On 9-10 October 2014, around 40 mental health and addiction nurse educators from clinical and education settings gathered at Whitireia Community Polytechnic in Porirua to hear from national and local speakers and workshop the issues presented.

The forum was warmly hosted by the nursing team from Whitireia: Dr Kathy Holloway, Jamesina Kett, Chrissy Kake, Carmel Haggerty, Wendy Trimmer, Juliana Korzon, Katie Owen and Catherine Fuller.

Thought provoking topics included: nurses and health care delivery; nursing workforce development; co-existing problems; physical health; current issues from the Nursing Council; the New Entry to Specialty Programme (NESP) for new graduate nurses; what mental health and addiction content should be taught in clinical, undergraduate and postgraduate nursing programmes; and how that knowledge should be taught.

The dinner was a night of much fun, with laughter generated by the quiz led by Kathy Holloway, Dean of the Faculty of Health. Emotions oscillated from feeling very clever to realising one's knowledge lacked in some areas!

Continued on page 3
Editorial

This edition of Handover is a real reminder that innovation and creativity are alive and well in our mental health, addiction and disability services.

Our lead story looks at the mental health and addiction nurse educators’ forum, including a model developed by Dr Kathy Holloway.

The flexibility of rural services to respond to service users is portrayed in a story about the Waitaki mental health service.

Clinical nurse specialist Dina Whatnell talks of her unique role supporting people with disabilities through their health care journey in a hospital setting.

Equally Well, a collaborative project aimed at taking action to support people experiencing mental health and addiction problems to improve their physical health, is presented in this edition.

Leanne Kirton reminds us that 2025 is not far away and shares her views and the evidence around some SmokeFree project work.

We meet Nathan Davis and Meg Baillie, recipients of the Blueprint Leadership innovation Award 2013.

Nadav Avny describes a workforce initiative which introduced Mindfulness Based Stress Reduction training for staff working in an acute adult mental health unit.

We look at the Care Capacity Demand Management programme, including insights from the pilot project at Southern DHB.

Improving perinatal and maternal mental service responses is on the agenda for Rising to the Challenge. Rosie Smith, chair of Perinatal Mental Health NZ Trust, helps raise awareness about this key issue.

Our family column is provided by Deborah Crichton who describes what works well and what could be done differently to support the families of service users.

Nurses, are you up to taking a pledge to reduce stigma and discrimination? If so, flick to the article provided by Dr Helen Hamer – a random act of kindness perhaps? This story dovetails well into Carolyn Swanson’s article which reminds us that it is the little acts of kindness, such as finding slippers or making a pot of tea for a person in distress that can make all the difference!

With Christmas and the New Year approaching Te Pou wishes you peace, joy and happiness. We appreciate your support of Handover and value our 2,000+ readers.

Kindest regards, Suzette

Suzette Poole - Editor
CLINICAL LEAD
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NEXT EDITION:

Nurses this is your opportunity to share some of the great innovations that are happening to support people with mental health and/or addiction problems with their physical health. If you would like to submit an article to Handover, or you just have an idea for one, please feel free to contact me as I would be delighted discuss this with you. Articles are due by Monday 19 January 2015. Email to suzette.poole@tepou.co.nz.
The forum used Dr Kathryn Holloway’s approach to shape workshop discussions, that is, ‘All, many, some, few’, – from her research about a specialist nursing framework for New Zealand (2011). The Health Care Context Model (see diagram) developed by Kathy outlines the level of health care needed and the level of nursing response required.

Kathy’s presentation, ‘All nurses are mental health nurses? Clarifying specialist practice’ provided an opportunity for educators to stop and think about the specialty area of mental health and addiction nursing practice. Kathy highlighted global expectations for nurses and reinforced a key message that “Nurses are a common thread linking all components of a patient’s care, and are therefore also the key to advancing a less complex, less costly health care system. The development of new roles for nurses is seen as an important strategy to improve access to health services” (IOM, 2013, Better care at lower cost).

Kathy put forward the following for educators to consider:

- All nurses will come into contact with people with a specialty need
- Many nurses will participate more frequently or for short intensive periods in the care of people with a specialty need (specialty nurses)
- Some nurses will choose to specialise and may be designated into senior roles by employers (nurse specialists).

Jane Bodkin, senior advisor, Office of the Chief Nurse, Ministry of Health, presented on integration, nursing sector partnership, nursing workforce (data, retention, planning) and what is happening in mental health and addiction. Her key messages included: that nursing is key to addressing health priorities; models of care need to change to shift expenditure away from hospital care; resources must be deployed more effectively to improve health outcomes and patient experiences; and that integration is key to higher system performance and future sustainability. A number of strategies to strengthen mental health and addiction nursing were also put forward for educators to consider. These included:

- encouraging students, new graduates and early career movers
- clinical supervision
- enabling the potential in mental health care by removing legislative and contractual barriers to making better use of the workforce
- having a well articulated knowledge and skills framework: generalist with specialist support (based on agreed models of care)
- better use of all nursing scopes: using enrolled nurses and nurse practitioners
- economic modelling of new models to gain the confidence of private business to agree ‘affordability’ and change
- education programmes and models of care that support effective nursing in other related services: primary care, aged residential care and home-based support.

Maureen Kelly and Liz Banks provided an update from the Nursing Council and advised that, all things going to plan, New Zealand is likely to see specialty and community prescribing by 2017. Maureen outlined the recertification audit process and noted that around 1500-1600 nurses are audited every year. There are now examples of nurses describing how they are meeting the competencies on the

![Level of Health Care Need](diagram)

Reference:
Farewell from Anne:

This will be my final Nursing Note for Handover. I started as the director of nursing, mental health and addiction at Counties District Health Board on 17 November.

I am both excited at the change and very sad to be leaving an amazing job at Te Pou. In the past five years I have had some of the most amazing opportunities while in this role, and I have loved every minute of it. I have observed some major changes in acute services such as reducing seclusion, the growing use of alternatives such as sensory modulation, and the development of high quality care being delivered in the least restrictive environments possible.

For 30 plus years I have been working as a mental health nurse in various roles. However it is in this current role as national nurse lead that I have been able to fulfil my ultimate aim of supporting nurses, believing in their ability to deliver quality care at all times and in all settings. I enjoy promoting excellence in practice and I will continue to do this in my new role.

I firmly believe that nursing is key to better outcomes for people seeking wellness. Nurses have the responsibility for doing so in a caring and kind way. Nurses have the potential to hold the hope for people when they can’t see it for themselves. Nurses are NOT in the business of judging, discriminating against, or just supervising people in their ‘care’. It isn’t good enough, in my mind, to do bare minimum for people who need us at times in their life when all must feel scary and hopeless. We need to engage and engage well.

I will miss visiting the various district health boards, speaking to the wide range of health professionals and hearing stories of success and challenge. I cannot thank the sector enough for supporting the workforce initiatives and being so helpful and open with sharing ideas and innovations.

To my colleagues at Te Pou, Matua Ra Ki, Le Va and the Wise Group, thank you for all you do for the mental health, addiction and disability sectors. Thank you all for supporting me both personally and professionally.

Nurses have the potential to hold the hope for people when they can’t see it for themselves
From Suzette:

I write these nursing notes in the glorious after moments of becoming a grandmother for the twelfth time and on my return from a short break with my daughter’s family in Melbourne. My family are often at the forefront of my thinking when I am at work. I am always pondering about how we can better support nurses to deliver the care they would want their families to receive or, as the case may be, that they would want to receive if they became unwell.

My role, as part of the team at Te Pou – which includes Matua Rakih, is centred on supporting the workforce to translate evidence and policy into practice, and over the past few months I have done this in a variety of ways. By accepting invitations to visit services, facilitate workshops or present at forums I have a unique opportunity to hear from nurses in a range of settings about their work and how they are also translating policy into practice.

For example, in compiling the story about rural services I had the privilege of meeting the mental health team in Oamaru. I saw warmth, expertise, commitment, connection and good use of information about the population that they serve in my discussions with staff. As part of the Cutting Edge conference I visited Ashburn Clinic in Dunedin and again saw the warmth, expertise and commitment of staff in a service that could flex its programme to meet the needs of people with co-existing problems (CEP).

My work also includes the CEP project. This is a key area of development as we know that around 70 per cent of people using secondary services are likely to experience both mental health and addiction problems. Our focus is on developing the mental health knowledge and skills among nurses practising in addiction services and developing addiction knowledge and skills among nurses working in mental health services. The end goal is that nurses in every setting are equipped with at least foundational CEP knowledge and skills.

