



Handover

Mental Health & Addiction Nursing Newsletter

Issue 4 - Summer 2008

EDITORIAL

Happy New Year from the *Handover* team. I think you will all agree with such fantastic summer weather it's a bit of a struggle to get back into work and focus on the year ahead! So I thought I might start my editorial by reflecting on the last part of 2007.

NURSING LEADERSHIP WORKSHOPS

The first of the five regional valuing leadership **workshops** for nursing leaders in acute inpatient units occurred in December for the Northern region. The high attendance by nurse leaders and consumer advisors was very much appreciated and the day received some great feedback as part of the evaluation process.

Everyone who attended felt they had gained something from the day. We will be working with the Auckland regional workforce coordinator, Emma Wood, to determine how best to move forward locally and regionally with the outcomes from the workshop.

Otago and Southland DHB nurse and consumer advisors should now have received their invitations to the workshop, which will take place at the end of February. Planning is commencing soon for the second South Island workshop and will include Nelson/Marlborough, West Coast, South Canterbury and Canterbury DHBs and we are really looking forward to participating with you during these workshops.

The presenting team includes Sonja Goldsack, from Goldsack consulting; Carolyn Swanson and Karl Metzler, both from Te Pou, and myself, with my stop watch at the ready to make sure the "shift" runs smoothly! Please contact me if you require anymore details.

SOME NURSING WORKFORCE PRIORITIES

The next six months will be busy for nursing workforce at Te Pou, so make sure you remember to check www.tepou.co.nz regularly for updates. Here is a bit of an idea of what you can expect:

Professional Supervision

Te Pou will start planning the direction of this project following the completion of phase one: the research. The literature review from the completed research will also be made available on the Te Pou website in the next few months.

CLIMATE mh E-Learning

At the start of this year, I was working alongside the CLIMATE mh team at St.Vincent's Hospital in Sydney. George Quinn, the nurse educator for St.Vincent's, and I spent a week developing storylines and dialogue for an illustrator and working with some of the content.

I have to say that CLIMATE mh is coming together well and it is a really exciting training and development tool. It's fabulous that nurses will be involved in piloting this within New Zealand.

Again, for more information visit the Te Pou website.



LEFT: CAROLYN SWANSON LEADS AFTERNOON SESSION IN VALUING LEADERS IN ACUTE INPATIENT SERVICES, AUCKLAND WORKSHOP.

RIGHT: FOREGROUND, FROM LEFT: INES FORD-BRUINS, BRIAN VICKERS, MICKY HARRIS AND TONY O'BRIEN.



I also had the opportunity while I was at St.Vincent's to be shown around (by one of our own New Zealand nurses!) their Psychiatric Emergency Care Centre (PEEC) which is located within the emergency department of the general hospital. This is where service users will initially be admitted to for up to 48 hours, rather than going to the acute inpatient unit. PEEC was established around two years ago, and one of its successes has been in reducing admissions to the acute inpatient unit. The emergency department also has a strong liaison psychiatry team and alcohol and drug clinician. This has proved to be really beneficial for both service users and staff with its short-term intervention strategy, and really supports the recovery philosophies.

NGO Nursing Workforce

I will be working with Te Pou's NGO workforce manager over the next month to start planning what and how we can best meet this group's needs. I have a few ideas, as do the nurses from the NGO sector who have made contact with me. If you have any ideas or recommendations please contact me, even if you are not from an NGO (ie, DHB or PHO), we would love to hear from you.

Valuing Leaders in Acute Inpatient Services

The workshops, of course, need no further detail (see previous page)! I will continue to work alongside a couple of DHBs to offer advice on specific initiatives or change. You can read more in *Handover* about the Anne Garland **workshops**.

WHAT'S IN THE SUMMER ISSUE?

A number of nurses have contacted me over the last few months with regards to wanting to begin their Nurse Practitioner Pathway. Our very first nurse practitioner, Bernadette Forde, has kindly contributed a piece about her role, a little about improved service user and service outcomes, and provides some advice on how to get started on the nurse practitioner journey.

Consumer advisor roles in DHBs have been in place now for 10 years in some places. It's one of most established service user workforce roles, often commented on by overseas people as the reason our services reflect a more service user-centred approach. I thought it was timely to ask Val Dockerty of Southland DHB to reflect on what the role is and isn't for her.

I hope you will find the remainder of *Handover* equally as interesting, from Lindsay Spirrett discussing an innovative workforce initiative to Dean Manley's research on madness on our screens, and so much more.

Keep safe over summer and enjoy that sun.

Bye for now,

Anna. ■



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INFORMATION and WORKFORCE DEVELOPMENT

NEW MANAGER FOR PECT

Gail Goodfellow has accepted the position of Post Entry Clinical Training (PECT) Manager with Te Pou. Gail trained as a comprehensive nurse and, on graduation, commenced work in mental health as a staff nurse in the early 1990s. Numerous roles followed as a clinician, educator, trainer and manager of services;

during this time she also studied through Waikato and Otago universities. Four years ago she took up a role as a portfolio manager of Mental Health and Addiction for the Lakes DHB.

"Leadership, I believe, is key to the success of services and a healthy, well supported

competent workforce ensures service users/tangata whaiora get the best outcomes and gain hope for their futures. I am thrilled to be part of the Te Pou team to promote a competent, happy and healthy workforce," Gail says.

