



### EDITORIAL

Welcome to the Autumn issue of Handover. To those people who have recently started subscribing – a big thank you. It's always with some reluctance that we farewell summer, however winter brings the opportunity to get out those boots and scarves, and wrap up all warm and cosy!

#### RECAPPING SUMMER

It seems that for most people, the first few months of 2008 have been really hectic, and the same can be said for the Te Pou **workforce development team**.

The year kicked off with a successful **Trailblazers** workshop – the primary health care initiative – and we also got straight into it with our now not so new **PECT** (Post Entry Clinical Training) contract.

The second regional **Valuing Leaders in Acute Inpatient Services workshop** was held in Dunedin in late February for Otago and Southland DHBs. This was well attended. Thank you very much to Southland for travelling to Dunedin and to Otago for having so many acute inpatient nurses in one room. As you can see from the photos, there was a great turn out.



KARL METZLER, NATIONAL MANAGER WORKFORCE DEVELOPMENT TE POU (BACK ROW, MIDDLE), CATCHES UP WITH HIS OLD COLLEAGUES FROM SOUTHLAND DHB.



OTAGO AND SOUTHLAND DHB NURSES ENJOY A MOMENT DURING SONJA GOLDSACK'S SESSION.

Christchurch was the venue for the third workshop. On 1 May, Canterbury, Nelson Marlborough, South Canterbury and West Coast DHBs came together for the event. Again, a lot of travel and fiddling with rosters from the DHB's perspectives, so thank you for a great day! We've included a couple of photos to give you a sense of the atmosphere. Don't worry if you are from the Central or Midlands regions – your workshops are soon. I am currently in the process of finalising the invitation list with the Central region's mental health nursing directors, and invites will soon be in the post. This regional workshop will be held in Wellington on 19 June.

We are aiming for a July workshop for the Midlands region. Please check the **nursing pages** on the Te Pou website for updates.

Phase one, the research phase, of the Professional Supervision project is nearing completion. As promised, this report will be available on the Te Pou website very soon. The outcomes from this phase will inform planning for phase two – which I am busy preparing at the moment!

CLIMATE mh E-Learning is also in a similar position. St.Vincent's Hospital in Sydney is nearing completion of the first set of lessons for this e-learning set.

I have to say the whole concept of e-learning is really exciting, promising so much potential for nursing workforce development.



AN AFTERNOON OF LAUGHS IN CHRISTCHURCH LEAD BY THE AMIABLE CATHY KING (THIRD FROM LEFT) FROM CANTERBURY DHB.



CANTERBURY DHBs COORDINATING CONSUMER ADVISOR FIONA HOWARD (FAR RIGHT) TESTS THE ART OF PERSUASION.

#### OUR HANDOVER SUPERMODELS

Valerie Williams is our last (but by no means least!) *Handover* supermodel profile. Angela McCarthy, Te Pou's contract writer, has done another great job of profiling Valerie's career and capturing her perspective on mental health nursing. Angela tells me that she has really enjoyed meeting and writing about such a diverse group of people that have chosen mental health or addiction nursing as a career. Given Angela's feedback, and that we have now profiled all our supermodels, *Handover* is looking for some more nurses to profile. Over the next few months your mental health nursing director or NGO leader may approach you to gauge your interest in being profiled in *Handover* or as part of the National Training

Plan's career profile on the website. Please take up the opportunity! You've been chosen because you're considered by your organisation as an exceptional role model to nursing. It is also really important that we celebrate one another as mental health and addiction nurses. I look forward to the flurry of emails!

### WHAT'S IN THIS ISSUE?

National interest from nurses in **Talking Therapies** continues to grow. This is fantastic and it aligns with the current national direction. Helen Hamer and Janet Peters share their perspectives on two Talking Therapies workshops that they took part in. Mark Smith, my nursing colleague from the **Te Pou Information programme**, has the first of a regular contribution on nursing informatics,

and there's an update on some of the work being carried out in the **Te Pou Research programme**. Plus, there's much more including an article from Debra Lampshire discussing how nurses can play a role in good physical outcomes for service users, a story about a new initiative at Auckland District Health Board and, a not-so-new initiative but one that has had media interest in the last month, nurses in police stations.

