A culturally sensitive practice approach is required when working with members of the Deaf community (upper case ‘D’ Deaf), who experience mental health problems at more than double the rate of the hearing community.

Deafness for this group is usually profound, and present from birth or before the development of language. They have a rich, proud cultural identity and heritage which binds them together, made visible by their own unique language, New Zealand Sign Language (NZSL – one of three official languages of New Zealand), upon which they are dependent.

Deaf culture and language is central to Deaf potential and wellbeing however it is often not well understood or accounted for by mental health practitioners, resulting in poor outcomes. Misdiagnosis and long periods of costly, ineffective care are common but can be averted by an approach to practice which places Deaf culture at the centre. The majority of Deaf people’s mental health problems result from the challenges of being Deaf within a hearing world and not from deafness itself. This makes it essential that practitioners work in this way and do not contribute further to their problems and experiences of discrimination.

Outlined below are some general guidance and useful links to further support good practice when working with the Deaf community.

- It is essential to engage a fully qualified English-NZSL interpreter for all practice interactions with a Deaf person, not just for assessment purposes. This is a fundamental human right regardless of whether there is a question over a Deaf person’s level of sign language fluency. Many Deaf people have additional learning challenges but this does not preclude the need for an interpreter. Use the following websites to make a booking.  

  Continued on page 3
It is my absolute pleasure to bring to you our winter collection of stories about supporting people with disabilities. In this edition we have opened with a stunning image, *Monarch Metamorphosis*, created by Rachel Coppage that captures a story about supporting people who are deaf.

We feel very privileged to share with you stories from four nurses working in a range of roles in a disability service: Tanya Higgott, Anthony Comerford, Anjali Lavulavu and Nikki Adams. These stories are accompanied by a photographic collage of their work environments and a story about how time to have ‘coffee, cake and a chat’ is working out to be an effective way psychologists can support a group of staff.

An interesting article from Megan McNeice discusses how to work with families and whānau who are supporting a child/young person with autism. Two nurses passionate about education and disability nursing, Henrietta Trip and Jeanette Love, highlight formal and informal learning options for nurses to increase their knowledge about people with disabilities.

A gathering of nurses from the central region is depicted in a story co-created with Tony Heyward and we elaborate further on two of these presentations. The professional supervision column highlights a presentation from Toni Dal Din about an ethical decision making framework and the nursing digest section provides you with a more in-depth article about Dr Stacey Wilson’s presentation on mental health crisis intervention.

Read about how we are placed in the world in the articles about the experiences of Te Pou’s chief executive Robyn Shearer, along with Rob Gill and Mark Smith at the International Initiative for Mental Health Leadership forums.

Fiona Hamilton prompts us to start turning our thoughts to post graduate study in 2015 and shares that planning is a key factor that enables successful outcomes from study, not only on the part of the nurse but also from managers and leaders of nurses. Klare Braye updates us on what is happening in the addiction sector. Carolyn Swanson invites nurses to consider participatory note writing and welcomes your views on this. Anne Brebner points you towards two new publications in the Acutes project update.

I hope, once you have taken time to read this edition that you will have more knowledge, skills, confidence and contacts to assist you in supporting people with disabilities and their families.

Kindest regards
Suzette

Suzette Poole - Editor
CLINICAL LEAD
EMAIL: suzette.poole@tepou.co.nz

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The National Centre of Mental Health Research, Information and Workforce Development

NEXT EDITION: FOCUS ON PHYSICAL HEALTH
Nurses this is your opportunity to share some of the great innovations that are happening to support people with mental health and/or addiction problems with their physical health. If you would like to submit an article to Handover, or you just have an idea for one, please feel free to contact me as I would be delighted discuss this with you. Articles are due by Monday 6 October 2014. Email to suzette.poole@tepou.co.nz.
Connect Interpreting, www.connectinterpreting.wordpress.com

Isign (interpreting service of Deaf Aotearoa New Zealand), www.isign.co.nz

Information on interpreters, www.isign.co.nz/interpreters/what-is-an-interpreter

- Interpreters need a good grasp of mental health concepts, treatments, terminology and therapies in order to assist with supporting therapeutic goals. Connect and Isign will match client needs to interpreters with the relevant expertise. The choice of interpreter should always be made according to the client's preference.

- Once the interpreter is in place, take time to discuss all communicative needs in collaboration with the Deaf person; good outcomes, adjustment to diagnosis and compliance with medication depend upon this. Adapting written resources using a visual format and providing pictorial aids will support the person's understanding and engagement.

- English takes a very different form to NZSL. It is not the first language of Deaf people who commonly have limited written and spoken language skills. Lip-reading, shouting, and slowing speech down are also highly ineffective and unreliable methods of communication.

- Deaf people have become accustomed to accepting inadequate communication and may not be able to express sufficient assertiveness to advocate fully for their own rights. Practitioners can check for understanding with the person through the use of open ended questions and asking people to paraphrase what has been communicated.

- Be aware that some Deaf people may not be comfortable with having to use an interpreter when discussing deeply personal and emotive issues. Referral on to a Deaf practitioner is the best option. When this is not possible, making sure that the same interpreter, according to client choice, is booked for consecutive sessions, and working alongside or in collaboration with a Deaf practitioner and/or advocate, can help.

Richmond Services Ltd is the only current provider of Deaf mental health services. There are two Deaf community workers covering the Auckland and Northland areas. For more information please call 09 847 9188 or email jtekanawa@richmond.org.nz.

The Coalition of Deaf Mental Health Professionals (CDMHP) can also provide advice and/or link you to Deaf practitioners/advocates in your area. Please call 022 647 1477 or email CDMHP@deaf.org.nz.

- Good eye contact, facial expression, and awareness of how body language is being perceived, including talking directly to the person as opposed to the interpreter, help to inspire trust, confidence and optimise the therapeutic alliance.

- Like us all, Deaf people have a diversity of culture. Many identify in part with Deaf culture and in part with the hearing world alongside other cultural affiliations. A holistic approach ensures that other important facets of identity are not marginalised. It is important to treat the person as an individual and to adapt generic approaches to meet Deaf needs. For more information on Deaf culture visit www.deaf.org.nz/resources/35-learning-about-deaf.

- Seek out ways to collaborate with Deaf staff and establish links with the Deaf community. This will give you vital insight on culturally influenced understandings of mental health issues and the related impacts, distinguishing what is normal within the Deaf context.

- It will also help you gain insight around the factors which make Deaf people more vulnerable to mental health problems such as childhood abuse, stressful relationships and isolation, and how to address these in a culturally affirmative manner.

- Think laterally about factors impacting risk and recovery, including a valued social role, a supportive peer group, and employment. We take these aspects of daily life for granted but they present much greater challenges for Deaf people.

- Working alongside a Deaf advocate will assist in gaining trust and establishing an effective therapeutic rapport. This is important as Deaf people are frequently reluctant to engage with mental health practitioners due to bad experiences seeking help in the past.

Deaf Aotearoa New Zealand provides a number of nationwide services for the Deaf community including service coordination for Deaf people with a range of needs. See http://www.deaf.org.nz/ or call 09 828 3282.

The Nationwide Health and Disability Advocacy Service has three Deaf advocates who can provide specific education on getting it right when providing health and disability services to Deaf people. See http://advocacy.hdc.org.nz/about-us/advocates-with-a-specialist-focus.
• Be aware that many Deaf people have not had an accurate mental health diagnosis and may have a very limited understanding of mental health and wellbeing as a whole. Flexibility of service eligibility criteria and creativity in the way you work is paramount.

• Problem solving and solution focused therapy support the deconstruction of harmful oppressive myths while reconstructing useful and empowering views of Deaf people's strengths, successes and expertise (Ouellette, 2002). In addition, the use of narrative reflects a core aspect of Deaf culture (Ladd, 2006).

• Working with Deaf people, interpreters, developing cultural insight and establishing links with the Deaf community demand additional time, flexibility and commitment, however the rewards are well worth it!

Developing NZSL skills is one of the most powerful ways you can demonstrate your commitment to meeting the needs of Deaf people.

Find out about NZSL classes at www.nzslta.org.nz.

The Coalition of Deaf Mental Health Professionals (CDMHP) was established following specialist service closures across the Central Region in 2010. They are a nationally oriented Deaf and hearing group providing advocacy in relation to the mental health needs of culturally Deaf people. Their focus is the development of a nationally coordinated network of Deaf mental health services to support cultural capability across the health sector and beyond. Their goal is equitable mental health care for Deaf people. They welcome opportunities to support clinicians in rising to this challenge in any way they can.

To connect please contact the coordinator, Catriona Sainsbury by emailing CDMHP@deaf.org.nz or calling 022 647 1477, and take a look at www.seeflow.co.nz/mm for more information on who they are and what they are doing. You can direct Deaf people to this site too as the information is also provided in NZSL. Also watch out for the website they will be launching shortly.

