The 5th Australasian Mental Health Outcomes and Information Conference (AMHOIC) was held 11-13 November in Queenstown. Soaring views of the Remarkables and the beauty of Lake Wakatipu made this an inspirational choice of venue.

Nursing was well represented with many nurse leaders present. It’s the largest workforce in the mental health sector so it was great to see nursing taking the idea of measuring outcomes so seriously.

The theme of this year’s conference rising to new heights was ably introduced by Te Pou’s chief executive Robyn Shearer and Rod Bartling from the Ministry of Health. Rod mentioned the New Zealand Health Strategy: All New Zealanders live well, stay well, get well (https://futuredirection.health.govt.nz) which is currently being refreshed and includes five strategic themes that signal areas for change:

- people-powered
- closer to home
- value and high performance
- one team
- smart systems.

Continued on page 3

Mark Smith, clinical lead, Te Pou
**Editorial**

Ngā mihi o te Kirihimete me te Tau Hou

Welcome to the final edition of *Handover* for 2015.

*Rising to new heights* is the focus of our lead story by Mark Smith who shares key points from the outcomes and information conference held in Queenstown.

In the family column Leigh Murray updates us on the valuable work of DHB family whānau advisors.

Klare Braye highlights events, resources and opportunities in the addiction nursing space. Steph Anderson shares snippets from the DANA conference *Many faces of addiction* in Sydney. Workshops to support primary care practitioners to see *Addiction as everybody’s business* are then described by Anna Nelson.

We profile a new associate director of mental health nursing, Christine Ball from Nelson-Marlborough DHB.

If you are curious about what it may be like working in tourist resort town then our article about the Queenstown/Dunstan Mental Health services may be of interest.

The outcomes of a care managers’ forum are provided by Anthony Comerford and Teresa Turish from the mental health, addictions and intellectual disabilities directorate, Te Korowai Whariki, 3DHB.

We introduce a new column – *Least restrictive practice* authored by Lois Boyd and Carolyn Swanson that will provide regular updates on Te Pou’s reducing restraint and seclusion initiatives.

Ever wondered what solution-focused brief therapy is? Check out an outline from Paul Hanton to learn more.


If you are interested in building your capability to respond to people with co-existing problems then check out our final section that focuses on foundational level assessment knowledge and skills.

We hope you enjoy this edition.

*Nga mihi Suzette*
Keynote presentations all challenged the audience to rise to new heights in service delivery. Scott Miller encouraged the conference delegates to become better clinicians and therapists using feedback and practice. Positive comments from many of the directors of mental health nurses present about Scott’s messages clearly signalled it is time for us all to reflect on what we are doing and how we can improve our practice to meet the needs of people experiencing mental health and addiction problems.

Jackie Crowe encouraged involving service users and families in therapeutic work in her presentation Your policy is my life: The importance of a strong evidence base in underpinning good policy development. Jackie’s message for the audience was clear. “You will never be able to truly step inside another person and see the world as they see it until you develop the pure desire, the strength of personal character as well as the empathic listening skills to do so”.

Andrew Page discussed how feedback could be used to improve services at all levels in his presentation Judging the success of feeding back outcome information to service users. He demonstrated how monitoring and feedback of patient outcomes had been used in Perth Clinic, Western Australia to (i) improve outcomes by identifying patients who are not on track for optimal outcomes, (ii) identify potential adverse outcomes (for example, self-harm) and patient risk to assist prevention, and (iii) monitor progress of therapeutically relevant variables during an admission.

Daryle Deering and Sheridan Pooley in their presentation Measuring outcomes in addiction services: A researcher, clinician, consumer partnership spoke about the co-production approach used to develop ADOM (Alcohol and Drug Outcome Measure). They discussed underpinning principles, important considerations and key tensions that arose in attempting to meet the overarching aim of developing a meaningful measure and process for both consumers and clinicians.

There were many more interesting and stimulating conference papers covering all aspects of outcomes and information including: data collection and analysis; revised outcome measures; training; use of IT systems; policy direction; and how to use information at different levels. Many ideas arose from the conference and some of the clearest were:

• the need to tell people’s stories using data (“Without data, you’re just another person with an opinion,” W Edward Deming)
• that we may not be as good as we think we are therapeutically and outcomes feedback can help us get better as clinicians and therapists
• that all services need to consider how they measure effectiveness
• that services need to learn how to share information with service users and their families.

As we know from the conference presentation the Ministry has indicated it wants an outcomes framework it can eventually use to commission health services. This will change the incentives within the system away from inputs and towards outputs and most importantly outcomes. Nursing needs to be on board with these changes!

The 6th AMHOIC is scheduled for Brisbane in two years’ time and perhaps it is time for nursing to become the outcomes focused and information centred profession it always promised to be.

Find out more about this year’s conference at www.tepou.co.nz/amhoic.

Congratulations Angela Field

A huge congratulations to Angela Field, clinical nurse manager iCAMHS at Lakes DHB. Simply by attending the closing session Angela won a free registration to attend the 6th AMHOIC to be held in Brisbane, 2017.
The last few months have flown by and things are getting busy at work and at home as the Christmas holidays draw closer. During this time I have had the privilege of attending two major gatherings. One the AMHOIC conference in Queenstown which Mark has mentioned in our lead article and the other the opening of a meeting house at Mangatoatoa marae. Both events really reminded me there are many ways of improving our health and wellbeing, the importance of connections and being listened to stand out for me.

Whether you are nurse who is fortunate enough to take a break over the Christmas period or not I encourage you to consider your role as holders of hope. For many families this is a time of happiness and joy and reconnecting with the people that matter. However we as nurses also know this is also a time of the year which can increase distress for some people and their families and whānau. As nurses we have opportunities to support people at work and at home.

Nurses who are hope holders have the right attitudes. They are compassionate and caring, genuine, honest, non-judgemental, open-minded, optimistic, patient, professional, resilient, supportive and understanding. Hope holders also have the right values. They believe in recovery and hope every service user can live a full and meaningful life, in the presence or absence of their mental illness and or addiction.

