Kaitiaki
NURSING NEW ZEALAND

NEWS

# ‘I won’t be silenced’ – Gisborne Hospital nurse whistleblower fears she is a target after disciplinary attempt

BY MARY LONGMORE

*October 9, 2023*

Tōpūtanga Tapuhi Kaitiaki o Aotearoa–NZNO is taking legal action to support Gisborne Hospital ward 5 nurse Christine Warrander after hospital managers threatened her with disciplinary action over a social media post.


*Christine Warrander, far right, with ward 5 colleagues Carmen West (left) and Carole Wallis, flanking NZNO organiser Lewis Wheatley on the May 24 one-hour strike.*

“I feel they’re coming after me – they’re trying to silence me,” she told *Kaitiaki Nursing New Zealand*. “But I’m going to continue speaking up until the patients and staff are safe.”

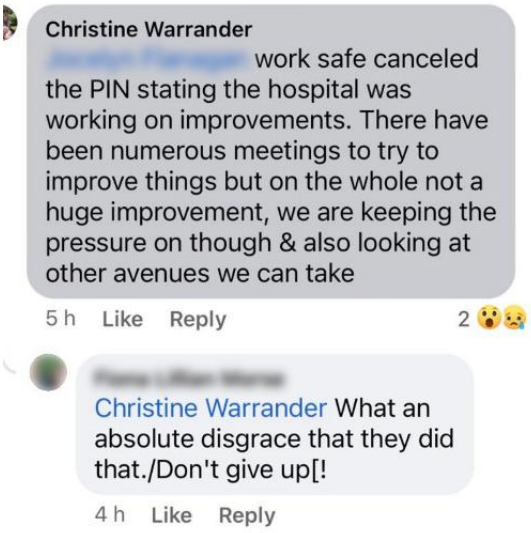
Warrander, an NZNO delegate, told *Kaitiaki* she feared she had a target on her back, since speaking out about unsafe staffing on her ward earlier this year.

“I did think I was going to be hung out to dry. I kind of figured when I stuck my neck out for the ward, that they’d come after me for something.”

> ‘I don’t want other people to be scared that they’re going to be silenced – and I don’t want other people being scared of speaking up for patient safety.’

After lodging a health and safety PIN (provisional improvement notice) in December 2022, Warrander, and about 20 other ward 5 nurses and staff went on a one-hour strike in May — fighting all the way to court to do so, after Te Whatu Ora Tairāwhiti unsuccessfully tried to block them with an injunction.

In August, Warrander posted a brief update on the ward 5 situation in the NZNO–Te Whatu Ora Facebook page (https://www.facebook.com/groups/nznohnztewhatuora), in response to a query.




A few days later, she received a letter from Te Whatu Ora Tairāwhiti demanding an explanation and referring to possible formal disciplinary action over the post.


*Christine outside the Wellington District Court in May, when Tōpūtanga Tapuhi Kaitiaki o Aotearoa–NZNO won the right for its Gisborne Hospital ward 5 members to go on strike for safer staffing.*

"I felt sick to my stomach. I panicked – I went through all the emotions. I was kind of angry." But with the support of NZNO, Warrander decided to fight back.

NZNO lawyers wrote to Te Whatu Ora Tairāwhiti complaining about the "threatening and intimidating" letter.

The lawyers' letter said such threats had a "chilling effect by creating fear in the recipient and others, especially where dismissal is threatened".

> **'It's definitely messed with me, mentally and emotionally. I have days when I'm like: 'Is it really worth it?'**

Te Whatu Ora Tairāwhiti did withdraw the letter, but issued a second one which — while less threatening — was still "totally unacceptable", NZNO chief executive Paul Goulter said.

NZNO had now lodged the matter with the Employment Relations Authority (ERA), over whether Te Whatu Ora's actions were contrary to the NZNO–Te Whatu Ora employment agreement and unjustified, he said.

Warrander said it was disappointing that Te Whatu Ora was putting its time and energy into this, rather than trying to fix the staffing problem on the 25-bed acute medical and COVID ward.

"We're still coming onto shift where there's only two of us on – a couple of weeks ago there was an EN [enrolled nurse] with a new grad."

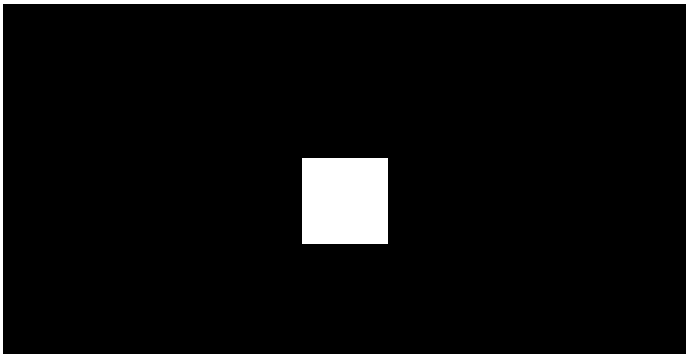
The situation had been extremely tough on her mental health, she said.

"It's definitely messed with me, mentally and emotionally. I have days when I'm like: 'Is it really worth it?' But then you go to work and see your colleagues stressed out and in tears because they have an unmanageable work load and your patients are not getting the care that they deserve."

> **'We're still coming onto shift where there's only two of us on – a couple of weeks ago there was an EN [enrolled nurse] with a new grad.'**

Warrander said she had experienced "huge" support from colleagues and the general public, which had helped her carry on.

"I don't want other people to be scared that they're going to be silenced – and I don't want other people being scared of speaking up for patient safety. So it's like, I have to continue fighting for them."



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NEWS

# ‘Without us, there’s nothing’ – more strikes considered by telehealth nurses

BY MARY LONGMORE

*October 19, 2023*

Telehealth nurses from crisis services like Healthline, ambulance triaging and 111 mental health response are considering two more strikes after rejecting the latest pay offer from employer Whakarongorau, which they say doesn’t reflect their value.


*Whakarongorau's Christchurch staff striking in September.*

“They just don’t seem to value their staff. They appear to value looking good and having all the fancy technology — but all of that is nothing if they don’t have the skilled staff to use it,” NZNO delegate Bruce Tomlinson told *Kaitiaki Nursing New Zealand.*

Staff at national telehealth service Whakarongorau, including nurses and other health workers like counsellors, went on two 24-hour-strikes in September and October, rejecting a 2.5 per cent pay rise after six months of negotiations.

Members are now deciding whether to go on two more strikes in November (16-18 and 25-27), this time for 48 hours. The strike ballot closed at 3pm on Tuesday, October 24.

### Offer ‘falls short’

Tomlinson said Whakarongorau’s latest offer of a 3.75 per cent pay rise still fell well short of cost-of-living increases. It also excluded some senior Healthline nurses who had already received a funding boost from the Government’s pay parity fund. This was despite Whakarongorau’s 2021/22 surplus of $7 million, he said.

NZNO is seeking a seven per cent pay rise for all Whakarongorau nurse steps, backdated to March 1 this year.

Many telehealth nurses were on the frontline of crisis situations, such as 111 mental health calls and ambulance triaging services, as well as mental health support services like 1737 Need to Talk?, he said.

Whakarongorau took 2.2 million calls from 1.6 million people over the year to June.


*NZNO delegate Bruce Tomlinson rallying last month in Hokitika.*

> **‘Without the frontline staff who take the calls, there is no business, there’s nothing else.’**

"We still are the first point of contact for most people who are in distress and we are complementary to GPs, EDs, ambulance and police and mental health crisis teams – those emergency crisis contacts."

Whakarongorau's NZNO members strike in Dunedin earlier this month.

Yet Whakarongorau appeared to want to put more money into technology than people, he said.

**Staff 'most valuable' asset**

"What is the most valuable asset the organisation has? It's their staff. Without the frontline staff who take the calls, there is no business, there's nothing else."

Tomlinson said there had been some gains in the offer — a living wage for the lowest-paid staff as well as the small pay increase — but overall, it still fell well short.


Whakarongorau's NZNO and PSA members on strike in Wellington this month.

Over the past month, five members from the mental health team alone had quit for better pay elsewhere, he said.

**Surpluses 'no more'**

Whakarongorau's chief employee experience officer Anna Campbell told *Kaitiaki* while it had made surpluses previously, the organisation made a loss in 2022/23 and was forecasting a loss again this financial year.

"Each year we need to live within our means and currently our expenditure is greater than our income," she said in a statement.

> **'Because Whakarongorau is a social enterprise, that [$7 million] surplus was invested into staff as well as infrastructure and technology to support them and their mahi.'**

Due to short-term COVID funding, in 2021/22 Whakarongorau made a surplus of $22 million — however this was divided between the telehealth service and its two owners, primary health-care organisations Pegasus Health and ProCare, who each received just over $7 million.

"Because Whakarongorau is a social enterprise, that [$7 million] surplus was invested into staff as well as infrastructure and technology to support them and their mahi."

Pegasus Health's 2022 annual report (https://issuu.com/pegasushealth/docs/annual-report-2022) (p35) describes a "very strong performance" from Whakarongorau for its response during COVID as a financial highlight with "extraordinary volumes" of activity.

*Anna Campbell*

**Pay disparity for telehealth nurses 'unfair'**


*NZNO timeline for Whakarongorau negotiations.*

Campbell acknowledged it was unfair to pay telehealth nurses less than Te Whatu Ora staff.

This was why Whakarongorau had joined 11 other community and telehealth organisations to lobby Government for pay parity, she said.

Whakarongorau's 40-plus telehealth services include Shine domestic abuse helpline, the National Poisons Centre, RecoveRing alcohol and drug support and after-hours support for general practices.

Tomlinson said Whakarongorau also stopped its early response mental health and ambulance triaging nurses from striking on September 8 with a last-minute injunction, claiming they were essential life-preserving services (LPS).

However, LPS had now been agreed between the parties, so those members would be able to participate next time, Tomlinson said.

About 300 staff at Whakarongorau are being represented by their unions, Tōpūtanga Tapuhi Kaitiaki o Aotearoa — NZNO and the Public Service Association (PSA).


