EDITORIAL Welcome to our second issue

Haere mai, hello, welcome back and, to those of you who are new readers, a warm welcome to the second issue of the Mental Health and Addiction Nursing e-newsletter. We received loads of great comments about the first issue. Nurses and other people with an interest in mental health and addiction nursing have told me how they appreciated reading first-hand about the wide and diverse nursing activity that is occurring nationally, and a number of readers have taken the opportunity to connect with one another. I am more than happy to assist with networking in any capacity, so please just contact me.

WHO IS CHRIS SEU?

We profile the second of our nurses who so generously posed for the photos pictured in the masthead, above. Chris Seu is the most recent of the group to have graduated, having completed his Bachelor of Nursing in the last few years. Chris discusses some of the challenges that are still there for men entering the nursing workforce, and the rewards of being able to work within a Pacific Island mental health team. You can read Chris’s profile on page 6.

THREE NAMES TO CHOOSE FROM

In the first issue, we asked you to email your suggestions for the name of this newsletter. There were lots of great suggestions from people all over the country - thank you for taking time out to enter our competition! The editorial board has narrowed the number of entries down to three and, boy, was that hard! So here they are:

- Handover
- Nursing Comment
- Nursing Matters

You now have until 23 September to have your say and vote for your favourite name by emailing me: anna.schofield@tepou.co.nz

The October issue will bear the new name and the person who suggested it will receive the fantastic gift basket, pictured here. So get voting!!

MORE ABOUT THIS ISSUE

We have a wide range of articles from people across the country, which is what we like to see! Sonja Goldsack (page 3) and Gary Sutcliffe (page 9) have both contributed articles that will get us (especially as nurses) thinking. Sonja profiles the elements of good mental health and addiction nursing, beautifully highlighting what is essential to the craft of nursing and how service users validate that. Gary discusses the learning that can occur for nurses when working in partnership with peer support workers and services. Peer support is a growing workforce and, it seems to me, a lot of gains and learning can come from nurses embracing and working collaboratively with these workers and services.
Readers may already be familiar with a key mental health and addiction workforce development project being led by the Ministry of Health together with the support of Te Pou - Let’s get real: Real skills for people working in mental health and addictions. Also known as Real Skills, for short, the project is about developing a set of essential knowledge, skills and attitudes for delivering excellent mental health and addiction services. Let’s get real recognises and validates current knowledge, skills and attitudes while also ensuring that it takes into account likely future service and workforce development requirements. In particular, it focuses on person-centred care, working in recovery-oriented services, working within communities, and culturally capable practice and ways of working. The ministry sees Real Skills as complementing the requirements of the Health Practitioners Competence Assurance Act 2003 and is committed to ensuring that both work well together.

As part of ongoing engagement with key stakeholders, the Ministry of Health and Te Pou held a workshop on 17 May with the directors of mental health nursing. The focus of the workshop was on how Real Skills fits with current expectations of mental health and addiction nursing practice, and how it might be effectively used as part of performance appraisal or review processes. General feedback from the workshop was that there is a good fit between Real Skills, current professional competency requirements and professional recognition development programmes. It was also seen as a very useful framework for healthcare assistants. There was some discussion about current practice for performance appraisals, including training and working with managers, links to human resources processes and business planning.

In response to the workshop, and as part of developing implementation tools to support the use of Real Skills in practice, the ministry, together with Te Pou, is planning a collaborative project to develop and pilot a performance appraisal tool linked to Real Skills.

In the meantime, the draft Real Skills are being finalised for the ministry’s final round of consultation and meetings in September. More information will be available on the ministry’s website (www.moh.govt.nz/letsgetreal) this month.

If you would like to subscribe to Let’s get real project email updates, please email Susan_Potter@moh.govt.nz

Bye for now,
Anna
You know how some things in your life are a given? Well, I was always going to be a nurse. It was the only occupation I ever contemplated. In fact, when I was only 10 years old I wrote to the head of nursing at a major Melbourne hospital and asked her to save me a place! (She kindly replied, saying that she would.)

When other girls thought Barbie way cool and made her their heroine, mine was Florence Nightingale! When I left high school I went to university where I trained as a general nurse. I worked mainly in medical and palliative care where, despite the emotional toll, I loved being a nurse. During this time, I was often drawn to patients who came in with psychiatric distress - people who had attempted suicide, overdosed or self-harmed and, eventually, I was the one to whom the ward handed these patients. The failure of my colleagues to attend to these people, in even the least humane way, was distressing to watch. Seeing them force charcoal through nasal gastric tubes simply so “they won’t try this again!” or, worse, ignoring them completely through their own ignorance and fear was something I will always remember.

