Handover

Mental Health & Addiction Nursing Newsletter

Issue 3 - Spring 2007

EDITORIAL *Haere mai, hello and welcome to* Handover.

Yes, that's right, *Handover* is the new name of our nursing newsletter (as you will have guessed by the new masthead!). Thank you to everyone who voted. A special mention must go to Southland DHB, from where 52% of the votes came - Go Southland!!! *Nursing Matters* was pipped at the post, coming in second. Sadly, *Nursing Comment* received just the one vote, but thank you to my 91-year-old grandmother who text me that one!

I think you will all agree that it has been a long winter and it is great to be on the downhill stretch towards the end of the year. The last few months have been a busy one for nursing leadership workforce development here at Te Pou.

VALUING LEADERS

Working with the northern region directors of mental health nursing, our planning is well underway for the first of the regional workshops in valuing leaders in acute inpatient services workshops. This first workshop will be held on 13 December, and planning with the other three regions will commence soon.

PROFESSIONAL SUPERVISION

The Centre of Mental Health Research, Auckland University, has been contracted by Te Pou to research current practices in professional supervision for nurses in DHBs and seven NGOs, and is due to finish this work by the end of the year. Thank you to those nursing leaders and supervisors who took the time to respond to the surveys. The next phase for Te Pou will be to pilot the recommended model or models – keep an eye on the website www.tepou.co.nz for updates and other nursing workforce news.

I must also mention the inaugural Te Ao Maramatanga, New Zealand College of Mental Health Nurses conference that took place in July, in Hamilton. Congratulations to the college and the organising committee. I am sure that those of you who attended will agree with me that it was a fantastic conference and a wonderful celebration of mental health nursing in New Zealand. You can read about the conference in this issue from Gail Philips (p3).

WHAT'S IN THE SPRING ISSUE?

From talking therapies and Debra Wells further clarifying Trauma Informed Care and what it means in practice to nurses, through to a national nurses meeting hosted by the Werry Centre – we have quite a mixed bag this issue. Barbara Hart, consumer advisor at Lakes DHB, has contributed a piece that I believe fits very well with the up and coming acute nursing workshops, valuing acute inpatient nursing, and she raises how important it is to "be with" service users (p4).

Once again thank you to all the contributors, without you there wouldn't be any *Handover*.

SO, WHO WON THE NEWSLETTER NAME COMPETITION?

The winner actually contributed the "Barbie or Florence" article in our previous issue – so, congratulations to Sonja Goldsack! As you can see from the photo, the gift basket prize has been handed over to Sonja herself, and I am told she is enjoying all the bits and pieces within it. Thank you to everyone who contributed to this competition, which began way back in April!

HAND IT OVER: ANNA SCHOFIELD PRESENTS SONJA GOLDSACK WITH HER GIFT BASKET FOR WINNING THE NEWSLETTER NAMING COMPETITION.

That's it from me for another three months. The next issue of *Handover* is due in January. So, to beat the Christmas rush, or blues (!), get your contributions in early – December can be a great month for putting something together.

Speak to you all in 2008!

Bye for now,

Anna

EDITOR

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Te Pou o Te Whakaaro Nui

The NATIONAL CENTRE *of* MENTAL HEALTH RESEARCH, INFORMATION *and* WORKFORCE DEVELOPMENT

CAMHS NURSES DISCUSS CHALLENGES

By Dr Bronwyn Dunnachie

This is a short report on a September meeting for CAMHS nurses that I chaired, and which provided a useful platform for raising a number of issues salient to nurses working in this field. It also highlighted that those gathered were able to identify their passion for working alongside children, young people and their families as being the key motivation for continuing to work in CAMHS.

The meeting, hosted by the Werry Centre for Child and Adolescent Mental Health, was part of the national conference for child and adolescent mental health and addiction workers held in Hamilton.

Twenty nurses from CAMHS services nationally attended, and our invited guest was none other than *Handover* editor, Anna Schofield. As readers will be aware, Anna is Te Pou's Mental Health Nursing Leadership Manager. She provided an overview of the current projects being undertaken by Te Pou that will be relevant for nurses, in addition to outlining the draft Let's get real competency framework for the mental health and addiction sector.

