they began seeing the group as a positive influence. They had a clearer understanding of the partnership between themselves and residents, and how that partnership was a force that could effect change.

The Advocate considers that the changes in staff attitudes toward residents and their needs, has been the most positive outcome of all.

2.9 Future Direction

There is a requirement that to satisfy accreditation standards under the *National Standards for Mental Health Services*, all facilities are directed to hold resident meetings (11.4.B.2). This directive will require the eight new facilities established under the Redevelopment to provide residents with a resident forum. The logistics make it impossible for one Advocate to facilitate all eight weekly meetings.

The Advocate is presently in negotiation with the Consumer Consultants whereby that organisation will be responsible for providing facilitators for the meetings. The Advocate is also providing the Consumer Consultants with training in the facilitation of the meetings.

The Patients/Residents Groups will only succeed if there is a strong partnership forged between residents and staff. The reality is that staff has the power. They have the resources and opportunities to effect change. But the patients know what are meeting and not meeting their needs with regard to service delivery. They have the voice. Joining the voice and the power together in a working machine, offers a formidable mechanism for change. The value of the consumer consultation and participation has been demonstrated by the changes made as a result of the Ward 7 Patients Group.

Section 3

Mental Health Nurse's Perspective

3.1 Purpose of the Group

Ward 7 is a secure ward for mentally ill clients presenting with a risk of harming themselves or others. A number of them can be floridly psychotic at any one time but because this particular group is vulnerable and in my opinion, probably the most stigmatised, I eagerly accepted the offer from the Advocate to be involved in a patient group on the ward. I believed that the patients of Ward 7 are the consumers with the most need to comment on the mental health services provided, or not provided them.

The purpose in establishing the group was to provide patients with access to a true consumer forum. Too often, consumers are thought of only as former patients who now live in the community. The consumers within the facilities are often overlooked when eliciting opinion and suggestion despite the fact that the opinions and suggestions of others can directly impact on their daily living environment.

Resident's meetings are also a requisite for accreditation under the *National Standards for Mental Health Services*.

3.2 Difficulty in Evaluation

Ward 7 currently cares for the acutely mentally ill as well as for some clients with chronic mental disorders. Fifty percent of the clients are transferred or discharged within a week of admission while twenty-five percent of clients have been residents for years. This means that each group is composed of different members than attended the session held the week previous. This fluctuation in membership makes evaluation of the group meeting difficult.

The Advocate and I have had great difficulty in quantifying our outcome measures. The best I can offer at this stage is a subjective account of the changes I have observed over the eighteen months the meetings have been held.

3.3 The Meeting Environment

The meetings are held weekly. They are held in the ward dining room around tables pushed together. Attendance is not compulsory. The doors to the room are left open and anyone is free to join, leave or return, at any time throughout the meeting. The group is open to who ever of the patients on Ward 7 want to attend.

There can be, at times, a lot of movement in and out of the doors. Patients will leave for a cigarette, or a cup of tea, or because they are exasperated that the group is listening to someone he or she regards with contempt. Often, these patients will return to the meeting; sometimes they will not.

3.4 Meeting Protocol

At the start of each meeting, there is a preamble that describes the purpose of the meeting and gives examples of what general things are that could be discussed. For example, it is explained that it is not a clinical meeting and individual patient's treatment plans can't be discussed because the group has no input into clinical matters. However, comments and suggestions about ward management and service delivery, and how they affect those persons admitted to the ward, are encouraged.

Some of the patients are too ill to distinguish the difference and may be disappointed in the meeting and its terms of reference, leaving the meeting believing that there has not been an attempt to resolve their primary issue which may relate to their desire to be discharged, medication etc.

A few of the long-term residents look forward to the meetings and always attend.

3.5 The First Meeting

The first group meeting was facilitated by the Advocate and myself, with no other staff in attendance although I wished there had been as this session demonstrated the dynamics of communication very clearly. Initially, the patients talked about issues relating to the community they came from and not the ward environment on which they had been invited to give feedback. The meeting talked about stigmatization. One of the presented suggestions was that there should be "safe houses" for the mentally ill. This was enthusiastically endorsed by the meeting.

