

Handover

Mental health & addiction nursing newsletter

Primary Mental Health Intervention Service (PRIMHIS) at Lakes District Health Board

by Wilma Foster and Jo Price

The Primary Mental Health Intervention Service (PRIMHIS) is part of the Mental Health and Addiction Services for the Lakes District and originated through a pilot project in 2009. Initially there was one nurse providing general practitioner (GP) liaison across the region.

A decision was made to develop the service further, delivering it through GP clinics using brief interventions (talking therapies) as the mainstay of treatment. Staff employed in the team currently comprise registered senior nurses, registered clinical psychologists and an occupational therapist. Based on the demand for clinic space and the need to meet the target group of Māori, Pacific Island, youth and low income people, the free service is now delivered in the community, at GP clinics, in high schools and sometimes in a hospital setting.

It is essential that clinicians are grounded in a talking therapy modality such as: cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), mindfulness problem solving along with anxiety management and mood management skills.

All PRIMHIS clinicians routinely use a tool called My Outcomes. This instrument is well researched and its results correlate highly with more comprehensive and time consuming measures of personal wellbeing. There are two scores collected.

Continued on page 3



Jo Price – clinical nurse specialist and Wilma Foster – clinical nurse manager for Single Point of Entry Team, PRIMHIS, Lakes District Health Board

The team members are a passionate group of people who enjoy seeing the positive results of their outcome informed therapy for the people they serve.

Editorial

Tēnā koutou katoa - Greetings to you all

Welcome to this edition of *Handover* – a compilation of stories which includes a focus on primary mental health.

Wilma Foster and Jo Price lead with their story about a primary mental health intervention service in the Lakes district, sharing how the service was developed and how they use 'My Outcomes' to support a persons' recovery.

In our regular update from Jane Bodkin, office of the chief nurse, Ministry of Health the role of the enrolled nursing workforce in mental health and addiction service delivery is discussed.

We also profile two nurses working in primary care. Chris Lundy reflects on her role in primary care within Dunedin's Mornington Centre that evolved from the primary care initiatives which were rolled more than a decade ago. Many years ago I visited Chris at work and was impressed with how the team of GPs and practice nurses were embracing this new role and the difference it appeared to be making in the people that were referred to her.

An impromptu meeting at the mental health nurses conference led to Tina Simmonds agreeing to share her story about the evolution her role as a clinical nurse specialist in a primary mental health service. Tina also acknowledges the value of the Blueprint leadership programme in developing the leadership skills needed to overcome some of the challenges of working rurally.

In this edition you will also read a profile about Yvonne Kainuku-Walsh, a registered nurse working for Le Va as a project leader. This story captures key messages about working with youth and shows how career pathways can open up for nurses to take on leadership roles in policy and workforce development.

Our research section highlights two abstracts by mental health nurses completing their Masters postgraduate study. We hope you enjoy this edition.



Suzette Poole - Editor

CLINICAL LEAD

EMAIL: suzette.poole@tepou.co.nz

Nāku noa, nā Suzette

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ISSN: 2324-3821

NEXT EDITION:

The theme of our next edition is eclectic and a great opportunity to share with others some of the great work that you do. Articles are due by Monday 16 November 2015. Email to suzette.poole@tepou.co.nz.

The Outcomes Rating Scale (ORS) which is completed at the beginning of the therapy session and the Session Rating Scale (SRS) completed at the end of the session. The ORS is a measure of subjective wellbeing and enquires about perceived personal, interpersonal, social and overall wellbeing using a brief four question visual analogue scale. A total score of 40 can be achieved. The SRS measures the quality of the clinician's alliance/working relationship with the person they are working with as perceived by that person, also using the ultra-brief four question visual analogue scale. This informed feedback allows the intervention to be redefined to best meet the persons' needs.

The data is loaded into the My Outcomes international database which ultimately provides a worldwide overview of the effectiveness of primary mental health interventions. The Lakes data consistently identifies positive outcomes of around 75+ per cent. The international average positive sits at 75 per cent.

One PRIMHIS nurse also has the role of clinical nurse specialist, supporting the practice nurses within the GP clinic setting to get credentialed in mental health. Other activities include attending and presenting at GP evenings and practice forums, developing a quarterly newsletter for the community of GPs and providing consult liaison to help GPs navigate services for support and advice – particularly in times of crisis or medication treatment review.

The team members are a passionate group of people who enjoy seeing the positive results of their outcome informed therapy for the people they serve.

To learn more about PRIMHIS contact Wilma Foster, clinical nurse manager, single point of entry, mental health and addiction services on 07 343 7756 extension 8219.

Nursing notes

by Suzette Poole

Tēnā koutou katoa

I think the words connection and relationships sum up the winter months for me and resonate well with the themes which permeated the previous edition of *Handover* – He tuhinga motuhake mō ngā tāpuhi hauora hinengaro Māori me ngā tāpuhi waranga Māori – a special edition about Māori mental health and addiction nurses. My recent move back home to where most of my family live and the loss of my children's grandfather gave me an opportunity to spend time at our marae with whānau and reinforced for me the value of remaining connected to family. Conversations with family and friends about accessing health care reminded me of why I am still doing the work that I do and the need to continue to support how health services best respond to Māori. Our latest story of success *engaging with Māori, authentically and holistically* about Health Hawkes Bay's Wairua Tangata primary mental health programme (www.tepou.co.nz/news/engaging-with-maori-authentically-and-holistically/662) is a wonderful example of how a service can adapt to better connect with Māori.

Nimble initiatives

Our work on improving responsiveness to people experiencing co-existing mental health and addiction problems sometimes involves co-facilitating meetings with leaders and staff of DHB and NGO services alongside Ashley Koning from Matua Raki. At a recent workshop it was great to see that sometimes even small initiatives can keep an agenda of change alive. This workshop highlighted that initiatives that are nimble enough to be actioned during wider organisational change are key to revealing the potential for change

where there are committed people wanting to improve services.

Being catalysts to generate discussions and support the development of local action plans is a rewarding part of what we do. Providing a space for people with a common bond to come together can assist in building across sector-service-team relationships especially when services are busy.

Conferences

The ability to attend conferences and represent Te Pou is a privilege which enables me to hear more about what is happening, new initiatives, new research and to share with delegates some of the work that we do. Delivering presentations, facilitating workshops and running the Te Pou stand are all part and parcel of my role. The high level of interest in the resources we have available on our stands really reaffirms for me the pivotal role that Te Pou has in supporting the mental health and addiction workforce to be the best they can be.

In July I attended the Te Ao Māramatanga New Zealand College of Mental Health Nurses' conference which had a focus on whānau ora. Around 200 nurses attended. A stand out for me was listening to an inspiring and thought provoking presentation by Tawni Kahukura Goombs about her journey through health and justice systems which she felt did not pick up on the key issues and failed to connect with her. She went on to describe how the whānau ora approach was instrumental in turning her life around.

At the college conference it was wonderful to see three new fellows being welcomed at the fellowship ceremony Daryle Deering, Toni Dal Din and Reena Kainamu acknowledging their contributions to mental health and addiction nursing.



Top Row: Tio Sewell, Chris Lundy, Chris Taua, Tony O'Brien, Brent Doncliff, Ron Baker.
 Bottom Row: Carmel Haggerty, Suzette Poole, Mere Hammond, Helen Hamer, Mark Smith, Tony Dal Din, Daryle Deering, Heather Casey.
 Absent: Brian McKenna, Kate Prebble, Chris Hattan, Frances Hughes, Hineroa Hakiha, Erina Morrison, Helen O'Sullivan, Brian Pickering, Kaye Carncross.

Later in July I and 200 other nurses attended the primary care nurses conference in Wellington I was pleasantly surprised by the level of interest in our resources on the stand and enjoyed hearing from nurses in primary care settings about some of the great work they were doing around mental health, addiction and also physical health. Our presentations on co-existing problems and Equally Well were warmly received.

A very interesting presentation from Lizzy Kepa-Henry, public health nurse who was also based at Work and Income described how a nurse could support people through Work and Income who have unmet health needs. Liz highlighted how the poor attitudes of some nurses towards people who needed health care often prevented people from getting the health care they actually needed.

A presentation from Chai Chuah, director-general of health and chief executive, Ministry of Health on 'Integration – A challenge and opportunity. What is needed to move to the next phase?' inspired me to purchase a book Transforming-Health-Care-Leadership by Maccoby, Norman, C., Norman, C.J., and Margolies (2013) to learn more. He mentioned leadership teams comprising of network leaders, strategic leaders and operational leaders.