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Nursing notes

From Anne:

Authentic leadership; it’s not a new concept but it’s one that seems to resonate with most. I had the fortunate opportunity to hear Dr Lester Levy present on this topic at the Sir Peter Blake Leadership Trust breakfast hosted at Te Pou recently in Auckland. Dr Levy’s inspirational talk reminded us that, as a rule, unless we mindfully operate in the zone of authenticity, leaders tend to default to management style. You can read more about this in Carolyn Swanson’s article online: www.tepou.co.nz/news/2014/07/07/leadership-an-ever-evolving-concept

Becoming an authentic leader is not easy. It takes a great deal of self-reflection (getting to know oneself) and the courage to do the right thing. It involves a degree of selflessness. I was thus inspired to read a little more and my very academic Google search was very fruitful. Authentic leadership is based on cardinal virtues such as prudence (fair-mindedness) temperance (being in control), justice (being fair in dealings with all people) and fortitude (courage to do the right thing).

It is an aspirational goal to lead with the right mix of all four authentic tenets and, when I am around a person who seems to have the mix of all four, it is a joy to be in their company. Leaders who lead in an authentic manner permit mistakes as long as there is learning, they allow for innovation and their followers feel valued and appreciated.

In my Te Pou role, I was recently invited to attend and present at a physical health day at Tauranga. It was incredibly encouraging to see mental health nurses wanting continuing education around better understanding diabetes, learning more about bowel health, understanding and learning about ECGs, and heart health. These nurses who attended, while acknowledging their already full days and caseloads, saw the importance of improving their knowledge of physical health impacts and had a genuine desire to improve the health outcomes for the people they serve. It is this that revitalises me and reminds me that, despite economic reforms and politics, there is widespread desire to promote better outcomes for people who need mental health and substance use support.

Recently, some of you will know I was elected national president of Te Ao Māramatanga, New Zealand College of Mental Health Nurses Inc. This is a leadership role that will offer me the opportunity to practice authentic leadership. The role will dovetail nicely with my current employment role, and I am delighted to have the support of my colleagues and employers to be able to lead the College.
From Suzette:

In compiling this edition of Handover, I had the privilege of meeting nurses and visiting three units where people with disabilities lived. I was greatly encouraged by the strong sense of determination and commitment the nurses had to working with youth and adults who have a disability, have committed an offence and who may also have a mental health and or an addiction problem. I could see that the redesign of the physical environment to better support services users was important, as was the availability of a range of programmes and activities. I was reminded about the skills nurses have that enable them to continually shape their practice to respond to the needs of service users in a range of settings. I also heard about the value placed on supporting the whole team to do their jobs. Thank you to the Regional Intellectual Disability team at Capital & Coast District Health Board (DHB) for this opportunity to highlight some of the work you do in this area of nursing practice.

Suzette Poole, clinical lead, Te Pou

Leaders who lead in an authentic manner permit mistakes as long as there is learning, they allow for innovation and followers feel valued and appreciated.

Authentic leadership is based on cardinal virtues such as prudence (fair-mindedness) temperance (being in control), justice (being fair in dealings with all people) and fortitude (courage to do the right thing).

Congratulations

Te Pou would like to extend congratulations to the following people.

- Jane Bodkin on attaining the position of senior advisor, nursing in the Office of the Chief Nurse, Ministry of Health. Jane has worked in a variety of clinical roles in mental health nursing and most recently as a senior nurse in the Consultation Liaison Psychiatry team, Capital & Coast DHB.
- Anne Brebner, clinical advisor, nursing lead at Te Pou who has been elected as the new president of Te Ao Māramatanga, New Zealand College of Mental Health Nurses Inc.
- Daryle Deering on receiving a Drug and Alcohol Nurses Australasia (DANA) life membership that acknowledges outstanding commitment to the development of addiction nursing, particularly in New Zealand. Daryle is also member of the Te Pou clinical advisory board. We would also like to take this opportunity to thank Daryle as the outgoing president of the Te Ao Māramatanga, New Zealand College of Mental Health Nurses Inc. for her work in developing a strong working relationship with Te Pou that is now underpinned by a memorandum of understanding.
- Sione Vaka on successfully completing his PhD which explored what mental illness means to Tongan people.
Already past the shortest days and well into Matariki, it may feel like the year is ticking past quickly. The achievements of your day to day work don’t always get celebrated and the paperwork may seem endless.

That said, there are a couple of activities and events I would like to draw your attention to that have occurred over the last few months or are in planning for the next few.

Matua Raki and the addiction nurses working group saw a need in the sector for some withdrawal management training. In part this was prompted by a call from the Department of Corrections to assist their nurses to up-skill in this area and this training is currently being delivered by Moira Gilmour. More widely, there are a number of nurses or practitioners working with service users with addictions who do not have access to specialist withdrawal management services. As such, Steph Anderson travelled the South Island last month, delivering three workshops and will take these workshops to the North Island later in the year. We are providing a one day workshop based on ways clinicians (in the addiction sector) and medical practitioners (outside of the addiction sector) can support service users with withdrawal management. These have been exceptionally well received and we are lucky to have such great and passionate nurses willing and able to encourage this area of development.

Another activity that I would like to promote is a support structure for those of you embarking on, or seriously considering, the nurse practitioner pathway. There is a peer support group hosted by Matua Raki that meets by teleconference on a monthly basis. Some of the korero is around guidance of what papers to do or getting the most out of supervision, some of it is knowledge acquisition and some of it is pure and simple support, motivation and encouragement. If you are interested in being part of this group give Louise Leonard a call on 07 834 6902 or email louise.leonard@waikatodhb.health.nz

Louise Leonard and Daryle Deering attended the annual Drug and Alcohol Nurses of Australasia Inc. (DANA) conference in Sydney in June. Feedback is that it was a small, but highly informative conference with New Zealand’s Dr Simon Adamson as one of the keynote speakers, talking about the science and the art of a controlled drinking programme and Dr Alex Wodak’s challenging keynote addressing the failure of drug prohibition. Other highlights were a presentation by DANA’s first ever patron, Professor Margaret Hamilton, and our very own Dr Daryle Deering was awarded DANA life membership, acknowledging her massive commitment to the development of addiction nursing, particularly in New Zealand.

A date to mark in your diaries is the next Addiction Nurses Symposium on 7 November. This time we are heading down to Dunedin where there is a small team of nurses from the wider region working with us to bring together a fantastic event. This symposium will highlight and encourage some of the national initiatives to support and encourage best practices of addiction nurses and spotlight a number of more local initiatives. A call for abstracts and registration will go out soon, so keep your eye out on the Matua Raki website, http://www.matuaraki.org.nz or contact klare.braye@matuaraki.org.nz if you would like to be added to the database to be informed of events such as this. Ka kite ano.
Disability Workforce Development

Supporting a stronger workforce

by Manase Lua, disability and pacific workforce manager

Disability Workforce Development at Te Pou is a programme dedicated to supporting workforce development for frontline disability support staff and the development of leadership skills for disabled people.

We support and facilitate access to leadership and training resources and in partnership with the Ministry of Health administer training, leadership and workforce development grants totalling just over $3 million per annum. We believe that where strong relationships exist, anything is possible. We are committed to a partnership approach with Disabled Persons Assembly NZ (DPA NZ) and other disabled persons organisations, NZ Disability Support Network and Careerforce, believing that working together is the most effective approach to support workforce development within the sector.

Our small but capable core team comprises of a national lead and three regional facilitators a part-time researcher, and support from a grants administrator. We support all organisations whose services are funded by Disability Support Services of the Ministry of Health to access these grants. Your organisation may be able to access resources for training to increase disability responsiveness so feel free to contact our regional facilitators:

- Cindy Searchfield, Northern and Midland region: cindy.searchfield@tepou.co.nz
- Frances Anderson, Midland and Central region: frances.anderson@tepou.co.nz
- Adrienne Henderson, Southern region: adrienne.henderson@tepou.co.nz

Our web pages, www.tepou.co.nz/supporting-workforce/DWD are a source for workforce development tools and research. Along with research papers and other resources we have developed include a training directory, fact sheets on the factors and tools that support effective workforce training and training needs analysis. We recently held forums throughout New Zealand providing an opportunity for disability organisations to consider how they can support staff to engage in, complete and use training information. We have also developed a knowledge, skills, values and attitudes framework ‘Let’s get real: disability’ which was launched on 13 August at the New Zealand Disability Support Network conference. This is to cement a workforce framework for the sector and can help provide a mechanism for prioritising workforce investment in the future.

The team has also been working with the Donald Beasley Institute to look at strategies to address health inequities for disabled people particularly barriers to primary care. We will have more on that in the next issue of Handover. In the meantime you can read the reports: Primary health and disability: A review of the literature and Improving access to primary care for disabled people at www.tepou.co.nz/library/tepou/improving-access-to-primary-care-for-disabled-people.
Disability nursing workforce statistics

as at 31 March 2013


Of the 47,751 nurses practising there were 276 nurses practising in intellectually disabled practice settings. They made up 0.6 per cent of the total nursing workforce, which includes nurse practitioners, registered nurses and enrolled nurses.

221 were female
56 were male

Over 60% were aged between 45-59 years of age
Around 20% were aged 60 years or older.

Most were European New Zealand/Pakeha or European

16 nurses identified as Maori
10 nurses identified as Pacific

Of the 44,286 registered nurses practising there were 224 in intellectually disabled practice settings. They made up 0.5 per cent of the total registered nursing workforce.

145 nurses trained in New Zealand
61 nurses trained in the United Kingdom

Of the 2,862 enrolled nurses practising there were 52 in intellectually disabled practice settings. They made up 1.8 per cent of the total enrolled nursing workforce.