I moved to the mental health wards in the early ’90s, believing that that would be a place where people were treated better. But, sadly, I was wrong. As a nurse, I was often confused about how individuals were treated, insulted or wounded by colleagues. I couldn’t understand why someone would be a mental health nurse if they didn’t believe in their own power to change the way individuals perceived themselves.

Not long after, I fell victim to the nature of internal auditing and spent time on “the other side”. A physical injury prevented me from ever returning to nursing as a career, but nursing as a profession has long remained an interest. After all, it was my first love… and we never forget our first loves!

Along the way I have learnt much about the nursing profession and, in particular, mental health nursing. These days I spend much more time training nurses around recovery-oriented services, or speaking with them in research. Service users also share their stories time and time again. From all of this, I have made the following observations about the nurses who make an incredible difference in the lives of individuals, and in mental health nursing:

• If you’ve done your job well, we will remember your name like you remember the small things about us.
• If you’ve done your job well, we will remember the time you gave us.
• If you’ve done your job well, you acted always in a way that advanced nursing as a respected profession.
• If you’ve done your job well, you asked us if we were in pain when we self-harmed again and then provided adequate pain relief and a hug, rather than judgement and criticism.
• If you’ve done your job well, you took it professionally and changed your plans to accommodate and support us.
• If you’ve done your job well, you cared greatly about our physical health and you took steps to encourage and motivate us towards taking action.
• If you’ve done your job well, you were courageous, and prepared to stand up against managers, families and colleagues when we needed you to.
• If you’ve done your job well, you didn’t see service users as a threat. You recognised the value of peer-run organisations and did whatever you could to assist them in working well.
• If you’ve done your job well, you cared for your colleagues. You shared their goals, aspirations, birthdays and cups of tea, knowing that they would do the same for you.
• If you’ve done your job well, you are inspiring, leading and making a difference.

Nurses continue to be the main workforce in mental health and, as such, in my belief, have the greatest amount of influence in practice. Mental health nurses have the ability to lead the way in ensuring services are recovery-oriented and supporting individuals to live well, in the presence or absence of their mental illness. Nurses are, and always will be, way cooler than Barbie!

Sonja Goldsack
Sonja is director of Goldsack Consulting, a consultancy offering research, advice and training to the government sector and NGOs in the mental health sector. Sonja also works part-time as national project manager/facilitator for Blueprint Centre for Learning in Wellington, as well as currently completing her PhD on Recovery from Mental Illness – Development of a Consumer-Driven Approach, at Victoria University. Sonja can be contacted by email: sgoldsack@xtra.co.nz
Mental health non government organisations are as diverse as any other health providers - they range from small to large national organisations providing a host of different services, depending on the needs of the service users and the funding available. The majority of these non government organisations (NGOs) are mid-sized and include residential and non residential services. And just as these organisations are diverse so, too, are the skills a registered nurse (RN) needs to work within them - you truly do become a “Jack of all trades”.

My experience as the RN and quality coordinator for Hillcrest Lodge, on the Kapiti Coast north of Wellington, illustrates this beautifully. Hillcrest Lodge provides community residential support to 20 residents, aged 40 to 70 or so, who live in four connecting properties on a large lifestyle block.

Our multicultural residents’ needs are high and complex, with the majority having enduring and severe mental illness. They come from many sources - other NGO providers, forensic medium secure units and acute inpatient units - via service coordination.

We are experienced in supporting residents who are on community treatment orders (CTOs) and have complex physical and aged-related conditions, and we have cared-for residents (with the support of district nurses) who are dying and choose to stay in familiar surroundings.

Here are some of the many roles that I need to fulfil at Hillcrest:

**Broker**
Arrange complex supports with various agencies to meet residents’ identified needs. Encourage institutions - ACC, DHBs, WINZ - to think outside the box.

**Coordinator**
Visits, activities, social events, leave entitlements.

**Personal carer**
Assist with daily activities, so that I understand the requirements needed, observe physical health and follow post-op discharge instructions.

**Domestic help**
Assist with preparing food, shopping with residents and providing guidance on household chores.

**Therapist**
Support through cognitive and diversional approaches.

**Dietician**
Support healthy options and advocate for resources to maintain healthy diets.

**Advocate**
Stand up to community discrimination, eg, challenging unfair trespass orders in local shops. Being assertive with mainstream health providers to ensure those with mental illness receive the appropriate service in a timely manner, eg, challenging attitudes of staff in medical wards over care, or lack of it.

