The mythical story of the phoenix, a bird of exceptional colour and vibrancy, is about rebirth and obtaining new life by arising from the ashes of its predecessors. In what was called Waiora Ward, which housed up to 50 female patients of the former Porirua Psychiatric Hospital until it was closed in the 1990s, now sits Taeaomanino Trust. This is a non-government organisation (NGO) “by Pacific for Pacific” health and social service chaired by the respected Pacific nurse leader Dr Margaret Southwick. The irony is that Porirua Hospital, like Oakley/Carrington Hospital in Auckland, with a long history of housing people from the Pacific Islands, was at that time, managed by a dominantly mono-cultural Palagi (European) worldview. The majority of the people were in compulsory care, male and aged in their late 20s to late 40s. Their diagnosis was unclear and they were detained in wards with locked doors with a “lack of culturally safe and unresponsive mental health service” (Crawley, Pulotu-Endemann, Stanley-Findlay, 1995).

In comparison, the contemporary Pacific services, mainly focussed on mental health and social wellbeing, are in response to meeting the needs of Pacific people that were not met by mainstream services. To be deemed a “by Pacific for Pacific service” it must be Pacific owned, with predominantly Pacific governance infused with Pacific values and beliefs. It recognises that capacity and capabilities of the workforce must include non-Pacific workers who subscribe to the values and beliefs of the service. However, it was clear that Pacific people must be at the helm to lead the Pacific services. This Pacific focus started in the 1980s-2000s to provide culturally safe social and health services that were holistic and include the mental health needs of Pacific clients and their families. As Vito Malo (Malo, 2000) stated, these services benefited Pacific mental health service users most because the staff can understand the intricacies of Pacific Island culture, their belief system and treat consumers as if they were part of the extended family.

Yesterday

The history of Pacific people in New Zealand mental health services started earlier. During the 1950s and 1960s the Union steam ships like Tofua, Matua, Moana Roa, and Taveuni picked up cargo in the form of copra (dried coconut), bananas and taro from Samoa, the kingdom of Tonga, the Rock of Polynesia, Niue and the Cook Islands. They also picked up passengers and mental health service users who could not be cared for in their home countries. They were destined for New Zealand especially to psychiatric hospitals such as Oakley Hospital, later to become Carrington Hospital, in Auckland.

Guest editorial:

Yesterday, Today and Tomorrow

Reflections of the Pacific Mental Health sector in New Zealand

By Fuimaono Karl Pulotu-Endemann RPN, RGON, Adv. Dip Nsg. MNZM, J.P.
This was not the case for Fiji which had its own psychiatric facility, St Giles Hospital in Suva. These people must have felt very isolated when they landed in New Zealand, with different geography, temperatures, people, languages, food and customs. The writer recalls reading the early files of some of the people and the significant changes they faced – the most telling is the changing to Palagi/European names for the benefit of the staff. Names like Gasegase became Gus. In the health system, the Pacific staff were mostly cooks, domestics or workers in the laundry. There were a few who were nurse aides or “assistant nurses” – those who started their training but were unable to register.

In June 1994, the paper Strategic Directions for Mental Health Services for New Zealand was released by Hon Jenny Shipley, the Minister of Health at the time, in the Christchurch Town Hall. A small group of Pacific mental health workers led by the writer made a public objection that the document didn’t address the special needs of Pacific people. Within a month, the writer was summoned to Wellington by the Ministry of Health to be the mental health consultant to a team to consult with Pacific people nationally and to come up with a report. A total of 19 regions were visited, culminating in a report Strategic Directions for the Mental Health Services for Pacific Islands People in March 1995.

This report was instrumental in the formation of Pacific mental health services such as Lotofale, Pacificare, Faleola, Isa Lei in Auckland, Pacific Community Health (PaCH) in Porirua and the Pacific Trust Canterbury based in Christchurch. Taeaomanino Trust was formed as a social service provider. The three broad aims were the development of Pacific mental health and addiction services in mainstream and NGO sectors, the recruitment and retention of Pacific workers and the development of Pacific models of services. The Fonofale model which the writer developed, pictorially in the form of a Samoan meeting house and holistic in its approach, was adopted by many of the new services.

The first Pacific mental health services in New Zealand were based at the former manager of Lotofale St Giles Hospital in Suva. These people must have felt very isolated when they landed in New Zealand, with different geography, temperatures, people, languages, food and customs. The writer recalls reading the early files of some of the people and the significant changes they faced – the most telling is the changing to Palagi/European names for the benefit of the staff. Names like Gasegase became Gus. In the health system, the Pacific staff were mostly cooks, domestics or workers in the laundry. There were a few who were nurse aides or “assistant nurses” – those who started their training but were unable to register.

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In order to train the Pacific staff of these new services, a series of mental health and addiction training courses were nationally funded by the Ministry of Health and led by the writer and the staff of Lotofale. The training acted as a launch pad for the workers to seek further studies such as the Certificate in Mental Health Support Work.

Due to the growth of the services and the demand for training, further funds were released by the Mental Health Directorate, Ministry of Health, in 2005-2006 for six projects headed by the writer in partnership with a fresh organisation under the trade name of Pava. The work by Pava included:

1. the mental health workforce development training nationally carried out by the writer, psychiatric nurse and Maori leader Moe Milne and David Lui, a senior Pacific mental health worker and former manager of Lotofale
2. the production of the Seitapu Pacific Mental Health and Addiction Cultural and Clinical Competencies Framework (Pulotu-Endemann et al., 2006)
3. improving recruitment and retention of the Pacific mental health workforce (Southwick, M. & Solomona, M. 2007)
4. the Pacific Mental Health Workforce Development Organisation – Feasibility Study (Kirk, Ray et al., 2006).

These pieces of work contributed to the formation of Le Va, the Pacific mental health and addiction workforce centre, which began under Te Pou and is now an independent entity.

The first Pacific mental health services in New Zealand were based at what was called Crown Health Entities (CHEs,) which later became District Health Boards (DHBs). They were Lotofale in Auckland, Isa Lei in Waitomata, Faleola at Counties Manukau, and Pasefika Health at Capital & Coast. There were also NGOs such as Pacificare in Auckland, Taeaomanino Trust and Pacific Community Health (PaCH) in Porirua, and Pacific Trust Canterbury in Christchurch.

Today

Whilst nursing, for instance psychiatric nursing, has undergone many changes and much development, such as the transition from hospital training to tertiary education, and the setting of practice from institutional to the primary health sector, there are core values and beliefs in nursing roles that remain as important now as in the future. For Pacific nurses “service to our communities and our people remain a core value and fundamental ethical principle” (Dr Margaret Southwick, 2011). These core values and principles are behind many success stories, such as the ones shared in this issue of Handover:

- Sione Vaka working towards achieving PhD qualification
- Cook Island nurses studying via the latest technology such as tele-health
- Natalie Leger appointed to a senior management role whilst navigating two worlds using heart, heads, and hands to make differences

“In order to see what we will be in the future, it is wise to look at yesterday which gives us a good idea why we are what we are today. Then we can the step into our tomorrow with some certainty.” (Pacific saying.)
• Ioana Mulipola being transformed by nursing and aiming high
• Makoni Havea being respectful of the therapeutic relationship
  with people.

This is consistent with the key value and belief faka Tonga or the Tongan
way or culture called fakaapapa or fa’aaloalo (Samoan) and Fakali’ifau
(Niuean). Funaki Pauta’s assertion of ‘of a/love and knowing one’s history’
connects Pacific people. There is also the negative side that requires
attention, which Makoni Havea rightly asserted, of the stigma and
discrimination around mental health among Pacific people. One of the
earlier works by Pacific workers was looking at their own beliefs about
mental health, in particular their behaviour and language used in
relation to Pacific mental health service users. Since then the ongoing
development of more inclusive language terms by Pacific groups are
used towards removing stigma and discrimination for service users
and their families.

The first contracted providers for the Like Minds, Like Mine campaign
were Pacificare, PaCH and Pacific Trust Canterbury.

Tomorrow – the future

Dr Debbie Ryan (Southwick et al., 2012) found that the Pacific total
health workforce made up 2.3 per cent of the total New Zealand health
workforce which is an under-representation compared to their national
population of 7 per cent of the total New Zealand population (2013).
Pacific nurses constituted 77.8 per cent of the Pacific health workforce.

The prevailing challenge to the health sector is the improvement of the
poor health status of Pacific people. For instance, in the mental health
area, Te Rau Hinengaro (2006), Pacific people experience mental disorders
at a higher level than the general population — 25 per cent of Pacific
people had experienced a mental disorder in the past 12 months and
46.5 per cent had experienced a disorder at some stage during their
lifetime. Together with the high incidence of obesity, diabetes, heart
conditions, to name a few, amongst Pacific people there needs to be
urgent action taken at all levels.

This is one of the Pacific nursing strategies to date. Since 2011, the writer
has worked closely with Dr Margaret Southwick and Dr Debbie Ryan
to deliver a post graduate nursing programme to registered nurses of
various Pacific ethnicities. Some of them are from the mental health
sector. To date 50 nurses have passed and another 24 are studying in 2014.
Le Va has funded some of these nurses through the mental health and
addiction scholarships and Futures that work programme. Master classes
for the top graduates from the previous cohorts started on 27 May 2014.

The focus of the post graduate programme is to encourage Pacific nurses
to take up leadership roles. This is over and above developing their clinical
and cultural competencies as a way of alleviating the poor health status
of their own ethnic Pacific communities.

During one of the workshops of the post graduate programme, Dr
Southwick said there were three Cs required for the Pacific nurse leaders
to consider in their current and future work. The first C relates to
credentials as nurses, as Pacific people. The second is credibility that
comes from being clinically and culturally competent in working with
Pacific consumers, their families and communities. And finally, the
courage to make it all happen.

Our families came to New Zealand with visions of good health, education
success, job opportunities and a better life. For a variety of reasons
for most, these visions have been postponed, in some cases forgotten,
but history has shown that ‘out of the ashes rises the phoenix’. With
motivation and hope this will be so for Pacific people.

La manuia,
Soifua

References


Welcome to this bountiful autumn edition of Handover focused on Pacific nurses and kindly opened by our guest editor Fuimaono Karl Puloto-Endemann, who also introduces you to the five Pacific nurses who are profiled in this edition.

We trust this edition will encourage and inspire you and that you will learn more about Pacific health and Pacific nursing.

As the sector abounds with great stories this edition also includes articles about Midlands solution to growing more supervisors, practice development support for primary care nurses, and a nurse practitioner profile on Mark Baldwin.

Sue Philipson writes about addiction – a family issue in the family column and Pat Mitchell from the Werry Centre gives us the HEEADS up on a new assessment.

In the addiction sector update you will read about the psychoactive substance resources that are available, addiction nurses update by Klare Braye and the New Zealand Addiction nurses seminar by Steph Anderson.