I provided an overview of the draft Real Skills Plus competency framework for the Infant, Child and Adolescent Mental Health and Alcohol and other Drug workforce, before opening a discussion on specific issues for CAMHS nurses.

Issues raised:

- How nurses working in a specialty CAMHS retain their nursing identity in the Multi-Disciplinary Team.
- The challenges, such as role clarity and working alongside the enlarging certificate/undergraduate-diploma level workforce, for nurses working in NGO service.
- The challenges for new graduates entering the CAMHS area of specialty practice.
- The challenges for CAMHS in recruiting and retaining nurses equipped to work in this area.
- The challenges of meeting increasing demands, such as documentation, which reduce available time for direct clinical contact.
- The need for continuing development of career pathways for nurses working in this area of specialty practice.
- The challenges of working in rural environments.

Recognition of the need to create a forum for CAMHS nurses to address issues specific to this area of practice was discussed. Anna offered this newsletter as a potential vehicle.

On behalf of the Werry Centre, I offer a big thank you to all the people who came to and participated in this meeting.

DR BRONWYN DUNNACHIE IS A SENIOR ADVISOR FOR THE WERRY CENTRE.

WWW.WERRYCENTRE.ORG.NZ

A FRESH LOOK AT NURSING

Te Ao Maramatanga Inaugural Conference, 19-20 July, 2007

By Gail Phillips

The theme of the conference this year was "A fresh look at nursing in the mental health and addiction sector in New Zealand", and throughout the keynote addresses, plenary sessions and concurrent sessions this theme remained true.

To set the scene, on the first day, keynote speakers helped to establish where we came from: Dame Margaret Bazley (Patron) gave us a tour of her life as a mental health nurse that provided us with some positive insights into how some of our pioneer colleagues helped change the face of mental health nursing; Dr Kate Prebble gave us a view of mental health nursing from a historical perspective, about the work and culture of nurses "on the floor", and provided some useful insights for us all.

Prior to this there were four pre-conference workshops looking at Practice Development, Solution-Focussed Brief Therapy, Whakatipuranga, Cultural Educational Tool Kit and The Use of Humour in the Workplace – all of which were extremely well received.

Also looking toward the future, keynote speaker Hineroa Hakiaha (Kaiwhakahaere) introduced Huarahi Whakatu "Maori Mental Health Nursing Professional Development and Recognition Programme", which will result in nurses working within NGOs gaining recognition for their dual competencies. She also shared her experiences working within mental health services as one of the few Maori nurses.

Dr Frances Hughes discussed the mental health needs of our neighbours in the South Pacific, and of some of the initiatives she has been involved with that are being carried out under the umbrella of the World Health Organisation.

What became obvious during the conference, was that there is research, innovation and examination of practice by nurses in many different contexts occurring all over the country and this was showcased by a diverse group of presenters.

While the conference itself provided excellent opportunities for networking – it was fabulous to meet so many new colleagues from other parts of New Zealand and from Australia - another undoubted highlight was the evening function. This was held at Vilagrad's vineyard, with a great meal, wine, excellent music, wonderful company and the inauguration of the first Fellows of Te Ao Maramatanga. This was a ceremony that lauded those who have given much to the college and to mental health nursing over the last few years. Also introduced was a new Fellow, Tony O'Brien, who was the inaugural president of the New Zealand College of Mental Health Nurses.

Much of the conference content was recorded by graphic artist Mary Brake, who was able to capture its essence in her art (available for viewing on, and printing from, the college website):

http://www.nzcmhn.org.nz

This really was a great conference, from the opening ceremony – with the welcome of the Waikato tangata whenua, and the introduction of the new college waiata – to the closing, and one that all mental health nurses should endeavour to attend in the future.

The next conference is to be held in 2009 in Wellington, and already the organising committee is hard at work preparing for the influx of mental health nurses to what I am sure will be another successful and inspiring meeting of like-minded nurses.

I look forward to being able to provide further updates from the next conference.