I encourage you to keep in mind that you are a person that can be the holder of hope – who can whisper ‘just give it one more try’ to a person who has lost hope and feels like giving up on life. Nurse who are hope holders make all the difference. Thank you for choosing a career in mental health and addiction nursing.

Ngā mihi,
Suzette Poole

I enjoy working alongside like-minded people for better health and wellbeing outcomes and contributing to further development of services, leadership and the workforce across all our sectors. Working at Te Pou has provided my first opportunity to participate at a national level.

My key projects include working alongside Emma Wood on Let’s get real and the Top of Scope initiatives. I am also working alongside Angela Gruar on the following projects: COPMIA: Children of Parents with Mental Illness and/or Addiction; primary mental health; and Equally Well.

Ngā mihi nui ki a koutou katoa.
Jo van Leeuwen
jo.vanLeeuwen@tepou.co.nz
Meri Kirihimete ki a koutou from the DHB family whānau advisors

by Leigh Murray, co-chair, DFWA, family advisor, ADHB mental health services

Meri Kirihimete ki a koutou from the DHB Family Whānau Advisors (DFWA). As 2015 draws to a close DFWA wants to wish all mental health and addiction nurses a joyful, peace-filled Christmas with their whānau and friends. 2015 has been a positive year for our group with several key developments.

We are thrilled to have our own page on the Matua Raki website (http://www.matuaraki.org.nz/workforce-groups/dhb-family-whanau-advisors/148) as one of its key workforce groups. The page provides helpful information about the systemic advocacy role of the family whānau advisor, contact details for DHB family whānau advisors across New Zealand and access to recent Handover family articles. Our grateful thanks go to Matua Raki for providing us with this great platform.

Another piece of progress is the recent confirmation of a mutually beneficial arrangement with the Werry Centre. DFWA will provide some family/whānau input into its projects, resources and publications. In return the Werry Centre has agreed to sponsor some of the costs associated with our annual meeting held in Wellington or Christchurch. Family/whānau input will draw upon the diverse experience and whānau expertise of the 25 advisors currently with DFWA.

This year Jim Dickinson and Sue Philipson from Tarankai District Health Board capably led us in the development of role guidelines based on our Family and Whānau Advisor competencies (see www.maturak.org.nz/workforce-groups/competencies-for-family-and-whnau-advisors/166). Most advisors work without the immediate support of peers so this document is a guide for those new to the role so they can be safe and effective. It is envisaged these guidelines will support the consistency and credibility of family whānau advisor roles across Aotearoa for today and into the future.

The last development needing mention is not something DFWA can take credit for, even if several advisors contributed as part of the advisory group. The recent Ministry of Health release of the Supporting Parents Healthy Children (COPMIA) guidelines is very much welcomed by our group. It outlines the responsibilities all mental health and addiction services have to the children of parents with mental illness/and or addiction and their families/whānau. DFWA fully supports the aim of the document: to see realised a mental health and addictions sector that supports and promotes positive family relationships and the social and emotional development of all children of parents with mental health and/or addiction issues.

We look forward to supporting mental health and addiction leaders, managers, nurses and the workforce to achieve this over the next three to five years.
Addiction update

Matua Raki update
by Klare Braye, project lead, Matua Raki

Tēnā koutou katoa

Matua Raki and Drug and Alcohol Nurses Australasia are really excited to be organising the next Addiction Nurses Symposium. This will be held in Wellington in early March. We already have an interesting line up of speakers who will offer insights into what is occurring nationally regarding best practice and top of scope; the future of nursing-integration across mental health and addiction; what it means to be a specialist addiction nurse; and the relationships and involvement with primary care nursing.

We would be really keen to hear about the local initiatives and activities you are implementing in your services and would like to give you an opportunity to do this at the symposium. If you have an idea or an abstract you would like to submit please email me at klare.braye@matuaraki.org.nz.

Other events of note over the next few months involve the roll out of alcohol and other drug and intellectual disability training. Matua Raki began a series of one-day workshops in November 2015 and these will continue into the New Year (see www.mataraki.org.nz/events). The workshops are for both addiction practitioners and disability support services and will discuss supporting people who may have co-existing addiction and intellectual disabilities. The workshops are delivered by Chris Taea, a registered nurse and fellow of Te Ao Māramatanga New Zealand College of Mental Health Nurses with an established clinical, teaching and research profile in mental health, rehabilitation and disability.

Scholarships

The addiction and mental health scholarships administered by Te Rau Matatini opened for applications on 30 November 2015. Of particular note are the Hoe Tahi addiction scholarships which are for people wanting to enter into, or continue their addiction training.

The Henry Rongomau Bennett Foundation Māori Leadership in Health Scholarship; Tohu Hiranga; Hoe Rua Addiction Work Based Placements are also open and Medibank Health Solutions is providing two telenursing scholarships to Māori.

Resource

The Adult addiction workforce: 2014 survey of Vote Health funded services is now available (www.mataraki.org.nz/resources/adult-addiction-workforce-2014-survey-of-vote-health-funded-services/661). This report describes the size, distribution and configuration of the Vote Health funded workforce in adult addiction services and is a useful document to inform workforce planning. Additional reports are available from the Te Pou website that focus on the mental health workforce, regional and district health board level reports and a selection of workforce groups.

On a final note, Noho ora mai rā – look after yourselves, your friends, your whānau and your colleagues as you head into Christmas and summer.

Hei kona mai

Klare
Drug and Alcohol Nurses of Australasia (DANA) is the peak nursing organisation in Australasia providing leadership to nurses and midwives with a professional interest in alcohol, tobacco and other Drug (ATOD) issues. DANA aims for excellence and the ongoing improvement of quality care in nursing in all practice contexts.