We have vamped up the nursing digest section and in this edition Helen Hamer shares a review about a new text book – Mental health: A person centred approach. We encourage you to check out the new journal clips.

With such a jam-packed issue we decided to let our regular acutes, services user and information alive columns take a break this time.

We hope you enjoy the issue, it has been an absolute pleasure bringing this to you.

Kindest regards
Suzette

Suzette Poole - Editor

Clinical Lead
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Nursing notes

By Anne Brebner, clinical advisor and nursing lead

An educated workforce plus a good work environment equals high quality care.

This year, as we celebrate International Nurses Day, the International Council of Nurses (ICN) has boldly stated that this simple, evidence-based equation is fundamental to understanding how to make the best of the vital resource which is nursing. In my role as national nurse lead, and clinical advisor at Te Pou, I totally agree with this statement.

As I visit services in New Zealand, I am struck by the tenacity, dedication, resourcefulness and willingness to adapt to change that nurses offer. I am a strong advocate for services using an appropriate mix of skills to ensure the quality of care does not fall short. I am seeing services return to building nursing seniority and leadership, which is having the spin-off effect of being able to lead out and sustain significant change.

The mental health and addiction workforce can and should change to adapt to newer ways of supporting people. However, this must build on what we know nurses are capable of – what we can expect as minimum standards. Nurses can be the vital resource that helps all other workforces to link together cohesively to support a person through episodes of care.

The last few months have been a mixture of hands on project work and supporting and developing some new work plan ideas for the coming 12 months. We are seeing sustained change with regard to seclusion rates decreasing nationally. We are seeing national development of co-existing problem expertise; we are seeing the development of a huge range of initiatives that support better health outcomes for people who require longer-term mental health support. There are examples where there is less division between specialist mental health and addiction support and primary health care. There are still huge amounts to do to break down barriers, reduce stigma and improve health outcomes, but change is happening and this excites me!

I have a number of places I will be visiting soon, so am really looking forward to connecting with nurses, hearing stories of change and innovation. I am also keen to hear where change is more difficult to establish or sustain, where policy to practice needs more support.

I enjoy Handover as much as you do, and would like to publicly thank Suzette Poole for taking this regular publication for nurses to the next level of interest and relevance.

Warm regards
Anne

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Suzette Poole

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Nursing notes

By Suzette Poole, clinical lead

Nurses: a force for change

Nurses: a force for change was the theme for International Nurses Day this year and the International Council of Nurses developed a toolkit to inspire us nurses to "change the picture" to demonstrate to governments, employers, and society that nurses are a vital resource for health.

I would encourage nurses to let the picture of your practice speak for itself. The people and communities we serve and our colleagues will see within us the inner strength we have to create change and support others to change where it is wanted and/or needed.

One of the highlights of this role is being able to meet with nurses who are a great source of inspiration to me. In compiling this edition of Handover, I had the privilege of meeting some Pacific nurses whom we have profiled.

I was in awe as I listened to their stories unfold. Being in their presence was humbling and I learned so much more about the strong connection Pacific people have with their communities. I was impressed by their inner strength, determination and their graceful way of supporting the people they work with, their families and also the communities that they serve. The nurses described with passion their future aspirations, not only for themselves as professional nurses, but also for the health of communities where they lived and practised.

The meetings with the Pacific nurses made me realise that the force of change can emanate from us wherever we are. I think the secret is to be wise about how we change the picture and consider how we can dynamically influence the way we provide services across a range of practice settings from homes to hospitals. Our challenge is to do this within a changing health care system.

Warm regards
Suzette
Le Va is now an independent entity (Pacific Inc Limited) within the Wise Group and works closely with Te Pou to continue to achieve outcomes for Pasifika. Le Va’s purpose is to create opportunities for families and communities to flourish through embracing Pacific solutions.

Le Va’s approach is holistic taking a mental, physical, social and spiritual perspective to wellbeing. Its portfolio supports this perspective, encompassing workforce development and support services across mental health and addiction, disability, public health and suicide prevention. The approach embraces Pacific traditional values, whilst delivering with contemporary execution.

We walk alongside organisations and communities providing carefully developed resources, tools, information, organisational development and support services all contributing to the best outcomes possible for our Pacific families and communities.

Sign up to the Le Va e-newsletter to be kept up to date.

Upskilling the Pacific workforce

As part of Le Va’s Futures that work programme, Le Va has awarded 199 mental health and addiction workforce awards (on behalf of Health Workforce New Zealand since 2009) and 651 Pacific health and disability workforce awards (as part of the Serau Pacific Workforce Development Programme, 2010-2013). Futures that work consists of three components, encompassing mentoring, coaching, career planning and monitoring of recipients.

- Get your fees paid - providing financial support for people enrolled in a health-related qualification.
- Get your study sorted - ensuring successful advancement in study and career through the holistic Teuila coaching and mentoring programme.
- Get your dream job - being job-ready and transitioning to work or undergoing career movement.

Of the Futures that work participants, 143 were enrolled in nursing courses of study and two of our key ‘connectors’ have been nurses – Hilda Fa’asalele (who is now Chief Advisor Pacific) at the Ministry of Health and Elizabeth Tiumalu, whom you can read more about on the Le Va website.

Growing Pacific emerging leaders

Le Tautua emerging leaders programme supports emerging Pacific health leaders to develop their unique cultural leadership and management skills. Le Va has supported the development and growth of 94 Pacific leaders over the past five years, 12 of whom were nurses, and are now alumni. We are looking forward to working more with our alumni this year.
Enhancing responsiveness of services

Le Va has developed and implemented Real Skills Plus Seitapu, cultural competency framework and training for the mental health and addiction sectors (part of the Ministry’s Let’s get real competency framework).

Le Va has also had well over 1,000 people through the Engaging Pasifika cultural competency training programmes across health, disability, social and educational sectors. The innovative approach is based on international evidence, supported by Dr Joseph Betancourt from Harvard University and acknowledged by the New Zealand Health and Disability Commission, and includes a blended learning experience with online modules (including ethnic specific approaches), face-to-face workshops, and online follow-up forums. Results show that 95 per cent of participants rate the course as ‘excellent overall’. Key success factors have included practical and interactive action learning sets and a facilitation team with cultural, clinical, community, organisational, systems, and service user expertise and experience.

Engaging Pasifika programme

Each year, more than 350 people who work in mental health, addiction, disability and public health take part in Le Va’s flagship cultural competency training programme, Engaging Pasifika (EP).

Engaging Pasifika focuses on the foundation and essential skills, knowledge and systems that people and organisations can aspire to in order to better engage with Pacific people and their families. EP is designed for workers at all levels, in roles from frontline workers to senior managers, and for all organisations, including district health boards, non-government organisations, primary health care, social services and education providers.

Le Va works with the Waitemata District Health Board Matua Council to ensure cultural knowledge holders are contributing to the programme. The workshops are tailored and adapted to needs – for nursing perspectives we ensure we cover the tenets of cultural safety.

EP Online – an online interactive learning module providing foundation information and knowledge on Pacific people and cultures in NZ. EP Online is a pre-requisite for EP Live

EP Live – face-to-face workshops facilitated by a team of expert facilitators and Pacific knowledge holders

EP forum – post-training support via a members-only online forum

Ethnic Specific EP Online - Online learning modules providing an introduction to specific cultures
GPS 2.0 - Growing Pacific Solutions Conference

In March Le Va hosted GPS 2.0: Growing Pacific Solutions for our communities, the national Pacific conference, in Mangere, Auckland.

GPS also stands for Global Positioning System – satellites in the stars that help us locate where we are at and where we are going. Similarly, in ancient Polynesian times the global positioning of stars helped us navigate waters to harvest the riches of the sea, and told us when to plant vital crops, providing sustenance for our people.

GPS 2.0 brought 350 people together from across sectors to share how we are ‘Growing Pacific Solutions’ for our families. Strong messages included a call for strengthening collective action, focus on specific cultural, ethnic, rainbow and youth approaches and that “it’s time to talk”.

Innovative solutions that meet the needs of our Pacific families and communities in New Zealand were shared, integrating approaches for collective solutions - particularly across social sectors and priority areas: mental health, public health, addiction, disability, suicide prevention, and our community workforce.

Common themes and messages across all keynote presentations and session presentations at the conference emerged.

• There is a call for strengthening collective action – we know the solutions lie within our own communities, so let’s work together and make it happen for better outcomes.
• Culture is key to integrated solutions. Ethnic-specific approaches, rainbow Pasifika approaches, and youth-specific approaches.
• It’s time to talk. Tapu issues like sexuality, sexual health, suicide, abuse, mental illness, addiction, disabilities. To have solutions we need to understand the issues, and to understand the issues we need to talk. There are safe ways of talking about things tapu. We provided a start.

Majority of attendees identified the following as “useful for their practice or service delivery”

What delegates said:

- 90% would recommend this conference to others
- 63% most learned innovative ideas they can use
- 80% excellent overall
- 50% many identified time improvement
- Praised as effective
- Sharing of lived experience and personal stories
Waka Hourua is New Zealand's Māori and Pasifika suicide prevention programme. It responds directly to the expectations of the New Zealand Suicide Prevention Action Plan. The four year programme is delivered by Te Rau Matatini and Le Va, who have formed a strategic relationship.

Waka Hourua has five key components.

1. **National leadership**
   This will be achieved by the National Leadership Group, Pacific and Māori leaders who will monitor the performance of the programme and provide a distinctive and informed voice for Māori and Pacific suicide prevention.

2. **Pacific community suicide prevention**
   A national coordination centre for Pacific community suicide prevention.

3. **Māori community suicide prevention**
   A national coordination centre for Māori Community Suicide Prevention.

4. **Community fund**
   A one-off contestable fund for Māori and Pacific families, whānau, hapū, iwi and communities to establish community based suicide prevention initiatives and effective community based responses when suicide has occurred.

5. **A strategic research agenda**
   A strategic research agenda includes a one-off funding pool that will be allocated in April 2014 to contribute to the evidence base of what works for Māori and Pacific.

Le Va leads the Pacific programme and manages the Pacific components of the $2 million community fund and $600k Te Ra o Te Waka Hourua research fund.

The Pacific community programme focuses on four interconnected and interdependent work streams.

1. **Engage**
   Community engagement and awareness raising is key to enhancing understanding of suicide and suicide prevention in Pasifika communities and families. Community engagement will also contribute to developing approaches and solutions that are culturally relevant for Pasifika communities.

2. **Inform**
   Gather, fund, translate and disseminate information, knowledge, research and best practice relevant to suicide and suicide prevention for Pasifika communities in New Zealand.

3. **Equip**
   Developing appropriate resources and effective training for those people working with or connected to Pacific communities in New Zealand that focuses on building resilience and leadership in suicide prevention.