*Whakarongorau staff strike in Wellington on October 8.*

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OPINION

# Dementia: Can we understand elder abuse better by understanding the effects of carer abuse?

BY ANONYMOUS*

*October 10, 2023*

A family carer describes the effect of the psychological abuse she suffered from a relative with dementia and worries that carers do not receive the support they need.

*Abuse by the patient is usually a result of the behavioural and psychological symptoms of dementia. Photo: iStock*

It is shocking and unacceptable that some dementia patients receive abuse from their caregivers. However I am also aware that many caregivers — up to 30 per cent in some data[1] — receive and deal with abuse from the dementia patient they care for.

Caregivers can also be abused by their family, who can completely misunderstand the situation that the caregiver is dealing with.

Given that the vast majority of community caregivers are female and unpaid for what they do, there is an issue here that is mostly hidden. This carer abuse is mainly undocumented and can affect caregivers both mentally and financially.

Community organisations, while supporting carers, do not seem to accept that the carers may need to recognise abuse *from* the dementia patient and learn to cope with it, *before* it accelerates to retaliation, ie patient abuse.

### Difficult to talk about

I have written this article hoping to educate carers about the abuse that may happen to them. Once abuse by the patient happens, the carer may find it difficult to even talk about, because of feelings of guilt and reluctance to tell others.

What can we do about it? How can we educate others — both carers and family — so they recognise that carer abuse can be part of dementia?

People with dementia can abuse their carer. This kind of abuse, despite the fact that it is unintentional, is as unacceptable as intentional abuse, and is usually a result of the behavioural and psychological symptoms of dementia.

## Are carers 'prepared' for the abuse that can arise while they take care of a patient?

To prevent abuse, carers must receive support. Why is this so little spoken about and acknowledged?

I am in no way condoning the abuse of dementia patients by carers. But could part of the problem be that dementia patients are abusing the ones they love – their carers? Are carers "prepared" for the abuse that can arise while they take care of a patient?

What does this abuse do to the carer's mental and physical welfare? Are carers supported in coping and understanding the abuse that can come from dementia patients?

What strategies are the carers using to cope with the abuse they are receiving? What lessons can other carers learn from them?

There are questions here that I feel are largely ignored because they are in the "too hard" basket.

I visited, loved and cared for my aunt over the final years of her life. I watched and knew she had paranoid dementia. I instantly forgave her all the abuse that she gave me – calling me dumb, a thief, a bully, and swearing at me.

She called me "the most selfish person she had ever met", told me I had "avaristic eyes", that I couldn't possibly have a master's degree because I was "too dumb", that I was "stealing" from her (what, I don't know), that she had to "hide her purse under her bed" (why, I don't know).

She said similar things to me about my brothers and sisters — which I instantly dismissed, as I knew they were part of her dementia.

**Signs of carer distress**

- avoiding the care recipient
- anger
- fatigue
- depression
- impaired sleep
- poor health
- irritability
- feeling of hopelessness

*Home carers need support and advice on how to deal with abusive behaviour from family members with dementia. Photo: iStock*

Communicating with my aunt became more difficult as she would frequently "misinterpret" what I said. I am sure she became frustrated or felt frightened, leading to angry outbursts.

One day I arrived to find that the lock on her outside door had broken. She told me that it was my fault and, since I owned a door factory, I should immediately fix it. It was hard not to laugh because she was serious — but I didn't.

I tried to find a suitable company in the phone book — all the while she was getting more agitated and telling me she didn't want them because it would "cost her money" and that's why I should do it.

In the end I went home, found someone to help, got them to come to my place and I walked them down to do the job. I had to introduce him as one of our "employees" and paid the bill myself.

#### Actions born out of frustration

I never heard about the door company again. I think my aunt's actions were born out of frustration that the door broke, knowing that she could not organise getting it fixed and fearing it would no longer lock and keep her protected.

The impact of understanding, supporting and loving my aunt while she had dementia was and is huge. But the impact of my family's lack of understanding about my role as her caregiver has been even worse.

I had all the warning signs of needing carer support — such as avoiding my aunt, anger, fatigue, depression, impaired sleep, poor health, irritability or that terrible sense that there is "no light at the end of the tunnel".

But when I asked my family for help, I was ignored time and again. My aunt constantly told them how she was "making all her meals, doing all her housework" etc, while expecting me to drop everything to come to her. Phone calls to clean up after an "accident" were common as she became more incontinent.

**The impact of understanding, supporting and loving my aunt while she had dementia was and is huge. But the impact of my family's lack of understanding about my role as her caregiver has been even worse.**

During this time, I was also nursing my dying husband, so I tried to get help for my aunt. Presbyterian Support were offering daily help at $13 an hour, and I arranged for them to come in.

My aunt called my brother and told him that this was a "scam" and that she did not need help – she was very "independent" and could "do everything herself". My family told me I was interfering, and I remember the exhaustion and depression that then threatened to overwhelm me.

A combination of a dying husband and a needy aunt who expected me to drop everything and attend to her was recognised by the palliative care team, and luckily they supported me. I feel it was this intervention at this time that stopped carer abuse moving into elder abuse.

I would like to see elder abuse investigated in this light — as coming from the stress and exhaustion of being a carer.

#### Felt caregiver resentment

After my husband died, I felt caregiver resentment — a feeling of unfairness or irritation. I became a reluctant caregiver, caring for my aunt more out of obligation than love. I began to resent the fact she was alive but my husband wasn't. I was the only one providing day-to-day care at this time, and resented others for not pitching in.

My aunt continued to tell the family that she was "fine" and they believed her. They did not see her on a daily basis. I resented the person I cared for, who was abusing me and, even though I was asking family for help, no one acknowledged it.

> **A combination of a dying husband and a needy aunt who expected me to drop everything and attend to her was recognised by the palliative care team – and luckily I could receive support from them.**

What I also didn't know is that my aunt was saying things to my family about me which they took as the truth. They never told me what she was saying – that she was "scared of me and had to hide her purse under the bed".

They never gave me any chance to defend myself. They did not recognise what she was saying as the result of paranoid dementia.

When I suggested she had dementia, I was told she was "too intelligent to have dementia". They supported her to change her will. After she died, they then accused me of abusing her.

They have now completely cut me off and refuse to speak to me – they refuse to hear my side of the story. They refused to share any of her possessions with me – I am even banned from having family photographs.

#### Losing my family

I have done nothing to deserve this and feel abused again. I am in counselling from the despair of having done my absolute best for my aunt and now losing my family because of that.

I am *not* telling you this to make you feel sorry for me. Rather I want *carer abuse to be recognised* as a real and possible product of dementia. I encourage carers who have been abused by dementia patients to speak out and talk about how they feel, to recognise the abuse and work on ways of dealing with it.

I think that left untreated, unrecognised and unsupported, carer abuse could be a precursor to elder abuse.

* The author of this opinion article is remaining anonymous, in agreement with *Kaitiaki Nursing New Zealand*'s co-editors, to protect the privacy of those concerned. She is a school teacher, and has been a carer in a number of different situations.

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1. Cooper, C., Selwood, A., Blanchard, M., & Livingston, G. (2010). Abusive behaviour experienced by family carers from people with dementia: the CARD (caring for relatives with dementia) study. (https://web.archive.org/web/20180722054016id_/https://jnnp.bmj.com/content/jnnp/81/6/592.full.pdf) *Journal of Neurology, Neurosurgery, and Psychiatry, 81,* 592-596.

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FEATURES

# Election 2023: As the timer resets, what do Māori think about health?

BY JOEL MAXWELL

*October 11, 2023*

What do Māori people think about the key election issue of health? Reporter Joel Maxwell discovers cultural clashes, a need for financial support – and hope for the future.

Life is not portioned out in three-yearly cycles.

Take Heremaia Parata, for instance. He went to war with the 28th Battalion – the Māori Battalion – and endured experiences beyond modern comprehension. The 28th fought Germans face to face in frenzied bayonet attacks, suffered through desert heat in North Africa, freezing weather in Italy; watched as bombs turned ancient masonry and modern humans to dust; till finally, the battalion, including a wounded Parata, was disbanded, sent home. World War II was over, but life went on.

These days, Te Toma Parata cries during Anzac ceremonies when her dad's old company is called out. As she gets older, for reasons she can't quite fathom, she feels his memory more keenly.

Heremaia Parata died at the age of 63 – much younger than both his parents. He was lucky to return alive from service, Te Toma Parata said, musing about her health experiences over the years, but his injuries shortened his life.

> **'The hospice nurse was like, 'Man, you'd make a good nurse,' and I thought, 'Maybe I can do this'.**

Māori have always given much, but we were left with the worst health of any ethnicity in Aotearoa. The ultimate embodiment of this inequity is that we die on average about seven years earlier than the general population. That's two whole elections we miss out on.

With the latest vote looming, I spoke to everyday Māori people about what health means to them as the timer gets reset again.

Parata (Te Whānau-ā-Apanui) is a health and safety officer with Te Wānanga o Aotearoa in Porirua.

*Te Wananga o Aotearoa health and safety officer Te Toma Parata. Photo by Joel Maxwell/Stuff.*

“He hōia taku Pāpā i roto i te rua-tekau-mā-waru. I hoki mai ia, mai i tā wāhi, and of course he’s depressed, he’s oppressed, his mates died there. He was wounded.”

Her dad wasn’t keen to hear te reo in their home when Parata was growing up (she mostly learned and spoke it elsewhere), but tikanga was deeply embedded in life from the many koroua and kuia still alive back then.

***TTP**: There wasn’t a doctor always around, so . . . he aha te rongoā hei whakaora i a rātou? (what was their medicine?)*

***JM**: Tērā pea, ko te rongoā ko te noho i roto i te ao Māori, me ōna tikanga, me tōna reo? (The Māori culture, language and tikanga, perhaps?)*

***TTP**: Probably. Nowadays, our people are getting cancers straight away, they’re getting diabetes straight away, arthritis. Nō hea ēnei mauiuitanga? Nō hea? (Where do these illnesses come from?)*

The system is “āhua pai – kāore i te kino, engari he āhua pai [noa]” (just adequate). Improvement would come from understanding the Māori world better, Parata said. “Ako i te tikanga, kia mōhio ai.”

