# LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO

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# Autumn 2023

## In this issue…

| | |
|---|---|
| Chair's Report | 3 |
| Editor's Report | 4 |
| He Ako Hiringa | 7 |
| Combined Committee Photo 2023 | 8 |
| Professional Practice Committee | 8 |
| LOGIC Committee | 8 |
| PNA Update | 8 |
| Urgent Care Nurses Network Pt 2 | 9 |
| NCSPAAG update | 11 |
| Symposium 2023 in pictures | 13 |
| Skin Sores | 22 |
| Whanau Awhina Plunket | 25 |
| Breastfeeding Matters | 28 |
| Youth Mental Health | 31 |
| Cancer Society | 38 |
| Hobbiton Medical Conference | 39 |
| Rare Disorders | 44 |
| Professional Supervision | 46 |
| Immunisations | 51 |
| Leadership (Haututanga) & Innovation (Tangongitanga) Award | 55 |
| ACE's | 56 |
| Capturing Voices and thoughts | 64 |
| NZNO Professional News | 67 |

# *Chairs Report*

*Tracey Morgan*
*Chair*

"Ahakoa he iti, he pounamu" – Despite being small, you are a treasure and of great value.

I would like to start by acknowledging all those that have been struck recently from the aftermath of Cyclone Gabrielle. To the Volunteers that have put their time to go and assist to the regions in need I applaud you and thank you.

Despite the significant recent climate change, nursing continues to play a pivotal role in providing that care that is needed not just for staff but families also.

**Maranga Mai:** To address the Nursing crisis permanently across the whole health sector. Maranga Mai is the campaign, which is a call to every nurse, everywhere. This campaign NZNO are driving to ensure everyone in Aotearoa can aid in having every nurse everywhere.

**Equity Grant:** The Executive Committee has proudly presented the Oritetanga Pounamu Equity Grant of $2,500 each year. This grant looks at diversity of Māori, Pacific Island, vulnerable and disabled communities with Te Tiriti o Waitangi embedded in the criteria.

**General Practitioners Leadership Forum:** Pay parity needs urgent resolution to avoid further erosion of the Workforce. Localities current iterations by Te Whatu Ora are confusingly inconsistent and frustrating to Health Practitioners. Where do Providers fit within this structure? PHO future; GPLF could strengthen its position with Māori membership around the table.

PSAAP (PHO Services Agreement Amendment Protocol) in its current form is not fit for purpose. It needs a new negotiation platform to design a funding mechanism. The aim is to co-design a fit for purpose primary care led process for policy and contractual issues.

Pay disparity funding for Nurses working in General Practices. Minister Verral and Abbe Anderson want to rectify nurses pay parity to extend funding to nurses in General Practices and Aged Care. The intention is to make funding available by July 1, 2023. Hoping to see 95% pay parity from 1 July (inclusive of ERA).

GPLF members stressed the importance of rural to be included in nursing discussion. Abbe has committed to engage with Paul Goulter, Phillip Grant and Tracey Morgan and that the outcome should not be overly onerous for practices to distribute money. Future funding will be population based and reviewed annually.

**Influenza:** April 1, 2023, marked the start of the Flu Vaccination programme. Pharmac have confirmed the eligibility criteria for funded vaccines widening access to tamariki ages 6 months to 12 years and offering to Māori and Pacific people 55-64 years. From the 16th of March 2023 flu vaccinations were able to

be booked on the book my vaccine website.

**Bexsero- (Meningococcal B) funded from 1 March 2023**. This vaccine commenced on 1 March 2023. Concerns raised that timeframe for this roll out not effective. Whilst the Webinar was handy more planning and preparation was needed before this roll out.

**Symposium:** "Caring for Ourselves, Caring for Communities, Caring for Aotearoa"

"Te tiaki I a tatou ano, te tiaki i nga hapori, e tiaki ana I Aotearoa"

11 March 2023; Arawa Park Hotel.

A huge thank you to Kelly Robertson for her tireless energy and time that ensured this Symposium ran smoothly alongside the support of her team.

# *Editors Report*

*Yvonne Little*
*Editor*

Welcome to the first edition of LOGIC for 2023. And what a bang 2023 started with, just when we thought our lives could get back to the "new" normal mother nature throws us something else to deal with.

It is hard to believe that at the time of writing this two months have passed since Cyclone Gabrielle entered our lives and turned many of them upside down, especially in my home area of Hawke's Bay. Whilst many of our family and friends are still doing the hard yards to bring some normality back to their lives in the most devastated areas, a big thank you goes out to the rest of the country and you our members for the help and support received. As a college we will be thinking of our colleagues/friends and families not just in the here and now but into the future, especially now that we have to deal with other health problems caused by the effects and aftereffects of the cyclone – not just the physical but the mental wellbeing of all New Zealanders is priority for nursing and the health sector now more so than ever.

