



Handover

Mental Health & Addiction Nursing Newsletter

Issue 12 - Winter 2010

EDITORIAL

Winter is well and truly here now, and that means we have to be creative about staying warm to keep the power bill in check! Although many of us miss the lovely summer weather, winter does have its charms. I enjoy the changing aspect in my garden, while nature takes a break; the plants are in rest mode and the trees are so relaxed they have dropped their leaves. The grass is also taking a break from growing, and all this lack of action means I, too, can take a break from gardening for a while.

IN THIS EDITION

From panelbeater to rehab nurse, Tony Berry works in a unique area of forensic nursing in Auckland, and his profile is inspirational and interesting. Tony exemplifies the leadership attributes that we are keen to profile and celebrate in *Handover*. We also have updates on information utility from Mark Smith, and on Seclusion: Time for Change from Tony Farrow. Jane Simperingham, director of mental health nursing at Northland District Health Board, writes about the experience of being involved in the pilot for professional supervision. The [final evaluation report](#) is now available on Te Pou's website.

AROUND THE REGIONS

In my role at Te Pou, I am fortunate to spend time in frontline mental health units around New Zealand. I am always impressed by the innovation I see in these tight and testing fiscal times. Despite working in a challenging economy, nurses are still driven to provide high quality care and find innovative and inexpensive ways to improve outcomes for people using services.

I had a great day with Michael O'Connell and his team at Lakes District Health Board as they embark on a journey to improve integration with their non-government partners.

At Whanganui District Health Board, we were invited to facilitate a *Let's get real* workshop for leaders and managers. This was a great event with plenty of enthusiasm for the NGO and DHB sectors to work together to improve the area's services.

Te Pou's Tony Farrow and I were guest speakers at Canterbury District Health Board (CDHB) in celebration of International Nurses Day. There was a great range of speakers and, although there were many different topics, the basic concepts of nursing leadership and innovation were central. Tony presented an overview of [Te Pou's Seclusion: Time for Change](#) project with discussion about sensory modulation. You can read more about this project on Te Pou's website. Stu Bigwood, director of mental health nursing for CDHB, has prioritised reducing seclusion as a key goal in 2010. Learning additional skillsets to assist this goal will enhance nursing practice at CDHB.

I was able to spend a day at Taranaki District Health Board with fellow Te Pou staff introducing Knowing the People Planning (KPP). This is a key piece of work which enhances delivery of care for people in the community who have contact with mental health services for more than two years. At this training day I was humbled by the great work being achieved and by the commitment

to quality within services.

I was fortunate to spend time with the Red Beach Community Team in Auckland. This was another wonderful opportunity to be reminded that acute services are wider than inpatient services. These assertive outreach and community teams are feeling the effects of the current fiscal environment, but continue to deliver quality services with passion, care and innovation.

LET'S GET REAL

It's heartening to see how well *Let's get real* is being adopted by education providers across New Zealand. This framework, which articulates the basic knowledge, skills and attitudes for the mental health and addiction workforce, is gaining momentum. The Ministry of Health now has the [national implementation plan](#) on their website. Te Pou's regional coordinators are a driving force behind the implementation of *Let's get real*, and you can read about their activity on [Te Pou's website](#).

Here at Te Pou, we have been going through our own change process. I am reminded about the importance of clear and committed leadership through changing times. I cannot recall where I heard it, but I am inspired by the quote: "leadership matters most when the path is no longer clear".

Workforce development is pivotal to recruiting and retaining staff. My role at Te Pou involves representing the mental health and addiction nursing workforce. I believe one of the best ways to do this is to meet with you and hear what you find works well, what you are proud of and what specific stresses and dilemmas you are experiencing.

I sincerely enjoy hearing from you! Please do not hesitate to make contact with me.

Ka kite ano, Anne



EDITOR

Anne McDonald

Clinical Project Lead - Nursing

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Te Pou

o Te Whakaaro Nui

The NATIONAL CENTRE of MENTAL HEALTH RESEARCH,
INFORMATION and WORKFORCE DEVELOPMENT

RECOMMENDED READING by Anne McDonald

I was delighted to read an article published recently in the *International Journal of Mental Health Nursing* (2010, 19, pp 30-35) by Carole Schneebli, Anthony O'Brien, Debra Lampshire and Helen Hamer. The title is *Service User Involvement in Undergraduate Mental Health Nursing in New Zealand*.

