Knowledge health promotion

The assignment will discuss and critically analyse in detail how clinicians would use their knowledge of Health Promotion to enhance abstinence of cannabis among young mentally ill service users in an acute and forensic setting. Advance knowledge and understanding of the importance of abstinence of cannabis will be discussed in detail. The Transtheoretical health promotion model (Prochaska & DiClemente, 1983) will be used to enhance their care, however other health promotion models are going to be discussed briefly but mainly critically analyse two models. Factors that hinder the learning process and different learning styles to raise awareness will be included and clinical supervision. Finally an evaluation and recommendation to monitor the effectiveness of this initiative on success of the interventions will also be explored.

Health promotion is understood as actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environmental for health (World Health Organisation WHO, 2001). It also defined health promotion as the science and art of enabling and empowering people to change their lifestyle toward a state of optimal health. Health therefore means focussing not merely on preventing disease, but also on individual’s physical, social and mental health (WHO, 1986). Health promotion has long been acknowledged as an important aspect of nursing practice, emphasis on this aspect of current nursing has been increased, nationally by the government through its documents; The Health of the Nation (Department of Health; DH, 1992); Saving Lives; Our Healthier Nation (DH, 1999), and more recently, Choosing Health; Making Healthy Choices Easier (DH, 2004).

Health Education

Health education refers to those activities which raise an individual's awareness, giving the individual the health (ill-health) knowledge required to enable him/her to decide on a particular health action (Mackintosh 1996). Health education is viewed as being based on an authority model that is derived from medical science and whereby its focus is on disease prevention which has in turn, meant that it is seen by some to have a negative focus (Naidoo and Wills 2000). Health promotion on the other hand involves social, economic and political change in order to ensure that the environment is condutive to health.

The main aim of health education is to help people to feel more comfortable, inform service user's about their illness and factors that affect their health, assess risk, provide a supportive environment and informed decision making. Allmark (2005) criticised some of health promotion practice arguing that they offend against Mill's liberty principle, that coercion should not be used against someone for his own good; that health promotion promotes an ascetic rather than a good life and that many of the interventions performed are either of dubious benefit or of uncertain harm-benefit balance. It is however well accepted that health promotion programs have the positive economic impact. Sir Donald Acheson Report (Acheson, 1998) criticised that health promotion action favoured the better off recommended that further steps should be taken to reduce inequalities and improve living standards of poor households.

Therefore while mental health will focus more specifically on the determinants of mental health and the creation of conditions that enable optimum psychological and psycho-physiological development these efforts will impact positively on physical health (Herman et al., 2005). The goals of health promoting nurse is to raise awareness about health, provide information, improve self esteem, encourage decision making, changing attitudes and behaviours, changing the physical and social environment (Naidoo and Wills, 2001)..

The rationale for choosing the topic was chosen upon recognition of the negative effects of use of cannabis and potential harm specifically among young mentally ill service users in an acute setting. The aim of the assay is to prevent/minimise mental illnesses associated with misuse of cannabis and relapse prevention by empowering & enabling service users to make informed choices. DH (2001) identified the three target groups, these included individuals at risk, vulnerable groups and people with mental health problems (NICE, 2007). It is noteworthy to highlight that the selected client group according to Jones and company (2002) fits the first two groups. According to Ewles (2005) a survey was conducted in 2002, 2003 and it indicated that over one third of the population young adults in the UK had used an illegal drug, whilst 28% of

the young adults reported that they had taken an illegal drug in the last year. Patton et al (2002) states that drug use and misuse increase with age peaking at 20-24 year olds who

have reported to have used drugs and more than 25% of 15-30 year olds reported using drugs regularly mainly cannabis.

Most young mentally ill service users use cannabis, eight out of ten people who suffer the onset of serious mental illness are heavy cannabis users, claims a scathing report on the effects of the drug. The report found that the huge majority of those undergoing a first episode of psychiatric disorder, schizophrenia or similar mental breakdowns are habitual users of the drug. The National Survey of Psychiatric Morbidity in the UK found a population prevalence of probable psychotic disorder of 5 per 1000 in the age group of 16 to 74 years (Singleton *et al* , 2000; NICE, 2007) which the DH (2006) associates strongly with the substance misuse statistics.