To our colleagues in the areas recently hit by tornado's our thoughts go out to you. And because of the effects that we are seeing in our lives with climate change we as a committee decided to add another section to our future LOGIC issues and it will be entitled Climate Change, this will be headed by our own Climate Change front person in Mikey Brenndorfer, who for those who attended our recent symposium will know of his history and passion about this subject.

This issue as you will see is quite a bumper one as we have received many articles and added to that we have photos of the recent symposium held in conjunction with the College of Nurses Aotearoa in Rotorua in March. The symposium was a huge success, and I need to reiterate our Chairs thank you to Kelly Robertson and her team of fantastic symposium committee members who once again put together a fantastic programme and most of it done remotely due again to working

conditions/commitments and the ongoing saga of COVID-19.

Having Tamati Coffey as MC was fantastic – so energetic and passionate about everything he does. Alongside him we had brilliant speakers on a range of topics:

Opening address by Kate Weston, Executive Director College of Nurses Aotearoa and Rhoena Davis, Kaitohu Whakatapuhi Director of Nursing (Primary Care), Mahitahi Hauora PHE.

Sarah Laurie, Founder of Take A Breath who will be providing us with some articles and has given us all access to her book, there is also the app to download which I can state from experience is well worth the download. Thank you, Sarah, for your inciteful informative talk I know it is going to help many people especially in this time of need for self-care.

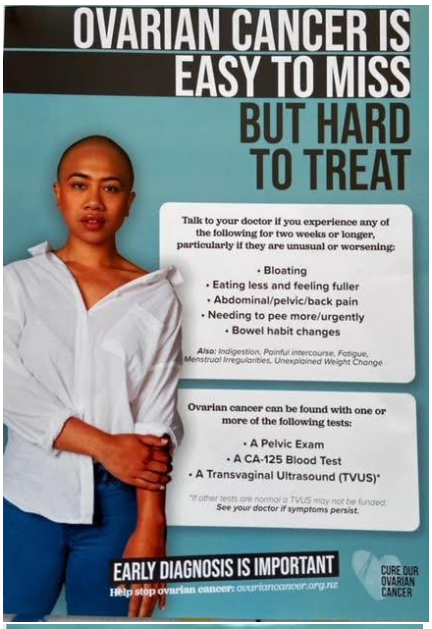
Carlton Irving, Kaitohutohu Māori for SRSL and Equity Advisor for National Ambulance Sector Office (NASO) at Te Whatu Ora spoke on Caring for our Communities. A passionate speaker on a subject that many would shy away from. I want to add here congratulations to Carlton on his recently starting his new position as Chief Clinical Officer – Allied Health at Te Aka Whai Ora Māori Health Authority.

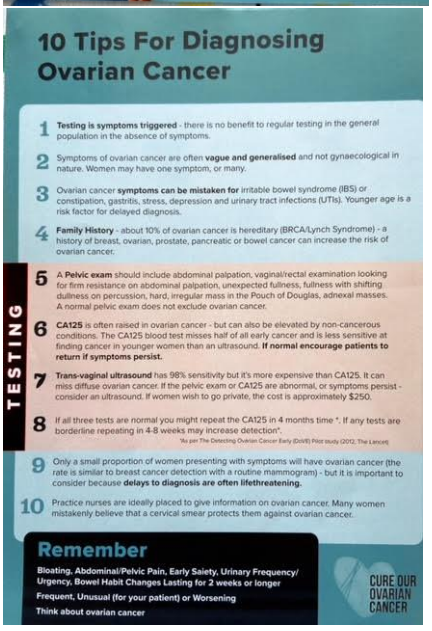
Michael Brenndorfer, NP, Youth Health Nurse Specialist, Executive Board Member, Ora Taiao: NZ Climate and Health Council (and our very own LOGIC committee member) spoke on Caring for Aotearoa. He's definitely passionate about this subject and we all need to take a lead from his passion and make changes for the better.

We then had breakout sessions in the afternoon when where members got to choose whom they went to hear from and all I believe were equally important:

Jeanette Banks, RN, Practice Nurse Lead, Tamaki Health, Small Group Leader, Pegasus Health Education: spoke on Health in a changing climate.

Liz Pennington, Operational Management Consultant & Leadership Coach/Managing Director – Kaihautū Whakahaere: spoke on Ovarian Cancer in Aotearoa. Having attended this one myself it was a very emotional subject of which we all need to be more aware of.