On that note I will say goodbye. *Handover* is always looking for interesting contributions, so please do consider contributing. If in doubt just drop me and email or give me a ring...I am sure I will be able to persuade you!

*Wrap up warmly and bye for now,  
Anna.*



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**Te Pou**  
o Te Whakaaro Nui

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

## ANNE GARLAND WORKSHOPS...A REAL WINNER By Helen Hamer

*Senior Lecturer, Helen Hamer from The Centre for Mental Health Research and School of Nursing at The University of Auckland led the recent initiative to host Anne Garland as a Distinguished Visitor in 2008.*

Anne Garland is an internationally renowned nurse consultant, scholar and clinical leader in the model of Cognitive and Behaviour Therapy.

Anne's extensive experience in teaching and researching the application of this evidence-based model in mental health settings was the platform for the informative workshops and seminars delivered over a two week period at Tamaki campus. These were well attended and very successful. As well as workshops Anne also visited key clinical environments within Auckland District Health Board and held meetings with senior nursing staff within the school and in the clinical setting.

Anne's current research focuses on the application of psychological approaches by mental health nurses in acute inpatient settings. Her findings, recommendations and the demonstration of clinical skills for practice were presented as part of the acute inpatient workshop. This was well attended by nurses and other allied professionals from around the country.

This workshop has been a catalyst for development and further dialogue about the application of psychological skills in that setting. Many of the participant's attendance was funded through scholarships offered by Anna Schofield at Te Pou. The following day a number of scholarship recipients and other stakeholders attended a forum to present their

thoughts and ideas about furthering the mental health nurse's role in Talking Therapies. Anne was able to use her extensive experience of leading a similar process in the UK to help guide the group's recommendations for practice in this specialty setting. This culminated in a submission from the group to the next Te Pou Talking Therapies report, authored by Janet Peters.



SOME OF THE NURSING LEADERS AND STAKEHOLDERS WHO CAME TOGETHER FOR THE TALKING THERAPIES FORUM ON 21 FEBRUARY. (L TO R) LINDSAY SPIRRETT (WAITEMATA DHB), TRUDI DENT (OTAGO DHB), HELEN HAMER (AUCKLAND UNIVERSITY), ANNE GARLAND (DISTINGUISHED GUEST), ANNA SCHOFIELD AND JANET PETERS (TE POU).



ANNE GARLAND LEADS THE ACUTE INPATIENT CBT WORKSHOP ON 20 FEBRUARY.

Having the opportunity to spend time with a nursing leader of Anne's calibre was appreciated by nurses. Many present at the workshop believed that Anne modelled to all professions that nurses do have a valuable role to play in the delivery of evidence-based therapeutic models in parallel with a nursing model.

Finally, this successful visit has further developed the strong links between The Centre for Mental Health Research, the School of Nursing and Te Pou, and their commitment to work collaboratively on workforce development, research and academic initiatives.

HELEN HAMER

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# IS THE MIND REALLY CONNECTED TO THE BODY?

By Debra Lampshire

It was with a heavy heart that I read the latest statistics relating to the death rate and physical health status of service users a) because that's me, and b) because I wonder why I'm bothering to pay outlandish prices for organics and why I gave up everything that tastes truly good in this world. And don't get me started on these health food supplements I have invested in. Looking at the stats saying I'm likely to die 25 years younger than the general population makes me grieve for those who have already passed away before their time and it makes me reflect on what lies ahead for those just entering services.

The rates are alarming and, from my perspective, especially heart disease, cancer, influenza, diabetes and respiratory illness<sup>(1)</sup> (see Table 1).

I am aware that some nurses have not been comprehensively trained and may not feel as competent as the new batch of nurses.

But it appears that sometimes even very basic health checks are not being queried and while current thinking is that service users' physical needs should be directed to a GP, unfortunately some service users just don't go.

There are a number of reasons for this e.g., access and/or the ability to pay.

Part of the transition process into the community may involve service users connecting with their local GP. Nurses may need to be proactive in ensuring that the service user takes this on, as their personal responsibility is to maintain good health.

physical addiction – it fills time, it can give me a connection to others and it is what service users do – isn't it? (It is also not uncommon to see staff in mental health services role-modelling this health risk).

