



THE JOURNAL

of the New York State Nurses Association

SPRING/SUMMER 2007

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■ Editorial.....	3
■ A Brief History of the Commission on Graduates of Foreign Nursing Schools: Shaping Policy through Collaboration	6
<i>by Veronica O'Day, PhD, RN</i>	
■ The Provision of Mental Health Services on Long Island College Campuses: A Pilot Study	9
<i>by Lorraine B. Sanders, DNSc, APRN, BC</i>	
■ A Campus Wellness Program: Accepting the Challenge	13
<i>by Bonnie Ewing, PhD, RN; Marybeth Ryan, PhD, RN, ANP; and Emilia Patricia Zarco, MD, MEd</i>	
■ Book Review: The World is Flat	17
<i>by Margaret Lunney, PhD, RN</i>	



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■ EDITORIAL


Frameworks for change

The history of policy development provides a framework for planning future policy developments. In O'Day's article in this issue, we learn about the steps associated with development and implementation of a national Commission on Graduates of Foreign Nursing Schools. Similar steps occur with any significant policy development, as discussed in a recent article by Abood (2007). For example, new policies generally have an element of controversy that must be addressed by proponents of the policy. The rationale for new policies must be clearly based on theoretical principles. And advocacy, persistence, and political savvy, such as that demonstrated by Frances Pell and her colleagues in the O'Day article, are needed to convince others of the need for new policies.

The historical development of healthcare policy in the United States related to health promotion and health protection services can also serve as a framework for the other two articles in this issue, i.e., Sanders' descriptive study of the mental health services of colleges on Long Island and Ewing, Ryan, and Zarco's description of creating a Wellness Center at a Long Island college. The authors of these articles refer to *Healthy People 2010* (U.S. Department of Health and Human Services, 2000), the latest U.S. health policy document that was designed to influence nationwide provision of healthcare services to improve quality of life, increase life expectancy, and reduce health disparities. The *Healthy People 2010* initiative represents the third major policy document since 1979, when the United States first addressed an overall lack of health promotion and health protection services in the document, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. One impetus for this advancement in health policy development was the World Health Organization's 1978 meeting about primary health care (WHO, 1986). With publication of the first major U.S. document in 1979 to emphasize the need for health promotion and health protection, public health officials decided to publish new policy documents every 10 years to track progress and provide guidance for upcoming decades. A new policy document, *Healthy People 2020*, is expected to be available in 2010, based on current data and influencing factors.

In the 1979 policy document, public health officials in the United States finally acted on the realization that the health statistics for U.S. citizens were worse than other industrialized nations, based on a lack of emphasis on health promotion and health protection. At that time, the United States was ranked 11th in the world in life expectancy and infant mortality rates, two major indicators of community health. An overwhelming emphasis in the United States was, and still is, the diagnosis and treatment of health problems instead of making more efforts to keep people healthy. Community health nurses, such as Nola Pender, and other public health providers were leaders and advocates in helping government officials to recognize the problem of emphasizing medical care for health problems instead of provision of sufficient services to promote and protect the public's health. In the public health literature, this problem-oriented approach became known as *downstream thinking* (Butterfield, 2002), based on the analogy of waiting until each person falls in the river and then pulling them out one at a time, instead of looking upstream to prevent them from falling in the river. The study of mental health services on Long Island (Sanders) and the description of a new Wellness Center (Ewing et al.) represent the concept of *upstream thinking*.

Continued—



In the historical evolution of U.S. policy development, a nurse, Nola Pender, played a major influencing role by developing the concepts of health promotion and health protection (Pender, 1982). She described health promotion as a positive approach to health that involves different motivations than disease prevention. Pender explained health protection as a positive approach to disease prevention that is also broader because it focuses on prevention of other problems besides disease. Examples of other problems are the human responses to health problems and life processes that were identified by NANDA International (2007) as the diagnostic focus of nursing, e.g., powerlessness and stress overload. Since then, Pender's perspectives on health promotion and health protection have been widely accepted and used by public health officials in the United States and other countries.

Knowing the history of policy development helps nurses learn how they can influence future policy developments. Health-related data in the United States compared to other countries is worse today than it was in 1979 and indicate a need for new policies and approaches. For example, the United States is now ranked 42nd in the world in life expectancy (Ohlemacher, 2007) and 40th in infant mortality rates (WHO, 2007), yet the money that the United States spends per capita on health care is more than two times greater than any other nation (United Nations Development Programme, 2006). Many new policy changes are needed, both locally and nationally, to improve health statistics in the United States. One of the most important policy influences for nurses is the right to vote. The 2.9 million nurses of the United States can become what Abood (2007) referred to as a "formidable" power aimed toward improved health policies.

In this issue of the *Journal of the New York State Nurses Association*, readers will also find a book review (by one of this issue's guest editors, ML) of Thomas Friedman's *The World is Flat: A Brief History of the Twenty-first Century* (2006). This book explores the impact that technological advances have wrought and concludes that our world is made "flat" by them. The effects on workers are challenging, to say the least, and nurses are encouraged to think about how these technologies may impact their own work as well as the healthcare environment within which we all function.

As a reminder, please note that the Editorial Board of the *Journal* is always seeking new manuscripts for publication consideration. The board will provide timely reviews and seeks to assist authors (both novice and experienced) by providing editorial suggestions to improve and strengthen manuscripts. For submission guidelines, contact the NYSNA Communications department at communications@nysna.org or go to the "publications" area of www.nysna.org.