On this note I would encourage nurses to do a bit of a stock take and read Te Whare o Tiki: co-existing knowledge and skills framework, which can help identify strengths and areas for development. This process could be undertaken during supervision sessions or as a group with other like-minded people. Te Whare o Tiki is available online at www.tepou.co.nz/library/tepou/te-whare-o-tiki-co-existing-problems-knowledge-and-skills-framework. I am sure you will be surprised at how much you do know. I know I was.

Over the past three months, Ashley Koning from Matua Rakih and I have been invited to facilitate three co-existing problems workshops and present at a mental health and addiction nurse educators forum. One workshop was designed to provide information for a group of people from many different organisations who were seeking more knowledge about addiction so they could in turn educate their colleagues. This was an example of sharing evidence, information and resources which participants can then re-design and contextualise to meet the learning needs of their staff. A key message here was the value in creating a gathering where people could connect across services to share knowledge.

In another workshop we were invited back to meet with a group of CEP enhanced practitioners who had attended a previous two-day CEP workshop delivered by Dr Fraser Todd, Ashley and myself two years ago. CEP enhanced practitioners play a critical role within their organisation in developing CEP capability. This workshop provided a forum for some of the original group to come together again to discuss how they had used the knowledge from the previous workshop. We found progress had been made in a number of areas and particularly where leaders and managers were very supportive. Many in the group were chipping away at things and making steady progress where opportunities arose. Reconnecting with like-minded people was one of the many positive outcomes of the day. A key message here is that there is value in gathering regularly to support each other to action change.

The third workshop, focused on the CEP service checklist, was designed for managers and leaders of DHB and NGO services, family advisors and service user advisors to come together to review how the system responds to people with CEP. Areas where action needs to be taken were identified and then prioritised and an action plan was created. Again, vital networking opportunities arose at this forum which can greatly assist in strengthening cross-service collaboration. A key message here was the value in creating the gathering as a means to connect and develop a plan to take action.

The mental health and addiction nurse educators’ forum provided a timely opportunity to share CEP information and resources with a group of around 40 clinical and tertiary nurse educators from around the country. We encouraged educators to consider how addiction knowledge is included in nursing education. Again, the end goal in mind was that nurses in every setting are equipped with at least foundational knowledge and skills that enable them to effectively respond to people with CEP.

This will be the last edition for Anne Brebner and I wish her well in her new role. It has been an absolute pleasure working with Anne over the past three years. I admire her courage and determination in the pursuit of improving and supporting nurses to respond to people experiencing mental health and or addiction problems and their families and communities. I am absolutely confident Anne will continue to make a positive difference in the lives of the people and nurses she connects with. I know she made a huge difference to mine in encouraging me to join the Te Pou team. Thanks, Anne.
The year is soaring past and I briefly dwell on where the time has gone. The last quarter has been really busy – no wonder it has gone so fast.

The Addiction Nurses Symposium was held in Dunedin on 7 November. This was the latest in a series of nurses’ symposia organised by Matua Raki (National Addiction Workforce Development) in collaboration with DANA (Drug and Alcohol Nurses Association) and Southern District Health Board.

Mark Greco, with support from his Dunedin colleagues and presenters from around the country, coordinated a great day and an excellent line up of presenters. The aims of these events are: to foster relationships; enhance skills; encourage advanced practice and nurse practitioner development; share journeys and ideas for enhancing skills; hear about new and planned initiatives; and explore career opportunities.

Over the last year Matua Raki has delivered a number of trainings around the country focused on supporting withdrawal management. In part this was prompted by a call from Corrections to assist its nurses to up-skill and this training is currently being delivered by Moira Gilmour, (Capital & Coast DHB).

More widely than that, there are a number of nurses or practitioners working with tangata whaiora with addictions who do not have ready access to specialist withdrawal management services. As such, Steph Anderson (Nelson Marlborough DHB) is travelling the Islands taking these workshops to a number of regions, typically those without large withdrawal management services or dedicated clinicians/nurses. These have been exceptionally well received and we are lucky to have such great and passionate nurses willing and able to encourage this area of development.

The DANA stand at the Cutting Edge Conference seemed to be permanently busy with a buzz of activity. It was great to see so many nurses supported to attend Cutting Edge this year. An informal DANA lunchtime meeting was held offering nurses the opportunity to gather and share initiatives. Matua Raki and Te Pou had the chance to highlight some of the workforce initiatives occurring throughout the country and hear about some of the great local work occurring amongst services.

Another activity I would like to promote is a support structure for those of you embarking on, or seriously considering, the nurse practitioner pathway. If you are interested in being part of a peer support group contact Louise Leonard (07 834 6902 or louise.leonard@waikatodhb.health.nz) and she can tell you more about it.

In the meantime, stay well, stay safe, aku mihi nui ki a koe, keep up the good work, Klare.
Let’s go rural – Oamaru mental health service

by Suzette Poole

Just imagine being professionally responsible for all the mental health and addiction nurses working in a geographical area the size of Scotland. Well that is just what it is like for Heather Casey, director of mental health nursing, Southern District Health Board.

While in the area for the Cutting Edge conference I accepted an invitation from Heather to meet with the Waitaki Community Mental Health Service, which is just under a two hour northward drive from central Dunedin.

I received a very warm welcome from a committed and passionate team (with a great sense of humour) led by clinical nurse manager Paul Cullen. The team includes, Nicola Belcher, registered nurse, adult team; Robert Peters, registered nurse, adult team; Jill Mc Diarmid, alcohol and other drug clinician, Community Alcohol and Drug Service (CADS); Kate Anderson, social worker, Child, Adolescent and Family Mental Health Services; Gwenda Laurenson, nurse therapist, Child, Adolescent and Family Mental Health Service; Dr Julia Gearhart, clinical psychologist, adult; and Frances Oakes, registered nurse. Laura Gudmundsdon, social worker, adult team, was not there on the day, nor was the visiting psychiatrist, Dr Chris Wisely who provides 0.2 FTE cover. There is also 1.5 FTE clerical staff made up of Jenny Barnett and Meredith Anderson and there are visiting consultants for the specialty services at approximately 0.2 FTE. The team has been carrying a vacancy for a full time CADS worker for more than six months.

This is an integrated team made up of members who can respond to people across the life span from child to older adult. The Child, Adolescent and Family team members and the Community Alcohol and Drugs team members also link into their respective city-based teams. Each member brings their own professional knowledge and skills to the team along with a more general knowledge base which enables them to adapt and be responsive to the needs of the service user. They know where to get help if they are out of their depth and feel supported to do so.
Oamaru has seen a demographic change which has brought about some changes in health needs. It has the third largest elderly population in New Zealand, and it is growing. Many service users also have physical health problems. The development of dairy farming has attracted more farm owners and workers, some of whom come from as far away as Argentina. Isolation for farmers is a key issue. Depression among male farmers is particularly common. Many seek help from their local GPs and there are some counselling services available. A local women’s Federated Farmers group plays a role in supporting some farmers to cope with rural living. The Pacific population is also growing as local freezing work jobs have opened up. Cheap housing has also drawn more people to the area following the Christchurch earthquakes.

Strong and effective relationships with other organisations in the community are vital (see diagram). Team leader Paul sustains relationships by meeting regularly with key people such as Police, PACT (NGO provider of community support workers, respite and residential care for mental health and intellectually disabled service users), Needs Assessment and Service Co-ordination (NASC) and local Community Trust Hospital emergency department staff. Staff also work closely with local GPs, though there has been shortage of GPs to cover this area. When services are reduced in the area there can be an increase in the work of the team. An example of this was the loss of a behavioural support team which resulted in Robert Peters needing to spend time supporting staff working in disability and mental health community services.

The physical environment of the Waitaki mental health team plays a major part in responding to service users. The spaces are large and inviting, and offices are decorated with creative and homely ambience.

The building also includes offices for the Supporting Families fieldworker. The co-location of a range of services means relationships can be developed and sustained, and the relevant information shared promptly. There is one door to this service so any door IS the right door.

People accessing the service may have a number of problems. Physical health problems are common and some have addiction problems. When people are referred the whole team is involved in the case discussion. Each person has one case manager and a co-worker when necessary to manage co-existing problems and one treatment plan. This closes any gaps in the system people may fall through which can occur when a person requires a range of health services which may be located in different places.