Gail joins the Te Pou team on 20 February. ■

POST ENTRY CLINICAL TRAINING

PECT is a critical enabler for *Te Tahuhu: Improving Mental Health 2005-2015: The second New Zealand mental health and addiction plan, 2005* and *Tauawhitia Te Wero, Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009* and provides an opportunity for refreshed training, planning and funding arrangements.

The mental health and addiction workforce training, planning and funding services have, in the past, served the mental health workforce population well. They have been overtaken, however, by an emerging workforce that consists of new roles, an exploding technology platform that offers new ways to support the delivery of training and education, and debate over what is required now and in the future.

Te Pou has a passionate belief that as a sector we can do better with regards to workforce, and that mental health training arrangements are a key bridge for our future workforce. You can read more about **PECT** on the Te Pou website. ■



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LOOKING AT THE WARD THROUGH ANOTHER LENS

by Lindsay Spirrett

A behavioural experiment where clinicians “worked as supernumeraries” in each other’s worlds, gave me great respect for nurses working in an in-patient setting.

Over the last four years, Waitemata DHB has worked hard to develop an integrated approach in delivering community mental health services. Recently there have been discussions as to how community and in-patient services can work more collaboratively in the care of service users.

In response, managers of mental health services in West Auckland suggested a behavioural experiment in which a series of clinicians from both in-patient and acute community teams would rotate for a two-week period through each other’s work environments. During this rotation, these clinicians would be super numeral to allow a rare opportunity to reflect and develop insight into the work experiences of their colleagues.

The purpose of this exercise was two-fold: it was hoped the rotation would foster better working relationships among staff, providing an opportunity to get to know each other and build trust; and to provide insight into the complexities clinicians in each service faced. When asked if I would participate, I was keen. I’d often been amused by the confidence and certainty with which various community and in-patient staff offered advice on how others could improve, often with little or no experience of working in that role.

Having chosen community mental health for most of my career, I admit to some anxiety at the thought of ward-based care. It had been over 20 years since I had worked on a ward. I was not convinced by colleagues’ statements that ward nursing was easy and could be done with your hands tied behind your back. I vividly recalled my last experience working on a ward as a graduate nurse. I had found it emotionally and ethically challenging and was left wondering if nursing had been a good career choice.

All in all, the “experiment” was an interesting two weeks for me, with aspects I really enjoyed. From my privileged position as a

supernumerary nurse, I spent longer periods of time with service users in a way that I couldn’t working on a crisis team. I saw the potential for more intervention-based nursing practice.

From this position I watched as many of my ward colleagues “ran their butts off” moving from one task to another. I felt guilty at times, and then had to laugh at myself - why did I feel guilty for spending quality time with people?

Things I learned from the experience:

- Staff on acute in-patient wards and acute community teams face many of the same difficulties.
 - In acute mental health, urgent takes president over important all too often.
 - The treatment component of care in terms of quality time and psychological interventions is often marginalised by crisis situations and unfortunately processes and procedures. In many ways this seemed more heightened in a ward experience. On busy days, I watched experienced staff over-seeing several different situations and tasks simultaneously. In between, those nurses would rush off to a planned one-to-one session with a service user, feeling guilty because half their mind was still out on the ward.
- I noted that some staff were very good at over-viewing the needs of the entire ward, while others were not, and some were better at adhering to individual’s needs, while finding it difficult to read the ward’s needs. It seemed to me that there must be a better way to capitalise on individual nurse strengths.
- I learned, in all work environments, there are staff who “coast” and staff who give 110%. It reinforced for me that if you can’t attend to everything, do the basics (communication, the bread and butter of being a nurse), really well. I observed some staff excelling at this and service users responding. The shifts these staff were on were more cohesive and relaxed for service users and staff alike.

One of the differences highlighted for me between community and in-patient care was the lack of experienced staff and ongoing training of ward nurses. It seemed that with only some exception, the ward was seen as a place to work until one has enough experience to move into the community.

Surely people admitted to acute in-patient units because they are so unwell should have access to some of the service’s most experienced and skilled clinicians?

The polarity of new graduate nurses keen to make a difference but lacking confidence and skills, and some older staff secure in their roles but less keen to embrace change, was obvious.

Lack of experience and further training seem to have impacted on the ward’s ability to fully develop a psychological model to complement the medical model within which it operates. Integrating new skills into practice is challenging and lack of mentoring and ongoing training seems to have resulted in most staff withdrawing into the safety of the medical model: minimising the range of treatment interventions available to service users and impacting on job satisfaction.

It highlighted to me that if management wants to capitalise on having new and inexperienced staff they should be seriously committed to ongoing training for these clinicians now - broadening their range of skills and attitudes, and building confidence to facilitate change.

This experience reinforced my belief that wards are hard places for nurses to work. Yes you can “coast”, but if you really want to work alongside people in their recovery, the challenge is significant. Any nurse that gives their all on an in-patient setting certainly has my respect. ■

LINDSAY SPIRRETT

Lindsay is a comprehensive nurse currently working with the Home Based Treatment Team at Waitemata DHB. She has an ongoing interest in psychological models, completed further education in Family Therapy, Psychodynamic Therapy and more recently a Postgraduate Diploma in CBT (with distinction) from Massey University.