Health knowledge is power for graduate registered nurse Anna Clarke (Te Aupouri, Ngāi Takoto, Ngāti Kahu ki Whangaroa, Te Rarawa) who lives and works in Whangārei.

*Anna Clarke*

She just wishes her understanding came sooner.

> **‘For me personally, I think it needs to start at student level. Because right now it’s terrible.’**

Growing up, Clarke always wanted to be a nurse, but she never thought she was smart enough. So she left secondary school and “had a whole life”, working 15 years as a hairdresser before realising that she wanted to do more. The resolve came after she helped her grandmother, Ana Jean Vaioleti, through her final days in hospice care.

“The hospice nurse was like, ‘Man, you’d make a good nurse,’ and I thought, ‘Maybe I can do this.’ ”

Clarke said she came from a whānau where comorbidities (multiple health conditions) were commonplace. “Diabetes, hypertension – high blood pressure – all the stuff that lots of Māori are affected by, so we had lots of hospital visits when I was growing up.”

It was a system that seemed to de-power Māori. Her whānau never really pushed back if they thought something wasn’t right, “we just went with it”.

Only through her nursing degree has she realised they should have followed their gut instincts instead. “I wish we had done it earlier, then a lot of my whānau wouldn’t be at the last stages of their life with diseases that could have been prevented.”

Many people got into nursing for love of the work, but financial support is important.

“For me personally, I think it needs to start at student level,” Clarke said. “Because right now it’s terrible.”

*Anna Clarke (far left) with Tōpūtanga Tapuhi Kaitiaki o Aotearoa — NZNO nursing students at their hui recently.*

> **‘Unfortunately, our drop-out rate is high because we’re having to choose. We have to eat.’**

Students have to complete up to 1100 hours of clinical placement in their degree. They need more than 360 hours in a single block in their final year. Many students are older with their own whānau and forced to choose between paid work or the full-time unpaid placement.

About half her cohort quit largely because of financial pressure, she said. “Unfortunately, our drop-out rate is high because we’re having to choose. We have to eat.”

Māori nurses make up about seven per cent of the workforce – less than half our proportion of the total population.

Maybe this shortage is what caused the "cultural clash" that marred the hospital stay, before and after childbirth, of Salvation Army business administrator Tamara Robati (Ngāti Kahungunu, Rangitāne).

> **'As a Māori person, the way to exit someone out of a place didn't really sit [well] with me.'**

Most of her eight-week hospital stay was great, she said, but the way they rushed her out the doors at the end "put a stain on the time".

"As a Māori person, the way to exit someone out of a place didn't really sit [well] with me."

Robati was told she had to go while in a communal room with other parents around. She was breastfeeding her baby, she said, and was thinking, "I don't want to have quite the conversation you want to have."

Health care overall has its problems, "not just [for] Māori", but it comes down to person-to-person communication. She understood there was pressure for beds, but patients still needed to be treated with human respect and dignity, she said.

"As Māori, I think, 'Hmm is it just because of that disconnect between the two understandings?' "

*Aotea College head boy Taranaki Te Hauora. Photo by Joel Maxwell/Stuff.*

Taranaki Te Hauora (Ngāpuhi, Ngāti Whātua) has just turned 18 and is a head boy at Aotea College in Porirua. He has a couple of understandings of his own about dealing with health for young people.

Take The 502 (https://www.the502.co.nz/) – a free wraparound combination of health and social services for 10 to 24-year-olds – to which he belongs. He'd like to see long-term government support locked in for the iwi-provider (Ngāti Toa) service. He wants Māori kaupapa initiatives to be given a chance to breathe.

"Maybe if we keep this alive for another 10 years we could look at the stats and the benefits . . . because if we have more time, we can have more data. That's the scientific way of looking at it."

Meanwhile, the Māori way of looking at it, Te Hauora said, was simply offering a welcoming space for rangatahi that other services don't quite have. "It low key gives off a marae-type of vibe ... with that sense of belonging."

He will study business next year at the University of Waikato – he has heard it has a strong Māori community.

With his future ahead of him, Te Hauora is around the same age as Heremaia Parata was when he went to war. The 28th Battalion was itself formed with wider goals in mind among those in the Māori political world: Proof Māori could take our place in the old Empire.

The empire dissipated, but questions of equity remain. What are Māori lives worth, and how should we go about collectively saving them?

Te Hauora will vote this year – "Of course!" – and is on the Māori roll. He will be taking his place, shouldering his responsibility at the voting booth to find some answers – for the next three years, anyway.

*— **Joel Maxwell** is a Stuff reporter and former Kaitiaki co-editor. This article was reprinted with permission from Stuff Ltd. The original can be found here (https://www.stuff.co.nz/pou-tiaki/300981430/election-2023-as-the-timer-resets-what-do-mori-think-about-health).*

Kaitiaki
NURSING NEW ZEALAND

NEWS

# Election 2023: Voting 'paramount' for nurses, health workers

BY MARY LONGMORE

*October 12, 2023*

Nurses and health workers are urging all health professionals to get out and vote in this Saturday's general election.


*Practice nurses Ali Lidgard and Deb May say it's 'paramount' nurses get out and vote.*

Lower Hutt practice nurse Deb May said nurses had a responsibility to "lead the way" and vote, as they were often looked to for guidance in the community.

"As nurses, we should vote because we are looked up to by others," she told *Kaitiaki Nursing New Zealand*. "People do ask us if we have voted," she said, in the same way they ask advice about COVID vaccinations and things like smear tests.

> **'As a woman, I feel it's really important to vote. I told my daughters how important it was, how hard we had fought for the right to vote.'**

New Zealand was also the first country in the world to give the vote to women, which made her "really proud" to vote as part of a female-dominated profession — and along with her three daughters.

"As a woman, I feel it's really important to vote. I told my daughters how important it was, how hard we had fought for the right to vote."

### 'Much at stake'

Another Lower Hutt practice nurse, Ali Lidgard, said there was so much at stake in this election, it was crucial nurses voted.

"Our voices matter — if we don't vote, everyone will think everything is fine," Lidgard said. The reality was that the health system was desperately understaffed and pay parity badly needed, to ensure all nurses were on the same salary scale, no matter where they worked.

May said she was deeply concerned about the racist rhetoric seen over the election campaign. "As nurses, we need to vote against that. This time, it feels paramount."

## ‘We look at the big picture – we are not individualistic. We vote thinking what is going to be good for our community.’

She also believed nurses had a duty to support vulnerable patients who might find it difficult to vote — the elderly, or people with disabilities or Alzheimers. “There are a lot of channels to help them, we can point them to.”

Nurses “tend to see the whole of society in our work”, May said.

*Stacey Wharewera: ‘We need to have a voice.”*

“We look at the big picture — we are not individualistic. We vote thinking what is going to be good for our community.”

Whakatāne nursing student Stacey Wharewera (Ngāti Awa, Te Whānau-ā-Apanui) said it was about having a voice.

“We’re up and coming nurses. It’s to have a voice, really — there is a hell of a lot at stake,” said Wharewera, chair of Te Rūnanga Tauira, NZNO’s Māori student body.

As Māori, Wharewera said: “We need to have a voice — we’ve had our voices heard [as nurses]. If we continue the wha whai [fight], then we’ll still continue to be heard.”

#### Younger generation will have their say

Whakatāne nursing student Shannyn Bristowe (Ngāti Porou, Ngāpuhi) said it was “definitely” important for student nurses and the younger generation to be voting. “It is for us to have a say when it comes to our future.”

## ‘The inequity will grow – there’s quite a lot at stake here.’

Her student nurse peers had been “very engaged” via social media in the election, party policies and preparing to get out and vote on October 14.

The choice was stark, said Bristowe, who co-leads NZNO’s students with Wharewera.

“You’ve got a party that is assisting in health-care at the moment and making some positive changes and positive groundwork. Then you have a party that is going to take it all away.

“At the end of the day, we want a party that’s going to support us and grow our nursing community and our health-care system.”

“The inequity will grow — there’s quite a lot at stake here.”

*Shannyn Bristowe*

#### Care and support workers

Tairāwhiti health-care assistant (HCA) Barbara Lloyd (Te Atiawa, Te Aupōuri, Te Rarawa), said older workers like herself had been encouraging the younger ones and internationally-qualified nurses (IQNs) in her aged care facility to get out and vote.

Pay and conditions for care and support workers — who recently missed out on a pay equity settlement (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6677/te-whatu-ora-must-stop-unjustly-delaying-pay-equity-for-65000-care-and-support-workers) — particularly in aged care, were key factors in her voting, said Lloyd, 68.

“I do feel for the way we’ve been treated as HCAs, and we work just as bloody hard as a nurse does.”

## ‘Every political year, we always see Māori being chucked under the bus, and this is no exception.’

HCAs were a “jack of all trades”, she said. “We do cleaning at night, we do porridge for the mornings at 4am, I’m in the laundry for two to three of the eight hours.”

Aged care in particular was struggling. “We’re just worked off our feet — it’s all come back down on us.”

#### Internationally-qualified nurses

Manawatū community mental health nurse Nithin Sreehari, who came here from India 11 years ago, said it was important for migrant nurses to have a voice.

“It’s very important for people to come out and voice their concerns . . . and vote for the best outcome for our nursing workforce.”

The IQN workforce faced its own challenges settling into Aotearoa and needed more support.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa — NZNO kaiwhakahaere Kerri Nuku said this year’s campaign had been “particularly brutal” for Māori.

“Every political year, we always see Māori being chucked under the bus, and this is no exception.”

Attacks on an iwi-partnership approach, created by the health reforms in response to a system that perpetuated inequities, “just seems to be another attack on Māori and Māori tino rangatiratanga”.

More than ever, it was important for nurses to make a “conscious vote for health”.

