Dr Frances Hughes from ICU to ICN via mental health nursing

Desire and determination to better support people in distress underpins Dr Frances Hughes’ career pathway. From an intensive care unit nurse in Lower Hutt, New Zealand into mental health nursing and now the chief executive role for the International Council of Nurses (ICN) in Geneva, Switzerland. We caught up with Frances to hear about her exciting step into a global nursing leadership position, a role coveted by 100 other applicants.

Over the course of her career Frances has held a number of nursing leadership roles. What appeals most to her about her new position is that it is focused on nursing and influencing global policy to bring about global change.

Prior to meeting with Frances she had just returned from five days in Zambia as part of her new role. There she met with the minister of health and nursing leaders to discuss developing community health assistants to support their scarce nursing workforce. Whilst in Zambia she also learnt more about the Girl Child Education Fund a project led by the ICN through donors. This fund supports the primary and secondary schooling of girls under the age of 18 in developing countries whose nurse parent or parents have died. Every girl in the program is paired with a nurse volunteer to monitor her progress at school and at home.

Also of interest is that the ICN annually leads out the theme for International Nurses Day (IND) celebrated on 12 May. This year the theme is *Nurses: A Force for Change: Improving health systems’ resilience*. As a direct result of Frances’ appointment it is exciting to see for the first time the name of a New Zealand mental health nurse appearing as co-signee of the IND Kit that is published for this event each year, alongside Dr Judith Shamian, ICN president.

These are just some of the aspects associated with Frances’ new role. The following excerpt from ICN’s vision for the future of nursing gives a better understanding of the far reaching scope of this influential role.

*Vision for the Future of Nursing: United within the ICN, the nurses of all nations speak with one voice. We speak as advocates for all those we serve, and for all the unserved, insisting that social justice, prevention, care and cure be the right of every human being. We are in the vanguard of health care progress, shaping health policy around the world through our expertise, the strength of our numbers, our strategic and economic contributions, the alignment of our efforts, and our collaboration with the public, health professionals other partners, and individual, families, communities for whom we provide care... Working together, we are at the forefront of incorporating advanced technology into health care without losing the human element. We are determined that science and technology remain the servant of compassionate and ethical caring that includes meeting spiritual and emotional needs.*

Continued on page 3
Welcome to our first edition of Handover for 2016.

We are absolutely thrilled to bring you an array of stories with a global, national, regional and local focus. We lead out with a global news story as we acknowledge the appointment of a New Zealand mental health nurse, Dr Frances Hughes, to the role of executive director for the International Council of Nurses.

We respectfully convey our feelings of sadness following the sudden loss of Bob Elliott in our nursing notes section.

We are delighted to bring to you two nurse profiles. Anne Brebner discusses her leap from the nurse lead at Te Pou to a clinical nurse director – mental health role. Mandy Shanley shares her story from being a UK enrolled nurse to becoming a New Zealand clinical nurse specialist.

The family column by Sue Cotton provides you with insights into how Counties Manukau Health are using a co-design approach with family and whānau to create a more family friendly service.

Our feature story relates to how nurses in the Waikato school-based health services are making a big difference to teen mental health.

Congratulations to Ronitha Reddy on completing a Master’s in Nursing. Check out her abstract in the nursing research section.

We hope you enjoy this issue.

Nga mihi Suzette

Suzette Poole - Editor
(RN-MH, MN) – CLINICAL LEAD
EMAIL: suzette.poole@tepou.co.nz

NEXT EDITIONS:
We know from feedback that readers are really interested in hearing about solutions, new innovations, new ways of working and new roles. So if you have an idea please feel to email me so we can talk some more.

Edition 35 will be released mid-year and we have a delightful mix of sector stories on the horizon. Articles are due 31 May. We would love to hear how you celebrated international nurses’ day.

Edition 36 will be this year’s special edition of Handover focused on supporting children and youth with mental health and addiction issues. Articles are due 31 August.

Edition 37 will be released at the end of the year. Articles are due 31 October.
What potential impact could having a mental health nurse as the ICN chief executive have on mental health and addiction nursing practice? Frances is already thinking about this and hoping to include a mental health and addiction stream into the programme for the ICN Congress which will take place in Barcelona, Spain from 27 May–1 June 2017. Furthermore she may be able to influence actions to support the United Nations Sustainable Development Goals (SDGs) which include a goal to ensure healthy lives and promote wellbeing for all ages. Targets for this goal include:

- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

(International Council of Nurses, 2016, p. 4-6)

Career path

How does an ICU nurse end up leading nursing globally?

As a mental health nursing colleague who has known Frances for many years I believe the secrets to her success lie in her ability to strategically lead and keep her finger on the pulse of nursing practice while having a clear end goal of improving the health and wellbeing of people in distress. When she sees something that needs doing she does her best to make it happen.

Frances has surrounded herself with like-minded people during the course of her career which has enabled her to identify the issues at hand and find the solutions needed. People such as; Dame Margaret Bazley, Dr David Chaplow, Dr Julia Hennessy, Dr Janice Wilson, Bob Henare, Chris Cottingham, Fuimaono Karl Pulotu-Endemann, Dr Chris Walsh, Kaye Carncross, Dr Daryl Deering, Heather Casey, Dr Linda Aitken to name but a few.