I applaud those of you out there having the courage as nurses to ask those 'below the waist' questions. Endeavouring not to blush as you ask all about those private bits and pieces we try so desperately to avoid in mental health. The relationship between the mind and the body is irrefutable. It is almost impossible to sustain your mental health when you're feeling 'poorly' or have an undiagnosed physical illness. Stress, poor diet, smoking and lack of exercise plague our service users and, as a consequence, we see the impact reflected in current statistics.

While the rest of the world's health is improving, service users' health is not. We need to educate service users about the impact of stress and the need to self-manage healthy lifestyles as an integral part of clinical practice. It is hard to comprehend that the group that gave us the attachment theory has yet to work out that a healthy attachment might be the head to the body! It is to our peril that we lose sight of the extraordinary power of the mind to affect the body.

1. Singh, A and Cohen, S (2001), *A general Practitioners guide to Managing Severe Mental Illness*. London: Sainsbury Centre, p5.

TABLE 1

HEART DISEASE:	DEATH RATE 2.2 TIMES THE GENERAL POPULATION
CANCER:	DEATH RATE 1.5 TIMES THE GENERAL POPULATION
INFLUENZA:	DEATH RATE 5 TIMES THE GENERAL POPULATION
DIABETES:	DEATH RATE 3 TIMES THE GENERAL POPULATION
RESPIRATORY ILLNESS:	DEATH RATE 2.8 – 4 TIMES THE GENERAL POPULATION

The reason I raise this topic is because of the role nurses play, which seems pivotal in physical health care.

It is the nurse that service users look to, to resolve and demystify the inner workings of our bodies. Just by virtue of being a nurse we expect that somehow, by magic, you can detect all those little niggles, aches and pains without us needing to tell you (rightly or wrongly). We often seem to think nurses have a sixth sense and can detect physical problems without the need to discuss them.

But somewhere amongst the rapport building, assessments and therapeutic interventions, we have missed the "have you moved your bowels lately?" question.

Let's face it, with all the other questions that get asked about our lives, this one is pretty low in the rankings of intrusive. It concerns me greatly when I hear of service users dying of constipation. In this day and age to die of constipation whilst being treated by a health service is extremely worrying!

Needless to say smoking is a significant risk factor for service users. It contributes to the top three diseases - heart, cancer and respiratory.

There are a number of reasons why service users find it hard to give up smoking. Some have a psychological addiction just as much as a



## DEBRA LAMPSHIRE

*Debra is an Experienced Based Expert (EBE) and recovery trainer who delivers lectures and workshops at DHBs, Auckland University, School of Nursing and other tertiary institutions. She has designed and delivered a variety of workshops to meet the needs of service users and mental health workers of both DHB and NGO providers. Debra identifies herself as an EBE and shares her lived experiences when teaching to cultivate empathy and a richer understanding of the triumphs and challenges faced by service users on their journey of recovery.*

# INFORMATION ALIVE!

By Mark Smith

Informatics is the study of data that is collected and used. Nursing informatics is concerned with data that is collected and used in nursing. You can read more about informatics on [Wikipedia](#).

A place to start perhaps is with an overview of what we mean by information. We are not referring to information in the broad sense of information but a narrower understanding, where information refers to mental health activities and outcomes.

The kind of material included in activities is currently captured by MHINC data and includes things such as the number of service users seen, number and type of appointments, the kinds of interventions by which type of professionals etc.

As of 1 July this year, MHINC will be decommissioned and replaced by PRIMHD (Programme for the Integration of Mental Health Data).

PRIMHD data will also include outcome data. Initially, outcome data will be based on HoNOS, HoNOSCA and HoNOS 65+ outcome measurement tools.

Over time, other outcome measurement tools may be added to this mandated collection, such as a consumer self-assessed outcome tool and a drug and alcohol outcome tool etc.

The Te Pou Information programme has commissioned a piece of work to provide a stock take on current and envisaged outcome tools in New Zealand's mental health services. The findings of the stock take will be available later in the year.

Why does any of this matter to mental health nurses? Fundamentally it matters because in order to make good clinical decisions we need good information, and good information needs both activity and outcome data as mentioned earlier.