DAME MARGARET BAZLEY DR KATE PREBBLE

HINEROA HAKIAHA – STANDING LEFT

TE AO MARAMATANGA FELLOWS, (L TO R) - HELEN O'SULLIVAN, ERINA MORRISON, BRIAN MCKENNA, FRANCES HUGHES, CHRIS HATTAN, HINEROA HAKIAHA, KATE PREBBLE (OBSCURED), TIO SEWELL, TONY O'BRIEN AND COLLEGE PRESIDENT HEATHER CASEY.

GAIL PHILLIPS

Gail is a national committee member for Te Ao Maramatanga and currently part-time secretary/organiser for the Canterbury branch. She is also the college representative on the New Zealand Guidelines Group on suicide prevention and lectures in mental health and pharmacology at the School of Nursing at Christchurch Polytechnic. As well as juggling all of this, Gail has completed a clinical Master's of Nursing as part of her journey towards applying for Nurse Practitioner (in mental health) status.

VALUING ACUTE INPATIENT NURSING

By Barbara Hart

As a consumer advisor, I have regular contact with mental health nurses; I see them first as students coming into mental health services, sometimes apprehensive and unsure what to expect but eager to learn. Then, as part of the interview process, I see new graduates who have decided that mental health nursing is for them. They arrive eager to become competent practitioners.

These nurses work on the inpatient unit learning new skills, but waiting to move to the community where they see the "real" work is done. Why is this? Do nurses in ICU see their next step as district nurses?

Mental health nursing in an acute inpatient setting demands great skills in a wide range of areas. Nurses work with people who are acutely unwell and, in a small unit like ours, you have service users with a range of symptoms. Nurses need to be able to assess and re-assess situations constantly, to be able to intervene early and de-escalate situations that minimize harsher interventions like restraint and seclusion. And they also have to understand and practise one of the great skills – "being with".

I am sure that some people unfamiliar with mental health nursing may suggest that "being with" is just time-wasting, of no value, especially since nursing has become so task orientated. Why would you spend time with a service user and appear to be doing nothing? There must be other tasks that need attention, other service users who would benefit from more constructive nursing intervention.

But it is not nothing to accept a person for who they are, when they are distressed, and to offer comfort in silence. It is a true act of kindness and humanity to be non-judgmental and allow a person to be who they are without imposing values or opinions on what needs to happen. To be silent, without meaningless chitchat and realising that silence is exactly what is needed, is truly powerful.

"To be silent, without meaningless chitchat and realising that silence is exactly what is needed, is truly powerful."

The one thing I remember, as a service user in an acute unit with a will to die, was staff who used this skill. Here I was, feeling of no value, feeling that taking my life was the best option for me and everyone else: a solution not a problem. They were dark days of distress and despair. And staff would sit with me, be with me, not talking, have no expectations of conversation but prepared to be with me in my distress. It went against everything I knew about myself. Here was I, feeling worthless, of no value, and these nurses were prepared to forsake other duties, other service users, and just be with me in my distress. Even though I don't remember the names of these nurses, I remember their actions, and of all the interventions I have experienced in my journey through the mental health system, this was, by far, the most meaningful and the most healing.

This is but one of the building blocks to therapeutic engagement. And the ability to engage meaningfully with service users who are acutely unwell is what good proactive acute inpatient nursing is all about. Only with therapeutic engagement can nurses fully work with their clients and provide good therapeutic care.

So my question remains, how do we show nurses working in an acute setting that we value them? How do we promote acute inpatient nursing as a career choice, instead of a stepping stone to the community?

I don't have any answers, but I truly value the work they do, for when we are acutely unwell, we need them to be with us and help us through those dark days.

BARBARA HART

Barbara Hart has been the consumer advisor at Lakes DHB for the last five-and-a-half years. Prior to her current role, Barbara was a facilitator for Serious Fun'N Mind Trust, which is the Likes Minds provider in the Lakes area.