16 nurses identified as Maori
10 nurses identified as Pacific
Profile:

Tanya Higgott

Working with people who have a disability has been a satisfying and rewarding career for Tanya Higgott, a clinical nurse specialist at Capital & Coast District Health Board’s Intellectual Disability Services in Porirua.

Tanya finished her training at Whitireia Community Polytechnic in 1994 and completed the RN1 programme in 1995. She worked as a mental health nurse at Purehurehu in the Regional Forensic Mental Health Service, Wellington before moving twice to the United Kingdom. There she worked as a prison nurse at Pentonville Prison and as a mental health nurse at Broadmoor High Security Hospital.

She returned to New Zealand in 2004 and worked at Te Whare Marie – Community Māori Mental Health Service in Kenepuru for five years before starting at Intellectual Disability Services. She started working in the ‘step down’ cottages where service users learn skills like cooking and cleaning prior to returning to the community. She became the clinical nurse specialist there in 2013 and says she has always had an interest in policy, quality and leadership. “I’ve been nursing for nearly 20 years and more than half of that time has been spent in forensic mental health services,” Tanya says. “I wanted something a bit different when I came back to New Zealand and Intellectual Disability Services just felt like home.”

Working at Intellectual Disability Services

The service provides for people with an intellectual disability who have seriously offended and may also have a mental health or addiction problem. The care is focused more on supporting service users to develop effective strategies to cope with life, and medication is only a small part of the treatment provided.

Tanya says this is an area of practice that does require some unique skills. “One of the most important skills is the ability to communicate, especially with service users who can be particularly challenging in this area. It’s a matter of getting alongside them, being self-aware and using your own therapeutic toolbox.” Frequently used tools are social scripting and cognitive coaching, which involve setting the tone with service users before taking them out on community trips – this is where we’re going; this is what we’ll do and when, etc. – so there are no surprises and their anxiety is lowered.

However, mental health, disabilities and forensics are areas that come with certain challenges, one of the most significant of which is attracting and retaining staff. “It’s a rewarding area of nursing but not always one new graduates are drawn to,” Tanya says. “So we work really hard to provide a supportive environment for our nurses, because we really want to keep them.”

To achieve this meetings between management and staff are held often and feedback forms are given to student nurses so they can let management know what they want and need. Efforts are made to distribute work evenly and fairly, and environmental safety workshops and refreshers are held to improve staff safety and security. These cover things like always having your cell phone charged in case of emergency, being aware and using checklists to assess and ensure safety when going out, and procedures with doors and keys.

Staffing challenges

The service has had some success in this area recently with two nurses on the New Entry to Practice Programme (NETP) working there last year for 12 months, both of whom want to stay, and four are scheduled to do their placement there this year. “Our service brings together nurses from the UK who have specialised in learning disabilities and have a behavioural approach to care, nurses who have only trained in mental health and some who have trained as comprehensive nurses,” Tanya says. “Each brings their own expertise and approach and they all need to be synthesised together to provide the care this group of service users need to live their lives.”

Fostering that supportive environment has improved interaction with service users and reduced incident rates. “We’ve come a long way, even in the last two years,” Tanya says. “It is important staff feel valued, are happy in their work and generally feel safe.”

The new legislation

Another challenge is that the legislation many service users are held under (The Intellectual Disability [Compulsory Care and Rehabilitation] Act 2003 [IDCCR Act] and Mental Health Act) is quite justice-oriented and doesn’t always marry well with the service’s model of care, which is walking alongside people and supporting them.

“So we’re kind of working between systems where a lot of things don’t quite line up,” Tanya says. The plan is to keep supporting nurses and to upgrade documentation to keep improvements coming. And, of course, Tanya says, more nurses would always be a good thing.
Profile:

Anthony Comerford

Anthony is UK-trained and qualified as a nurse 14 years ago. He did three years of undergraduate training – 18 months in general nursing and 18 months in learning disabilities, his chosen area of practice.

He says his interest in intellectual disability came about pretty much by accident. As a 19 year old he applied to be a camp counsellor at a United States summer camp. He assumed he would be working with children but it turned out he was there to support people with intellectual disabilities. This was a shock at first, but by the end of the summer he was really enjoying it and in fact went back four times.

Anthony says he enjoyed the human interaction, working alongside people who need help and support even for small things. “It’s great to think you can help make a difference, even if it’s just in how someone’s day goes. I actually feel quite lucky that things happened the way they did, opening up this field to me.”

Career steps

When Anthony was fully qualified one of his first posts was working as a disabilities nurse in a mental health service for Deaf people. He then decided to come to check out New Zealand with a friend and fellow nurse in 2002 and was employed by Intellectual Disability Services as a registered nurse (disabilities). His next career step in 2004 was helping to establish the Deaf mental health service in Wellington, and then he worked as a nurse in Sydney for six months. Eventually he found himself back in Wellington and was employed as a care manager at Timata Hou, a community-based therapeutic service supporting people with intellectual disabilities and high and complex needs. After three and half years he returned to Intellectual Disability Services (in 2011) to take up a care manager post.

The care manager role

Anthony was one of the first group of people to be appointed as a care manager and completed a course run by Mason Clinic in Auckland. The Guidelines for the Role and Function of Care Managers define care managers as “health and disability professionals who have undergone training in, and are competent in, the assessment, care and rehabilitation of persons with intellectual disability. Care managers are designated by the compulsory care coordinator for each individual under the IDCCR Act 2003 and are responsible for developing and implementing an individual’s care and rehabilitation plan and for ensuring that regular clinical reviews of care recipient’s condition take place.”

Anthony says one fascinating thing about the role is working with this new legislation, which is still in its ‘bedding down’ phase. He’s excited by the progressiveness and newness of the New Zealand approach. “You’re always learning something new about working under the IDCCR Act and about the role, particularly when there are test cases going on; so it is interesting to see how things develop.”

He is currently responsible for five people who are care recipients, but has had as many as 12 before. To become a care recipient an individual must have “an intellectual disability and been charged with, or convicted of, an imprisonable offence” (IDCCR Act 2003).

Anthony says he enjoys the diversity of the role. “You need to be a jack of all trades; you need a good understanding of service users and how their identified needs can go into a plan that both they and staff can work with. So you need to know the systems that are in place in your organisation and how needs can be met within that framework.

“Communication skills with people and staff are vital – and with people from outside the service too. Facilitating communication with families is imperative because you want to involve them in the person’s care, but you may have to explain the legislation to them and sometimes you don’t always see eye-to-eye, so it can be a bit of a balancing act.”

Rewarding and holistic

Anthony’s key messages to other nurses include that they should definitely consider the field.

“I believe this is the most holistic area of health there is. In ID nursing you are working with the person from head to toe so all the different elements of nursing are rolled into one: supporting them to make safe choices, dealing with health issues, adjusting your communication style to meet their needs, working in partnership therapeutically and so on.

“Nurses have come in and said how amazed they are at the breadth of the practice,” Anthony says.
Profile:
Anjali Lavulavu

Anjali has been at Intellectual Disability Services for a year and first came as a new graduate nurse on the New Entry to Specialist Practice (NESP) programme.

She trained at Whitireia Community Polytechnic and came through the Nursing Pacific Programme with a scholarship from Le Va. She is now in her second year of practice.

Intellectual disabilities were only very briefly covered in theory during her training so this was her first time working with people with this experience. “I didn’t know what to expect, but having a preceptor was really helpful and I found the staff environment very supportive. I enjoy this area of practice and really want to stay for now.”

What she likes about the work is building therapeutic relationships with service users, being a key worker and being involved in their care plans. She enjoys working alongside service users, to encourage them with their daily care and programmes which will support them with their rehabilitation and wellbeing.

“There’s a lot of stigma around mental health and intellectual disability and that’s a concern to me, and it’s about educating the community which is something I hope to contribute towards. It’s hard work and really challenging, and there aren’t always a lot of immediate successes but when they do occur it is a great feeling, knowing that goals can be achieved. All you can do is be patient and caring, sticking by the service users and helping them through whatever they’re dealing with.

“We coordinate service users’ care and put plans in place to support them in developing coping strategies to manage their own behaviour. This can include strategies like taking some quiet time, talking with staff and, on occasion, using some additional medication. They learn a lot of skills in their programmes and our job is to support them and put those skills into practice.”

A typical day

A typical day for Anjali starts with handover where teams of nurses and intellectual disability support workers (IDSWs) are allocated clusters of three or four service users by the co-ordinator. The cluster nurse will then delegate and support service users to follow their daily plans. Typically there are eight staff on at any one time, up to four of whom will be registered nurses, and there are currently nine clients in the Haumietiketike medium secure forensic unit. It is quite intensive nursing, especially working and supporting people with challenging behaviours.

Throughout the day, nurses and IDSWs will provide support for service users, usually on a one-to-one basis, prompting and encouraging them with their activities of daily living and to attend their programmes. Sometimes there are trips out into the community as preparation for transition or as rewards. These community outings are planned through care team meetings and are done according to Ministry of Health approved leave plans, which must be strictly adhered to.