4. **Lead**
   A national suicide prevention hub for Pasifika communities that will provide access to relevant information and grow and promote leadership for Pasifika suicide prevention.

Hon Tariana Turia, Associate Minister of Health, formally opened GPS 2.0, following a warm series of formalities led by kaumatua and the Northern Region Matua Council (Waitemata District Health Board).

“The concept of growing Pacific solutions is about building momentum amongst our communities by first and foremost being responsive and respectful of the nations from which they come,” she said.

Minister of Pacific Island Affairs Peseta Sam Lotu Iiga also introduced the 18 new Le Tautua graduates and presented 46 scholarship awards to recipients at the conference dinner.

Le Va would like to thank Te Pou and Matua Raki for its support and sponsorship of GPS 2.0. Faafetai tele lava Robyn, Vanessa and the aiga potopoto (extended family)!

Read reports from Le Va staff about what happened at GPS 2.0 and see photos from day one, day two, the conference dinner and Le Tautua graduation.

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**Suicide prevention for Pasifika**

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More susceptible to suicide behaviours

Suicide attempts and planning

Pacific peoples
NZ-born Pacific peoples

General population
Migrated to NZ as adults

Pacific peoples
and mental illness

Access to mental health services

Suicide deaths are rare for those aged 40 and over.

2017
24 Pacific suicides

2017
92 intentional self-harm hospitalisation

not including those who stayed for less than 48 hours in hospital, misclassified as ‘accidents’ or who sought GP assistance
Call to action for suicide prevention at GPS 2.0

Following Hon Tariana Turia’s launch of Waka Hourua to Pacific communities at GPS 2.0, Le Va chief executive Dr Monique Faleafa said Waka Hourua was a call to action for collective responsibility for suicide prevention.

“The truly tragic issue is that our Pacific people who attempt suicide usually don’t want to die – they usually want a better life. And if we think about our conference theme, GPS and drawing upon the knowledge of our ancestors to guide us into the future, it reminds me, as a child of the migration that our parents came to New Zealand for - a better life. “They came to New Zealand with so much aspiration, courage and hope, and their dream was for their children and generations to come to flourish well in to the future. We need to come together for suicide prevention – look past our differences and come together – to ensure that every single Pacific person in New Zealand has the opportunity and the hope to achieve a better life.

“We know that no one organisation can prevent suicide on its own – we can all play our part; we can all take collective responsibility and collective action to prevent suicide in our communities, in our workplaces, and in our families.”

A picture of the Pacific nursing workforce

Pacific nurses represent 3% of the total nursing workforce.

The Pacific nursing workforce had slightly fewer men than the nursing workforce as a whole.

The Pacific nursing workforce has a significantly younger age profile than the nursing workforce as a whole.

31 March 2013 practising nurses who identified with at least one Pacific ethnic group

- nurse practitioners: 2
- registered nurses: 1504
- enrolled nurses: 100
Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health 2012, p30-35) makes it clear there is a need to build on and cement the gains made in supporting Pacific people with mental health and addiction problems. Pacific people have higher rates of mental health issues than the general population and there is a need to continue to develop a workforce that reflects the populations served across primary and specialist services. Pacific people represent 7.4 per cent of the population (New Zealand census, 2013) indicating the development the Pacific nursing workforce is vital.

Statistics are drawn from The New Zealand Nursing Workforce: (Nursing Council of New Zealand, 2014) http://www.nursingcouncil.org.nz/Publications/Reports
Celebrating diversity in mental health nursing: Development of the Bachelor of Nursing Pacific

By Wendy Scott. Academic leader: Faculty of Health, Whitireia New Zealand. Programme manager for Bachelor of Nursing Pacific and Diploma in Enrolled Nursing, Wendy.Scott@whitireia.ac.nz

Bachelor of Nursing Pacific programme

The Whitireia New Zealand Bachelor of Nursing (BN) Pacific programme celebrates 10 years since its inception this year. The programme was developed by Dr Margaret Southwick in response to the findings from her PhD research on Pacific women’s stories of becoming a nurse in New Zealand (Southwick, 2001). A key finding from this study was that nursing’s hegemonic values and beliefs were strongly embedded in curricula hence reproducing conditions of oppression for marginalised groups, in this case Pacific nurses. These hegemonic processes saw few Pacific undergraduates’ nurses succeeding in their BN programmes of study nationwide.

Aotearoa New Zealand has a growing population with Pacific peoples making up 7.4 per cent (345,000 in 2011) of the total population (4,353,198 – Statistics New Zealand, 2013). With a projected increase of 2.4 per cent by 2026, Pacific people will make up 9.8 per cent of the total population (Statistics New Zealand, 2013). Given the current poor health status of Pacific people, there is a need to ensure their health needs are able to be better met.

Increasing Pacific nursing capacity and capability will create a reservoir of professional mental health practitioners who will potentially be able to make a greater contribution to developing culturally appropriate mental health models of care.

One way of doing this is by preparing a nursing workforce that is reflective of the diverse communities it serves and by ensuring they are equipped to deliver safe nursing services. The intent of the Bachelor of Nursing Pacific programme is to build capacity and capability in the Pacific nursing workforce by deconstructing the dominant assumptions, values and beliefs around how one becomes a nurse and to reconstruct a new pathway for Pacific people to become nurses.

The development of a curriculum that incorporates and validates both Pacific and non-Pacific ways of knowing is one approach that has helped the programme meet its goals. Students are required to navigate both their Pacific world and that of the dominant culture to become a nurse. As with similar programmes the Bachelor of Nursing programme has been accredited and monitored by both the New Zealand Qualifications Authority and the Nursing Council of New Zealand.

Outcomes

Building capacity and capability in the Pacific nursing workforce is being achieved on various fronts. During the opening of the new Faculty of Health Wikitoria building at Whitireia New Zealand in 2013, Health Minister Tony Ryall spoke of how the Bachelor of Nursing Pacific contributed a third of all Pacific nursing graduates to the New Zealand workforce. Given that the Pacific population is far greater in Auckland than in the Wellington Region, Whitireia New Zealand’s contribution to the Pacific nursing workforce is significant.

In 2004 26 students entered the programme, with 19 of those students completing the qualification and gaining employment. Ten years on intakes have doubled, with the 2013 cohort gaining a 100 per cent pass rate for students who completed the degree qualification and went on to sit the NCNZ state final examination for registration. The programme is supported by a team of well-qualified tutorial staff who come with a range of both clinical and academic experience.

An argument can be made that, by increasing numbers of Pacific nurses in the workforce, Pacific people’s health outcomes will improve. This is yet to be evidenced widely in research. What we do know is that health...
gains for Pacific people have been minimal over the past two decades under the almost exclusive influences of dominant western culture.

To date research has not been undertaken to provide evidence on the impact of the increased numbers of Whitireia New Zealand Pacific graduate nurses has made in health care. This remains a future research opportunity. Anecdotal feedback from health care providers and service users has, on the whole, been positive regarding the contribution of Pacific graduates. Graduates have secured employment in a variety of settings including mental health, neonatal, medical surgical, primary health and community nursing.

Mental health is a key priority area for Pacific peoples as 46.5 per cent will experience a mental health event during their lifetime. This is compared to 39.5 per cent of the total population (Oakley Brown, Wells, Scott, & Ministry of Health, 2006). Oakley et al., (2006) also contend that 16.9 per cent of Pacific people have considered suicide compared to 15.7 per cent of the overall population. These statistics more than suggest the current mental health needs for Pacific people are not being met. Nurses have a key part to play in ensuring good mental health outcomes for Pacific people and developing the capability and capacity of Pacific graduates is critical. One pathway toward this development is through Pacific graduate nurses entering New Entry to Specialist Practice (NESP) programmes (new graduate mental health).

In saying this there has been a marked increase in the number of Pacific graduates entering NESP programmes – in the 2001-2004 period 3 per cent of graduates entered mental health programmes. This increased to 17 per cent in 2008 (Trimmer, Laracy, & Love-Gray, 2008), to which the Bachelor of Nursing Pacific programme makes a substantial contribution.

Where to from here?

Increasing Pacific nursing capacity and capability will create a reservoir of professional mental health practitioners who will potentially be able to make a greater contribution to developing culturally appropriate mental health models of care. Engaging with the foundational and influential work of Fuimaono Karl Pulotu-Endemann (2004), these practitioners have the opportunity to develop models of care that make a significant contribution to the mental health and wellbeing of their communities and in turn contribute to wider society. This is a win-win for everyone.

References


Tele-health: A real milestone for Cook Islands nurses

In the Cook Islands, just over 110 nurses deliver health care to around 15,000 people. There is one 100-bed hospital in Rarotonga and seven smaller outer-island hospitals that are supported by a few community-based clinics. Mental health services are scarce. There are no actual mental health hospital beds and no resident psychiatrist, so options for people with mental health needs are limited. These needs are not generally understood or acknowledged by the community and some hold to an underlying traditional belief system where mental illness is considered ‘tapu’. Not many people with mental health problems are admitted into hospital. Most are either Cook Islanders who have returned home or tourists who have become unwell while on holiday in the Islands. Often there is very little information available about their health.

Until recently, there was no formal mental health education or training for nurses. However, in 2013, thanks to modern technology and the determination of three nurses from Northland District Health Board (DHB) that picture began to change. Maurein Betts (team manager, community mental health – addiction services) has family ties to Rarotonga and had been working with nurses there to increase awareness of mental health issues. As a result, interest in tele-health as a solution began to rise and a project evolved. Jewel Reti had been working with Northland DHB to develop a local tele-health system to increase access for service users finding it difficult to access opioid substitution treatment in Northland. She used a Te Rau Matatini Medibank scholarship to develop telenursing frameworks that were also used in the design of the tele-health programme with Rarotongan nurses. Claire Glover, a Northland DHB mental health nurse who specialises in community mental health care also joined the project.

The Northland group of nurses, in collaboration with Ngakiri Teaea the chief nursing officer, Hospital Health Services, Rarotonga Cook Islands and Simione Tagicakibau the charge nurse in the medical ward, designed a regular training programme that is delivered using video conferencing. The overall objective was to enhance the skills, knowledge and confidence of Cook Island nurses to work with people experiencing mental health and addiction problems. One-hour conferencing sessions were set up each fortnight, with pre-information sent to the nurses in Rarotonga so they could prepare for the sessions. During each tele-health session the previous session is reviewed, scheduled education is delivered and then there is time for questions. After each session the Rarotongan nurses send a feedback form to the Northland group. On average 10-19 nurses participate in each session and 120 nurses have participated overall during the first three months to September 2013.

Simione explains how helpful the sessions have been.