CONGRATULATIONS TO NEW DIRECTORS

Over recent months, a number of DHBs have welcomed new directors of mental health nursing:

- Jane Simperingham – Northland DHB
- David Warrington – Hawke's Bay DHB
- Bernice Goulding – Hutt Valley DHB
- Stu Bigwood – Canterbury DHB

Congratulations! Te Pou wishes you all lots of success in these roles.

ANNE GARLAND

RMN, BA (Hons) Master's in Advanced Cognitive Therapy Studies (Oxford)

THE UNIVERSITY OF AUCKLAND DISTINGUISHED VISITOR FOR 2008

By Helen Hamer

The Centre for Mental Health Research and School of Nursing is delighted to welcome Anne Garland as a distinguished visitor in 2008. Anne is an internationally renowned nurse consultant, scholar and clinical leader in the model of Cognitive and Behaviour Therapy (CBT). She holds the position of Senior Fellow of the Institute for Mental Health, which is an affiliation between the University of Nottingham and Nurse Consultant with the Nottinghamshire Healthcare NHS Trust.

Anne has extensive experience in teaching and researching the application of this evidence based model in mental health settings, as well as researching collaboratively with all disciplines in mental health settings. She has also been President of the British Association of Behavioural and Cognitive Psychotherapies in the UK (the first nurse to hold this position) and has been recognised for her contributions to the Royal College of Nursing in the UK, editorial boards and journal review committees.

Anne has been a co-director and leader in many environments promoting the use of the evidence based model of CBT. She has also worked with many distinguished scholars and researchers in the international arena in CBT. Her current research is on the application of psychological approaches by mental health nurses in acute inpatient settings. The research findings and recommendations for practice will be presented as part of the acute inpatient workshop and will be of interest to those mental health nurses and their colleagues working in this specialty as well as those from acute crisis settings.

Anne will be conducting a number of workshops and seminars in Auckland during the weeks of 11 February to 22 February 2008 on the following topics:

WORKSHOPS:

- Basic Skills and Formulation in CBT: A Refresher.
- Acute Inpatient Nursing: Using Generic Psychological Skills versus CBT.
- Integrating the Best of the Nursing Models.
- CBT for people with Bi-Polar Affective Disorder.
- CBT for people with Acute & Persistent Depression.

SEMINARS:

- Integrating CBT into the Standard Psychiatric Consultation & Approach to Treatment Concordance.
- The Role of the Nurse Consultant in the UK: Leadership and Change in the Mental Health Setting.

A SELECTION OF ANNE'S RESEARCH AND PUBLICATIONS:

- Scott, J., Garland, A. and Moorhead, S. (2001). A pilot study of cognitive therapy in bipolar disorders. *Psychological Medicine*, 31, 459-467.
- Kinsella, P. and Garland A. (in press). Cognitive Behaviour Therapy for Mental Health Workers, Routledge.
- Garland, A. and Scott, J. (in press). The obstacle is the Path: Obstacles to homework assignments in complex presentations of depression. Invited paper to a Special Issue of Cognitive and Behavioural Practice Beyond Basics: *Using homework in Cognitive Behaviour Therapy with challenging patients.* Guest editors: N. Kazantzis and F.M. Dattilio.
- Mannix, K.A., Blackburn, I.M., Garland, A., Gracie, J., Moorey, S., Reid, B. and Scott, J. (2006) Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliative Medicine*, 20: 579-584
- Williams, C. and Garland, A. (2002). A cognitive–behavioural therapy assessment model for use in everyday clinical practice. *Advances in Psychiatric Treatment*, vol. 8, pp. 172-179.
- Paykel, E.S., Scott, J., Teasdale, J., Johnson, A., Garland, A., Moore, R., Jenaway, A., Cornwall, P.L., Hayhurst, H., Abbot, R. and Pope, M. (1999) Cognitive Therapy prevents relapse in residual depression: A controlled trial. *Archives of General Psychiatry*, September, vol.56, pp 829 - 835.

Further programme details and a more detailed outline will be available in November. Please email Helen Hamer to register your interest or for early bird booking to secure your enrolment.

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HELEN HAMER

Helen, RN, MN, is a senior lecturer/doctoral candidate at the School of Nursing, Faculty of Medical and Health Sciences, University of Auckland.