Values and attitudes

The quality of the relationship between the person needing and wanting support with their mental health and addiction problems and the health professionals providing that support is critical to improving

health outcomes. Pivotal to this partnership is the ability of a health professional, regardless of their practice setting, to demonstrate they have the right values and attitudes to best respond to people experiencing mental health and addiction problems. These were key messages that Carolyn Swanson and I shared when we accepted an invitation to write the editorial for the September edition of Kai Tiaki – New Zealand Nurse Organisations' monthly journal which had a focus on mental health.

"The best outcomes in mental health care will be found in the marriage of two types of expertise working in partnership – expertise by profession and expertise by experience"
 (Faulkner & Layzell, 2000).

As mental health and addiction nurses take up more and more roles within the primary sector one of the key challenge is likely to be acting as a role model to their new colleagues on how to best support people experiencing mental health and addiction problems. The actions and words of these nurses will also be crucial in helping to reduce any stigma and discrimination which can stop people seeking treatment early and maintaining their wellness. Essentially, discrimination is behaviour that says to people with mental health or addiction issues that, “you are not welcome”, “you’re not as good as us”, “you’re not one of us” and “you are not important and you don’t belong”.

To prepare for their entry into a new practice area mental health and addiction nurses could, perhaps during a supervision session, take time to reflect on their own values and attitudes and identify and correct any thoughts, beliefs or behaviours they have that may contribute to stigma and discrimination. In turn supervisors of new nurses should be actively listening out for opportunities to support them to develop strategies to reduce stigma and discrimination.

If you would like to explore your values and attitudes a bit more then please feel to complete the *Let’s get real* values and attitudes learning

module on the Te Pou website, www.tepou.co.nz/resources/lets-get-real-values-and-attitudes-learning-module/203. There is also a module to develop your skills for challenging stigma and discrimination, www.tepou.co.nz/resources/lets-get-real-challenging-stigma-and-discrimination-learning-module/208.

We are really interested in stories from nurses about how they help to reduce stigma and discrimination so please feel free to contact me.

Ngā mihi - Salutations

Suzette

PS: Yah I finally graduated in September with a Master in Nursing and a Post Graduate Diploma in Forensic Psychiatry. Big thanks to all those that supported me on this journey. You can read the abstract in the research section.



Suzette Poole, clinical lead,
Te Pou

Five ways to wellbeing

*Ētahi ara e rima ki te
ngākau ora, help people
stay mentally well*

The Mental Health Foundation outlines five ways to wellbeing.

1. Connect (me whakawhanaunga)

2. Give (tukua)

3. Take notice (me aro tonu)

4. Keep learning (me ako tonu)

5. Be active (me kori tonu)

If we were to use this as a checklist for wellbeing, you could ask yourself these questions.

- Am I happy with my relationships and how much time I spend with those who are important to me? Do I laugh often?
- Am I happy with how I am with others and myself? Am I the kind of person I want to be around? Am I kind, thoughtful, giving to myself and others? Am I kind and forgiving to myself if I’m not travelling well and don’t have the capacity to give today?
- What are some of the things I like to do? Am I happy with how much time I spend doing things that I enjoy? Do I notice what I have rather than what I don’t have?
- Would I like to try something new? How can I plan for this to happen?
- Am I okay with asking for support when needed?
- Am I ok with how I look after my physical health? Am I regularly eating well, exercising and resting?

Managing a good work-life balance is challenging but essential for wellbeing. Doing this effectively means identifying the things that you would like to improve, in the areas you can control, and making some adjustments in your schedule to make this happen.

Visit the Mental Health Foundation’s website,
www.mentalhealth.org.nz for more information.

Addiction nurses' update

by Klare Braye, project lead, Matua Raki

Tēnā koutou

The approaching summer provides a great opportunity to reflect on some of the activities and highlights in addiction nursing over the year so far, and also those coming up.

In July the Te Ao Māramatanga New Zealand College of Mental Health Nurses conference was held in Wellington. The conference had a whānau ora theme and offered ideas and practices that could be shared across the mental health and addiction arenas as we work with family wellbeing. The focus was mainly on mental health so it was encouraging to note presentations from many addiction sector nurses who had previously shared their work at Matua Raki addiction nurses' symposia (www.matuaraki.org.nz/workforce-groups/addiction-nursing/155). This suggests the symposia are valuable, not only to disseminate innovative practice but also to encourage presenters to take their work further.

The Matua Raki stand was a hive of activity as we shared resources to support addiction interventions in existing mental health or primary care services. There was particular interest in A Guide to the Addiction Treatment Sector in Aotearoa New Zealand (www.matuaraki.org.nz/resources/a-guide-to-the-addiction-treatment-sector-in-aotearoa-new-zealand/369) and Brief Intervention Guide: Addressing Risk and Harm Relating to Alcohol, Tobacco and Other Drugs and Gambling (www.matuaraki.org.nz/resources/brief-intervention-guide-addressing-risk-and-harm-relating-to-alcohol-tobacco-and-other-drugs-and-gambling/394) and the recently released What is opioid substitution treatment? – an information booklet for family, whānau

and people supporting those receiving opioid substitution treatment (OST). This complements OST and you: A guide to opioid substitution treatment (www.matuaraki.org.nz/resources/what-is-opioid-substitution-treatment-booklet/645).

On a smaller scale, although equally valuable, was the opportunity to talk with a number of nurses from the NGO addiction workforce. The Salvation Army organised an event for nurses working at The Bridge, Auckland Odyssey House and Higher Ground. The day acknowledged some of the sense of isolation occurring for nurses working in these settings and addressed some strategies to manage it. I was able to use data from the workforce stocktake to offer some context for NGO addiction nurses working within the wider mental health and addiction workforce (www.matuaraki.org.nz/news/forum-for-nurses/639).

The Cutting Edge Conference was held in Nelson in early September. This is the annual gathering of the addiction treatment sector, embracing not only treatment practitioners but also by those who work in brief interventions, primary care services, smoking cessation, public health and mental health (www.cmnzl.co.nz/cutting-edge-2015). This event also provided an opportunity for nurses working in addiction to gather at the lunchtime DANA and Matua Raki nurses' meeting to network and share ideas and resources.

With increasing recognition that many people with problematic substance use may never need to access specialist services, there are opportunities for GPs and nurses to provide brief interventions for people with alcohol and other drug problems. Anna Nelson and I have provided training to a number of PHOs in the Greater Wellington area to support the use of the ABC model of screening and brief intervention and the use of AUDIT C integrated into patient management systems.



Klare Braye, project lead, Matua Raki

The Ministry of Health launched the new COPMIA guideline *Supporting Parents, Healthy Children* in September (www.matuaraki.org.nz/initiatives/the-copmia-initiative/161). These are not nursing specific but will be essential reading for nurses. Also coming up in November is Addiction Leadership day in Christchurch (www.matuaraki.org.nz/events/addiction-leadership-day-christchurch/890) and some introductory training dealing with the issue of intellectual disability and co-occurring substance use (<http://www.matuaraki.org.nz/events/alcohol-and-other-drug-use-in-people-with-intellectual-disabilities/908>).

Those interested in developments around nurse prescribing should note changes proposed in the amendment of the Misuse of Drugs Act 1975 to allow nurse practitioners and designated prescriber nurses to prescribe controlled drug dependency treatments.

Last but not least can I alert you to the next Addiction Nurses' Symposium which will be held in Wellington in early 2016. Please think about some of the initiatives and practices you are engaged in as an addiction nurse, either within your service or across services, and consider sharing this as a presentation at this symposium. If you would like more information contact klare.braye@matuaraki.org.nz or visit www.matuaraki.org.nz/workforce-groups/addiction-nursing/155.

Hei kona mai
Klare

Message from Jane:

Enrolled nurses in mental health and addiction services

by Jane Bodkin, senior advisor nursing – Office of the Chief Nurse, Ministry of Health

The Ministry of Health is encouraging more employers and health professionals to understand and use the skills of enrolled nurses. As regulated health professionals, they play a valuable role within health care teams under the direction of registered nurses.

Enrolled nurses contribute to nursing assessments and care planning, provide nursing care, and evaluate outcomes of care for patients and their families. Many also undertake other nursing responsibilities, including administering medicines and assisting patients with daily living activities, and can play an important role in nursing education through mentoring new graduate nurses.

As health professionals, they are well placed to work in a range of settings, including mental health and addiction. With their knowledge of wellness activities such as mobility, nutrition, hygiene, hydration and skin care, enrolled nurses can contribute to improving the physical health of people with mental health and addiction problems.