“The programme has really improved nursing assessment skills. Most nurses were not aware of the Mental Status Examination (MSE) but after completing three tele-health sessions they are now able to understand and use the MSE effectively. The programme has helped to improve the nursing care of people with mental health problems. Previously, care used to be generalised and now it is more specialised to meet the needs of the service user. Nurses who used to be scared or reluctant to provide care to a person with mental health problems are now able to understand that person better and confidence in their practice has increased.

“Having the ability to access professional support and advice from Northland DHB provides an opportunity to discuss our approaches to treatment. This has been particularly helpful when we are working with people for the first time and have very little information about their health histories.

“The learning forum enables nurses to reflect on how people with mental health problems have presented – their appearance, speech and behaviour, and to understand what is happening for that person and then learn how to effectively respond to their needs.”

She says the ability to see, talk with and learn from other health professionals has been eye opening for most nurses and a great experience for them to work with experts in mental health. “It’s a real milestone for Cook Islands nurses.”

If you would like to know more about this workforce development initiative project contact Maurein Betts: maurein.betts@northlanddhb.org.nz.
Profile: Sione Vaka

Juggling PhD study with work, family, social and church commitments has been a big yet necessary challenge for Sione Vaka. He was driven to persevere with his PhD to improve support in the New Zealand mental health system for Pacific people.

“From a Tongan perspective, a healthy person is one who maintains healthy social relationships with the living, along with spiritual relationships with their faith and the supernatural world.”

“Family and community are sometimes not aware of the requirements needed for PhD study and the biggest challenge is trying to complete your study while also maintaining those relationships,” says Sione, who is in the final stages of his PhD research.

When Sione first considered doing a PhD, he was keen to look at why Tongan people have a higher risk of mental illness in New Zealand than they do in Tonga. However, after much discussion with his supervisors and the Tongan community, he decided it was more important to clarify what mental illness means to Tongan people; to look at how Tongan people conceptualise and construct mental illness.

“It is a fundamental starting point because Tongan people do consider mental illness to be something different from what the mainstream considers it to be. For example, there are no Tongan/Pacific words for mental disorders like depression, schizophrenia etc. My research explored mental illness for Tongan people and I sought to find ways to ensure mainstream and the Tongan community are calling a spoon a spoon.”

Sione says relationships play a significant role in the health of Tongan people and this is something that needs to be emphasised more strongly in the current New Zealand health system.

“Our health systems address the social aspects of health, along with the medical, and we need to put more emphasis on spiritual needs as these are an essential part of mental health.”

He says, as a result, many Tongan people will stop taking their medication or not even engage in mental health services, even when they are unwell.

“If we can engage better through addressing these social and spiritual relationships, we will be able to provide better treatment and higher quality care.”

Sione successfully completed his master’s thesis in 2005, which was on the validation of Alcohol Use Disorder Identification Tests (AUDIT) on Tongan people and is now working towards his PhD. He moved from clinical work to teaching in 2008 and worked at the Manukau Institute of Technology lecturing on mental health and for the Bachelor of Nursing Pacific programme. He moved to Massey University’s School of Nursing last year, and is now lecturing in its undergraduate programme.

“I moved to Massey for the research opportunities. The researchers here are very established in the field of nursing and mental health and I’m gaining a lot from being here.”
Profile:
Funaki Pauta

Funaki Pauta is 36 years old and migrated to New Zealand from Tonga in 1999. He is a registered nurse working at Rangipapa Acute Forensic Medium Secure Psychiatric Unit, Te Korowai Whariki (Capital & Coast District Health Board). Funaki is part of a multidisciplinary team that assess individuals who are before the courts for committing a crime but who may have a defence because of their mental illness.

The people usually stay in the unit for several weeks while being assessed. Funaki is part of a multidisciplinary team who take a holistic approach to the person – caring for both their mental and physical needs. The team’s goals include reducing health disparities and reducing the incidence and impact of chronic diseases.

He has been at Porirua Hospital for four years. Before this he worked with inpatients at Te Whare Ahura (Hutt Valley District Health Board) and for Pacific Community Mental health (also Hutt Valley District Health Board).

Funaki was inspired to become a mental health nurse because he saw so many people in the community who were stigmatised and discriminated against.

“As a Pacific Islander I grew up with the belief that you should love one another (as you love yourself). That is our way. And I thought I could help make a difference for people who find it hard to get help with their health because they face so many barriers.”

He enjoys the work immensely, especially sitting down and talking with people about their history and what they can do to get well and achieve their goals, and he loves it when he receives positive feedback.

“It feels good to know you’re being effective and doing your job well.”

He also enjoys the different cultural perspectives and says he is learning on a daily basis – but that the most important thing about his work is being an advocate for Pacific people with a mental illness.

“Someone with a mental health problem may feel neglected and depressed because there is no one on their side to speak for them. There’s no difference between someone with a mental illness and someone with diabetes or a heart problem, but as soon as we hear they have a mental illness we label them and they become ‘different’ from us.

“So I often talk with the families about how they can help. It’s important not to ignore or neglect them. I show the families how to get help and advice for their loved one so we can help them recover and have a better life.”

Funaki says Pacific people can face language and culture barriers when dealing with health services, so it’s really helpful when they can talk to someone in their own language. Often non-Pacific nurses don’t understand Pacific culture enough to make the person feel respected and comfortable. This makes it hard for them to express themselves.

His key message is that it’s vital we have more Pacific nurses and he encourages Pacific people to consider nursing and Pacific nurses to consider working in mental health.

“I was the only Tongan nurse at Porirua Hospital, but I encouraged some colleagues who had just graduated to go into mental health, and now we have three. It’s an excellent opportunity to network together to make a difference, not just for our own people, but for everyone in the community.”
Natalie Leger

Profile:

Natalie Leger is a registered nurse and team manager of Faleola Pacific Adult Community Mental Health Service at Counties Manukau Health and also the Pacific advisor for mental health services. She is based at Matariki in Otahuhu. She leads a busy life as a full-time working mother and is completing a Masters in Business Administration (MBA) under scholarship from Le Va. Natalie’s husband is Samoan and they have two beautiful children. Natalie believes she has a servant-leadership style and was very humbled and honoured to share her story in the hope that it would raise the profile of Pacific nurses.

Natalie is third generation New Zealand born Tongan. Her great grandparents were one of the early families to immigrate to New Zealand “to the land of milk and honey” and her grandparents raised their 13 children as Kiwis. Her mother is Tongan and her father Palangi.

Natalie felt like she grew up and learned to walk in two worlds which now shapes her professional way of working. As a child she recalls having very little money and that just about everyone in her family worked in a factory. She saw members of her family being injured by workplace accidents and experience many hardships and social issues. It was these experiences that inspired Natalie to stay at school, study hard, and create a different pathway.

She was declined entry into the first nursing training programme she applied for because they didn’t think her family could pay. That experience made her feel ashamed initially but turned to outrage due to the injustice. Her family challenged the decision, but it took letters and calls to local MP (at the time) Helen Clark before anything changed and Natalie was offered a place on a different nursing programme. Natalie was the first in her family to get a tertiary education and there are now others, including her mother who also went on to become a registered nurse.

After graduating from the Manukau Institute of Technology in the late 1980s, Natalie worked at Auckland Hospital and then Waitemata District Health Board for the first 18 years of her nursing career. She spent the first four years working in a medical ward which included supporting people who were receiving medical detoxification for substance use. She noticed that, although people were treated, there was no support for them when they were discharged and they had very little or no connection with services available in the community.

She also saw that a lot of people coming into the ward were not having their needs met. So Natalie created a ‘resource nurse for substance use’ role within the hospital and then moved into the community within the mental health and addiction sector and began a number of projects which included the establishment of Tupu, an Auckland-based mobile Pacific Island alcohol, drug and gambling service.

About five years ago she took up the role of service manager at Faleola. She was excited about the idea of returning to work in the South Auckland community. The role was later restructured into two positions, team manager for Faleola and a unique Pacific advisor role for mental health. Natalie enjoys her roles as they provide her with opportunities to contribute at an operational and strategic level to matters that impact on the health of Pacific peoples. One of the organisational goals is to build cultural capability, ensuring that we can respond to the needs of Pacific at all touch points in the journey is important to achieving that goal,” explained Natalie.

Natalie is passionate about supporting Pacific nurses along the workforce pipeline from encouraging youth and adults to consider careers in health and also supporting nurses towards obtaining leadership roles and attaining nurse practitioner status. She describes her team as an ‘incubator’ which provides nurturing for staff and then encourages them to go out and work in other services to grow and develop their careers.

One recent exciting initiative was to provide two nurses from Samoa with a four week placement to develop their mental health knowledge and skills. A new mental health unit will be opened in Samoa later this year so support such as this can assist Samoan nurses to work with people experiencing mental health problems.

Natalie’s key messages for Pacific nurses include that each of us has a role to play, individually and collectively – using our heart, head and hands – to make a difference.

“We need to believe in ourselves and support each other as we look beyond our current roles and think about how we can best serve our communities. It’s about learning all the time and stepping out of our comfort zone to serve in different ways,” she says.

“There’s a real need to grow Pacific nursing leadership and build the Pacific nursing workforce in order to increase connectedness and build support systems alongside individuals, families and communities.”
Profile:
Taavale (Ioana) Mulipola

Taavale (Ioana) Mulipola was born and educated in Samoa. Alongside her husband she had worked in a bank until they migrated to New Zealand in 1998. Ioana currently works as clinical nurse specialist (primary care) at The Cottage Community Mental Health Centre (Counties Manukau District Health Board).

She is a mother to four daughters and lives with her husband in Mangere. Once her youngest had started school, she thought about becoming either a nurse or a teacher. She now says nursing was a “wise choice” because she enjoys how it has increased her connections with people, families, other health professionals and community networks.

Ioana completed nursing training at the Manukau Institute of Technology in July 2007 and then did a new graduate programme. Her placements were with Whirinaki, (child and adolescent team) and Faleola Services, (Pacific mental health team). Following completion of the programme Ioana continued to work as a nurse at Faleola Services and then spent some time practising in the intensive care treatment team.

She started in her present role in April 2013. She is currently enrolled in a clinical Masters programme and completing a pharmacology paper at the University of Auckland. Her goal is to become a nurse practitioner specialising in mental health and intellectual disability.

Ioana loves her nursing work.

“Knowing that I’ve made a difference makes my day and it’s a job that comes with wonderful opportunities. Nursing comes with many blessings. My confidence has grown and I have been transformed by the non-stop learning involved. My family even comment on how much more confident I am since becoming a nurse,” she says.

“It’s not just a job. It’s something more and rewarding. Every person brings a different issue and I need to do their assessment and find the right supports for that person’s individual needs. As their stories unfold, I learn so many new things.”

The focus of Ioana’s role is liaising with GPs and practice nurses, but she has extended this to the wider community. Representing the Cottage, she attends various community network meetings where all local support services gather together every second month to facilitate working together. She has had positive feedback about this from her manager.