MEET JANETTE SYMES

Five practising nurses Chris, Janette, Elly, Patrick and Val have been chosen to represent the human face of mental health and addiction nursing in Aotearoa – they are depicted on the masthead on the front page of this e-newsletter. Each nurse is being profiled over the coming issues.

Janette Symes's passion to enable people with distressing psychotic symptoms to live meaningful lives has not disappeared after 25 years. Rather it has become a lifelong quest into promoting and using psychological interventions and ways of working collaboratively with service users, with a particular emphasis on CBT and mindfulness approaches.

"Quite early on I was keen to find other ways to help people cope and manage their symptoms so that they didn't have to keep going back to hospital and could experience some level of recovery," explains Janette, who works as a clinical nurse specialist at the Taylor Centre, an Auckland District Health Board (ADHB) community mental health centre in Ponsonby.

"It is about trying to improve quality of life. Medication can help but people can also gain techniques for dealing with voices and develop coping strategies that enable clients to identify patterns so that they can move from vicious to victorious cycles."

Janette's clinical work includes facilitating hearing voices groups and belief groups and professionally providing guidance and direction on use of psychological approaches and strategies in mental health interventions.

Janette came to the Taylor Centre 18 months ago from England where she worked in a specialist role training mental health professionals in new ways of working with clients in mental health services.

PSYCHOLOGICAL INTERVENTIONS

Her interest in hearing voices, belief groups and mindfulness stem from the nineties when she did a psycho social intervention course for mental health professionals. This introduced her to using CBT as a framework and intervention for working with distressing symptoms of psychosis. Janette eventually became a skills-based trainer on psychological interventions. She also completed an MSc in Cognitive Therapy (CBT) for Severe Mental Illness at Southampton University. Through the MSc, she learned how to effectively use CBT with people experiencing distressing symptoms of psychosis. Her research year focused on using mindfulness with CBT.

"My supervisor was already well known for his work on psychosis and he was developing an intervention using a group CBT and mindfulness based intervention."

It also introduced her to hearing voices groups; groups she describes as a "privilege" to be part of.

"People who suffer from mental illness are real heroes; they put up with so much distress and tolerate so much. It is a privilege to work with them."

Now in New Zealand, Janette has been delighted to continue working in the hearing voices and mindfulness area through working with Dr Patte Randal and Debra Lampshire, both of whom have experienced psychosis first-hand, Janette says.

Debra, a voice hearer, was instrumental in setting up a hearing voices group that Janette now co-facilitates with her. They run the groups throughout the ADHB community mental health centres.

Janette and Patte co-facilitate a beliefs group, using the recovery approach which, like the hearing voices groups, incorporates CBT and DBT principles. "We have also included an introduction to mindfulness in these groups."

MINDFULNESS

She describes mindfulness as a meditation practice of being fully present in the here and now and fully aware of how we are feeling in our body.

"By observing our thoughts, voices, images, beliefs as they arise in our consciousness, we see how transient they are. We become observers of our thoughts but without the usual emotional buy in. Therefore we can choose to react emotionally or just let it go."

While simple this is not easy to follow and needs practice. Service users are introduced to the concept in the hearing voices and beliefs groups, but it is with the mindfulness groups that the meditation practice is used as a therapeutic intervention.

Service users benefit a lot from these groups, Janette says.

"Evaluations from the hearing voices groups show service users report a 30% to 70% reduction in the distress and frequency of voice hearing. The benefits come mainly from the client's experience being validated and normalised."

LEARNING AND RESEARCH

Janette is currently looking into further research into CBT and mindfulness. She has enrolled in a New Zealand Master's in Nursing in January, which she hopes will lead into a PhD.

She believes lifelong learning and research is essential because nursing continually evolves and nurses need to keep up to date and interested.

Traditionally nurses haven't been seen as participants in research, but in the last 20 years that has been changing, she says.

"If you have a research background, it is easier to work out how to put research into practice. Nursing is a fascinating job because you can pursue so many different avenues, yet you'll never learn everything you need to know."