Nursing is an extremely important professional group in this regard because it collects more data than any other professional group. If

there is any cynicism within nursing over the development of information systems, one suspects it is largely because information sometimes can appear to have little use at the clinical level, since so much of the information provided is aggregate statistical information (which is useful and important but at a national rather than a personal level).

How we use information as nurses is crucial to making sure we make the best decisions that we can. How, for example, we integrate outcome measures into our everyday practice is clearly important at a team level but it is also important at the individual clinician and service user level.

*How we use information as nurses is crucial to making sure we make the best decisions that we can.*

In the past, the emphasis upon clinical utility has not been as central as many nurses would like. I personally share some of those concerns.

The Te Pou Information programme is currently developing information utility workshops, which will be available later in the year, and also updating its website so that mental health outcome data and information has more clinical utility.

These informational utility workshops will focus on making activity and outcome data more useful and relevant, particularly to clinicians.

*The National Mental Health Information Strategy*, Ministry of Health, 2005, emphasised the need to move from data collection to information use. Our focus upon clinical utility is very much in keeping with this.

Before finishing this issues column, it is worth mentioning the mental health outcomes conference to be held in Australia later this year, which, hopefully, New Zealand nurses will attend.

This conference follows on from the inaugural Australasian mental health outcomes conference, [He Kakano](#), hosted by Te Pou last year.

This year AMHOCN (the Australian Mental Health Outcomes and Classification Network) is hosting the National Mental Health Outcomes Conference at the Crowne Promenade Hotel, Melbourne, Australia. The conference is being held on 24 – 26 November 2008.

For regular updates on the Te Pou information programme's projects, including PRIMHD, clinical utility developments and the team, visit the Information pages of the [Te Pou website](#).

The Information programme has recently moved premises and is now based at 293 Grey St, Hamilton East.

Please email me ([mark.smith@tepou.co.nz](mailto:mark.smith@tepou.co.nz)) for more information about the programme or advice related to matters informational, and catch this column again in the winter edition of *Handover*.



MARK SMITH

*Mark has the Clinical Lead Specialist role within the Information programme at Te Pou.*

# THE ROLE OF THE MENTAL HEALTH NURSE SPECIALIST POLICE CONSULT-LIAISON, LAKES DISTRICT HEALTH BOARD

By Jeanette Knight

In the usual course of their work, the police interface with offenders with experience of mental illness is often problematic. Both national and international studies have revealed the proportion of police-demand associated with mentally unwell people is over-represented.

Police are not pseudo mental health professionals, receiving very little training on mental health, with most of their knowledge coming from 'on the job', first-hand experience. The 'one-size fits all'/generalist approach of police is recognised as no longer being appropriate in these cases.

Since December 2001, a mental health nurse has been working across the two diverse worlds of police and community mental health services in Rotorua. This is a first for New Zealand.

The police consult/liaison nurse is a ground-breaking role in mental health service delivery, placing clinical expertise, liaison and support within the 'thin blue line'.

This approach has required shifts in traditional paradigms for both services in ensuring a collaborative response to timely mental health intervention.

I am the inaugural appointee. My role as police liaison nurse involves:

- being employed by Lakes DHB, being part of the Rotorua community mental health team
- being based at Rotorua police station full-time - a 0.5FTE position for Taupo has also recently been established

- bringing clinical mental health expertise into the Rotorua police force
- providing early intervention in mental health service delivery, with assessment and treatment planning for people coming to the attention of police
- liaison with stakeholders (including family/whanau) in the police-mental health interface.

For this role, effective management and early identification, support and treatment of people is paramount. In order to do this, the following activities were adopted:

- timely assessments and prompt referral to appropriate care and treatment, which means the person is not in the cells in an unwell state and is able to be diverted if they are not charged with an offence, or if the offence is of a minor nature
- the provision of treatment plans, appropriate monitoring regimes and management while the person is in police custody
- continuity of care and minimisation of stress for people with a mental health illness through prompt referrals to appropriate treatment services
- the provision of mental health advice and support to the police when they are dealing with people with a mental health illness
- improved coordination with, understanding of and accessibility to other service agencies - as a result,

interagency relations have been significantly enhanced (this liaison takes up approximately one third of the role)

- an identified point of contact and police interface for mental health services, making for improved resource utilisation of both mental health and police staff.
- increased interagency awareness of police and mental health service provision in relation to mental health through education, a key aspect of the role.