Nithin Sreehari

"We have to make sure we cast our votes and look at what the future [holds] and how responsive governments will be in the future."

Anne Daniels

NZNO president Anne Daniels, too, urged people to "vote health".

"We need to be voting people into power now who will set the groundwork for finding 4000 more nurses in a hurry, who will reduce costs and restore health justice by finding and employing more Māori and Pasifika nurses and who have the foresight to see that funding health properly now will save the system money and resources in the long run."

Kerri Nuku

See also NZNO's political scorecard (https://maranga-mai.nzno.org.nz/scorecard) where nurses assess parties' health policies.


Auckland NZNO delegates Jojemarie Oaminal, Lauren Weir and Jade Power hope to triple the vote for health.

*— Authorised by Paul Goulter, The New Zealand Nurses Organisation Incorporated, Level 3, 57 Willis Street, Wellington 6011.*

Kaitiaki
NURSING NEW ZEALAND

NEWS

# Emergency nurse ‘flow bros’ finally win back pay

BY MARY LONGMORE

*October 20, 2023*

After a three-and-a-half year battle, 18 Wellington nurses are celebrating winning hundreds of thousands of dollars in back pay after their role as patient flow coordinators at Wellington Hospital emergency department (ED) was underpaid for 13 years.

*Some of the "flow bros" (left to right): Stacy Harrison, Victoria Richmond, Jessica Buckley and Helen Armstrong. "We did it so diligently -- our team were just performing at such a high level."*

But it had been a “frustrating” and drawn-out process due to hospital management reluctance to pay higher rates for the demanding new role, they say.

“I felt disappointed, frustrated and also quite naive because I just assumed they would act in good faith, being that the nursing workforce is such an integral part of how we function as a health system,” said ED nurse Helen Armstrong. “I’m a little bit more sceptical now.”

Armstrong was the first and only patient flow coordinator (PFC) at Wellington’s ED department when the role was first created in 2010, in response to the then-National-led Government’s six-hour ED waiting time targets.

> **‘You can’t just invent jobs and decide to pay them on the lowest rung. That’s the whole point of the MECA, fairness and equity.’**

It was paid at low senior nurse rates yet was a complex, high pressure job. “It’s very high level decision-making. You’re trying to advocate for the patient, advocate for the department and advocate for the hospital all at the same time,” she told *Kaitiaki Nursing New Zealand.* “It’s really exhausting – and I don’t think anyone appreciates that unless they’ve actually done the role.”

### 'Fairness and equity'

Former PFC Jess Buckley said the nurses only realised in early 2020, when another department was creating a new nursing role, that the PFC role had never been scoped as required by the NZNO multi-employer collective agreement (MECA) with then-district health boards.

"You can't just invent jobs and decide to pay them on the lowest rung. That's the whole point of the MECA , fairness and equity," Buckley told *Kaitiaki.*

Under the collective (https://www.nzno.org.nz/Portals/0/Files/Documents/Support/CA/Te-Whatu-Ora-31-March-2023-31-October-2024.pdf?ver=fAIFkIoEyozV5bSxfz6f1w%3d%3d&timestamp=1694481687194) (p76), new senior nursing roles must be evaluated and graded by JERC (the job evaluation review committee), a joint NZNO–Te Whatu Ora body.


*Former Wellington ED nurse and patient flow coordinator Jess Buckley: "It shouldn't have taken that long."*

> **'We were asking for the money we were owed already if they had followed the proper process they agreed to as part of the MECA.'**

With the support of Tōpūtanga Tapuhi Kaitiaki o Aotearoa — NZNO, Buckley sprang into action and asked JERC to investigate. COVID delays meant that didn't happen for another year, but in March 2021 JERC agreed the hospital had failed to scope what the role was worth.

### Drawn-out process

But the hospital continued to resist — taking another year to appeal, doing so it the day before the JERC hearing in March 2022. The night before, a nine-month-pregnant Buckley stayed up late to rebut the hospital's argument (that it was not a complex role, that it did not deserve a higher pay scale) point-by-point. "We disagreed," said Buckley.

The employer lost. JERC ruled the 18 former and current PFCs should be paid — and back paid up to six years — at grade 3 on the senior nurse pay scale, which was $7000 to $11,000 more per annum for a full-time-equivalent.

While the PFC role had been underpaid for 13 years, under the Wages Protection Act claims can only go back six years from when they were lodged. In the PFCs' case that was back to 2014.

> **'For the district health board to turn around and act in the way they had, it felt disrespectful for the amount of work that goes into that job and the amount of stress that those nurses have to work with each shift.'**

"They didn't have a case," said Buckley. "We weren't asking for more money – we were asking for the money we were owed already if they had followed the proper process they agreed to as part of the MECA. We just wanted to be paid what we deserved."

### Wait 'too long'

It took another year-and-a-half to kick in (and a fight to include those who had left the hospital), but all 18 former and current PFCs had this month received their lump sum, Buckley said. While happy about the win, the process had been frustrating and felt "disrespectful".

"Three-and-a-half years — it shouldn't have taken that long," Buckley said. "For the [then] district health board to turn around and act in the way they had, it felt disrespectful for the amount of work that goes into that job and the amount of stress that those nurses have to work with each shift. So it's pretty frustrating."

**‘We recognise the frustration that the delays have caused and we apologise for this.’**

**Patient flow coordinating role ‘huge’**

*Photo:AdobeStock.*

The job was “huge”, she said. Not only did PFCs have to explain and apologise to patients and their families for the delays, they also wrote safety reports about those who had experienced harm due to the delays.

“There’s a real complexity and a huge autonomous decision-making part to it. It’s very complex clinically, it’s very stressful, you’re trying to manage multiple admissions per hour in a busy ED.”

Armstrong says the role had a lot of “kudos” for its support of an understaffed, often overwhelmed, ED. “We did it so diligently — our team were just performing at such a high level.”

She was “really pleased” everybody was getting the pay they were owed. “I know as well as everyone else how hard you have to work, mentally, in that role.”

**‘We’re sorry’ – hospital**

Te Whatu Ora Capital, Coast & Hutt Valley acting chief nursing officer Claire Jennings acknowledged its failure to scope the role and the delay in rectifying the error. The hospital highly valued its nurses’ work and “was committed to learning from this experience”, she told *Kaitiaki* in a statement.

“While we are pleased to have been able to resolve this matter, and pay our staff appropriately, we recognise the frustration that the delays have caused and we apologise for this.”

Jennings said the hospital would work closely with NZNO to meet its obligations when new roles were established and provide training for managers and HR staff to ensure they understood. “. . . we expect all of this will help to ensure that such a situation does not happen again”.

*Claire Jennings*

While Armstrong is back in ED, Buckley has left the hospital for a regulatory role. “I really love emergency nursing and the team — but I didn’t love the system and the position it put patients in,” she said.

The experience showed the value of the union beyond negotiating collective agreements, Buckley said. “For Jo (Coffey, NZNO organiser) to work beside me for this hard for this long — shows how dedicated NZNO is to nurses being valued.”

Next up, the “flow bros” are planning a celebratory dinner after their hard-fought win.

Kaitiaki
NURSING NEW ZEALAND

FEATURES

# It's cool to kōrero – October 2023

BY KATHY STODART

*October 26, 2023*

**Kurī** — dog.

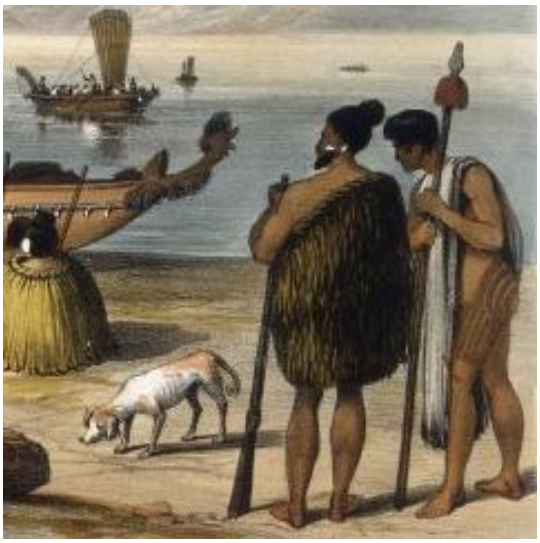
*Dog ownership in Aotearoa is more popular among Māori families than any other ethnic group. Second in line are Asians, then European New Zealanders, then Pacific people. Photo: iStock*

*Kurī, the original dog of Aotearoa, brought here by Māori and now extinct. Photo: Kane Fleury / © Otago Museum / Wikimedia Commons / CC BY 4.0*

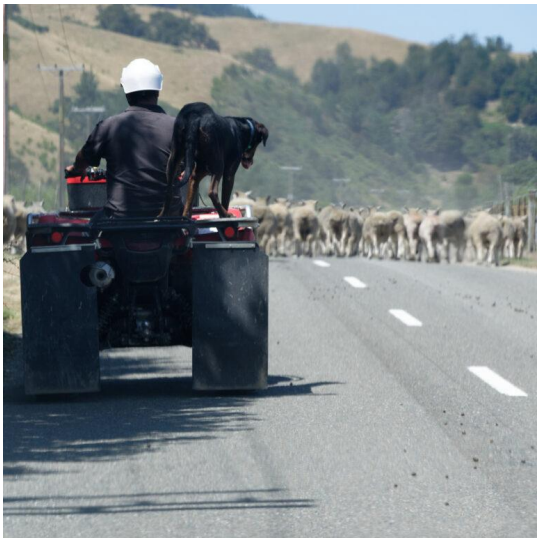

Haere mai and welcome to the October kōrero column. Kurī is a commonly used word for dog in te reo Māori, and kurī are popular animals in Māori homes.
There are over 800,000 dogs in this country, and a survey done in 2020 found that Māori households were the ethnic group in Aotearoa who were most likely to own a dog.

Kurī is also the name of a now-extinct breed of dog that Māori brought with them to Aotearoa — and which played an interesting part in traditional Māori culture.