CONSUMER ADVISORS WORKING ALONGSIDE NURSES

By Val Dockerty QBE, EBE, DipEd, DipMHSW

“Ours is a difficult and challenging field of service. There is a priceless reward to our efforts – Every time progress is made, Every time hope is evident, Every time we see in those we serve and in ourselves... A simple smile.”

- Bluegrass Regional MH & M Retard Board Inc, Kentucky 2007, Annual Report

I have discovered, during my relatively short time as a consumer advisor, that there is confusion among my nursing colleagues about the consumer advisor role, as opposed to that of a consumer advocate.

To work in an advisory capacity is to be empowered to make recommendations, whereas to work as an advocate (according to the Collins Dictionary) is to give active support and this pretty much describes the two roles.

Consumer advisors in mental health services make recommendations at management level on service policies and quality issues, from a service user perspective, to ensure service users as a whole receive the best services possible.

I am not a “watch-dog”. I am in this position for the same reason as anyone else employed in mental health services - from general manager to health care assistant - for the service-user/consumer/client/tangata whaiora.

We do advocate for service users, but not on an individual basis. Sometimes I have been called to the acute unit as an “advocate”, but once I have found out what the service user wants, I can then steer them and their nurse in the right direction.

It’s heartening to have nurses popping into the office or seeking me out in the dining room, saying “I was wondering if I could run something past you”, or “Do you think this would help so and so, who is... ”.

The role of consumer advisor is not an easy one. The family advisor I work closely with

likens it to sitting on Number Eight wire with one foot in the provider camp and the other in the service user camp or, in her case, the family camp. Sometimes, I go home from work feeling as if the Number Eight has been upgraded to barbed wire!

It has been said that Management might be seen to be merely “ticking the box” by employing consumer and family advisors. But when nurses, in particular, approach us for advice, such feelings of tokenism are certainly dispelled.

Recently, as part of study for a diploma, I interviewed work colleagues about service user employment in mental health services. One of the elements required was to describe the value (or otherwise) you feel that service users bring to your service when they are employed as part of the mental health workforce. I’d like to share some of the responses with you:

- service users can look outside the square, compared to clinicians, they can give clinicians a broader view of what services could provide
- they have a different level of understanding: “the voices of the forgotten”
- they bring a service user perspective, insight and use of the service – a “been there/done that” service user view, they bring that perspective to the table and keep the service user focused and grounded.

It was interesting that after the interviews a couple of the interviewees sidled up to me and said something along the lines of: “You know, I can really empathise with a lot of my service users now. I had a bit of depression a couple of years ago.”, and it shows in their practice. They have the attributes of insight, understanding and empathy. I’m not saying that others in the service do not have these attributes, but it is a case of the clichéd but true, “walk the walk and talk the talk”.

One of the roles and benefits of having consumer advisors is to promote destigmatisation. We are successful at doing this within the services by encouraging this

kind of open dialogue and acknowledgement of general experience of mental illness. We work hard at growing awareness of a service user perspective in service development and contribute our valuable experience when planning with colleagues. Also, we are able to build bridges between service user groups and service users, and families and services, by creating better recognition of the needs of service users and families and, at the same time, recognising the commitment and skills of staff, especially in acute services.

Last year Chris Hansen, one of the leaders of the New Zealand consumer movement, was talking with a mental health nurse who had experienced a mental illness. She said: “Tangata whaiora status is probably your best qualification for the job you do. I believe that as tangata whaiora we need to acknowledge the healer within, and professionals are the richer and need to be encouraged to find and acknowledge the service user within themselves.”

Now, I don’t mean that the only nurses who should work in mental health should be those who are QBEs (Qualification by Experience) or EBEs (Expertise by Experience), I would never be so discriminatory.

I greatly admire anyone who works at the coal face in mental health. I was a special needs teacher and I would rate the challenges in mental health work way beyond anything those kids could present. When I look back on the times I was hospitalised and “playing games” with the nurses and doctors, I wonder how in the world some of those nurses managed to come back the next day and face it all over again.

Acute nurses have my highest regard. Their patience and understanding astound me. To know when to just sit and listen, when to try to tease out some information or guide a service user into the area of self-realisation are all great skills and take very special people.

Nurses out in the community need different kinds of skills. They get to know their service users in a far broader environment. They are guides in the community – they walk

beside their service user and to do this they need a vast understanding and knowledge of the community and its resources as well as an understanding of their clients, their aspirations and needs.

I have often listened to some of our community case managers bemoaning the fact that nowadays they have so much more paperwork and recordkeeping to do which takes them away from their “real job” of nursing. Unfortunately, and we know this only too well in Southland, this is an age of accountability and if it isn't written down it didn't happen. It is also an age where “outcomes” is the catch-cry – every service is looking for outcomes of whatever is put in place.

Again this involves paperwork, but surely the outcomes will be for the betterment of nursing, and for the betterment of the service user.

I would like to thank, on behalf of all service users, those dedicated nurses in the acute units and those hundreds out in the community for the wonderful services they provide, their care, their understanding, their empathy. And please remember there are people in your service called consumer advisors and family advisors who can help you in many ways, if only you ask.

I would like to include the Consumer Workers' Prayer by Michael Leunig because I feel it says it all. (See panel) ■

God be with those who explore in the cause of understanding

Whose search takes them far from what is familiar and comfortable

And leads them into danger or terrifying loneliness.

