DOWNLOAD PDF THE MENTAL HYGIENE SURVEY AND RECOMMENDATIONS.

Chapter 1 : Full text of "Report of the Arizona mental hygiene survey : with recommendations"

The report of the Maryland Mental Hygiene Survey has been referred to the following special Maryland Mental Hygiene Survey With Recommendations.

You might also like these other newsletters: Please enter a valid email address Sign up Oops! Please enter a valid email address Oops! Please select a newsletter We respect your privacy. Good personal hygiene is essential to promoting good health. Personal hygiene habits such as washing your hands and brushing and flossing your teeth will help keep bacteria, viruses, and illnesses at bay. And there are mental as well as physical benefits. People who have poor hygiene â€" disheveled hair and clothes, body odor, bad breath, missing teeth, and the like â€" often are seen as unhealthy and may face discrimination. Healthy Habits Include Good Grooming If you want to minimize your risk of infection and also enhance your overall health, follow these basic personal hygiene habits: Wash your body and your hair often. Otherwise, it will cake up and can cause illnesses. Keeping your finger and toenails trimmed and in good shape will prevent problems such as hang nails and infected nail beds. Ideally, you should brush your teeth after every meal. At the very least, brush your teeth twice a day and floss daily. Brushing minimizes the accumulation of bacteria in your mouth, which can cause tooth decay and gum disease, Novey says. Flossing, too, helps maintain strong, healthy gums. Unhealthy gums also can cause your teeth to loosen, which makes it difficult to chew and to eat properly, he adds. To maintain a healthy smile, visit the dentist at six-month intervals for checkups and cleanings. Washing your hands before preparing or eating food, after going to the bathroom, after coughing or sneezing, and after handling garbage, goes a long way toward preventing the spread of bacteria and viruses. Get plenty of rest â€" 8 to 10 hours a night â€" so that you are refreshed and are ready to take on the day every morning. Talking about the importance of proper personal hygiene for preventing illnesses and providing personal hygiene items may help some people. Be candid but sensitive and understanding in your discussions, Novey says. Despite your best efforts, your friend or loved one may need professional help. Good Habits Help Keep You Healthy For most people, good hygiene is so much a part of their daily routines that they think little about it. They bathe, they brush their teeth, visit the dentist and doctor for regular checkups, and wash their hands when preparing or eating food and handling unsanitary items. To keep those you care about healthy and safe, help them learn, and be sure that they are practicing, good personal hygiene.

Chapter 2 : National Committee for Mental Hygiene (Author of Report of the Arizona Mental Hygiene Surve