A quick glance into Frances' career pathway provides some insight into how a New Zealand mental health nurse attained this pivotal role in global nursing.

1970s’ – becoming a nurse

Frances trained as a general and obstetric nurse at Hutt Valley Hospital and graduated in 1979. The moment that pivoted her towards mental health nursing was the suicide of a person in a medical unit. This very sad tragedy made her realise she wanted to learn more about supporting people in distress.

1980s’ – becoming a mental health nurse

In 1981, Frances graduated as a psychiatric nurse. What she loved then and still values now is the ability to use different therapies – to do group work and one-to-one work with people, to talk with people and support them with their recovery. While working in female wards she facilitated groups looking at anger management and also organised for women to have cervical and breast screening checks. She then went on to delivering in-service training. The arrival of her son and daughter over the ensuing years led to a reduction in her work hours, working 6-11pm. In the late 1980s’ Frances partnered with Chris Cottingham and Fuimaono Karl Pulotu-Endemann to design and deliver a certificate in forensic psychiatry.

1990s’ – becoming a strategic nursing leader

In this decade Frances entered the world of strategic nursing leadership as a professional nurse advisor in a district health board. This was not long after the triumvirate model of manager, medical superintendent and matron and many nursing senior leadership roles were disestablished and replaced with advisory type roles.

Her achievements and positions held included:

- developing a mental health new graduate nurse programme and an advanced post graduate for mental health nurses alongside Jill White from Victoria University and Julia Hennessy
- inaugural president for the Australian and New Zealand College of Mental Health Nurses
- senior advisor nursing, Ministry of Health, in 1996 which became the Chief Nurse role in 1998
- commandant colonel for the Royal New Zealand Nursing Corp, providing strategic nursing leadership to the New Zealand Army.

2000s’ to current – becoming a global nurse leader

The later decades in Frances' career are filled with many international connections that positioned her towards her latest role. Her achievements and positions held were multiple and include:

- being awarded the Harkness Fellowship in Health Care Policy from the Commonwealth Fund in New York and working with Dr Linda Aitken on research relating to nurse practitioners, costing nursing turnover and the effects of nursing on patient outcomes
- first professor of nursing at Auckland University, chair of mental health nursing and established the centre for mental health policy, research and service development
- visiting professorship at the University of Sydney
- facilitator for the Pacific Island Mental Health Network (PIMHNet) and worked for World Health Organization (WHO)
- Officer of the New Zealand Order of Merit (ONZM)
- executive officer in a national disability group
- acting deputy director of mental health for New Zealand
- being awarded a Fulbright New Zealand Senior Scholar Awards and spending five months based at Rutgers University College of Nursing in Piscataway, New Jersey, USA researching the preparation of health professionals for psychosocial response to natural disasters
- receiving a Distinguished Alumni Service Award from Massey University in New Zealand
- chief nursing and midwifery officer for the Queensland Department of Health, Queensland Health, Australia.

We are delighted that Frances has agreed to provide a regular column in Handover to keep mental health and addiction nurses current on global nursing change.
I would like to take this opportunity to pay our respects to Robert (Bob) Mingi Elliott, Ngāti Maniapoto, MNZM, Dip. Teach, RPN, RGN, RGON, MNZM and Whetū Kanapa award recipient (Te Aotā Māramatanga NZCMHNurses), a remarkable Māori mental health nursing leader, who suddenly passed away on 11 January this year.

Uncle Bob originally trained as a teacher before embarking on a career in nursing and practiced for many years at Tokanui Hospital as a staff nurse, charge nurse and supervisor. He was instrumental in developing Whai Ora Cultural unit at Tokanui Hospital and supporting the development of Māori Mental Health services throughout New Zealand. In the later years Uncle Bob worked at Hauora Waikato and Te Rūnanga O Kirikiriroa.

As a mental health nurse who trained at Tokanui Hospital, I was one of many people who had the privilege of working with Uncle Bob. He was a gentle man who inspired me greatly by his calm and caring nature and wise words. His creative writing gave you insights into the talents and gifts that he had to offer. He had a way of touching your heart and soul with his words.

In 2014, at a wānanga hosted by the Māori caucus of Te Ao Māramatanga NZCMHNurses, Uncle Bob presented ‘The Galleries – A Māori Perspective of Psychiatric Nursing’, which was first presented at the Australian Congress of Mental Health Nurses conference in 1987. Following this he kindly sent me a copy of The Galleries to “do as I wish”. Therefore, in keeping with Uncle Bobs desire to share his work I include a very small snippet from this publication. See into the heart of this very treasured mental health nurse whose presence continues to live on in many lives.