Enrolled nurse training was re-introduced in New Zealand in 2003, after being disestablished 10 years earlier. At the time, the scope of practice was limited and the role was re-named nurse assistant. In 2010, a new scope of practice for enrolled nurses was introduced, which saw a return to the original title and a new, improved education programme rolled out. Almost all nurses practising as nurse assistants

transitioned to the new enrolled nurse scope of practice by completing the required education and competency assessments.

Today, there are nine Diploma of Enrolled Nursing programmes offered, which are accredited by the Nursing Council of New Zealand. The diplomas provide a foundation in generalist nursing and include mental health modules. They take 18 months to complete and graduates receive an NZQA Level 5 qualification.

During the period when no enrolled nurses were trained many health care teams, particularly in mental health and addiction settings, became unaccustomed to having them in their models of care. This was also partly due to an inquiry into mental health services at Southland District Health Board (DHB) by the Health and Disability Commissioner in 2001, which created a drive to have only registered nurses in mental health units.

Since the roll out of the new scope of practice and diploma qualifications, the Ministry has been working with DHB directors of nursing and heads of schools of nursing to strengthen the recruitment and retention of enrolled nurses.



Jane Bodkin, senior advisor nursing – Office of the Chief Nurse, Ministry of Health

Key points about the enrolled nursing workforce from Te Pou's *More than numbers* report – Adult mental health and addiction nursing roles

In adult mental health and addiction services enrolled nurse positions comprised 75 people working in 72 FTEs (employed plus vacant).

- Addiction services reported two enrolled nurses in 2 FTEs.
- Mental health services reported 73 enrolled nurses in 70 FTEs.
- Most (92 percent) enrolled nurse roles were reported in DHB services.
- DHB inpatient services reported 46 per cent of the enrolled nurse workforce, with another 29 per cent reported in forensic services and 10 per cent in other services.
- NGOs reported 6 FTEs for enrolled nurses split between residential (68 per cent) and community services (32 per cent).

The enrolled nurse vacancy rate was 6 per cent (4 FTEs).

- In DHBs, only forensic services reported enrolled nurse vacancies, albeit at a high rate of 21 per cent (4 FTEs), giving an overall DHB vacancy rate of 6 per cent.
- The NGO vacancy rate was slightly higher than DHBs (8 per cent). However, NGO vacancies amounted to only 0.5 FTEs.

For more information check out the full report on the Te Pou website, www.tepou.co.nz/resources/adult-mental-health-and-addiction-nursing-roles-2014-survey-of-vote-health-funded-services/653

Today, anecdotal evidence suggests enrolled nurses are increasingly sought after in the mental health sector, which is good news.

For example, Southern DHB actively recruits enrolled nurses in mental health and addiction services and works closely with education providers, offering a supported orientation programme. In July Otago Polytechnic launched its own diploma in enrolled nursing.

Further up the island, Canterbury DHB offers a 'supported into practice' programme for enrolled nurses entering mental health services, with preceptorship and planned professional development opportunities. It now has more than 50 enrolled nurses working across mental health inpatient services including intellectual disability, rehabilitation, forensic, acute adult and child and family inpatient units.

I recently attended a nurse educators in the tertiary sector meeting where nurse educators spoke of other DHBs' mental health services, signalling an intention to employ new graduate enrolled nurses.

The recent NZNO enrolled nurse section conference was also a positive event, where enrolled nurses working in a range of roles described the activities they contribute to. Speakers, including associate health minister Peter Dunne and nurse leaders, expressed strong support to improve the uptake of the enrolled nurse role in health care teams and models of care.

The enrolled nurse scope of practice can be found on the Nursing Council of New Zealand website, www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Enrolled-nurse.

In addition, Alison Hussey, senior advisor in the Chief Nurse's Office at the Ministry, has produced a factsheet on the role and best use of enrolled nurses, which is available on the Ministry's website, www.health.govt.nz/our-work/nursing/nurses-new-zealand/enrolled-nurses.

Care Capacity Demand Management Programme –

Mental health and addiction project update

by Huia Swanson and Brenda Hall



Like you, the Safe Staffing Healthy Workplaces Unit (SSHWS) has had a busy year, and is very pleased to provide an update on progress and developments.

An evaluation of the implementation, outcomes and opportunities of the Care Capacity Demand Management (CCDM) Programme was released to the DHB sector earlier this year. The report can be found along with other publications on our website, www.dhbsharedservices.health.nz.

Following the reports' release, the DHB CEOs have endorsed many of its recommendations, including that the unit's funding continue until June 2018. This endorsement and continued support is hugely encouraging as it ensures continuation of the implementation work currently underway.

The Mental Health Addiction and Disability Advisory Group (MHADAG) has been tasked with ensuring that patient acuity staffing methodology of the CCDM programme is suitable for DHB mental health services. As part of this work, Southern DHB participated in a pilot evaluation of the Mix and Match process and tools, testing their suitability within an inpatient mental health setting. The findings from this initial pilot informed adaptations being made to the tools (improving the data coding sheets and end of shift surveys). As a result we anticipate we will be better able to capture the work that is sometimes invisible. To progress this, we are very pleased to announce that Bay of Plenty DHB will be the second pilot site to further test the work analysis tools and process.

We look forward to sharing key findings from this work with you later in the year.

For more information contact Huia Swanson, secretariat for the MHADAG, huia.swanson@dhbss.health.nz.

Kind regards, Huia Swanson and Brenda Hall

Nurse profiles

Chris Lundy- clinical nurse specialist, Mornington Health Centre, Dunedin.



Chris Lundy

Born and raised in South Otago, I started my psychiatric nurse training nearly 40 years ago at Cherry Farm

Hospital in Dunedin. They were certainly different times. As I started writing this piece I looked back and thought what a long way psychiatric/mental health nursing has come in what seems to me to be a very short period of time.

Back then a mental health nurse being based in a GP practice was probably not something any but the very enlightened had considered. This year marks the tenth anniversary of the establishment of my role as a clinical nurse specialist at Dunedin's Mornington Health Centre (which is part of the WellSouth Primary Health Network) as part of a brief intervention service. I had completed a Bachelor of Nursing and a Master of Arts (Applied) in nursing prior to this.

The *Evaluation on the Primary Mental Health Initiatives*¹ states there is a high prevalence of mental health conditions in the New Zealand population, with the New Zealand Mental Health Survey predicting that 46.6 per cent of the population will meet the criteria for a mental disorder some time in their lives. The Mental Health in General Practice (MaGPIe) study found that 36 per cent of people attending general practice had one or more of the three most commonly presenting mental health disorders: anxiety, depression or substance use. Nearly all of these have mild to moderate conditions and are first seen in primary health care and general practice settings.

Primary mental health care refers to the assessment, treatment and management of people with mental health problems and/or addiction in the primary care setting. It encompasses promotion, prevention, early intervention and ongoing treatment related to mental health problems.

Being the only full-time mental health clinician was not without some early challenges and I knew I had been accepted as part of the team

The contact they have with us is generally their first ever with a mental health service and, if all goes to plan, it is the only contact they require

when two older GPs (they have both since retired) referred people to see me. This is a large practice with about 12 practice nurses so their acceptance of me in this role and as part of the team continues to be invaluable.

I work full-time Monday to Friday in a clinical capacity. Another mental health nurse works here part-time and holds several evening appointments one day a week. Most people we see have depression and/or anxiety disorders but are people like you and me: trying to raise families, work, keep on top of relationships, finances, etc., while struggling with low mood and/or an anxiety disorder. The contact they have with us is generally their first ever with a mental health service and, if all goes to plan, it is the only contact they require. Last year we were referred 461 new people which averaged out to 38 per month. Of these 307 were women, 146 were men and 8 not specified. Thirty-four identified as Māori, 13 as Pacific Islanders, five as Indian and six as Asian.

Since starting this role I have added to skills developed in the secondary care setting by furthering my education in treatment modalities such as problem solving, solution focused therapy, CBT and ACT. The evaluation (page 42) said "data clearly indicates that the majority of therapists use an eclectic approach, most commonly grounded in a general CBT model".²

I believe primary mental health is an evolving branch of nursing. There is scope for more work to be done for people with co-existing problems in primary care but also in the area of chronic conditions that affect not only people's physical health but mental health and wellbeing as well.

Meeting needs in primary care settings requires resources, not only monetary but also through staff interested in this setting developing the necessary talking therapy skills.

Contact me if you would like to find out more about a rewarding career as a primary mental health nurse, clundy@mhc.co.nz.