Having a mental health nurse at the Rotorua police station to help police deal with arrestees or detainees who present with mental health problems alone or a dual-diagnosis of mental health and alcohol or other drug problems, has clearly benefited key stakeholders and tangata whaiora.

A formal evaluation of the nurse liaison role was carried out by contracted personnel during 2007 as part of the Ministry of Health's 'Effective Interventions: Review of the Interface between Mental Health and Alcohol and Other Drug Services and the Criminal Justice System - the Police Setting Project'.

This report is due for publication shortly.

JEANETTE KNIGHT

*Jeanette has worked as a mental health nurse for over 24 years and completed her training at Tokanui Hospital. Prior to taking up her current role, Jeanette set up and led a residential mental health service in Te Kuiti.*

## CONGRATULATIONS TO OUR NEW NURSING LEADERS

ANNE TACON AND ERIN MORRISON

Anne started in her new role as Director of Mental Health Nursing at West Coast DHB in March.

Erina took up the role of Director of Mental Health Nursing at Waikato DHB in April.

It is wonderful to have two nurses of such a high calibre in lead roles and I am sure you will all join me in congratulating them both.

# INSPIRING WORKSHOP HELD AT NELSON MARLBOROUGH DHB

By Janet Peters

*Janet Peters reports on the success of the Scott Miller Workshop.*

Dr Scott Miller is from Chicago and is co-director of the Institute for the Study of Therapeutic Change. Scott is a hilarious speaker but the message is serious – clinicians must work alongside service users to assess their own performance as well as work to assess the service user's progress over time.

Robyn Byers (general manager of Nelson Marlborough DHB) had the foresight to ask Scott to New Zealand and Scott's message sits nicely alongside any other outcome measures.

Robyn notes, "The clinical session/outcome scales are more specific to individual therapy and as such they are valuable tools between the service user and clinician to track progress (and also compare to [USA] norms). To facilitate this, there is a computer program developed by Scott's group for clinicians called A.S.I.S.T. (Admin, Scoring, Interpretation and Data Scoring Tool). They can be aggregated for use in professional and service development. It could be part of the suite of outcome measures".

John Clarke, a nurse from the DHB's Early Intervention Service attended the seminar, and had this to say about the workshop.

"After learning several models of therapy, and in particular, solution focused therapy, more of my service users got well, stayed well and learned to manage their emotional health. While I enjoy watching service users recover, I have remained puzzled about why some don't do as well as expected. It was with the hope of learning something to improve outcomes that I attended this seminar and I left with my hopes well and truly exceeded."

## BECOME A SUPERSHRINK?

Scott Miller's 'supershrinks' presentation was entertaining, highly informative and for some, very contentious.

Scott presented a lot of material on factors which lead to better outcomes, he debunked many commonly held beliefs about what helps people change, and he provided some simple

tools for improving service users' outcomes.

I left the workshop with a better understanding of what I do that is ineffective and with strategies for addressing this.

In particular, Scott stressed the importance for clinicians to use brief, weekly service user feedback to ensure the service user is improving and that a strong alliance is maintained.

Research shows that clinicians are far less adept at recognising these factors than they believe.

This simple questionnaire is completed within 60 seconds and effectively alerts clinicians about aspects of the treatment or alliance that need addressing.

Researchers have also found that no amount of 'good science' will change the minds of clinicians devoted to the medical model.

I therefore hope that more clinicians will become disturbed by poor outcomes and, as a result, revisit the 'supershrink' material presented by Scott.

Mike Staite, a nurse who currently works in the DHB's acute inpatient unit, also attended and made the following comment.

"As an inpatient unit nurse, Scott's workshop provided many pertinent points to ponder

over and look to incorporate into our service delivery.

Firstly that 'practise-based evidence' is certainly the way forward for staff in our services. I believe that our service needs to develop and improve feedback from service users regarding what it is that we do well. This should become a driving issue for informing service users on how to give constructive feedback, and for clinicians to be trained on how to receive feedback so that we can grow our own expertise.