She says what’s important to her as a nurse is her family, culture and her community. Being honest, reliable, humble and genuine is important.

“I have real empathy for clients and see my work as a golden opportunity to provide care for them and their families.”

Her key message for other Pacific nurses is always to aim high to achieve your goals, seek the right support and never give up.

Ioana knows she has a strong determination to succeed and achieve goals in her life. She felt very honoured about being approached to share her story as she was aware that there are many other Pacific nurse leaders.
Makoni is a registered nurse in the child and adolescent team based at Whirinaki Child, Family and Youth Mental Health (Counties Manukau District Health Board). She works within the Vaka Toa team which provides services to Pacific people, and those connected to them, in the 4-18 year old age group.

She was born in Tonga and migrated to New Zealand in 2001 with her father and siblings – and after her mother passed away in 1997. Tongan is her first language, though she completed high school in New Zealand where she learned to speak English well.

Makoni loved chemistry at school and wanted to become a pharmacist. But after a year of study she decided it wasn’t for her. She didn’t want to become a doctor as she wanted to spend more time with patients, so becoming a nurse was the obvious choice.

In 2009 she graduated with a Bachelor of Nursing from the University of Auckland. Makoni knew in her second year of nursing training that she wanted to work with children and adolescents. Before completing a new graduate programme she took time out to focus on family commitments.

In 2011, Makoni completed the new graduate programme and her placements were in the Vaka Toa team and Kuaka Ward in Tiaho Mai (Counties Manukau District Health Board). In 2012, she returned to work in Vaka Toa as a registered nurse and has completed a post-graduate diploma in mental health. Makoni is exploring a Masters programme and would like to become a nurse practitioner in the future.

She says she loves the study and recently completed Le Va’s emerging leaders programme, graduating at the Global Pacific Solutions 2.0 Conference in March 2014.

“If Pacific people don’t engage, there could be a number of reasons. Be respectful and open-minded, but don’t be afraid to ask questions and explore things a little more.”

She’s passionate about her role and, as a young nurse, felt quite honoured to share her story.

“I’m so thankful. I think about the workday ahead from the moment I wake up and I love that every day is different. Children and youth all bring different problems,” she says.

“I would not suit doing the same routines every day like in some other areas of nursing, I like a challenge. I enjoy working with people who are acutely unwell, getting alongside them as they recover.”

She also enjoys the therapeutic relationships she has with service users, their families and with other health professionals and thinks she is very fortunate, being able to speak the language and work with Tongan families where many parents do not speak a lot of English.

Makoni has personal experience of losing loved ones to suicide. Her family at the time found it hard to seek help because of the stigma and discrimination around mental health among many Pacific people. She has found her own experiences of loss have helped her to connect with the people she works with.

But things are improving.

“There are now more children, youth and families engaging in services and that suggests the stigma and discrimination around mental health are decreasing,” she says.

Makoni’s key message for those working with Pacific people is always to be yourself, because Pacific people can see right through you.

“If Pacific people don’t engage, there could be a number of reasons. Be respectful and open-minded, but don’t be afraid to ask questions and explore things a little more.”
Supervision has been signalled as one workforce development strategy that can support the mental health and addiction workforce to achieve the goals outlined in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*.

While not all New Zealand nurses working in mental health services are engaged in regular professional supervision, a number of different supervision training programmes are underway, including programmes designed and delivered internally by some district health boards (DHBs). One such programme is an exciting new workforce innovation involving the Midlands DHBs: Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato.

Just a couple of years ago, only 30–40 per cent of mental health nurses in the Midland region had access to supervision, and training opportunities to become a supervisor were not being sufficiently used. Often this was because those who wanted training had to go out of the region, which was inconvenient and costly.

“So we started looking at how we could provide foundation training in supervision in the Midland region,” says Moira O’Shea, a mental health nurse educator at Waikato DHB. “And eventually we thought, we’re actually quite able to do this ourselves.”

Moira teamed up with Carley Jones, a mental health nurse educator at the Bay of Plenty DHB. Together they put a proposal to the midlands regional directors of mental health nursing to develop a foundation course that would allow participants to become confident and competent to supervise. The proposal was supported and development work began in early 2013.

“As we were developing the proposal we did a literature review looking at what the best practice was for supervision,” says Carley.

“We incorporated that information into a three-day model. Two days would be based on background and theory and the third day would look at more practical issues.”

The course covers what supervision is, some models of supervision, how to run a supervision session and how to develop a supervision contract. Supplementary reading and exercises are given after the first day and participants reconvene after a week to discuss and build on their ‘homework’. After that second day participants are required to contract to supervise someone (preferably their own supervisor or someone with supervision experience) and the person contracted sends an evaluation form back to Moira and Carley. After six weeks participants come together again for the third day of their training so assessment and further learning can take place on the basis of what they have accomplished.

Three months after their training participants are contacted again to see how they’re getting on with supervision. What the participants say and the feedback from those contracted is used to further refine and improve the course.

“It’s very experiential and interactive. We include activities useful for various styles of learning including role plays and role modelling from our own supervision experience,” says Carley.

“We talk about organisational issues around supervision. The literature showed people need to understand the wider focus and where supervision fits in. We also look at professional development pathways so participants can see this is just one step in their development.”

Fourteen people completed the first training course held in late 2013 – all of them mental health and addiction nurses from Waikato, Lakes and Bay of Plenty DHBs. The second training course took place in early 2014. Attendance was more ‘inter-professional’, and included some who were alcohol and other drug clinicians or other allied health colleagues. Another two training courses are scheduled for later in 2014. Each can have up to 16 participants.

“Feedback from those first 14 was very positive, with most saying they now feel confident to engage in supervision with at least one, if not more, supervisees,” says Moira.
“They said they had a better understanding of the supervision process and that they would encourage others to take part in the programme. The aim is that, by the end of 2014, 45 newly trained staff will be in place across the Midland region.”

The next step in the programme is to develop a ‘train the trainers’ set of workshops so DHBs can roll the training out and manage it themselves.

The course has been recognised by dapaanz (The Addiction Practitioners’ Association, Aotearoa-New Zealand) which means participants can achieve some official accreditation and acknowledgement. It is not yet New Zealand Qualifications Authority (NZQA) approved, but that is a target for the future.

However, as Moira points out, “You don’t need to have an academic qualification to be a good supervisor, but you do need to understand the process and be confident and competent. And this training certainly meets those needs for mental health and addiction nurses.”

Michael O’Connell is the director of mental health and addiction nursing at Lakes DHB and member of the Midland Regional Directors of Mental Health Nursing. He says the programme has been a great success.

“Our strategy was to develop a user-friendly process for continuing to grow our resource base of new supervisors, and this is a nursing-driven process to do just that. It was a pragmatic way of using what we already had so nursing could manage its own workforce development. It also confirms nursing’s commitment to work collaboratively at a regional level. The programme is economical, relevant, accessible and key to driving the ongoing development of critical and structured reflective practice in nursing and health care.”

While it has not officially endorsed the programme, Te Pou has assisted its development by providing advice, guidance and supervisor/supervisee guides that could be used with participants. Te Pou supports it as a local solution to workforce development needs. Our initial conversations with Te Pou were invaluable,” Carley says.

“We didn’t want to be doing this in isolation and we wanted to be sure it truly aligned itself with existing needs, so guidance from the national organisation responsible for developing this sort of training was really important.”

Te Pou will continue to support this workforce innovation.

Nurse practitioner profile: Mark Baldwin

The journey to nurse practitioner

The desire to find new challenges in mental health nursing set Mark Baldwin on a two-year journey to nurse practitioner (NP) status.

“I chose to go for NP status following a discussion with my then colleague in the community mental health team, who became my clinical supervisor. I was keen to remain in the clinical field and stretch myself rather than go into management, so that meant investigating clinical nurse specialist and NP roles.”

The role of an NP was not very familiar to Mark who had come to New Zealand from England in 2008, having worked for 13 years there as a mental health registered nurse.

“However, when I looked into the NP role I realised it was not too dissimilar to the community nurse role I had held in the UK. I was in a primary care liaison team where I did initial assessments of patients and provided feedback to the GP who then did the prescribing. So I decided to pursue NP status.”

Road to NP status

Once he’d decided, Mark contacted the Nursing Council who told him to have his UK Masters degree in mental health nursing transcript viewed by the University of Otago. He completed it at Peninsula Medical School in Plymouth in 2007 before moving to New Zealand.
His qualification was found wanting in the area of clinical knowledge so Mark enrolled in four papers from the clinical Masters pathway; pharmacology, advanced health assessment and the two prescribing/practicum papers.

“In the UK, only basic physical observations were covered in my mental health nurse training so that meant I didn’t have the physical health assessment knowledge required for NP status. Therefore it was a great feeling to come out of the objective structure clinical examination (OSCE) with a 78 per cent score.”

Intervention of soccer

It was an intensive study period for Mark as he developed his knowledge and expertise in physical health, ironically helped by a broken collar bone from playing soccer.

“I had six long weeks at home recuperating during which I was able to study the pharmacology paper, which was quite physical health focussed.”

Mark says the two prescribing papers were also intensive and he was grateful for the support of his supervisor Professor Paul Glue and of NP Bernadette Paus with whom he undertook initial assessments in the community.

"I was very lucky. Professor Glue has an encyclopaedic knowledge of psychopharmacology and it was invaluable working in the community with Bernadette.”

After passing the four papers, Mark completed his postgraduate diploma in health science, then turned to working on his portfolio. At this point soccer provided another opportunity to concentrate on study – he broke his leg while playing and ended up with another lengthy stint at home. “I used that time to complete my portfolio.”

Gaining NP status

In November 2013 Mark attained his goal, gaining NP status with adult mental health as his NP scope of practice. He is now waiting for an NP position.

“Our nurse director Heather Casey has been very supportive of the NP concept and is currently working on a business case similar to the model in Balclutha for an NP role within the community sector working alongside the non-governmental organisation (NGO) sector in Dunedin.”

Currently Mark is working as a clinical nurse specialist on ward 9C at Wakari Hospital, where he is responsible for supporting and developing nurses and nurse practice through education, training, quality assurance, practice development, student placements and professional leadership.

He applied for the clinical nurse specialist role about the same time as embarking on NP study, keen for the challenge and to be in a position of influence in a ward he had worked on when he first arrived in Dunedin. Previously he was working with the North Community Mental Health team as a community liaison mental health nurse.

“I was keen to gain experience in quality assurance and help with the practice development of others. I also had some ideas of what I would like to implement to improve the working lives of the nurses and the patient care experience. Having the scope to do that appealed to me,” he explains.

Background

Mark became interested in nursing after suffering from a status epilepticus due to viral encephalitis when he was 15. The experience made him keen to learn more about epilepsy and viral encephalitis and he spent hours in the local library reading up on it. He then got a work experience opportunity at secondary school in a burns and plastics unit and an orthopaedic ward.