1 - Dowell, A.C., Garrett, S., Collings, S., McBain, L., McKinlay, E., & Stanley, J. (2009). *Evaluation of the Primary Mental Health Initiatives: Summary report 2008*. Wellington: University of Otago & Ministry of Health.

2 - Dowell AC, Garrett S, Collings S, McBain L, McKinlay E, Stanley J. 2009. *Evaluation of the Primary Mental Health Initiatives: Summary report 2008*. Wellington: University of Otago and Ministry of Health.

Focus on primary mental health

Tina Simmonds clinical nurse specialist, Primary Mental Health Service.



Tina Simmonds

I am currently the team leader and clinical nurse specialist for a primary mental health service based in the Central Otago and Queenstown Lakes area.

I had always wanted to do nursing. This was probably largely influenced by my connection to St John as I spent 11 years as a young cadet competing in competitions which included first aid scenarios, managing trauma that involved caring for older people. I can remember finding out how I could become a nurse, however was never particularly strong on the science field, and tended to have a natural talent with numbers, which headed me towards accountancy.

After a year at university and really not connecting, I decided to do a pre-nursing course run through the Otago Polytechnic to follow my real dream. I completed a Bachelor of Nursing in 1994 as part of the inaugural programme at Otago, but would never have considered mental health nursing. This changed when I had an amazing experience as a third year student.

Over the years I have worked in inpatient, community and crisis services and have been involved with the coordination of a new graduate nursing programme for eight years. In 2006 I moved to Central Otago and in 2008 I successfully applied for the role of a mental health professional setting up and running a primary mental health service. This led me into the primary care setting which I have really enjoyed.

I have completed two post graduate certificates; the first being a Post Grad in Advanced Nursing (Mental Health) and the second being the academic part of the Blueprint for Learning Leadership programme (Management), which I completed last year. This programme has been paramount in my ongoing leadership development.

Evolving role

My role has developed over the years, and we now have an additional clinical support. Initially I covered the entire Central Otago district in a clinical capacity, which was extremely challenging and, on reflection, unmanageable. The area has a large rural component over a vast geographical area. I now have a joint team leader/clinical specialist role and support staff working in both Central Otago/South Otago and Queenstown, and also seeing people referred into the service.

Highlights

I really enjoy the work around supporting people within the primary care setting and working in partnership with them and their families. I also enjoy my clinical leadership role in both supporting the team I am working with as well as other staff within the primary care and community settings.

Key challenges

The biggest challenge I face is managing the demand for the service. Referrals are high in relation to the human resources available. We are currently looking at how we can reduce waiting times. One way is to support and strengthen our nursing colleagues in primary care to build the capacity to manage and respond to people who are experiencing emerging mental health issues. I believe that over time, with the introduction of primary mental health run services, we have possibly taken away rather than enhanced the skills of practice nurses.

Another key challenge is the geographical area of the Southern District, and the Central Otago/Queenstown Lakes area. We are looking at how services within this district could be delivered, possibly in a different way, so people in all areas have equal and timely access to services.

A typical week

I could be anywhere at the moment, from Dunedin to Balclutha to my home town in Wanaka, so currently there is no typical working week. What does remain the most stable is my clinical days. I am currently involved in a group working on a stepped care service framework for the mental health sector, which has been a great experience. The importance in building relationships and the interface with all people involved in the mental health sector and also keeping the person at the centre of all that we do has remained my passion and reason for being involved in this group.

Improved outcomes

Both the clinical work and my leadership work is about improving outcomes for people experiencing mental health and addiction problems, whether by working closely with service users and their families, or supporting my colleagues within the primary care setting.

Key messages

I would like to see more mental health nurses and more mental health care delivered within a primary care context. The work has its frustrations, particularly when people have to wait to be seen, but overall the work is very satisfying. I feel very privileged to be working closely with people and being able to hear their stories and assist them on their path. I also find being in a position where I can support my nursing colleagues a very rewarding experience.

Future aspirations

I hope to continue working with nursing colleagues to build the mental health capacity within the primary care context so more mental health care can be delivered and people can be seen in a timelier manner.

Focus on primary mental health

Yvonne Kainuku-Walsh, registered nurse/project leader, Le Va.

Kia Orana

I am of Cook Islands and Irish descent. On my Kuki Airani side my whakapapa connects to the villages of Ngatangia, Takitimu and County Tyron in Ireland. I am a registered nurse and have been specialising in sexual and reproductive health and adolescent health and development for more than 23 years.



Yvonne Kainuku-Walsh

At a very young age, I recall telling my mother, I wanted to be a nurse, even though I didn't like hospitals – the smell and what they represented to me as a child. Soon after telling mum, I sought out my school guidance counsellor for advice on study pathways, but her discouragement deterred me for a number of years. When I was 19 my mother talked to me about how important it is to not only 'dare to dream' but 'dare to share your dream', for when you lose focus or hope, others hold it for you. This lesson has been a strong driver for me in connecting with the young people I am privileged to walk alongside.

As a student nurse, two things became very apparent to me (in terms of future focus and positioning myself in the sector). I enjoyed working in the community and primary health care sector, and I had a strong sense I wanted to work with young people.

Essential principles which underpin youth development (Youth Development Strategy Aotearoa 2002) include:

1. young people being connected (sense of belonging)
2. a consistent strengths-focused approach (fostering confidence)
3. it happening through quality relationships
4. it being triggered when young people fully participate
5. it having good information (evidence and experience of others)
6. it being shaped by the 'big picture' (locally, nationally, and globally).

With these in mind, we can't afford to be siloed in our approach to the health and wellbeing needs of young people who consistently appear to be over-represented in teen pregnancy rates, high STI rates, suicide and suicide attempts and obesity related illnesses, to name a few.

In my many roles within the youth health and development sector (which spans almost 25 years) I am a true believer in these and other key values, which include 'keeping it real'. I love the quote by

T Roosevelt, "people don't care about how much you know, until they know you care".

It's also critical to ensure we are walking **alongside** young people, not only addressing their risk factor issues, such as violence, crime and safe sex, but taking an interest in their everyday lives and aspirations for the future.

Evidence must also underpin any successful youth development approach/programme/initiative. Education alone does not change behaviours, nor do scare tactics have long lasting effects towards reducing teen pregnancy and safe sex.

I like talking about the difficult topics ('real speak'). For the past eight years I have enjoyed my contribution to Radio ZM's Sealed Section late night podcast team as the resident 'sexologist'. Sealed Selection confronts all sorts of issues and queries providing listeners with relationship tips and information on the human body.

Effective clinical approaches in my role as a clinician in sexual and reproductive health include:

- quality clinical services
- partnership with the young person and whānau
- being linked with other providers in a way that supports young people to navigate the complex health system adults have created
- the right people being caring and approachable from reception to the consultant (multidisciplinary).

It's been such a privilege to have walked alongside so many different people through my capacity as a registered nurse which has taken me into many areas in the health, community and education sectors. My roles have included: executive officer for the Pacific Society for Reproductive Health; project managing Healthy Eating Healthy Action (HEHA) initiatives with youth populations within the Auckland

When I was 19 my mother talked to me about how important it is to not only 'dare to dream' but 'dare to share your dream', for when you lose focus or hope, others hold it for you. This lesson has been a strong driver for me in connecting with the young people I am privileged to walk alongside.

Focus on primary mental health

District Health Board (ADHB), and being the lead writer of the ADHB's Youth Health Improvement Plan 2010-2015. Furthermore, I held an interim role as the programme leader of the Bachelor in Human Services, Youth Studies major at The University of Auckland.

Role at Le Va

My title is special projects, which means my role within the Le Va team is determined by a variety of needs required. Currently I am part of the FLO programme (www.leva.co.nz/suicide-prevention). Within the programme I support, manage, monitor and evaluate 17 community-funded initiatives which address Pasifika suicide.

The FLO programme is the first Pasifika Suicide Prevention programme in the country and is part of the Waka Hourua, a joint programme for suicide prevention in Māori and Pacific communities delivered by Te Rau Matatini and Le Va. Waka Hourua responds directly to the expectations of the Ministry of Health's New Zealand Suicide Prevention Action Plan 2013-2016. Other important facets to the FLO programme includes: FLO Talanoa, Le Va's free, train the facilitators education workshop, FLO resources including our new video B.R.A.V.E. <https://www.youtube.com/watch?v=eloUUm2IUMU>

Being a nurse in a workforce development centre

Le Va has set one of its key priority's as relationships – hence 'Le Va' aka 'the sacred space between'. With this in mind we also need to consider the ata mai (from you, to you), what we offer up into the Va (space between) is critical and often precipitated to nurturing relationships. As a nurse, this sits perfectly with my personal and professional life values so working for Le Va aligns with my own ways of being.