**Challenges**

With rural life comes challenges such as no public transport, which means that ‘did not attends’ (DNAs) are common. Some people have limited money to pay for prescriptions or transportation to appointments so time is spent finding solutions to these problems. “It’s all part of what we do,” explained one of the team.

Providing on call cover is one of the biggest challenges and a plan is underway to address this. Individual staff members provide on call cover eight nights a month, including one weekend. This may result in around 140 hours of additional work per month for staff. On call staff can spend several hours after their usual work day is finished managing a crisis. This may include working alongside a person’s natural community to increase support for someone in order to avert hospital admission. It also includes assessing people in distress in the emergency department at the local Trust Hospital or responding to calls from Police. At times a person may need admission into the acute inpatient unit located 110kms away, and this may take several hours.

**Stable team a real positive**

A low turnover of staff results in a stable cohesive team where each member knows the others’ strengths and expertise. The stability of the team enables strong internal and external relationships to be developed and sustained.

The nature of working in a rural setting means that connections outside of work are highly likely and the team are well aware of how to balance their professional and personal lives. The team are clear that this is their community too; “we all live and work here”. They may often bump into people who are engaged with the service, or who have been in the past, while they are out and about. Sometimes they are providing support to three generations within the same service, so maintaining a service user’s privacy is paramount. People in this small community also provide support to service users and at times and, out of concern, do let the team know if someone may need a bit more support.
Dina Whatnell
clinical nurse specialist, lead developmental disabilities restraint coordinator at Palmerston North Hospital

The person is the focus
A photo of Dina Whatnell’s brother Mark, who has a diagnosis of intellectual disability and Down syndrome, hangs on Dina’s office wall as daily inspiration in her role as clinical nurse specialist, lead developmental disabilities at Palmerston North Hospital.

“Whenever I’m working with a person to develop a plan or advocate on their behalf, there is always one question in the back of my mind. Would this be good enough for Mark? If not, then it is not good enough for this person either!” declares Dina.

This inspiring woman’s specialist developmental disabilities nursing role, which is unique in New Zealand’s acute sector, was created by Dina after she saw the gap in intellectual and developmental disabilities support in community and hospital settings 12 years ago.

Role
Dina’s prime focus is to meet the needs of people with intellectual and developmental disabilities across hospital and community settings. A key aspect of Dina’s role is to assess clinical needs and develop individual care plans that ensure people are well supported. She also meets with people at many points in their journey through the system; during pre-admission for surgery, on day of surgery, at emergency departments, on the wards and at outpatient appointments.

The support she provides varies depending on the person’s level of communication, ability and severity of developmental disability, as well as the competency of the health professional or care giver involved. Some people only need a smile and hello to know she is there if they need her in hospital. Others require full support.

Core messages
Dina works in collaboration with health professionals, encouraging them to adapt their practice to meet each individual person’s needs and focus on seeing the person first and the disability second.

“I encourage them to do whatever it takes to enable a person to feel relaxed and empowered, whether it be dancing into operating theatres, completing a dental assessment in the car park or playing ABBAs Money, Money, Money while taking a patient’s blood pressure.”

Figuring out how to establish the correct and most effective channels of communication is the key to working with people with intellectual disabilities, declares Dina.
“Staff must be prepared to make reasonable adjustments for each individual and, remember, every person is an individual with their own strengths and weaknesses.”

To this end she has developed tools, including the pink passport she introduced into the hospital to help bridge difficulties in communication between people and staff members. The passport provides simple guidelines on the needs of the person, whether for taking medicine, completing a clinical assessment, visiting the dentist or having a meal.

Part of her role is to educate staff around intellectual disabilities, autism spectrum disorder and dual disability (intellectual disability and mental health), and she also does follow up referrals from health professionals, visiting people in their homes for assessments on physical or behavioural or cognitive dysfunction.

Establishing the position

Dina emigrated to New Zealand from England in 2002 to work at Kimberley Centre, the only specialist institution in New Zealand for people with intellectual disabilities. After a year she was promoted to the role of clinical nurse specialist, high and complex behaviours. When the Centre closed four years later, Dina found her specialist role didn’t exist in community or general hospital settings.

With the support of her then director of nursing, Sue Wood, she built a case for the creation of a clinical nurse specialist role for intellectual disabilities at Palmerston North Hospital.

“I developed a report and business plan based on recommendation three of the 2003 document To Have An ‘Ordinary’ Life – Community Membership for adults with an intellectual disability. It was produced by the National Advisory Committee on Health and Disability for the Minister of Health and the Minister for Disability Issues.”

The essence of recommendation three was the systemic neglect of the health of adults with an intellectual disability needed to be urgently addressed. It listed, amongst many points, the need for clearly developed policies for access to services, comprehensive health assessment tools, appropriate staff education programmes and good health promotion material.

Dina’s business plan was adopted and she was offered the position, which she has now held for nine years.

“Some DHBs have clinical nurse specialist roles specialising in intellectual disabilities across mental health but this role is working with people with intellectual and developmental disabilities of all ages across the whole of secondary health.”

Impact on users

Having a specialist nursing role in intellectual disabilities definitely impacts positively on the quality of care for people with intellectual disabilities, says Dina. Patients, family, whanau and carers now feel they have a voice that is recognised, heard and acknowledged.

“Parents of people with complex needs have gained confidence in the certainty that there is a health professional with the knowledge and skills to assess and support the individual needs of their loved one. Strong relationships have also been fostered with the local intellectual disability services enabling greater coordination of care and delivery of services.”

Ongoing role development

In 2012 Dina changed her title to clinical nurse specialist lead developmental disabilities to better reflect the increasing number of referrals she was receiving of people with a diagnosis of autism but no intellectual disability. Her role continues to develop, with Dina now receiving referrals from the Needs Assessment and Service Coordination (NASC) agency, GP practices and intellectual disability services working in health promotion and preventative roles.

Since being in New Zealand, Dina has undertaken a Graduate Diploma in Psychiatric Nursing and completed a Master’s of Nursing. Both qualifications have enhanced her holistic approach to assessment and care, with the acute nursing focus of the Master’s degree also furthering her skills, knowledge and ability to complete advanced physical assessments.

“I encourage health professionals to adapt their practice to meet individual needs, focusing on seeing the person first and the disability second.”
The pink passport

The pink patient passport is a popular tool, introduced to Palmerston North Hospital by Dina in 2006, to promote better and more empathetic communication between patients and staff. Dina had used a similar system in England so she knew how useful it was for people, families and health professionals. “When I first took up my position, I wanted to establish something that would have an immediate benefit for as many people with an intellectual disability as possible, as well as any person who presented with a communication impairment,” explains Dina.

She says the pink passport helps people who don’t physically have a voice to be heard, understood and safe when using health services. It also helps staff become more effective with their care and communication.

Family, friends and whānau provide the information and tips for the passports that are written in simple language and are easy to follow. The passport’s first section outlines the vocal and non vocal expressions of the person. For example, if someone is twitching or twisting their hair, the booklet will explain whether that means they’re stressed, angry or happy and explain how to manage the response.

Another page outlines the process of daily living activities, such as eating, drinking and dressing, says Dina. “It might say the person can communicate using sign language, or picture cards, or that the person is hypersensitive to certain textures or colours because of sensory overload.”

If the passport states the person can’t use a knife and fork but can use an adapted spoon, then the caregiver/health professional knows to provide that rather than disable the person further by taking away that ability. There is also a section explaining the person’s individual coping mechanisms for procedures like blood samples or blood pressure or taking medicine.

“Anaesthetists, in particular, are very supportive about helping people feel comfortable in what is a scary, unknown environment. They will play a favourite tune, sign with them, even dance if it helps. It is about just thinking outside the box a bit more.”

Dina has also introduced a comprehensive annual health assessment, My Yearly Health Check, which is written in plain language for people with an intellectual disability.

“This tool developed out of a nurse-led clinic for annual health checks that I did as part of my Master’s study. The tool has since been adopted by a number of intellectual disability services.”

She has also been involved in developing a preoperative health questionnaire for people with intellectual disabilities, and leaflets with visual cues that she is helping create in conjunction with the New Zealand Down Syndrome Association.