If you would like to read more about Bob Elliott then I encourage you to read the chapter on Māori Mental Health in the Changing Times, Changing Places – From Tokanui Hospital to Mental Health Services in the Waikato, 1910-2012 (2012) book. Click here to order this book www.waikatodhb.health.nz/about-us/historical-interest/waikato-health-memorabilia-trust/
Supporting parents having hard times to have healthy happy loved children

by Caro Swanson, service user lead, Te Pou

Being a parent while negotiating the challenges of serious mental health problems, treatment and recovery has, in my experience, been herculean at times. My children are gifts – often my reason for continuing and like nearly every other parent in the world, I wanted to do only the very best by them.

But what was best? I had no idea. There was no handbook for this and worse, no one to talk to about it. It wasn't the sort of thing you talked about at mothers groups where you had the "I'm normal/coping/ordinary/not crazy" mask firmly locked on, when you managed to actually go. Parenthood has seriously huge, ravenous, guilt and shame dragons that are always circling. For a lot of people managing mental health or addiction problems they are gigantic!

This is one of the reasons I am so pleased to see this topic coming up currently for inclusion in the way we work with people who experience mental health and or addiction problems. It's been an area that has mainly been about managing risk until now, so to see this extend towards strengths based approaches is really exciting.

When it came to raising my children, I had strengths from my own childhood – being the child of a parent with serious mental health problems – that were incredibly useful. I only recognised this retrospectively though. I knew to make sure they were never frightened, unsure and kept silent or in the dark about what was going on. I knew judicious openness worked. I knew they needed to feel safe, loved, accepted and not responsible for my problems. And they needed plenty of fun. I certainly didn't get it perfect but we have done ok and they are both such amazing adults now.

What I’m excited to see next is how this works, who is already doing what and where. How can it fit into all the different roles, what works and what doesn’t? What does mental health nursing have to do with parenting and how? Most all, what are the stories of success and better-ever-afters!

Supporting Parents, Healthy Children

If you want to know more about Supporting Parents, Healthy Children check out a video message from Dr John Crawshaw, director of mental health on the Werry Centre website, www.werrycentre.org.nz/professionals/current-workforce-projects/copmia.

Upcoming event

He Waipounamu He Maunga Pakohe

Excellence in Māori Mental Health Nursing

Bringing the gems of our past into the future

Te Ao Māramatanga Māori Caucus proudly presents their bi-annual wānanga.

Date: 12-14 October
Time: Powhiri Midday
Venue: Whakatū Marae, 99 Atawhai Drive, Nelson
Cost: $325 or $200 student/consumer

Keynote speakers
- Dr Peter Meihana – lecturer in Māori history, Massey University
- Maria Baker – workforce innovation manager, Te Rau Matatini
- Dr Lorraine Eade – director, Marlborough Children's Team

If you are interested in presenting at the hui please forward an abstract (up to 300 words) to the organising committee via lois@loisboydconsulting.co.nz by Friday 29 April. There are several half hour presenting slots available (20 minutes presentation and 10 minutes korero) for attendees to present their research and/or work.

Further information and registration forms are online, www.nzcmhn.org.nz/Maori-Caucus/Upcoming-Wananga.
Co-design: beyond consultation, a family perspective

by Sue Cotton, family advisor mental health services, Counties Manukau Health

There is a growing body of evidence indicating that working with service users and their family/whānau in a healthcare environment to better understand and improve their experience, leads to better health and organisational outcomes.

At Counties Manukau Health, mental health services are using a co-design approach to support a number of service improvement initiatives across a spectrum ranging from service brochures to the big picture strategic challenges of systems integration.

Co-design moves beyond the traditional ideas of stakeholder ‘consultation’ and engages people in a more active and ongoing role in identifying the issues and developing the solutions. It is only when stakeholders are actively involved in the key decisions about the design of any building, service or resource that we can say that ‘co-design’ has taken place.

Family/whānau members of people using our mental health services are responding enthusiastically to the participation opportunities available in the current planning environment at Counties Manukau Health. In particular there is significant interest from family/whānau members in the planning of the new acute mental health inpatient unit that will replace Tiaho Mai at Middlemore Hospital.

While it is always satisfying to have a room filled to capacity with enthusiastic participants, the value of information gathered from family members in the early stages of this initiative was not necessarily determined by the numbers of people present. Rich insights about what matters to a family can come from hearing one person’s enduring memory of a distressing incident or what one staff member did that made a world of difference to their overall experience.

Central to ‘co-design’ methodology is the bringing together of stakeholders at key points of an improvement process to work together to find solutions and determine priorities. Throughout the planning process for the new acute inpatient unit, events have been held at significant milestones, bringing the various stakeholder groups together and celebrating the ongoing contribution of all participants. Service users and family/whānau sit side by side with clinical staff, police, project managers and other stakeholders to see how the design is progressing and how their contributions are being integrated with current international best practice to inform and drive the development of the new model of care and environmental design.

As family advisor, one of the pieces of co-design that I have particularly enjoyed being

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1 Co-design Engagement Process. Mental Health and Addictions Whole of System Integration. CMH 2015
2 Experience Based Design: Using patient and staff experience to design better healthcare services. NHS Institute for Innovation and Improvement. United Kingdom 2009
involved has been with Annamarie Lowndes and her team at Te Rāwhiti Community Mental Health Centre. Annamarie has made a personal commitment to developing a ‘family friendly’ service for people in the eastern locality of Counties Manukau.