Why do they use cannabis

Cannabis can be used as form of medication in a number of illnesses

Cannabis seems firmly established as another social drug in Westerncountries, regardless of its current legal status (Class B). Patterns of use varywidely, as with other social drugs, the pattern of use is critical indetermining adverse effects on health. Perhaps the major area of concernabout cannabis use is among the young mentally ill. Using any drug on a regularbasis that alters reality may be detrimental to the psychosocial maturationof young persons. Chronic use of cannabis may stunt the emotional growthof youngsters. Evidence for a motivational syndrome is largely based onclinical reports; whether cannabis use is a cause or effect is uncertain. The evidence for a link between psychosis and cannabis seems unequivocal, long rumoured has been difficult to prove.

No onedoubts that cannabis use may aggravate existing psychosis or other severeemotional disorders. Brain damage has not been proven, physical dependenceis rarely encountered in the usual patterns of social use, despite somedegree of tolerance that may develop. The endocrine effects of the drugmight be expected to delay puberty in prepubertal boys, but actualinstances have been rare. As with any material that is smoked, chronicsmoking of cannabis will produce bronchitis; emphysema or lung cancer havenot yet been documented. Cardiovascular effects of the drug are harmful tothose with preexisting heart disease; fortunately the number of users withsuch conditions is minimal. Fears that the drug might accumulate in thebody to the point of toxicity have been groundless. The potentialdeleterious effects of cannabis use on driving ability seem to be self-evident; proof of such impairment has been more difficult. The drug isprobably harmful when taken during pregnancy, but the risk is uncertain. One would be prudent to avoid cannabis during pregnancy, just as one woulddo with most other drugs not essential to life or well-being. No clinicalconsequences have been noted from the effects of the drug on immuneresponse, chromosomes, or cell metabolites. Contamination of cannabis byspraying with defoliants has created the clearest danger to health; suchattempts to control production should be abandoned. Therapeutic uses forcannabis, THC, or cannabinoid homologs are being actively explored. Onlythe synthetic homolog, nabilone, has been approved for use to controlnausea and vomiting associated with cancer chemotherapy.

The models

There are various theoretical perspectives on health promotion and models that can be used to develop a strategic framework (DH, 2001). There is a distinction between analytical models (Beattie`s, 1991 model), descriptive models (Ewles and Simnett, 1999 model, and Tannahill, 1985 model) and Transtheoretical model (Stages of change, Prochaska & DiClemente, 1984). Jones et, al (2002), Nutbeam and Harris (2004) consider the differences between analytical models such as the Beattie`s model and, descriptive models such as Ewles and Simnett model, and the Tannahill model. Analytical models are clear about values as keystone for practice and often prioritise certain kinds of practice over others, while descriptive models identify the range of existing practice but make no judgements about which kind of practice is preferable, the Stages of change model, which is theoretical (Naidoo and Wills, 2000). Naidoo and Wills (2000) state that health promotion models provide valuable representations of the factors and processes which influence health related behaviours and interactions. As mentioned by Naidoo and Wills (2000) that using a model can be helpful as it encourages thinking theoretically, and come up with new strategies and ways of working, also helping prioritise and locate more or less desirable types of interventions. Ewles and Simnett (2003) suggest that there is no one `right` aim for health promotion and no one `right` approach or set of activities.

Thompson (1995) argues that analytical models are clear and concise about values as keystone for practice and often prioritise certain kinds of practice over others, while viewing descriptive models as identifying the range of existing practice they make no criticism about which kind of practice is

preferable. The Transtheoretical model of Prochaska and DiClemente (1984) will be the model used focusing on cannabis users.

The transtheoretical model is a model of intentional change, it is a model that focuses on the decision making of the individual. It is a theoretical model of behaviour change which has been the basis for developing effective interventions to promote health behaviour change. The model desribes how people modify a problem behavior or acquire a positive behaviour in this case young cannabis users. In comparison, the transtheoretical model of change explains or predicts a person’s success or failure in achieving planned behavioural changes unlike other theories that have a lesser practical application (Tones and Green, 2004). This model is ideal for the concerned client group for a number of reasons. For instance the client group has accepted that they have a problem and some may be or are willing to change while some potentially will consider changing. Looking at three primary concepts, the model integrates the stages of change, the process of change and the levels of change as its base. Jones et, al (2002) stipulates that the model configures five stages of change that individuals go through when individuals are modifying behaviour.

Colella and Laver (2005) and Ewles and Simnett (2003) highlight that the model construes change as a process involving progress through a series of stages which are; precomtemplation where the client does not intend to take action in the foreseeable future, maybe due to being uninformed about the consequences of their behaviour and interventions available. Comtemplation is where the client is intending to change in the next six months and are more aware of the pros of changing but are also deeply aware of the cons.