Beginning in our next issue, the *Journal* will also include brief reviews of published research that we think will be relevant to readers. Best wishes for a safe and peaceful autumn.

Margaret Lunney, PhD, RN
Craig R. Sellers, MS, RN, APRN, BC, ANP
Guest Editors



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A Brief History of the Commission on Graduates of Foreign Nursing Schools: Shaping Policy through Collaboration

Veronica O'Day, PhD, RN

Abstract

In the late 1960s many foreign nurses arriving in New York City were unable to pass the New York State Board licensing examination. In this article, the author explains how a group of leaders and organizations proceeded systematically to address this problem through effective policy development. The process is presented from the establishment of a local program to meet the needs of this group of nurses to the creation of a national commission to oversee issues encountered by professionals seeking employment in the United States. Today, the Commission on Graduates of Foreign Nursing Schools is recognized worldwide as an authority on the education, registration, and licensure of nurses and other healthcare professionals.

In the late 1960s there was a marked increase in the number of nurses who were immigrating to the United States with the hope of employment as professional nurses. Many were from non-English-speaking countries, presenting a two-fold problem of evaluating both their ability to comprehend the English language as well as their clinical nursing skills. At the time, only 15-20% of nurses educated in other countries were able to pass the U.S. registered nurse licensing exam on their first sitting (Davidsen, 1974). Clearly, there was a need for change.

Garnering support for foreign nurses

In March 1972, Mildred Schmidt of the New York State Education Department (NYSED) approached Ruth Pell, dean of the Lienhard School of Nursing at Pace University, with a proposal for Pace to prepare a special program for foreign nurses seeking licensure in New York State. When Pell brought this proposal to the Council of Nursing Directors in New York City, she encountered considerable hostility. The council perceived that it would be a conflict of interest for Pace to help foreign

nurses become qualified for positions that would otherwise be available to American educated nurses.

After much soul-searching, Pell and the group concluded that nursing is a helping profession aimed at assisting others, including fellow nurses of every nation, color, and creed. The group agreed to proceed with the proposal. The university received a grant from NYSED of \$100,000 for the first year; the grant was increased to \$150,000 the second year. On May 1, 1972, Ruth Drury was appointed director of the Education Center for Nurses of

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The role of the nurse in America was far more assertive and decision-making was an expected behavior.

Other Countries. Drury was assisted by John Waldman, director of the Pace College Reading Laboratory, and Robert Brazakas, who was employed as guidance counselor. The program was offered on the New York City campus (Pell, 1972).

The first class in the Education Center for Nurses of Other Countries consisted of 96 students. Sixty were enrolled in the Comprehensive Nursing course and 36 in an English language skills course. The courses ran from May 17 through July 8, 1972.

The Comprehensive Nursing course consisted of 48 hours and was taught by four faculty members as follows: Medical Surgical Nursing, 16 hours; Psychiatric Nursing, 14 hours; Pediatric Nursing, 10 hours; and Obstetrical Nursing, 8 hours. The time allotment was based on the degree of difficulty that foreign nurses demonstrated in taking the State Board Examination (Pell, 1972).

Assessing language skills

In order to determine which students should be assigned to the English skills course, all applicants were required to take an English comprehension pre-test. This was the identical test used for incoming freshmen at Pace; however, it quickly became apparent that the cutoff score required adjustment. For Pace freshmen the cutoff score was 60; for the foreign nurses, the minimum required score was reduced to 30. Before reaching this decision considerable consultation took place with Pace administrators such as George Knerr, a vice president of the university. A decision was made that these nurse applicants had completed educational preparation and professional nursing competence in their own countries well beyond the high school level, and so the modified standard was justified (Pell, 1972).

Applicants who scored less than 30 on the language comprehension pre-test were disappointed to be assigned only to the English

skills course. There was considerable resentment and anger expressed; guidance counselor Brazakas was kept busy explaining to these nurses how the deficit in reading comprehension would hamper their success on the licensing examination. The test format may have been partially to blame for the low scores. Multiple-choice questions were popular at that time, but the foreign students were more accustomed to essay questions. A major difference in the philosophy of nursing practice in the United States also presented a problem to the foreign students. The role of the nurse in America was far more assertive and decision-making was an expected behavior. This thinking was reflected in most of the test questions on the licensing examination.

Enrollment grows with immigration

In the spring of 1972, Pace had two Comprehensive Nursing courses; by fall of that year, total enrollment had increased and 176 students were assigned to five nursing groups. The English courses had 72 students; 18 nurses received more individual attention in a special class for those whose scores were close to 30 (Pell, 1972).

As Pace continued to make thoughtful curricular changes to facilitate success for foreign students, other related health agencies began to share concern about the nurse immigration problem. The Division of Nursing of what was then the Department of Health, Education, and Welfare (HEW) called a special meeting with representatives from these other agencies including members of the Immigration and Naturalization Services (INS). At this meeting, INS expressed the hope that HEW could provide assistance with addressing the needs of nurse immigrants. INS recommended that a pre-immigration examination be established for graduates of foreign nursing schools similar to the one now

offered to foreign medical graduates. The agencies agreed that a certificate from such an examination would serve as a requirement for granting a visa, and would also be appropriate as one criterion to determine preference status for immigration (Davidsen, 1974).