The skillsets I bring, are based on my clinical experience, policy writing, programme and project management, health promotion, teaching and facilitation skills.

Future aspirations

I want to continue serving in the community, sharing good information and creating opportunities for others to enhance their growth and development.

Key messages for nurses about how they can bring about change

- Work in the areas you are passionate about, i.e. specialty, people.
- Take every opportunity to capacity build, i.e. post grad studies.
- Keep a healthy balance of career, family, recreation.
- Don't be defined by your title. Some of our best work (using our skills sets) comes in everyday relationships, supports, voluntary work, church, sports (for example, the manager of your child's team), etc.

I believe that the most important thing of all is He tāngata he tāngata he tāngata – It is the people, it is the people, it is the people.

In April 2016 Le Va will hold its third GPS – Growing Pasifika Solutions – conference. The theme will focus on young people. For more details go to our website, www.leva.co.nz. You don't want to miss out on this progressive and exciting meeting, which will be co-created with young people.

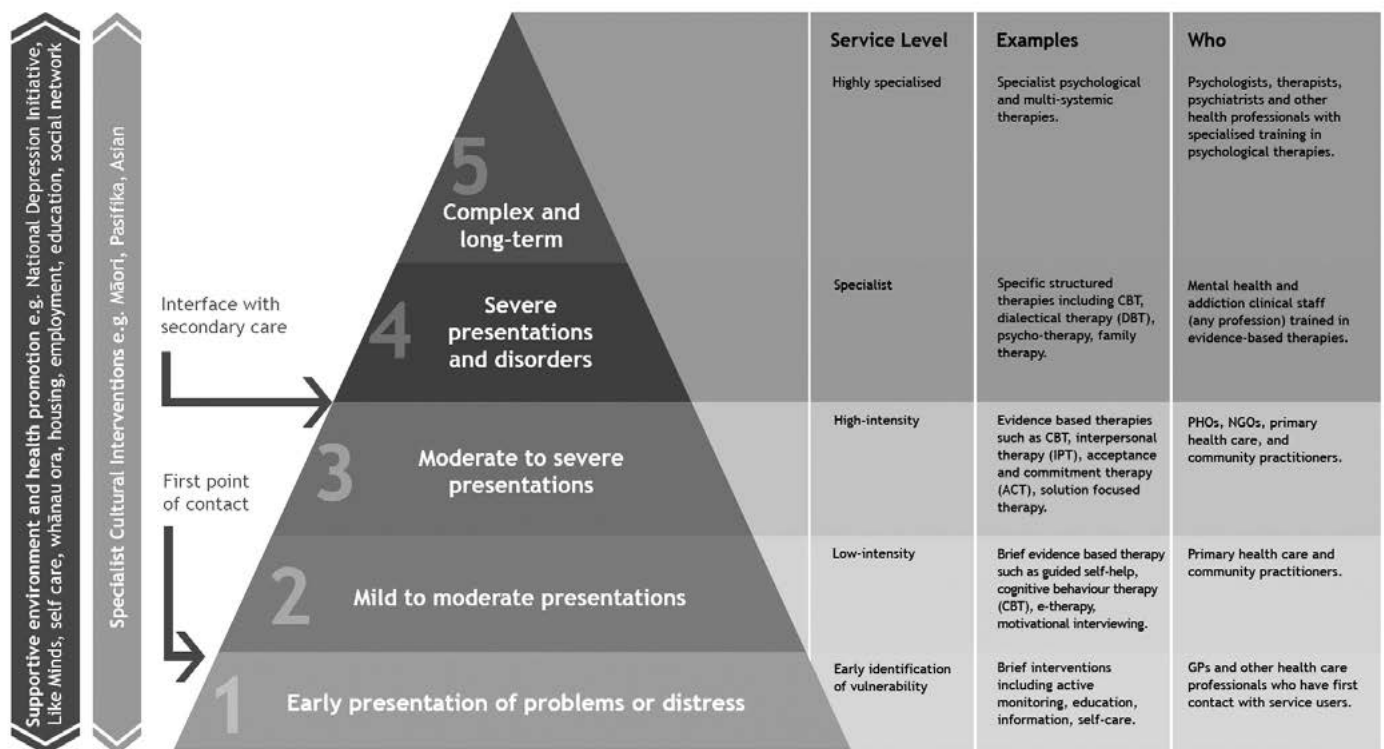


The young people featured in Le Va's B.R.A.V.E video for Pasifika suicide prevention.

Let's get talking in primary and secondary services

by Tina Earl

Let's get talking is a set of tools developed by Te Pou to support primary and secondary health services in Aotearoa New Zealand to deliver effective talking therapies using a stepped care approach.



Stepped care is an approach aimed at matching the right therapy to a person at the right time to help them achieve the best health gain. The level of the person's distress or problem indicates the level of intervention, and a person may move to a different step (level) of care as their needs change.

In New Zealand primary care delivers the majority of services for common mental health issues. As it is the first point of contact for most people it has an important role to play in the early detection and treatment of people with mental health and addiction problems, to improve their lives and reduce demand for specialist services. The GP practice mainly sees people at level 1 of stepped care, early presentation of problems,

and level 2, mild to moderate presentations. The aim is to use resources available to the GP practice such as brief interventions and low intensity therapy to relieve distress and build resilience. However, there is an increase in people presenting with moderate to severe problems who may be referred on to PHOs and community practitioners for more intensive therapy.

The *Let's get talking* toolkit consists of seven tools to support planning and delivery of talking therapies using a stepped care approach. The first four of these tools were recently released and are available on the Te Pou website.

1. Introductory video: a stepped care approach to talking therapies.

2. Planning: for delivery of talking therapies.
3. Skills survey: identify strengths and areas for development in talking therapies delivery.
4. Assessment: how to match talking therapies to people's needs.

The following three tools will be released later this year.

5. Therapy: a guide to evidence-based talking therapies and brief interventions.
6. Review: use of outcome measures for effective therapy practice.
7. Practice support: information on competencies, training and supervision for delivering talking therapies.

Visit the Te Pou website for more information and to download the tools, www.tepou.co.nz/letsgetalking.

Information pulse and primary mental health



Mark Smith, clinical lead, Te Pou

I occasionally find myself being asked the question: which outcome measure should primary mental health services collect? It is a good question.

As matters currently stand there is no outcome measure that primary services are required to collect. However, there are many measures which could be useful.

In view of the increasing incidence of depression and anxiety in society, it would be helpful for clinicians to make available a self-rated measure which could assist with depression and anxiety.

I would like to make the case for the Kessler 10. This is an ideal and simple to use self-rated measure.

It's a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms a person has experienced in the most recent four-week period.

Why use the K10?

The use of a service user self-report measure is a desirable method of assessment because it is a genuine attempt by the clinician to collect

information on the service user's current condition and to establish a productive dialogue.

How to administer the questionnaire

As a general rule, service users who most commonly rate "some of the time" or "all of the time" categories are in need of a more detailed assessment. Referral information should be provided to these individuals. Service users who most commonly rate "a little of the time" or "none of the time" may also benefit from early intervention and promotional information to help raise awareness of the conditions.

The following 10 questions ask how the service user has been feeling in the last four weeks.

For each question, they mark the option that best describes the amount of time they felt that way.

Kessler 10	None of the time	A little of the time	Some of the time	Most of the time	All of the time
In the last four weeks, about how often did you feel tired out for no good reason?					
In the last four weeks, about how often did you feel nervous?					
In the last four weeks, about how often did you feel so nervous that nothing could calm you down?					
In the last four weeks, about how often did you feel hopeless?					
In the last four weeks, about how often did you feel restless or fidgety?					
In the last four weeks, about how often did you feel so restless you could not sit still?					
In the last four weeks, about how often did you feel depressed?					
In the last four weeks, about how often did you feel that everything was an effort?					
In the last four weeks, about how often did you feel so sad that nothing could cheer you up?					
In the last four weeks, about how often did you feel worthless?					