Disability workforce development update

A helping hand for highest attainable health

by Frances Anderson, regional facilitator, DWD

www.tepou.co.nz/supporting-workforce/DWD

Article 25 of the United Nations Convention on the Rights of Persons with Disabilities acknowledges that people with disabilities have the right to the “highest attainable standard of health” and that health services are accessible responsive to issues of gender, community based and free (UN General Assembly, 2009).

However we are some way from attaining this. Disabled people experience a range of health disparities such as lower participation in screening programmes and a greater incidence of preventable health conditions. The starkest contrast is the significantly lower life expectancy of particularly those with an intellectual impairment, for whom it ranges from 18-23 years less than the general population.

Some disparities may be due to the health conditions associated with specific impairments. But like the drivers of inequity for those with addiction or mental health issues, outlined in the Equally Well position paper, disabled people face a similar range of systemic, iatrogenic and workforce factors.

Te Pou is working with stakeholders across both sectors to support the solutions that are required to improve this situation, compiling information and resources that can help those in the health workforce strengthen disability responsiveness and those in the disability workforce strengthen their health knowledge.

If you would like to receive further information on this project please contact Frances Anderson (frances.anderson@tepou.co.nz).
This article provides an opportunity for nurses to learn more about how we can take action to support the people we serve to improve their physical health outcomes. We need to consider how we can do this in a supportive way that respects the person’s own needs and wants regarding their health.

It’s so important that we become familiar with the literature about this issue to inform our practice. In this edition we have included an insert of the infographic for you to use that highlights key findings.

It’s now well known that people who experience mental health and addiction problems also often face reduced longevity and more physical health issues than other population groups. Equally Well is a national programme of collaborative action to create better equity in physical health outcomes for people who experience mental health and addiction issues. This programme was initiated by Te Pou and Platform Trust and its members, and is coordinated by Te Pou.

The Principles of Equally Well

**Policy level recognition**
People with mental health/addiction issues should be recognised as a priority group, based on their exposure to health risk and relatively poor physical health outcomes.

**Equal access**
People with mental health/addiction issues have a right to access the same quality of care and treatment for physical illnesses as everybody else, including assessment, screening and monitoring for physical illnesses.

**Personal support**
People with mental health/addiction issues have a right to understand how their physical health is affected by that experience and the medication they take as a result, and to enhance their physical wellbeing.

**Information and resources**
Organisations can access evidence and resources on the Te Pou website to support action in their areas of work and connect with other organisations working towards similar goals.

Resources

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

This evidence review brings together information on the extent of the issue in New Zealand, and approaches that are underway around the country to address it. The review highlights the need for a coordinated and concerted response, and points to further work that needs to be undertaken. Importantly, this work must be done in partnership with the people who are most affected by it – mental health and addiction service users and their families. [www.tepou.co.nz/library/tepou/the-physical-health-of-people-with-a-serious-mental-illness-andor-addiction-an-evidence-review](http://www.tepou.co.nz/library/tepou/the-physical-health-of-people-with-a-serious-mental-illness-andor-addiction-an-evidence-review)

**Podcast**

**Infographic and presentation**
The key findings from the evidence review are illustrated in these resources. [www.tepou.co.nz/library/tepou/equally-well-evidence-review-key-findings-infographic-and-presentation](http://www.tepou.co.nz/library/tepou/equally-well-evidence-review-key-findings-infographic-and-presentation)

**Equally Well consensus position paper**
The Equally Well consensus position paper has been written in consultation with a range of agencies. Organisations can show their commitment to Equally Well by formally endorsing the position paper. Please feel free to check this out, [www.tepou.co.nz/library/tepou/equally-well-consensus-position-paper](http://www.tepou.co.nz/library/tepou/equally-well-consensus-position-paper)
Schizophrenia and physical health: what does the data say?

by Mark Smith

Schizophrenia is a serious mental illness that affects people’s mental health in many ways. We also know that people with this condition (or conditions if you prefer) have poorer physical health outcomes than other New Zealanders.

Given that New Zealand collects data on diagnosis and outcomes which go into the national mental health and addiction information collection (known as the Programme for the Integration of Mental Health Data or PRIMHD) we will have some idea on how schizophrenia affects a number of items, including physical health.

The following table shows the number of people over a one year period, April 2013-March 2014, diagnosed with schizophrenia or paranoid schizophrenia in New Zealand’s mental health services.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Schizophrenia</th>
<th>Paranoid Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>2,633</td>
<td>1,770</td>
</tr>
<tr>
<td>Pacific</td>
<td>805</td>
<td>557</td>
</tr>
<tr>
<td>Other</td>
<td>4,592</td>
<td>2,621</td>
</tr>
<tr>
<td>Total</td>
<td>8,030</td>
<td>4,948</td>
</tr>
</tbody>
</table>

These numbers amount to an approximate population prevalence of 0.25 per cent. Most studies for schizophrenia place it in the 0.3-0.4 per cent prevalence range. Therefore the figure of 0.25 per cent would indicate underdiagnoses or misdiagnoses in the New Zealand context.

The numbers of people with paranoid schizophrenia who are Māori are higher than might be expected and, given the population, this seems an interesting area for further exploration. However, we do know that diagnosis is poorly captured in New Zealand. This is due to a number of factors, for example the use of different classification systems with slightly different criteria in diagnostic and statistical manuals (DSM), currently on the fifth revision, and the international classification of disorders (ICD) now on the tenth revision. It is a fact that inter-rater reliability is not especially high for diagnosis generally and for schizophrenia in particular. Finally there are the problems with differential diagnosis given there are different types of schizophrenia.

Also, we know that diagnosis can be a cause of stigma and discrimination and that inappropriate diagnosis can make recovery harder. For this reason we need to be very careful with diagnosis while still ensuring we are capturing the data about schizophrenia. When we consider schizophrenia and outcomes for inpatient and community services we find some interesting information.

Graph 1 shows item 5 on HoNOS is connected to physical health, and this indicates around 20 per cent of admissions to inpatient units were in the clinical range (that is scored 2 or higher on HoNOS). It can be seen that the physical health item is comparable for people with schizophrenia and all other diagnoses.

**Graph 1:** Percentage of collections in clinical range on each HoNOS item, Schizophrenia vs. not been diagnosed with Schizophrenia, inpatient admission, New Zealand Apr 2013 – Mar 2014

**Note:** Percentage of service users in the clinical range (2, 3 or 4) for each HoNOS item. Schizophrenia: DSM-IV = 295, ICD-10 - F20.0, F20.1, F20.3, F20.5, F20.6, F20.8, F20.9

Source: Extracted 9 July 2014 from PRIMHD by Ministry of Health, analysed and formatted by Te Pou
It can be seen that the physical health item is comparable for people with schizophrenia and all other diagnoses.

Graph 2 shows that in the community the percentage of admissions in the clinical range was comparable to inpatient admissions, with around 20 per cent having a score of 2 or more on HoNOS.

Clearly this information raises a number of questions. Is the data accurate and reliable? Would we expect the physical health of people with schizophrenia to be lower than for other mental health problems? Would we expect community admissions for physical health to be lower than inpatient admissions?

These are questions that warrant further investigation. However, given we are already collecting this information it emphasises the need to ensure we input good and reliable information into the system and that we monitor the physical health of people with schizophrenia and other disorders.

Graph 2: Percentage of collections in clinical range on each HoNOS item. Schizophrenia vs. not been diagnosed with Schizophrenia, Community admission, New Zealand Apr 2013 – Mar 2014

Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOS items. Schizophrenia: DSM-IV = 295, ICD-10 - F20.0, F20.1, F20.3, F20.5, F20.6, F20.8, F20.9

Source: Extracted 9 July 2014 from PRIMHD by Ministry of Health, analysed and formatted by Te Pou

The HoNOS tool now available

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

How to access the HoNOS tool

- **Online:** The tool is also available as online at https://honos.co.nz for use on desktops, laptops and Windows devices (phones and tablets).
- **Android:** Launch Google Play on your Android phone or tablet and search ‘HoNOS’.
- **iOS:** Launch The App Store on your iPhone or iPad and search ‘HoNOS’.

Your data will sync across devices so you can use your computer, phone and tablet – whatever suits you best. Create an account (https://honos.co.nz/register) and start now!
In March 2011, the New Zealand Government put a stake in the ground and committed internationally to New Zealand being smokefree by 2025. Is this achievable? Yes, but only if it's well supported by a concerted effort from all health and social sector agencies. If current trends continue, and without further focused intervention, mental health and addiction service users will be the only people left smoking come 2025, arguably providing yet another reason for social isolation, stigma and discrimination.