Rewarding work

Anjali’s key messages include that it’s a rewarding field to work in. There isn’t a high service user turnover, so longer-term relationships are possible, allowing you to get to know and build rapport with service users. “You also learn how to keep yourself safe. We’re taught to ‘assess, assess’ all the time. Staff are taught how to ‘de-escalate’ when situations might be getting out of hand. This usually involves talking with the person, supporting them to focus back on their plan and practice what they have learned in their programmes. Sometimes people just need to take some quiet time for themselves.

Anjali says it can be quite intense work. She’s is looking at doing post graduate studies in intellectual disability and forensics next year so she can increase her skills and contribute even more. She says career opportunities are good in this practice area because there are so many different roles.

“I didn’t know what to expect, but having a preceptor was really helpful and I found the staff environment very supportive. I enjoy this area of practice and really want to stay for now.”

Anjali Lavulavu, new graduate nurse

Mental Health & Addiction Nursing Newsletter - Issue 28 - September 2014
Nikki Adams began work as an enrolled nurse in the UK and changed her scope of practice to registered nurse (mental handicap).

She has worked in the intellectual disabilities (ID) area most of her career. In New Zealand in 2005 she studied at Whitireia Community Polytechnic to extend her practice to include mental health and she completed a Masters of Nursing from Victoria University in 2011.

“This is just such a different area of nursing because of the skills required to develop therapeutic relationships,” Nikki says. “Rather than relying on machines or medication, working in ID is all about communication and the therapeutic use of self. That is something you just can’t teach. It’s never boring.”

Nikki describes herself as an educator, not a nurse educator, because she provides education to a range of people in a variety of settings across the disability service workforce – including forensics and out in the community. Nikki has been doing this for the last three years and says she’s really happy in her work.

Every day is different
There is no typical day for Nikki. It’s always different. Some days she’s teaching; on others she’s supporting staff in their work. Each month she focuses on a different core competency and works with the clinical nurse specialist on staff appraisals. The aim is to get as many staff as possible onto the Professional Development and Recognition Programme (PDRP) and supporting them to achieve Proficient level. PDRP assesses nursing practice against competencies, recognises level of practice and supports on-going professional development.

Nikki would encourage other nurses to try working in this area and is keen to highlight the service because not a lot of people know about it or what it does. She points out intellectual disabilities is not even an option in ACE (Advanced Choice of Employment) – a system which allows nurses to apply for multiple positions using one application and in which they can choose their preferred practice areas.

Training and placements
Nikki deals with new graduates on the New Entry to Specialist Practice (NESP) programme who take up the service’s offer of three-month placements as part of their mental health placements. In 2013 the service ran a pilot project and also offered two places on the New Entry to Practice (NETP) programme at the mid-year intake – the new graduates doing three four-month placements. This has been a great success with the two new graduates deciding to stay working in the ID area and its planned to run the project again this year by offering four places for NETP nurses. The service also offers placements to second- and third-year student nurses.

“These nurses often say nothing in their training had prepared them for what we do,” Nikki says. “The ID service facilitates education for undergraduate nursing students but there is no specific content about working with people with ID in the nursing curriculum.

“We’re different, even from most other mental health services. We’re quite specialised and we do our utmost to support staff really well and look proactively at what they need. We encourage things like clinical supervision (one-on-one) and the psychology team regularly holds ‘coffee, cake and chat’ sessions (see opposite page). The role is quite challenging so we need to provide that supportive environment.”

The management team are very supportive of all core competency training and training initiatives. The service has 80-100 staff at any one time and this can be challenging for Nikki.

“As a team we work hard to provide education and training that meets the needs of the workforce. For example, we may have a mental health nurse who needs education in intellectual disabilities or an intellectual disability nurses who needs education in mental health and forensics. We use the expertise within the team when we look at providing education and training.

“So the team and I work really hard to make sure the education we provide is suitable for a range of staff needs.”
Every fortnight, clinical psychologists Emma Gardner and Paul Oxnam facilitate a group supervision session, named coffee, cake and a chat, for Regional Intellectual Disability Secure Service (RIDSS) clinical staff. Each session is typically attended by 6-12 members who are nurses, mental health support workers (MHSW) or occupational therapy support workers (OTSW). RIDSS management supports the sessions by providing cover on the floor and funding for the provision of coffee, cake and fruit for attending staff.

Coffee, cake and a chat is a confidential and safe forum for staff to discuss any workplace issues. Emma and Paul encourage participants to openly express their concerns about their experiences with service users, colleagues, management, and ‘the system’. Chain analysis (a technique designed to help a person understand people’s behaviour) is used to provide a solution-focused framework to the matters raised.

Staff have provided positive feedback on their experiences at coffee, cake and a chat:

“I have found coffee, cake and a chat very helpful. Our role can be stressful at times and this session is a place to talk about any common problems that may have occurred throughout the week. The group is also a great place to unwind with your work colleagues and chat about the roles of other staff within the service. I also find it good just to sit and listen to other staff members’ problems and hopefully help them resolve issues they may have.”

Rocco Squatriti, MHSW

“I have been attending coffee, cake and a chat for the last year or so, when my schedule has allowed. I have found these sessions so valuable as a form of supervision to get out frustrations and work through issues relating to my role. The chain analysis format the supervisors provide is a great way of stepping back from a situation and having a look at the overall picture. It helps me to come to an understanding of things I could have done better or of different approaches I could try next time if the same issue arises. From the experience I have had with coffee, cake and a chat I would recommend it to all people who are in need of supervision. I have found it an uplifting experience.”

Sam Cripps, OTSW

Emma and Paul will continue to provide this service for the foreseeable future, with the aims of maintaining safe practice, increasing confidence and skill, and fostering greater team cohesion across RIDSS staff.
Whakaruru Cottage is an open ‘step down’ home. These cottages are set up much like a flating environment. All the residents help cook meals each night, help with the household chores and are out all day at programmes. These are houses set up especially for people transitioning to a lower level of care.

Haumietiketike is one of two national secure facilities (the other being in Auckland) that provide services for people with an intellectual disability who have offended and who have behaviour which poses a serious risk to themselves or others may have co-morbid psychiatric disorder, and who are involved in the criminal justice system.

The creative room has been set up to give people space to work on projects, both individual and group. It is also used for quiet time away from others and can be used for computer games if that is your thing. Staff say some lovely pieces of art have been produced in this space.

Hikitia Te Wairua Youth Intellectual Disability Secure Service is a national inpatient service for youth aged 12-18. This service is for young people who have an intellectual disability and may have offended, or have behaviours that are a high risk to others or themselves.
Having a family member with autism is a journey and each family’s journey will be different. Autism impacts by causing communication difficulties, difficulties with understanding social behaviour and behavioural inflexibility.

The autism spectrum is huge and everybody will be affected differently by their autism, even those within the same family. Below are some of the ways families have said health professionals can help them.

The autism is secondary
People who have a family member who is on the autism spectrum will know that autism can bring challenges, but that their family member is a person first; they should not be seen primarily as autistic. There are difficulties which can happen when someone in your family is on the spectrum, but there is so much more to that person than just their diagnosis. One family I met with after their child had been recently diagnosed were concerned that other people would start to treat their child differently, when he was still the same person that he was before he got the diagnosis.

Help with what is and isn’t autism
Families can have difficulty working out what autism is and what is ‘typical’ child behaviour – or as one father put it to me “what is naught and what is ‘aughty’”. This can be a particular issue where the person on the spectrum might be the eldest child and so the parents may not have a clear idea of what typical child development looks like. Sitting down and talking through different ways their child might be behaving is a really helpful way for parents to start to work this out. This also assists you in working out what might be a behaviour because of a person’s autism and what is caused by their mental health issue.

Having confidence in what they are doing
It can be very easy to doubt yourself as a parent, and this can be more pronounced when your child is on the autism spectrum. Taking the time to listen to a parent and discuss different strategies can help them to have confidence in themselves and how they are approaching different situations. Reinforce to them that they are doing a great job – they don’t often hear that.

Talking to others in the same situation
Ask families if they would like to be put in contact with Parent to Parent (www.parent2parent.org.nz). They have a nationwide database they put families on and match them up to others who are in a similar situation. Talking to someone who knows just what you are going through can be so therapeutic and it is a great way for families to find out about different strategies or resources they might have used.

Parent to Parent also has camps for siblings of those with autism. Autism can be quite a specialised area but there are people available to support you to get more information. Autism NZ (www.autismnz.org.nz) is a fantastic source of knowledge, especially around what is available locally.

Another organisation is Altogether Autism (www.altogetherautism.org.nz). Altogether Autism will send out evidence-based information packs on any topic around autism. They also have a professional experts group (www.altogetherautism.org.nz/professional-expert-group/) available to give advice.

“What would happen if the autism gene was eliminated from the gene pool?
“You would have a bunch of people standing around in a cave, chatting and socialising and not getting anything done.”

Temple Grandin, The Way I See It: A Personal Look at Autism & Asperger’s
Developing nurses’ knowledge about people with an intellectual disability

by Jeanette Love – registered nurse, Master of Health Care

The focus of my Master of Health care was nurse education and in particular the need for all nurses to receive education regarding the high and complex needs of adults with an intellectual disability (ID).