These smallish dogs were often highly valued, though not quite what modern people would regard as a pet. They helped Māori hunt prey, including moa. Some were the valued companions of chiefs, and had their own whakapapa and burial sites.



*This scene, taken from Augustus Earle's painting "War Speech" shows two Māori chiefs with a kurī in front of them, in the 1820s. (Wikimedia Commons)*



*Many dogs in this country are working farm dogs. Here farmer and dog guide sheep along a rural road. Photo: Adobe Stock*

They were also highly valued for their hides and fur — a cloak made of dog skins (kahu kurī) was fit for a high-ranking chief.

Kurī gradually became extinct in the years after Europeans arrived on these shores, bringing with them their own dog breeds.

#### Kupu hou (new word)

- **Kurī** (dog)– *pronounced "coo-dee"*
- **Kei te hikoi haere i te kurī e au. —** I am walking the dog.

More words related to kurī:

- **auau —** the bark of a dog
- **māwhiti —** cape decorated with white dog hair
- **taparenga —** to muzzle a dog
- **Tautahi —** Sirius, the Dog Star
- **tōtiti wira —** hot dog
- **kūao kurī —** puppy
- **kaitiaki kakarehe —** vet
- **kara kurī —** dog collar
- **kai ma te kurī —** dog food

*E mihi ana ki a Titihuia Pakeho rāua ko Mairi Lucas.*

#### Sources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Kaitiaki
NURSING NEW ZEALAND

PRACTICE

# Navigating youth mental health

CPD 0.5 hours

BY HIRAN THABREW, DAVID CHINN AND KARIN ISHERWOOD

*October 26, 2023*

Mental health is a dynamic spectrum that ranges from a state of wellbeing, through mental distress, to mental disorder or illness. Consultations with young people (rangatahi) may be challenging due to the various presentations of mental health issues and the range of services and treatment options they may require.

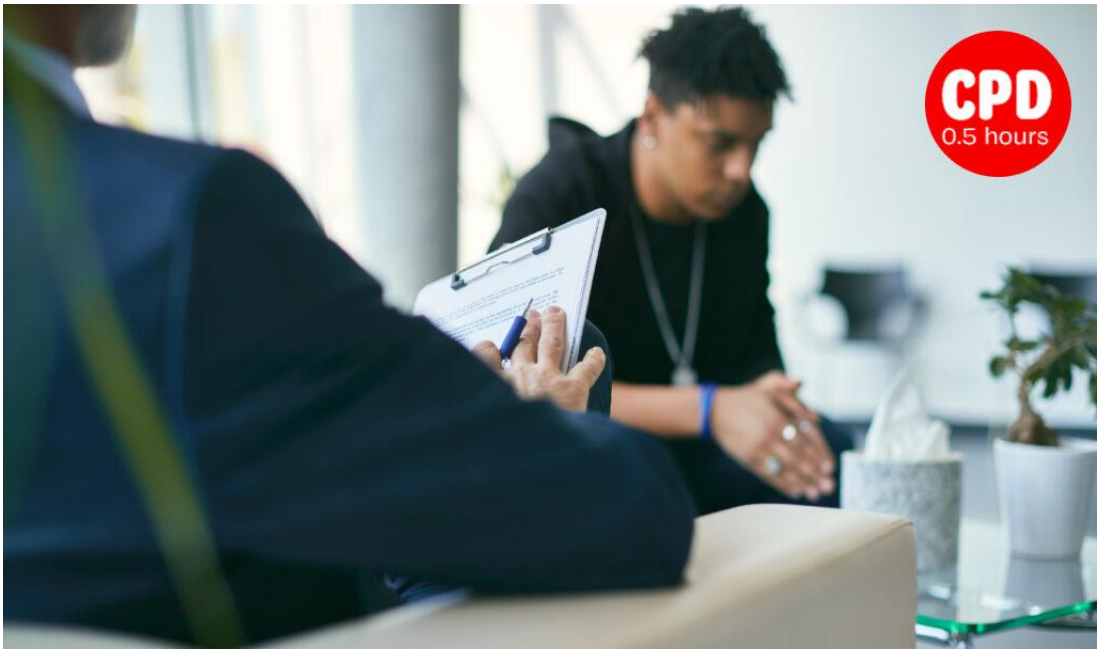



*Photo: Adobe Stock*

** Reading this article qualifies as 30 minutes of CPD.*

## Case scenario

*Laura checked her clinic list and sighed. Running 10 minutes late into her afternoon list wasn't too bad in the big scheme of things, but next up was Zoe, a 15-year-old whom she had been seeing weekly for a month.*

*Although Zoe had initially presented with poor sleep and worries about a relationship breakup, she was now also missing many days of school, not attending her beloved netball team's games and spending most of her time in her bedroom.*

*Despite coming to Laura's clinic for counselling, Zoe was adamant that she did not want her parents to be contacted about her problems because they had been unsupportive in the past. During her last appointment, Zoe disclosed that she had begun cutting her arm when she felt overwhelmed.*

*When asked directly, she also admitted to occasional, but not strong, thoughts about wishing she was dead. Laura considered what she should do to help Zoe – should she continue to offer her counselling, should she speak to the clinic's GP about prescribing antidepressants, or should she try and refer her to the overburdened local child and adolescent mental health service (CAMHS)?*

*With all these thoughts running through her mind she walked to her office door and, with a warm smile, invited Zoe into her room.*

## The spectrum of mental health

Consultations such as the one introduced by Laura above are typical. Still, for many practitioners they remain challenging due to the variety of ways in which young people present with mental health issues and the range of treatment options and services they may require.

Before considering these in greater detail, it is useful to define some key terms and to consider how mental health is a dynamic spectrum that ranges from a state of wellbeing, through mental distress to mental disorder or illness.

Any of us can be at any of these stages at any time and we can also move to a different stage by doing (or being supported to do) things that are helpful or unhelpful.

He Ako Hiringa
Learning Always

## Key points

Written for a broad primary health care audience, including nurses, this article helps health professionals navigate youth mental health by providing information about:

- distinguishing between mental wellbeing, distress and disorder
- tools and questionnaires that help you make a good mental health assessment, formulation and diagnosis
- where young people can find support
- the importance of relationship-building
- the roles of health coaches, peer support workers and health improvement practitioners
- the range of management options and delivery modes

- when a referral should be made to a specialist mental health service.


**Wellbeing**

Wellbeing (https://mentalhealth.org.nz/what-is-wellbeing) is defined by the World Health Organization (WHO) as a state in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community.

Although historically construed as merely the absence of illness, it is now recognised as a distinct and complex phenomenon, related to resilience and health literacy, and affected by individual and environmental factors.

Culture also has an impact on wellbeing; non-exclusive examples being whenua (land) and moana (ocean/sea) providing sustenance and spiritual connection for Māori, spirituality being of great importance to Pasifika and collective identity being valued by Asian peoples.

**Cultural expressions of wellbeing**

*Whenua (the land) and moana (the ocean) can provide spiritual sustenance and connection for Māori. Photo: Adobe Stock*


*For a large proportion of Pasifika, spirituality is vitally important.*

*Asian families tend to value the collective over the individual. Photo: iStock*

Intergenerational influences, including colonisation, can have less visible, yet significant effects on individual wellbeing. For young people, family and school connectedness have been shown to be important for wellbeing.

In Aotearoa New Zealand, information about young people's wellbeing has been collected for the past couple of decades via the high-school-based Youth 2000 (https://www.youth19.ac.nz/) series of studies.1 Although previously stable, wellbeing was found to have declined prior to the onset of the COVID-19 pandemic (from 78.2 per cent in 2007 to 69.1 per cent in 2019), especially among female and Pasifika students.

For more information about wellbeing, check out the Mental Health Foundation (https://mentalhealth.org.nz/what-is-wellbeing) page.

#### Mental distress

Mental distress (https://healthify.nz/hauora-wellbeing/m/mental-distress-what-you-need-to-know/) (also known as psychological distress) is an unpleasant emotional state that is usually transient and often occurs in response to stress or life events.

Commonly, people experience non-specific symptoms such as troubled thoughts, anxiety, low mood and poor sleep. They may also change their daily routines and relationships with people around them.

> **Rates of mental distress have increased among young people since the onset of the COVID-19 pandemic.**

Mental distress may range in intensity from unpleasant to profound anguish, and the latter may lead them to use self-harm as a coping mechanism. Despite this, many people with a significant degree of distress may not meet criteria for a diagnosable mental health condition.

Rates of mental distress have increased among young people since the onset of the COVID-19 pandemic, with more young people presenting for support to school counsellors, engaging in self-harm (eg, rates of presentation to emergency departments increased by 150 per cent at the peak of the pandemic) and being referred to Child and Adolescent Mental Health Services (CAMHS) for assessment.

#### *Management of mental distress*

Counselling and talking therapies (eg psychotherapies) can help people make sense of their experiences, address underlying stressors and develop useful coping strategies for situations that are not easy to alter.

Although medication is not usually indicated (and almost never as a first-line intervention), it may be occasionally useful for people experiencing significant anxiety or sleep difficulties for whom non-medication strategies have not proven helpful.

#### Mental distress versus mental disorder

The distinction between mental distress and mental disorder may not always be easy to make, especially in young people. It requires sound knowledge about normal development, an understanding of diagnostic criteria for mental disorders, and sufficient clinical skill to adequately engage and obtain clinical information from a young person who may not be used to talking with health professionals.

A HEEADSSS assessment (https://wharaurau.org.nz/elearning/working-youth-heeadsss-assessment) can be a useful tool for obtaining a wide range of information about psychosocial factors affecting a young person's mental state. More specific questioning about symptoms is needed to identify mental disorders (https://www.who.int/news-room/fact-sheets/detail/mental-disorders#:~:text=A%20mental%20disorder%20is%20characterized,in%20important%20areas%20of%20functioning.).

To be termed a "disorder", according to the Diagnostic and Statistical Manual version 5 – Text Revision (DSM-5-TR (https://www.appi.org/Products/dsm)), a person's symptoms need to be present for a specific length of time and be severe enough to limit their functioning on a daily basis.