Spread the Word

Family matters at Community Alcohol and Drug Services Auckland



by Michelle Brewerton, family advisor/clinical supervisor, Community Alcohol and Drug Services, Waitematā DHB

Michelle Brewerton

Community Alcohol and Drug Services in Auckland (CADS Auckland) is a Waitematā District Health Board (DHB) based regional service that covers the three Auckland metro DHBs. The drive to include family, whānau and significant others (FWSO) as clients in their own right at CADS Auckland derives from research indicating that large numbers of people are adversely affected by another's problematic substance use, especially children. The range of effects of another's substance misuse felt by others can be mild, such as missed appointments or the odd day off work, to the catastrophic such as foetal alcohol spectrum disorder/drug injuries, home, workplace or road accidents resulting in permanent injury or death. Estimates of the numbers of people experiencing harm for each person misusing substances varies greatly, between two and seven.

There is a growing body of research to indicate that when FWSO engage in getting support for themselves, the person with problematic substance use is more likely to enter into a change process. Harnessing the natural desire of FWSO to want to help their relative, while developing their own self-care and boundary setting skills, is an approach that fits well with the Whānau Ora approach adopted in New Zealand.

CADS Auckland has worked to welcome FWSO as clients in their own right since 2002 when the first family services coordinator was employed into a part-time position. This was

upgraded to a full-time position in 2005 and remains so to ensure CADS has appropriate systems, procedures and resources to achieve a family inclusive approach. The family perspective is included in all policy development and business meetings, while external trainers offer our workforce regular professional development to meet the needs of our FWSO community.

FWSO can self-refer through the walk-in clinic or over the phone, or come via referral from a health, social or justice agency and are given a choice of either, or both, individual appointments and specific FWSO groups. They can also access the managing mood or writing groups working alongside clients with substance misuse problems. The CADS service is free and people can attend for as long as they feel it is beneficial. All clients are encouraged to include support people in their treatment to whatever level they are comfortable with. Specific cultural support is easily accessed as are interpreters.

FWSO have a choice of interventions. Some groups adhere to the Abstinence-Twelve Step model which is consistent with Alcoholics Anonymous. Others are based on the principles from Community Reinforcement and Family Training and use a harm reduction, behavioural model developed into a programme of change for family members in the book *Beyond Addiction* How science & kindness help people change (Foote et al 2014).

Family Connections is a twelve-week skills based group for FWSO whose relative has emotional dysregulation disorder, otherwise known as borderline personality disorder. People with this problem often use substances in an attempt to regulate their mood or, alternatively, the effects of substance use and withdrawal impact on mood and behaviour, either way causing difficulties for their FWSO.

Single Session Work (SSW) is a model designed for family and whānau to come together, including their relative with substance misuse problems, to resolve a particular issue identified by all participants as important. Further sessions are offered if that is desired by participants. FWSO can also access individual support at CADS.

Despite us being as welcoming as possible, a relatively small percentage of FWSO attend the service. This may be because of the stigma FWSO experience as they are often portrayed as both responsible for the origin of the problem in the substance misusing person and for getting the person to attend treatment. They may also be responsible for children, maintaining the family finances and day-to-day management of their household, leaving little time or energy to attend to their own needs. Often it is because they are unaware of the free services available to them, so please spread the word to family, whānau and friends living in the Auckland area.

Six Smokefree best practice principles:

Guidance for Mental Health and Addiction services

by Kim Williams, smokefree community systems coordinator, Hawke's Bay District Health Board



The Hawke's Bay District Health Board (DHB) was successful in gaining funding for a pathway to Smokefree 2025 innovation project entitled "National Mental Health Services Smokefree Guidelines Development – Shifting the Culture". The purpose of this Ministry of Health fund is to invest in innovative efforts to reduce the harm and wider costs of smoking in our most vulnerable population groups and therefore make meaningful progress towards a Smokefree New Zealand by 2025.

Why target mental health and addiction services?

We know smoking prevalence among mental health and addiction service (MH&AS)

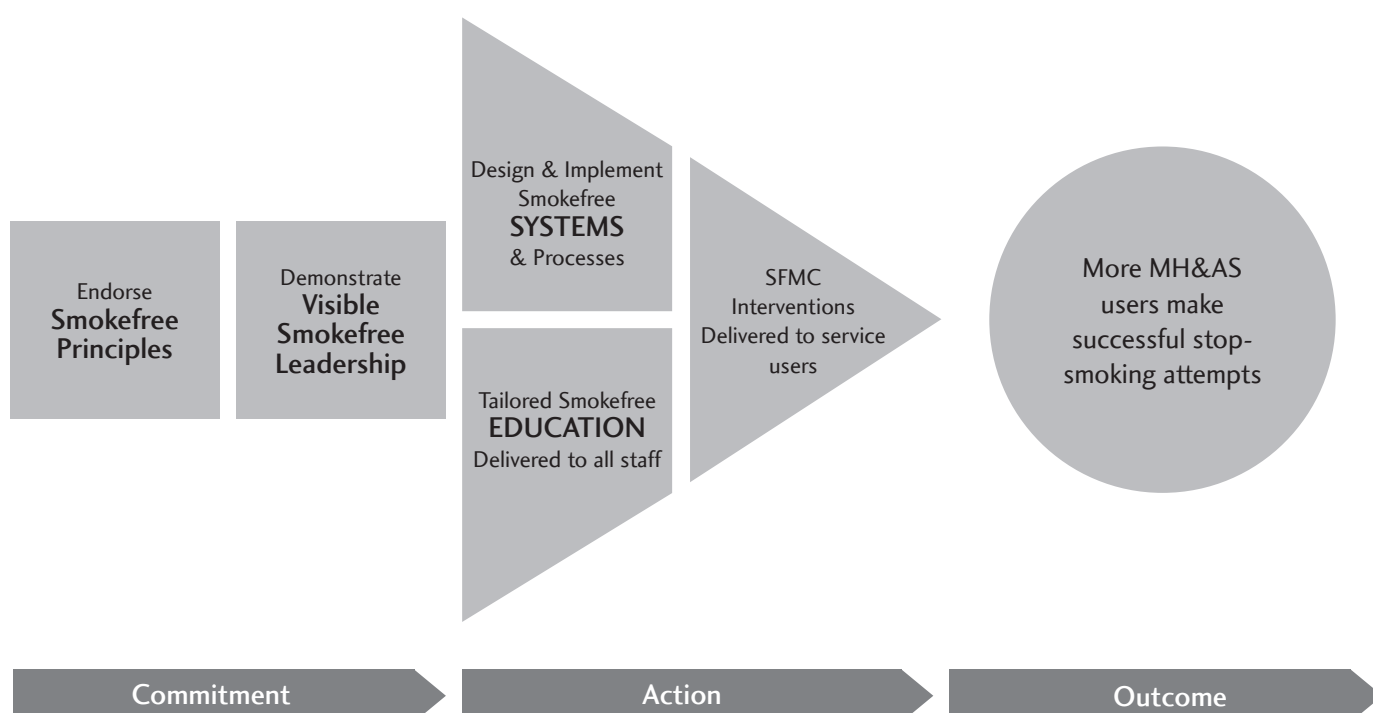
users is more than twice that of the general population and smoking rates among mental health and addiction staff are much higher than in other areas of the health workforce. Yet, despite smoking related harm accounting for much of the reduced life expectancy of people with serious mental health disorders, treatment of tobacco dependence remains a low priority.

These high smoking rates and poor health outcomes stem from a strong historical culture of acceptance and tolerance of tobacco use across the mental health and addiction sector. These views and practices persist despite growing evidence that people with experience of mental health disorders do

want to be smokefree and stopping smoking may improve mental health and addiction treatment outcomes.

Project background

The project manager led a national stakeholder engagement phase designed to explore the current barriers to providing MH&AS users equitable, consistent smoking cessation support. Six DHBs agreed to take part. A wide range of DHB and NGO MH&AS staff from Counties Manukau, Taranaki, Tairāwhiti, Invercargill, Dunedin and Hawke's Bay agreed to participate in focus groups and key informant interviews.



A key finding of the national engagement phase was that inconsistent smokefree messaging and practice was creating mixed smokefree messaging and confusion for service users. This finding significantly informed the decision to site the Hawke's Bay demonstration phase across 16 DHB and NGO services. Representatives from each of these services participated in the project working group, tasked with developing the programme's components and supporting their implementation.

Smokefree culture change approach

This new culture change programme is designed to support smokefree attitudinal change across the MH&A sector in order to deliver consistent smokefree best practice. The programme aims to change the way organisations think and behave by:

- challenging staff perceptions and attitudes that create inconsistent behaviour
- engendering buy-in to organisational best practice principles
- supporting visible leadership with the understanding that maintaining these principles is everyone's responsibility
- providing systems and processes to support practice changes.