The Division of Nursing of HEW then entered into a contract with Pace University, which called for the development of a plan to insure that foreign nurse graduates could meet state requirements for registered nurse licensure. Pace University provided an office at 150 Nassau Street in New York City. Lillian L. Davidsen was appointed project director and Dolores M. LeHoty was appointed project officer. Pace was selected because of its Foreign Nurse Center, which offered review courses both in nursing and in English language training. At this time, an estimated 2,400 foreign nurse graduates had been enrolled.

Birth of the CGFNS

Project Director Davidsen submitted her final report on December 30, 1974, acknowledging the excellent support she received from her advisory committee. The group suggested a name for the proposed non-profit organization: The Commission on Graduates of Foreign Nursing Schools (CGFNS). The rationale for the name was based on their concern with graduates of foreign nursing schools rather than foreign nurse graduates. In 1975 HEW sponsored a conference to discuss a plan of action based on this report and, in 1977, the ANA and NLN agreed to cosponsor an independent, non-profit organization called the CGFNS.

During the first 15 years of the commission, the focus was on further development of predictive testing and evaluation procedures for foreign-educated nurses. This CGFNS certification program consisted of a credentials review and a one-day qualifying exam of nursing knowledge and English language skills. The credentials review determined the applicant's

knowledge of theory and practice in various specialties such as medical and surgical nursing, care of children, maternal and infant nursing, and psychiatric/mental health nursing. The qualifying exam comprised two sections. The English language segment included emphasis on vocabulary, grammar, and listening comprehension. The nursing content segment was similar to the NCLEX-RN test plan (CGFNS, 1994).

By the early 1990s almost 300,000 tests were administered to more than 170,000 applicants (CGFNS, 1994). At this time the qualifying exam was offered at more than 40 locations worldwide, three times each year in March, August, and November. As a result of this approach, the pass rate for first-time RN candidates who held a CGFNS certificate rose to 70-75%. By earning a CGFNS certificate in their own country before traveling to the United States, the nurse could save considerable time, money, and emotional stress (CGFNS, 1994).

Marking Pace's contributions

On November 1, 1995, Pace's Lienhard School of Nursing hosted a program for a group of guests from the Consortium of Institutes of Higher Education in Health and Rehabilitation in Europe (COHEHRE) in New York City. Virginia M. Maroun, then executive director of CGFNS, was a guest speaker. In later correspondence she stated, "we never talk about the history of CGFNS without describing the initial work of Pace to analyze the need for the organization."

Carol K. Pforzheimer, president of the Westchester Council of Social Agencies, worked very closely with Edward Mortola, president of Pace College, to bring the first collegiate school of nursing to Westchester County at Pace College in Pleasantville. During Mortola's tenure as president of Pace, he delegated George Knerr and Ruth Pell to deal with the thorny problem of foreign nurses joining the American nursing community. Their hard work and leadership led to the creation of the CGFNS, which today is recognized as an international authority on the education, registration, and licensure of healthcare professionals worldwide (CGFNS, 2002).

Strengthening engagement

Through the years the CGFNS has maintained an active interest in foreign nurse graduates in the United States workforce. In an effort to identify the roles that internationally educated nurses fill, the CGFNS conducted its first survey of this group of nurses in 2000-2001. The

project director, Richard Freeman, opted to use a 76-question telephone interview to explore areas such as immigration data, education, licensure, and employment characteristics (CGFNS, 2002). The results were published in a monograph, *Characteristics of Foreign Nurse Graduates in the United States Workforce, 2000-2001*. Participants also identified strategies that were helpful during the transition to United States culture. The monograph is a valuable resource for future candidates who are considering immigrating to the United States (CGFNS, 2002).

In 2005, Barbara L. Nichols, chief executive officer of the CGFNS, conducted five international forums in India – three in New Delhi and two in Cochin. Nichols is a past president of the American Nurses Association (ANA) and has served in the CGFNS leadership role since 1998. The purpose of these forums was personal interactions with potential candidates considering immigration. The timing of the visits to India coincided with the November qualifying exam for CGFNS certification program applicants (CGFNS, 2004).

The CGFNS now proudly boasts of 27 years of reviewing credentials of nurses from six continents, totaling nearly 400,000 individual cases, and implementing the CGFNS certification program in 44 international locations four times a year. In addition to nurses, CGFNS is now authorized to screen other healthcare professionals, including occupational therapists, physical therapists, speech/language pathologists, audiologists, medical technologists and technicians, and physician assistants. This huge expansion of authority encompasses broad changes in healthcare policies and is a tribute to the leadership of the CGFNS (CGFNS, 2006).

Conclusion

Many lessons can be learned from this chapter in nursing history. The initial resistance to change that Ruth Pell encountered from the Council of Nursing Directors in New York City seems trivial when one learns of the growth and scope of the CGFNS' activities today. The broad representation of the nursing leaders who served on the advisory committee included the International Council of Nurses, the ANA, the National League for Nursing, the ANA Council of State Boards of Nursing, the World Health Organization Regional Office for the Americas, the Pan American Health Organization, and the Assistant Surgeon General. This breadth of involvement demonstrates the merits of pooling resources to develop a workable plan for major change in healthcare policy.