Currently 15 per cent of the New Zealand population as a whole smokes tobacco1 while between 32-56 per cent of people who use mental health and addiction services smoke tobacco.2 People with other substance use disorders are also more likely to smoke tobacco with one early study of people in treatment showing that up to 73 per cent were smoking tobacco at that time.3 Smoking prevalence in the mental health and addiction services workforce has also been observed to be high compared to other health professionals.4

People who experience mental health and/ or addiction problems over their lifetime die much earlier than others in the general population, with a two to three times greater risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature mortality is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5 Two-thirds of this premature death is due to cardiovascular disease and cancer, both diseases that increase the risk of premature death (defined as dying before the age of 65).5

Historically the mental health and addiction sector accepted tobacco use as being of lesser risk than other behaviours. In the past access to tobacco was also used for behaviour modification as well as a currency and reward system in institutional settings. Smoking cigarettes together was also often seen as an acceptable way of building rapport between people using services and staff. Many people also believed that smoking relieved client stress. However, a recent meta-analysis of 26 studies found consistent evidence that smoking cessation is associated with improvements in depression, anxiety, stress, quality of life and positive effect.6 This benefit was similar for people in the general population and for those with mental health disorders.7

Health providers working in the mental health and addiction sector can be instrumental in supporting a smokefree culture. One way is to introduce the ABC brief intervention approach.

The ABC approach

- Asking people about their smoking status and documenting this, providing
- Brief advice to stop smoking to all people that smoke, and strongly encouraging every person who smokes to use
- Cessation support. Cessation support usually works best when there is a combination of behavioural support and stop-smoking medicine such as Nicotine Replacement Therapy (NRT). The cessation support stage is the key, and it is vital that assistance is provided to help people access the support they require.

Any registered health professional can complete the online ABC training course to learn how to support people who want to stop smoking tobacco and to become a NRT provider (see http://learnonline.health.nz). The importance of offering stop smoking support to those that smoke is highlighted in the New Zealand Guidelines for Helping People to Stop Smoking, www.health.govt.nz/publication/new-zealand-guidelines-helping-people-stop-smoking.

Workers who smoke tobacco are less likely to provide cessation support to people who use mental health and addiction services. Supporting staff when they are ready to address their own tobacco use may make it more likely that they will in turn support the people they are working with who want to stop.8 Organisations can put in place a number of initiatives to support workers who wish to stop smoking tobacco, such as:

- inviting quit support agencies to visit the workplace to provide support to staff as well as people using the service
- agreeing to pay the pharmacy part-charge that is required when accessing subsidised Nicotine Replacement Therapy
- general health promotion strategies such as running internal smoking awareness campaigns and competitions.

If you don’t feel people within your organisation have the time to learn how to provide intensive cessation support there are a number of free quit smoking support services available. Find out what is available in your local area at www.smokefreecontacts.org.nz/search/filter/cessation-services/.

When 2025 arrives we need to be confident we’ve done all we can to support people who use mental health and addiction services to stop smoking tobacco when they are ready to do so.

Please feel free to contact Leanne if you have any questions, leanne.kirton@nra.health.nz.

References:
1 - NZ Census 2013
2 - Tobias et al, 2008
3 - Adamson et al 2006
4 - Edwards et al, 2008
5 - http://www.tepou.co.nz/improving-services/physical-health/the-evidence
7 - ibid
Blueprint Leadership Innovation Awards - *Nurses making a difference*

Blueprint for Learning is passionate about developing leadership skills in people. Its programmes are among a very limited number of programmes in the world where students from backgrounds of consumer, clinical and management study together to develop a sector-wide culture of leadership excellence.

Nathan Davis and Meg Baillie received the Blueprint Leadership Innovation Award in 2013 which is given to students who have completed a project within their workplace. The project needs to show innovation, support change and make a difference for people who use their services. Their award winning projects which were implemented within their services as part of the Leadership Programme are described below.

**A group effort**

'Toast, a cup of tea and knitting' has resulted in positive changes at the Mental Health Admission Unit (MHAU) at Nelson Marlborough DHB.

Nathan Davis, inpatient manager – Mental Health Directorate for the Nelson Marlborough District Health Board, completed a leadership programme with Blueprint in 2013. As part of his course he completed a six month research project.

Nathan chose to focus on creating positive change for the clinical team and service users by introducing new opportunities for engagement and connection. To do this he encouraged staff to try new things, while letting low-priority administration tasks wait; and he supported staff around any anxieties about the extra time they needed to spend on the ward.

Over several months the team introduced a number of new initiatives including a knitting group, an exercise group and having breakfast together with service users.

“All of these things helped to improve our relationships in the unit. It demonstrated to service users that staff really did care and were interested in them as people, not just in getting them to take their medication.

“Interpersonal attention and support makes the difference in inpatient success and care. By communicating more freely we have broken down barriers and there is more trust.”

The end result was an overwhelming success and staff are continuing to look for innovative ways to improve engagement.

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**Allowing the team to take charge and come up with their own ideas was crucial to the success of the project, Nathan says.**

"The project helped staff see the things that were crowding their days which were preventing them from 'walking alongside a person in distress and providing hope, encouragement, support and healing'. These concepts had tended to get lost in the administration work of the hospital system.

"It was really good for the team spirit. It was really inclusive – we had psychologists, nurses, service users and visitors all working together."
We are continuing to look for the things that are working and for the things that can work better. It’s made us more self-reflective as a team. The team building part has been a great side benefit.”

Personally, Nathan says it has meant he had to model the behaviour and outcomes he was looking for and, as a result, he has re-discovered his passion for his work.

“I’ve been interested in positive psychology for a long time. I’ve often found that it doesn’t exist, particularly in the aged care and disability workforce. The project was a good opportunity to take the skills I’d learnt in the classroom and apply them to the real world.”

Meg started by surveying people working in the sector. From that she produced a workbook that outlined things people could do to make their interactions with colleagues more positive. The Promoting Positive Organisations Workbook is based on the principles of positive psychology. It covers topics such as emotional intelligence; self-acceptance and self-compassion; self-esteem and confidence; strategies for positive communication; gratitude; forgiveness; happiness; and mindfulness in the workplace. It also asks what we can do individually to make workplaces happier.

“Over the years there have been large changes and this level of connection and engagement had lessoned. I re-discovered the joy of doing and interacting with people within our service. Fun and enjoyment really do help to get successes.”

Nathan says one of the biggest advantages of Blueprint’s leadership programme is the ability to take the skills you learn in the classroom and apply them in the real world.

“After hearing about the work I was doing, one of my colleagues has enrolled in the 2014 programme.”

You can read more about Nathan’s work at www.tepou.co.nz/stories.

Changing negative workplace attitudes

As part of her leadership course Meg undertook a six month research project. Meg looked at negativity in the workplace and how to change it.

She identified she had witnessed negative interactions between health professionals during her 30 year health career and wanted to find ways of creating a more positive working environment.

Over the years Meg has worked as a nurse, managed a private hospital and is currently consulting in the health care sector as well as running a natural skincare business.

Meg says there are wins for everyone. Workers enjoy going to work more; employers have more engaged and productive staff.

“Improving engagement helps with productivity in an organisation. The happier people are the more productive and creative they will be. When people flourish so too does the organisation.”

Meg is now looking at turning her research into a half day workshop for people working in the health sector.

“The Blueprint leadership programme was incredibly valuable. I found the content very dynamic and interactive, and the lecturers really helpful and supportive. I met people on the course that I still network with.”

Te Pou funds the Blueprint Leadership Programme, for more information please visit www.tepou.co.nz/training/leadership.
Mindfulness-based stress reduction training for acute mental health staff

To enhance the supports in place for staff working in Te Whetū Tāwera, acute adult mental health unit at Auckland District Health Board (DHB), an initiative in mindfulness has commenced.

Training for staff in Mindfulness-based Stress Reduction (MBSR) has been implemented by Nadav Avny, a clinical psychologist at Te Whetū Tāwera. The programme is fully supported by leaders and managers.