I urge you all to get hold of a copy and read it.

The conclusion states: *"Nurses are one of the largest professional groups within the mental health workforce, and more than other disciplines continue to have a frontline position in service provision. Therefore the attitudes, values and beliefs they hold will invariably impact on the quality of care provided and as such have an immense impact of experience and health outcomes of service users."*

Handover has a role in identifying and promoting relevant and recent literature that informs and improves the quality of care. I congratulate the authors on this excellent article.

NEW ZEALAND MENTAL HEALTH AND ADDICTION NURSE EDUCATOR FORUM

23- 24 SEPTEMBER, LE GRAND HOTEL, HAMILTON.

Sharing the knowledge, sharing the skills: "Challenging traditional pathways in mental health nurse education"

This forum for clinical, DHB, undergraduate and postgraduate mental health and addiction nurse educators will have a hands-on interactive workshop style.



PROFESSOR
EIMEAR
MUIR-COCHRANE

Keynote speaker Professor Eimear Muir-Cochrane will share her knowledge of mental health nurse education, and the need to deliver work-ready graduates. "Our approach is to place a strong emphasis on developing students' critical thinking skills. We also engage students in evidence-based learning activities and carefully designed clinical experience."

Professor Eimear Muir-Cochrane is Chair of Nursing (Mental Health) within the School of Nursing and Midwifery at the University of Flinders, Adelaide. Eimear is also a Visiting Professor at City University, London; Australasian Editor of the *Journal of Psychiatric and Mental Health Nursing* (UK) and, in 2007, won a Carrick Citation for 'Sustained innovation in mental health nursing education in the last decade'.

Principal forum sponsor Te Pou will host a workshop about professional supervision

exemplifying *Let's get real*, and the forum agenda also includes a panel discussion/presentation by guests, including Anne McDonald, Te Pou; Maureen Kelly, NCNZ education officer; and Willem Fourie, MIT lecturer.

Registrations are currently open and close in mid-August. Mental health and addiction nurse educators from across the sector are invited to register.

Support for the forum to date has been very positive, says organising committee coordinator Moira O'Shea, nurse educator mental health and addiction Waikato District Health Board.

For registration enquiries please contact Lurendharen.Reddy@waikatodhb.health.nz

To register, print and return the registration form on the following page.

Registration Form 2010

“Sharing the knowledge, sharing the skills”

Challenging traditional pathways in Mental Health Nurse Education

New Zealand Nurse Educator Mental Health & Addiction Forum

September 23rd & 24th, Hamilton

Title: _____ **First Name:** _____

Last Name: _____

Nurse Educator Position (circle): Post graduate Under graduate Clinical/ DHB

Organisation: _____

Address _____

Phone: _____

Mobile: _____

Fax: _____

Email: _____

Share your email address with others at the forum **Special Diet:** Vegetarian Gluten free

Registration Forms without payment details cannot be processed

Payment details: **Fee \$190** **Registration fee includes- am/pm Tea, Lunches & Dinner on 23rd**

Cheque Enclosed Internet Banking

Bank: Kiwi bank **A/C name:** NZ College of Mental Health Nurses: Waikato Branch

A/C number: 38 9006 0105031 01

Post completed form to the address shown below

Luren Reddy, Nurse Educator, Mental Health & Addiction Services

Post: P O Box 1372 Hamilton 3200

Email: Lurendharen.Reddy@waikatodhb.health.nz

Telephone: 07-8346902

Accommodation links: www.visithamilton.co.nz/page/pageid/2145834015

The Forum will be held at Le Grand Hotel, in CBD. If you book there inform them that you are attending forum, as there will be a special price for accommodation.