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The Provision of Mental Health Services on Long Island College Campuses: A Pilot Study

Lorraine B. Sanders, DNSc, APRN, BC

Abstract

College students, often away from home for the first time, are at risk for mental health disorders that can affect academic performance and quality of life. The purpose of this pilot study was to describe the provision of mental health services to students attending colleges on Long Island, NY and to explore information about the policies developed in regards to disclosing mental health information to a student's family in the event of crisis. A descriptive questionnaire was developed for the purpose of this study. Qualified professionals are providing mental health services to students on Long Island college campuses but few policies exist to enhance communication in the event of crisis. Nurses employed in college health centers can work with students and families towards health-promoting behaviors and to proactively plan for the management of health information in the event of a mental health crisis.

Young adults attending a university or college are often away from home for the first time and generally utilize the college health center for evaluation and/or treatment of symptoms related to illness. This includes symptoms related to mental illnesses, which may be of recent onset or related to a previous diagnosis.

According to a survey of college students ($n=47,202$) conducted by the American College Health Association (ACHA) in 2004, 14.9% (6,884) of these students had previously been diagnosed with depression sometime in their life (ACHA, 2004). Forty-five percent (20,897) of students surveyed reported that at least one time over the past

academic year they felt so depressed that it was difficult to function (ACHA, 2004). These feelings of depression were linked to suicidal ideation in 10.1% of students (4,680) and suicide attempts in 1.4% of students (629) (ACHA, 2004).

In 2004, suicide was the third leading cause of death among those 15-24 years old (American Foundation for Suicide Prevention, 2004). Families of young adults entering college expect quality care to be available to their child on campus. This expectation includes the ability to share information in the event of a healthcare crisis. Although the student may legally be a financial dependent, laws in most circumstances prevent the

disclosure of healthcare information without permission of the patient.

College health centers (CHCs) are established to provide for the healthcare needs of students, staff, and faculty. These centers should provide a full range of mental health services along with care for physical disorders, but few data exist to fully describe how mental illnesses are managed in CHCs. A pilot study, utilizing a descriptive questionnaire design, of college health centers on Long Island, NY ($n=30$) was conducted to describe available mental health services, how services are delivered, and to explore how disclosure of student health information is managed in relation to mental illness, especially during a mental health crisis.

Lorraine B. Sanders is an assistant professor at Adelphi University School of Nursing in Garden City, NY. This study was supported by a grant from Sigma Theta Tau, Alpha Omega.

Review of the literature

The college health center

College health centers were developed to meet the healthcare needs of students, faculty, and employees on college campuses. The ACHA, founded in 1920, is the primary advocate and leadership organization for college health (ACHA, 1999). Guidelines published by the ACHA provide information based on the standards set by the Accreditation Association for Ambulatory Health Care and the Joint Commission on Accreditation of Healthcare Organizations for the development of college health centers (ACHA, 1999). In 2002, the ACHA published *Healthy Campus 2010: Making It Happen* as a companion guide to the federal government's *Healthy People 2010*, with the intention to improve the delivery of health care on the nation's college campuses (ACHA, 2002; U.S. Department of Health and Human Services, 2000).

College health centers provide a variety of services including health screening, immunizations, contraceptive counseling, and primary care. According to the guidelines published by the ACHA, mental health services are an integral component of college health services (ACHA, 1999). Students, often away from home for the first time, may experience significant academic and social pressure. Mental health crises have ended in tragedy on a number of college campuses in the United States. Essential services should include screening programs, on-site counseling, and emergency or crisis intervention with qualified providers (NMHA, 2005). However, college administrators face many challenges when planning CHCs, including recruitment of personnel and allocation of resources. Few studies exist to describe the delivery of mental health services on college campuses. Collins and Mowbray (2005), in a study of campus disability services, found that the range of students that registered for disability services was broad, that fear of disclosure was a barrier to registration, and that disability service offices had many responsibilities with low staff-to-student ratios. Cook (2007) had similar findings in that stigma was a barrier to seeking mental health services on campus as well as lack of knowledge about available services.

Mental illness among adolescents and young adults

The prevalence of mental illnesses among college students supports the need for a comprehensive mental health plan on every college campus as outlined by the ACHA. According to the National Institute of Mental Health (NIMH), 1 in 10 children and adolescents have mental illnesses that are severe enough to affect normal functioning (NIMH, 1999). By the time a person in the United States is considered an adult, the prevalence of mental illness increases to 1 in 4 in any given year (NIMH, 2006). It is estimated that in a given year, 8% of adolescents have depression and 13% have an anxiety disorder in the United States (NIMH, 1999). Although disorders like Attention Deficit Hyperactivity Disorder (ADHD) are usually diagnosed in childhood, others like schizophrenia are more commonly diagnosed in early adulthood, the typical age of a student entering college (NIMH, 2007). And although

mental illnesses like bipolar disorders, eating disorders, and personality disorders are not as prevalent, young adults with these disorders are enrolled in colleges throughout the United States (Collins & Mowbray, 2005; Arehart-Treichel, 2002).

A review of the literature using CINAHL and PubMed determined that few studies have been conducted to describe the delivery of mental health services on college campuses. Much of the data that exist have been collected by the ACHA.

Methodology

College health centers were identified through a search conducted of all post-secondary schools listed on the New York State Department of Education (NYSED) Web site (NYSED, 2007). Phone calls were then made to verify the mailing address of each college health center. The Institutional Review Board at Adelphi University gave approval for this study.