DANA actively promotes a legitimate role for nurses, midwives and their professional non-nursing peers to respond to ATOD-related issues. In doing so DANA promotes practice based on the best available evidence, and promotes active involvement in research in ATOD-related interventions, and other issues relevant to the ATOD field.

There is an elected representative in each state in Australia and in New Zealand we have Moira Gilmour in the North Island and Steph Anderson in the South Island. We seek to provide opportunities for professional development, education, mentoring and support for all nurses and midwives and our non-nursing peers through a variety of activities. Our showcase event is our annual DANA Forum which this year was held in Sydney at the Novotel Hotel. The theme was Many faces of addiction.

This dynamic nursing forum brought together leaders in the addiction field from across Australia and New Zealand to share their knowledge about the science of addiction and effective clinical practices.

The theme Many faces of addiction reflected the diverse nature of addiction, where the impact of drug and alcohol misuse can be viewed from multiple perspectives. As nurses we are conscious that understanding each of these views is important to determine best practice.

Approaches to the treatment of addiction are continually evolving and, in order to effectively respond to these changes, nurses and other health care workers need to be aware of contemporary substance use and associated issues.

This year the oration was delivered by Dr Daryle Deering, the first New Zealand life member of DANA. She gave her personal perspective on the theme of Many faces of addiction and ended with the statement featured on this page.

Another New Zealand nurse and DANA member, Anne Carroll, gave a presentation about her workplace (Higher Ground in Auckland) becoming smokefree. Anne had been awarded the Professor Margaret Hamilton Scholarship in order to attend and present her work and she captivated the audience not only with the content of her presentation, but also with her stylish shoes!

Anne’s and Daryle’s presentations (as well as others at the forum) are available on the DANA website at www.danaconference.com.au

In New Zealand DANA has always worked closely with Matua Raki and Te Pou to support addiction nursing expertise and to collaborate on initiatives which enhance the opportunities for professional development.

Our next collaborative initiative will be another Addiction Nursing Seminar which will be held in Wellington in March 2016, and will once again showcase presentations from around the country. If you are interested in presenting at this seminar please contact Klare Braye at Matua Raki.

To find out more, please visit the DANA website, www.danaonline.org.
Primary care – ‘addiction is everybody’s business’
by Anna Nelson

In the latter half of 2014 Matua Ra ki was invited by two of the largest Wellington public health organisations (PHOs) to provide ABC for alcohol screening and brief intervention workshops for their staff and practices. Te Awakairangi Health Network, the biggest PHO serving the Hutt Valley and Compass Health covering Wairarapa, Hutt Valley, Kapiti and Wellington, are implementing the ABC alcohol screening and brief intervention model.

Attendees at the workshops ranged from practice nurses and general practitioners through to the Well Health teams who operate outreach, health promotion workers (including dietitians and diabetes nurses) and primary mental health teams who work with clients/patients across a range of issues and interventions.

Matua Ra ki believes that ‘addiction is everybody’s business’ and as such has been delivering screening and brief intervention training to a variety of audiences for a number of years. Matua Ra ki was particularly happy to be asked to support the primary care workforce as we know many people with problematic substance use will never access specialist services, and that primary health and community care settings are the perfect places to:

- initiate conversations about substance use
- engage people
- screen for substance use
- provide brief advice and interventions as appropriate
- provide ongoing referral.

The ABC model of screening and brief intervention (similar to the ABC approach to smoking cessation) stands for Ask, Brief Advice and Counselling. It is promoted by the Health Promotion Agency (HPA) and the Ministry of Health as an appropriate model of alcohol screening and brief intervention to use in a range of primary health care settings.

Workshop participants were able to explore attitudes, values and assumptions about people who use substances; understand some basic alcohol (and other drug) effects, both in the short- and long-term and across the lifespan; and appreciate the concept of a ‘standard drink’ and the HPA low risk alcohol drinking advice. They learned about practice and implementation of the ABC approach and pathway alongside their colleagues and the AUDIT C that is integrated into their patient management systems/dashboards.

As part of the ABC approach, workers in primary care settings who complete ABC training are expected to be able to use the AUDIT C, offer brief advice, assess readiness to change and, where appropriate, refer to brief counselling (usually within the PHO or with local specialist addiction services).

The invaluable role brief interventions play with many people who use substances harmfully, but may never seek treatment through an addiction service, was highlighted. Participants were encouraged to practice some basic strategies and approaches to brief intervention including understanding ‘motivational approaches’ the ‘Wheel of Change’ and ‘FRAMES’ – a brief intervention acronym that encourages the provision of non-judgemental ‘Feedback’, client self ‘Responsibility’, ‘Advice’ that is realistic and pertinent, a ‘Menu’ of options suggested, and an ‘Empathic’ style in which ‘Self efficacy’ is encouraged.

Anna Nelson and Klare Braye have provided various training to these PHOs, each adapted for the target audience and requirements of the practitioners attending. The participants have been open and enthusiastic about realistic, manageable and ‘brief’ approaches to facilitating discussions about client/patient substance use. This has made the training fun and engaging.

Matua Ra ki is open to discussions with all PHOs about training and support regarding substance use interventions. Please contact Anna Nelson, programme lead, Matua Ra ki, anna.nelson@matuaraki.org.nz.
Christine Ball was appointed associate director of nursing – Mental Health and Addictions Service for the Nelson Marlborough District Health Board (DHB) in February this year. This came after approximately 30 years of mental health nursing which began in 1983 when she started her hospital-based training at Kingseat Hospital, Auckland.

Once registered she moved to Nelson and has worked in several different areas of the mental health service including inpatient, community and management roles. During this time Christine completed her Bachelor of Nursing degree.

“That was a real turning point for me,” she says. “Studying towards a degree opened up a lot of doors including the opportunity to become involved in nursing education.”