*For the health professional, distinguishing between mental distress, which is usually temporary, and a mental disorder, which can be longer term, is not always easy. Photo: Adobe Stock*

As stated above, mental distress is usually transient. Although mental disorders may also naturally resolve, symptoms can last for a much longer time and cause significant distress if untreated.

For example, depressive episodes often resolve within a couple of years, but are associated with increased risk of self-harm and suicide as well as delayed developmental tasks of early adulthood; with treatment, on the other hand, they can resolve within weeks to months.

In addition to confirming a diagnosis of mental disorder, a good mental health assessment should also gather information to understand:

- why a person may have been vulnerable to developing a problem in the first place (eg, they have a family history of the same disorder, they have experienced early life adversity or have a specific temperament or personality)
- what might have triggered the problem
- what might have kept it going, and
- what factors might have prevented it from getting worse.

This is called a formulation. While the same diagnosis can apply to many people, a formulation is specific to an individual. Both are important for determining a suitable treatment plan.

## Common mental disorders among young people

While almost all mental disorders begin by early adulthood, the most common mental disorders during childhood and adolescence are anxiety disorders and depression. As self-harm and suicide are also common among young people in Aotearoa, these will also be briefly discussed below.

### ♦ Anxiety disorders

Anxiety is a normal human response to danger. However, if it occurs in the absence of, or disproportionate to, genuine danger and adversely affects a person's daily functioning (eg, refusal to go to school), it may be termed an anxiety disorder (https://www.kidshealth.org.nz/anxiety).

Photo: iStock

Anxiety disorders affect around one in 10 children and young people, and may be classified as mild, moderate or severe. Validated questionnaires such as the Generalised Anxiety Disorder – 7 item scale (GAD-7), the Screen for Child Anxiety Related Disorder (SCARED) and the Multidimensional Anxiety Scale for Children 2 nd Edition (MASC 2) can also be used to confirm symptoms. The most common types of anxiety disorders in this age group are:

- **separation anxiety –** worries about separating from caregivers, especially among younger children
- **generalised anxiety –** worries about multiple issues at home, school or elsewhere, usually in older children
- **social anxiety –** worries about performing or being seen in public, primarily in teenagers.

Treatment of anxiety (https://www.jaacap.org/article/S0890-8567(20)30280-X/fulltext) usually involves talking therapy (most commonly cognitive behaviour therapy — CBT) to help people understand how anxiety works, what might set off their anxiety and how to change their responses.

Newer electronic (e-) therapies have also been developed and are now recommended as first-line interventions for mild to moderate anxiety disorders.2 If these are not effective, or anxiety is so severe that a child or young person cannot usefully engage in talking or e- therapies, anxiolytic medication (usually a selective serotonin reuptake inhibitor (SSRI) such as fluoxetine) may be indicated.

### ♦ Depression

While everyone feels sad from time to time, depression, otherwise known as major depressive disorder, (https://www.psycom.net/depression/major-depressive-disorder/dsm-5-depression-criteria) is a state in which one feels low in mood, loses interest in things that one usually enjoys (anhedonia) and experiences specific cognitive and physical symptoms for more than two weeks.

Graphic: Adobe Stock

Like anxiety disorders, depression affects around one in 10 young people and may be classified as mild, moderate or severe, based on the number of symptoms present and level of functional impairment (the extent to which it gets in the way of important day-to-day activities).

While adults often experience sustained low mood and difficulty sleeping, young people may experience fluctuating low mood (often better around peers, worse when alone) and excessive sleeping.

Validated questionnaires such as the Child Depression Inventory version 2 (CDI-2) and Kessler 10 scale can also be used to confirm symptoms. We now know that even mild depression during adolescence can predict symptoms continuing to adulthood and recurrent episodes of mood disorder during adulthood; therefore, it should be identified and treated.

Depression often co-occurs with anxiety, but fortunately, the treatments for both are similar.

Recommendations for the treatment of depression are influenced by its level of severity, which in turn hinges on the number of depressive symptoms (five connotating mild depression, six to eight moderate and over eight indicating the severe end of the spectrum) and the degree of resulting functional impairment.

**While adults often experience sustained low mood and difficulty sleeping, young people may experience fluctuating low mood (often better around peers, worse when alone) and excessive sleeping.**

First-line treatment of depression (https://www.nice.org.uk/guidance/ng134) (of any level of severity) may include supportive counselling, stress management, physical activity and brief psychological interventions. These are more likely to work if a therapist has a good relationship with the young person.

In addition, addressing life events or adversities that may be precipitating or prolonging the symptoms can also be helpful. If available, structured psychological interventions such as CBT, interpersonal therapy (IPT) and acceptance and commitment therapy (ACT) are all potentially excellent interventions. These may be delivered in person, online or as e-therapies (https://www.nice.org.uk/guidance/ng134/chapter/Recommendations) (eg, SPARX (https://landing.sparx.org.nz/?gclid=Cj0KCQjwl8anBhCFARIsAKbbpyTGcF9U8CAkAD5vhDUSpoJWg5bIBloSRfE5qMjBa4nAJrd_CQ1I8FgaAk9xEALw_wcB)).

It is also important to consider when to (or not to) prescribe a psychotropic medication. Prescribing such a medicine is not inherently wrong by any means; in fact, for many this can be lifesaving when undertaken in a considered manner.

Whilst antidepressant medication does not work for mild depression, for depression that is more severe, antidepressant medication can be significantly beneficial if provided for the right people at the right times.

When talking or e-therapies are ineffective, or if depressive symptoms are so severe that a young person cannot gain full benefit from them, antidepressant medication (usually an SSRI such as fluoxetine) may be indicated.

Data recently released by He Ako Hiringa (https://epic.akohiringa.co.nz/youth-mental-health#section-6448ab112b490afdf706c1ab) reveals that approximately one in eight young people (aged 12–25 years) had at least one psychotropic medication dispensed in the last 12 months. Between 2019 and 2022, commonly used antidepressants in young people increased from 1 per cent to 4 per cent in those aged 14 to 17, and 7 per cent and 10 per cent in those aged 18 to 25.3


*Antidepressant medication, usually an SSRI, may be indicated where talking therapies are ineffective or depressive symptoms are severe. Graphic: Adobe Stock*

**. . . for depression that is more severe, antidepressant medication can be significantly beneficial if provided for the right people at the right times.**

On the other hand, use of benzodiazepines or antipsychotic medication in this age group should be exceedingly rare (and only after discussion with a child and adolescent psychiatrist).

Regardless of how effective medication is, recurrence of depression is common (between 30–40 per cent within one to two years). Therefore, it is useful to educate young people about depression, help them develop a better understanding of what affects their mood, learn new skills for managing stressful situations in the future and how to identify early warning signs of a recurrence. Whānau involvement can also increase the effectiveness of these strategies.

### ♦ Self-harm

Self-harm (https://www.kidshealth.org.nz/self-harm) (also known as deliberate self-harm and non-suicidal self-injury) is common among young people, with up to a quarter of those surveyed during the Youth 2000 series reporting they have engaged in some form of self-harm during the past year.

Rates for rangatahi Māori and Pasifika are two to three times those of other ethnicities, and young people from rural and more deprived areas are at greater risk. Common methods of self-harm include cutting, head banging, biting, scratching or burning of skin, pulling out hair or eyelashes, inhaling or ingesting poisonous substances, and overdosing on prescribed medication.

Most individuals who engage in self-harm do so in an impulsive manner, with the aim of managing mental distress or overwhelming life events. For others, these events occur in a more planned manner and in the context of acute mental illness, most notably depression.

**Management of self-harm includes education about the connection between triggers, emotions and behaviour.**

Self-harm can make people feel better for a little while, but usually not for long. It can also become an unhealthy habit that is hard to break. Young people are often embarrassed about engaging in self-harm and may not volunteer information unless asked. Self-harm can have short and long-term consequences including increased short-term rates of hospitalisation, later anxiety and depression, and three to four times greater rates of completed suicide.

Management of self-harm includes education about the connection between triggers, emotions and behaviour; provision of ideas about alternative coping mechanisms (https://www.helpguide.org/articles/anxiety/cutting-and-self-harm.htm) and improving peer and family support. Counselling or more formal talking therapies (eg, dialectical behaviour therapy (DBT) or CBT) may also be useful. Involvement of whānau can also increase the effectiveness of these strategies.

Commercial apps such as Headspace® (https://www.headspace.com/) and Calm® (https://www.calm.com/) have accessible and appealing, relaxation and mindfulness-based modules that can be used to prevent and manage thoughts of self-harm. Locally developed communication apps such as Village® (https://villageapp.kiwi/) can help young people learn to reach out to trusted whānau members and peers, and for these people to support them in helpful ways.