Let us try to understand their sometimes strange or difficult ways,

Their confronting or unusual language, the uncommon life of their emotions,

For they have been affected and shaped and changed by their struggle at the frontiers of a wild darkness just as we may be affected, shaped and changed

By the insights they bring back to us.

Bless them with strength and peace.

Kia Kaha



VAL DOCKERTY

Val comes from a teaching and agricultural background. She's been the consumer advisor for Southland DHB Mental Health Services for 16 months and has just graduated from the Southern Institute of Technology with a Diploma in Mental Health Support Work. Val thinks she has finally found her niche.

CELEBRATING OUR EXPERTISE

By Jane Collins - Associate Director of Nursing for SDHB

Southland DHB mental health nurses took the time late last year to come together for a one-day event that celebrated the wide range of specialist mental health nursing expertise.

The day was also an opportunity for different nursing expertise to be profiled and to hear more about new nursing and other service-wide initiatives.

The new Primary Mental Health Brief Intervention Service was a particularly popular presentation for those wanting to

learn more about the new service initiative. The service involves Southland DHB-employed mental health nurses working alongside GPs in their surgeries with patients. The service aims to provide early treatment in order to support recovery.

Other presenters included Richard Harris, Future Directions Network Coordinator, who gave an update and overview on the work being done by Future Directions - The Southland Mental Health Network. This

included the new service contracts Southland DHB has funded, the Mindful Focus radio programme run by consumers, and the website www.futuredirections.org.nz which is an excellent resource for the sector.

The day attracted a range of attendees, including mental health nurses, NGO representation and nurse educators. Thanks to the assistance of David O'Connell, community mental health nurse, the event was a great success. ■

ANNE GARLAND SCHOLARSHIP RECIPIENTS - CONGRATULATIONS!

Congratulations to all the nurses (and one social worker!) from DHBs and NGOs who were successful with their applications for a scholarship to attend one of the Anne Garland workshops at Auckland University, School of Nursing.

Thank you to all who took the time to apply; we were well over-subscribed from DHBs!

For those who are still interested in attending any of the Anne Garland workshops, please discuss this with your employers – more information about the series of workshops can be found on the [University of Auckland's website](#). ■

ARE NURSE PRACTITIONERS GOING TO PLUG THE GAPS?

By Bernadette Forde

One of the guiding principles behind the development of nurse practitioner (NP) roles in New Zealand is to “reduce inequalities and inequity in health.” Therefore, it was envisaged that NP role development would inevitably be centred on patient and population health needs and improving health outcomes.

With these principles in mind I will tread on very sensitive territory and bravely raise the question, which has often been asked in recent years “Will NPs fill doctor shortages?”

The reality is, in fact, that many NP roles will develop as a direct result of medical shortages, not because nurses want to take over the medical profession, but because there are serious shortages of medical staff in some areas of health care within this country which has resulted in certain groups of people not getting their health needs met.

For some time I have tried to avoid this sensitive territorial issue, but now realise that it needs to be talked about so that people can get a grasp of what NP roles look like, why they have been developed within certain services and also to guide discussion about the potential benefits of creating NP roles within services.

While in some ways it is a shame that the focus on NP roles is often on the incorporation of those skills considered exclusive to the medical domain, the reality is that, in order to meet the health needs of particular populations, these are the skills that are often scarce, as is the case in the dual diagnosis area of mental illness and intellectual disability, where I work.

For years, people with a dual diagnosis of intellectual disability and mental illness have had a poor deal in terms of health care. The inequity in their mental health (and, in fact, physical health) status has been clearly identified. There is an extremely limited pool of clinicians in New Zealand who are skilled in this speciality area of mental health. This, in turn, has resulted in mental illness in this group often being untreated, as it is often unrecognised and, therefore, undiagnosed. Consequently, many people with an intellectual disability lead unnecessarily

difficult and unhappy lives. Given this background and history it wasn't difficult to propose the development of a NP role.

My NP role at Otago DHB was developed on the basis of a clearly identified gap in service provision for adult mental health clients with intellectual disability, combined with a lack of psychiatrists with dual diagnosis skills. All of which had resulted in:

- long waiting lists for psychiatric diagnostic assessments
- long waiting lists for follow-up visits (up to 12 weeks)
- crisis admissions due to non-responsive service
- no established dual diagnosis service in Southland, or clinicians with dual diagnosis experience and Southland wanting to contract services from Otago DHB.

The following outline of my role is intended to provide an overview of how it looks and works on a day to day basis.

CURRENT NP ROLE

I have primary/clinical responsibility for people who have a dual diagnosis (DD) of major mental illness (adult mental health services criteria) and an intellectual disability. My NP role is autonomous and functions in the following ways. I:

- directly receive all DD referrals
- conduct initial, comprehensive assessment
- establish or consider a diagnosis/differential diagnoses, which includes the ordering and interpretation of laboratory findings
- treat/manage, which generally occurs in one of the following two ways:

- o Independently: I manage the service user independently in the same way a GP would. An example of this would be a person presenting with classical symptoms of depression without any additional health complications. I would prescribe and manage medication independently along with providing psycho-education to the service user and their significant others and some brief CBT work.