WE NEED TO TALK *By Janet Peters*

The report We Need To Talk *was commissioned by Te Pou. www.tepou.co.nz*

Earlier work (eg, by the Mental Health Commission) suggested that service users were asking for better access to therapies in mental health and addiction services, and this suggestion was borne out in the report. This report is seen as merely a start to discussions about how we might support services to provide more therapies.

As nursing makes up the majority of the mental health and addiction workforce, the report may be of particular interest to nurses working in the sector. In the process of completing the report, I talked with 46 people from around New Zealand to get a feel for the issues. I also looked briefly at what was happening in the area of talking therapies in Australia, Scotland and England.

Emerging issues were:

- Some staff across mental health and addiction services are increasingly upskilling in therapies (most commonly Cognitive Behavioural Therapy, Motivational Interviewing, Dialectical Behavioural Therapy and Multi Systems Therapy), with other therapies also featured. However, other staff were reported as not seeing the need for such skills.
- Some services operate in such a way as to enhance therapy provision (eg, clinical leadership supports the approach, staff are able to practise therapy skills and there is ongoing training and supervision in place). Other services do not support staff being able to practise therapeutic skills.
- We have little information on how therapies can be culturally responsive to Maori, Pacific and Asian peoples and research in this area was suggested.

In summary, all people thought that a good start would be to increase access to staff training in Cognitive Behavioural Therapy and Motivational Interviewing. For me this is an interesting finding, as both mental health and addiction staff agreed on this suggestion. An added benefit would be that staff would increase their ability to "talk the same language" – the lack of a common language has historically been a problem between mental health and addiction sectors.

We welcome feedback on this report – feedback can be completed using the Te Pou website's standard online feedback form **http://www.tepou.co.nz/page/129-Feedback** or you can email me. I do hope you find this work useful – remember: it is just a start!

janetpeters@xtra.co.nz

JANET PETERS

Janet is a contractor for Te Pou. She worked for Waitemata mental health services for 10 years, has worked on several national projects (eg, Like Minds) and for several national agencies, including the Mental Health Foundation, Mental Health Commission, Ministry of Health and Health Research Council and for one international agency, International Initiative for Mental Health Leaders (IIMHL).

PEER SUPPORT SUCCESS *By Carolyn Swanson*

On 14 September, 12 presenters from the Auckland Peer Support Network told stories of their peer support work to a packed audience at Sorrento in the Park. The presenters were from a variety of services, some service user led, some NGO and some DHB. Although they used different models, processes and methods, the recovery philosophies were obviously paramount and robustly underpinned their work.

The deeply personal stories were told with humour, empathy and poignancy, and covered not only the impact of their work on the people they serve, but on themselves (learning their experiences had value, confidence gained), their organisations (valuing this incredible workforce and their experiences) and communities. The audience was captivated and engaged from the opening statements to the last applause. They laughed, they listened and, sometimes, in spaces where you could hear a pin drop, more than one surreptitiously wiped away tears.

It was lovely to see a really good turn out of DHB and NGO clinical staff, including nurse leaders and psychiatrists who enthusiastically agreed that the positive value of this newly emerging workforce is undeniable. The groundwork for future partnerships and working relationships was well laid and encouraged.

CAROLYN SWANSON, SERVICE USER WORKFORCE, TE POU.

TRAUMA INFORMED CARE: WHAT IS IT?

By Debra Wells

What recovery focused care, as a concept, means has grown and developed since it was introduced into New Zealand as a service delivery principle – just as new research about what people need to recover has grown.

It is now recognised in international research and writings that to deliver recovery focused care, services must work to recognise and respond to the profound impact of trauma in people's lives. When talking of recovery focused care, this now implicitly connotes care that is trauma informed. However, at this point in our history, it seems we need to be explicit about this as, to date, this aspect of recovery focused care has been largely ignored. It is, however, heartening to see it beginning to appear in national documents, such as *Te Kōkiri* 2006-2015 and *Te Hononga* 2015.