Prior to becoming an associate director of nursing (ADON), she was a senior academic staff member at Nelson Marlborough Institute of Technology teaching mental health nursing for 12 years. She continued with her post graduate education and has almost completed her Master of Health Sciences thesis. The thesis explores new graduates’ experiences of violence and aggression and how well prepared they are to respond to it.

Christine believes her appointment to the ADON position is a result of having the support and mentorship of colleagues throughout her career and ‘being in the right place at the right time.’ The move into nursing leadership has been a natural progression with clinical experience, education and involvement in professional networks providing relevant preparation for the role.

Christine's key message for nurses aspiring to leadership is to make the most of learning opportunities.

“Post graduate education provides a lot of opportunities; it is not just about obtaining the qualification, but the process of researching and networking that goes along with it is invaluable. It provides a broader perspective and an awareness of what is happening nationally and internationally.”

The ADON role is part of the professional nursing leadership team for the DHB. A key aspect of the work is ensuring mental health and addiction nurses have sufficient infrastructure including training and education, processes, policies and guidelines in place to deliver quality nursing care in community and inpatient settings and across the Nelson Marlborough region. This includes student nurses on clinical placement and new graduates.

Christine says there is an increasing need to work with nurses in primary health and non-government organisations. There is also a need to develop clinical leadership positions such as clinical nurse specialist and nurse practitioner roles to recognise the specialist nature of mental health nursing and to provide clinical career pathways. To achieve this effectively Christine works collaboratively with management, medical staff, allied staff and nurses.

“A lot of what I do involves working with others,” she says. “It’s really important to involve and consult with those who are going to be directly affected by any developments. That way you get the benefit of collective wisdom and a greater degree of cooperation.”

Restraint coordination across the service is also part of her role, with the goal of reducing the use of restraint and maintaining safe practice. It provides an opportunity to liaise and establish relationships with services outside of mental health such as medical/ surgical wards, emergency department and day stay units.

For mental health the focus is on implementing the Six Core Strategies® initiative and Christine is part of the project team driving this. The latest development has been the introduction of safe practice and effective communication training which has an emphasis on communication skills and will replace calming and restraint as the mandatory training for mental health staff.

Christine is part of the national body of Directors and Associate Directors of Mental Health and Addictions services which enables liaison with others in similar positions and with representatives of the Chief Nurse’s Office, Te Pou, the Nursing Council and the Ministry of Health.

“It is important for those of us working in smaller regions to be involved at a national level. Knowing what is happening in larger centres, advocating for nurses working in smaller and often isolated areas and the pooling of resources are all part of belonging to this network,” she says.

Having been in the position for almost a year, Christine is busy planning for 2016.

“The first year of this position has given me a greater understanding of the direction mental health services are heading in and the role nurses have in this. It has also given me renewed respect for frontline nursing and the challenges these staff face in providing quality care that is consumer focused.”
While in Queenstown for the 5th Australasian Mental Health Outcomes and Information Conference in November I made use of the opportunity to meet with the Central Lakes Community Mental Health Team Queenstown Office. I spent a few hours with Jo Harry, clinical nurse manager and her team, listening intently to the work they do, sharing key aspects of our work and discussing some of the poignant issues facing mental health and addiction services today. Further opportunities to connect with a number of nurses in the Southern area arose at the conference, and I came away feeling very energised by those conversations.

This story captures some of the unique aspects about working in the Queenstown area.

Queenstown is an international resort town located in the South Island of New Zealand. Opportunities for adventures and thrills are plentiful. Tourist numbers peak over the summer season and spike during winter as thousands of Australians take advantage of the package deals which result in 3-4 direct flights each day from Sydney. It is known as a ‘party town’ and alcohol use is high. Recently, the use of methamphetamine has increased.

Queenstown has a population of around 30,000 people who largely work to serve an estimated two million visitors each year. There are large numbers of foreign nationals working in this town ranging from 19-30 years of age (the cut off age for work permits). It is a growing population of people aged mainly in their 30-40s.

You need to be able to work to live here. Two incomes are needed to survive as the cost of living is high. Some of the population are low income earners and many of those will not have community services cards, therefore they are often unable to afford to see a GP. This includes people experiencing mental health and or addiction problems who do work. Costs to access a GP for health care range from $56 (if enrolled) or $93 (if not enrolled).

People receiving an invalids’ benefit struggle with the high cost of living. People experiencing mental health and or addiction problems who do not work frequently move out of this area due to the high cost of living.

It sounds picturesque and it is. However, the local Mental Health and Addiction Community Team sees the adverse impact that living in an international resort town can have on the lives of people and their families. In particular the high use of alcohol, which is a socially accepted part of the party town culture, and the impact of consumerism on peoples’ lives which often leads to depression or anxiety.

The service

The Central Lakes Community Mental Health Team formed in October 2014 following the merge of two separate community mental health teams. This merge contributes towards the Southern District Health Board (DHB) strategic plan Raise HOPE – Hāpai te Tūmanako. This service covers a large geographical area and is based in two locations. Part of the team are located in Frankton, Queenstown just opposite the Lakes Hospital with a glorious view of Lake Wakatipu. The other part of the team is located in Clyde, on the Dunstan Hospital site, also in an outstanding rural setting. The closest urban hospitals are between 2.5-3.5 hours away in Invercargill or Dunedin.

The clinical team manager is Jo Harry. She and Annie Jennings, the clinical nurse specialist, work across both sites. Team clinicians work...
district wide according to the needs of the community. The use of technology is embraced in this rural setting. For example, psychiatrist clinics frequently use Lync (a Skype service internally within the DHB) or video conferencing. Technology is also used by staff for training and education opportunities or clinical supervision.

Supporting people who access the service includes attending to their social needs such as finding a place for a person to sleep as there are no night shelters, or getting them a bus ticket. In Queenstown the Salvation Army and Happiness House are two community agencies that provide invaluable support to people in need.

Staff believe that as a team they have a wide range of skills enabling them to effectively respond to the needs of the people accessing services. Staff in both sites provide after-hours cover in addition to the usual work day. They are all trained as Duly Authorised Officers. In Queenstown staff work on their own when they are on-call, but feel well supported by their team.