Using the co-design methodology of 'Experience Based Design', the Te Rāwhiti team set out to discover how they could improve engagement with family/whānau at an individual care level and as a service.

Following questionnaires for service users and family/whānau, a family focus group and investigation of current international best practice, some family members met with a small group of staff to help us identify priorities and plan our journey towards Te Rāwhiti becoming a more ‘family friendly’ service.

Eighteen months down the track, the monthly ‘Family and Friends Evening’ has become a regular feature at Te Rāwhiti. Initial participants developed the terms of reference for the sessions, putting a strong emphasis on good facilitation and learning opportunities and inviting various staff members to come along and share their particular professional expertise.

What I have found fascinating is the mutual benefit of these opportunities. As well as sharing their expertise, individual staff also take away a better understanding of family needs, what is working well for them and how things could be done better.

The team is demonstrating an increased confidence around engaging with families.

I didn’t really understand the sense of isolation and confusion some family members have, when facing the challenges of getting help for their loved one, from mental health services. The feedback from the family members of the group has been extremely valuable for me as a clinician and for the service. I have encouraged all my fellow key workers to attend at least one of the evening meetings, so they to have the opportunity to broaden their perspective of care, to include the families.

Nurse participant

The team is demonstrating an increased confidence around engaging with families. There is more frequent discussion amongst the clinical team about challenging information sharing scenarios and an ongoing steady increase in the number of family/whānau contacts each month.

As a mental health service, we are becoming more skilled in using co-design processes and we are developing a growing network of family/whānau members keen and skilled at working with us on service improvement initiatives. Their contributions add value to the care we provide for service users and ensure that we build better relationships with those that care about them.

Experience Based Design

**Capture:** Helping people tell their stories, describing their respective experiences of receiving care, providing care or being otherwise engaged in some way with a service or process.

**Understand:** Organising the rich information into themes relevant to the context of the work.

**Improve:** The defining feature of co-design where stakeholders come together and work together to design improvements and turn their experience into action.

**Measure:** Evaluating and sustaining improvements.

Experience Based Design: Using patient and staff experience to design better healthcare services. NHS Institute for Innovation and Improvement. UK 2009
The 7th Addiction Nurses Symposium was recently held in Wellington with a fantastic attendance of 80 nurses working with addiction across the health sector. Representation came from District Health Board (DHB) and non-government organisation (NGO) provider arms, community and residential services, addiction, mental health, education providers and primary care.

The formal component of the day was packed with a broad range of speakers and topics, whilst the breaks and intervals were bursting with discussions, networking and sharing of stories and relationships. Presentations from the day can be found at www.matuaraki.org.nz/resources/presentations-from-the-7th-matua-raki-addiction-nurses-symposium/678

The day was opened by Kuni Shepard and Corien Simpson (Capital and Coast District Health Board (CCDHB) who set the scene, acknowledging the wisdom past and present from those who were attending and presenting from around the motu. Klare Braye (Matua Ra ki) then gave the opening address providing insights into the addiction workforce from a national perspective. She drew on the data from the More than numbers workforce stocktake to highlight and honour the position of nurses working in addiction, while recognising their role within the wider workforce. Klare highlighted a few of the current national initiatives; Substance Addiction – Compulsory Assessment and Treatment Bill, Supporting Parents Healthy Children, fetal alcohol spectrum disorder and outlined the work of Matua Ra ki and the role that nurses have within this. She encouraged and challenged participants to enhance their relationships with colleagues and other service providers while extending their own practice and opportunities – themes that were reiterated throughout the day.

We were privileged to have two hepatitis C presentations, with recognition that the field is currently going through a number of changes and opportunities. Belinda Heaphy (Nelson Marlborough DHB) highlighted the impacts of the current treatment regimes and the need to ensure client preparedness for treatment in order to achieve the best outcomes. She was optimistic about new treatment opportunities including the development of anti-virals. Mark Greco (Southern DHB) described an initiative in Dunedin to receive Hepatitis C through a simple saliva swab, accessing those who may not consider themselves high risk.

Presentations offered insights into areas of practice and evidence, encouraging attendees to consider how and what they could implement in their own services. Blair Bishop (CCDHB), summarised his findings from his Master’s thesis on service users’ perspectives of what it is like to receive suboxone and the need to prepare the client/citizen and their whānau for not only the treatment itself, but also changes in behaviour, energy and the ‘rediscovery’ of the person. Moira Gilmour (CCDHB) highlighted the risks associated with refeeding syndrome. A reduction of ten per cent weight loss over two months, or five days of no eating followed by a full diet, created risks that required some basic but important management strategies. Anne Carroll (Higher Ground) provided enthusiasm, energy and optimism as she talked about her successes and challenges of introducing a no smoking policy at Higher Ground – a policy that despite relapses was highly successful, providing a vast array of learning opportunities about addiction, making choices and taking control. Carol Devlin (PACT) talked us through the journey of residential support, acknowledging the medical, emotional and wellbeing needs but also recognising the stages of care and support required in the person’s journey. Steph Anderson (Nelson Marlborough DHB) used a number of case scenarios to highlight some of the incredible relationships created between palliative care and the addiction service.