♦ **Suicide**

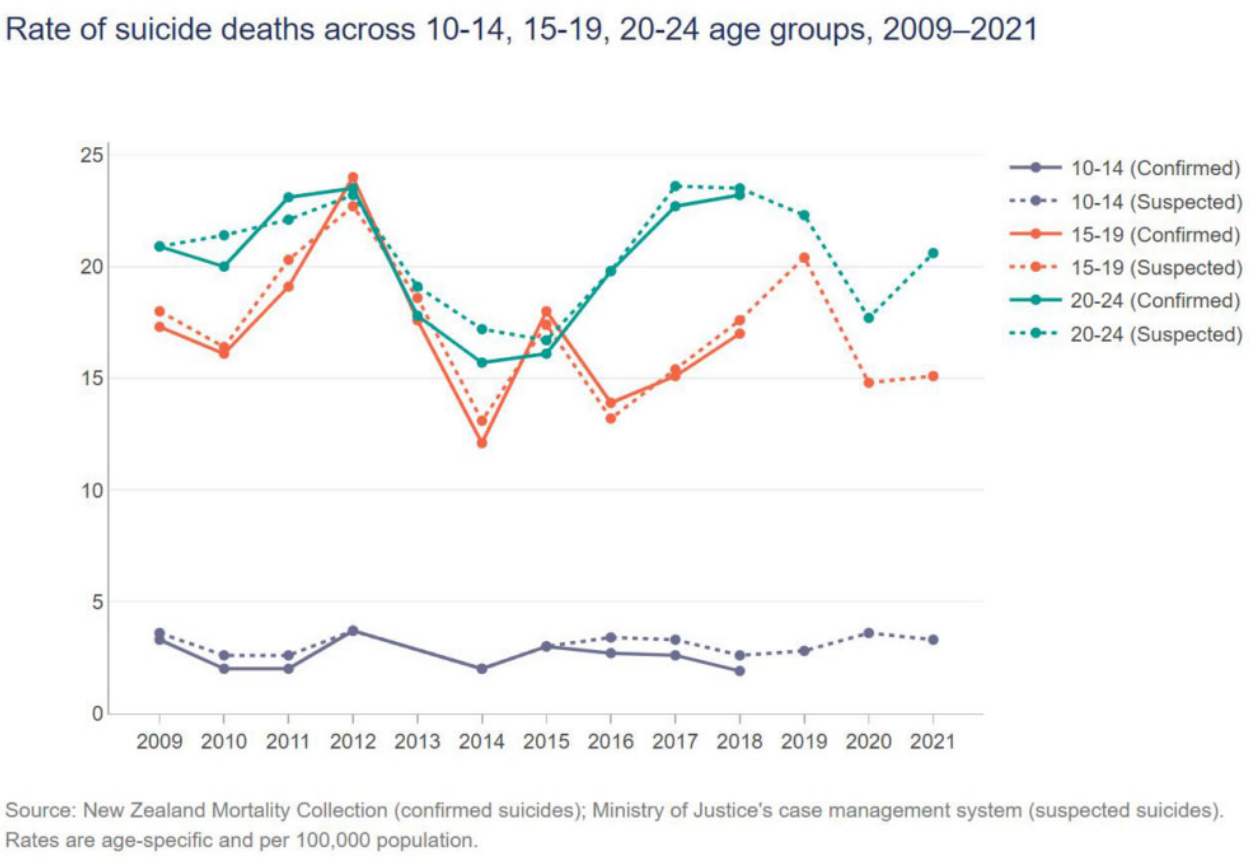
Aotearoa has one of the highest rates of youth suicide in the world (between 15–25 per 100,000 people), with particularly high rates among rangatahi Māori and Pasifika (see Figure 1, below).

Although reasons for this remain unclear, it is possible that individual factors (including previous suicide attempts, family history of completed suicide, association with someone who has recently completed suicide and current mental illness – particularly depression), environmental factors (including relationship difficulties, bullying and poverty) and societal factors (including widespread "she'll be right" and "harden up" attitudes that limit help-seeking, and colonisation-related disparities) may all play a role.

Enquiring about suicidal thoughts and actions does not increase the risk of suicide and should be sensitively undertaken as part of routine mental health assessment.

However, it should also be noted that, given how rarely suicide occurs, clinicians and risk-related questionnaires are notoriously bad at predicting who will end their life by suicide.

As such, management of identified suicidal thoughts and actions includes immediate safety planning with young people and whānau, routine referral for specialist assessment and follow-up, and further treatment depending on the presence and type(s) of associated mental disorder.




Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides). Rates are age-specific and per 100,000 population.

### Where can young people get help with mental distress or disorders?

Children and young people primarily receive support from whānau, peers and members of their usual communities (including school counsellors and churches).

When experiencing mental distress or disorder, reliance on these individuals for support will depend on the young person's previous experiences of help, their own knowledge about prevailing attitudes and prejudices, and their immediate mental state. They rarely present to health services themselves, usually being brought in or referred by others who are concerned about them.

The landscape of mental health services in Aotearoa can broadly be divided into primary health services and specialist mental health services:

**Primary health services**

- School-Based Health Services (SBHS) – these vary in composition, with most high schools having school counsellors and some having psychologists and visiting GPs.
- Primary health organisations (PHOs) – including GP clinics.
- Non-governmental organisations (NGOs).
- Kaupapa and iwi services.

**Specialist mental health services**

- CAMHS (child and adolescent mental health service) – funded to see those with the top 3–5 per cent of needs (ie, usually those with severe and/or life-threatening mental illness).
- Private practitioners – usually counsellors, psychologists or psychiatrists who can offer talking therapies and medication.

#### What are Access and Choice Services?

Following the release of He Ara Oranga (https://www.mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/): Report of the Government Inquiry into Mental Health and Addiction (2018), the *Access and Choice* (https://accessandchoice.org.nz/about-us/) programme was developed, and rollout started in February 2020. *Access and Choice* builds on mental health and addiction expertise in general practice teams and adds additional staff to services already providing mental health and addiction input.

There is a specific work stream for kaupapa Māori, Pacific and youth primary mental health and substance use services. Funding has also been provided to InsideOUT and Rainbow YOUTH to expand mental health and wellbeing services for takatāpui/rainbow young people.

Within PHOs, health coaches, peer support and health improvement practitioners (HIPs) were offered as part of the *Access and Choice* programme:

- Health coaches (health navigators, Kaiāwhina or Kaiarahi, community health workers or whānau ora workers) have five roles including self-management support, being the bridge between clinicians and service users, assisting navigation of the healthcare system, providing empathy for the person and ensuring continuity of care. Health coaches generally work with those with long-term conditions and may not have the training to support young people. There is room for the development of health coaches to work specifically with young people with mental health and addiction needs.
- The peer support workforce, also known as the peer, consumer or lived experience workforce, comprises people who have lived or living experience of mental distress or difficulties with substance misuse. Te Pou (http://tepou.co.nz/our-work/lived-experience), the national workforce development agency for adult mental health and addiction, has led the development of a trained peer support workforce, complete with a strategic direction, action plan, values, competencies, training and resources. Whāraurau, the national workforce development agency for infant, child and youth mental health and addiction issues, leads the development and training of the youth peer workforce.
- HIPs are registered health professionals and can be psychologists, nurses, GPs, social workers, psychotherapists, or other health professionals with a mental health qualification. They provide brief interventions (usually one to four sessions) using fACT (a brief version of ACT) and culturally appropriate therapies.

Examples of services that have been specifically tailored for youth are outlined below:

- **Youth One Stop Shops (YOSS):** These services have been available for more than 20 years and provide wrap-around health care for young people aged 12–24. The staff comprise GPs, practice nurses, counsellors, social workers, youth support workers and administrative staff. Some YOSS have specialist mental health practitioners including psychiatrists, clinical psychologists, and alcohol and drug coexisting problems (AOD-CEP) counsellors. Along with sexual health and primary medical care, interventions include individual counselling, various groups (eg, young parents, transgender, rainbow), peer support, assistance with life skills (employment, education, housing, benefits, etc.) and a drop-in or hang-out space. Some YOSS accept walk-ins and others are appointment only. YOSS are known for being youth friendly and engaging well with young people; they all have some level of youth advisory in how the services are developed and continue to run.
- **Youth-focused services:** There are several youth specific services throughout the country that offer wellbeing care across the age range, with some programmes specifically designed for young people. Many of these services, including Pacific and Māori specific services, received additional *Access and Choice* The national mental health and addiction workforce development centres, Whāraurau, Le Va and Te Rau Ora provide support and training to improve service delivery and upskill staff to work with young people.
- **Fresh Minds:** This service in Auckland is part of ProCare Health, the largest PHO in Aotearoa. They offer free or low-cost wellbeing services and receive *Access and Choice* funding. The staff include registered mental health professionals such as psychologists (clinical, educational, general, health), mental health practitioners, mental health nurses, and social workers.
- **The Piki programme:** Co-designed with young people and service users, Piki is part of Tū Ora – Compass Health, a PHO providing services in the greater Wellington and Wairarapa regions. It was developed as a pilot programme in 2018 following the release of He Ara Oranga. Piki is noted for its innovative service delivery using peer support, professionals and technology to assist young people 18–25 to overcome adversity and strengthen their wellbeing. Like Fresh Minds, the Piki staff include a range of registered mental health professionals. The Piki service also offers peer support services, through PeerZone, using the Intentional Peer Support model.

#### What are Child and Adolescent Mental Health Services?

Traditionally called CAFS (child, adolescent and family services) or CAMHS, these secondary youth services are now known as Te Whatu Ora services. Some services include maternal and infant mental health and go by the titles ICAFS (infant, child, adolescent and familiy service) or MICAMHS (maternal, infant, child and adolescent mental health services).

Nationally, almost all secondary youth services offer same day "acute" appointments for young people presenting with particularly high levels of risk. Many services also offer an "urgent" appointment, within a day or two, for those who are not suitable to be waitlisted. In most cases, anybody can refer a person to Te Whatu Ora CAMHS services, and most services will accept self-referrals.

The national KPI (key performance indicator) Programme has waiting time targets of 80 per cent of young people being seen within three weeks of "first contact" (ie, referral letter), and 95 per cent of young people being seen within eight weeks. Most secondary youth mental health services structure their approach using CAPA (choice and partnership approach), a supply and demand model.

The initial "choice" appointment is primarily to understand what brings the young person in and determine which service may work well with the young person and whānau. At this point, the young person and their family may be linked in with another more suitable service, or care will remain with the secondary service and move on to a partnership appointment.

A fuller assessment will be conducted, and a plan developed in collaboration with the young person and whānau, which outlines potential wellbeing options and identifies who will be involved.

Secondary services use a multidisciplinary team approach and generally have a range of registered mental health and addiction staff, including child and adolescent psychiatrists, child psychotherapists, social workers, clinical psychologists, counsellors, nurses and occupational therapists.

All young people are discussed with the team and each member uses their expertise to help guide the care. The teams may have disciplines different to the ones mentioned above (eg, employment specialist, speech and language therapists, youth support workers) and each team will have a range of registered professionals.

### When should children and young people be cared for in non-specialist settings?

In general, children and young people experiencing mental distress may be effectively cared for by school-based health services, primary health organisations and non-specialist health services. Those experiencing mild to moderate levels of mental disorder are also likely to benefit from talking therapies in these settings.