Preparation is where the client is intending to take action in the immediate future and they have significantly taken action and have an action plan, and these are the people that should be recruited for action oriented like the substance misuse team. Action is where the client has made specific clear modification in their lifestyle within the past six months and action is observable. Maintenance is where the client is working to prevent relapse but they do not apply change processes as frequently as patients do in action stage.

However the individual is still not ready to change his/her cannabis use because of various reasons. When the decision to change is made, thus begins the preparation stage where mental or even physical preparation takes place. Inevitably the action stage presides and appropriate steps to change commence. Next the maintenance stage aims to prevent the relapse stage where former behaviour is temporarily retained.

Nutbeam and Harris (2004) highlight that the use of models encourages practitioners to think conceptually to develop new strategies and ways of functioning, helping them prioritise and find more adequate types of intervention. Since health education is such a complex concept, Wimbush and Watson (2000) suggest that there is no isolated model that can be considered as the best because models exist to balance the demands of the modern healthcare industry (Thompson, 1995). They all simply function differently and may be suitable for different situations like cannabis use (Whitehead, 2003).

TEACHING PLAN

When planning a subsequent teaching session there are various learning styles that include, andragogy, pedagogy, behavioural, cognitive, humanistic and experiential (Sidell et al, 2003). Particular attention was drawn to behavioural and andragogy learning styles. Behavioural learning style is believed to be a change in observable behaviour which occurs when a link is made between a stimuli and a response/reward (McKenna, 1995), so by manipulating the link the behaviour is altered (see appendix Pavlov 1927). Behaviour change aims to encourage individuals to adopt health behaviours, which are seen as the key to improved health. Laverack (2004) argues that changing health behaviour is a problem and complex task. The style involves working with clients, enabling communication and feedback that can in turn be used to fine tune the intervention to enhance its effectiveness; however clients may reject advice preferring experiential learning style due to life experiences (Naidoo and Wills, 2000).

Andragogy is a concept and theory of adult education based on assumptions about adults as learners opposed to pedagogy which focuses more consistently upon the learning of children (Marquis and Houston, 2003), and is more suitable for teaching psychiatric clients about cannabis to achieve a healthy lifestyle. It is a pro-active approach, opposed to pedagogy which is ineffective because adults are mature, self directed people who have learned a great deal of life experiences (Marquis and Houston, 2003).

Factors that hinder/enhance the learning process of the clients

Tones and Green (2004) identified factors that hinder the learning process for psychiatric clients such as; lack of knowledge, being excluded or given minimal information about quitting and miscommunication.

Clinical Supervision is a formal process of professional support and learning which enables individual practioners to develop knowledge and competence, assume responsibilty for their own practice and enhance consumer protection and safety of care in complex clinical situations. It is central to the process of learning to the scope of the expansion of practice and should be seen as a means of encouraging self assessment and analytical reflective skills (DH, 1993). NMC (2004) asserts that clinical supervision helps to develop skills and knowledge throughout one’s nursing career, helps evaluate and improve contribution to nursing care, reflection on practice and improve patient care.

Evalution

Evaluation is the critical and objective assessment of the degree to which services or intervention fulfil stated goals. The archievement must be compared with predertermined standards of expectation (Root et al 2001 by Tones and Green 2004). The reason why health workers or any project evaluate is to see if the initiative has worked. Whitehead (2003) asserts that nurses need to evaluate health promotion initiatives to ensure that ongoing survival and validity of health promotion, evidence that health promotion actually works, ensure efficient and cost-effective use of resources, ensure ethical practice and identification of strenghts and weaknesses of programmes and show an evidence based practice.

The main bennefits of evaluation are, contribution to knowledge base/theory of health promotion, an insight that will result in more effective health promotion practice, relative cost and benefits in financial terms, evidencne to influence policy makers development of health policy, continuing research and the impact on individual and public health (Tones and Green 2004). The assignment acknowledges different learning styles, young mentally ill clients need a lot of motivation in order to pay attention. A drug manual with examples of drugs appeared to have caught the attention of the clients, however after evaluation comments, the educator learnt that the timing of showing the manual meant attention was drawn away from the lecture. However Botvin (2000) argues that there was a danger of introducing drugs than stopping, were concerns highlighted during the evaluation. One of the difficulties faced by the educator was to limit the amount of information for the session. This appeared to have been a barrier to the learning process as there was too much information for the time scale.

Motivational interviewing

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