A 27-question descriptive questionnaire developed for the purpose of this study was mailed to the directors of the 30 college health centers on Long Island, NY. The questions were developed to collect data on the existence of a CHC on campus; the delivery of mental health services; and services provided on campus for screening, treating, and/or, referring students to off-campus providers. A series of questions was also developed to describe the staffing of CHCs, training of those staff members, policies regarding health privacy information, and disclosure to parents and significant others. Other questions included handling of psychiatric emergencies on campus and the use of healthcare proxies and advanced directives for medical emergencies including psychiatric emergencies. The questionnaire was reviewed and evaluated by two psychiatric/mental health nurse experts for readability, inclusiveness, and comprehension.

Data were analyzed using SPSS version 13. No reliability and validity testing was conducted, as the survey was developed to describe services that are currently provided with no intention of reusing the tool or use of inferential statistics.

The prevalence of mental illnesses among college students supports the need for a comprehensive mental health plan on every college campus as outlined by the ACHA.

Results

A total of 10 questionnaires were returned for a response rate of 33%. In an effort to increase the response rate, all of the CHC directors were contacted by telephone after the initial mailing as a reminder to complete and return the questionnaire. Due to financial constraints, a second mailing was not undertaken.

In an effort to maintain anonymity, no data were collected that could lead to possible identification of participating colleges and universities. Therefore, no data exist to describe the location, setting, degrees offered, or private or public status. One question asked for total student enrollment. It was estimated by response that approximately 52,000 students were enrolled in these 10 responding colleges. Three CHCs

delivered mental health services at a single site, four colleges provided services at a separate mental health center on campus, one CHC had personnel evaluate mental health problems but referred students to a local hospital for treatment and additional services, and two colleges responded that all health problems were referred off-campus for treatment.

Three colleges took a multimodal approach by publishing information in the student handbook, posting a link to the CHC on the college Web site, discussing the CHC during student orientation, and offering free screening days. In addition, one college had counselors come to selected classes and used posters placed on campus to increase student awareness of counseling services. In response to screening, treating, and providing referrals, most CHCs were providing comprehensive services. Screening for psychosis and schizophrenia were not provided by any responding CHC. The results are presented in Table 1.

College health centers most commonly utilized psychologists (5), registered nurses (4), and social work personnel (1) to provide triage to students with mental health problems. Two CHCs had a physician on-site to provide triage services to students.

Disclosure of health information to outside parties was well-protected. As in any other health center, students over the age of 18 are protected by the Health Insurance Portability and Accountability Act (HIPAA) (U.S. Department of Health and Human Services, 1996). The policy of the surveyed directors ($n=10$) is not to notify parents/guardians if the student enters into treatment for a mental illness or is hospitalized for a mental illness. These were not independent policies of the CHC manager. All responded that nondisclosure policies were developed by the academic institution and were guided by HIPAA. However, four CHCs in this study had a policy to notify parents if the student provided either verbal or written permission. All of these respondents provided notification by telephone and by the provider caring for the student. All colleges had a medical leave policy for students with mental illness. No CHC reported having a formal program that provided counseling and/or support services to family members of the student with a mental illness. Furthermore no CHC reported training personnel to discuss healthcare proxies and/or advanced directives with students.

Discussion

The findings from this pilot study support that care for mental illness is a service provided by these 10 colleges to students utilizing CHCs on Long Island college campuses. All respondents had some type of healthcare services for students with symptoms of mental illness, even if it was to refer the student to an off-campus provider. The most commonly addressed disorders were alcohol abuse, substance abuse, stress, anxiety, and depression. There were fewer services for psychosis, schizophrenia, OCD, and eating disorders.

One troubling report, which mirrors what often occurs in community settings, is the use of campus police when the CHC is closed. Although there is certainly the potential for danger and harm in a crisis, the addition of a mental health services provider who is available on a 24-hour basis may de-escalate a crisis situation. Campus administrators may want to consider the use of a qualified mental health provider along with campus

Table 1. Types of Mental Health Problems Managed at 10 Colleges

Problem	Screened	Treated	Referred
Alcohol/drug	87.5%	62.5%	62.5%
Anxiety	62.5%	87.5%	37.5%
Depression	87.5%	87.5%	37.5%
Eating Disorder	50%	50%	75%
Obsessive Compulsive Disorder	37.5%	50%	75%
Psychosis	0	25%	100%
Schizophrenia	0	25%	100%
Stress	75%	87.5%	37.5%

police as first responders. Limitations to the study include self-report data, small sample size, and inability to analyze non-respondent data. The high rate of non-responders may be attributed to the fact that data were collected in the summer when CHCs may not have a fully functional staff. It is also possible that some of the colleges did not maintain a CHC and therefore did not respond to the questionnaire.

Implications for practice

Student suicides and substance abuse issues on college campuses have become fodder for the media. Parents and potential students may not have a clear understanding of their rights in relation to disclosure of health information. The law may prohibit disclosing information about a student's use of mental health services unless permission is given by the student to notify next of kin (U.S. Department of Health and Human Services, 1996). At the point of accessing mental health services through the CHC, if the student chooses not to notify his/her parents, the provider cannot override the decision unless the risk of harm to self or others is apparent (Clemens, 2002). The parents or legal guardians, on the other hand, might assume that information is provided because the student is a dependent. A policy outlining the disclosure of health information with respect to all parties should be a priority for all CHCs. One way to address disclosure is to provide written information followed by a short discussion with all students seeking care at the CHC. This provides an opportunity for students to designate how they want their health information managed. Another method is to provide written information in the package sent to all students when they are accepted for admission to school. A follow-up query about designating a procedure for disclosing health information can be addressed at freshman orientation. This method permits the possibility of parental involvement. An active approach may prevent problems from spiraling out of control.