“The team will gather around and provide support at the drop of a hat. Issues related to assessing and managing risk are shared. We all have a really good sense of each other’s workloads,” Jo Harry says.

The average call-out is 10 hours which is the time required to assess a person experiencing acute mental health problems and, if needed, to transport that person to an inpatient unit in either Dunedin or Invercargill. The sustainability of the after-hours service is currently being examined. Staff commented that supportive partners with supportive employers, especially for those with children, are needed given the length of time some callouts take.

Queenstown

The Central Lakes Community Mental Health Team (Queenstown office) is nestled just below the Lakes Hospital in Queenstown on a small hill overlooking the glistening Lake Wakatipu and the lightly snow-dusted peaks of the Remarkables. In this service the number of people assigned to each staff member fluctuates quite a bit due to the tourist and transient nature of its population. There are only a few people engaged in the service who experience ongoing mental health and addiction problems. The short-term use of some services by people does mean that the staff often see people recover quickly which is a rewarding aspect of working in this area.

“We can see we made a difference,” says Jo Harry, Referrals can be for a range of mental health and addiction issues. Staff say the overuse of alcohol and other substances by some people more often than not triggers a series of events that adversely impact on their lives.

For many financial worries and relationship problems impact on their health and wellbeing and result in anxiety and depression. For example, the pressure to maintain a high lifestyle in a relationship can be strained by a planned or unplanned pregnancy. For some women new to New Zealand, such as Asian or UK women, post-natal depression is common. The absence of grandparents to support a new mother, or the absence of a partner who has had to increase their work hours to make up for the reduced income, can exacerbate feelings of despair. Some may not be able to afford childcare to enable the mother to return to work.

If the relationship breaks down and there are children this brings unique challenges especially if one of the parents no longer wants to reside in New Zealand. Shared care arrangements are now common and often children spend half their time with each parent. However, following a relationship breakdown, if the mother is from another country, she may get depressed as there is no support and she can’t return to her home country with her children due to custody arrangements. She may be faced with a choice to return home without her children. The recently released Supporting parents with mental illness and or addiction and their children: A guideline for mental health and addiction services is currently being embedded into practice and provides clinical staff a framework to consider.

The team also provides support to students. One of the local high schools provides a boarding facility and there is a tourism training resort college used by many students who are experiencing problems with their mental wellbeing.

If a person requires inpatient mental health care this can be accessed in either Dunedin or Invercargill. Admissions from Queenstown are often people who are travelling and English is not their first language. Different time zones between New Zealand and their country of origin make communication difficult and many have no support networks. Many of the people admitted do not return to the Queenstown area as they return back to their home of origin.

This team is keen to develop stronger links with the leaders of primary care organisations and would welcome more NGO services to help them respond to the mental health and addiction needs of this growing and transient population.
Who are we now? The 2015 National Care Manager Forum
by Anthony Comerford and Teresa Turish

In October 2015 Anthony Comerford and Teresa Turish, both nurses from the Mental Health, Addictions and Intellectual Disabilities Directorate, Te Korowai Whariki, 3DHB facilitated a two-day National Care Manager Forum at Te Papa, Nga Wahi Akonga in Porirua. Their co-hosts were two community based care managers, Tracey McArthy from Navigate and Brendan Hayward from IDEA RIDSAS, which gave the team a great opportunity to show how cross service collaboration can work in practice.

The Care Manager Forum was initially part of the wider Mental Health Intellectual Disability Conference but has evolved over the last couple of years to focus specifically on care management. It was the first time Te Korowai Whariki had hosted the forum and the organisation received funding from Te Pou to help organise the event.

Care managers are drawn from a number of different disciplines, but their role is defined under the Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDCCR Act). They are legally entrusted with the oversight of the treatment and rehabilitation of people who are cared for under this legislation.

It’s a role that carries enormous responsibility but care managers form a small proportion of the workforce and can easily become isolated within specific services or regions. This sort of forum is therefore a much-needed opportunity for collective examination of issues related to care management and for the development of some best practice guidelines.

The pair collaborated with colleagues and with local community based disability service providers in organising the forum, and found it a daunting task initially.

“This was a first for both of us!” they say.

“Neither of us had undertaken anything of this magnitude and we were fortunate to have on hand the expertise of Intellectual Disability Services educator Nicola Adams; the support of national manager Intellectual Disability Services Rachel Daysh; and the enthusiasm and hard work of care manager, IDEA RIDSAS Brendan Hayward and care manager Navigate Tracey McCarthy.

“The care manager role sits within a legal framework and we tried to provide a balance between education relevant to the legislation and a solid disability rights focus. Having Frances Anderson (regional facilitator, Disability Workforce Development, Te Pou) provide support and information was invaluable. She introduced Let’s get real: Disability and reminded us how the seven Real Skills are all important and interlinked.”
The role of the care manager has changed significantly since the inception of the IDCCR Act, so the chosen theme for the forum was “Who are we now?” Once this was decided Anthony and Teresa were able to identify and approach some suitable speakers and to begin planning the schedule for the two days. Tasks included organising catering, approaching sponsors and planning workshop activities. One thing they thought essential was to protect time for facilitated discussion on topics pertinent to the care manager role.

Anthony and Teresa think the experience has benefited their own career development as well as that of their peers.

“One of the major benefits of having organised this year’s forum has been the positive working relationship we have had with community disability services and service users. Closer ties between care managers nationally has led to greater opportunities to share and to develop positive ways of supporting people with disabilities.

“We feel the forum and its focus on current role-specific issues has encouraged us all to take ownership of what we do. It will also allow us to develop a framework through which we can look at future role development, improved resource sharing, and better collegial support.”

The pair say the feedback they received from the forum was overwhelmingly positive and clearly demonstrated how passionate care managers are about the role entrusted to them and how committed they are to working in partnership with people with disabilities to achieve shared goals.