So what exactly is trauma-informed care? Harris, M & Fallot, R. D (2001) outline the five principles as follows:

- An appreciation of the high prevalence of traumatic experiences in persons who receive mental health and addiction-funded care and support.
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual.
- Care/support that recognises that mental health and addiction "treatment" can itself be traumatic for all users of services and, therefore, seeks to provide services (ie, not just people with trauma histories) that minimises this.
- Care/support that addresses the effects of trauma, which is collaborative, supportive, strengths-based and recovery oriented.
- A system that recognises that practitioners are impacted when working with very distressed service users, and that seeks to minimise impact on practitioner. In the literature this impact is known as "vicarious traumatisation".

The differences between trauma-informed and non-trauma informed services are outlined below.

TRAUMA INFORMED CARE	NON-TRAUMA INFORMED CARE
Recognition of high prevalence of trauma	Lack of recognition/attention to trauma
Life context/exposure is appreciated	Service user lacks historical context
Mandatory screening for traumatic histories	Inadequate or no screening for traumatic histories
Power/control dynamics minimised	High use of power/control dynamics
Collaboration	Compliance
Address training needs of staff to improve knowledge and sensitivity	Service user blaming
Understands function of behaviour (rage, repetition-compulsion, self injury)	Behaviour seen as intentionally provocative or manipulative
Includes service users' perspectives in planning, including care planning and advance directives	Lack of self-directed care or planning
Psycho-education and alternative skills development	Over reliance on medication without skills focus
Low/no seclusion and restraint	High rates of seclusion and restraint
Low rates of staff/service user assaults and injury	High rates of staff/service user assaults and injury in both groups
Recognition of primary and co-occurring trauma diagnoses, ie, a diagnosis is not necessarily indicative of whether there is trauma present	Misunderstanding of trauma related diagnoses or consideration that PTSD as only diagnosis
Lower staff turnover and burnout	Higher staff turnover and lower morale

What can you, as an individual practitioner, do in order to be more trauma-informed in the care and support that you provide?

- Understand the profound neurological, biological, psychological and social effects of trauma and violence on the individual by getting some training. There is also a huge amount of material on the internet if you enter "trauma-informed care" if you can't find any training.
- Have an appreciation of the high prevalence of traumatic experiences in persons who receive mental health and addiction-funded care and support.
- Recognise that just asking whether a person has a trauma history is not enough. You then need to seek to understand what impact that has had on the person's life from their perspective.

CONTINUED ON PAGE 10

- Work with service users in a way that is collaborative in all areas of care.
- Work with your managers to ensure that the actual service delivery supports trauma-informed care.

I will leave the last words to service users. This is an extract from a paper I wrote for the Mental Health Commission called "Disturbing the Sound of Silence". The full article can be found on the Mental Health Commission website.

http://www.mhc.govt.nz

"What, then, do we service users with abuse histories want from mental health services?

We want:

- mental health services that are willing to look beyond diagnosis to the whole person, and practitioners who are willing to form therapeutic relationships with us
- training for ALL mental health staff in all aspects of trauma treatment and recovery, some of which would be provided by abuse survivors
- the creation of alternative services designed to diminish or eliminate the need for hospitalisation for those with abuse histories
- a stop to pathologising and medicating our distress
- mental health staff who ask about our histories and what we believe about what has created our distress, and who then work accordingly
- mental health services that do not perpetuate the abuse through its practices
- access to professionals who work effectively with people with trauma histories
- movement beyond a bio-medical approach to mental illness
- national recognition in mental health policy, planning and funding of the ongoing effects of abuse in peoples' lives
- national leadership in this area.

DEBRA WELLS

Debra Wells is a service user consultant and trainer who provides training in working with people with trauma histories.

WARM WELCOME FOR REGIONAL WORKFORCE COORDINATORS

Te Pou last week welcomed on board its two newest staff members: Regional Mental Health and Addiction Workforce Development Coordinators Janet Edmond (central region) and Stuart Gray (southern region). These two regions have elected to transition the roles to Te Pou, while the northern and midland regions have elected to sub-contract the service. Emma Wood is acting coordinator in the northland region, and Mandy Lacy is the midland coordinator.