When the patients believed they were “safe” enough to discuss Ward 7 itself, it was in terms of “the patients”; then in terms of “we” and “us”; then individuals would give examples of events experienced by particular patients not necessarily attending the group but present on the ward. Finally, one patient was moved to tell of a personal experience, describing the circumstances and expressing feelings (and clearly re-experiencing emotions during the telling).

This first meeting was the longest meeting that has been held and the Advocate and I had to work hard as facilitators to ensure nothing was left unfinished and satisfactory closure occurred. I expected that following meetings would probably exhibit the same dynamics but this did not prove to be so. Just about every subsequent meeting has been unique. Some meetings can get heated at times. Sometimes, they can be very quiet with little interaction.

3.6 Patient Issues

Complaints vary. Over time, I have seen a progression from quite serious human rights complaints to recurring complaints such as no basketball or football because it’s been thrown/kicked onto the roof, to minor repairs not being attended to because of the imminent completion of the Redevelopment project.

Sometimes, the complaints about staff and service delivery will be driven by delusional beliefs and/or lack of insight but sometimes, they involve human rights issues such as staff withholding patient’s’ cigarettes or patients believing they were being treated like children when they were required to line up and be served their meals. Issues like these resulted in changes to ward policies and protocols and often required attitudinal changes from staff.

Some issues were easily and immediately resolved. eg: a complaint about not enough seats in the smoking area was attended to immediately after the meeting. This met with cries of approval and was a satisfying experience for both patients and staff.

Other complaints have been somewhat humorous such as the patient complaining about the absence of doors in the toilet, being the same man who had kicked the three doors to pieces and damaged the masonry to which they were attached. It took several days to effect repairs.

3.7 Staff Participation

I did not want the meeting to a “them against us” scenario so I stressed that staff needed to be aware that they are not group members as such; that the Ward 7 Patient’s Group Meeting is exactly that, a patient’s group. Any contentious issues arising for the staff were to be discussed in a staff meeting and any decisions would involve the whole team. Decisions would not be made *ad hoc* by one staff member at the patient group meeting although it would be appropriate

for a staff member to answer a request for information directed towards him or her.

Nursing staff attending need to be aware of their role as group facilitators, helping patients to clearly communicate their thoughts and feelings. If complaints are made about staff for example, the nurses are not to be defensive but to ensure they fully understand what the particular client/s are trying to say. This includes bringing broad sweeping statements to specific details. An undertaking is given to fully investigate the complaint and feedback will be provided to the complainant and to the next meeting.

I also believe challenging patient's versions of events during the meeting will disempower them and leave them feeling unheard and believing the whole exercise was pointless. I stress to my staff, the need for active listening. It is not necessary that every issue raised be resolved during the actual meeting. Some will be but many require further investigation and consideration. One of our aims is to empower patients by enabling them to make real changes to the service delivery on ward 7. Being adversarial will not achieve this aim.

3.8 Staff Attitudes

Initially, some staff feared the Advocate was attending in order to detect deficiencies in service delivery. They resented the Advocate seeking negative comments from the patients and resisted attending the earlier meetings.

Staff have since come to see that the Advocate does not run off telling tales about our faults but assists us to overcome them. She even acknowledges our strengths. Nurses also have a role of patient advocacy and these meetings have reinforced that we are on the same side as the Advocate and the patients. We now comfortably work together and are no longer threatened. Some of us are proactive and consult the advocate about issues causing concerns or dilemmas outside of these meetings.

3.9 ISSUES FOR THE WARD CLINICAL NURSE CONSULTANT

- ü A need to increase the group facilitation skills of nursing staff.
- ü Attitudinal changes required.
- ü High use of casual nursing staff impacts on staff familiarity with the group.
- ü Facilitation skills need to be at play around the clock. The approach required during the group is also required throughout the day.

- ü Hard to make it a patient's group (as opposed to the Advocate's group) as there is not a continuity of patients attending and many of the patients are too unwell to take responsibility of/for the meeting.

- ü The CNC needs to display a commitment (and necessity) for the group to be held on time each week.