The model in the Smokefree guidance document represents the direction and the steps required for sustainable change, as below.

SFMC – Smokefree motivational conversation interventions

You will find suggestions on how to embed smokefree work within everyday practice in this document. Please open the Dropbox link below to access the e-book,

https://dl.dropboxusercontent.com/u/67467039/eBooks/HBDHB_Smokeyfree_eBook/Smokefree_Guidelines.html

Please contact Kim Williams if you or your organisation would like to be sent hard copies, kim.williams@hawkesbaydhs.govt.nz.



Mental health, addiction and disability job vacancies

You'll find Te Pou and Matua Raki job vacancies on the Te Pou website – alongside a wide range of job ads from the mental health, addiction and disability sectors, updated daily.

There are currently more than 50 vacancies listed, from peer support workers to psychiatrists, leadership roles, nursing positions and other relevant jobs across New Zealand.



www.tepou.co.nz/jobs

Te Pou
o Te Whakaaro Nui

Matua Raki
National Addiction Workforce Development

Thesis:

A grounded theory study of the provision of mental health nursing by practice nurses

by Carole Schneebeli, clinical nurse advisor, Auckland Regional Forensic Psychiatry Services and CADS, Waitematā DHB



Carole Schneebeli,
clinical nurse advisor,
Auckland Regional
Forensic Psychiatry
Services and CADS,
Waitematā DHB

In New Zealand changes to health policy have affected health professionals working in primary health care. This group has had to expand its role and involvement in the care of patients with mental health problems. Practice nurses, the largest primary health care nursing group, have developed their role to provide identification, assessment, and monitoring of patients with mental health problems. However, little is known about the knowledge, skill, and capabilities practice nurses have, or the strategies they use to manage patients with mental health problems.

The aim of this study is to explain the processes practice nurses use when

they work with patients who have mental illness. The methodology was grounded theory. Data was collected from 17 interviews with practice nurses working in city and rural practices. Data was analysed using Strauss and Corbin's axial coding model. Data was constantly compared during the analytical process. Theoretical sampling was used to develop categories and examine relationships and dimensions until data was saturated, and a substantive theory of referring was clarified.

The research has shown that practice nurses have limited knowledge about patients with mental health problems. They manage this situation

using the strategy of referring. Referring occurs in conditions of generalist nursing practice, changing values and attitudes, and interchangeable boundaries that include time, funding, and medical dominance constraints. Consequently, practice nurses resort to handing over the responsibility of care for patients to experts in mental health care. It was evident that referring was multidirectional, sometimes circular, and depended on the strength of the relationship with the referral source.

This research is significant as it has analysed the taken for granted practice of referring, which is a common nursing strategy when nurses have limited knowledge in an area. It was also evident that if health policy changes were to be enacted in practice, funding stream structures must change to support policy development, and the profession also needs substantial involvement in promoting professional development.

Recommendations for practice include:

- professional development using protected educational time
- shared clinical governance
- inclusion of mental health nursing in all areas of the undergraduate curriculum
- national implementation of primary liaison roles in all primary health organisations and general practice
- the development of postgraduate pathways in primary mental health nursing care management.

Calling all nurse researchers or nurses who have conducted research

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



Thesis: New Zealand Mental Health Nurses' Perceptions of Structural and Psychological Empowerment



Suzette Poole,
clinical lead,
Te Pou and
daughter Talitha on
graduation day

by Suzette Poole, clinical lead, Te Pou

Purpose

The purpose of this quantitative study was to investigate structural and psychological empowerment among registered nurses providing direct care in New Zealand mental health and addiction services.

Background

Nurses' perceptions of structural and psychological empowerment have been extensively investigated, led mainly by Laschinger who has expanded on Kanter's structural empowerment theory. Nurses can be empowered to practise professionally if they have access to structural empowerment factors, that is; opportunity, support, information, resources, informal power and formal power in their work environment. Nurses can also feel psychologically empowered by their work environments in that they may feel a sense of meaning, self-determination, impact and competence about the work they do.

Methods

A non-experimental descriptive correlational survey design was used to examine the levels

of structural and psychological empowerment and relationships between these two variables. A convenience sample of 306 registered nurses who were members of the Public Service Association, New Zealand Nurses Organisation or Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc. participated. Nurses who held formal management positions were excluded.

A web-based anonymous questionnaire which included the Conditions of Work Effectiveness Questionnaire II, Psychological Empowerment Scale and a demographic questionnaire was used to collect data. Data were analysed using the IBM Statistical Package for the Social Sciences version 21 programme. Data were also analysed using descriptive statistics and Spearman rank-order correlation methods.

Results

Three hundred and eighty nine nurses responded to the online survey. However, only 306 surveys were usable. More than half were female and in the 45-59 age group. Most identified as New Zealand European/Pākehā and most were community-based nurses.

Similar to other studies, nurses in this study perceived they had only moderate levels of structural and psychological empowerment. Overall nurses felt they had most access to opportunities to learn and grow and least access to the resources needed to do their job. Furthermore, nurses in this study felt most strongly that they had a personal connection to their work; that is, a sense of meaning, and least strongly that they made an impact in their work environment.

A significant relationship between structural and psychological empowerment was also found ($r = .366, p < .000$). Overall structural empowerment was most strongly related to self-determination (the feeling of having control over your work). Overall, psychological empowerment was most strongly related to informal power (alliances with others).

Conclusion

The moderate level of workplace empowerment suggests that improvements in mental health and addiction nursing work environments are needed to better support optimal nursing practice, and to attract and retain nurses. The main areas where improvements are needed are the provision of support and resources by managers and the development of organisational processes that increase nurses' self-determination and identify the impact that nursing work has on organisational outcomes. The relationship between structural and psychological empowerment amongst registered nurses practising in New Zealand mental health and addiction services gives further support for Laschinger's theory by finding a similar relationship in a previously unstudied group.

Main implication

Managers and leaders of nurses must make every effort to enhance workplace empowerment for nurses in order to fully optimise the significant contribution nurses working at the point of care make to achieving organisational goals, and in order to attract and retain a sufficient supply of nurses to deliver services.

Skills Matter update

by Angela Gruar, practice and leadership development manager, Te Pou



Angela Gruar,
practice and
leadership
development
manager, Te Pou

Since 2010 Te Pou has contracted seven programme providers to deliver the six post entry clinical training programmes (under the Skills Matter brand) to ensure professional development of the clinical mental health and addiction workforce.

The six programmes are:

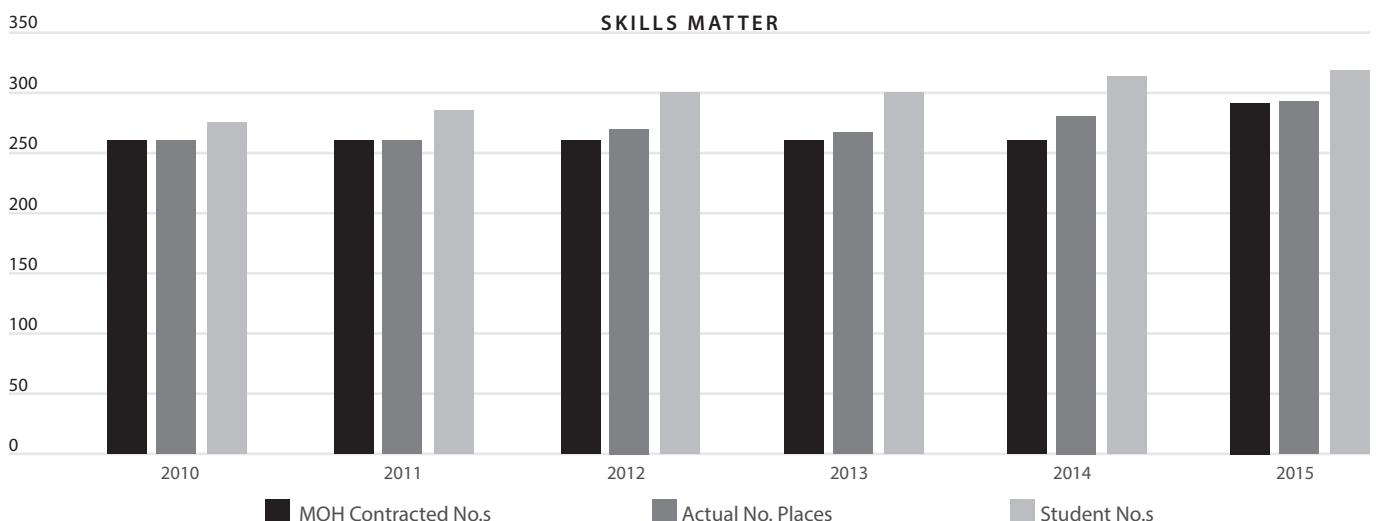
1. New entry to specialist practice (NESP) – mental health and addiction nursing
2. New entry to specialist practice (NESP) – allied mental health and addiction
3. Core skills for specialist practice in infant, child and adolescent mental health and addiction
4. Postgraduate Diploma in Cognitive Behaviour Therapy (CBT)
5. Assessment and management of co-existing substance use and mental health (co-existing)
6. Clinical leadership in nursing practice (clinical leadership)

These programmes reflect three themes: supporting new entrants to mental health and addiction to develop the specific skills required in this field (the new entry to specialist practice programmes); and supporting existing practitioners in mental health and addiction to develop advanced or specialist skills in high priority areas (e.g. co-existing, cognitive behaviour therapy programmes) and supporting leadership through the clinical leadership in nursing practice programme.