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To assess knowledge, attitudes and practices of U. Data are needed to assess compliance, prevention and behavioral issues with current ICG practices. Dominant themes were identified from open-ended responses. Dental hygienists are adhering with most aspects of the ICG. Investigate methods to decrease errors, risks and or hazards in health care and their harmful impact on patients. You must be signed in to read the rest of this article. Registration on CDEWorld is free. Introduction Clinical practice guidelines are evidence-based recommendations set forth by regulatory and advisory agencies to promote safety in the implementation of patient care. Knowledge, attitudes and practices and compliance with ICG among nurses and hospital personnel has been studied extensively, and findings indicated low compliance. Evidence suggests a need for improved compliance with some aspects of the ICG in dental settings. Dentists from smaller communities were more compliant with Hepatitis B vaccination and less compliant with use of ICG manuals and handwashing. However, these studies showed low compliance with pre-procedural rinsing. King and Muzzin found that, of U. This survey assessed 4 research questions: What are the attitudes of dental hygienists regarding ICG? What are the infection control behaviors used by dental hygienists? Are there any relationships among knowledge, attitudes and practices data? A item questionnaire was used to survey a proportional stratified random sample of dental hygienists. The questionnaire consisted of 3 parts, including 10 demographic questions and 31 knowledge, attitudes and practices items part 1 and part 2. Demographic questions included sex, age, degree type, years of practice and practice setting. Part 1 of the questionnaire included 20 statements on agreement or disagreement and 2 additional open-ended questions specific to the CDC ICG to assess knowledge, attitudes and practices of dental hygienists. Subjects rated their knowledge, attitudes and practices behaviors in part 1 by using a 6-point Likert-type scale. Thirteen of the 20 knowledge, attitudes and practices items were positively worded, with a score of 6 indicating strong agreement. Seven items were negatively worded, with 1 indicating strong disagreement, so these items were reverse scored for data analyses. After the instrument was redesigned for dental hygienists, the PI convened a panel of expert dental hygiene clinicians to evaluate content validity. Ten dental hygiene practitioners with over 10 years of experience each reviewed the items and provided feedback on content and clarity based on criteria provided by the PI. The evaluation criteria included length of time to complete the survey, clarity of the questions and format of the survey, and also asked for suggestions for improvement. The survey instrument was revised to enhance clarity and content validity. Surveys were coded with a number available only to the PI to ensure that individual identity was protected for confidentiality while also allowing a mechanism for follow up of non-responders. The customized list included a proportional stratified random sample of all dental hygienists who worked in clinical practice settings, included both members and non-members of ADHA, and excluded students and retired dental hygienists. After exclusions were applied, a percentage of dental hygienists in each of the 50 states in the U. This stratification method was utilized to contain costs and to gain a fair representation of dental hygienists in each state. Data Collection Postal mail addresses were the only available means of contact from the ADHA master list, so this study utilized a mixed mode survey method. The mixed method included sending a letter via bulk postal mail inviting the 2, subjects in the proportionate randomized sample to participate in an online survey. These domains were not validated with a value of 0. Descriptive data summarized demographic characteristics and knowledge, attitudes and practices item responses from part 1 and part 2. Ninety-nine percent were ADHA members. Demographic data describing the sample are reported in Table I. Knowledge and Attitudes Table II shows knowledge, attitudes and practices responses for part 1 of the survey. Fourteen items in part 1 of the survey instrument assessed attitudes about the ICG. Sixty-one percent of respondents strongly to somewhat agreed that they felt competent using alcohol-based hand products. Items in part 2 of the survey were also designed to assess practice behaviors Table III. Six items