MBSR is an evidence-based intervention that can help reduce stress and burnout among health care professionals. Nadav describes mindfulness as "a way of intentionally paying attention to, and being present with, whatever is happening in our lives while maintaining an accepting and non-judgmental awareness. Accordingly it involves cultivating an alternative way of being with our experiences in general and with difficult feelings, thoughts and physical sensations in particular. This increases our ability to consciously respond to situations, rather than simply reacting, and enables us to cope better with stress, enhance our resilience, reduce burnout and improve physical and emotional wellbeing."

The idea for the programme emerged while Nadav was working at Counties Manukau DHB. There, his colleagues Dr Jo Soldan, a clinical psychologist, together with Dianne May (Mindfulness Auckland), had developed a shorter version of MBSR training for a range of staff working at Counties Manukau DHB. When Nadav came to Te Whetū Tawerā in late 2012, he introduced the concept to the clinical leadership and management group. They readily embraced it and he began setting up the programme. Other senior managers, Dianne May and Dr Jo Soldan, have been 100 per cent supportive in establishing the programme, which has made all the difference. The programme fits well with the organisation's commitment to healthier workplaces and integrates well with strategy three (workforce development) of the Six Core Strategies© to reduce seclusion and restraint.

The programme
All staff, nurses, doctors, allied health and administrators are invited to attend the programme which is held on site at the wharenui. The programme runs over an eight week period and is comprised of weekly two hour sessions and a one day ‘retreat’ at a local wellbeing retreat centre. The programme trains around 12 staff at a time and so far Nadav has delivered four courses. The training has now been extended to staff from Auckland DHB’s Adult Community Mental Health Centres. The programme includes a silent retreat day which usually takes place between session six and seven. During this day participants are guided by the facilitator through the various mindfulness practices. The retreat day is an essential part of the MBSR programme as it brings together all of the mindfulness practices covered in the course and allows for their further deepening. Nadav says he finds participants’ commitment and engagement with the programme inspiring and has a sense of gratitude for having the opportunity to walk this type of journey with his colleagues.

Measuring effectiveness
Nadav is developing a research project to assist with evaluating the impact of the MBSR training programme on staff. This project was approved by the Auckland DHB Research Committee. Participants are encouraged to complete anonymous outcome measures at the start and end of the course and three months after the course, using both paper questionnaires (Maslach Burnout Inventory – Human Services Survey, Brief Resilience Scale, Five Facet Mindfulness Questionnaire) and an engaging online evaluation by GROW (www.growhq.com), which covers a number of wellbeing related variables.

Feedback from staff
Jiajia Chen, a mental health nurse at Te Whetū Tawerā and university clinical nurse educator who completed the MBSR training says: "As an experienced mental health professional I thought I had been dealing with my own feelings and emotions fairly well! I now take a second thought after taking Nadav’s MBSR programme at work. I had training in this area through work in the past and always recommended it to clients. However, and it probably sounds corny, participating in MBSR is life changing! I had no idea how detached and repressed I was, and..."
now I’m able to feel more in touch with my feelings and be truly calm towards challenges. I find regular mindfulness practice helps me keep in touch with the present and reduces my stress level in life and work, and enables me to have my own space to stay in equilibrium. I would like to invite you to feel that for yourself. The idea in mindfulness is not to expect anything, and I believe the result is surprising."

Further information
If you would like to read more about MBSR try these following resources.

Centre for Mindfulness in Medicine, Health care and society: www.umassmed.edu/cfm/stress/index.aspx

Mindfulness Training Institute Australasia: www.mtia.org.au

Care Capacity Demand Management

by Brenda Hall, programme consultant, Safe Staffing Healthy Workplaces Unit and Paul Stewart, charge nurse, Southern District Health Board

The Care Capacity Demand Management (CCDM) programme was developed by the Safe Staffing Healthy Workplaces (SSHW) Unit in partnership with participating district health boards (DHBs) and health unions following the recommendations of the SSHW Committee of Inquiry Report 2006. It was initially between DHBs and the New Zealand Nurses Organisation (NZNO). Other unions, including the Public Service Association (PSA), have subsequently joined the programme governance and activity.

CCDM is about improving the quality of care for patients, the work environment for staff and organisational efficiency. All aspects are equally important and a balance must be achieved which does not sacrifice one aspect in order to achieve the others.

The programme is an organisational approach to ensuring the demand for patient care is matched accurately and effectively with the resources required. Engaging and involving staff at all levels acknowledges that all staff influence and contribute to the successful functioning of the organisation.

Mix and Match is the part of the programme that enables a service to determine the most productive match between demand and base staff resourcing. This includes the determination of skill mix, staff numbers and scheduling.

In February 2014, the Mental Health, Addictions and Disability Advisory Group (MHADAG) was formed to ensure Mix and Match was fit for purpose in DHB inpatient mental health units. Membership is made up of DHB leadership, frontline and union staff.

Mix and Match in the CCDM by Brenda Hall

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In February 2014, the Mental Health, Addictions and Disability Advisory Group (MHADAG) was formed to ensure Mix and Match was fit for purpose in DHB inpatient mental health units. Membership is made up of DHB leadership, frontline and union staff.
Work started with a survey of TrendCare users in DHB mental health, addiction and disability services to gain a user perspective on the use of TrendCare. Survey results indicate the majority of respondents have concerns about the use of TrendCare in mental health services. Almost half the respondents strongly disagree that TrendCare accurately captures all aspects of their work. The survey is being followed by a series of focus groups with staff to further understand and address their concerns at a national level. Currently, a pilot of the Mix and Match work is being undertaken at Wakari Hospital in Dunedin to ensure the process is fit for purpose for mental health settings.

The survey report recommendations included the running of a ‘train the trainer’ workshop focussed on the mental health setting for TrendCare coordinators and champions from the mental health setting; the identification and inclusion in national training of a consistent way to capture the staffing intensity required to reflect multiple staff providing care at one time to one person; and working with DHBs to identify consistent use of patient types and indicators to enable benchmarking.

The recommendations have been endorsed by the MHADAG, together with the recommendation to DHBs that following the evaluation of the Mental Health Mix and Match Pilot, the Mix and Match Part One (Work Analysis), be undertaken in all inpatient mental health units that use TrendCare. This will enable a more detailed understanding of staffing activity and therefore assist in the identification of appropriate staffing profiles for service user and staff safety.

Southern DHB pilot by Paul Stewart

On 1 September ward 9b, intensive care acute inpatient unit, embarked on a two week voyage into the realms of Mix and Match. This was an interesting process and one that all staff were reasonably accepting of, even though it added to their weekday activities. The pilot was well prepared beforehand with good guidance and support from Brenda Hall from the SSHW Unit and the local NZNO organisers Lorraine Lobb and Simone Montgomery.

We found that, while the project required a reasonable amount of work, it worked well due to the positive uptake by the staff and the DHB. Fortunately, I was able to discuss Mix and Match with Shayne Wylie who has been involved with several of these within the general wards of Southern DHB. He was able to give sage advice on how to make it easier it to manage and organise.

The process depended on a number of people and two that must be mentioned are Stacey Smart, associate charge nurse and Jean Wiseman, administration support for being very organised and putting together the data sheets and coordinating their recording and collection.

All staff on the ward responded to the project and willingly undertook the data collection requirements. This was evident by the comments on the ward about having “filled in your 15 minute activities” and also by the state of some of the forms after being folded and unfolded as recording were made.

Registered nurse Epe Elisara reported she found the process was ‘ok’ but what was really interesting was that she was now able to look back and see what she did during the day in more detail, rather than the usual overview at the end of a shift. Epe indicated she was surprised about the wide range of work activities undertaken and how busy she was at times.

Another staff member said she had to finish a sheet at home as she was too busy to finish it at work.

Certainly the need to do the data sheets in a small block was the best advice provided, as it became difficult to remember in detail what you did exactly if this was left for long periods. Stacey was involved in coding and indicated that the work activities varied a lot between staff. Some staff provided 15 minute information in great detail while others used a single word. Sometimes she found information provided (in the data sheets) was vague and could be open to interpretation.

One issue was the data collection period may not reflect reality given the fluctuating nature of admissions and discharges. However, it is generally felt that the two week period was a realistic representation of the workload the ward experiences. The project resulted in the collection of a significant amount of information which was well supported and coordinated and we all await the outcome with anticipation.

The data collected is currently undergoing analysis and the report will be developed to be returned to the ward in January. The evaluation of the pilot is expected to be completed in February when the advisory group will meet in Wellington.

Heather Casey Director of Mental Health Nursing is fully supportive of the pilot. “Having data that is reflective of the realities of nursing within mental health inpatient wards is a huge positive,” she says.