From a perspective of professional practice Louise Leonard (Waikato DHB) talked about the challenges of her journey of nurse practitioner and the changing landscape. At another end of the career spectrum Jennifer Davidson (CCDHB) reflected on her progression through nurse training and the nurse entry to specialty practice (NESP) programme, highlighting to education providers and colleagues where further support for addiction

Kuni Shepard and Corien Simpson from Capital and Coast District Health Board (CCDHB) – opening our day

Klare Braye, project lead, Matua Ra ki

Belinda Heaphy

Blair Bishop

Anne Carrol, Steph Anderson and Moira Gilmour

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training could occur. Sarah Barkley (Lakes DHB) provided the final formal session emphasising how and where the opportunities for joint care and relationships can occur. She encouraged us to consider how we can take the initiative in shared relationships, recognising that sometimes other providers or professionals are not able to ask the questions or don’t know where to start. This led nicely into a concluding session that encouraged participants to go back to their services with practical ideas and solutions as to how they could advance their own practice, support their colleagues in their professions, implement initiatives in their workplaces and build on the relationships across the sector.

Profile: Anne Brebner, clinical nurse director, mental health, Counties Manukau Health

It’s been more than a year since Anne Brebner left her role of nurse lead at Te Pou and joined Counties Manukau Health as the clinical nurse director – mental health.

Anne's nursing career spans thirty years and includes specialising in child and family services and working in primary care. Currently Anne is the president of Te Ao Māramatanga New Zealand College of Mental Health Nurses.

Anne is really loving her new role, especially being back amongst mental health nurses and influencing standards of practice, coaching and mentoring and seeing some of the innovations in practice.

She has also found the work and development she did at Te Pou incredibly useful. In particular, learning to write succinctly and clearly, understanding how to effectively influence plus using levels of authority to improve the impact of services on people. Anne has found that her knowledge of the national strategic picture, policy and drivers of change, along with her many connections and networks, made during her time at Te Pou continue to strongly support the work she does now.

One of her favourite things is seeing the work developed at Te Pou being used and operationalised in practical and useful ways. Of note is least restrictive practice and wellbeing work. Anne says, "people want to work in ways that support that, but sometimes waiting for systems to catch up with developments can be a barrier." She sees enormous opportunities to improve what happens for people who need the most serious of mental health services.

Anne sees some of the biggest challenges in the future will be understanding what the workforce, in an increasingly squeezed environment that is also responding to growing complexity and pressure of people and their families and whānau, needs to be. Maintaining appropriately skilled staffing levels and new graduate nursing numbers is a continuing concern. Staying current and relevant is something that needs to be continually assessed and strived for.

Despite those challenges Anne feels positive and inspired by the forward momentum and positive changes over the last years’ in mental health service provision. She is proud of mental health nursing and is looking forward to the next years and most of all, the opportunities to ensure services support people to have lives they want to live.

Ehara taku toa i te toa takitahi, engari he toa takitini
Success is not the work of one, but the work of man

Check out the Matua Raki addiction nursing webpage, www.maturaki.org.nz/workforce-groups/addiction-nursing/155
This story began with an invitation from Sarah Haldane, nurse educator at Waikato DHB to meet a clinical nurse specialist. An invitation endorsed by the nurse director Carole Kennedy, that clearly signalled that this nurse is valued and respected.

“I just wanted to raise the profile of our fabulous clinical nurse specialist Mandy Shanley... She arranged this health promotion event for our service users. It was a wonderful event… In addition, she has been working tirelessly supporting service users and staff to quit smoking over the last few months and she inspires nurses and other allied health professionals to work alongside with her in this work. She is one of our stars... Kind regards Sarah Haldane…”

“Mandy had been a driving force down at London Street. Not only is she the only clinical nurse specialist we have at London Street but she leads by example. I think it would be wonderful for Mandy to share your passion with others... Regards Carole Kennedy, Nurse Director…”

Mandy’s response gives you a glimpse into her attributes “Thank you all so much for your lovely comments, I feel very humbled. I have not done all of this on my own and have had lots of support…”

The event Sarah referred to was the Equally Well Day ‘Treat yourself for Christmas – Look after your health’ held in an urban mental health service base, London Street, Hamilton in December. Mandy worked alongside many others to create an event where people could talk and think about holistic health within the mental health services. Promoting simple things people can do to improve their physical, mental, emotional and spiritual health. Balloons, music, information stalls and activities filled the day that was attended by over 70 people.

The Equally Well event was one of Mandy’s objectives following her appointment to the position of clinical nurse specialist in March 2015. She was a bit hesitant to apply for this role, as her career path had taken her into the specialist area of supporting people with eating disorders. However soon after her appointment she quickly realised that her knowledge and skills were easily transferable. She now relishes opportunities to work alongside other nurses while also supporting a small group of service users. Having a very supportive manager in Nicola Livingstone who has a social work background, is key to her developing the confidence to create change, says Mandy.