assessed the percentage of time specific infection control practices were used. Significant direct relationships were found between implementation of the ICG and posi-tive attitudes regarding: Significant direct associations also were found between the negative attitude that the ICG is not practical and negative attitudes about: Significant inverse relationships were found between implementation of the ICG and the following knowledge, attitudes and practices items: Open-Ended Questions Dominant themes were identified through qualitative analysis of 3 open-ended items. Themes related to factors that influenced implementation of the ICG included: Dominant themes identified related to barriers to using the ICG included time, staff education and training, attitudes and cooperation of others in the office, lack of supplies, high cost of supplies, employer unwillingness to support full implementation, environmental waste issues, and a lack of understanding of the ICG. Although no dominant themes emerged from the item asking for general comments, responses characterized challenges dental hygienists face and practice patterns. Respondents expressed a need for involvement of all dental coworkers in infection control education. Discussion Demographic characteristics of the respondents in this study, with one exception ADHA membership , were similar to the National ADHA profile of dental hygienists with regards to gender, race, age, type of practice setting, practice type, years practiced and entry level degree. Similarly, the majority of respondents in the current study were White females, aged 42 years or older, with an entry-level associate degree and more than 10 years of experience working in 1 general private practice setting. Most participants reported they did not find the ICG to be impractical, cumbersome or inconvenient to use. Results related to infection control practices indicated that most respondents had adequate supplies to use the ICG and had implemented the ICG. Specific infection control practices that were previously identified in the literature as needing improvement indicated little change. Low compliance with ICG recommendations for pre-procedural rinsing, utility glove use, and handpiece sterilization were reported. It appears that little change in these practices has occurred since Interventions targeted toward improvement of compliance of these behaviors need to be developed and implemented for all dental professionals. Interdisciplinary webinars or online learning modules may be one strategy to reach a large audience of dental healthcare workers. Dental and dental hygiene educators also need to focus on teaching these practices to improve compliance. Approximately half of respondents in this study reported that they believed they were somewhat to strongly competent in using alcohol hand products hand sanitizer gels for routine hand hygiene. Conversely, the respondents who believed the person they reported to did not expect them to use the ICG reported that they did not have time to use the ICG, believed it was not practical to use the ICG and felt the ICG was cumbersome and inconvenient to use indicating a less positive safety culture or climate. Most respondents in this study worked in a general private dental practice. The dentist-supervisor, or designee such as the office manager, often oversees office infection control policies and monitors costs of supplies, and is very influential in establishing the safety climate in the practice. Barriers reported in the open-ended questions revealed factors that might also explain low compliance reported with a few aspects of the ICG. Overall, it appears that dental health care workers are aware of the importance of follow-ing ICG and are generally compliant with implementation. Hands are the biggest culprit in cross contamination and have been identified in several studies of nurses and hospital personnel as the cause for many HAIs. Ninety-nine percent of the subjects in this study were ADHA members; therefore, results are representative of members of that professional association. They suggested that professional affiliation may impact knowledge, attitudes and practices through exposure to current research and education. Non-response bias from younger dental hygienists with fewer years of experience also may have impacted results of this study; however, national data indicate the average age of the practicing dental hygienists is 44 years. Another limitation was the low response rate, possibly related to using the mixed mode survey method. Bulk mail was used to contain costs, and incorrect addresses were not able to be tracked. Future research should include studying the infection control knowledge, attitudes and practices of other groups of dental healthcare workers such as dental assistants, dentists, and office managers. Assessment of reasons for continued low compliance with pre-procedural rinsing, utility gloves use, and handpiece sterilization, and targeted interventions for

improvement need to be developed and evaluated. High compliance with ICG among respondents in this study was associated with positive safety beliefs and practices; whereas lower compliance with ICG was associated with less positive safety beliefs and practices. Positive beliefs about infection control and a safety culture or climate in the work setting seem to be important in compliance with ICG and are influenced by decision makers in the practice.