“Nurses within these settings take great pride in making the complex activities they undertake look easy and relaxed. Mix and Match makes the invisibleness of practice visible. I look forward to being able to use this data to articulate the knowledge, skill and numbers of staff required in a manner that is reflective of the needs of people accessing mental health inpatient services, rather than providing anecdotal evidence which is then often compared to medical and surgical inpatient activity data.”

“The nursing team are to be commended for their attitude and commitment to the pilot. Having their charge nurse involved in the national project has helped, as this project ensured that tools and processes used did actually meet the needs of mental health inpatient realities.”

If you have any questions please feel free to contact Brenda Hall, brenda.hall@dhbsharedservices.health.nz
The Perinatal Mental Health NZ Trust (PMHNZ Trust) had its third birthday this year, and is now enjoying its toddler stage – venturing out and exploring opportunities.

It is exciting to be a part of PMHNZ Trust and watch it become established as the "go to place" for training and information about perinatal mental health resources in New Zealand, raising awareness and educating those who care for young families.

Current government and charity funded support probably reaches at most 2,000 mothers. That leaves around 5,000 mothers, 3,000 fathers and 10,000 children with inadequate or no support every year. While some issues will have a time or period of recovery, others will be accumulating.

A third of women who give birth will still be experiencing symptoms when their child is two years old. The picture of post natal depression (PND) is complex and there are many interwoven potential causal factors, such as isolation, loss of autonomy, loss of financial independence, lack of sleep, hormone changes, body changes, birth trauma, external and internal expectations, perfectionism, lack of support, and a move away from wider whānau and community.

"Women are more vulnerable to developing emotional problems after childbirth than at any other time in their lives and the life-time prevalence of major depression in women is almost twice that of men," says Rosie Smith Chair of PMHNZ Trust.

PMHNZ Trust’s purpose is to educate, network, inform and raise awareness, making it okay for parents to talk about their anxiety and distress, and to access the support they need.

Many families fail to recognise and report distress, inability to cope, unhappiness and frustration for fear they will be targeted with ‘negative attention’ by childcare agencies. The myth of ‘the perfect, happy, smiling, contented mother’ is still around and being perpetuated by the constant euphoric images in the media.

The focus for PMHNZ this year has been on developing partnerships with key agencies including, Father & Child Trust, Midwifery Council of NZ and Parents Centre NZ. PMHNZ Trust works closely with these agencies to advocate for change and development in perinatal mental health training and information. As a Trust, they are conscious that there is much to do to encourage an open and positive dialogue about perinatal mental health. They have been networking all around New Zealand to facilitate awareness, knowledge and policy sharing. There is a passion for enabling the exchange of resources, information and good practice and for opening up the issues about perinatal mental health.

Following on from the extremely successful Symposium last October 2013, when we took over the Psychology Centre at Massey Albany, we held five training/seminar days this year. We even added an extra event

NZ has around 60,000 births per annum, with 40–60 per cent of those not planned. Around 12 per cent will include significant perinatal mental health issues, and at least one in five families will experience mild to moderate distress which could impact on their family and personal wellbeing. Approximate estimates are that at least 7,000 mums, 3,000 dads and 12,000 children will be affected.
Christchurch. Feedback has highlighted the need for specific training in perinatal mental health amongst midwives, childbirth educators and supporters, other perinatal clinicians and other health and social service providers working with young families. Recently, a midwifery training provider shared her intentions to increase the amount of time spent on perinatal mental health issues in the syllabus after attending the Symposium.

The PMHNZ Trust has built up an impressive team of advisors to the Board. These are all New Zealand experts in their own branches of perinatal health, and they have provided wonderful opportunities for other agencies to hear about their work. They have given insight into the many challenges of early parenting and how this affects mental wellbeing.

The PMHNZ Trust urges, encourages and will support agencies to up-skill their staff, so they are not scared to talk about distress and adjustment issues with people. There is always someone else in the agency that staff can share their concerns with. Know who those people are in your network. The mum and/or dad need staff to listen and sit beside them as they struggle with early parenthood – it’s their experience. Families don’t necessarily come forward and speak out because they are afraid that they will be labelled, ignored or referred on to yet someone else.

Do get in touch.

Rosie Smith PG Cert CBT, B Cons., MNZAC, ANZACBT
Chairperson PMHNZ Trust
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www.pmhnz.org.nz

Women are more vulnerable to developing emotional problems after childbirth than at any other time in their lives, and the life-time prevalence of major depression in women is almost twice that of men.

Your stories

Your stories is a feature of the Te Pou website to profile new or unique service developments, quality improvements and other inspiring mental health and addiction initiatives. Here are two recent stories, you can check them out plus more at www.tepou.co.nz/stories.

Physical and mental emphasis in recovery

The health passport and recovery action plan (RAP) workbook helps people gain control over their physical and mental health. The workbook is being adopted by people and professionals within the Tairawhiti District Health Board area. The workbook encourages a more person-centred approach to help people track their physical health. It also aims to reduce stigma by emphasising both physical and mental wellbeing.

Working towards better services in the MidCentral District

A group of leaders and managers from MidCentral DHB, NGOs and PHO have found a way to collaborate to achieve better outcomes. After years of working together the group developed the Connected Workforce – Te Hononga Kaimahi work plan in 2013. This plan ensures that organisations and services supporting people with mental health and addiction issues work better together at a management and leadership level.
So often what nurses and mental health workers do is a bit invisible to themselves.

Over the years I have heard so many stories from service users about a pivotal moment in their lives brought about by the person that has been working with them. Often they are quite ordinary or small things, part of daily work in a busy inpatient unit or appointment, but at that time they mean everything to that person. These are the real stories of recovery and the role of service in those gains.

Here is one that I have permission to tell.

Anne had come in to hospital in a state of overwhelm and chaos. Her head was filled with unfinished overlaying thoughts that screamed despair, fear, pain and distress. Nothing felt like it could ever possibly be okay again and she was lost in a tortured mega-maze of hopelessness. The nurse admitting her noticed she kept squinting and grimacing a little, she asked her if she had a headache, which she did. The nurse ducked out for a minute and came back with a cup of tea and some paracetamol plus a pair of fluffy socks because she had noticed Anne only had jandals on and seemed to be cold.

Anne told me much later what that had meant for her. That small action in making a very distressed person more comfortable had warmed her soul. She said it made her feel seen, of some value and cared for, like a bear hug in a cold dark night. For her it made such a difference and every time she looked at those socks she knew she mattered.

When I heard this story it was some years later – she still had the socks.

Recovery mostly isn’t about winning a marathon, earning six figures or creating a masterpiece. It’s often about gathering up the last ragged threads of courage and grit and taking the next breath for that moment.

You won’t always hear those stories – when people leave the dark behind they don’t want to turn and wave goodbye. But never forget those stories are there and YOU have been a pivotal part in them.

Conference: Te Ao Māramatanga New Zealand College of Mental Health Nurses

15-17 July 2015, Wellington, New Zealand

The 2015 theme “Whanau Ora: New Growth from Old “ has been chosen as it embraces the never ending evolvement of nursing, practices, interventions and the future of New Zealand health.

Whanau Ora is characterised by “family wellbeing”, the “harakeke” in the logo is a metaphor to represent keeping the whānau together and well. We note that if one part of the harakeke is damaged the effect is on the whole plant or in this case the wider whānau and community. The tohu signifies a journey, from kākano (seed) to mature harakeke (flax) and also demonstrates raranga (weaving). The Pūmanawa (a connecting life force of energy) is an integral part of the tohu as it connects the kakano (centre) to harakeke (outside).

Abstract submission opens November 2014 and registration opens January 2015.

Visit the conference website to register your interest, for information about sponsoring and exhibition and to keep updated on the conference programme: www.conference.co.nz/nzcmhn15.
Taking the pledge

By Dr Helen Hamer

How can mental health nurses reduce stigma and discrimination and increase social inclusion for people who experience mental health problems?

In June 2014, a research study titled: Stories of Success: Mental Health Service Users’ Experiences of Social Inclusion in Aotearoa New Zealand was published (Hamer, Clarke, Butler, Lampshire, & Kidd, 2014). The research was funded by the Ministry of Health and commissioned by the Mental Health Foundation of New Zealand to complement the existing suite of research for the Like Minds, Like Mine programme (Ministry of Health, 2007) to counter stigma and discrimination through a national media advertising campaign.