**Pharmacist**
Work with pharmacists and multiple prescribers to ensure safe practices. Question from an informed base, supporting residents to provide narratives of their experiences with medications. Ensure safe administrative practices with all staff.

**Educator**
Provide materials and opportunities for discussion to both staff and residents. Provide competency training, and assessment of, community mental health support workers (CMHSWs).

**Delegator, supervisor, supporter**
All of these things in relation to key care plan areas with CMHSWs, and also when residents are developing and reclaiming skills, such as self medication of insulin etc.

Working at Hillcrest would be the most fulfilling and challenging of all my RN roles. I am very fortunate that I work with other RNs and CMHSWs, and have wonderful support from practice, district and community mental health nurses, GPs and psychiatrists in the Kapiti area. I find that my physical health knowledge has increased dramatically as a result.

Yet when I talk about the work I do with other mental health nurses, they often imply that somehow this is not real nursing or that it is pretty boring. Let the following case study illustrate, then, that this is most certainly not the case!

**Mrs T’s recovery journey... and the untethered goat**

**History**
Mrs T has a long history of bipolar disorder and type 2 diabetes, and is insulin dependent. Mrs T’s management has been challenging, her dietary regimen combined with her unstable behaviour means she was on large doses of insulin twice daily, and it required external administration.

Mrs T has had many different primary care provider and this has made continuity of care difficult for her and her mental health care team.

Living at home with family proved too difficult and she was placed in varying types of residential care facilities and on a community treatment order. She came into...
Mrs T began to experience the benefits of specialist and full physical reviews by a GP provider and given access to a diabetes nurse with the mental health team and family. She assessment and monitoring was carried out in conjunction with Mrs T, and regular acute symptoms. The RN set up a lifestyle and care plan required extra medication to help manage snacks were biscuits and potato chips. She have noticed there does not appear to be a national stakeholder group to represent specific groups to nominate representatives of their sector to be involved in a range of activities. Since I started in this role, I noticed there does not appear to be a national stakeholder group to represent.

Mrs T’s mental state was labile and volatile; she spent large amounts of time in a distressed state. Her diet consisted of large amounts of processed foods and soft drinks, snacks were biscuits and potato chips. She required extra medication to help manage The RN set up a lifestyle and care plan in conjunction with Mrs T, and regular assessment and monitoring was carried out with the mental health team and family. She was enrolled with the local primary care provider and given access to a diabetes nurse specialist and full physical reviews by a GP. Mrs T began to experience the benefits of integrated mental health and primary health care.

One challenge was to address her lifestyle choices. Day to day in-home support from the RN and CMHSWs was established to assist her with these. From the day of Mrs T’s arrival at Hillcrest, she experienced a change in her dietary regimen; she was introduced to fresh foods, cooked from scratch, offered healthy food options and encouraged to take responsibility. She became involved in growing vegetables in the garden and shopped with staff at local market gardens. Slips occurred, but Mrs T was given support and positive reinforcement. As her blood sugars started to lower and, with that her mental state improved, she became less agitated, demanding and aggressive in her engagement with others.

Access to healthy food, with an emphasis on low fat and low sugar, combined with increased exercise, was the platform to stabilising Mrs T’s diabetes. The RN liaised frequently with the GP and diabetic nurse and also provided regular monitoring and education, not only to Mrs T but also the CMHSWs. Her psychiatrist was advised of progress and this resulted in her medication being decreased. Within six weeks of these interventions, Mrs T’s insulin was reduced to 24 units in the morning and 10 units in the afternoon. Her blood sugar average was 8.5. After 10 weeks, her weight was down 10kg.

The keys to addressing Mrs T’s health issues were her participation, the commitment of the people who interact with her daily, and the oversight of RNs. An experienced mental health RN, in partnership with the service user, local primary health care providers – GP and diabetes nurse specialists – can improve physical health which supports good mental health outcomes and recovery.

And lastly… the goat

Every day I feel privileged to work within this environment, but I am often asked if I “have trouble with the community” (we still have a long way to go to break down the walls caused by ignorance and misinformation concerning those with mental illness), and I say the biggest trouble we have had has been with our goat, when it got loose and ate the neighbour’s gardens.

In front of one of our residents, Mr P, the neighbour challenged me on why we didn’t properly restrain our animal. Before I could answer, Mr P interjected: “we have a no restraint policy, don’t you know”.