- o Collaboratively: In more complex cases I collaborate with the psychiatrist. In this situation I would consider diagnosis and then either arrange a joint appointment with the service user, the psychiatrist and myself, or the psychiatrist and I would do a case review. The outcome is an agreed upon treatment plan, which generally includes pharmacotherapy.

From this point I manage the service user autonomously, triaging to the psychiatrist and referring to other health professionals as I see necessary. Within the role, the responsibility is on me to consult with other health professionals as needed.

- carry out my work mostly through out-patient clinics within the various community mental health teams, or by providing a domiciliary service to people unable to attend the clinic; generally for people with a significant level of disability.
- offer a consult-liaison service to the primary health care teams (GPs, and practice nurses) and provide coaching, teaching and mentoring to the NGO sector to enhance their capability and capacity to manage people with DD in the community.
- continue to case manage the service user until she or he transitions back to the GP or to another community nurse.

The establishment of the role from a pilot to a permanent position was based on:

- low relapse rate
- low admission rate
- low use of the Mental Health Act
- evidence of decreased waiting times for assessment and follow-up appointments (from eight-10 weeks to two weeks)
- evidence of significantly decreased requirement for psychiatrist consultations (allocation of psychiatrist time reduced to one hour per week)
- establishment of a nurse-led out-patient clinic across mental health community teams
- feedback from NGO and PHO staff on the benefits of the role.

WHAT IS THE DIFFERENCE BETWEEN A NP POSITION AND OTHER SPECIALIST NURSING ROLES?

One of the intentions of outlining my role is to try to show the difference between an NP role and a clinical nurse specialist (CNS) role, as this still remains confusing to many nurses and other health professionals. I have developed the following table to clarify the differences.

| The distinction between level four, CNS and NP roles is not reliant on any one factor, but rather it is based on an array of factors that, together, create the terms of a role. The ability for NPs in New Zealand to have narrow, defined scopes of practice, and with or without prescribing, has made the difference between CNS and NP roles less distinct than in other countries, where NPs are involved in wider scopes of practice. | | | |
|--|--|--|--|
| CRITERIA | LEVEL FOUR NURSE (EXPERT) (REGISTERED NURSE SCOPE) | CLINICAL NURSE SPECIALIST (REGISTERED NURSE SCOPE) | NURSE PRACTITIONER (NURSE PRACTITIONER SCOPE) |
| Focus | Works within a specific practice area/narrow field, but with proven in-depth knowledge and skills. | Specific skill/intervention and/or disease/health problem management. Limited/narrow specialist area of practice. | Often broader (NP) scope of practice related to population and speciality. May case manage population/patient group. |
| Nursing role | May include extended aspects. | Extended aspects/expanded role. | Extended, expanded and advanced practice role (ie, service users' needs assessment, diagnosis and treatment, which may include pharmacotherapy). |
| Resource for | Practice area. | Skill or specialty care, service users, family. | Service user, family, community health professionals. Consultant for organisations. Local and national. |
| Result | Needs focussed. | Output – outcome focussed. Health promotion. | Outcome focussed. Health promotion. |
| Context | Multidisciplinary team member within a ward or unit. | Independent within a specialty team, may extend across services. | Autonomous role and ability to take clinical responsibility for specified population, often across services (primary, secondary, tertiary and community). May run nurse-led clinic, often ambulatory. |
| Practice scope | Skilled management of patient care in speciality ward, unit or community practice. | Specialist care that may include delegated medical responsibilities, diagnostics and implementation of treatment protocols, standing orders. | Comprehensive management of patients utilising specialist expertise. Uses advanced assessment, diagnostic and treatment skills, which may include pharmacotherapy. |
| Registration requirements | May have a leadership role. May be involved in policy at a national and local/service level. | May be a strong and progressive leader. May be involved in policy at a national and local/service level. | Must be a strong and progressive leader Must be involved in policy at a national and local/service level. |

For years, nurses and other health professionals have extended and expanded their skills allowing for efficiency in the use of valuable resources in times of need. An extreme example of this is nurses working as surgeons during times of war. Clinicians who work in the area of mental health understand there is often substitution among professional groups, allowing for flexibility in the use of resources, e.g., nurses, social workers or psychiatrists with additional skills will work as therapists and, at times, psychologists case-manage service users.

The development of the NP qualification has developed from a pending crisis in New Zealand related to shortages of doctors and health professionals in general. While I would highly recommend the role to any nurse who is passionate about their work and would like the challenge of an autonomous role using

advanced skills, it is important to examine the health needs within your service or area.

Some nurses in this country have been in the unfortunate position of becoming NPs and then experienced major difficulties getting a NP position. For this reason it is important that nurses considering becoming NPs talk with their directors of mental health nursing, and funders and planners, and familiarise

themselves with their district annual plans and health needs analysis to ascertain whether there is the potential for a NP position.

There is no doubt that acquiring the NP registration requires a lot of time and commitment, so to find yourself with no prospects of a NP position is frustrating and disappointing, and should be avoided at all costs.

BERNADETTE FORDE

Bernadette has been a nurse for 20 years, gained NP registration in May 2004, and started working as an NP soon after. She is now a mental health nurse practitioner working in the Otago DHB's Mental Health Service, and has clinical responsibility for people who have a dual diagnosis of major mental illness and an intellectual disability. Much of Bernadette's work occurs in the community where she has a passion for working with families, NGO support staff and GPs to increase their understanding of mental illness in this group of people. She has developed a variety of training packages, resources and workshops in this area. Bernadette also has a particular interest in medication and physical health issues for people with serious mental illness. She also has postgraduate teaching responsibilities with the Otago Polytechnic's School of Nursing.