In a nutshell, the coordinators act as conduits, working to translate policy into the work of the mental health and addiction sector, and listening to the sector to take its key messages back to the policy makers and workforce centres.

Te Pou held a small powhiri for Janet and Stuart last Tuesday, and the pair spent two days meeting staff and discussing work plans. You can read more about the regional workforce coordinator role on the Te Pou website (www.tepou.co.nz), just use the search function on the homepage.

STUART GRAY AND JANET EDMOND VISITING TE POU

CREATING A CENTRE OF EXCELLENCE

By Georgina Darkens

An innovative group of calming and restraint instructors from the northern region is working towards becoming a centre of excellence. Here Georgina Darkens, a member of this group, gives some background to its formation and highlights the nature of its work.

Following the closure of Green Lane Training Services in the late '90s, a few like-minded people (commonly known as "C and R instructors") maintained an informal network to discuss activities and concerns regarding the education and clinical practice related to de-escalation and restraint activities.

There was often talk of consolidating ideas and, it seemed, with the diversity in approaches within respective services, that a cohesive effort – though difficult to organise – would be the best way forward. However, nothing came about until the introduction of the NZS 8141: Restraint Minimisation and Safe Practice (aka the Standard) in 2001 and, accordingly, senior instructors decided to identify and define the specific techniques taught and practised within Waitemata DHB.

The expected "few sessions" to complete this task turned into something quite different and, now, several years down the track we refer to our efforts as a living document!

In 2003, the like-minded network had grown into something bigger throughout the four northern DHBs (Waitemata, Auckland, Counties Manukau and Northland) and branches were spreading into management systems and educational set-ups, with the creation of new leadership roles. Ideas were flowing and it made sense to give more formal recognition to the work that was going on.

The inaugural Regional Forum was held in October, 2004, with the blessing of respective managers, and oversight was sought from the then Northern Regional Workforce Development Coordinator.

The purpose of the group was to ensure that educational activities of the four DHBs meet the requirements of the Standard.

The terms of reference focused on:

- promotion of evidence-based practice and minimal use of all restraint activities
- working toward a restraint-free environment
- ensuring education programmes are standardised, valid and reliable
- developing a framework that addresses competence
- working toward becoming a centre of excellence.

The group meets quarterly with each DHB acting as chair on a rotational basis, with consumer and cultural representation being drawn from the host organisation.

Over the past few years, a core group of senior educators has been instrumental in progressing:

- a centralised 'train the trainer' programme
- levels of development for instructors
- identification of core elements for communication and de-escalation teaching modules
- standardising restraint methods in line with the ongoing development of the techniques manual
- an understanding for recognition of prior learning
- promotion of the reduction of restraint and coercion practices within a perspective of trauma-informed care
- support of an NGO to tailor specific training needs.

More recently, we have turned our attention to such issues as the specific safety requirements for working with children, adolescents and older people. Our "expert" at Starship Hospital, Auckland DHB, is making contacts with international organisations to get a sense of what others do that we might find useful.

Counties Manukau DHB will be hosting a four-day visit by Kevin Anne Huckshorn who is the director of the Office of Technical Assistance within the National Association of State Mental Health Program Directors, USA, and largely responsible for the development of the USA programme, Creating Violence Free and Coercion Free Mental Health Treatment Environments. We are also in communication with European organisations looking at Zero Tolerance initiatives and other restraint methods.

At Waitemata DHB, we have worked with staff in the older persons' unit to adopt less stringent techniques, and are gathering evidence of good practice within the three inpatient units. A brief exemplar template is used for staff to identify in themselves, or in others, those interactions that support service users to move from a heightened emotional state and maintain dignity and control through timely and confident use of effective strategies.

While debate has yet to produce agreement on some issues, such as organising a conference and how competency might be measured, we engage in discussion with the knowledge that each service is able to maintain its uniqueness and matters will be resolved in an atmosphere that recognises the differences and promotes the similarities.

If you are interested in discussing these developments further, or sharing your ideas, the following people can be contacted and we welcome the opportunity to talk with you.

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