Michelle Piercy, RN, Nurse Practitioner Intern and Advanced Community Paramedic. Facilitator of the NZCPCHN Urgent Care Nurse Network (and a member of the NZCPCHN Professional Practice Committee): spoke on Expected Knowledge and Skills for Urgent Care Nurses. There is an article in this issue which is Part 2 to "What is Urgent Care" and we will have a follow up in the next issue on the findings from her study about which she spoke at the symposium. There is also an abridged version in NZ Doctor.

Joanna Turner, Research & Education Manager/ Asthma & Respiratory Foundation NZ: spoke on Supporting you, your patients, and the community in practice.

Dr Zoe Tipa, Whānau Āwhina Plunket Chief Nurse: spoke on Mahi Ngātahi: Culturally Responsive Ways of Working with Whanau Accessing Well Child/Tamariki Ora Services. Having attended this session, it is certainly eye opening even to those of us who have been nursing for some considerable years how we can still get this wrong.

Cathy Leigh, RN. BA, NZNO Professional Nursing Advisor: spoke on Workforce issues – the new reality – Possibilities, Pitfalls and Precautions. We have an article from Cathy in this issue also as the NZCPHCN PNA.

The slides from these sessions are all available on the NZCPHCN website and I believe also on the College of Nurses Aotearoa site.

After so long not being able to connect and reconnect with colleague's face to face this opportunity was welcomed and celebrated by everyone who attended. And once again collaborating with the College of Nurses Aotearoa was great. The venue and the staff at the venue could not have been more helpful if they tried – so a big thank you to the Arawa Park Hotel staff. Highly recommended for any stay whether it be symposium or holiday (if any of us remember what a holiday looks like).

We hope you enjoy this issue of LOGIC and visit our Facebook page and the NZCPHCN website for updates between the issues of LOGIC.

Dear Members,

It's great to be able to share some information about the **He Ako Hiringa resources** in the issues of Logic this year.

Around six months ago, Pharmac appointed me as a member of the He Ako Hiringa advisory group. As an advisor, my role has been to provide information on the educational needs of primary care nurses with respect to the medicines used by their enrolled population, working with general practitioner and community pharmacy colleagues from around New Zealand.

**Data on your enrolled patients**

To kick off this first update, I wanted to draw your attention to one of the most valuable resources from He Ako Hiringa – a free dashboard called **EPiC**. EPiC allows practices to monitor how medicines are used in their enrolled population and compare this to how they are used nationally. Prescribers can also view their own data.

After reviewing the latest EPiC update, it's great to see that our combined primary care efforts over 2022 seem to be making a difference in some key areas. Between January and December last year, there was an increase in the number of people getting their prescriptions dispensed regularly. This indicates that, nationally, patients are more likely to be persisting with taking their medicines. We are also celebrating an uptake in the number of Māori and Pacific peoples receiving SMART therapy for asthma, as recommended in the most recent national asthma guidelines.

But there is heaps more to do, particularly in the areas of gout and diabetes where nursing input can make a real difference.

**Sign up: free EPiC walk through!**

If you are interested in looking at medicine use in your enrolled population visit **www.akohiringa.co.nz** and click on the EPiC link. You can also email Varun Vartak (varun@akohiringa.co.nz) to arrange free access or a free training session.

**New resources on He Ako Hiringa**

New resources on liraglutide, updates on the COVID-19 medicines, and managing patient expectations around antibiotics have all been released this month. Logging in will allow you to capture your reading or watching for your education portfolio. You will also be notified of upcoming free webinars, and new resources as they are published.

Ngā mihi

**Bridget Wild**
Chair - Professional Practice Committee
NZCPHCN (NZ College Primary Health Care Nurses)

## *NZCPHCN Committee Members 2023:*

NZCPHCN committee:

FRONT ROW: Missy Brett, Jess Beauchamp, Tracey Morgan, Yvonne Little, Jeanette Banks, Erica Donovan, Katie Inker, Charleen Waddell, Bridget Wild, Ellie Moloney.

BACK ROW: Lee-Anne Tait, Shell Piercy, Cathy Leigh PNA, Melanie Terry, Mikey Brenndorfer, Nicola Thompson – outgoing Treasurer.

(Missing is Secretary Rachael Maheno who was unable to attend the symposium).

## *NZCPCN Executive Committee Members 2023:*

Bridget Wild (Chair PPC), Cathy Leigh (PNA), Yvonne Little (Editor/Interim Publisher LOGIC, Facebook Page Admin), Nicola Thompson (Outgoing Treasurer), Tracey Morgan (Chair), Charleen Waddell, Missy Brett (PPC and Incoming Treasurer). Missing is Secretary Rachael Maheno.