Findings are limited due to the fact that the sample was restricted to institutions in one geographical area and the low response rate. Generalizations, therefore, are not warranted. Further research is necessary to develop a comprehensive understanding of services being offered on college campuses nationwide and to institute plans for mental health services that best suit this community.

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A Campus Wellness Program: Accepting the Challenge

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Abstract

The federal government challenges universities to promote health and prevent illness by creating awareness of health issues and encouraging healthy practices. Establishing a wellness program on campus is a means to provide excellence in health care for students and a way to reach out to faculty and the community at large. In this paper, the authors explicate the process of a multidisciplinary, collaborative effort in a university to develop a wellness program. Various data supported the need for the program. Using a model center, the design and implementation of the program are addressed, as well as the benefits of the wellness program.

Healthy People 2010 (U.S. Department of Health and Human Services, 2001), a systematic national plan, focuses on the importance of good health for all Americans. Major goals are to increase quality of years of life and eliminate health disparities. The federal government, which is increasingly aware of the burden of healthcare costs imposed by curative practices, challenges universities to provide an educational foundation related to health for college students. *Healthy Campus 2010*, another initiative by the American College Health Association (ACHA, 2006), establishes objectives for promoting health and wellness on college campuses.

In this paper, the authors explicate the process of a multidisciplinary, collaborative effort in a mid-sized university to develop a wellness program with the ultimate goal of creating a university Wellness Center. The impetus for the project began with two disciplines, nursing and health studies, working with the existing campus Health Service Center, and has evolved into a campus-wide project involving several disciplines. Pender's mid-range health promotion theory (Pender, Murdaugh, & Parsons, 2006), provided the theoretical framework for this endeavor.

Literature review

Healthy People 2010 (USDHHS, 2001) is a set of health objectives for the nation to achieve over the first decade of the 21st century. It is a national prevention 'blueprint' with two goals, 467 health objectives, and 10 leading health indicators to improve the health of all individuals and communities. In response to this national initiative, ACHA, the leading professional organization dedicated to the health needs of students at colleges and universities, developed three documents to guide development and implementation of university wellness programs: *Healthy Campus 2010* (2006), the *Standards of Practice for Health Promotion in Higher Education* (2005), and the *National College Health Assessment* (2007). *Healthy Campus 2010* is an adaptation of *Healthy People 2010* that addresses higher education communities. The 178 health objectives selected are relevant for student populations and people working in campus settings. *Healthy Campus 2010* identifies the following priorities: (a) social and emotional health, (b) coping with stress, (c) psychological relationship to food, (d) sexual health, (e)

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A Campus Wellness Program

nutrition, (f) unintentional and intentional injury, (g) alcohol and other drugs, (h) tobacco, (i) health services cost, and (j) insurance availability.

The ACHA also developed six standards of practice to enhance the quality of health promotion programs in higher education. The standards are designed to guide daily efforts, assess individual skills and capacities, and assist in decisions to improve practice through professional development. The standards also delineate a set of indicators to evaluate comprehensive health promotion programs and guide recognition of those programs.

The *National College Health Assessment* (2007) provides important data about students' health behaviors, health indicators, and perceptions. These data can be used to plan programs, prioritize campus needs, allocate resources, design strategies for intervention, identify protective and risk factors associated with academic performance, and measure progress on national health objectives. Since the initial spring 2000 assessment with 28 participant schools and 16,024 respondents, the survey response has grown to 117 participant schools and 94,806 respondents. The spring 2006 assessment identified the following top five reported health impediments to students' academic performance: (a) stress, (b) cold/flu/sore throat, (c) sleep difficulties, (d) concern for troubled friend or family member, and (d) depression/anxiety disorder and seasonal affective disorder.

The focus of these documents is health promotion and disease prevention in higher education settings specifically targeted to students. University wellness programs also need to address faculty and staff health promotion. The Wellness Council of America (WELCOA) (Hunnicut, 2006) is another resource to accomplish this goal. WELCOA is a national nonprofit membership organization dedicated to promoting healthier lifestyles for all Americans, especially through health promotion initiatives at the worksite. A recent annual WELCOA membership survey that queried member companies' practices, approaches, strategies, and priorities found the following: (a) employees are the primary focus of worksite wellness initiatives; (b) organizations are embracing health risk appraisals and health screening; and (c) stress management, exercise, and weight management interventions are organizational priorities (Hunnicut, 2006).

A recent health habits survey of undergraduate students attending health classes on campus revealed some alarming health behaviors (Zarco & Page, 2005). The mean average time of going to bed at night was past midnight. Although 13% of the students surveyed reported sleeping at least 5 hours on school nights, almost 75% were sleeping less than 8 hours each school night. Almost 30% did not engage in vigorous cardio-respiratory activity at least 3 days a week. Another third of the students (32.71%) never engaged in relaxation exercises. Only 34% reported eating breakfast daily and almost half of them (48%) were missing breakfast at least 3 days every week. Daily consumption of

at least 3 servings of vegetables was reported by only 11% of students. Fifty-eight percent never engaged in prayer or meditation. About 30% of the students reported feeling "usually or always" overwhelmed by time pressure and demands (Zarco & Page, 2005).