With concurrent changes in undergraduate nurse education and the move to the ‘social model’ that came with deinstitutionalisation, ID specific content in undergraduate nurse programmes has diminished. Recent government reports emphasised the health inequities of people with intellectually disability. Literature also identifies gaps in nurse education, calling for the involvement of a skilled nursing workforce to address these issues (Cook, 2009; Ministry of Health, 2011).

During the course of my studies I took the initiative to develop a learning tool for student nurses (SNs) on clinical placement in a medium secure inpatient unit for persons with ID, within the Southern District Health Board.

An orientation and resource module was developed in collaboration with the tertiary institute delivering the Bachelor of Nursing programme. The process involved reviewing relevant literature on adult education, nurse education, preceptorship, intellectual disability and mental health. I also drew from preceptor experiences and feedback from SNs. The aim is to support the learning experience of SNs on clinical placement in the inpatient unit through the interactive process of experienced nurses providing preceptorship for students on clinical placement. This will help the transference of generic nursing knowledge to the skills required to provide nursing care for persons with ID in any practice setting.

Although the resulting booklet was initially developed for SNs on clinical placement in an ID service, the information contained within it is pertinent to guide all nurses to adjust their practice to meet the high and complex needs of people with ID.

The booklet includes information about the service, what an intellectual disability is, and important points for nurses such as communication, family and whanau support, legislation, informed consent, health lifestyle, sexual health, intellectual disability and mental health, substance use diagnoses, medication, nursing assessment, risk, therapeutic tools and challenging behaviours.

If you would like to know more about the information booklet please feel free to contact Jeanette, jeanette.love@southerndhb.govt.nz.


Creating a positive relationship is vital.

Need to understand the person’s life/experiences.

Need for flexibility.

Simplify communication without devaluing the person.
What is an Intellectual Disability?

1. Impaired intelligence (IQ of 70 or less on an individually administered IQ test) – a significantly reduced ability to understand new or complex information and to learn new skills and
2. Impaired adaptive functioning (impaired social functioning) – a reduced ability to cope independently and
3. Onset before adulthood (under 18 years) with a lasting effect on development.

Intellectual disability may present in varying degrees and is categorised as:

- mild – 85 per cent (of persons with an ID)
- moderate – 10 per cent
- severe – 3-4 per cent
- profound – 1-2 per cent.

Guidelines

- Creating a positive relationship is vital.
- Need to understand the person's life/experiences.
- Need for flexibility.
- Simplify communication without devaluing the person.
- Constantly check that the person understands.
- Need to be concrete.
- Consistency.
- Need for a holistic approach and involvement of other health professionals for specific issues.

Communication

Persons with an ID often experience communication difficulties. This poses issues when completing health assessments. There is also a direct link between communication difficulties and challenging behaviour. Behaviour is often used as a form of communicating. Communication difficulties can be categorised as follows.

- Expressive – articulation difficulties because of physical impairments, limited vocabulary, psychological trauma, and difficulties of putting feelings into words.
- Receptive – too much language to process at the one time, use of abstract language, unrecognised hearing loss, difficulties in attending to and remembering what was said.
- Social – inability to expand on topics, turn taking, initiating conversation, may give responses automatically.

It is important to complete a communication assessment to ascertain the needs of an individual with ID to ensure:

- means of communication – support/teach people how to communicate
- reason to communicate – choice and autonomy to influence why communication is necessary
- opportunity to communicate – provide the right environment and tools to assist communication.

Communication techniques

- Speak clearly and slowly.
- Use short sentences.
- Limit amount of information given at one time.
- Avoid abstract concepts.
- Consistent responses.
- Allow time for their responses.
- Reassure and give prompts.
- Show you are listening.
- Repeat back what was said to show you have understood.
- Check the person has understood what you have said.
- Use other means of communication such as gestures, objects, pictures.
- Be mindful of body language and non-verbal cues (yours and consumers).
Compared to the general population, people with intellectual disability experience higher levels of ill health (Davis & Mohr, 2004; van Loon, Knibbe & Van Hoeve, 2005), and a decreased life expectancy (Ministry of Health, 2011);

however, the longevity of this population is advancing (Bigby, 2004; Emerson & Baines, 2010). The World Health Organization noted that whilst health is pivotal, it is equally important to address social, economic and environmental factors which impact on persons with intellectual disabilities, and the wellbeing of families and communities (Emerson et al., 2012).

There is a distinct lack of undergraduate and postgraduate education in New Zealand about intellectual disability across the health disciplines (Ministry of Health, 2003). This is concerning given that the move from institutional settings to community care has been achieved and New Zealand is currently embedding new philosophies of service delivery. As a leader in the United Nations Convention on the Rights of Persons with Disabilities [UNCRPD] (2006) New Zealand has a responsibility to meet standards: Article 4(i), for example, requires participating countries “to promote the training of professionals and staff working with persons with disabilities” with the aim of providing “assistance and services guaranteed by those rights” (p.6).

Recently, the Directors of Mental Health Nursing from district health boards nationwide identified the issue of recruiting and retaining health professionals with knowledge and expertise in this specialist field as a range of disciplines are often sourced from overseas. The University of Otago, Christchurch was approached to develop a paper which was delivered for the first time last year between the Department of Psychological Medicine and the Centre for Postgraduate Nursing Studies.

NURX433/PSMX439 Intellectual disability: Theory into practice is a level 8, interdisciplinary postgraduate paper. A key aim of the paper is grounded in Article 19 of the UNCRPD which requires signatory countries to demonstrate how people with intellectual disability are supported to live and be included in their community. In this paper the application of current philosophical frameworks within practice are explored with the aim of engaging individuals and their family/whānau to optimise their physical and mental wellbeing in accessing the community across the lifespan. Content includes the epidemiology and aetiology of intellectual disability with links to physiological, sociological, pharmacological and behavioural approaches to person-centred care.

This paper is available to those who have completed a three-year undergraduate degree – not just registered health professionals with equivalency. In 2013, seven students from across the South Island completed the paper, and came from a range of disciplines (social work, nursing, occupational therapy, speech and language therapy), and worked in either education, mental health, disability, inpatient and/or community settings. Their feedback indicated the value of the course was in developing an understanding and/or update of key concepts linked to the evidence base. They were stimulated by the range of topics which were presented using a range of technologies. The paper provided a platform for students to develop their expertise by directly applying the philosophical principles into practice – thereby ensuring relevance to their respective clinical settings and, ultimately, to people with intellectual disability themselves.

References
Planning to make the most of postgraduate study

It is the time of year where you may be turning your thoughts to postgraduate study in 2015, or you may be supporting nurses to undertake further study.

Skills Matter within Te Pou funds post graduate clinical training for health professionals working in the mental health and addiction workforce. Nurses make up a large proportion of those funded – over 70 per cent. Many of these nurses are undertaking the New Entry to Specialist Practice (NESP) Mental Health and Addiction Nursing programme. Others are working towards postgraduate certificates in the areas of cognitive behaviour therapy; infant, child and adolescent mental health; co-existing problems or studying up to Masters level on a postgraduate pathway funded under the Clinical Leadership in Nursing Practice programme.

The 2014 programme information will be updated as soon as all programmes confirmed, but they are likely to remain the same for 2015 (see www.tepou.co.nz/training/skills-matter).

Skills Matter surveys funded students at the end of every year, and each year their responses tell us that postgraduate study is a big undertaking, no matter which programme of study. This is especially true for those working and juggling the commitments and responsibilities of a life outside work: partners, children, families and whānau, friends and community involvements. For those studying, managing the work-life balance is extended to managing the work-life-study balance.

However, the survey responses also point to significant benefits from postgraduate study. Nurses (and others) describe a whole array of positive outcomes: increased confidence, knowledge, skills; strengthening of overall practice; gaining practical tools; and increased ability to critically reflect on practice. Some also report how they are sharing their learning with their team and positively changing practice in the workplace.

Planning is a key factor that enables successful outcomes from study. This is on two levels. The first is planning on an individual level – understanding the nature of the study commitment involved and what this means in terms of managing the workload. Also, planning where to obtain support while studying is important. Former students have described the importance of support from a range of people: family, work colleagues, managers, supervisors, academic staff and nurse educators.

The second is planning on more of an organisation level. This involves taking a strategic view: assessing whether the proposed course is right for a nurse’s career path and a good fit with the organisation’s needs around skill development. In addition, there is establishing whether the nurse can be released to attend lectures or use study leave to assist with completing academic work.

For organisations, planning and good preparation around supporting students may lead to opportunities to obtain more benefit from the Skills Matter training programmes (see Skills Matter Student Survey 2013 – Key findings at www.tepou.co.nz/library/tepou/skills-matter-2013-student-survey-key-findings). Studies on training effectiveness have identified factors that increase training transfer – that is the application of learning into practice (Salas, Tannenbaum, Kraiger, & Smith-Jentsch, 2012). Evidence-based strategies include:

- preparing the learning climate in the workplace including the preparation of leaders and supervisors
- being clear about training needs
- building trainee motivation to learn and self-efficacy
- removing obstacles to the transfer of training
- providing tools/advice for supervisors
- encouraging the use of debriefs and other reinforcements (Salas et al., 2012, p. 80).

We hope this provides food for thought to nurses opting to study in 2015, as well as those who support them.
Central nurses gather to learn and connect
by Tony Heyward and Suzette Poole

On 21 May 2014 around 75 nurses from the Central Region gathered to attend the third Mental Health Addiction Intellectual Disability (MHAID) Annual Nurses Forum in Porirua.