## *NZCPHCN Professional Practice Committee Members 2023:*

FRONT: Bridget Wild (Chair), Jeanette Banks, Erica Donovan, Melanie Terry.
BACK: Cathy Leigh (PNA), Shell Piercy.

## *NZCPHCN LOGIC Journal Committee Members 2023:*

Ellie Maloney, Mikey Brenndorfer, Jess Beauchamp, Yvonne Little (Editor/Interim Publisher), Lee-Anne Tait, Katie Inker.

## *PNA Update – Cathy Leigh*

An excellent two-day meeting with progress towards workplan and discussion of many workforce issues.

The committee reviewed their rules; the CPHCN brochure; the website and updates have been approved.

Discussion re how to be proactive with Government initiatives in PHC – eg giving

early feedback about any rollout of immunisations.

Discussion was had on how to promote and share material via podcasts or on NZNO platforms – further discussions with Rob Zorn and Andrew Casidy to be arranged.

**UC network** is growing. Shell Piercy gave feedback on the survey to members regarding what is needed for education and a nursing framework**.**

**Planning:** Next Face to Face is planned for October 2023 with plans to invite Rhiana Manuel, Paul Goulter, Kerri Nuku & Anne Daniels

**AGM and Professional practice Forum in March 2024** – practical; ideas to be garnered from symposium feedback.

**Paul Goulter, Kerri Nuku and Anne Daniels** were able to zoom in on day two with the combined committee. Update given from BoD recent Hui. Maranga Mai strategy was shared, and the work being done by NZNO around pay parity/pay equity, particularly recent meetings related to PHC (GPLF; discussion with Ayesha Verral). The committee outlined vital work being done by nurses in PHC and discussed many issues - Nurses individual stories of struggle and feeling like the "poor cousin" in nursing– feeling undervalued, not seeing enough coverage and support (even from NZNO) for the PHC sector issues and workforce.

Request – for NZNO to advocate for Universal MECA – every nurse on same pay and conditions -

The committee want PHC to be a focus in the April 15 day of action. They have collated short videos showcasing the roles of PHC nurses which can be shared.

Paul suggested that further research projects are undertaken to quantify the gaps in PHC – patient numbers, nurse shortage, models of care etc. Questions raised re how to resource this? Plan is to pen a letter to Paul/BoD regarding what funding and support is needed to do this mahi. Also work on how PHC nurses will adapt to future changes– AI; Climate change; innovations and new models of care ….

Paul, Kerry and Anne encouraged further sharing of issues via himself to go to BoD – the impact of the workforce issues are having on PHC; also collating stories of work being done in PHC – to promote the sector. Discussed how to make the issues more visible in the media.

**One of the committee members contacted Paddy Gower who is willing to meet to consider a documentary about the "day of the life of a PHC nurse".**

## *NZCPHCN Urgent Care Nurses Network development; Part 2*

*Michelle (Shell) Piercy*

The Urgent Care Nurses Network is a special interest group of the NZCPHCN. It was established in early 2021 in response to calls for support from Nurses across the urgent care sector, resulting from several health and disability commissioner (HDC)

complaints about urgent care (UC) and concerns about staffing levels.

The Urgent Care Nurses Network's (UCNN) aim is to support urgent care nurses with industry-specific education, practice standards, and resources, liaison with external providers, industry research, and advocacy.

The NZCPHCN recognizes that UC is a specialty of nursing, and as such there are specific knowledge and skills required for career progression in UC nursing. These knowledge and skills are in addition to the Primary Health Care Nursing Standards of Practice 2019 which is a requirement of all PHC nurses.

Consider Emergency Nursing, it is accepted that within your orientation into an Emergency Department (ED) you will complete a certain list of skills and obtain certain knowledge supported with education packs and online learning. Within two years of practice within an ED, you are expected to add additional courses and move to areas of higher equity, such as triage. This system also means that if an experienced nurse transfers from one ED to another the credentialing process is seamless, the UCNN would like to support UC nurses and clinics in a similar way with a knowledge and skills framework to not only credential nurses with experience but also provide a pathway of education for nurses new to UC.

As the Founder and Facilitator of the UCNN I am conducting industry research in the form of a survey asking, 'what knowledge and skills are expected of a highly trained and experienced Urgent Care (UC) Nurse?' this way a framework and pathway can be built to get there.