It is humourous moments such as this, that make you realise your efforts do not go to waste!

The nursing leadership role within Te Pou aims to be inclusive, and often requires specific groups to nominate representatives from their sector to be involved in a range of activities. Since I started in this role, I noticed there does not appear to be a national stakeholder group to represent NGO nurses for mental health or addictions. As these roles are very different from DHB nursing roles, it makes sense to bring NGO nurse leaders together to represent, inform and peer support each other and the sector. We would like to begin by identifying nurses in various leadership positions - governance, quality, nurse managers and nurses leaders - within NGOs, then aim to form some type of national NGO nurse leader group. If you are interested in this, too, please contact Anna Schofield, or if you know of nurses working in the sector encourage them to do so. Email: anna.schofield@tepou.co.nz

He community houses eight months ago, 25kg overweight, on 84 units of insulin in the morning and 22 units in the afternoon. Blood sugars average was 18.6.

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Frances Hughes
RN, DNurs, ONZM

As well as working as a mental health nurse and a quality coordinator at Hillcrest Lodge, Frances does work for the WHO. She has had 25 years of experience in the New Zealand health service, working as a registered nurse, manager and educator. Frances has played a major role in nursing leadership in New Zealand, and was instrumental in the development of government policy around nurse prescribing, and nurse practitioners. In 2005, Frances received a Queen’s Birthday Honour and became an Officer of the New Zealand Order of Merit for her services to mental health.
Teenager Christmas Seu was mocked by his mates when he first talked of a career in nursing after helping his mother with her resthome job. So he kept his thoughts to himself, successfully completing a bridging health science year, then a year at physiotherapy school. But in the end, the pull of nursing was too strong and, in 2002, he enrolled in University of Auckland’s Bachelor of Nursing.

A positive second year placement at Faleola Services, a specialized Pacific Islands community mental health service in south Auckland, led Chris to community based mental health nursing.

“Language can also be a big barrier and, in the past, there have been some misdiagnoses because of language issues. Appropriate communication is a big thing; making sure the family understands what is going on and what treatment is required.”

To further improve communication, Chris gets guidance from a cultural supervisor.

“As a New Zealand-born Samoan, I need cultural supervision for guidance regarding Samoan etiquette and language. Although I can hold a good conversation with service users, I’m still learning the appropriate way to communicate with elders using respectful formal Samoan.”

He also has clinical supervision and receives strong support from within his team, he says. Outside work he focuses on his fiancée and family, and works off his stress playing premier rugby league for the Marist Saints.

“League chases away work anxiety and stress. It refizes me and prepares me for the next day.”

This year Chris is doing a couple of psychology papers to get a different perspective on people’s thinking and behaviour and how that affects wellness. There are many opportunities to keep growing and learning in mental health nursing, he says.

Now he has settled into the team, he intends to begin his Post Graduate Diploma in Mental Health Nursing study and undertake new roles within Faleola.

“I can’t see myself moving out of community mental health. I feel right here. It is very rewarding putting interventions into place and getting an outcome that improves life for our service user and family.”
Canterbury Celebrates Nursing

By Anne-Marie Wijnveld

Nurses Day 2007 at Canterbury DHB was a great event that promoted discussion, a way forward for mental health nursing and celebrated the roles of nurses in the region.

Each year the Specialist Mental Health Service of the Canterbury DHB holds a Nurses Day, co-ordinated by the Nursing Directorate and supported by the DHB.

It is an excellent opportunity for mental health nurses across areas in the South Island, NGOs and under-graduate providers and students to network, present and listen to clinical presentations from service areas.

The theme this year was “Positive practice environments: quality workplaces equal quality patient care” and the day opened with the usual buzz of anticipation, coffee to warm us all in the chill Christchurch autumn, and a mihi from Te Korowai Atawhai Services.

The first presentation was from Heather Casey, director of nursing from Otago Mental Health Services and the president of Te Ao Maramatanga. Heather presented her vision for mental health nursing, which set the direction for the afternoon’s session on creating a vision. Important factors to be considered when developing a vision were values, attitudes, leadership, knowledge and skills, and working collaboratively across sectors.

Linda Smith and Fiona Clapham advocated the use of advanced directives in mental health and encouraged nurses to work positively with service users in the development of these. The pair promoted the views of service users, who strongly believe advanced directives are pivotal to future working relationships and their recovery.