Additionally, a needs assessment survey for a campus alcohol prevention program revealed that 76% of the university students consumed alcohol in the past year and 58% of underage students consumed alcohol in the past month (Core, 2005). The university also reported 176 liquor law student violations occurring in one year. Universities are, therefore, important settings in which collaborative work can be done to improve and maintain the health and well-being of college students.

Benefits of a wellness program

The wellness program of a university can be a model for other schools and the community. Complementing the national and local public health initiatives, such a program establishes good health as the norm within the university. The ACHA (2006) states that the scope of practice of health promotion in higher education includes individual and environmental approaches. Professionals need to build individual capacity and address individual risk of illness and injury. In addition, health professionals and educators should address larger institutional issues, community issues, and public health policies that affect the health of students.

Educators and healthcare providers are in a prime position not only to teach health and wellness courses, but also to create wellness programs. Wellness programs promote changes in quality of life for students, faculty, and staff that can improve health status (ACHA, 2006). In turn, improved health increases productivity and ultimately reduces society's economic burdens. Health-related programs increase morale and provide knowledge to individuals

about the relationship of health to lifestyle. Educators have more opportunity to develop collaborative relationships, and students may develop stronger bonds with their peers, by engaging in health promotion activities and programs on campus and in the community. Prevention programs offer the means to reduce risk and harm resulting in less suffering and pain. Work productivity is known to increase and absences decrease (McKenzie, Neiger, & Smeltzer, 2005).

A campus community exists within the surrounding external community, and these entities cannot be separated. The activities and learning processes of individuals and groups on campus flow into the community and there is an exchange of information between and among citizens of both communities. The opportunity for healthcare partnerships and healthcare planning exists and to this extent can be conducted through a wellness program. Plans for this wellness program include an invitation to community members to actively participate.

A recent health habits survey of undergraduate students attending health classes on campus revealed some alarming health behaviors.

Seeing a model in operation helped to crystallize the vision and identify aspects of program development.

Initial planning: Establishing the need for the program

With an awareness of the *Healthy People 2010* and *Healthy Campus 2010* goals, the leading indicators, and a strong desire to translate health promotion into action, one of the authors invited interested faculty from the school of nursing to participate in a meeting to discuss the need for the development of a wellness program. Those who attended had expertise, knowledge, and a special interest in health and wellness, holism, and disease prevention. Leaders who emerged were faculty from the nursing and health studies departments who had expertise in community health, health education, and research. Their interests were to form a collective group whose main objectives were to: educate students, faculty, staff, and the community about health promotion and disease prevention; create innovative health promotion and disease prevention projects that could be implemented on campus with community outreach; establish a venue where these services would be provided; and collaborate with the Health Services Center and other schools and departments within the university.

A formal written survey revealed faculty expertise within the school of nursing that could be tapped for the wellness program such as: stress reduction programs, exercise and fitness programs, massage, reflexology, yoga, addictions counseling, alcohol prevention programs, nutrition counseling, healthy cooking, therapeutic touch and Reiki, spiritual counseling, and other creative health-promoting projects.

Learning from a model center

Faculty from nursing and health studies and the Health Services Center director visited a model site located in a nearby, similar-sized university that had an established Health and Wellness Services Center. Seeing a model in

operation helped to crystallize the vision and identify aspects of program development. The model center's professional staff offered health and wellness services as well as treatment for some diseases. A stress-reduction room allowed for meditation and relaxation, and other wellness services included massage, reflexology, yoga, chiropractic interventions, acupuncture, and addictions counseling. The knowledge, information, and experiences shared during this visit proved to be valuable for the faculty from both institutions.

Identifying targets and stakeholders

According to Rossi, Lipsey, and Freeman (2004), program participants can be direct or indirect targets. Direct targets are individuals who receive the program intervention directly while indirect targets experience the program's services or benefits through intermediate individuals or processes. The intended direct targets for this program were the university's students, faculty, and staff; indirect targets were the surrounding community and society at-large.

Next, the deans from nursing and student life and the chair from the health studies department were enlisted for their support since their leadership was deemed essential to the program's development. They were considered critical links who would promote the program to central administration and the rest of the university.

Program design and implementation

After determining the stakeholders and other supporters of this endeavor, the primary aspects of the program to be developed were identified as: physical environment adaptation, health promotion services, and education and research.

Physical environment adaptation

The first physical change within the university was in the Health Services Center. The Health Services Center director converted an available room into a stress-reduction room, where individuals can meditate and relax. Soothing blue paint and artwork were applied to the walls, and a comfortable recliner was made available to create a relaxing ambience. An audiotape and a DVD of nature sounds and scenes were available. Students also were encouraged to bring their own soothing musical choices.

The room was opened initially to students and a kickoff was conducted to advertise that the room was open for use. As a part of the launch, nursing students enrolled in a community nursing course gave an ongoing stress reduction presentation with music in the university center. They also did blood pressure screening and worked with students from peer counseling to provide educational packets of information on stress and its effects on the body. Since the room's inception, students have been found to prefer to use time and resources in the room according to their needs. It also has been observed that graduate students are using the room more readily than undergraduates. Additional space in the center will be adapted to accommodate other health promotion services, such as yoga, chair massage, Reiki, and nutritional counseling.