- ü The Mental Health Tribunal holds its reviews on Wednesday and the Nurse Manager convenes in-service sessions at the same time. Seeing as I have been unsuccessful at changing in-service times, thought should be given to changing the meeting day to Thursday mornings.

3.10 Conclusion

Over time, there seems to have been a decrease in the number of complaints. I believe that this is due to the changes made and reflects an improvement in the services offered on Ward 7. In effect, the patient meetings serve as a strategy in our efforts to achieve quality improvement in the services offered and have established working partnerships with the consumers of Ward 7, Advocacy Tasmania Inc and staff.

These meetings have also impacted on relationships between staff and patients. Many of the patients are admitted involuntarily and resent being locked up and believe the ward staff are against them because they do not let them leave. The patient meeting enables them to see staff "on their side" – listening to their concerns and endeavouring to achieve solutions that are mutually satisfactory to staff and patients alike. When actively listening to the patients, the staff can appreciate the patient's point of view. Understanding and a therapeutic relationship are more likely to develop.

It probably sounds like a group-workers nightmare but I find it very valuable – and not just because it satisfies a requirement of the National Standards for Mental Health Services to have consumers participate in the review and evaluation of services provided but because I also enjoy the meetings because they are unpredictable, challenging, enhance therapeutic relationships, meet the needs of patients, are mutually satisfying and bring about positive changes – just what mental health nursing is all about.

Section 4

Resident Group Meetings for Persons with a Mental Illness

4.1 The Facilitator

The definition of a facilitator is a person who makes something happen smoothly, quickly, efficiently, and for the case in point, a group meeting. The facilitator needs to be clear on their role, and that that role is not an impartial one. They are there to ensure that residents have the opportunity to be heard without fear of retribution, regarding any issue that they may have directly related to their present environment.

The facilitator does not mediate between residents and staff, but listens to the residents and supports them through the meeting process and assists in making the issue clearer by asking relevant questions of the resident and explanatory questions of the staff.

There also needs to be an acceptance by the facilitator that the power imbalance between the two groups, staff and residents is different but not necessarily unequal if a partnership between the two groups is developed. Residents identify the issue, and staff rectify the issue. With the two halves working as a whole, they can quickly improve the deficiencies in service and environment which residents have identified. If the issue is a systemic one beyond the proximity of staff, the partnership can work as a team to instigate systemic change.

The facilitator also needs to accept that the group meetings will often lack continuity of participants. A consumer may be admitted to a facility, move to another in the mental health structure after four days, then to another facility after three weeks, and to another after two months, and then into a community housing whereby they are supported by the Community Teams.

4.2 Recommendations for Facilitators of Resident Group Meetings for Persons with a Mental Illness

- Prior to commencing a new group, meet with the staff to talk about the expected goals and outcomes for the group. It is important that both the facilitator and staff are aware of the function of the group, and that the meeting is not a general housekeeping forum designed to make easier, the day to day running of the facility.

- Provide education for staff on rights particularly, the right to complain. Offer to train staff so that they may understand that comment and complaint are possitive and requisite components of quality improvement, and should be approached proactively as a force for improved standards and best practice. This is important for the development of the partnership relationship necessary for staff to commit to consumer participation and meaningful client consultation, and efficient resolution.

- Elicit the partnership of staff in the group. If staff feel they have a real role in, and contribution to make towards change, they will support the group rather than try to sabotage it because of a sense of alienation. The facilitator must recognize that there is a power imbalance, power resting with staff. If staff have not committed wholly to the process of consumer participation in service delivery then much of the output of the group will not be resolved via apathy, disregard or obstructionalism.

- Establish a protocol for liaison with the senior staff member to discuss outcomes of each meeting.

- Determine with staff, a suitable day and time for the meetings. Staff are aware of resident's programs and Doctor's rounds, regular leisure outings, meal breaks and other events which would make one day and time less suitable than another.

- Promote the meetings through posters and brochures that are clearly displayed in the residents living areas. Promotion materials should be colourful, with large print and concise, plain English. Medication often makes it difficult for residents to read.