The future of the clinician and service user relationship is exciting for those seeking to work within the partnership model. It would drastically reduce service user complaints and dissatisfaction, and improve staff flexibility, moral and expertise. We need to have the courage to move away from 'evidence-based practice' to 'practice-based evidence' - it might not be as great a paradigm shift as we think, for we have much of the systems in place. It is what we prioritise and our ability to welcome feedback, as this information is vital if we are to move forward and become 'supershrinks' in a superior service."

An article which includes much of what Scott presented can be downloaded from the following link: <http://www.talkingcure.com/documents/BeyondIntegration.pdf>



## JANET PETERS

*Janet is a contractor for Te Pou. She worked for Waitemata District Health Board for 10 years, has worked on several national projects (eg. Like Minds) and for several national agencies, including the Mental Health Foundation, Mental Health Commission, Ministry of Health and Health Research Council, and for one international agency, International Initiative for Mental Health Leaders (IIMHL).*

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# SECLUSION – TIME FOR CHANGE By Monika Divis

*Everything changes; nothing remains without change - BUDDHA*

There is enormous interest in the sector, nationally and internationally, about the use of seclusion. It is a time of and for change, and New Zealand could well lead the way.

Te Pou has been asked to support the Ministry of Health in the national goal of reducing seclusion in New Zealand's mental health services so that people receive services in the least restrictive settings.

Taking a careful and planned approach, the Te Pou Research programme is carrying out this work through the 'Seclusion – Time for Change' project, with phase one well underway. This involves identifying best practices for reducing seclusion and surveying DHBs to see what initiatives are being carried out in this area.

A literature review of best practices in the reduction and elimination of seclusion and restraint was recently completed by Mary O'Hagan. This report was published in April and is available on the [seclusion webpage](#) of the Te Pou website.

The report describes evidence-based best practices and identifies two US training curriculum that incorporate a range of best practice methods. These two packages are The National Association of State Mental Health Program Directors' (NASMHPD) 'Training Curriculum for the Reduction of Seclusion and Restraint' and the Substance Abuse and Mental Health Services Administration's (SAMHSA)

'Roadmap to Seclusion and Restraint Free Mental Health Services'.

DHBs have also been surveyed to identify what seclusion reducing initiatives they have implemented. A report examining DHB initiatives is being compiled.

*There is enormous interest in the sector, nationally and internationally, about the use of seclusion. It is a time of and for change, and New Zealand could well lead the way.*

Thelma Puckey has recently been appointed to the project team to undertake an in-depth study of DHBs using the NASMHPD and/or SAMHSA initiatives, either in whole or part, in conjunction with other best practice initiatives. Thelma will evaluate their implementation and adaptation for the New Zealand context and what impact they've had (intended or otherwise).

Thelma has extensive mental health and leadership experience and is a lecturer at Victoria University. She has a strong interest in this area and recently commenced a PhD study on the practice of seclusion in acute adult mental health inpatient units.

"We are very fortunate to have Thelma join the project. Her academic and clinical experience

will support the development of strong building blocks for best practice in this area," says Te Pou National Manager Research, Jane Vanderpyl.

Phase two of the project focuses on translating the outcomes of phase one into sector resources, with the intention that they will be piloted and evaluated. Te Pou is also currently inviting people to become involved in a 'Project Establishment Group'. This Group will include people with clinical, management, cultural and service user perspectives, to provide a voice for the interests of the sector, inform decisions and support effective development and implementation of phase two.

For more information about this project visit the Seclusion – Time for Change project page on the Te Pou [website](#).



MONIKA DIVIS

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## CHILD & FAMILY UNIT LIAISON COORDINATORS... A NEW INITIATIVE By Lisa Cartledge and Melanie Lee

*The Child & Family Unit (CFU), based at Starship hospital, Auckland District Health Board (ADHB) provides a specialist inpatient adolescent mental health service to the upper half of the north island. Its child unit has the north island's only specialist inpatient child mental health beds. The unit interfaces with 15 DHBs and twenty two referring services, all specialising in community based child and adolescent mental health provision.*

CFU has been operational for several years. Currently we provide a 24hour, seven days per week resource for 0-18 year olds. We have an eight-bed high dependency unit (a locked, therapeutic environment), a twelve-bed open unit for young people able to manage a greater level of activity and a five-bed child unit,

available for pre-planned admissions.