INTRODUCING PATRICK AU

Five practising nurses, Chris, Janette, Elly, Patrick and Val have been chosen to represent the human face of mental health addiction nursing in Aotearoa – they are depicted on the masthead of the front page of this e-newsletter. We profiled Elly, Chris and Janette, respectively, in our first three issues.

Cross-cultural understanding plays a vital role in the wellness of people, says Patrick Au, mental health nurse and co-ordinator of Auckland DHB's (ADHB) new Asian Mental Health Service, which has been running for about two years.

"I believe human beings have more commonalities than differences. What is needed is modification and an increased understanding of the culture of Asian ethnic groups to facilitate the work of clinicians with service users. But I believe that once clinicians understand the culture, they are able to work with them," he says.

This belief is a major driver behind Patrick's choice of a service delivery model for the Asian Mental Health Service that involves consultation, liaison and working alongside mainstream clinicians, rather than cultural specific clinicians taking over service users.

"We provide direction and individual consultation but we never take 'ownership' of the service user. Clinicians determine when to consult and the purpose of the consultation." He has called this approach HUB, to highlight that the service is a central point between

the ADHB Mental Health Services and community resources. He adds that another reason for choosing the HUB model was limited resources. It was initially only funded 1.5 FTE, which meant the consultation model was the most efficient way to maximise funding and resources.

"Even so, I do believe in up skilling rather than taking over," Patrick says.

The Asian Mental Health Service initiative was set up in recognition of the need to improve access to mental health services for Auckland's burgeoning Asian population (now making up 9.2% of the region); according to the 2006 Census, 93,000 Asians now live within the ADHB catchment area and, of those, 46% are Chinese.

At present, the team includes a consultant psychiatrist and two recently acquired mental health support workers. As coordinator of the service, Patrick provides mental health assessments, crisis assessments and clinical management planning, alongside mainstream clinicians. When required, he participates with mainstream clinicians in psychotherapeutic interventions with Chinese service users.

He is also heavily involved in training Asian interpreters by equipping them with the skills to work in mental health settings. Part of this training includes a day of combined training for interpreters and mainstream clinicians on cross-cultural interaction with Chinese clients. To date, 96 Asian interpreters and 235 clinicians have been trained.

He says the major challenges to mainstream clinicians working with Asian service users are the presentation and acuity of symptoms, lack of support, misunderstanding of mental health disorders and the New Zealand mental health system, issues of shame and issues with language.

He says Asians don't separate mind and body symptoms, so Asian service users may present with a physical problem, rather than mental - a situation that can then be exacerbated further by poor English language.

In addition, once diagnosed, mental health symptoms are often acute because there is a lack of understanding about mental disorders within the Asian community and a sense of shame that prevents Asian service users seeking help earlier.

There is a real lack of education in Asia about mental disorders, Patrick says.

“It is often associated with spirits, possession, evil, karma, something bad in their past or poor parenting. All associations are negative. Back home most people with mental disorders are locked away in hospital, which makes people very reluctant to seek help. There are also a lot of rumours about treatment.”

Sadly, many migrants view New Zealand health services with the same misunderstanding and suspicion, he says, and will often hide mental health histories because of fear of deportation or problems around residency or citizenry.

“It is also worrying that this attitude can lead to people buying what mainstream clinicians would consider inappropriate or untested medication overseas for their disorders.”

Because shame is felt collectively, not individually, the extended family is implicated in a mental health diagnosis.

“This makes family support really important. Mainstream clinicians need to recognise the need to engage with the family and client in partnership. You may start work with the client, but you have to include the family.”

The positive side to the collective ownership is that family involvement can make a big difference.

“Yet many migrants are socially isolated and without family, which makes them particularly vulnerable to mental health problems,” says Patrick.

And finally, language barriers make it very difficult for a mainstream clinician to come to grips with a client’s situation and concerns, Patrick believes.

He describes a very depressed service user in hospital with poor English - when Patrick was brought in to work alongside her clinician, he found out her husband had a stroke shortly after they arrived in New Zealand four years ago. The wife was burdened with guilt at bringing her family here and putting them into such a difficult situation. She had not been aware of the social welfare benefits available and had become over-loaded with work and very depressed.

“We suggested they apply for the sickness benefit and she became well within days because she could finally see a positive way out. So sometimes it is information and language and small social interventions that are needed, rather than therapeutic work.”

Indeed, Patrick says, a vital part of his job is creating networks across government agencies, from social welfare to immigration services.

He insists that the key to success with Asian service users is to gain trust as an insider.

“It is very important to be acknowledged as an insider, because it is only then that there is free sharing of the problem, and therefore of information and feelings. Clinicians are outsiders and it is up to us to gain our service user’s and their family’s trust in order to become insiders. Acceptance is marked by a gift or an invitation to a meal,” he explains.

Although Patrick, who came to New Zealand from Hong Kong in 1991, is fluent in Cantonese, Mandarin and English, he points out his expertise in working with Chinese does not necessarily make him an expert on all Asian cultures.