Transport information in & around Hamilton: www.visithamilton.co.nz/page/pageid/2145833969/Transport

INFORMATION ALIVE, *by Mark Smith, Clinical Lead Specialist, Te Pou*

MAKING A CASE FOR NURSING INFORMATION: GETTING BACK TO BASICS

The problem - for I think it is a problem - can easily be put: nurses need to use information in their clinical work, but there is a problem with relying solely on nursing-specific information.

For example, there has been an attempt historically to develop nursing-specific information based on nursing diagnosis. This attempt is generally seen to have failed. However, does this invalidate all attempts to have nursing-specific information?

As will become clear, this column supports the notion that nurses need to develop some nursing-specific information while still having a common pool of information which they share with other professional groups.

Without nurses having an information stream identified as nursing, it becomes hard for nurses to make a case for the importance of nursing as a professional role.

Nurses need to assess and plan, and provide implementation notes and evaluation of their work. It is to this nursing process I appeal.

This appeal to the nursing process is often seen as a traditionalist approach to nursing but personally I prefer to see it as *getting back to basics*. These so-called basic activities too often fall by the wayside and one wonders what could possibly be more important for a nurse.

The first step in all clinical care is assessment.

Generally, though not always, some prior clinical notes would be available from a referrer. However, no amount of prior clinical work can limit the need for the clinician to do a new assessment.

Assessment, and the information generated by assessment, can take three main forms. There is the comprehensive clinical assessment. If this is done by a nurse it would seem reasonable to identify this as a nursing assessment.

Another understanding of assessment involves using a particular assessment tool (of which there are many). Some of these are nursing-specific but most of them, certainly the best of them, aren't.

Finally there is the informal casual assessment.

All of these understandings of assessment can have a nursing flavour, but the comprehensive and casual assessments probably should be identified as nursing where these are performed by nurses.

Somehow nursing has allowed itself to become the generic cement for mental health services and this has meant the 'nursing' component of a nurse's work has been diluted away. This has also meant the distinction between assessments

“Too often good nursing work remains invisible because it is simply not identified as nursing”.

done by nurses and nursing assessments is emphasised.

Surely if a nurse does an assessment it is a nursing assessment?

The assessment leads into the plan. The plan uses information from all three sources of assessment information identified above. The plan needs to have two components: the generic component if it is a key worker completing the plan, and a nursing-specific component if a nurse is completing the plan.

The clinical progress notes show how implementation of the plan is occurring. Once again there is nothing wrong with identifying nursing-specific interventions (I mean identification beyond a name and role stamp).

Finally nurses need information which shows how they are evaluating their work.



MARK SMITH

Mark Smith is Te Pou's clinical lead specialist and an independent nurse practitioner (mental health) with the Hamilton East Medical Centre, mark.smith@tepou.co.nz.

HoNOS can certainly assist nurses (and other professionals) demonstrate they are evaluating their work, although this will only ever provide an indicative level of accuracy.

Nurses need to demonstrate the good work they are doing. Too often good nursing work remains invisible because it is simply not identified as nursing.

If *getting back to basics* helps nursing become more visible then that must be in everyone's interest.

FOSTERING CHANGE.

TONY BERRY, FORENSIC PSYCHIATRIC NURSE.

A pool hall may seem an odd place for a forensic psychiatric nurse to be found during work hours, but not if you're Tony Berry and the people you are supporting are practicing drug refusal techniques.

Such outings are part of a Mason Clinic dual diagnosis programme, Maintain the Change.

"We go into pool halls and bars to practice drug refusal skills in the real world so they experience the sensory effects of these environments. The focus is looking at the good and not so good things around using substances. By ordering their own non-alcoholic drinks at the bar the people we are supporting have to talk to bar staff and cope with this new experience of not drinking. We also walk down Ponsonby Road afterwards, again for the sensory effect of seeing others drinking. Some clients state this is the first time they have been on Ponsonby Road straight," explains Tony.

"Before the community outing, we do a motivational interviewing group programme, You Call the Shots, and a theoretical block that focuses on goal setting, assertiveness training, drug refusal skills and relapse prevention.