We are a diverse multi-disciplinary team and our service model is predominantly bio-psychosocial with a strong emphasis on recovery and family/whanau involvement. There is a school on site (part of the Northern

Health schools) and an established programme of psycho-educational groups. The team is organised to serve distinct geographical areas in order to increase the effectiveness of response to local need.

In addition to the 169 inpatient admissions in

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2007, a number of young people living locally to the unit attended as day patients and the team were involved in a significant amount of liaison and consultation with referring services around potential admissions.

### LIAISON COORDINATOR ROLES

The two liaison coordinator roles are a new initiative; a pilot project developed as a direct result of feedback from referring teams and recognition from within the service that improving relationships with our multiple referrers will impact positively on the overall experience of service users.

The posts are funded for an initial 12-month period.

On appointment, we were set the task of making contact with all referring services and following up with a visit to provide current information about CFU, referral pathways and admission criteria.

Prior to visits, we asked teams to complete a questionnaire designed to provide a snapshot of their knowledge and experience of CFU. This will be repeated at the end of the year.

All our referrers have a level of contact with the service, but keeping people regularly informed of service developments has proved challenging historically. Part of the liaison coordinator role is to work with teams to think about and come up with solutions for how we can build on existing relationships and strengthen connections between our services. For CFU, the process is as much about developing our appreciation of the work of other services as providing information about ourselves.

### NO SURPRISES

In addition to developing and delivering a universal presentation, we have created a short montage of photographs documenting the unit and staff. Distance means that many colleagues haven't visited CFU and report finding it difficult to talk with families in preparing them about what to expect.

It is often a huge source of relief for services and service users to be able to see that CFU is designed specifically for children and adolescents.

In addition, we have developed some written information for families/whanau and young people about what they can expect from admission through to the support available to them.

Over the course of the year, we plan to build on and develop this initial 'package'.

We are working with ADHB technical services to develop the existing CFU link on ADHB's website and we have just finished putting together the first edition of a quarterly newsletter about the Child & Family Unit.

This will be circulated widely to services working with young people's mental health.

As liaison coordinators we contribute to the development of referral pathways and the strengthening of CFU's internal systems to ensure a consistent quality of response to enquiries about potential referrals/admissions.

These range from brief enquiries regarding criteria, to calls from community teams who are with a highly psychotic young person at that moment and requesting urgent admission, to calls from adult services arranging transfer of a young person to a more age appropriate setting.

Referrals are discussed with CFU's consultant child and adolescent psychiatrists and charge nurse for a decision on admission.

We liaise between referrers and ward staff to ensure that appropriate arrangements are made for the young person's admission (thinking with people prior to arrival about the need for cultural support: are family/whanau members available to accompany the young person, if so, do they need accommodation on site, etc).

Where possible we offer pre-admission meetings, the opportunity to look around and to meet members of the team.

### SIMPLE INTERVENTIONS

Having a family member who is unwell is very traumatic.

Relatively simple interventions like phoning a family, talking them through what to expect on arrival and giving the name of the staff member who will meet with them, makes a significant difference to their overall experience. It's also central to setting the tone for CFU as a service which views children, young people

and those around them as the driving force in the recovery process.

We have a busy six months ahead of us; continuing to develop resources, building on relationships and strengthening links.

The feedback from referring teams and families so far is very positive – visiting teams in their own areas, providing a consistent point of contact and being

available to talk through possible options is helpful.

Feedback from our own service is constructive too; having a conduit between CFU and our multiple referring interfaces helps to facilitate a more positive experience for children and young people.

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*It is often a huge source of relief for services and service users to be able to see that CFU is designed specifically for children and adolescents.*

### LISA CARTLEDGE

*Lisa trained as a mental health nurse in 1986. She has worked in both adult mental health services and then child and adolescent services, managing a primary mental health project in the UK. She moved to New Zealand at the end of 2006 and worked as a staff nurse at CFU prior to commencing this role.*

### MELANIE LEE

*Melanie arrived in New Zealand a year ago to work as a nurse at CFU. She has worked in child and adolescent mental health in the UK for the last 12 years both in in-patient and community-based services as a nurse and, more recently, a team manager.*

# INTRODUCING VALERIE WILLIAMS

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

Mental health nurse educator Valerie Williams reckons she has one of the best jobs going in the mental health sector.