The survey sent out in October 2022 has had a great response and the research findings will be presented in March at the NZCPHCN and CNANZ Symposium 2023 in Rotorua. Following the presentation of the findings, a recommendation will be available for NZCPHCN and to the Royal New Zealand College of Urgent Care (RNZCUC).

The UCNN is also working closely with the RNZCUC to address some of the HDC complaints specifically looking at Triage in Urgent Care, there will be findings from this available in March 2023 also.

One of the areas the UCNN gets asked about the most is nursing staff allocation and safe staffing. There is no specific guidance in this area yet. However, there are roles that need to be filled in an UC clinic that provide all the necessary requirements for the Urgent Care Standard 2015, expedite patient care, and provide safety to nurses and patients alike while also improving the business bottom line. This is a win-win-win, better for patient outcomes, safer for nurses, and more cost-effective for urgent care businesses. The patient's journey in urgent care is different from general practice. Triage is hugely important for episodic care due to the high risk of acute and urgent patients presenting at unpredictable times with unpredictable levels of acuity. For this reason, the RNZCUC has set a standard for triage using the Australasian triage scale in 'The Standard 2015' this means there needs to be always a dedicated triage nurse. Patients arriving at a UC clinic ***MUST*** be triaged within 15 mins of arrival at reception and therefore it is imperative that triage only takes 2- 5 min as stated in the ATS training and not a full nursing assessment with Observations and

weights, analgesia, and all the other wonderful things nurses provide. Once patients have been triaged, they are given a safe to wait time, this mitigates the risk to patients presenting to triage. The triage nurse is also the only clinician legally responsible for the well-being of patients waiting to be seen. The triage nurse can also allocate patients to the most appropriate clinician, for example, a nurse-only encounter will be allocated in urgent order to a treatment nurse or a patient appropriate to see a community paramedic will be allocated in urgent order to a community paramedic working within the UC. The next role needed in UC is an assessment nurse, this nurse is responsible for ensuring the patient journey is expedited appropriately. In this role a nurse will see patients in the ATS urgency order, they will read the triage and provide a nursing assessment appropriate for the patient and presentation, this will include a full set of vital signs, weights where appropriate, visual acuity if needed and will be able to provide analgesia and a series of standing order medication where appropriate, additionally diagnostics like simple X-rays can be ordered and point of care (POC) urine tested. The patient once assessed, and some management provided e.g. splinting of injuries and analgesia is able to more appropriately wait to see the Nurse Practitioner, Community Paramedic or Doctor diagnosing the presentation. The next nursing role is an assistance role to the diagnostic clinic, this role is flexible like a float nurse, this nurse will undertake further diagnostic testing as requested by the diagnostic clinician, where immediate treatment is needed this nurse is there to provide that. They assist when the diagnostic clinician needs support and they are available if a surge of patients presents to any of the other nurse's roles on the floor, to ensure the flow of patients through the clinic is working well. The last UC nursing role is following the diagnosis by the clinician, this is the treatment nurse. The treatment nurse takes the treatment plan from the diagnostic clinician and ensures it is carried out. This will include casting, wound care, referrals, patient information, and much more, this nurse ensure that patient has everything they need following their presentation to prevent representation and improve patient outcomes.

As nurses, we need to speak up about safe staffing and risk mitigation for patients presenting to urgent care, we need to be working to improve patient outcomes, especially for high-risk patient populations, this is a requirement of our nursing registration to practice TE TIRITY O WAITANGI.

If you or your clinic manager would like more information on this topic, please contact the UCNN.

*Yvonne Little, Nurse Practitioner, NZCPHCN Representative on the National Cervical Screening Advisory and Action Group (NCSPAAG)*

As many of you are likely already aware there will be changes coming to the area of cervical screening. The roll out date is set for July 2023.

Please take a look and sign the petition if you haven't already and also spend some time watching this amazing documentary about how underserved certain wāhine are.

New Zealand College of Primary Health Care Nurses NZNO

**A Call To Action Campaign: Time to Value the Women of New Zealand.**

**The time is NOW.**
**We need your help in an urgent and important matter as members of NZNO. Please read the information below and let's get this information and petition out to all our colleagues, family, and friends. We need the Government to stand up and take notice.**

Let's not waste this biggest and important change to cervical screening we have seen in the past 30 years. Cervical Cancer can be eliminated but we need equity and access for all women in New Zealand.

The proposed programme is currently the ONLY national health screening programme NOT fully funded by the Government.

To ensure there are no barriers, a FULLY FUNDED, screening programme is called for – which includes FREE screening, follow-up, diagnosis, and treatment.