"These programmes focus on their skills and strengths as people, their communication with others, and what they need to do to cope with cravings and offers of AOD [alcohol and drugs] in the community. It is a progressive thing. Once we know they have the theory down, we choose people who are ready for the community part.

"The people we are supporting are referred through the multidisciplinary team reviews once they have been transferred to sub-acute or rehab areas, although some clients from acute areas are involved in earlier stages.

"Approximately 40% self-refer as they receive positive feedback from peers or staff about the programmes. Many users of our services are highly motivated in this regard."

The AOD programmes, which are now ongoing, are part of the overall wellness and recovery programme implemented and coordinated by Mason programme manager Dean Cathrow.

The aim is to involve all Mason clients who need AOD intervention.

"Those who don't grasp the concepts can do the programme again", explains Tony. "One person did the programme four times, but generally people do it once; twice if need be.

"When they commence the programme, many service users have a sub-acute illness, which sometimes affects their concentration and thought processes. With support from their peers and staff, they recover and normally complete programmes successfully. It's great to watch this recovery."

Narcotics Anonymous (NA) is also involved in the dual diagnosis programme. NA's Hospitals and Institutions Group runs a programme for people in the Mason Clinic acute wards every two weeks and clients also engage with community NA groups; sometimes with staff support.

Maintain the Change has been running regularly for about four years. It was set up after Tony offered to write a proposal to formalise a dual diagnosis programme being run on an ad-hoc basis at the time.

While researching the proposal, Tony conducted a small audit of 30 people in acute units and found 93% had been doing alcohol and drugs, including 'P', in the weeks leading up to their index offence.

"Many relapses of illness occur in the context of substance use/abuse when transitioning into the community, when in the community and occasionally in the inpatient areas."

Tony runs the programme around his job as a rehab nurse in a 20-bed mental health unit.

He also lectures at Auckland University in dual diagnosis process and, for the last three years, has been a clinical lecturer for second year nursing students taking a secondment in Mental Health and Disability papers. It is a busy workload but one he embraces because of his passion about the dual diagnosis approach.

"About 90% of people at Mason Clinic have, or have had, drug and alcohol problems as



TONY BERRY

well as mental health issues," explains Tony, adding that international literature regularly cites integrated dual diagnosis programmes as best practice.

"With this programme we are bringing about change, and I really like change and being a change agent."

Tony is no stranger to change. He didn't start working in mental health until he was 29, but it was a familiar work environment because his dad had nursed for many years at Oakley and Carrington.

He was thinking about a change from his panel beating trade when his dad told him about vacancies at a newly-opened unit at the Mason Clinic. He has not looked back since, although he did question his decision in the first couple of weeks.

"Atypical antipsychotic drugs were introduced about three years after I started, which changed things markedly." Tony soon found he was enjoying his work more than he'd ever done in his life; a feeling that hasn't left him.

"I don't see it as a job but as a way of helping people and doing some good in the world."

After working in acute wards for about six years

as a psychiatric assistant, he was offered the opportunity to study to become a registered staff nurse. It was time for another change and Tony jumped at it, along with four other psychiatric assistants.

“Mason Clinic was finding it hard to get male nurses so they looked at the psychiatric assistants who’d been there a while and offered us the chance to continue working full-time, while studying part-time over five years. It was a brilliant opportunity for someone with three kids wanting a profession and job for the future.”

He spent four years as a registered staff nurse in the acute units, moving to rehab for the past three years. Over that time Tony also continued studying, gaining a postgraduate certificate and then diploma. After gaining his diploma, he took time off study to pursue another keen interest, purchasing and refurbishing rental property. He bought his first house at 21 and continues to do up houses. It requires a completely different way of thinking, he explains.

“Manual labour does something good for me. I have to focus totally on what I’m doing in quite a different way. It clears my head.”

A year later he was back studying; this time for his Masters with the aim of gaining Nurse Practitioner with prescribing status. “Study is all about extending your level of knowledge, particularly of best practice,” explains Tony, adding “it is easier to bring about change if you have postgraduate knowledge to enhance and support your nursing practice.”