Nurse educator Tony Heyward from Capital & Coast District Health Board designed a programme filled with topics of interest to nurses in many settings. Here are some of the key messages from the day.

Lesley Maskery, a community nurse working with older people, presented on delirium, a state that is transient and of fluctuating intensity, which most people recover from within four weeks or less. Delirium should be suspected in anyone with an alteration in mental status and, when detected, a workup should be initiated urgently. The delirious state may be superimposed on, or progress into, dementia. Delirium is potentially life threatening and failing to understand this may lead to premature death. A third of elderly service users who develop delirium during acute hospital admission continue to have symptoms many months later.

Lynley Byrne, GP liaison nurse, gave an overview of an Australasian conference: Medicine for Psychiatrists (www.medicineforpsychiatrists.com/conference-programme) pitched at psychiatrists, GPs and specialist nurses. It focused on physical health co-morbidities seen commonly with mental health service users. The presentation highlighted the more common physical health illnesses seen by nurses and common drug interactions. Metabolic syndrome was highlighted as an issue and Lynley spoke of the monitoring tool she recently completed. Being aware of the risks that mental health service users have in terms of metabolic syndrome is an integral role and skill of contemporary mental health nursing and the monitoring will be nurse led within the Capital & Coast DHB.

Toni Dal Din, Associate Director of Nursing, presented an introduction to using an ethical decision making framework to assist nurses and other health professionals to work through ethical dilemmas. “We are often faced with ethical issues in our work and in the main are able to deal with the majority of them. However, sometimes they become very complex and more difficult to come to a resolution on. The framework is a way of ordering the decision making so that the problem can be looked at sequentially from a number of angles”. You can read more about this in the professional supervision column.

Stacey Wilson, lecturer at the School of Nursing, Massey University, discussed some of the findings of her PhD that nurses might consider in their approaches to service users and their families in a situation of crisis. You can read more about Stacey’s research in the nursing digest section.

Sandy Smith, community mental health nurse and Michael Dorofaeff, team leader and community mental health nurse, discussed disability and mental health. People with an intellectual disability can present with mental illness and are often said to have a dual disability. They may require input from both mental health and Disability Support Services (DSS) funded agencies, but there are often barriers to this shared support. Mental health and DSS funded services both have a commitment

Feedback from the day

“Informative, clear, passion came through the presentation.”

“Great day, thanks.”

“Excellent day, thank you everyone.”

“Very relevant, more please.”

“Great to see ID nurses presenting on issues around access to treatment/services for the client group I work with.”

“Very interesting and relevant to my practice.”
to inclusion, and good service delivery for people with a dual disability is possible if services are flexible and willing to work collaboratively.

Pip Bradley, comprehensive nurse in the addiction team, explained that dialectical behaviour therapy (DBT) is a well-evidenced, effective treatment for borderline personality disorder, other emotional dysregulation and co-existing problems, particularly those involving repeated self-harm and crisis presentations. It is both a treatment for clients and a structured model for staff that reduces staff burnout and crisis reactivity. Treatment focuses on validating relationships and includes individual therapy for behavioural analysis and problem solving of the client's moment-to-moment actions, and group therapy for teaching of skills for managing emotions and relationships. Often clinicians lead the development of DBT services but management support is essential for the funding of training and clinician time.

Kym Park, project leader and team leader, shared her story of leading change and setting up Te Ara Pai, a local service that undertakes assessment of tangata whaiora/service users who may require additional environmental, social or independent living support in the community to facilitate recovery (see http://mentalhealthservices.org.nz/page/56-general-adult+service-coordination). The assessment, planning, implementation and evaluation skills that we nurses have make taking a lead role in the development and implementation of new services a perfect match. Change can and should be challenging but it is exciting and ensures that services are contemporary. Good supervision is vital to both ensure you remain on the right track and to support and challenge you when times get difficult.

Duncan Milne, nurse educator, and Janssen-Cilag facilitated an ‘intramuscular injection technique’ workshop that ran throughout the day in a breakaway room.
Here are the highlights from the 2014 IIMHL held in the UK in May this year. Te Pou was represented at the exchange by chief executive Robyn Shearer, business development support manager Rob Gill and clinical lead Mark Smith.

**Benchmarking and quality improvement indicators**

Robyn and Mark attended a London meeting led by Professor Harold Pincus of Columbia University, New York, on international benchmarking. They presented on the work done by New Zealand on key performance indicators (KPIs) and outcomes (see Mark's information pulse column on page 24).

“We had many meaningful discussions over two days to compare what member countries measure (and what they don’t),” Robyn says.

“This enabled us to look internationally at creating best practice guidance for some of those areas here in New Zealand. We were able to have deep conversations about each other's areas of expertise and share ideas and learning.

“New Zealand is seen as an international leader in outcomes, indicators and measurement. We can demonstrate how our national collection system (PRIMHD) is being used to tell us what is happening in services. We are one of the only countries in the world with such a system and, while it's not perfect, it is better than most.”

**Recovery, services, policy reform and more**

Robyn next attended a network meeting in Manchester. During the two day event she heard from some innovative leaders in the UK who shared practices on recovery, NGO services, early psychosis, forensic/police liaison, UK policy reform, and service user perspectives.

“My personal favourite was a session by Professor Rachel Perkins who has lived experience and has worked with services on making improvements by being clear on the intention of their work with service users, measuring what they do and ensuring they focus on early intervention,” Robyn says.

One address was by the UK Minister for Mental Health Norman Lamb who spoke about the need to ensure services are accessible, accountable, recovery-focused and have a strong focus on good physical health. Evidence from Te Pou's *Equally Well* (http://www.tepou.co.nz/improving-services/physical-health) agrees with UK evidence that those with mental health and addiction problems have poor health outcomes and the UK has brought in policy targeted at general health practices to try and amend this.

“There were a number of other interesting presentations. The International Initiative for Disability Leadership event, for example, focused on a number of initiatives and practices we are seeing come to fruition in New Zealand, such as individualised funding.”

**Workforce for the future**

Robyn also gave a three-minute presentation on the workforce for the future at the Dublin Dialogues in Ireland. She presented material regarding the World Health Organization's definition of workforce development and the challenges with ensuring mental health and addictions are a sustainable career choice driven by clear values.

She says the time away confirmed New Zealand is in a good place in relation to how we measure our results and focus on recovery and wellbeing for mental health and addiction.

“There are a number of challenges in predicting what is needed for the future, and leaders struggle with this, and it's our role at Te Pou to assist in mapping the future in workforce planning. We need to ensure we remain focused on growing our peer and service user workforce and ensure we strengthen support being provided at the earliest opportunity when people need it most.
“Housing, employment and good physical health are good agendas for wellbeing in our communities. Leadership is challenging and we need to build resilience in leaders and enable them to use evidence in their decision making.”

**The economics of mental health**

Rob represented New Zealand at a two-day meeting on the economics of mental health in Galway (see [www.tepou.co.nz/news/2014/06/18/reflections-on-international-perspectives-on-the-economics-of-mental-health](http://www.tepou.co.nz/news/2014/06/18/reflections-on-international-perspectives-on-the-economics-of-mental-health)).

Participants discussed how public mental health systems were coping given the relentless pressure to reduce expenditure in many countries, how mental health compared with other categories of expenditure, and the impact of the recession on mental health itself.

“It was evident there is a growing awareness of the social cost of poorly designed or delivered mental health services. For example, the global recession has led to reduced demand for psychiatric services and more demand for practical support to cope with distress related to debt. Consequently the transformation of service models was discussed as an urgent need.”

English delegates reported that hospital closures had changed the locus but not the focus of service provision. They shared concerns about fragmentation and workforce pressures within the NHS, linked to the frequency and scale of major reforms. They said the national mental health budget (of around 100 billion pounds or 12 per cent of the national health budget) is increasingly at risk.

The meeting concluded that leaders will play an increasingly important role in fostering imagination within their countries to stimulate more innovation.

Delegates identified the following opportunities to better respond to anticipated future needs for services and support.

- Introduce incentives for primary health services to respond early to mental health needs.
- Deliver more services through community-based providers.
- Allocate savings from reduced acute admissions to services that focus on prevention and early intervention.
- Quantify the costs of poorly managed coexisting conditions and shift funding to early intervention where indicated.
- Create incentives for all employers to deliver practical mental health support.
- Require lending institutions to work more supportively with borrowers who fall on hard times.
- Use novel contracting methods to share risks and rewards across multiple parties.
- Develop information systems that enable better monitoring of outcomes across primary health and mental health services.
- Embed evaluation in our organisations.

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### The HoNOS tool now available

The HoNOS tool assists mental health clinicians to use the HoNOS suite of outcome measures. The dashboard gives you a deeper understanding of your caseload with snapshot statistics. Input your entire caseload to get the full benefit of features such as number of cases, severity, ethnicity, gender profile and more. The HoNOS tool keeps track of who is due or overdue to be rated. Visit [www.tepou.co.nz/honos](http://www.tepou.co.nz/honos) to learn more.