Rebecca Clark and Sharon Isherwood presented on the huge improvement to service user care, reduction of incidents and improved staff morale in the Psychiatric Services for Adults with an Intellectual Disability (PSAID) since the introduction of the clinical nurse specialists (CNS) positions. They have been pivotal in driving changes in practice, increased staffing through a proposal for change, and collaboration between staff and service users. Nursing recruitment and retention has improved, and nurses feel more involved in the development of the service.

The afternoon was devoted to focus-group work looking at what needs to be attended to in regard to developing a 10-year vision for mental health nursing.

The focus groups were preceded by a panel identifying key considerations from each of their perspectives. The panel incorporated nurses working at executive level, NGOs, primary care, Pacific Trust, education centres, service users and family and whanau advisors.

Key themes to emerge were recruitment and undergraduate nursing education. It was agreed that one way of assisting with recruiting was to increase the profile and value of nursing in communities. Some solutions offered were promotion of mental health nursing as a career through secondary and tertiary education providers and developing an under-graduate pathway for mental health nursing with strong clinical leadership and support.

Sustaining the nursing workforce was another major theme - nurses want to be listened to, valued, supported (to prevent burnout) and have healthy workplaces. Nurses also value the protection of time spent with service users, gained by having decent technological equipment and good clerical support in the workplace.

Anne-Marie Wijnveld

Anne-Marie is a nurse consultant in Te Awakura, Hillmorton the Acute Inpatient Services at Canterbury DHB. The role has a strong focus on restraint minimisation, service user involvement to promote recovery and career development focus for the nurses within the services. Anne-Marie completed her training as a comprehensive nurse in 1986 and is currently completing a Master’s in Health Sciences. She can be contacted via email: Anne-Marie.Wijnveld@cdhb.govt.nz
Late in 2005, I was one of eight clinicians who embarked on a dialectical behaviour therapy intensive training programme run by MidCentral DHB.

Dialectical behaviour therapy (DBT) is a programme for service users experiencing difficulties with emotional regulation, in particular, those with the diagnosis of borderline personality disorder. Those who enter into the programme commit to meeting with an individual therapist on a weekly basis and to attending a weekly skills group. Service users learn psychosocial skills in the group and are helped by the therapist to apply these to their daily life.

With me on the 18-month training were four psychologists and three social workers. The course required us to expand the existing DBT programme at MidCentral.

Having worked previously with service users who have committed suicide, I noticed I was becoming increasingly cautious and stressed by suicidal behaviours in service users. The training was excellent and really informed my practice, giving me the knowledge I need about effective interventions for addressing a range of problematic behaviours and helped me to develop skills to deliver these interventions.

**Keeping clinicians motivated**

DBT is a supportive package for both service users and clinicians. Several aspects of it help to keep clinicians motivated to work with service users whose behaviour can be very testing.

DBT clinicians have weekly meetings that are unlike our other team meetings: we have become a consultation group and agreed to DBT ground rules that support healthy, challenging discussion among colleagues. In short, we are committed to applying the skills that we teach our service users to our own lives and our consultation group is ideally a reflection of this. When we slip up, our colleagues are expected to identify this openly and help us get back on track. This helps us to keep renewing the energy of the consult group, rather than it becoming another meeting in our week.

**A hierarchy of behaviours**

DBT has a hierarchy of behaviours that therapy needs to address – firstly, suicidal behaviours, then the need to decrease therapy interfering behaviours, ie, any behaviour that gets in the way of the therapist wanting to work with the service user. This reflects the importance of the therapeutic relationship in DBT; working out problems in the therapeutic relationship is excellent skills practice for the service user and is intended to be done in a supportive and open manner. This helps to keep me motivated, and I’ve also found that it helps promote genuineness in the therapeutic relationship. In many therapies, service users drop out, and the DBT focus on engaging the service user and genuinely wanting to help them helps keep them in therapy and hence reduces their suicide risk.

At present, MidCentral has two skills groups and two consult groups running - a child adolescent and family group and an adult group. Both groups have their own consult group, which the individual therapists and skills trainers attend. We are looking at ways of implementing more consult groups, and have more skills groups planned for the future.

**Looking to a healthier future**

A more consistently trained workforce is emerging, which will hopefully help to reduce burnout and enhance recruitment. This work will also indicate we are adhering to international recommendations for treating self-destructive service users.

Service users with high-risk behaviours can be testing for even the most skilled and committed clinicians. Through being consistent with DBT principles, as this is the best therapy for working with suicidal and emotionally dysregulated service users, we can expect a lower suicide rate in service users, and improved quality of life for them.