He gives the example of his supervisor and nursing mentor Dr Brian McKenna. An

associate professor in the School of Nursing at Auckland University and nurse consultant for Regional Forensic Psychiatry Services, Brian McKenna has a major research focus and provides mental health direction to the Mason Clinic.

“He has a strong voice, in a good way, because he looks at how to enhance the system.”

“With this programme we are bringing about change, and I really like change and being a change agent.”

Next semester Tony will be concentrating on his dissertation, which argues the need for a mental health nurse practitioner in the prison system to do first contact screening and assessment and ongoing mental health treatment alongside the forensic prison team.

“Prescribing, with support from the team’s psychiatrist, would be part of this treatment process.”

Currently the Mason Clinic’s forensic prison team visits prisons in the greater Auckland area on a daily basis to interview caseloads referred to them or to see prisoners assessed previously by the team.

“While the most acutely unwell prisoners get picked up in prison and referred to Mason Clinic, a number of others pass under the radar, or remain unwell in prison,” explains Tony.

The value of a mental health nurse practitioner in the prison system is threefold, argues Tony. Firstly, formal mental health screening and assessment at first contact is very important, says Tony, because once someone is within the prison system it can be much harder to refer them out to the Mason Clinic due to bed availability.

Secondly, the risk of suicide in prison is massive, especially for young male prisoners, says Tony. Thirdly, the quality of their life when they get out and the speed with which they return to prison.

“If people return to the community unwell and do drugs and alcohol, or don’t cope, this may lead to crime and they are back in again. It is that revolving door syndrome in the prison system that we want to stop for people affected by mental illness. Up to 60% of prisoners return to prison after being released.”

Tony’s passion is palpable even though the position of prison mental health nurse practitioner is still only a hypothetical concept. “A 2007 draft document focusing on future needs and mental health nursing numbers in forensics alludes to increasing involvement of mental health clinicians at the interface between correctional services and regional forensic psychiatry services,” says Tony.

He points out the nurse practitioner role is still relatively new in New Zealand and many gainfully employed nurse practitioners have created their own positions through proving a need or gap in their service for a specialist advanced nurse.

“I really like the idea of making change and to do that you need to understand theory and gain knowledge of best practice.”

WORKFORCE DEVELOPMENT REMAINS A TOP PRIORITY

Te Pou would like to introduce Tania Waitokia, the newly-appointed northern region workforce development coordinator based at the Northern District Support Agency (NDSA).

Tania has an extensive background working in the health sector in both clinical and managerial roles. Most recently, Tania held a planning and funding role at He Kamaka Oranga, the ADHB Maori Mental Health Service.

With a strong commitment to this role, Tania brings a deep understanding and knowledge of health and workforce issues.

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phone (09) 580 6886

mobile 021 988 524.

PROFESSIONAL SUPERVISION PILOT IN NORTHLAND DHB: A NURSE LEADER REFLECTS

by Jane Simperingham, Nurse Leader Northland DHB

In 2009, Northland District Health Board completed a six month pilot of the [*National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses*](#). The [evaluation report](#) can be found on [Te Pou's website](#) along with the guidelines.

I am writing to add the DHB's perspective on the pilot experience, and what we learned conducting the pilot.

My role in the mental health service is professional leader, mental health nursing.

Northland DHB provides services to a population of 150,000 people, from Te Hana, just north of Wellsford, to the top of the North Island. There is a 31-bed adult inpatient unit at Whangarei hospital. Community mental health has offices across the region with the associated physical distance and travel times for staff.

Prior to the pilot, our DHB was reflective of others. Staff and service commitment to supervision, in principle, was definitely present, but the constraints of workload demands and reducing supervisor numbers had eroded the substance of supervision culture over time.

The supervision pilot coordinator was Bernie Cameron, clinical nurse specialist for community mental health in the mid and far-north areas. Pilot funding supported one day a week for Bernie's role.

Because of difficulties accessing supervisors in the mid and far-north, Bernie's initial focus was building up supervision capacity by recruiting participants. The area is geographically remote from other clinical services with accompanying recruitment and professional support challenges.