#### How to access the HoNOS tool

- **Online**: The tool is also available as online at [https://honos.co.nz](https://honos.co.nz) for use on desktops, laptops and Windows devices (phones and tablets).
- **Android**: Launch Google Play on your Android phone or tablet and search ‘honos’ to install the app onto your device.
- **iOS**: An app for iPhone’s and iPad’s will be launched in the coming months.

Your data will sync across devices so you can use your computer, phone and tablet – whatever suits you best. Create an account ([https://honos.co.nz/register](https://honos.co.nz/register)) and start now!
New Zealand doing well internationally  

by Mark Smith

Those of us who have chosen to live in New Zealand know it truly is, by most benchmarks, a very desirable place in which to live. As someone involved in mental health information, it has been gratifying to learn recently that New Zealand compares very favourably with other countries in terms of the information we collect and use.

As mentioned earlier, New Zealand is part of the IIMHL (International Initiative for Mental Health Leadership (see http://www.tepou.co.nz/supporting-workforce/leadership) and Te Pou chief executive Robyn Shearer is the New Zealand representative on this work. In May I attended the IIMHL forum in the UK.

One of the areas for much international collaboration is the development of a set of international key performance indicators (KPIs). This work is led by Prof Harold Pincus from Columbia University in New York. All IIHML countries are participating but it has proven challenging to get agreement. The initial phases of this work involved identifying hundreds of KPIs which were then whittled down to a more manageable number based on surveys of clinical leaders from each of the countries involved. Finally, member countries were asked to supply data. The final list of KPIs covered the following domains:

- patient safety
- continuity/co-ordination of care
- pharmacotherapy
- outcome assessment
- access
- substance use
- service user perceptions of care
- efficiency
- recovery
- country-based proposed indicators: New Zealand proposed employment.

At the most recent meeting in London it was evident that New Zealand is able to supply data to this process because of the national collection (PRIMHD) and the existing KPI work we are doing. Many other countries struggled to supply national data. It is noticeable that there are many similarities between the KPIs we are collecting for adult services and the set of international KPIs. While it is hard to make comparisons between countries, since they record and report differently within varying health systems, it was evident that New Zealand generally has a good profile for many indicators.

The country that seemed most like ourselves in terms of the information being collected and used was Scotland and we have established some useful contacts with them.

In New Zealand we are looking to capture social indicator information in our national collection from July this year (housing, employment and primary health organisation enrolment) and this is the kind of information many other countries are keen to start capturing. The country that seemed most like ourselves in terms of the information being collected and used was Scotland and we have established some useful contacts with them.

There is also work underway to develop a recovery measure which could be used across countries. This is a very ambitious project given there are so many recovery measures already. This work is currently at the literature review stage. We will endeavour to keep the sector updated on this interesting and potentially important work.

Mark Smith, clinical lead, Te Pou
Let’s get together, yeah, yeah, yeah.

Recently, at a meeting with some local addiction consumer leaders, the subject of participatory notes came up.

We were discussing what authentic person-centred or strengths-based services would look like from our perspective, and collaborative documentation definitely comes into that.

One of the enduring issues for people working in mental health and addiction services is finding a decent amount of good therapeutic time to spend with service users amongst all the administration work and tasks that are expected now. It seems to me that collaborative documentation is a viable answer to some of that. Why not write up notes together as part of service delivery?

This could provide different opportunities to engage, build rapport and trust, have those clarifying conversations and create meaningful plans with clearly outlined roles and responsibilities.

Good engagement usually involves eye contact and being very present to hear the person, and sitting at a computer or tablet may not seem ideal for this. I had a GP once who did that, fine for embarrassing things but it felt rude otherwise.

However there are solutions – what about using the last 10-15 minutes writing up together what has been discussed, or, using reflective models, listen, reflect, agree, then write?

So much of what is involved in mental health and addiction service delivery has this shroud of mystery and secrecy for the people using services. Why? Isn’t it time to let the light in a bit and ensure people are involved in what’s said about them and can learn about themselves?

To me it makes sense and embraces true resilience building. The opportunities are wide open for this to be done really well.

Here are a couple of articles that were sent to me that are worth a look:

- Could collaborative documentation be the next big and effective thing in behavioural healthcare? by Claire Barbetti (http://iretablog.org/2014/06/13/could-collaborative-documentation-be-the-next-big-and-effective-thing/)
- Boston hospital pilot gives patients electronic access to their therapists’ notes by Lena H Sun (www.washingtonpost.com/national/health-science/boston-hospital-pilot-gives-patients-electronic-access-to-their-therapists-notes/2014/05/18/2d891bac-cfe5-11e3-a6b1-45c4dfb85a6_story.html).

Could this become an effective part of modern nursing practices? Are you already doing it? What are the barriers? I would love to hear what your thoughts are. Happy nursing!
An ethical decision making framework  

by Suzette Poole

Recently I attended the Mental Health Addiction Intellectual Disability forum in Porirua highlighted earlier in Handover. There I heard a presentation from Toni Dal Din, associate director of nursing, Capital & Coast District Health Board, about ethical decision making, which I think is a fitting story for this column.

Toni has drawn from his experiences as a director of nursing reviewing incidents in the practice setting. In his previous role, while preparing for Magnet recognition, Toni and his colleagues in the Nursing Development Unit noted there was no structured approach to assisting nurses with solving ethical dilemmas. Led by the associate director of nursing, Michele Halford and Joy Bickley Asher (an external advisor), they designed an ethical decision making framework which considers the perspectives of the child/patient, next of kin, health professionals, and organisation.

Nine questions are put forward for health professionals to consider.

1. What are the rights of those involved?
2. What are the duties of those involved?
3. What issues of justice are involved?
4. How has autonomy been addressed?
5. What about informed consent?
6. What issues of safety or freedom from harm are inherent, and how are they best addressed?
7. Who benefits, and how?
8. Whose rights, duties, access to justice, autonomy, information, consent, safety and benefit takes precedence over whom else’s?
9. Which value prevails over all others? How is this decided?

Toni explained that ethical dilemmas may occur when the values of the nurse, other health professionals and a consumer lead to different decision options.

"None of these options may be wrong – they are just different". He stressed it is important to be able to say how we reach a particular decision, rather than saying that either choice is inherently wrong. At times health professionals may experience a sense of moral distress when constraints (internal or external) prevent them from following the course of action they believe is right.

"You know the ethically appropriate action to take, but you are unable to act upon it," said Toni. Often there is no right or wrong answer, even when you’ve examined the issue thoroughly by using a framework – this is why it’s a dilemma! What is important is that you are able to say who you consulted with, how you’ve arrived at a particular decision and why, rather than operating solely on gut instinct which ignores other perspectives. Above all remember to document clearly all parts of the process.

If you would like to know more about the ethical decision making framework please feel free to contact Toni at toni.daldin@ccdhb.org.nz.

What is important is that you are able to say who you consulted with, how you’ve arrived at a particular decision and why, rather than operating solely on gut instinct which ignores other perspectives.
Over the last six issues of *Handover* we have covered in detail the Six Core Strategies© and how fidelity to this change model will positively impact to reduce seclusion events.

In this column I want to draw attention to some recent literature that supports the need to stay focussed on the ‘end goal’.

Te Pou has recently produced two videos, which are a succinct summary of two key pieces of literature.

- An evaluation of the efficacy of the Six Core Strategies© intervention to reduce seclusion and restraint episodes in an acute mental health unit by Trish Wolfaardt, from Auckland University of Technology.
- Health professional’s experiences of implementing seclusion and restraint reduction strategies in an acute mental health unit by Sharon Webster from Auckland University of Technology.

These research papers were commissioned by Te Pou to build the evidence base that sustained change requires focus and commitment. We want to draw attention to some key findings that are important to think about when moving into a sustainability mode for reducing restrictive practice.

The video describes three key themes.

- The first is rethinking power and control, which brings the notion of partnership and person-centred care into sharp focus.
- The second theme, into the unknown, discusses the importance of recognising that new practices can be challenging and uncertain areas and leadership is needed to reinforce good outcomes.
- The third theme, unsurprisingly, is getting all staff on board, knowing about, supporting and understanding the need to practice in ways that support least restrictive practices and that this applies to all staff, not just those working in the acute areas.

The videos are found in the library section of the Te Pou website, along with the full dissertations for anyone who wants more detail about what can support on-going sustainability of seclusion and restraint reduction.

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**Latest Publications - Te Pou**

**The physical health of people with a serious mental illness and/or addiction: An evidence review.**


The review highlights the need for a coordinated and concerted response to this significant health issue for New Zealand, and points to further work that needs to be undertaken, in partnership with those who are most affected – mental health and addiction service users and their families.

**Do seclusion reduction initiatives increase risk to staff safety?**


The publication in 2004 of the Six Core Strategies© bolstered seclusion and restraint reduction initiatives in western nations. At about the same time, studies appeared suggesting that seclusion reduction initiatives could pose unique risks to the safety of staff. The perception of risk to personal safety associated with seclusion reduction initiatives remains a concern in mental health inpatient settings in New Zealand and elsewhere. To begin to understand how to manage this Te Pou recently released an integrative review of intervention studies to identify and synthesise the evidence related to seclusion reduction and safety.
New Zealand nursing research

Mental health crisis intervention: A discourse analysis involving service users, families, nurses and the police

This New Zealand study investigated the discourses involved in mental health crisis intervention and includes discussion on law, policy and practice from the perspectives of people who use services, their families, mental health nurses and the New Zealand police.