The enthusiasm of the people who attended the forum was evident in the feedback they gave. Several people commented on how valuable they had found being able to meet other care managers face-to-face, to compare notes and learn from each other. Others focussed on “growing new care managers” and taking time to reflect on practice. This is particularly relevant at the current time as the feedback Anthony and Teresa received showed that 41 per cent of the care managers who attended the forum had been in the role for less than two years. However, the consistent theme was on working in partnership with care recipients and their whānau towards the best possible outcome. When those people who had been employed as care managers over several years were asked “what keeps you in the role?” the overwhelming response was “the clients – helping them to make a difference in their lives”.

Anthony and Teresa also received some useful critique about what changes could be made. “More time for discussion” was a common request and attendees identified some gaps in current training and practice that care managers could consider further as a group.

“One of these identified areas was having a clearer, uniform role definition for care managers, which in turn will inform the orientation and training of new care managers and ongoing professional development,” Anthony and Teresa say.

“And representatives from each region have agreed to work together on this over the next 12 months, and then feed suggestions back to the wider group at next year’s forum. We see this as an extremely constructive outcome.”

Anthony and Teresa have also been nominated to host the 2016 forum in Wellington and say they are really looking forward to it.

“We would like to say a huge thank you to Te Pou and to all those who gave us the support and guidance in putting together the forum. We hope the event will be just as successful next year!”

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**Least restrictive practice**

*by Lois Boyd and Caro Swanson*

**Introduction**

Kia ora from Carolyn and Lois. This is the first of a regular column that will focus on information, initiatives and practice-based research that supports and informs the reduction and prevention of seclusion and restraint. We are co-leading this important work for Te Pou into 2016 and are excited by the positive practice changes we are seeing and hearing about.

Through this column we will share information and updates and we encourage you to let us know about what is happening in your practice area. Eight years on, the Six Core Strategies® are being transitioned into practice by most district health boards and staff members are sharing with us their new and often unique New Zealand twists and adaptations.

These everyday innovations are often considered by people in the workplace to be relatively small occurrences, but we know that in reducing restrictive practices it is often the small but thoughtful things that make the really big difference. A recent example
was shared with us by a person who had completed a sensory assessment and plan to reduce agitation and anxiety when in hospital. He had found that ice-blocks were soothing when he was feeling distressed. He had been using popsicles but his community case manager was concerned about his physical health (http://www.tepou.co.nz/initiatives/equally-well-physical-health/37). Once out of hospital he worked with a family member to make his own low sugar alternative ice-blocks. He shared his recipes with the inpatient team, who now use them in a group activity that introduces healthy diet, sensory modulation and emotional self-regulation.

The person and his family felt they had been assisted and listened to by the mental health service. They also stressed the improvement in his sense of control and the nil use of restrictive practices in his last two hospital admissions, which was a significant change. The community and inpatient teams were mindful of physical health concerns, promoting practices that reduce restriction, supportive peer relationships and activities that promoted wellness and wellbeing.

What everyday innovations that support reducing seclusion and restraint are happening in your workplace?

We would really like to share information from your practice that is supporting your efforts to reduce and prevent seclusion and restraint so please be in contact by emailing either lois.boyd@tepou.co.nz or carolyn.swanson@tepou.co.nz. Big or small, please let us know about it.

What we’ve been reading

Last year Lois read an article that made an impression, about the use of the Six Core Strategies© in a child and adolescent hospital (Azeem, et al 2011). The reductions in seclusion and restraint were large and the article also discussed the importance of using a trauma informed approach. Just this month, Azeem and colleagues have published a 10 year evaluation of their approach (Azeem, et al 2015). This article details the 10 years of implementing the Six Core Strategy© approach and the importance of trauma informed care as a part of this. Outcomes reported include a complete elimination of the use of mechanical restraint and large reductions in personal restraint and seclusion.

Caro has been reading Reducing Stigma Towards AOD Service Users issued by the AOD Provider Collaborative June 2014 (see www.aodcollaborative.org.nz/destigmatisation-research). This is well worth a read and we've been wondering how many people end up in seclusion or a restraint because they are in withdrawal and too ashamed to tell the service about their alcohol or drug use?

Where we’ve been surfing

SAMSHA is the organisation that launched and continues to promote and develop the Six Core Strategy® approach. The National Centre of Trauma Informed Care (NCTIC) and Alternatives to Seclusion and Restraint (www.samhsa.gov/nctic) continues to contribute to the wide range of information and innovation, based on large scale implementation and research, of both the Six Core Strategies® and working in a trauma informed way.

A few months ago Te Pou chief executive Robyn Shearer, in her weekly message, referenced The Hexagon Tool (http://implementation.fpg.unc.edu/resources/hexagon-tool-exploring-context). We have recommended this to a few services now because it is a quick and easy snapshot tool to help an organisation consider whether changes could improve resources readiness and capacity.

Reflecting on…

As we work as a sector towards services free of restriction, coercion, seclusion and restraint, the importance of reflection, understanding the experience and perspective of others and supporting changes based on shared goals are key recurring themes. We believe strongly that the best opportunities for success in this work come from sharing leadership, knowledge, skills, experience, influence and power between people who use services and people who lead and work in services. We enjoy working together in this way as well as meeting with others in the sector co-leading and co-designing services. Again, we would love to hear your co-leadership stories so please get in contact.

References


Solution-focused brief therapy

by Paul Hanton BA (Hons), PG Cert. (Substance Misuse), MA (SFBT), BACP (Accred.), DAPAANZ accredited supervisor.

Paul Hanton is a clinical lead at Te Pou o Te Whakaaro Nui and is the project lead for ADOM (Alcohol and Drug Outcome Measure). His background is working in HIV/AIDS, mental health and addiction in a solution focused way.