We knew the numbers and relationship options would have been greater if the focus was on the urban area, but this would have defeated our motivation for taking part in the pilot. Our view was "if rural Northland can do it, anywhere can". We may also have achieved more sophisticated results, but the minimum sustainable outcome seemed more useful than a "six month, one-hit wonder".

In the end though, participation was strong and injected much more capability into the more remote areas of Northland.

The pilot evaluation report has comprehensive detail. From my perspective, the key learnings were simple and logical. These follow under the areas of coordination, training, policy and technology.

COORDINATION

The final evaluation strongly supports a coordinator's role, however we do not have a large infrastructure of senior nurses in Northland and, by the end of the pilot the recession made it clear new roles were unlikely. The use of clinical expertise for a coordination role was not realistic. As a solution we have added supervision into the existing training administrator's role. We now have a resource for maintaining a supervisor's list, advice and a central repository for administration such as contracts and attendance records. Coordinating supervision training was already the responsibility of this role.

Our view was "if rural Northland can do it, anywhere can".

TRAINING

The three-day supervisor training provided in the pilot is, to my mind, a suitable initial role preparation for nurses. We have chosen to continue using these trainers. This training is suitable for multidisciplinary groups and the uptake of nurses has been stronger than it was prior to the pilot.

We will also offer the one-day supervisee training again this year, but engaging participants has been slower. It is not something we have a history of providing prior to the pilot, so it may simply be poorly understood or appreciated. Having undertaken the training myself, and with pilot participant feedback very positive, I see very strong value in its contribution to the effectiveness of supervision time management.



JANE SIMPERINGHAM, NURSE LEADER NORTHLAND DHB

POLICY

Northland DHB had, coincidentally, completed an organisation-wide policy within the pilot's duration. This policy had strong mental health input from myself and the general manager.

During the pilot I worked on the assumption that a more informed and detailed policy for the mental health service, if not mental health nursing-specific, would be a logical outcome. Ironically, this has been decided against, as we eventually came to the conclusion it would not add value. "Less is more". There are, however, guideline resources available to mental health staff to supplement the DHB's policy.

TECHNOLOGY

Quality and availability of technical assistance reduced the range and depth of technology use throughout the pilot. This was disappointing for a DHB with such a geographical spread. Skype and videoconferencing is definitely growing in the DHB but I think staff reluctance for anything other than face-to-face supervision is a hurdle we have not yet completely overcome. As facilities become more readily available and are more commonly used for clinical activities, training and general business, I expect the technology culture within the DHB will grow.

I am pleased to have had support from Te Pou and the training providers to develop supervision for mental health and addiction nurses. I believe we have a simple, yet stronger, culture of supervision with a clear structure for sustainability.

**Jane was profiled in [Handover in Spring 2008, Issue 7](#).*

SECLUSION: TIME FOR CHANGE

By Tony Farrow, Clinical Lead, Te Pou

In the last edition of *Handover* we announced Mike Wilson was leaving Te Pou, and that I had been appointed project lead for the seclusion reduction project, *Seclusion: Time for change*, including sensory modulation. I want to thank Mike and all the other champions for the work they have put into this project.

Mike remains involved at a number of important levels, including analysing data from the adult arm of the research study. This is currently nearing completion, while the child and adolescent study continues, with a projected completion date of November this year.

Mike has previously written (also in the last *Handover*) some of the emergent results from the studies.

Significantly, it

appears that sensory modulation assists people using services to retain or regain personal control when

they are in distress; can rapidly induce a sense of calm in times of crisis, and helps clinicians to quickly build a therapeutic relationship with service users.

A number of services around the country have picked up sensory modulation and applied it in varying forms in acute inpatient units.

However, it is clear that further advice in, and guidelines on how to actually apply, sensory modulation in the New Zealand context, with a number of practical implementation issues, need addressing.

These include a lack of confidence in how to best use rooms or tools; where to set up

rooms; which clinicians should make sensory assessments and when; matching tools and people; how to manage infection control; and how policies should be written.

For this reason Te Pou is in the process of developing an implementation package that will be trialled and, if successful, offered to DHBs.