By exploring the elements of social life and institutional practices, or discourses, certain privileged or suppressed ways of understanding crisis and what works or not can create a new approach for those working in the field to better enable inclusive care and best practice. Tensions between normalisation and medicalisation of crisis are political practices involved in the access and delivery of services.

This study found that nurses want to practice in ways that authentically and ethically engage people in a situation of crisis, but say they cannot as they are required by the dominant discourses to be risk adverse and strive to meet the economic needs of the organisation. This results in considerable surveillance and responsibility on service users, nurses and interrelated agencies such as the police.

A desire to make change in a situation of crisis is largely underestimated by all involved and at times impaired by access to and allocation of resources. There are structural, systemic inequities that counter the deeply personal and highly productive experience of mental distress. Inequity leads to a perception that service users, families and services are ultimately negative and a costly burden to the self and community.

Alternative interpretations of embracing change and resistance in the experience of crisis is dominated by reconfirming the necessity of state power over its people, but with new responsibilities for those involved, to liberate oneself from the distress and the interventions on offer. This contradicts our New Zealand recovery policies and practice guidelines and the philosophical stance in which mental health nurses aim their practice to engage, enable and partner people and their families.

Historical discourses of madness have converged with biomedical, accountability and social development discourses to sustain imposing restrictions. In effect, imposing restrictions and surveillance on people thought to be experiencing mental illness is legitimised in a system driven by politics and regulation. Survivors argue against violence toward people deemed mentally ill and participants in this study attempt to resist the disabling power of language and practices associated with psychiatric labelling.
However, a lack of awareness exists regarding the ways and means of persuasion and coercion nurses might use in order to be favoured by medicine and policy writers to achieve their goals. Some examples of what the predominant discourses are and what underpinning strategies (so called ‘truths’ and thinking) and technologies (roles, approaches, guiding practices) are summarised in figure 1.

Policy and expectation of service delivery has changed significantly since the implementation of the Mental Health Act (MHA) (1992) and implementation of the Ministry of Health recovery approach in 2000. Whilst the intention was movement toward a self-determining, personal recovery focused system, significant economic discourses resulted in budgetary restraints and questioning of social service spending has taken place. A key approach of social development discourse is the integration of economic and social policy argued to bring benefits of prosperity to all; and provide social welfare that enhances people’s abilities to participate in a productive economy. Therefore, delivery of crisis services is now less the prerogative of the state. However, housing, education, income support and the justice system are involved in the discourse of social development and have a direct correlation on the development of mental health problems, resourcing, access to services and impact on recovery.

Practices of crisis intervention, indeed any actions, are made possible and shaped by a range of strategies/technologies and by the discourse that justifies them, but practices are not just determined by those. Clinicians, be it in a crisis specific team or in a situation of urgency in an institutional or community setting, bring a human approach and personal agency. Past experience, local knowledge and subjective, emotional responses result in situated judgements and choices when deciding what to do and how to do it. People bring their own agency, or ways of acting, to an episode of assessment, or moment of policy delivery. They respond to and engage with their own understanding and sense of what constitutes a fair or unfair outcome. Therefore, a sense of openness about the process, potential outcomes and a negotiated meaning are required.

In the crisis situation the authority of the nurse is legitimised by legal powers and professional knowledge that can place strict limitations on an outcome. Crisis service users are people and their families, but also a wide range of health, social service and justice agencies. Alternative strategies such as therapeutic risk taking from the perspective of socially inclusive recovery policy co-exist in a sometimes uneasy relationship with the MHA (1992). Furthermore, for those who attempt to access services early in crisis, as is suggested to lead to a better outcome, provision of services and rights appear to be reversed through an attempt to exclude them through screening out practices, rather than prioritising a choice in access.

<table>
<thead>
<tr>
<th>Discourses</th>
<th>Strategies e.g.</th>
<th>Technologies e.g.</th>
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<tbody>
<tr>
<td>Biomedical</td>
<td>DSMV; psychopharmacology.</td>
<td>Mental state exam; medication monitoring; diagnostic imaging.</td>
</tr>
<tr>
<td>Accountability</td>
<td>Mental Health Act; other related legislation; mental health service specifications.</td>
<td>DAO role; triage; risk assessment; free crisis line.</td>
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<td>Social development (citizenship)</td>
<td>MHC policy; case management models.</td>
<td>MHSMART; HoNoS. WRAPS; choice appointments.</td>
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<tr>
<td>Personal recovery</td>
<td>Service user activism/ consultation/organisations.</td>
<td>Peer support; enduring power of attorney; no force advocacy.</td>
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Accessing full-text journal articles

In the last issue we walked you through the process of setting up Google alerts. Now you’ve set up your alerts, conducted a quick Google scholar search and found some exciting abstracts – only to discover that the full text isn’t easily available. This can be very frustrating, but you can try other methods to get the full text, such as the Mental Health Foundation’s journal subscriptions (see www.mentalhealth.org.nz/page/314-journal-subscriptions).

If you work for a district health board (DHB) ask the health librarian for assistance. They may be able to access it through DHB-wide subscriptions. Many city libraries, including New Plymouth, Auckland, Wellington and Christchurch, offer free access to research databases and journals using your library card. Finally, if your local library doesn’t have access to the article, ask the librarian about inter-library loans, often they can get a copy for a small fee.
This article provides a synthesis of a literature review and its implications for nursing practice to support the development of an education programme focused on the emergency management of near-hanging.

Use of a sensory room on an intensive care unit. Smith, S., & Jones, J.
This study explored the use of a sensory room on a psychiatric intensive care unit. Findings suggested staff and patients viewed the sensory room as a positive therapeutic intervention, and that use of the sensory room had improved staff-patient communication and patients’ overall experience of the unit.

Primary health care in the mental health workplace: Insights from the Australian experience. Cleary, M., Dean, S., Webster, S., Walter, G., Escott, P., & Lopez, V.
Although primary health care has been highlighted in all models of care, it appears that services are not always delivered in a planned or systematised way and that much needs to be done to further improve the situation for individuals accessing the health care system.

Depression screening on a maternity unit: A mixed-methods evaluation of nurses’ views and implementation strategies. Segre, L., Pollack, L., Brock, R., Andrew, J., & O’Hara, M.
This study found maternity unit nurses viewed depression screening positively and were able to screen patients in relatively few steps, which they implemented using strategies they had developed themselves. Depression screening on the maternity unit was found to be feasible and embraced by attending nurses.

The results of this study show nurses can identify recovery and articulate with pragmatic clarity how to care within a recovery-oriented paradigm. Pragmatic
modes of care described by nurses support using ‘champions’ to assist with eventual system transformation in the delivery of mental health services.

**International Journal of Mental Health Nursing**


Volume 23, Issue 4 Pages 285-380, August 2014


The study explored mental health consumers’ experiences with formal crisis services (i.e. police and crisis assessment and treatment (CAT) teams), preferred crisis supports, and opinions of four collaborative interagency response models. Most participants welcomed collaborative crisis interventions. Of four collaborative interagency response models currently being trialled internationally, participants most strongly supported the Ride-Along Model, which enables a police officer and a mental health clinician to jointly respond to distressed consumers in the community. The findings highlight the potential for an interagency response model to deliver a crisis response aligned with consumers’ preferences.

**Therapeutic engagement between consumers in suicidal crisis and mental health nurses.** Lees, D., Procter, N., & Fassett, D.

This article summarises qualitative findings from a multi-method study undertaken in Australia, which surveyed and interviewed mental health nurses who had recent experience of caring for consumers in suicidal crisis in a hospital setting, and interviewed consumers who had recovered from a recent suicidal crisis. The findings highlight that therapeutic interpersonal engagement between nurses and consumers was central to quality care. This was particularly noted as engagement could help reduce consumer isolation, loss of control, distress, and objectification of the delivery of potentially-objectifying common interventions. Of concern was that the results indicate a lack of therapeutic engagement from the perspective of both consumers and nurses.

**Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study.** Manuel, J., & Crowe, M.

The study examined how mental health nurses understood clinical responsibility and its impact on their practice. Three major themes were identified: being accountable, fostering patient responsibility, and shifting responsibility. Being accountable involved weighing up patients’ therapeutic needs against the potential for blame in an organisational culture of risk management. Fostering patient responsibility described the process of deciding in what situations patients could take responsibility for their behaviour. Shifting responsibility described the culture of defensive practice fostered by the organisational culture of risk aversion. The study highlighted the challenges mental health nurses experience in relation to clinical responsibility in practice, including the balancing required between the needs of patients, the needs of the organisation, and the perceived need for self-protection.

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**Latest Publications - Le Va**

**Healing Stories**

www.leva.co.nz/suicide-prevention/healing-stories

Digital storytelling highlighting prevention, hope, resilience and help-seeking is one way to communicate suicide prevention within our Pasifika communities. Healing Stories is a series of digital stories from Pasifika communities, emphasising the message that suicide is preventable and lives can be saved. These stories challenge the status quo by shedding light on a ‘tapu’ subject often not talked about within Pasifika communities. Healing Stories provides insights into personal experiences that connect individual past events to the present, as well as to a desired future.