“But I felt squeamish in the burns unit and faint in the orthopaedic surgery. Those experiences and my interest in the brain and epilepsy drew me to mental health nursing.”

Mark moved from Cornwall to Sheffield to do his nursing degree, wanting to experience a more cosmopolitan and ethnically diverse lifestyle.

“Being in Sheffield challenged my worldview and made me encompass different viewpoints into my thinking.”

Half way through his nursing degree, Mark had to choose whether to pursue adult (general) nursing, child or mental health. “I chose mental health which means I can only work in mental health in New Zealand.”

After 14 years of mental health nursing in the UK in areas including adult acute admission, community, psychiatric intensive care and psychiatric district care, Mark and his family moved to Dunedin.

“We moved to New Zealand for the better lifestyle for the children, and so far we have not been disappointed. We chose Dunedin because it had fairly similar weather to Cornwall, so the family and I felt right at home.”

His life in Dunedin revolves around his profession as well as his family and, of course, soccer. Currently he is secretary for the Nurse Practitioners New Zealand (NPNZ) and chair of the research sub-committee of Te Ao Māramatanga New Zealand College of Mental Health Nurses.

Difference to nursing practice

He is looking forward to working as an NP, keen to become a one-stop shop.

“The holistic NP approach provides more opportunity to see the big picture and use prescribing to assist people in becoming all they are capable of being.”

He says as a registered nurse he had strong opinions about the medication people should be on, but now realises how very complicated prescribing can be and the vast number of variables that need to be taken into consideration when choosing drug and dose.

“Being a novice NP I will be glad of the collegial support of my supervising psychiatrist and of the peer support from the bi-monthly meetings with Southern DHBs three other mental health NPs,” he adds.

Mental health nursing offers a satisfying and challenging career, says Mark.

“I enjoy the complexities of the human mind and how individuals see the same world but view it slightly differently. The buzz of the job for me is in watching people recover and looking at what they have learnt on the journey that they can take forward to face their next challenges.”
Family Column
By Sue Philipson, AOD family advisor and FADS group facilitator, Alcohol and Drug Services, Taranaki District Health Board.

Addiction – A family issue

Here in Taranaki we are fortunate to have a unique role in our alcohol and drug service – that of alcohol and other drug (AOD) family advisor. Across the country you will be aware of the family advisor roles for mental health and addiction services. These hard-working people are tasked with providing the family and whanau a voice while advising management across the services from a family and whanau perspective.

My role as AOD family advisor allows me to focus solely on our addiction services. One of the prerequisites in becoming a family advisor is that we must have lived experience as a family member of someone with mental illness or addiction and as the mother of an amazing daughter with her own journey, I took on this role eight years ago.

Anyone who has a loved one with substance abuse issues knows this is not only an issue for the individual – addiction is a family and whanau concern. For every person who has a drug or alcohol problem, it is estimated five other people are adversely affected. Therefore it makes sense to involve family members in their loved ones’ treatment.

Most alcohol and drug services, CADS, hospital or community treatment centres aim to involve family in three different ways.

- Service delivery – this is where family inclusive practice includes the family as part of the treatment team and enlists their help in assisting a person towards recovery. This may involve working on some of the existing family dynamics and building on strengths within the whanau.
- Service evaluation and development – this is where, often via a family advisor, feedback and opinion relating to the policies, procedures, structure and delivery of alcohol and drug services.
- Support and education – this involves provision of easily accessible, non-judgemental, confidential peer support, including information and education around addiction, specific substances, treatment options, navigating the addiction health system, communication skills, boundaries, rescuing, enabling, self-care and more.

Although all three of these levels of family involvement are important, it is support and education which may provide the most significant opportunity for positive change for these families.

Most of us, when we first come to realise our loved one has a serious problem with alcohol or other drugs, are feeling the pain and anxiety, shame, guilt, frustration and desperation of watching them struggling with their alcohol and/or drug use. There may also be a co-existing mental illness which further compounds the distress for the person and their family. A family member, when presenting for support for the first time, is typically experiencing:

- loss of sleep
- high anxiety
- not eating well
- tearfulness
- fear
- anger
- financial problems
- legal issues
- physical and/or emotional abuse
- other symptoms of stress.

Whether our loved one is engaged in treatment or not, is focussed on their own recovery or not, it is important we do whatever we can to ensure our own lives do not become or remain unmanageable. If we are given some new skills and offered support and encouragement, we can learn coping strategies and gain strength in knowing we are not alone in our journey. We learn alternative communication skills and that there is always hope for improvement.

Support and information is best offered in the form of a facilitated peer support group. The purpose of such a group is to:

- reduce isolation, stigma and discrimination by meeting with others experiencing similar situations
- exchange information and practical ideas, exploring alternatives to strengthen coping strategies
- understand the nature and power of addiction, sharing ways of helping our loved one without rescuing or enabling addiction
- promote ‘self-care’ and encourage the use of boundaries as protection from the consequences of another’s drinking or drug use.

Research shows people with alcohol and drug issues are more likely to engage in treatment if those closest to them are receiving support and education, so in seeking support for ourselves, we can impact positively on our loved one’s issues.

Taranaki DHB runs a weekly group called Family Alcohol and Drug Support (FADS) and, when asked about the benefits of attending the group, family members had the following to say.

- “I am no longer feeling alone.”
- “I have learned to accept, without condoning, the addiction and also know it’s not my fault.”
- “I have learned it’s ok to say NO – actually I NEED to say no more often.”

“It is encouraging to see that today, for people who are ready to address their alcohol and drug issues, their families and whanau are being recognised as part of the solution.”
“I have gained a more thorough understanding of addiction and different substances.”
“I have learned the importance of taking care of myself.”
“I now know that his recovery is his responsibility – not mine.”
“I have learned how to communicate without so much anger – from a place of love.”
“I’ve learned about ‘enabling’ and no longer give money or lie for her.”
“I no longer rescue him by phoning his boss or protect him from negative consequences.”
“I feel supported when things get tough.”
“I know there is always HOPE.”
Clinicians report that when a family member has been receiving support and education they are better prepared to contribute in a productive and helpful way when involved in family inclusive practice.
Historically, alcohol and drug treatment has focussed predominantly on the individual while families may have been seen as part of the problem. Today there is a refreshing and well-informed shift towards involving family members and natural supports in the treatment process and also offering support and education for the family member in their own right. This can be highly beneficial, even if the individual is not yet ready to engage in treatment. It is encouraging to see that today, for people who are ready to address their alcohol and drug issues, their families and whanau are being recognised as part of the solution.

Addiction Updates
Psychoactive substances – resources

In response to the recent Psychoactive Substances Amendment Act coming into force Matua Ra ki, in partnership with the Ministry of Health, developed a series of downloadable fact sheets to provide guidance and advice for mental health and addiction services, primary care, public health, police and people and their families/whānau. The fact sheets are designed to support those who were unable to access new psychoactive substances legally and who may have been be in acute withdrawal.


A possible dramatic rise in the number of people needing to access support services highlights the requirement for appropriate and consistent management of withdrawal symptoms, despite little being known about the nature of new psychoactive substances and the long-term effects of use.

After review of the known withdrawal symptoms that have been observed in people stopping use, the 2012 Matua Ra ki suite of withdrawal management guidelines were identified as being current best practice for withdrawal management. Most of the new psychoactive substances mimic the effects of cannabinoids or stimulants and the Substance Withdrawal Management: Guidelines for Medical and Nursing Practitioners in Primary Health, Specialist Addiction, Custodial and General Hospital Settings contains clear guidelines for the appropriate medical management of substance specific withdrawal symptoms.

Specialist services that do not have copies of these guidelines are able to download them from: www.maturaki.org.nz/library/maturaki/substance-withdrawal-management-guidelines-for-medical-and-nursing-practitioners.

The Managing Your Own Withdrawal booklet, written for people who are able to manage their own withdrawal without specialist and or medical support, is available at: www.maturaki.org.nz/library/maturaki/managing-your-own-withdrawal-a-guide-for-people-trying-to-stop-using-drugs-and-or-alcohol.
Matua Raki nursing update

by Klare Braye, project lead

The last few months have seen a number of addiction nursing activities occurring around the country. The Addiction Nurses Seminar, organised by Matua Rāki, with the support of Jewel Reti (Northland District Health Board and Manaia PHO), and the Addiction Nurses Working Group, was held in Whangarei in February. Referred to briefly in the last edition of Handover, there is now a comprehensive write up of the event in this issue of Handover, and presentations for the day are now available on the Matua Rāki website. Thanks to all those involved for their attendance, participation and behind the scenes organisation and support pre and post event.

The other exciting bit of activity is the recent roll out of the managed withdrawal workshops. These are initially being delivered in the South Island through May and June by Steph Anderson (NMDHB). The workshops draw on an earlier delivery to Corrections by Moira Gilmour (Capital & Coast District Health Board) and the Substance Withdrawal Management: Guidelines for Addiction and Allied Practitioners. The training is targeted at nurses and addiction practitioners who directly support withdrawal management, assisting them to better understand signs and symptoms and effectively use services and resources to support service users/tangata whaiora. This training will be rolled out to the North Island later in the year.

The addiction nurses practitioner pathway peer supervision teleconference is a monthly event, facilitated by Louise Leonard (Waikato District Health Board nurse practitioner) to support those actively pursuing the nurse practitioner pathway. As an informal supervision, it is a valuable opportunity to share ideas and stories, to overcome challenges and gain support from colleagues on a similar venture.

Less high profile, but equally important, are the Proposed amendments to the midwives and nurse practitioners’ prescribing of controlled drugs, on which a number of individuals have provided submissions. It is encouraging to see this progressing and the consultation process occurring, which will allow for greater scope for addiction nurses to support service users/tangata whaiora.

The Matua Rāki Addiction Nurses Working Group met in April, representing a number of areas of addiction nursing (DHB, NGO, OTS, managed withdrawal, education, and nurse practitioner). Through this representative group, (geographical, service delivery, special interest) Matua Rāki is better able to encourage and promote nursing leadership and use the strengths of individuals for the benefit of the wider group of addiction nurses. Planning at our last meeting focused on the Addiction Nurses Symposia, managed withdrawal training roll out, supporting addiction nurses on the nurse practitioner pathway, the proposed changes to prescribing of controlled drugs, promoting the activities of DANA and encouragement of reflecting on practices that can gain recognition through the Matua Rāki Innovation Award. This group also works to maintain a contact database of nurses working in addictions.

If you want more information on any of the above activities or want to be part of this database please contact Klare Braye at klare.braye@matuaraki.org.nz.