The graph below shows the number of contracted places, the number of actual places, and the total number of students supported by the Skills Matter programme since 2010.

Health Workforce New Zealand has confirmed funding for the Skills Matter six programmes listed above for 2016 and planning is underway. There will be a total of 282 places available to support the mental health and addiction workforce across these programmes.

More information can be found on our website www.tepou.co.nz/skillsmatter.



Online learning

One of the areas requiring a continual evidence focus is training. We need to have a number of mechanisms in place to transfer knowledge to our frontline staff. One of these developments is e-learning.

E-learning is a form of electronic self-directed training that ensures everyone receives consistent, high quality learning experiences. It gives people the opportunity to complete essential training online on a PC, laptop or tablet – at your own pace and at a time that suits you.

Te Pou is excited to move into the e-learning space, with two modules on offer currently and more to come.

HoNOS refresher training

Te Pou has developed a HoNOS refresher e-learning module for all mental health clinicians and outcome trainers. Use the module to refresh or update your current knowledge about the HoNOS family of measures. Refresher training is recommended for all mental health clinicians every two years, and required if you are an outcomes trainer. This free of charge e-learning module will provide you with a time and cost-effective way to keep your certification current. Remember your trainer is still the main champion in your service. Find out more on our website, www.tepou.co.nz/outcomes-and-information/honos-training-online/33.

A new resource to help explain OST to families, whānau and support people

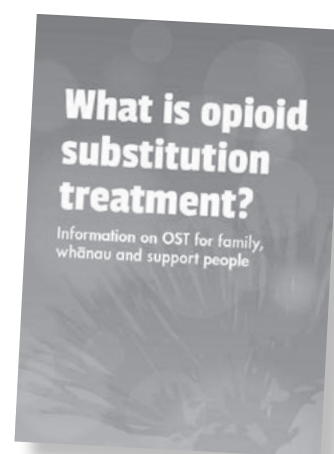
Matua Raki and the National Association of Opioid Treatment Providers (NAOTP) have released an informative pamphlet that sheds light on opioid substitution treatment (OST) for the family, whānau and supporters of people receiving the treatment.

It includes sections on understanding addiction, what OST is and how it works, OST and pregnancy, and how family, whānau and friends can look after themselves. The pamphlet is a companion guide to OST and you: A guide to Opioid Substitution Treatment produced by the Matua Raki Consumer Leadership Group.

The pamphlets will be available from all OST services throughout New Zealand and can be downloaded from the Matua Raki website, www.matuaraki.org.nz/resources/what-is-opioid-substitution-treatment-booklet/645.

Introduction to foundation co-existing problems knowledge

Seventy-seven per cent of New Zealand's mental health and addiction services have said they want to develop better workforce capability in co-existing problems (CEP) (More than numbers, Te Pou, 2014). Matua Raki is pleased to launch the first in a series of CEP e-learning modules which is available to anyone working in the mental health and addiction sector. The module provides an introductory overview of CEP: what co-existing problems are, their prevalence, interactions between mental health and addiction problems and the impact of CEP. More advanced CEP modules are also in development. Find out more on the Matua Raki website, www.matuaraki.org.nz/initiatives/cep-e-learning/170.



Success stories

Te Pou develops and publishes success stories regularly. It's a great way of sharing knowledge and ideas between services. The stories are published on our website, www.tepou.co.nz/stories. You can also find all articles from *Handover* published there – use the filters 'success stories' and 'Handover nursing newsletter' to help you find what you are looking for. Here is a snapshot of a few of our recent stories...

Engaging with Māori, authentically and holistically- How Health Hawkes Bay's Wairua Tangata primary mental health programme hit the right note

www.tepou.co.nz/news/engaging-with-maori-authentically-and-holistically/662

This success story describes how a primary care organisation improved their responsiveness to provide support to Māori who experience mental health and addiction problems. The Wairua Tangata programme, offered by Health Hawkes Bay Primary Health Organisation, developed new practices that allowed for increased flexibility in delivery and use of a more whole-person and whānau-centred approach. They worked with key people to identify barriers to engagement and reduced their 'did not attend' rates from 30 per cent to 3-5 per cent.

Leadership and innovation in primary mental health at Manaia Health Primary Health Organisation

www.tepou.co.nz/news/leadership-and-innovation-in-primary-mental-health-at-manaia-health-primary-health-organisation/629

This story describes how a primary care organisation (PHO) has committed their resources to support primary care nurses to develop their skills and knowledge in supporting people who experience mental health and addiction problems. Since 2013 Manaia Health has supported their nurses to complete a training programme, based on the mental health and addiction credentialing framework offered by Te Ao Māramatanga NZ College of Mental Health Nurses.

Connecting mental health services in Whanganui

www.tepou.co.nz/news/connecting-mental-health-services-in-Whanganui/627

This success story provides an example of a peer support service playing an active role in building closer relationships with local GPs in order to connect with people looking for more support with mental health issues. Balance, a Whanganui peer support service has worked with the Aramoho Health Centre, where local GPs refer people with mental health issues directly. The team at Balance then works with the person to find out what other supports they may need, and facilitates that support in-house or connects them with other services.

Improving access to primary care in Tairāwhiti

www.tepou.co.nz/news/improving-access-to-primary-care-in-tairawhiti/628

Another success story which also focuses on improving primary care responsiveness to people who experience mental health and addiction problems and in particular to improve their physical health is an initiative by Tairāwhiti DHB who are working with GPs to fund free primary care visits to people with mental health and addiction issues.

Addressing the revolving emergency department door: The Health and Wellbeing Connection

www.tepou.co.nz/news/addressing-the-revolving-emergency-department-door-the-health-and-wellbeing-connection/585

A Christchurch innovation shows how organisations can work together to help people experiencing mental health issues access the right supports, at the right time.

Events

Healthy Deaf Minds Conference

Auckland 20 November, Wellington 24 November and Christchurch 30 November

The Coalition of Deaf Mental Health Professionals (CDMHP) is pleased to announce a full day workshop which will explore the unique dynamics involved in providing culturally affirmative care to Deaf people with mental health needs in NZ/Aotearoa, to be facilitated by international expert Dr Brendan Monteiro.

The programme has been designed to reflect the needs of:

- the Deaf Community
- mental health/health clinicians, criminal justice workers, corrections staff and legal representatives
- service commissioners.

Delegates will learn about factors which impact upon Deaf development, mental illness and recovery, including the place of communication in attaining positive treatment outcomes. An examination of the therapeutic journey, assessment, diagnosis and treatment will support understanding of the unique approach required when working with Deaf clients and their family/whānau.

For more information check out the conference website, <http://conference.cdmhp.org.nz/>

Healing Our Spirit Worldwide, The Seventh Gathering: Mauri Ora

Hamilton, 16-19 November

www.tepou.co.nz/events/healing-our-spirit-worldwide-the-seventh-gathering-mauri-ora/839

Early Intervention in Psychosis Training Forum 2015

Wellington, 22-24 November

www.tepou.co.nz/events/early-intervention-in-psychosis-training-forum-2015/897



Rising to new heights: the 5th Australasian Mental Health Outcomes and Information Conference (AMHOIC)

Queenstown, 11-13 November

www.tepou.co.nz/events/rising-to-new-heights-the-5th-australasian-mental-health-outcomes-and-information-conference-amhoic/766

People in Disasters 2016, Response, Recover, Resilience

Christchurch, 24-26 February 2016

www.tepou.co.nz/events/people-in-disasters-2016-response-recover-resilience/716

Visit www.tepou.co.nz/events for more upcoming events.