“I like the challenge of working in an area where no one has worked before. I like to have my limits tested. I think this comes partly from my experiences as a migrant.”

“There are a number of cross-cultural differences even within the Chinese population.”

Ongoing learning is very important to the 48-year-old, but not just in clinical matters. His role requires him to be up-to-date with the cultural values of new migrants.

“I’ve been here 16 years now and my cultural values could be different from new arrivals. So I make sure I update myself by watching Asian TV, reading popular magazines, visiting my home country and talking to as many people as possible.”

The need for new challenges is a major driver behind Patrick’s career path in mental health.

“I like the challenge of working in an area where no one has worked before. I like to have my limits tested. I think this comes partly from my experiences as a migrant.”

Patrick took up a Carrington Hospital staff nurse job, after 12 years of working in mental health hospitals in Hong Kong. When Carrington shut down in 1992, he moved to the Mason Clinic where he worked for three years in the rehab ward, before working for the Court and Prison Liaison Service for five years.

“I was seconded to the district court and prisons to provide mental health assessments for adult offenders to the Court.”

He continued to study in New Zealand, gaining a Master’s in counseling and family therapy qualifications. In 1999 he was offered the opportunity to set up a youth forensic service for the Auckland DHB child and adolescent health service, the Kari Centre. He describes this as one of his biggest achievements.

“We changed the way things were done. Most service user reports were done by private clinicians and our new service took that away from existing clinicians, so we faced a lot of reluctance to change the system initially. But with support of Child, Youth and Family Services and Youth Court judges, we did it.”

Patrick says the model was well received by the judges and acted as an exemplar for the rest of the country.

In 2005, he helped set up another innovative service, the Mental Health Clinic for the Youth Justice Residential Centre in Auckland. Then, at the end of that year, he was asked to set up the Asian Mental Health Service which he has been managing ever since.

As well as his public roles, Patrick also runs a small private practice with a colleague. This is needed, he says, because Chinese people perceive seeing doctors and therapists in the public system as shameful, and they feel they might not be treated appropriately because of the high demands on those services from the general public.

He adds that many Chinese people have medical insurance and wish to make the most of it.

“Once they have momentum, they want to make changes immediately and don’t want time in which to change their minds. They are also fearful of deterioration if they have to wait.”

A significant number of Patrick’s private service users are international students who are not eligible for free public medical treatments.

However, he says, the Asian Mental Health Service role is his first love and priority.

“Bridging the gap between the Asian population and Auckland’s mental health services is very satisfying, although there is still more work to be done to make it work more smoothly.”

RESEARCHING MADNESS ON SCREEN

By Dean Manley

I was fortunate enough to be employed by Case Consulting in late 2006 to work as a writer and researcher. Case Consulting specialises in training and education, research and community development projects for people with experience of mental illness.

I brought to the company the experience of working in supported employment, co-ordinating a peer support pilot in West Auckland, and Master's and PhD theses in the representation of madness on screen. The combination of these experiences had led me to a sociological and philosophical perspective of madness, which complements, and compares with, bio-clinical models of mental illness, but does not reject them.

My research has taught me that art, literature and popular culture colludes with other societal factors to make madness, at best, misunderstood and, at worst, feared and loathed. Stereotypes of serial killers, psychopaths, troublesome eccentric people, homeless people, goths, emos – examples of extreme people behaving outside the “normal” spectrum - line up with examples of mad genius, scientists and artists to create the image of mental illness as a diabolical or evil affliction.

Even if there is a positive, romantic, mad-genius perception, it is not a great leap between this and criminal insanity. If one allows the positive extreme romantic versions of madness, then this also allows animal unpredictability and violence.

Whatever the perception of mad people, there is an underlying theme of “abnormal”, self-and-other-destructive people, people who pose challenges and threats to peaceful, orderly society. Sometimes, this is absorbed by mad people themselves, this “othering” colonising their identity and sense of belonging to the “norm”, therefore exacerbating negative perceptions on people already categorised and marginalised by virtue of their diagnosis.

Only rarely are mad people represented as contributing, ordinary people trying to get ahead in life. People are more likely to see Norman Bates (Psycho), Hannibal Lector (Silence of the Lambs, Hannibal,

Red Dragon), and other misrepresentations of madness, as criminality, speaking for and about madness. Even the exemplars of success and fame (movie stars, sporting greats, business leaders) can spark a backlash of failure among those “ordinary” mad people. Only rarely do everyday mad people speak for themselves, represent themselves as citizens, mothers, fathers, sisters, brothers, managers, employers, leaders and workers.

Upon starting work with Case Consulting, I learned about The Like Minds Like Mine programme - its goals, aims and methods. This brought together the practical grass-roots strategies and approaches I had gained from supported employment and peer support, as well as the theoretical idea of media-based construction of mad people as violent and dangerous, unpredictable and threatening, pathetic or incompetent.

“Only rarely do everyday mad people speak for themselves, represent themselves as citizens, mothers, fathers, sisters, brothers, managers, employers, leaders and workers.”

The role of research and education to deconstruct stereotypes and stigma currently emerging from Like Minds Like Mine is helping us to understand how myths communicate these messages of violence and unpredictability, and how these translate into policies and, or, practices, especially within the mental health sector.