Career path

How does a UK trained enrolled nurse become a NZ urban sector clinical nurse specialist and a strong advocate for Equally Well?

During the 1980s Mandy spent the first decade of her nursing career as an enrolled nurse (EN) which included time in UK accident and emergency settings and in the Royal Airforce with postings in Germany. Mandy recalls taking time to talk with a person who had taken an overdose and being told off by a senior nurse who told her not to be nice as it might encourage it to happen again! This incident led her to seriously start thinking about what other areas of nursing she would like to work in.

She then trained to become a registered mental health nurse (RMN) in the early 1990s, in Wales. As a RMN Mandy, worked with older people in services in Wales and in the Channel Islands. In the late 1990s she took up a position in New Zealand at Pathways and after the birth of her son returned to the UK and worked in community and crisis teams.

During the mid-2000s Mandy began specialising in supporting people with eating disorders and was instrumental in setting up a service NAVIGO- Rharian Fields specialist eating disorder services. She helped to develop and manage community, inpatient, home treatment and a day patient service. This brand new service won the Innovation award from the North East Lincolnshire Care Trust Plus.

Around 2012, Mandy and her family returned to New Zealand and she gained a role as a specialist eating disorder clinician based in Hamilton. Mandy strongly believes in holistic health and during the course of her career she has developed skills in cognitive behavioural therapy, emotional freedom techniques, motivational interviewing, mindfulness and family based therapy for eating disorders. She completed further training at the Maudsley Hospital.

She does not describe herself as an academic but is very proud of successfully completing a postgraduate certificate through the Skills Matter clinical leadership programme, given she left school with only one O level. Over the coming year Mandy plans to continue with postgraduate studies while carefully balancing family life. Heading towards a nurse practitioner role is an aspirational goal but in the meantime her dream would be to run a wellness clinic. Her next goal is to hold another Equally Well day on 31 May which is the World Smokefree Day.
Adolescence can be a stressful experience and helping young people find their way through adolescence can be difficult, especially if their families are not supportive.

Common health issues for teenagers include contraception, teen pregnancy, family and partner violence, substance use and misuse, physical activity and sexually transmitted infections (STIs).

Risk of suicide is a huge concern and self-harm has become a bigger problem in more recent years, says Nicki Spring, coordinator of Waikato school-based health services (SBHS) where school nurses and GPs are making a big difference to teen mental health.

SBHS provides access to free primary care services within schools, removing barriers such as cost, transport and lack of access to appropriate clinicians. The services are particularly precious in rural communities where teenagers are often at their most vulnerable because of their isolation from health services, particularly mental health services.

Currently, Midlands Health Network (MHN) employs 13 youth friendly nurses who work in 19 different sites across decile one, two and three secondary schools, wharekura, alternative education services and teen parent units. MHN also funds general practitioner clinics in decile one to six secondary schools (two hours per week). As well as providing medical expertise, GPs also underwrite standing orders so school nurses can dispense some treatments without students having to wait for the GP’s next visit.

School nurses play a crucial role in not only delivering a service that adolescents will accept and trust, but also in building relationships with school staff and the health services within the community in order to access help for students in a timely manner.

“Students can access our services easily because we are on site which is particularly important for students,” says Waikato school nurse Melissa Davidson. She says confidentiality is very important and some of her biggest concerns are the socio-economic environments the students return to after school.

“We can educate kids, giving them the best messages we can – to eat healthy, not smoke or not have unprotected sex for example. But sometimes they see conflicting messages outside the school environment. This is difficult and sometimes disheartening as a health professional, but at least we offer options and show them there are other choices they can make.”

HEADDSS Assessments

School nurses conduct HEADDSS psycho-social assessments on all year 9s in eligible schools as well as providing one to one health consults and health promotion activities in and out of the classroom.

“When confidentiality is assured and the nurse has developed a good rapport, the students will often communicate very personal information to the nurse,” explains Nicki.

The assessment interview opens up opportunities to discuss potential problems, check students have an adult they can turn to for support and offer strategies where required. Concerns are flagged on a private medical database for follow up, such as risk taking behaviours or thoughts of self-harming.

Sue Caldwell, who works in several school clinics and an alternative education site, says many of the young people she is supporting have never talked with a health professional in complete confidence before the HEADDSS assessment.

“As an important part of supporting a student and engaging them with referral agencies is educating them about the support available; what it involves, who it involves, what confidentially means and what they feel is the appropriate intervention,” she says.

As well as winning the trust of the students, the nurses must also develop relationships with guidance counsellors, deans and other senior managers in the schools.
“So we get involved in the school community, interact at sports days, go to prize giving, talk to teachers in the playground, talk in classrooms on specialty topics,” explains Melissa.

Nurses also develop strong relationships with local health services, including local mental health agencies where they will be referring students.

“Services are more easily accessed for acute cases - the suicidal student or the severely depressed - but it is more difficult to get help for students living with longer term issues. Resources are limited and stretched.”

Challenges for nurses

Nicki says there is a lot of pressure on primary health services when addressing mental health issues in youth under 16 because of the required parental consent in accessing secondary services.