This package consists of an online pre-workshop component describing the physiological, research and theoretical basis of sensory modulation.

The pre-workshop component will precede a two-day workshop about the practicalities of implementation, including a hands-on approach to understanding and using the tools and sensory modulation rooms in the

have not been able to attend a workshop. We think this package will give a clear introduction so clinicians can determine whether they are interested in finding out more.

We will also be including a downloadable FAQ sheet that clinicians can consider, and potentially use as a basis for discussion with clinical colleagues and service managers.

On a personal note, I am pleased to be involved with *Seclusion: Time for change*.

I believe that sensory modulation is one way of supporting best nursing practice.

The implementation workshops, in particular, are a way to help clinicians safely embed sensory modulation into their personal practice and be seen as a legitimate suite of tools that nurses can use to support people using services.

Significantly, it appears that sensory modulation assists people using services to retain or regain personal control when they are in distress.

clinical setting; undertaking personal safety assessments with service users (and how these fit into current nursing assessments); determining how to intervene with people presenting with different needs; and writing guidelines and policies for sensory modulation.

We are very hopeful the workshop trials will be successful, and the package can be offered to DHBs in the second half of 2010.

We are also developing an 'introduction to sensory modulation information' package that will sit on Te Pou's website. This is for clinicians who have heard of sensory modulation but



TONY FARROW

Tony is a clinical project lead at Te Pou. While he is Christchurch based, much of Tony's nursing practice occurred in Auckland in a variety of settings, including inpatient, continuing-care and crisis team roles.
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SEE YOU IN SPRING!

I hope you have enjoyed the 2010 winter edition of *Handover!* Please pass it on either electronically or by hardcopy to colleagues and people using services who may not have easy access to a computer. If you like the look of *Handover* and you would like to receive your own quarterly issue, please subscribe on Te Pou's website.

The spring issue of *Handover* will be a bumper edition. If you have an outstanding leader in your team or relevant and recent literature you think we should share, please don't hesitate to contact me. Anne McDonald, Ph: 09 373 2125, Email: anne.mcdonald@tepou.co.nz



community youth
family culture
child infant

Attachments

Child & Adolescent Mental Health Conference 2010
15–17 September 2010 • The Rutherford Hotel, Nelson

The Werry Centre in partnership with Nelson Marlborough DHB is pleased to invite you to attend the New Zealand Child & Adolescent Mental Health Conference 2010 to be held in Nelson 15-17 September 2010.

The theme is “**Attachments – community, youth, family, culture, child and infant**” and the conference is being held at the Rutherford Hotel in sunny Nelson.

This innovative conference will bring together our workforce including psychiatrists, clinical psychologists, mental health nurses, social workers, therapists, paediatricians, registrars, kaupapa Maori health service providers, education service providers, care and protection agencies, youth justice services, community organisations, youth and family advisors and all other organisations and health professionals who work with children, adolescents and their whanau/families.

This conference will enable us to build on past experiences, share research, discuss and debate the key challenges and opportunities, and develop emerging solutions. It is an opportunity to showcase programmes and innovative ways that families and communities help secure those important attachments. We hope to enhance your own models of working with children and youth in the mental health sector with outstanding keynote speakers who understand the challenges of today’s young people and ways of us all working together for a better world.

An exciting range of keynote and invited speakers are being planned. Check out the conference website to see confirmed speakers and watch out for more announcements in the next couple of weeks.

For full information on the conference including speakers, pre-conference workshops, abstract and registration information go to the conference website <http://www.confer.co.nz/camhsconf10>

The Werry Centre is pleased to announce the **Inaugural Werry Centre Innovative Workforce Development Awards** which recognise and encourage innovation in workforce and service developing in infant, child and adolescent mental health. Find out more <http://www.confer.co.nz/camhsconf10/papers.html>.

The first 50 delegates have already registered. We encourage you not to miss out. You’re in for an excellent few days. A diverse and stimulating programme has been designed with something for everyone.

For further information please contact the Conference Secretariat, Conferences & Events Ltd , phone +64 (0)3 546 6022 or email: camhs2010@confer.co.nz

We look forward to seeing you there!