Health promotion services

Faculty from nursing and health sciences and other external care providers, for example, Reiki masters, nutritionists, exercise trainers, and massage therapists, have agreed to provide health-related services within the center. Programs are planned to meet the needs of the direct targets, in accord with university liability considerations, and will be offered according to the availability of resources. Pender et al.'s (2006) health promotion model includes several interrelated biopsychosocial

variables that influence individuals in their efforts to engage in health-promoting behaviors. Perceived benefits and barriers to behavior change, as well as individuals' perceived self-efficacy, are among the variables that impact health promotion. For example, students' perceived inability to stop tobacco and alcohol use can be an obstacle to behavior change. Creation of the wellness program allows those using its resources to strengthen the cognitive-perceptual factors and individual characteristics in the model that are associated with promoting healthy lifestyles.

Education and research

A plethora of opportunities exist to educate the direct targets of the wellness program and conduct research to determine outcomes. Rossi et al. (2004) state that an impact assessment will determine whether a program's objectives have been obtained and if there has been an impact on the social conditions the program was intended to improve. The program is still in its infancy, however; both formative and summative evaluations, using quantitative and qualitative data, will be required to determine whether the center is being utilized and successful in attaining its goals.

Evolution into a wellness center

The originally conceived wellness program took a new turn as administration became more involved. Because many wellness-related services were already in existence on campus, a university committee was established to assess and evaluate what is occurring throughout the entire campus. Enthusiasm, information, and ideas have been exchanged in early planning meetings regarding how to establish a university wellness center. In this way, the founding faculty of the wellness program will realize their desire to translate health promotion into action on campus on an even larger scale through the wellness center.

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Conclusion

A myriad of implications for nursing practice exist related to the creation of the wellness center. Students in the school's nursing program can use the wellness center to learn how to work with generally healthy people by helping them to promote and protect their own health. By their participation in the program, students from any discipline can identify strategies that will help them improve their own health. In addition, the center affords the nursing faculty an excellent venue in which to practice.

A university administration that advocates and promotes a wellness center will encourage the development of a campus community that works to achieve and maintain a healthy lifestyle. Extant health-related university policies can be implemented and/or revised based upon the health needs of the campus community. The wellness center also can serve as a springboard for nursing and interdisciplinary research related to further exploration of the biopsychosocial factors and individual characteristics that influence health-promoting behaviors.

Wellness programs and therapies are surfacing across the nation. They complement the government's plan to help people develop a healthier lifestyle by including measures such as promotion of physical fitness, nutrition education, screening for illness, and prevention of disability and disease through increased awareness of safety and harm reduction. With this emphasis on health, universities have a responsibility to provide education and services about health promotion and disease prevention to students, faculty, staff, and citizens in the community. Developing a wellness program that is on the way to evolving into a campus wellness center is a testimony to how the *Healthy People 2010* objectives and other aforementioned health promotion initiatives can be operationalized.

Acknowledgement

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BOOK REVIEW: The world is flat: A brief history of the twenty-first century

Margaret Lunney, PhD, RN

Friedman, Thomas L., (2006). *The world is flat: A brief history of the twenty-first century*. New York: Farrar, Straus & Giroux.

If any nurses doubt whether technological advances are important to learn about and apply, Friedman's book will convince them. The thesis is explained in the following sentence (p. 8):

"It is now possible for more people than ever to collaborate and compete in real time with more other people on more different kinds of work from more different corners of the planet and on a more equal footing than any other previous time in the history of the world."

The concept of a 'flat' world is supported with information about technological advances that have leveled the playing field for workers around the planet. For example, in some McDonald's™ restaurants, orders that people place in the drive-thru are now being processed by workers in another state and then electronically communicated back to a local employee who hands you your burger. In the future, with high-speed fiber-optic cables that enable instantaneous communications, this task may even be outsourced to workers in other countries. As technologies continue to advance, the world will become even flatter, with workers in other countries being able to do anything that can be supported by technology. As this occurs, it will be critically important for American workers to remain competitive with workers from all over the world.

Service jobs such as nursing have generally been thought of as safe from being replaced by technology, but this is not necessarily so. For example, certain robots can now be programmed to do many of the tasks that are considered nursing. It is clear from Friedman's book that it will be very important for nurses to provide high quality services that are based on interpersonal relationships with patients, and to measure the positive outcomes that occur with these services. This may be the only way to prevent being replaced by robots and other technologies that we have not yet even dreamed about.

In order to deal with these rapid changes, Friedman encourages everyone, including nurses and other healthcare workers, to become as educated as possible and to use imagination, creativity, and ingenuity. Some of the rules and strategies he gathered from researching the book will help nurses deal with the changing future: "Rule #1, when the world goes flat – and you are feeling flattened – reach for a shovel and dig inside yourself. Don't try to build walls" (p. 426). See also, "Rule #2, and the small shall act big... And the key to being small and acting big is being quick to take advantage of all the new tools for collaboration to reach farther, faster, wider and deeper" (p. 431).

I strongly recommend this book to nurses who want to understand the breadth and depth of technology's impact on today's world.

Margaret Lunney is an Editorial Board member of the *Journal of the New York State Nurses Association*.



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The Journal of the New York State Nurses Association is currently seeking papers for the Fall/Winter 2007 issue.

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