New Zealand Addiction Nurses Seminar, 2014

The fifth Addiction Nurses Seminar was held on 21 February in Whangarei with the theme: the journey to advanced practice in addiction nursing. This event, organised by Matua Rāki and with the support of the Addiction Nurses Working Group, has gone from strength to strength since its inception in 2011. So far the seminars have only been hosted in the main centres: Hamilton, Wellington, Auckland and Christchurch, so we are endeavouring to get them out to the smaller regions. Jewel Reti, from Northland District Health Board, facilitated our day in Whangarei, welcoming more than 50 nurses working in addiction from around the country to the Manaia Health primary health organisation (PHO) venue.

The aims of these events are to foster relationships; generate a national drive and understanding; enhance skills; encourage advanced practice and nurse practitioner development; share journeys and ideas; and provide inspiration for new and planned initiatives – all of which were met by the diverse and dedicated group of attendees.

We were spoiled with the quality of presentations. Dr Daryle Deering set the scene, speaking about future directions for addiction nursing. Henriette de Vries and Bart Van Gaalen (Northland District Health Board) gave a great overview of the work they have been leading around
supervision for nurses. Louise Leonard (Waikato District Health Board and Drug and Alcohol Nurses Australasia [DANA] Vice President) and Moira Gilmour (Capital & Coast District Health Board) talked about the nurse practitioner role and the certification process for addiction nurses.

Jewel Reti and Claire Grover (Northland District Health Board) spoke about their innovative practice and the use of video conferencing to reach geographically isolated communities, their rural service users/tangata whaiora at the top of the island and their mentoring of a group of mental health nurses in the Cook Islands.

We had great representation from the Manaia Health PHO, with Mary Carthew and John Hartigan speaking about a local credentialing programme for practice nurses. This was an initiative from Health Workforce New Zealand in conjunction with Te Ao Māramatanga (New Zealand College of Mental Health Nurses) aimed at giving more nurses in primary care the opportunity to enhance their skills in mental health nursing and become credentialled in this.

Agnes Hermans presented on ‘the ABC model for general practice’ and told us about the project she has begun, which aims for improved responsiveness in maternal and child health.

A number of these presentations are available on the Matua Raki website.

DANA was also present with both Moira Gilmour (North Island representative) and Steph Anderson (South Island representative) promoting DANA membership as a means of supporting practice based on the best available evidence and promoting active involvement in alcohol and other drug research. The interest in the recently developed DANA certification process was encouraging.

Steph Anderson (Nelson-Marlborough District Health Board) wrapped up the day and supported participants to think about what addiction nurses needed to move forward together. Feedback from the day was very positive and, when asked about what would be useful in the future, participants agreed that nurses talking about their own experiences is invaluable. They were also keen to have some input from nurses working with young people, care and protection work, and complex case reviews.

Matua Raki and the Addiction Nurses Working Group, in conjunction with Southern District Health Board, are planning the next seminar to be held in Dunedin later in the year.

If you are interesting in attending, hosting or presenting any future seminars please contact Klare Braye at klare.braye@matuaraki.org.nz.

The Ministry of Health is leading a cross-agency project looking at improving services for young people with, or at risk of, mild to moderate mental health issues. The expanded use of the Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide, Depression and Anxiety, Safety (HEEADSSS) assessment across primary health care is one of 22 initiatives to be implemented as part of the Prime Minister’s Youth Mental Health initiative.

HEEADSSS is an acronym that enables a conversational assessment with a young person. The framework is widely used across the health sector for the early identification of mental health, alcohol and other drug (AOD) – and other information – to assist a young person’s development.

In partnership with sector experts and the Goodfellow Unit, the Werry Centre has developed an online e-learning module which introduces learners to the HEEADSSS assessment and key information to support practitioners working with young people.

Project manager Pat Mitchell has led the project and can be contacted at p.mitchell@auckland.ac.nz.

You can access the module at: www.goodfellowclub.org – search for ‘Introduction to HEEADSSS’.

Three additional blended learning workshops will be held in Whanganui, Hawke’s Bay and the West Coast. Dates and venue information is available at our website, www.werry.org.nz.
Access to regular quality practice development support for primary care nurses was one of the keys to the success of a mental health and addiction credentialing programme developed by Manaia Health primary health organisation (PHO), Northland. This workforce initiative was featured in the spring edition of Handover. The mental health and addiction credential is offered by Te Ao Māramatanga (New Zealand College of Mental Health Nurses), see www.nzcmhn.org.nz/Credentialing.

Practice development support in this context was delivered in the form of group peer supervision of which the focus is to assist primary care nurses with translation of knowledge and skills into practice.

Manaia Health PHO in Whangarei, under the leadership of Mary Carthew, associate director of nursing primary health care and John Hartigan, primary mental health co-ordinator, set up the programme. They could see much value in supporting primary care nurses and set up the education component of the programme to increase their mental health and addiction knowledge and skills to respond to people in their local communities.

One of the initial steps was to find supervisors with specialist mental health and addiction knowledge/skills. “This required some planning and negotiation between the nurse leaders from the local district health board and our PHO,” said Mary.

“One of the biggest challenges was to set up a form of supervision that could be regularly accessed by nine primary care nurses working in different organisations across a large rural area.”

Two local experienced supervisors, Bart van Gaalen and Henritte de Vries, who were registered nurses from the local mental health and addiction services, were contracted to provide practice development support in the form of group peer supervision.

The programme ran for six months and included six education days that were delivered by a range of local specialists with mental health and addiction knowledge. Practice development support sessions occurred fortnightly on Thursdays between 5.30pm and 7pm, in a venue provided by the PHO. During the programme many professional relationships were created. Not only did the nurses build relationships with local specialists who provided the education, but the strength of their relationships grew as a group.

The sessions were a time of professional and personal growth and had a balanced blend of learning, reflecting, and laughing. To structure the sessions the supervisors used the Collegial Consultation Incident Method tool, which they had adapted. The tool included four phases:
1. information about a problem
2. forming an opinion
3. solving the problem
4. evaluation.

The fortnightly sessions provided a safe environment for nurses to share how they were integrating their new knowledge into practice.

Te Pou met with two of the nurses on the programme. Judith Hall, a registered general nurse employed by Northtec as a student health nurse, completed the programme alongside her colleague Jann Leaming. Judith found the process of learning together with a colleague invaluable given they both worked in an isolated practice setting. Judith found the group peer supervision sessions very useful.

Suzanne Mackay, a practice nurse, found the forum of group supervision enabled her to build relationships with the other nurses on the programme and made it much easier to feel able to pick up the phone to discuss any issues arising in practice. It was a time of learning to be vulnerable, learning to trust, having a willingness to be critiqued and growing in confidence.

The skills and style of the supervisors were keys to the success of the supervision experience for the nurses. Judith’s comments included the following. “The complimentary style of Bart and Hen worked well… they were the right fit… they demystified supervision for me… learning about the tool and how we could use this to focus our sessions was really helpful.

“In each session we began with a round of checking in to see ‘what was on top’ for each of us so we could discuss any burning issues.”

Similar comments were expressed by Suzanne. “The supervisors were a great resource of knowledge… had a great sense of humour… sessions were enjoyable and not a burden… it was a good social time and a time of learning and reflection… the tool kept our discussion on track and focused… the sessions enabled us to keep our learning at the forefront… the supervisors modelled how to be effective mental health and addiction nurses.

“In each session there was an opportunity for us all to discuss a practice issue and then discuss how we dealt with it and then answer questions and receive feedback from the group. The size of the group was small enough to enable us to get the most out of the sessions.”
Suzanne’s key messages to other primary nurses engaging in practice
development support are:

• engage in the whole process
• do your presentation
• reflect on your practice
• keep your eyes and ears open
• process your learning
• bring good topics to the sessions.

The positive experience of practice development support in the form of
group peer supervision coupled with the tool convinced this group of
primary care nurses this is something that they would like to continue
with as part of the re-credentialing process for the programme. To that
end they have set up a regular time to meet and continue to grow and
learn as a group of primary health care mental health and addiction
credentialed nurses.

If you would like to know more about practice development support for
primary health care nurses please feel free to contact Mary Carthew:
Mary@manaiapho.co.nz or John Hartigan: JohnH@manaiapho.co.nz.

Nursing digest

New text book: Mental health – A person-centred approach

_Mental health – A person-centred approach_ is a recently published textbook co-edited by
Dr Helen P Hamer, senior lecturer and nurse consultant based at the University of Auckland
(UoA) School of Nursing and Centre for Mental Health Research and four Australian mental
health nurses: Professor Nicholas Proctor, Denise McGarry, Rhonda Wilson and Terry
Froggatt.

Helen was approached by Professor Proctor in late 2012 with an invitation to contribute four
chapters. The book presents a collaborative text for nursing and other health and undergraduate
students that departs from usual formats. It adopts a storytelling approach that encourages
generation and human connectedness with the lives and needs of service users, their
families, whānau and carers in mental health.

All the chapters include stories from those with direct experience of recovering from
mental distress/illness, using mental health services or providing mental health support.
Each chapter has been written in collaboration with service users, carers and clinicians, but
also considers issues of context and practice setting. The overall topics examined include
the determinants of mental health, and the impact of mental illness on Māori, Aboriginal
Australians, migrants and refugees and the homeless.

The four New Zealand chapters are as follows.

Maori mental health

This chapter was led by Dr Jacquie Kidd (School of Nursing, UoA in Waikato), senior lecturer
and co-director of the Centre for Mental Health Research. This chapter is co-authored
by Kerri Butler and Reina Harris (tangata whai i te ora) and covers the ‘different ways
of being Māori’; the importance of accurately identifying cultural needs; how nurses’ own
ethnicity might influence their care of Māori; how historical trauma and current health care
practices have impacted on the mental health of Māori; and how health professionals can help
to improve Māori health outcomes and skills in culturally safe assessment. This includes
whanaungatanga, and facilitating the culturally safe care of tangata. Whai i te ora and whānau
are also discussed.

Legal and ethical

This chapter is co-authored by Tony O’ Brien (senior lecturer, School of Nursing, UoA) and
Debra Lampshire (professional teaching fellow and experience-based expert in the School
of Nursing) and describes a framework for practice; the effects of compulsion/coercion
on service users and their families and whānau; the tension between the therapeutic
relationship and compulsory treatment; using a procedural justice framework to underpin
human connectedness; the role of the nurse in implementing mental health legislation;
and alternative approaches to compulsory treatment, such as advance directives. The
chapter concludes with a section on how future, less coercive mental health legislation could
look.