“This can be a huge barrier as teenagers often don’t want to disclose their drug and alcohol and other mental health issues to their parents.”

The lack of quick access at times to appropriate treatment and referral services can be exasperating, says Janice Wotton, registered nurse lead for Waikato SBHS. Confidentiality and trust are hard won from students, making it very frustrating when the necessary follow up isn’t available reasonably quickly.

“Services are more easily accessed for acute cases – a suicidal student or a severely depressed person – but it is more difficult to get help for students living with longer term issues. Resources are limited and stretched,” explains Janice.

Another major issue is getting schools and parents to treat mental health problems as seriously as a physical illness and not expect a student to return to school before they are well enough to cope with such a complex social environment, says Sue.

Poor health literacy is another ongoing challenge. Many teenagers don’t understand the complexities of the health system, particularly that it is their inherent right to give informed consent when engaging with health services, says Nicki.

The school clinicians work hard at developing student health literacy during consults so they learn to manage their own health outcomes, particularly sexual health. The nurses also lobby for and support teachers to improve the quality of sexual health education in the classroom.

“A lot of mental health issues stem from sexual health problems, such as historical abuse or lack of knowledge about consent,” says Nicki.

Successes for network

Nicki sees her coordinator role as one of advocacy and support for the work of the nurses and is proud of a number of improvements within the network.

She advocated successfully to retain funding for GPs in schools up to decile six (funding was limited in 2013 to decile five and under), in acknowledgement of extra barriers experienced by rural youth, especially transport.

She also won more clinic time for wharekura. The funding formula for nurses is school population based, so small rural wharekura with 100 per cent Māori population and multiple barriers to access were only getting 1.5 hours’ per week. This didn't provide time to develop relationships with the students or the community, an important element in wharekura schools.

“Wharekura now get one day a week. It is still not much but it is more than before. We also got sign off to develop a whānau-centric model of care in wharekura and extending services to the whole school whānau is an integral part of a kaupapa Māori based model of care” says Nicki.

Professional development

Regular team professional development is held during school holidays and includes dealing with mental health issues.

“The minimum training requirements for nurses is the HEADDSS training, Certificate in Child Protection, smoking cessation and a four day family planning sexual health course that also covers mental health aspects, especially the consent module. We also have annual training in mental health including sessions with Dr Sue Bagshaw and iCAMHS Waikato,” says Nicki.

She is excited about a new pilot, a motivational interviewing pilot programme the nurses started in January, and will completed in July. It was introduced to help nurses feel more confident about providing brief interventions when needed.

“The nurses spend a lot of time trying to find referral services that youth can engage with, that are timely, appropriate and responsive. We thought it may make a big difference for rangatahi if that time and energy could be put into interventions.”

“A lot of mental health issues stem from sexual health problems, such as historical abuse or lack of knowledge about consent.”

3 A full immersion Māori school that work from a kaupapa Māori framework.
Least restrictive practice
by Lois Boyd and Caro Swanson

Kia ora from Carolyn and Lois. Welcome to our second column. Last issue we asked to hear about practice innovations that support seclusion and restraint reduction and we have had some great conversations since then with quite a few of you! Thanks so much for getting in contact. It’s great to hear what is working well and we are working on creative ways of sharing information on your best reduction innovations.

Lately we have had a few enquiries about debriefing systems and processes for both service users and frontline staff involved in seclusion and restraint adverse events. This year we will be reviewing and updating the information we provide and are really keen to hear from teams that are currently developing this in practice. Towards restraint-free practice highlights the importance of tertiary prevention of which debriefing, a core strategy, is a key component. There are many good reasons to offer debriefing to both service users and staff members.

• To support recovery and personal wellbeing – if offered correctly, it is known to reduce ongoing trauma symptoms associated with adverse events, for everyone involved.
• Understanding what occurred and why - this is crucial to both resolving concerns about what occurred and preventing it from happening again. Having these conversations encourages collaborative and therapeutic relationships that support a strengths based, recovery approach.
• People involved in an adverse event often have only part of the picture of what happened and why. Debriefing can help explain and explore this and complete any gaps in information that help with understanding, reviewing and processing what occurred.
• To support systems and quality improvement – information from debriefing can usefully inform both system and practice change and innovation.

Check out these resources on our website

• Debriefing following seclusion and restraint – A summary of relevant literature www.tepou.co.nz/resources/debriefing-following-seclusion-and-restraint-a-summary-of-relevant-literature/547

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

We continue to be very keen to hear from you so please be in contact Lois.Boyd@tepou.co.nz and Carolyn.Swanson@tepou.co.nz. Big or small, please let us know what you are up to and what we can do to support your practice.

What we’ve been reading
Lois read an article that she has continued to think about over the last month or so, which is usually a sign it was interesting and relevant! Titled “The Art of Noticing” this nursing focused article discussed the everyday and often taken-for-granted skill of noticing. The attraction of this article was that Watson and Rebair discuss something that we often “just do” and don’t necessarily think about as an important aspect of our skill and work. A lot of the examples in the article were about nursing people with physical health concerns but the ideas discussed were very transferable and certainly gave pause for thought and reflection on where “noticing” fits into our professional skill set.