The response received from Minister Verrall in December 2022 **did not** include a decision for a free programme. Additional letters have been sent to the Prime Minister and other Ministers. **BUT WE NEED YOU** to keep signing, sharing and lobbying MP's about the petition for a FULLY FUNDED programme. Every person can campaign for this necessary change.

Click on the link below which takes you to the petition page which also has more information about the programme.

https://our.actionstation.org.nz/petitions/urgent-call-for-free-cervical-screening-no-one-should-die-of-this-preventable-cancer

https://thespinoff.co.nz/society/12-04-2023/the-struggle-for-access-to-cervical-screening-in-rural-aotearoa

*New Zealand College of Primary Health Care Nurses, NZNO and College of Nurses Aotearoa, NZ CAN (NZ) 2023 Symposium in pictures*

*Caring for Ourselves, Caring for Communities, Caring for Aotearoa*
*"Te taiki a tatou ano, te tiaki i nga hapori, e tiaki anad i a Aotearoa"*
*A focus on primary & community health care nursing.*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Mahi that matters


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on the professional issues of nursing
and on the health of our communities
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The organisation which focuses entirely


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matters


PHCN
NURSES


Mahi that matters


Mahi that matters

*Lee-Anne Tait*
*Nurse Prescriber - Te Whare Ora O Eketāhuna – Eketāhuna Health Centre*

## Skin sores - how are we tackling them post Covid?

Lee-Anne Tait Nurse Prescriber and member of the Logic Committee looks at ways we can support children /care givers/ the general public in ways to address the ever-increasing presentations related to skin infections – predominantly Impetigo and Cellulitis within clinical settings in primary health care.

The background to this article, for those of you that haven't read my articles before is that I work as a Rural Nurse Prescriber in Eketahuna. I'm now into my third year of Nurse Prescribing and have been collating data on all forms of medication that I prescribe / order under MPSO etc. I really only prescribe under acute medication, as we are a nurse led GP/NP support clinic, therefore we try our best to encourage to patients stay abreast of their regular prescriptions through twice yearly visits with their respective GP/NP's.

In daily practice I am aware that I have been prescribing Flucloxacillin more often than any other medication in the past year. Therefore, in order to further clarify why I started to collate data in relation to service delivery. From this data collection I noted our greatest reason for clinical presentations for 0–17-year-old, aside from immunisation have been for skin infections. Next, I looked into adults 18-64, and then 65 and over. This search illuminated around a third of our presentations for dressings and ACC are also for skin infections. I'm awaiting a report back from ACC on exactly what percentages are in each age category for claims lodged in relation to cellulitis.

We occasionally see minor skin breaks following a graze, cut or an insect bite – usually these are the ones that respond to a good wash or clean with an antiseptic solution and a plain breathable dressing along with the cutting of nails to reduce the spread of bacteria such as S*taphylococcus aureus* or S*treptococcus pyogenes*.

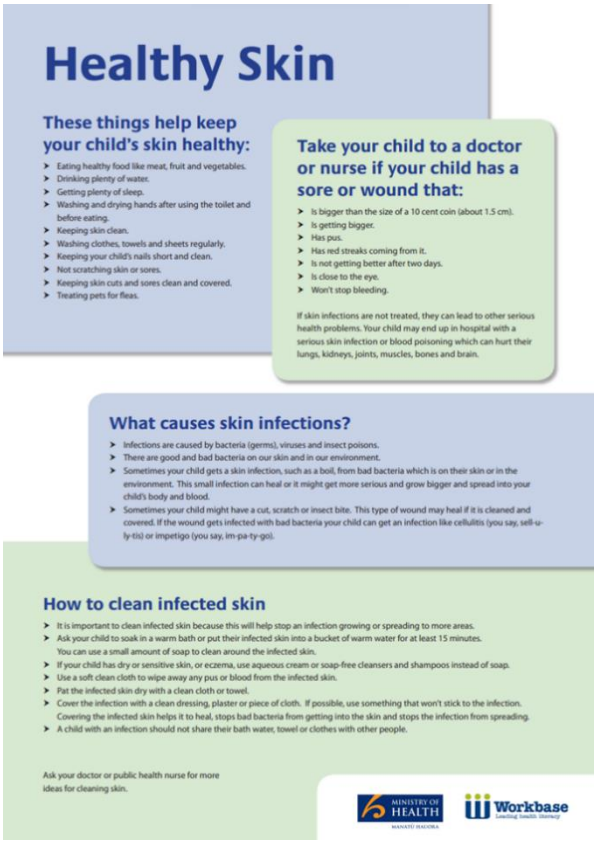
We tend to see more of the next stage up which already have a more significant overgrowth of bacteria and require Povidone-iodine 10% or Hydrogen peroxide 1% cream two to three times a day with a plain breathable dressing along with the cutting of nails. Or if totally localised and nil previous infections and little response to the above treatments we occasionally try BD Fusidic Acid 2% ointment or cream, again with a plain breathable dressing where possible and a nail clean and trim however this said if it appears adherence will be of concern, to lessen the burden already associated with topical antibiotic resistance, we go straight for oral antibiotics as these always appear to have better compliance/health outcomes. If a topical antibacterial cleansing agent has failed to work , for the non-resolving / non adherent skin bacterial colonisation and there is noted spread, infecting other areas of skin or developing Cellulitis then Flucloxacillin is my go to first