Gender and sexuality

This chapter is co-authored by Jane Barrington (professional teaching fellow, School of
Nursing, UoA), Joe McDonald (Rainbow community liaison and trainer for Affinity
Services in Auckland) and Debra Lampshire. The chapter provides a comprehensive
understanding of the continuums of sexual orientation and gender identity; the impact
of heteronormativity, cisnormativity, homophobia and transphobia; inter-personal violence and
abuse; and the complexities of privilege and oppression in relation to gender, sexuality,
ethnicity and ability. The chapter concludes with a discussion on the notion of culturally
competent human connectedness with gender and sexually diverse populations; trauma
theory; and a focused and detailed account of the practical skills required for providing
trauma-informed nursing care.
Older people
This chapter is co-authored by Debra Lampshire and Sue Thomson (nurse specialist in dementia care, Northern Regional Alliance, Auckland) and covers a range of topics including the process of positive ageing; life course and the changing cultural norms of older people; the impact of ageism; the skills required to detect and assess the major mental health problems; the medico-legal aspects that relate to collaborative care planning; and the future challenges for working in the specialty practice of older peoples’ mental health nursing.

A range of other chapters in the book explore nutrition and physical health, children, young people and those living in rural and regional areas.

Mental health – A person-centred approach is a comprehensive resource that supports high quality, person-centred care in both the New Zealand and Australian context. Each chapter features learning objectives, reflective and critical thinking questions, extension activities and further reading. Significantly, the book addresses the transition by health students to professional roles, and the need to ensure they maintain human connectedness with the people they serve, as well as inter-professional collaboration.


Journal clips

Journal of Psychiatric and Mental Health Nursing

February 2014
Psychiatrists had a significantly higher degree of emotional exhaustion and a lower sense of personal accomplishment, while non-medical mental health professionals adopted more frequently depersonalisation as a coping strategy and had higher scores for depression, which is associated with a higher level of burnout.

Mental health service users’ experiences of diabetes care by Mental Health Nurses:
an exploratory study. Nash, M.
Participants encountered a split between their mental health and diabetes care needs, which resulted in a lack of holistic or integrated care. Mental Health nurses need to ensure physical and mental health care are wholly integrated and not split.

March 2014
Mental health nursing staff’s attitudes towards mental illness: an analysis of related factors. Mårtensson, G, Jacobsson, G.W., & Engström, M.
Staff have more positive attitudes if their knowledge about mental illness is less stigmatised and currently have or have once had a close friend with mental problem.

Barriers to the reporting of medication
administration errors and near misses: an interview study of nurses at a psychiatric hospital. Haw, C., Stubbbs, J., & Dickens, G.L.
Nurses commonly said they would not report errors or near misses because: there was a good excuse for the error/near miss; they lacked knowledge about whether it was an error/near miss or how to report it; they feared the consequences of reporting it; or reporting it was too much work.

Practitioners’ experiences of working with families with complex needs.
Reupert, A., & Maybery, D.
There is evidence for family sensitive practice but few practitioners employ this approach. Several strategies have been found to be effective; working in

Setting up a Google alert

With the myriads of information being published daily in academic journals, reports, publications and even through news mediums, it is easy to lose track of all the latest information. Luckily, Google provides an alerts system that allows you to receive email updates of the latest search hits in your area of interest.

These are available through Google search and include news items, reports and other general web search items. You can find ‘alerts’ under Google products, using the ‘specialised search’ feature by following the simple form. You will need a Google account so you can manage your alerts.

Under ‘specialised search’ you will also find ‘Google Scholar’ and, as you know, this is a search engine specific to academic articles. Google Scholar also offers alerts. You can create a key terms search from the ‘alerts’ button in the menu above the search bar, you can also create alerts for new articles that cite a previous article of interest (through the ‘cited by’ link on a search result).

You usually do not need an account for Google Scholar, just an email address.

See this blog for more details about Google Scholar, or more details and instructions can be found through your Google search bar.
a strength-based manner, establishing clearly defined and negotiated goals, and balancing the sometimes competing needs of children and parents.

An update to depression case management by practice nurses in primary care: a service evaluation. Murphy, R., Ekers, D., & Webster, L.

Primary care nurses are ideally placed for delivering care to depressed patients; especially in cases where a patient also has a co-morbid long-term medical condition.

Substance use and violence among psychiatric inpatients. Stewart, D., & Bowers, L.

This study found relatively few incidents of substance use among patients and no link between physical violence and substance use on wards, but there was an association with verbal aggression.

April 2014

Barriers and facilitators to treatment participation by adolescents in a community mental health clinic.

Oruche, U.M., Downs, S., Holloway, E., Draucker, C., & Aalsma, M.

Teenagers and their parents wanted: staff who showed respect; involved teenagers and their parents in the counselling sessions; communicated in a timely manner; and suggested that provision of automated appointment reminders, transportation to clinics, and provision of education and support groups for caregivers would improve attendance to counselling sessions.

The use of psychological therapies by mental health nurses in Australia. Fisher, J. E.

Mental health nurses overwhelmingly want to employ psychological therapies in their practice, however they identified barriers which included lack of confidence, low nurse morale, no support from other nurses, low staffing levels, lack of training opportunities, and inadequate support from nursing management.

May 2014

Mental health nurses in primary care: quantitative outcomes of the Mental Health Nurse Incentive Program.

Lakeman, R., & Bradbury, J.

The Mental Health Nurse Incentive Program is a funding scheme in Australia that enables mental health nurses to work in primary care settings with people with complex mental health problems for as long as necessary. Findings showed people had high levels of symptom severity and distress on admission and experienced significant improvements in all problem areas except physical health over their time working with the nurse.

Issues in Mental Health Nursing

Vol. 35, No. 2, February 2014

Cardio metabolic Health Nursing to Improve Health and Primary Care Access in Community Mental Health Consumers: Baseline Physical Health Outcomes from a Randomised Controlled Trial. Happell, B., Stanton, R., Hoey, W., & Scott, D.

People with serious mental illness (SMI) are more likely to have poorer health and poorer health behaviours, and therefore are at greater risk for cardio metabolic health co-morbidities compared to those without SMI. Results showed the high prevalence of obesity, hypertension, low activity, smoking and nicotine dependence, alcohol misuse disorders, and poor diet among people with serious mental illness.

Vol. 35, No. 5, May 2014

The Views of Heads of Schools of Nursing about Mental Health Nursing Content in Undergraduate Programs. Happell, B., & McAllister, M.

In terms of influencing factors the quality of mental health content was found to be influenced by the overcrowded curriculum, the availability of quality clinical placements, the strength of the mental health team, and the degree of consumer focus. The findings suggest the current model of nursing education in Australia does not provide an adequate foundation for mental health nursing practice and alternative approaches should be pursued as a matter of urgency.

Journal of Mental Health

Vol. 23, No. 2, April 2014

Effective support for those who are “hard to engage”: a qualitative user-led study. Davies, R. L., Neslop, P., Onyett, S., & Soteriou, T.

Relationships with staff were central to maintaining engagement with services. Almost all participants wanted help for their problems, and preferred services that responded to their priorities and offered practical support with everyday living. Negative perceptions of inpatient care were common, and a focus on medication put many participants off mental health services. Many participants were not receiving support for the full range of their complex needs.

Treatment preferences among men attending outpatient psychiatric services. Carlos, A., Hernandez, S., Oliffe, J.L., Joyce, A. S., Söchting, I., & Ogrodniczuk, J.S.

Contrary to assumptions that portray men, generally, as unwilling or uninterested to engage in psychotherapy, men who have sought mental health services appear to prefer psychotherapy as their intervention of choice to address their mental health problems.

International Journal of Mental Health Nursing

Volume 23, Issue 2 Pages 99 - 192, April 2014

What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. Gunasekara, I., Pentland, T., Rodgers, T., & Patterson, S.

Findings highlight a need for renewed attention to the basics of relationships and the importance for nurses of self-awareness and support. We urge nurses to make time to really get to know the people for whom they provide care and to work to maintain passion for mental health nursing.

Reduction in the use of seclusion by the methodical work approach. Boumans, C.E., Egger, J. I., Souren, P. M., & Hutschemaekers, G.L.

This study looked at the effect of the methodical work approach on the use of seclusion at a ward for the intensive treatment of inpatients with psychoses and substance-use disorders. Five phases: (i) translation of problems into goals; (ii) search for means to realise the goals; (iii) formulation of an individualised plan; (iv) implementation of the plan; and (v) evaluation and readjustment. Special attention was paid to the involvement of the patient and his/her family in the treatment process and to the role of the coordinating nurse. Compared to control wards within the same hospital, at the ward where the methodical work
approach was implemented, a more pronounced reduction was achieved in the number of incidents and in the total hours of seclusion.

Transition to a smoke-free culture within mental health and drug and alcohol services: A survey of key stakeholders. Glover, M., Fraser, T., Bullen, C., Wallace-Bell, M., McRobbie, H., & Hadwen, G. Most organisations were on a continuum between permissive and transitional cultures. They are not helped by exemptions in smoke free policies for mental health services, staff smoking, negative staff attitudes to becoming smoke free, poor knowledge of nicotine dependence, smoking-related harm and co-morbidities, and poor knowledge and skills regarding cessation-support options.

Volume 23, Issue 3 Pages 193 - 284, June 2014


Insiders or outsiders? Mental health service users’ journeys towards full citizenship. Hamer, H.P., Finlayson, M., & Warren, H. The degree to which service user participants were accepted as full citizens with the same civil, political, and social rights as others was contingent on their ability to adopt their society’s rules and norms and appear as ‘normal’ citizens. Participants often experienced being ‘othered’ and excluded from the many rights and responsibilities of citizenship due to society’s perception that service users lack certain attributes of normal, productive citizens. Participants reported that being labelled with a mental illness led to them being marginalised and ostracised, thus placing conditions and barriers on their citizenship status.

Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. Effective mental health nursing is predicated on understanding the lived experiences of service users in order to provide sensitively-attuned nursing care. However, the literature suggests that within mental health practice, a disproportionate amount of time is taken up by other activities, with little time being spent listening and talking to service users. This study discusses the evidence relating to the therapeutic relationship in acute mental health wards and explores why, after five decades, it is not recognised as a fundamental metric of mental health nursing.

No place to turn: Nursing students’ experiences of moral distress in mental health settings. Wojtowicz, B., Hagen, B., & Van Daalen-Smith, C. Nursing students reported significant moral distress related to the perceived lack of nurses talking meaningfully to patients on the unit, a hierarchical power structure for physicians, a lack of information given to patients about their psychiatric medications, and an inability of their nursing instructors to advocate for ethical change on the units. Several students made a specific connection between their moral distress and not wanting to pursue a career in mental health nursing.

Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J.

Four themes emerge from the literature: consumer perspectives, whose tenor is generally one of negativity; staff-reported attitudes and influencing factors, such as age, experience, and confidence in working with mental health presentations; the environmental climate of the ED, which might not be conducive to good mental health care; and interventions that have been used to evaluate changes in attitudes.

Latest publications

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- The mental health and addiction workforce planning and forecasting literature review. Te Pou (2014).

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- Preventing Suicide for Pasifika – top 5 tactics. Le Va (2014).