“I get to help develop up-and-coming mental health nurses; the future leaders of mental health nursing. What other role can there be where you have hands-on ability to develop people like this?”

Valerie is also enjoying the academic stimulation she gains through regular contact with University of Auckland's School of Nursing as part of her educator role.

Valerie has been running the mental health nursing internship programme at Waitemata DHB since February 2007. The job involves coordinating, liaising and guiding 22 interns. This year, 18 are new nurse graduates; the other four are nurses wanting to transition after working as registered nurses in a different scope. They are all ages, all nationalities and lots of fun, says Valerie.

In order to practice as a mental health nurse, Waitemata DHB require the interns to complete a 10-month programme, which includes two postgraduate Master's level academic papers through University of Auckland and two clinical rotations within the DHB.

Valerie, who has been nursing for 10 years, didn't start her training until she was 27. Her mother was a registered general obstetric nurse and she has strong memories of the commitment her grandparents had to their rural Maori community where her grandmother had tohunga status. Valerie became interested in mental health during her first year of training, discovering a commitment to the mental health community.

“To me community is inclusive not exclusive. People should be accepted into a community because of their commonalities, although their differences should also be acknowledged. We need to look past ethnicity, academic achievement and socio-economic status. If I look at you and see me, then wouldn't I want the best for you because I want the best for me?”

After finishing her degree, Valerie did a nine month stint at Waitemata Taharoto Mental Health Inpatient Unit.

“I was surrounded by highly skilled people so I learned lots. I developed skills very quickly because of the skill level around me.”

From there she spent time in the CAT (Community Assessment and Treatment) team culminating in leading the team. She then moved to the Hawke's Bay in 2003 where she worked for Hawke's Bay DHB Kaupapa Maori Service, Te Puawai O Te Whanau Oranga Hinengaro (kia ora whanau) for eight months, before spending a year and a half with the child and adolescent mental health team. Valerie, and her husband Phil, who is a social worker, returned to Auckland in 2006 where she joined Waitemata DHB's Rodney mental health service. She also completed her Master's degree through Massey University, and in 2007 was appointed into her current role.

As nurse educator, Valerie liaises with the DHB and the university on behalf of the interns. She takes part in the delivery of their university education and co-ordinates their clinical rotations. One of the challenges of the job is balancing the tension between learning and working, and that includes making it clear the interns cannot be part of staffing numbers on teams.

“Our goal is to give them 10 great months of learning and experience, where they can learn about the rigours of mental health nursing in a safe and supportive environment.”

When asked what she finds challenging about the role, Valerie responded that marking academic papers is a discipline that is difficult to master.

“I remember failing one of my first assignments at Master's level and not understanding why. I now understand it's about maintaining the academic standards and balancing that with practice. It's about praxis. We need that academic rigour in the mental health nurse workforce, alongside practical experience and clinical competencies.”

This includes the challenge of finding ways to assist interns in obtaining competence in the work environment, which involves close coordination and discussion with the interns and their preceptors.

Valerie has also been a part of the research component of the Te Pou '**Professional Supervision**' project that was contracted to the University of Auckland's Centre of Mental Health Nursing Research. She believes maintaining clear boundaries is an important skill within mental health nursing, and sees supervision as vital in this. “I have regular line management and individual supervision.”

While she misses the day-to-day contact with service users, Valerie says the skills she needs and her approach to work hasn't changed.

“How I approach things, how I engage, my processes and decision making are still the same, regardless of the title. Where I've come from, what I've learned, what I know, what I believe in and how I bring that to my work (praxis) makes me a mental health nurse. It is all about building professional and ethical relationships.”

Recruitment is another part of her role, and one that she values. It is important to attract graduates into mental health, says Valerie, who refutes the suggestion that interns will lose their medical skills if they don't do medical nursing first.

“The bio-psycho-social/recovery model emphasises a holistic approach to mental health nursing.”