While initially a therapeutic intervention/model, solution building talk has become commonplace in areas such as management coaching, sports, suicide prevention, social work and nursing. The language of ‘solution focus’ is quite specific and you may hear terms like “what would that look like” in relation to preferred futures and goals rather than a behaviourist approach of “what do you have to do to get to…” or “what would others notice that tells them that you have…”

The approach is building momentum in New Zealand where it is taught on a Masters counselling programme in Christchurch (www.education.canterbury.ac.nz/healthsciences/study/counselling.shtml). Having a wide evidence base has meant that SFBT is now included in the Te Pou Talking Therapies toolkit which is aimed at supporting primary and secondary health services to deliver effective talking therapies. If you are interested in the evidence base for SFBT, a useful place to start can be found at www.solutionsdoc.co.uk/sft.html.

If you want to learn more about solution-focused brief therapy then check out “The first Aotearoa Solution Focused Practice Conference” which will be held on 4th March 2016, Napier Boys’ High School. Please see: https://www.facebook.com/SFPConference for more information, booking forms and payment details. Paul is on the organising group for this conference outside of his work role as he believes passionately in the solution focused approach.

ADOM update

Since the mandated implementation of ADOM (1 July 2015) 77 of the 78 eligible outpatient, adult community addiction services have begun using the outcome measure, with over 70 per cent already reporting into PRIMHD.

Te Pou is offering sector support to the services through an enhanced website page, e-message group, refresher training and site visits.

Early indications of ADOM use are encouraging with over 7,000 collections being reported, which means 7,000 opportunities for practitioners to discuss reported changes with tāngata whai ora about their drug and alcohol use, health and wellbeing and recovery journey.

The discipline of mental health support work in New Zealand makes up a significant part of the total mental health workforce. This study explored the contribution of mental health support workers taking an Appreciative Inquiry approach. It examines how mental health support workers add value to the quality of mental health services by asking "What is working well?" It examined possibilities for the role of a mental health support worker and discussed what it is that they do that is different from other health professionals in the mental health sector.

The findings from the study recognise the contribution being made by this group of health workers, highlighting what is working well and what could be different, while examining the nature of relationships between mental health support workers, mental health consumers and other key stakeholders. The study could also inform discussion around the regulation/professionalism of the support worker's role and future workforce development. Mental health support workers, in the study, sought to be part of aspirational service developments.

Appreciative Inquiry

The four phases of the Appreciative Inquiry cycle were used throughout the study. The Discovery phase created an environment that encouraged participants to tell stories of their peak experiences. In the Dream phase, mental health support workers and others spoke about 'discovered potentials' and what it is that mental health support workers do that brings a different perspective to that role. Common ideas from the Discovery and Dream phases were further developed through the provocative statements captured in the Design phase into the Destiny goals. The stories and ideas provided a blueprint for a plan to create the aspirational future expressed throughout the study. The blueprint provides the basis on which to design a realistic means for reviewing the current model of service development and delivery, including the role and employment practices around mental health support work.

Figure 1 creates a template to action the findings and recommendations from the study. Hennessy and Hughes (2014) also gave consideration to the use of Appreciative Inquiry as an effective evaluative tool that could be used within mental health services due to its strong alignment with the principles of recovery and strength-based practice.

Role of mental health support workers

Mental health support workers provide a unique role within mental health services. In order for their true potential to be realised, they want and need to be involved in service planning and (just as importantly) involved and informed about service delivery. It is the view of mental health support workers that mental health services need to strive for aspirational services rather than being content with mediocrity. These aspirational services need to be based on realness and not on buzz words. In order to meet these aspirations there is the need to break down real and perceived barriers in order to view what is legitimate citizenship for consumers.

The role of the mental health support worker is different and complementary to the roles of other professionals working in mental health services. Mental health support workers facilitate the consumer's journey of recovery. They are able to spend time with mental health consumers and not have those interactions restricted through legislation. Mental health support workers provide the human contact sought by mental health consumers because their role is seen as non-clinical and non-judgmental. They create space in the life of the consumer that enables hope for recovery to be the consumer's aspirational future. Managers, educators and other health professionals require an understanding about what it is that mental health support workers bring to the relationship that they have with consumers and how that knowledge can assist other health professionals. This relationship is built up over time and displays qualities distinctive from other professionals. These qualities offer a unique form of support and care, which is highly valued by consumers. It seems that being on-the-ground alongside the people they work with, being flexible, and offering their own unique personal characteristics to the relationship (i.e. they become real people known by more than their name) offers a different type of healthcare and support.

The mental health support worker comes to know the client in their own home, and social context, they discern the consumer's aspirational
hopes and they listen to their fears. The relationship with consumers is time intensive, and provides care and support. It affords a non-judgmental and non-clinical way of working. Because the mental health support worker is free from formal assessment and treatment responsibilities, they are able to engage at a level that engenders trust and openness with consumers.

Paradoxically it seems that the very characteristics that professionalise a role with regulated health professionals may be the barrier preventing the ‘knowing of others’ within the relationship. This is an authentic relationship that fosters possibilities for recovery. In order to have potency within that relationship, the study has revealed that it is important that the right mental health consumer is matched to the right support worker, the chemistry of the relationship matters. Elliot and Alderson (2008) suggest that the “key to support work is knowledge of self and the community and that knowledge fuels our passion” (Elliot & Alderson, 2008, p. 4).

Managers of mental health services need to recognise and understand their own roles and how these can be enhanced so that they are better prepared to work alongside the mental health support workers. While the emphasis of the study was on mental health support workers, it has become clear that managers are critical to the success of the utilisation of this workforce.

Summary

Three main themes were identified from the study, these are set out below and in Figure 1:

- aspirational service framework
- professionalisation of the mental health support worker
- employment practices.

![Figure 1: Blueprint to meet the aspirational future](image)

References


I am a recently appointed charge nurse manager of the Otago Regional Forensic Mental Health Services. I have completed a Master's degree by dissertation on workplace violence titled: workplace violence against psychiatric nurses and the impact on nursing practice: an integrated review.