My area of speciality in reading media (including films, electronic games, magazines, comics etc) for communications about myths and stereotypes about madness is proving handy; I am working on media literacy and education to encourage people to read media critically, to respond appropriately to representations and to not buy into and continue myths and stereotypes. Media speaks to youth, especially, and to their online, wired, technology-savvy lives.

I recently presented my doctoral thesis on the representation of madness in film to a postgraduate class of nurses; two impressions

hit me immediately:

- Some people (mostly younger members of the group) “got it” and saw how the use of film, television and media could be used as examples of negative and, or, positive representations of madness, thus colluding with stigma and informing discrimination or working to debunk them
- I was struck by unconscious (yet coming from a caring place), well-meaning but stigmatising attitudes some had and communicated openly. These people added to and confirmed negative stereotypes and myths of violence and otherness, and asserted the us/them dichotomy. Some people who work in areas that are the last resort for treatment, have contact with the worst examples of people who are not supported in their community and have had limited access to treatment in early stages of distress, can be understood as having negative perceptions of mental illness. These people are often as much victims of a stigmatising and discriminating society as those who are left without appropriate, timely treatment and support in the community, and end up in forensic units.

The people who “got it”, including the course convenor, were progressive and open to how fictional representations could be used, and that role in constructing stigma and informing discrimination. Those who didn't, saw film and television study as an interesting but non-scientific (meaning non-clinical) avenue to pursue and resented time taken away from “real” study. These people were not “bad”, merely unenlightened and not exposed to positive contact with mad people.

The latter were also unaware or unaffected by how the use of language confirms and increases stigma, and felt alternative words used to reframe negative terms into positive or less loaded terms were do-gooder “political correctness”. They seemed unaware that stigma taints their work and keeps them undervalued - just as much as those who are affected by it are - and makes their role more in the corrections line than health. There is still more work to be done here, and I am bringing film, television and media studies to the mix.

I see Like Minds Like Mine expanding and widening to include social and community development strategies, including media literacy, general wellness and resilience, and health promotion to the social development arena. More research into how stigma works – how it means and not what it means – will add to the positive work done in the clinical fields and widen it to include social development policies.

Peer support showed me how a comprehensive, multi-disciplinary approach works best, and that there is not one “right” way or approach that fits all. Mostly, it showed me how grassroots, “real world” conditions often contradict official data and research. I have seen the need for better surveys and ways of gathering information that emerge from what mad people want said and recorded, not systems.

The new Like Minds Like Mine programme is looking to build a greater, wider, more multi-dimensional approach to what has been created as a social problem, a threat and burden. I am privileged to be part of using popular culture to debunk what it plays a big part in creating: myths about madness, and the widening scope of health promotion and literacy.

MAKING CHANGE HAPPEN *By Rebecca Hennephof*

An inaugural mental health nursing workshop recently held in Otago was well-attended and identified practical, accessible strategies to facilitate change.

As an alternative to the one-day nursing conference held in previous years, organisers decided to change the format and focus on developing the knowledge and skills of nurses as change agents in practice.



HEATHER CASEY GIVES THE WELCOMING SPEECH.

Organised by the Otago Branch of Te Ao Maramatanga, and supported by the Otago DHB, the Otago Polytechnic and Eli Lily, the workshop was held in Dunedin late last year. Titled “Making Change Happen” and facilitated by Dr Frances Hughes, it drew a good number of registered nurses employed across the mental health sector in various DHBs and NGOs. They travelled from Invercargill, Queenstown, Timaru, Dunedin and Christchurch to attend.



FRANCES HUGHES – WORKSHOP FACILITATOR.

The content of the workshop was based on the recently published book *Have Your Say*, written by Dr Hughes and Stephanie Calder.

The focus of the first day was an introduction to policy analysis with an overview of the role of government and the stages in policy development. In small groups, delegates brainstormed various issues looking at the policy process in organisational, political and wider public contexts. Some of the topics that emerged for discussion included the growing use of party pills and their impact on people’s mental health, overcrowding of inpatient units and the transportation of proposed patients under the Mental Health (CAT) Act 1992 for assessment from rural areas. The second day continued with a focus on policy research, evaluation and tools for policy analysis.

Dr Hughes presented informative and thought-provoking sessions and, in doing so, created and facilitated lively and interested discussion. This was certainly evident in delegates’ feedback - many made reference to Dr Hughes’ skillful policy presentation.

Delegates agreed the discussions on policy identified practical, accessible strategies to facilitate change. As a result, the workshop increased nurses’ knowledge of how to act as change agents in their own practice areas and within their own practice realities.

It was a pleasure to meet Anna Schofield, Te Pou’s Nursing Leadership Manager, and Stuart Gray, Te Pou’s Workforce Development

Coordinator (Southern Region), who attended and participated in the workshop.

Anna gave a very useful presentation on the aims of Te Pou and her role within it, and she



GROUP WORK AT OTAGO DHB’S NURSING WORKSHOP.

highlighted some of the current projects on which Te Pou is working, linking these back to the mental health nursing framework.

The opportunity for registered nurses to gather together and discuss issues relevant to the profession and clinical areas in which people work is always extremely helpful and welcome.



MIHI WHAKATAU.

REBECCA HENNEPHOF

Rebecca is a Senior Lecturer at Otago Polytechnic who teaches in the specialty area of mental health. Rebecca currently coordinates the New Graduate Mental Health Programme and teaches in the undergraduate nursing degree.