- Maintain continuity with meeting times. Even if no residents wish to attend, arrange the meeting setting and wait seated for at least twenty minutes. This allows for continuity and structure for both staff and residents. It shows a commitment on behalf of the facilitator and allows for residents to join when they choose. There is no quorum necessary for a group meeting. A meeting held with just one resident in attendance can be as fruitful and satisfying as a meeting with ten participants.

- Prior to the start of the meeting, walk around the facility inviting residents to attend. The facilitator will often be asked what the meeting is for and it will be necessary to give residents an outline of the goals of the group, and even past achievements if necessary.

- Ensure that the environment is conducive for a meeting. Arrange for radios and televisions to be turned off if possible, or turned down.

- Bring staff into the group compound. Too often, staff tend to stand over the group, or sit at a distance away from the group if permitted.

- The permanence and the higher level of wellness of the residents of some facilities such as Group Homes may enable the group to elect its own officials and follow accepted meeting formats. This should be encouraged. Ownership of the group should rest with the residents.

- The reality of the mental health system is that most of the consumers who are in an in-patient facility are experiencing an alleviated level of unwellness, and/or are resident for only a short period of time. However, the facilitator should actively promote at all times that the group meeting is owned by the residents and should discourage the use of any other name such as the Consumer Consultant's Group, or the Advocate's Group etc.

- The facilitator should begin every meeting with a preamble on the goals and rules for the meeting because often, the residents have not been before, or have forgotten they have been.

- Due to medications that residents are taking or to their levels of anxiety and paranoia, there is often a need for them to move around. Residents need to feel comfortable about leaving the meeting and returning as they choose. Doors should not be locked and only closed for extreme reasons, and the facilitator should not negatively comment on departures and arrivals during the meeting.

- The Group needs to be clear about its role, and that the meeting does not discuss clinical issues such as medication and discharge. The forum will however, provide information about rights such as the right to refuse treatment, the right to a second opinion, the right to appeal an Order etc.

- Ensure that each meeting is attended by at least one staff member and that that member writes an issue and action list which is reported on the following week. This allows residents to see the process of change happening.

- The facilitator needs to be able to listen to consumers who have a mental illness. Thought and speech patterns can be distorted, and some statements may be based on delusion however, they can, and do have at times, real issues which they are trying to raise.

- The facilitator needs to treat all issues raised by clients as worthy of action. The issue may seem insignificant to others while representing a major issue for the resident. Respect for resident's issues is fundamental for gaining the trust of the group. The resident needs to believe that

his/her issue has had a fair hearing, and satisfied that it has been resolved or will be acted on.

- The facilitator must identify issues that are not raised by the group as an issue but are brought forward in general group conversation. For example, it came out in conversation that a resident of Ward 7 who had been admitted 10 days earlier had spent that time in a room that contained a bed and a chair with no other furniture. He kept his clothes in his overnight bag. He stated that he was not complaining. The staff member present said that he and other staff knew that the resident was in that room, that he had been admitted there by night staff, that he was surprised that there was a chair in the room, and that if the resident had of complained, he would have been moved to a proper room. When the Advocate discussed it with the CNC, she stated that she did not know the resident was in that room, that effectively he had fallen through the cracks. She was not surprised that the resident did not want to complain as they had a Tribunal hearing in a few hours and just wanted to go home. The issues were the resident has been inappropriately accommodated and staff had allowed this to continue, and that the CNC in charge of a ward did not know for 10 days what room a patient was in, and whether their accommodation needs were being met.

- The facilitator should ensure that the meeting is not confrontationalist. Staff should only offer explanation on a point when asked. They are not in attendance to defend staff action/behaviour or Mental Health Services.

- The facilitator should ensure that all participants are given their chance to speak.

- Residents should be offered the opportunity to discuss, after the meeting, one on one with the CNC or their primary nurse, issues raised which would be better discussed privately.

- The facilitator should appreciate the group dynamics and levels of wellness of the participants.

- There needs to be a closure to the meeting in which participants feel something has been accomplished, even if it just has been the opportunity to vent dissatisfaction with the system. Residents should feel better for having attended the meeting.