Chapter 3 : Canadian Mental Health Association - Wikipedia

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This section does not cite any sources. Please help improve this section by adding citations to reliable sources. Unsourced material may be challenged and removed. Hincks and Clifford W. Beers on April 26, Hincks was very interested in the field because he had experienced bouts of mental illness. War Work a Psychiatric examination of recruits. Mental examination of immigrants post-war to ensure a better selection of newcomers. Adequate facilities for the diagnosis and treatment of cases of mental disease. Adequate care of the mentally deficient. Prevention of mental disease and deficiency. Hincks solicited friends and professionals to join the committee, with an emphasis on those in the medical profession. He already had the backing of C. Clarke, Dean of Medicine and Professor of Psychiatry at the University of Toronto; his persuasive address to the medical faculty of McGill won him its unanimous approval. Hincks then established a Board of Directors. He asked 20 business and professional leaders to sit on the Board; 18 accepted. Angus, Montreal financier and philanthropist; Dr. Hincks gained further support through a series of "drawing-room meetings". These were afternoon teas hosted by socially prominent women, each of whom invited her wealthy and influential friends. Hicks would present a speaker, his friend and co-founder Clifford W. Beers, author of the book, A Mind that Found Itself. It proved very successful: A provisional constitution was adopted. Clarke was appointed Medical Director, and Dr. Hincks was appointed Associate Medical Director and Secretary. In the fall of , the Committee established itself at College St. Miss Keyes was a graduate nurse who had been associated with Dr. During the summer of , Miss Keyes prepared for her new role by taking psychiatric studies at Smith College. Russel was the consultant neurologist to the Department of Soldiers, and had visited many of the provincial mental hospitals which were caring for soldier patients. He was particularly distressed with those facilities in Manitoba. On September 30, , Hincks and Keyes arrived in Winnipeg, where they visited several institutions. They also toured the Salvation Army Industrial Home and the Home for Incurables in Portage la Prairie and were so shocked by what they found that they immediately returned to Winnipeg to consult with government representatives. As in Manitoba, these surveys included all institutions. Results of these surveys, however, have had controversial implications, including how they were used to argue for pro-sterilization policies by the Alberta Eugenics Board and in the form of the Sexual Sterilization Act of Alberta. It became evident to Hincks that soldiers under care were not receiving adequate treatment. Assisted by Miss Keyes, Dr. Clarke conducted a quick inspection soldier patients in 10 hospitals in the western. The results of this preliminary survey were published in Highlighting the problem of shell shock and other neuropsychiatric disorders affecting so many able-bodied men helped pave the way for the work of the National Committee. Schools were another areas of involvement. Helen MacMurchy pressed for surveys to assess the extent of mental retardation and other psychiatric disorders among schoolchildren and to provide support for the establishment of auxiliary classes for the special education of such children. In its first five years, the CNCMH built a firm foundation for meeting the objectives established in Surveys on the care and treatment of people suffering from mental disorders were conducted in every province. Mental hospitals in all provinces, except Ontario and Quebec, were inspected at the request of provincial governments. The extent of mental disorder was found to be greater than expected, and preventive programs were non-existent. CNCMH surveys of schoolchildren, conducted in several centres in Ontario and Quebec, resulted in over special classes for retarded children being established by school boards. Mental Hygiene clinics were promoted and, in some cases, partially supported. A study of the psychiatric screening of immigrants resulted in a reduction of the number of new Canadians with mental disorders. The problem of "shell shock" and the rehabilitation of soldiers suffering from mental and nervous disorders was addressed through co-operation with DSCR and the Director General of Medical Services in the army. A beginning was made on public and professional education in mental hygiene and psychiatry.

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Chapter 4 : Hand Hygiene in Healthcare Settings | Hand Hygiene | CDC

Excerpt from A Report of the South Carolina Mental Hygiene Survey With Recommendations: Survey Authorized by the Honorable Robert A. Cooper, Governor of South Carolina; Conducted by the National Committee for Mental Hygiene Under the Auspices of the South Carolina Mental Hygiene Committee This report contains only data gathered from a study of chil dren in Pickens County, Anderson County.

Chapter 5 : Temporary Exemption from Licensure under Chapters and of the Laws of

Hygiene Directors (CLMHD), and several county mental hygiene agencies. The three state mental hygiene agencies have a fully integrated mental hygiene local services planning process.

Chapter 6 : National Committee for Mental Hygiene (Author of Report of the Arizona Mental Hygiene Surve

Local Services Plan Guidelines for Mental Hygiene Services 1 CHAPTER 1: Introduction A. Integrated Local Mental Hygiene Planning New York State Mental Hygiene Law (Â§) requires the Office of Alcoholism and Substance Abuse Services.

Chapter 7 : Report of the Arizona Mental Hygiene Survey,

The report of the Maryland Mental Hygiene Survey has been referred to the following special comm ittee appointed by Dr. Lewellys F Barker for further consideration and recommendations.

Chapter 8 : A CALIFORNIA MENTAL HYGIENE SURVEY - Europe PMC Article - Europe PMC

Mental Hygiene. human of mental hygiene and by practitioners involved in the promotion of mental hygiene.I - Mental Hygiene A. Meaning and Aim B. Importance of Mental Hygiene C. Aspects of Mental Hygiene II - Mental Health A. Meaning of Mental Health B.

Chapter 9 : Office of Health Care Quality

The Maryland Department of Health and Mental Hygiene (the Department), Office of Health Services, is family of surveys that ask consumers and patients to.