Vivienne Filkins

Vivienne is a community mental health nurse with Midcentral DHB and is trained in Interactive Therapy and DBT. Vivienne sees Interactive Therapy as an extension of her passion for her creativity - prior to training as a nurse, she worked in art galleries in London and has a degree in History of Art. A change in career was prompted by doing voluntary work with young homeless people in central London. Vivienne completed her mental health nursing training in 2003 in Plymouth, in the UK, and moved to New Zealand with her partner in 2004. She can be contacted via email: Vivienne.Filkins@midcentral.co.nz
FROM DUSTY SHELF TO VALUED INTRANET RESOURCE
an online education and training framework

By Stuart Marks

A novel idea from Otago DHB has made its way into the hearts of staff and the final five of the DHB’s CEO Quality Improvement Awards for 2007.

Last year Otago DHB mental health educators were asked to develop a document that summarised its service-wide education and training, as well as provide the justification for what was being offered.

Cautioned by the reality that many similar-styled documents sit unused in unit or ward shelves, the educators sought to develop a way that the information would be of interest and value to both management and staff.

This resulted in the documents being created electronically and posted on the DHB’s intranet system. As writing commenced, initial objectives were met. However, it wasn’t long before the documents, now referred to as the Education and Training Framework, exceeded the initial brief. The framework was well received, continued to grow and has now become an information portal for all staff to use.

Some of the key features of the framework include:

- List of all courses with synopsis, and flyers for course dates
- Training calendar
- Maps to locate training venues
- List of available clinical supervisors
- An electronic library (which includes the DHB’s self-paced learning package)
- An electronic handbook for educators
- Full time equivalent calculations for course delivery
- Justification for mandatory/additional training
- PowerPoint in-service presentations
- List of staff-recommended websites
- Monthly quality improvement newsletter

All training opportunities available in the wider DHB are listed on the intranet, as well as the various individual teams in-services.

One of the key features that ensured the framework’s success was that mental health educators scripted the framework themselves, which means that it can be edited as required without needing to use the IT department.

Staff say they really enjoy the ability to search for themselves, rather than rely on the traditional information dissemination processes.

If you are looking at developing service-wide documents, I would encourage the use of an intranet based online system.

Stuart Marks
Stuart Marks is the clinical nurse specialist - Ward 9b Acute Inpatient Unit at Otago DHB.
Stuart can be contacted by email Stuart.Marks@otagodhb.govt.nz

FROM DUSTY SHELF TO VALUED INTRANET RESOURCE
an online education and training framework

By Stuart Marks

I am a peer support worker, in training, with Action for Mental Health Society (AMHS), an Auckland-based NGO, and about to embark on a new and exciting contract to deliver peer support services on the North Shore in Auckland.

Firstly, let me say that on the one hand peer support is nothing new - Alcoholics Anonymous is peer support-based and has been around for 70 plus years - but on the other, in mental health, peer support is something of a buzzword, the next in-vogue approach that rolls off the tongue after “recovery”.

Peer support provides people who experience mental illness a form of support that is not medically-based but founded on the strength of people sharing experiences, of empathy and understanding that only people who have actually been there, those who have felt the pain, devastation and demoralising affects of mental illness, can authentically provide.

As described by many people, recovery from mental illness is a journey rather than an end point. It is a journey that determines its own path and is unique to each individual.

For many people who have chosen to work as peer support workers or specialists, this presents an opportunity for us to work in a way that can potentially make a significant difference in the lives of the people we are supporting. Importantly, it also has positive implications for those of us choosing this career.

Through this work, we will continue to travel on our own recovery journey. We acknowledge that no one person has all the skills or solutions necessary, which, in turn encourages the people we are working with...
and supporting to feel that their contribution to the relationship is of equal value.

So, how can peer support interact with and work alongside nursing to enhance the recovery of tangata whaiora? Firstly, I think it’s a given that anyone who works in a support role in mental health chooses this work because they want to make a positive difference in the lives of the people they are supporting.

Secondly, peer support workers and nurses are both part of someone's care team. It is most important this support is both complementary and complimentary to each other. All too often we hear about the conflicting information and direction that tangata whaiora are given by different people from within mental health services and the potentially damaging affect this can, and does, have on their lives.

For our care to be the best it can be, there must be a close collaboration between nursing and peer support services to ensure the best outcomes for the people we serve.

Together we can make a real difference.

**GARY SUTCLIFFE**

*Gary works part-time as peer support worker and as a consumer development project manager; both positions are with AMHS. He can be contacted at gary@amhs.org.nz*