medication if there are no penicillin allergies/ hepatic or other contraindications for prescribing **Child:** 12.5 - 25 mg/kg/dose, four times daily, for five days (maximum 500 mg/dose) **Adult:** 500 mg, four times daily, for five days. As per best practice guidelines. It blows me away to see patients with severe infections that they have never thought to consider adequately washing or cleansing themselves for days prior to presenting for treatment, therefore I spend a great deal of time on education throughout every stage of the treatment process and do my very best to get the patient to own their health and the bacteria on their skin, getting them to do the washing the cleansing the covering -so they understand the process of colonisation and how to disrupt it, in order return the skin to homeostasis and maintain this when under threat in the future.

This leads me to wonder if we need to do a little more proactive health promotion in order to reduce the possibility of an infection in the first place. I was wondering how well we are currently educating children, parents and the general community to clean/ cut / cover in the very early stages of a break of any kind to the skin's surface/integrity and where the most useful information on early self-care can be sought?

Initially post Covid lockdowns we saw far fewer presentations of any level of skin infections, thanks to the messages in relation to hand washing / self-hygiene/ cleaner and wider personal spaces– but it appears they have waned somewhat of late.

So, I have been scouring MOH, Public Health and general internet sites for the best messages/websites to use in education for people to turn to in terms of prevention rather than treatment. Interestingly enough there appear to be far fewer messages of ways to prevent than there are ways to treat/cure.




This poster comes from MOH – and can also be found on the Health Navigator site which we often encourage Patients to use to seek accurate health information. It has really good preventative information – but is a little dull and possibly not bright enough to draw attention to it, however treatment information is also really good but again relies on ability to read well.

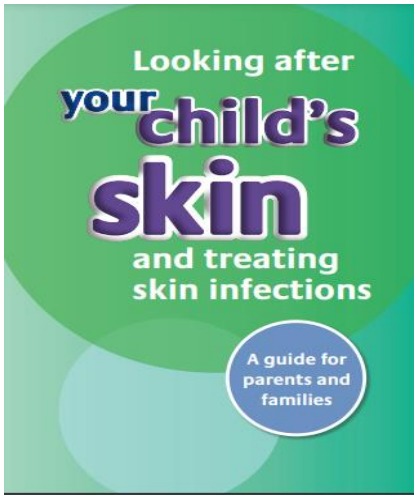
Whereas the Impetigo poster again relies on ability to read, it has far more shapes and images on it, overall is more eye catching and is more interesting to look at. It made me wish the preventative one above could be slightly more appealing.


On the Kidshealth website I found these Stop Skin Infections - Resources for Printing in four commonly used languages in Aotearoa. Again, prior to finding these I noted the website had a really excellent section on treatment of Impetigo and with prevention strategies afterwards.





This booklet remains one of the best resources to encourage Patients to look at and to read, as it shows how to clean hands and skin ways to initially prevent or treat breaks in the skins integrity and should these breaks result in infection how to treat. It covers presentation's seen in skin throughout the ages.



Overall, it seems there were many websites and educational posters for recognition of Impetigo and similar skin conditions along with treatment options and prevention strategies for going forward. However, it was harder in the reverse order to find tips on keeping your skin healthy and preventing deterioration / bacterial infection.

I feel we must again acquire the stance of the MOH Public health Covid messages -in that we have the ability to convey proactive preventative health messages – in this instance proactive rather than reactive skin health - prevention rather than cure.

As we are already seeing resistance to topical antibiotics, we do not want to find ourselves in the same position with oral antibiotic resistance in the treatment of Impetigo. Let's try to get the clean cut and cover message out there before the ignore/get someone to treat/repeat cycle message gets back into full swing once again.