Where we’ve been surfing…

We recently found a UK based Knowledge and Learning Exchange, www.mentalhealthpartnerships.com, focused on bringing together people, partnerships and networks. Supported by the national clinical director for mental health, it profiles a wide variety of mental health related information and innovation and supports a number of practice networks.

Reflecting on…

This month we find ourselves reflecting on the global nature of our world and how information shared on our website and at international collaboratives and conferences, has contributed to best practice and innovation across the world. We have had several international enquiries this month from clinicians and researchers who are keen to link with us and make contact with frontline mental health professionals and New Zealand based researchers. Facilitating some new international connections and hearing about how others are working on reducing and preventing seclusion and restraint, reminds us that we are all part of something that is a universal concern around the world.

References
I am a registered nurse from South Africa, having trained and worked there as a comprehensive registered nurse for ten years. Living in a developing country such as South Africa, I observed the powerful effects of social inequality on health and health outcomes. Regrettably I was not awarded the opportunity to formally undertake any research due to lack of funding.

Since 2004 I have been working in forensic mental health in New Zealand. From my own discussions with patients, I have once again become aware of the influence of social factors such as poverty and social disadvantage impacting on their recovery. From people’s very own narratives I have found that psychosocial stressors triggered by lack of resources and opportunities in the community have often resulted in acute admissions. Their perspectives have often led me to reflect on their social circumstances.

Given the reality of social deprivation as a factor in use of mental health legislation, I have also reflected on the need to focus on aspects of my professional practice that might impose stigma, exclusion, discrimination and marginalisation. It is an interest in these matters, which has led me to consider the topic of social deprivation and the use of mental health legislation. The topic also provided me an opportunity to consolidate my knowledge in the wider understanding of health, as in 2014 the two main papers that I focused on as part of the Master’s in Nursing had an advanced biological component of understanding of health. This dissertation further developed and supported a better understanding of the social context of mental health in New Zealand.

ABSTRACT

Background
A previous study reported high levels of deprivation positively correlated with use of acute admissions and long term provisions of mental health care in the community for the period of 2005 to 2009 (O’Brien, Kydd & Frampton, 2011). The current study is a replication of the earlier study and will examine data from 2009-2013.

Methods
The study used an ecological design to explore the relationship between two measures of relative deprivation and the use of section 11 (acute care) and section 29 (long term community care) of the New Zealand Mental Health (Assessment and Compulsory Care) Act 1992.

Results
For the current study period there is a significant variation in use of section 11 and section 29 across the 20 DHBs. Analysis of relative deprivation between DHBs showed an inverse relationship between high and low measures of deprivation. The correlation between the low area deprivation and high area deprivation measure was -.817 and is significant at p= 0.01 (two tailed). The area measure NZDep 8-10 (most deprived) was positively correlated with both use of section 11 (r = 0.422; p = .06) and section 29 (r = 0.426; p = .06), explaining 17% and 18% of the variance respectively. The measure of least deprivation (NZDep 1-3) was negatively correlated with use of both section 11 (r = -0.43; p = .06) and section 29 (r= -.331; p = 0.51). Analysis showed no significance in any of the NZDep correlations, but three NZDep measures approached significance (p =.06). The size of the correlations (range -.43 to .43) was large and in the same direction as that reported in 2011, indicating that the small sample size of 20 DHBs may have prevented the correlations showing significance. The proportion of Māori was highly significant for section 11 (r = 0.471; p = .03) explaining 22% of the variance, but was small for the use of section 29, which is a new finding.

Conclusion
The wide variation in use of section 11 and section 29 has persisted over the past five years, with legislation being used disproportionately in areas of most deprivation. With rising inequality in New Zealand, these findings have implications for mental health services, for equitable resource allocation and for initiatives to improve mental health in disadvantaged groups.

If you would like to know more please feel free to contact Ronitha.Reddy@waikatodhb.health.nz
Get to know Te Pou’s work

At Te Pou our work generally fits into four portfolios. We recently ran a series of ‘get to know’ articles in our e-bulletin that were very popular. Check them out in the news section of our website.

1. **Practice and leadership**, led by Angela Gruar
   Supporting the workforce with day-to-day practice guidance on anything from talking therapies to reducing seclusion. Leadership skills are essential to effective practice and we continue to support endeavours where leadership capacity and capability is improved.

2. **Workforce planning**, led by Emma Wood
   Promoting what effective workforce development looks like.

3. **Training and development**, led by Vanessa Caldwell
   Providing training opportunities through Skills Matter, disability workforce grants and e-learning.

4. **Information and outcomes**, led by Richard Woodcock
   Striving to ensure that information collected by mental health and addiction services is accessible, and able to be used to enhance practice and service delivery.

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**How the workforce centres are supporting you: April – June 2016**

Te Pou has just published an update from the workforce development centres of activities and initiatives happening during April - June 2016.

Check it out online, www.tepou.co.nz/resources/how-the-workforce-centres-are-supporting-you-april---june-2016/721