Although medication is ideally prescribed in specialist settings, it may be usefully commenced by prescribers if initial approaches (talking therapies) have not been effective, symptoms are worsening or there is likely to be delay in accessing specialist services. Telephone consultation with a child psychiatrist is usually undertaken at this stage.

### The importance of relationship building

Working with young people is often complicated by the very fact that they are young and many of us are not.

We cannot stress enough the importance of engagement and rapport building. Time taken to find out what's important to the young person and how they spend their time is never wasted; a successful treatment strategy starts with particular founding principles (such as the ideas presented in this article) and must be carefully tailored to the young person and their individual context.

Young people, for a variety of reasons, often do not want their whānau to know that they are sad or distressed, and while we need to respect their confidentiality, use available opportunities to revisit the discussion. Many young people do want the support of their parents and whānau, yet they are afraid of their reactions. Talking through the fears and discussing the value of family support, can assist young people to see things differently.

**We cannot stress enough the importance of engagement and rapport building.**

Other relationships that are important to both make and sustain are those with services in your area that work with young people, such as YOSS, PHOs and other youth specific services. There are also pharmacists with expertise in mental health and addiction issues who can provide valuable assistance with prescribing options.

Often NGOs effectively provide counselling in many areas, and places such as Catholic Social Services, Presbyterian Support, City Mission, etc, are all around. Consultation with local CAMHS, even prior to making a referral, may help with this orientation process.

A strong network of providers in a local area is often really helpful to draw upon when weaving together a plan for a young person and their whānau at a time when they are feeling most challenged.

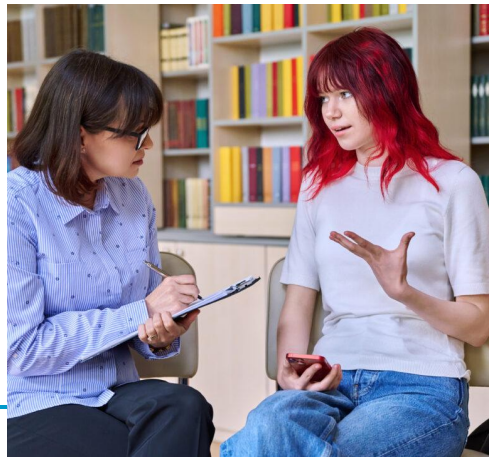


*Photo: iStock*

### When should a referral be made to a specialist mental health service?

Referral to specialist mental health services (usually CAMHS) should be considered in the following instances:

- When there has been no improvement and/or worsening of symptoms with the treatment employed to date, whether this is a talking therapy or a psychotropic medication.
- If multiple issues are identified and need treatment (eg, the ADAPT study found 85 per cent of young people presenting with depression had another mental disorder, especially anxiety or obsessive-compulsive disorder (OCD).4
- If acute risk is identified – most commonly this pertains to risk of suicide, with a young person actively thinking about or having recently tried to end their life. It may also include more frequent or severe self-harm, harm to others or harm from others.

*Returning to Laura's clinical dilemma, she's right to consider referring Zoe to CAMHS. Zoe's lack of improvement despite ongoing therapeutic work, and her behaviour showing increasing evidence of acute risk are both consistent with situations in which CAMHS involvement may be beneficial.*

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**David Chinn** is a consultant child and adolescent psychiatrist for the Infant, Child, Adolescent and Family Service (ICAFS), Mental Health, Addiction and Intellectual Disability Service (MHAIDS), Te Whatu Ora; he is also a clinical senior lecturer in the Department of Psychological Medicine, University of Otago.

**Karin Isherwood** is a senior consultant clinical psychologist and senior advisor at Whāraurau, the national mental health and addiction workforce development centre for infant, child, youth and whānau.

Options for recording your CPD activities and hours include:

- the Nursing Council's MyNC (https://www.nursingcouncil.org.nz/MyNC/MYNC/Sign_In.aspx?WebsiteKey=940918e5-df3e-4c60-9746-7312cd202474&LoginRedirect=true&returnurl=%2fMYNC) "continuing competence tab"
- the council's "professional development activities template" (you can download a PDF from this page (https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952))
- the app "Ascribe" which can be found on Google Play (https://play.google.com/store/apps/details?id=com.ascribe.pdrp_diary) or the App Store (https://apps.apple.com/nz/app/ascribe/id1667199802).

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Kaitiaki
NURSING NEW ZEALAND

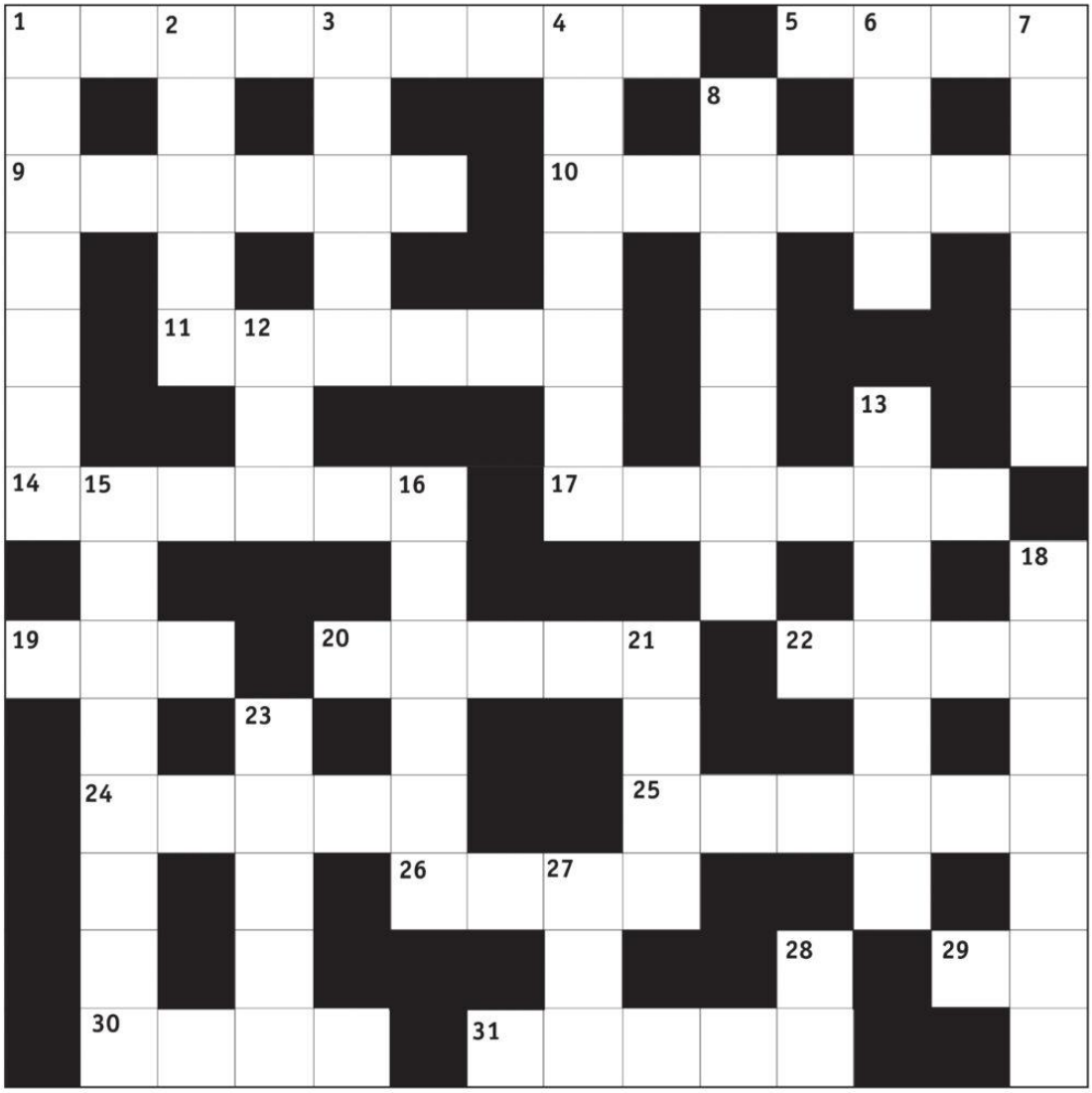
PUZZLES

# OCTOBER 2023 crossword

BY KATHY STODART

*October 12, 2023*

Print out the grid (using PRINT tab at the bottom right of this page) and use the clues below. September answers are below the clues.



**ACROSS**

1) Rising price of goods and services.
5) Seaweed.
9) Green fragrant fruit.
10) Water-borne gastro illness.
11) Concealed.
14) Possessing.
17) Floor covering.
19) Shed tears.
20) Horse (Māori).
22) Indian flatbread.
24) Main artery.

25) Dangerous situation.
26) Aroha.
29) Colloquial thankyou.
30) Biblical leader, ark-builder.
31) Small branches.

**DOWN**

1) Raging fire.
2) Religious belief.
3) Stay away from.
4) Grown without artificial chemicals.
6) Finishes.
7) Karakia.
8) Soldiers on horseback.
12) Tribe (Māori).
13) Return to illness.
15) Anti-coagulant drug.
16) Worldwide.
18) Not typical.
21) On one occasion.
23) Stadium.
27) Promise.
28) 'Two of __'. Opening track on Beatles' *Let It Be* album.

**September answers**
ACROSS: 1. Theatre. 4. Paella. 7. Moon. 8. Broom. 9. Dip. 11. Urgent. 13. Pain.
15. Again. 16. Pea. 18. Widen. 20. Pit. 21. Backlash. 24. Lamb. 25. Koru. 26. Sand.
28. Retired. 29. Emerge.
DOWN: 1. Tumour. 2. Enough. 3. Rib. 4. Prompt. 5. Lid. 6. Aspirin. 10. Diagnosis.
12. Tauira. 14. Week. 16. Popular. 17. Attempt. 19. Bridle. 22. Cloud. 23. Louse. 27. Air.