The study was informed by Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health, 2012) which sets the direction for all staff working in mental health and addiction services in seeking to improve the mental health and wellbeing, physical health and social inclusion of people who experience mental health problems.

Two of the commonly reported barriers to social inclusion are the negative labelling and stereotyping of people diagnosed with mental health problems, resulting in their subsequent experience of overt stigma and discrimination (Thornicroft, 2011), and coercion (Ministry of Health, 2011). There are currently many programmes worldwide to reduce and eliminate the exclusionary and traumatising use of seclusion and restraint. One innovative strategy is ‘Taking the pledge’ (Restraint Reduction Network, 2014).

The Restraint Reduction Network is founded on the belief that professionals who work in environments using restrictive practices want improved safety for the people that use services and themselves. They invite professionals who have the desire to work toward creating restraint-free environments to take the pledge to willingly develop a plan outlining their particular strategies for restraint reduction. Each professional can benefit by joining the Network in order to receive the support and learning from their peers and consumer advisors to share approaches, outcomes and best practices.

Of concern, mental health professionals continue to be reported as one of the many discriminating and stigmatising groups that New Zealand service users will encounter (Peterson, Pere, Sheehan, & Surgenor, 2007; Wyllie & Brown, 2011). Can we, the collective of mental health nurses, take a similar pledge to reduce and even eliminate social exclusion, thereby increasing social inclusion for the people we serve? The key themes from our study of the Stories of Success will help us to reposition our practice. What follows are the key findings and the suggestion of the type of pledge that mental health nurses could take.

Firstly, the findings from the Stories of Success study confirmed that social inclusion is a complex, fluid and subjective experience. Social inclusion is not merely the absence of social exclusion. The participants defined social inclusion as the fundamental right to be recognised as an equal alongside others in society.
Pledge: I will challenge any practices in my work setting that do not provide the full recognition of the person’s right to respectful and dignified treatment so that the people I serve will experience care in the same way I would choose to be treated.

Secondly, many participants described their feeling of social inclusion. This was described as a two-stage process. The ‘before’ stage represented the person moving beyond their self-stigma to a feeling that social inclusion was a possibility; the ‘after’ stage represented an increased sense of participants’ personal power, a deepening of social relationships and a belief that they have the right to contribute to society.

Pledge: I will attend to the internal and often deep shame and demoralisation experienced by service users as this can perpetuate their distress. In so doing, I will help the person restore their sense of personal agency and, in turn, promote their recovery.

Thirdly, finding the champions – social inclusion was often linked to a particular person or event. Health professionals, peers, family members and cultural leaders were regarded by participants of the study as champions of social inclusion. The study found that social inclusion was seen to work both ways; including others also meant including oneself.

Pledge: I will be a champion for the people I serve. I will exercise my personal power to advocate and, as required, challenge the existing institutional structures that perpetuate stigma and discrimination towards service users.

Finally, what others did and said played an important role in successful social inclusion. For example, the importance of reciprocity, the give-and-take of social connection, generated mutual positive regard between participants’ co-citizens.

Pledge: I will undertake at least one random act of kindness each time I am with a service user and acknowledge the kindnesses and learning I also receive from service users.

References


"E fofo e le alamea le alamea."

Interpretation: Solutions for issues affecting a community can be found within that same community.

By Debbie Crichton, co-chair National DHB Family Whānau Advisors and Pacific Family Advisor for Takanga A Fohe, Waitematā DHB Pacific Mental Health and Addiction Service

It has been said among Samoan traditional fishermen that if you get stung by the spines of the alamea (crown-of-thorns starfish), you should turn the starfish over and have its spongy-like feet touch the area where you have been stung. The alamea will heal its own doing.

The following is an address given by Debbie at the August 2013 Health and Disability Advocates Conference in Auckland.

My name is Fiapaipai Deborah Puaga-Crichton. I have been named after my mother's mother, my grandmother, who comes from the beautiful island of Savaii in Samoa. My father, who is from the island of Upolu in Samoa, gifted me with the name Deborah after the prophetess in the Bible. Puaga is my husband's father's first name also, and Crichton is the family name. In this way I am never nervous nor apprehensive in presenting publicly for I am a New Zealand born Samoan married to a Samoan born, bringing with me my mother's family and my father's family of which all is centred around God. And for the benefit of all the mainstreamers out their today you can call me Debbie Crichton.

When I speak of my family I refer to eight children ranging from 7-25 years of age and one granddaughter- three boys and five girls including four children for whom we have legal guardianship. My household is made up of a three bedroom home, a double garage and two caravans. We currently have three families living in our home. In total we have eight adults and nine children who live on site. Some would find this hard to fathom. However, Pacific families would relate to this, hence the proverbs that are often referred to by elders such as "it takes a village to raise a child". The circumstances that brought these families to our home are varied and riddled with issues ranging from relationships, financial, immigration and health. And we all know there is no health without mental health.

I have been involved with mental health and addiction services with Waitematā District Health Board for more than 10 years and seen children diagnosed with disorders of dysregulated emotions, depression and addiction issues.

What has worked well
1. Having people who could relate to my story (as a Christian, as a Pacific Island, speaking the language).
2. Having cultural support from people who could share that type of knowledge with children and wider family, giving my family a different voice to hear from.
3. Having people understand family dynamics without judgement.
4. Having a multidisciplinary team under the same roof – nurses, cultural workers, psychologists, social workers, psychiatrists, family therapists, occupational therapists etc.
5. Having a variety of support groups available: men's groups, women's groups, anger management groups, Dialectical Behaviour Therapy groups, family groups, etc.
6. Pacific family forums where different mediums are used to get messages across, music drama, breakout groups etc.

What I would have wanted done differently
1. As Pacific Islanders we have a family centred approach that does not necessarily fit into mainstream frameworks and makes it difficult for providers to work in a family inclusive way.
2. Services available to loved ones that are also made available to their family members.
3. More resources available in ethnic specific languages, i.e. use of medication, diagnoses, signs and symptoms.
4. More Pacific Island family ethnic specific support groups.
5. DBT language specific courses.
6. Recognising the value and connecting with family culture.

As a family we must decide that neither mental illness, alcohol or other drugs, or problem gambling need dominate the whole of life.

I leave you with this excerpt by Tui Atua Tupua Tamasese Ta'isi Efi, Head of State of the Independent State of Samoa.

"I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because I share my tofi (an inheritance) with my family, my village and my nation. I belong to my family and my family belongs to me. I belong to my village and my village belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my belonging."

88x829
family column

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2015 Pacific Mental Health and Addictions Scholarship are now open!

Le Va is committed to contribute to the Government’s intentions to address workforce shortages in the Pacific health and disability workforce. Le Va is going on to its sixth year of managing the Pacific mental health and addictions scholarships on behalf of Health Workforce New Zealand. The purpose of the scholarships is to grow and up-skill the Pacific mental health and addictions workforce as part of our Futures that Work programme. Applications for the 2015 academic year are now open and will close on 20 February 2015.

Eligibility criteria

To be eligible to apply for a Le Va mental health and addictions scholarship, all applicants must:
• be a New Zealand citizen or a permanent resident at the time of application
• be enrolled in a mental health and/or addiction related qualification at a tertiary provider in New Zealand
• submit a correctly completed application form with required documents no later than Friday 20 February 2015.

Completing the correct application form

There are two types of application forms available to download, new and fast-track. Please read the information in the table below to ensure you download and complete the correct application form.

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<tr>
<th>Fast-track</th>
<th>New</th>
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<tr>
<td>You can complete a fast-track application if you:</td>
<td>You can complete a new application if you:</td>
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<tr>
<td>• were a successful recipient in 2014</td>
<td>• are a first time eligible applicant</td>
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<td>• gained a grade point average of 5.0 (B grade)</td>
<td>• were a 2014 successful scholarship</td>
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<td>in 2014</td>
<td>recipient who did not meet the 5.0</td>
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<td>• submit all the required documents no later</td>
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<td>than 20 February 2015.</td>
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<td>recipient prior to 2014 and returning to</td>
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<td>If you don’t meet the criteria above, please</td>
<td>study 2015.</td>
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<td>complete a new application</td>
<td>All applications must be received by Le Va</td>
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Applications close Friday 20 February 2015. Check out www.leva.co.nz or email futuresthatwork@leva.co.nz for more information.