ABSTRACT

Objective
The principle objective of this study was to identify the effects of workplace violence on nurses working in mental health inpatient settings, and the impact of this on nursing practice, as reported in the literature. An additional objective was to identify the barriers for reporting workplace violence.

Background
Psychiatric nurses, by virtue of the central role they play within the health care team, are particularly vulnerable to violence from patients in adult mental health inpatient settings. Workplace violence against health care workers is a common and widespread phenomenon. Understanding of this phenomenon is limited by lack of consensus amongst health professionals about what constitutes violence, and the lack of clear, accepted definitions. Psychiatric nurses’ experience of workplace violence has the potential to have a negative correlation with job satisfaction and performance, which impacts on patient care and consequently the effectiveness of the health care system.

Methodology
An integrative review was conducted of the literature from 2001 to 2013 using the CINAHL, PsychInfo and MEDLINE databases. The web search engine, Google Scholar, was also checked for reproduction of the most popular articles associated with workplace violence. Rigour was enhanced by use of the Joanna Briggs Institute processes for critiquing and analysing literature. Fourteen studies met the criteria for inclusion in this review.

Results
Psychiatric nurses are likely to encounter violence in the workplace from patients at least once in their career. The most commonly reported workplace violence is physical assault, followed by verbal abuse and threats. Psychiatric nurses who experienced workplace violence have been shown to experience a range of symptoms, including somatic and psychological effects. Psychiatric nurses commonly reported the effects of exposure to occupational violence to be associated with reduced productivity, decreased job satisfaction, burn-out, increased use of sick days, and drug and alcohol abuse.

Practice implications
Despite different countries, cultures and research designs, psychiatric nurses’ responses to workplace violence in adult mental health inpatient settings were similar. The integrative review identified an array of physical and psychological effects experienced by psychiatric nurses after being subjected to violence in the workplace. The effects were derived from review of 14 studies, conducted in nine countries, and all in adult mental health inpatient settings. Due to the different study methods, populations studied, and the definitions of violence, some studies were not directly comparable. Despite this, the findings effectively highlight psychiatric nurses’ emotions and responses to violence at the hands of patients in their care. Male psychiatric nurses experienced higher rates of violence compared to their female counterparts.

Email contact details: ronak.singh@southerndhb.govt.nz

Ronak Singh

Calling all nurse researchers or nurses who have conducted research

This is your opportunity to share your findings and go on to publish your results. From experience I know how hard the journey can be - taking the next step to publishing can be daunting. If you would like to discuss this please feel to email me, suzette.poole@tepou.co.nz.
CEP knowledge and skills snapshot

Check out the foundational level knowledge and skills related to assessment of people experiencing mental health and or addiction problems.

The checklist below is a subset of the foundation base knowledge and skills described in Te Whare o Tiki that focuses on assessment. The results could surprise you. If you breeze through then we encourage you to check out the remaining areas on the Matua Rāki website, www.maturaki.org.nz/resources/te-whare-o-tiki-co-existing-problems-knowledge-and-skills-framework/437

### ASSESSMENT: Screen all tangata whai ora presenting to mental health and addiction services for co-existing problems and ensure that a comprehensive assessment and problem formulation is carried out when co-existing problems are identified

<table>
<thead>
<tr>
<th>Knowledge and skills</th>
<th>Foundation - Base knowledge and skills</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
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<tbody>
<tr>
<td>Screening for:</td>
<td>• Has knowledge of and is able to use common screening tools</td>
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<td>• substance use disorders</td>
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<tr>
<td>• mental health disorders</td>
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<td>• problem gambling</td>
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<tr>
<td>Brief Interventions</td>
<td>• Has knowledge of brief interventions</td>
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<td>• Demonstrates the ability to use simple brief intervention strategies with people with co-existing problems</td>
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<tr>
<td>Mental health, substance use and gambling assessment</td>
<td>• Has knowledge of mental health, substance use and gambling disorders</td>
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<td>• Demonstrates the ability to briefly assess recent and lifetime mental health symptoms/problems</td>
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<td>• Demonstrates the ability to briefly assess recent and lifetime substance use (patterns of use and previous treatment)</td>
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<tr>
<td>• Demonstrates the ability to briefly assess recent and lifetime gambling behaviour (patterns of gambling and previous treatment)</td>
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<tr>
<td>Assessment of impact of substance use, gambling and mental health disorders on children, family and whānau</td>
<td>• Has knowledge of the possible impacts of mental health, substance use and gambling disorders on children, family and whānau</td>
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<tr>
<td>• Has knowledge of COPMIA (Children of Parents with a Mental Illness and Addiction) and the resources and supports for children, family and whānau</td>
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<td>Mental state examination (MSE)</td>
<td>• Has knowledge of the mental state examination processes</td>
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<td>Risk management</td>
<td>• Has knowledge of risk assessment and management principles</td>
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<td>• Demonstrates support for risk management strategies for people with co-existing problems</td>
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<td>Assessment (and synthesis) of relationships between substance use disorders, problem gambling and other mental health disorders</td>
<td>• Has knowledge of potential interactions between substance use, gambling and mental health symptoms and disorders</td>
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<tr>
<td>Monitoring and testing of substances, including alcohol and medications</td>
<td>• Has knowledge of common substance and medication testing procedures and laboratory investigations</td>
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<td>• Has knowledge of common blood and urine tests used with people with co-existing disorders</td>
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<td>Evaluation of 'stages of change' in relation to problematic issues and the application of the model to treatment planning</td>
<td>• Has knowledge of importance of people's motivation to change and their goals in relation to each problematic issue</td>
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<td>• Has knowledge of the benefits of matching interventions to peoples apparent stage of change for each problematic issue</td>
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Meri Kirihimete
and
Season’s Greetings
from the team at
Te Pou
o Te Whakaaro Nui