REFERENCES


https://bpac.org.nz/antibiotics/guide.aspx#impetigo

Chaplin, S. (2016), Topical antibacterial and antiviral agents: prescribing and resistance. Prescriber, 27: 29-36. https://doi.org/10.1002/psb.1480

Chaplin, S. (2016), Topical antibacterial and antiviral agents: prescribing and resistance. Prescriber, 27: 29-36. https://doi.org/10.1002/psb.1480

https://nzf.org.nz/nzf_3012

https://bpac.org.nz/antibiotics/guide.aspx\

https://www.healthnavigator.org.nz/health-a-z/s/skin-infections-in-children/

https://www.kidshealth.org.nz/how-treat-when-seek-help-school-sores

https://www.kidshealth.org.nz/sites/kidshealth/files/pdfs/skin-infections-booklet-nov13v2.pdf

Chaplin, S. (2016), Topical antibacterial and antiviral agents: prescribing and resistance. Prescriber, 27: 29-36. https://doi.org/10.1002/psb.1480



*Jess Beauchamp –Whānau Āwhina Plunket*


**Whānau Āwhina Plunket and other Well Child Tamariki Ora service providers: a very brief history 1907 - 2023.**

The Society for the Promotion of the Health of Women and Children started in 1907 in Dunedin. It soon became known as the Plunket Society (after Lady Victoria Plunket, the wife of the Governor General to New Zealand at the time). This choice reflected the prevailing ideas and practice of colonial New Zealand. The Plunket Society is acknowledged by Linda Bryder in her book, *A Voice for Mothers* (2003) as having a significant national role in caring for mothers and babies for most of the twentieth century in New Zealand. Plunket nurses provided baby checks and advice to over 90 % of families during the last century, with Public and Māori health

nurses also providing care, often in rural or remote areas New Zealand that Plunket did not serve.

Over its 100 years plus history, Plunket has amended its name to reflect operational changes but the addition of Whānau Āwhina in 2020 reflected a re-examination of its history and the rightful inclusion of two wāhine Māori into their origin story.

To read more about this change and Whānau Āwhina Plunket's history, please follow the link below.

https://www.plunket.org.nz/plunket/about-plunket/who-we-are/our-history/

In 2002 the term Well Child Tamariki Ora (WCTO) was formalised by the New Zealand Ministry of Health with the publication of the first WCTO National Framework. At that time Plunket provided the vast majority of WCTO nursing services. Subsequently primary health care services have developed to include an increasing number of WCTO nurses working in local health services, many iwi lead, as well as in public or rural nurse roles. These nurses often work across the life span in their community but have a special part of time funded for their WCTO work. A disadvantage can be professional isolation from other WCTO nurses but conversely their work team can be culturally rich, diverse, and multidisciplinary so collaboration with others to support whānau health is enhanced.

The *Well Child Tamariki Ora Review Report* done by the Ministry of Health (2020) records that, along with Whānau Āwhina Plunket as the national provider, there are more than 60 local WCTO service providers mainly contracted through DHBs. In 2022 Whānau Āwhina Plunket's Annual report said over 500 registered nurses worked with them. The numbers of RNs working for other providers is hard to quantify, but a guess would be at a minimum 120 nurses, as each local provider has at least one nurse and many have several. This diversification of WCTO providers aligns with growing national and international evidence about the impacts of health determinants, the profound and unjust effect of colonisation on health outcomes for Māori, and the pressing health system change required to reorientate the health system towards a preventative and collaborative approach to reduce health inequity for Māori pēpi, tamariki and whānau in Aotearoa. Well Child Tamariki Ora nurses work from North Cape to Bluff and even further south where Awarua Whanau Services, based in Invercargill, have a Tamariki Ora nurse serving whānau on Rakiura/Stewart Island.

To find WCTO service providers in your area, follow the link to this interactive map.

https://www.health.govt.nz/your-health/pregnancy-and-kids/services-and-support-you-and-your-child/well-child-tamariki-ora-visits/find-well-child-tamariki-ora-provider

A professional unifying factor for WCTO nurses regardless of employer, is the recognition that WCTO is a special scope of nursing practice framed by the WCTO National Schedule (MoH, 2013). Currently the Ministry requires all RNs who deliver the WCTO Schedule, to have a post graduate qualification in WCTO nursing. This is a two-paper, level eight qualification, with a focus on praxis in the community and population health. It is run through Whitireia and has two intakes per year. The PGCert PHC WCTO nursing is a dynamic education space committed to translating theory to practice. This year we have our largest RN intake ever at just under 60 nurses (normally max 40) in the first semester. Consequently, for the first time, we are running two study streams concurrently. Watch this space for an update on how the year goes!

Research is crystal clear that money spent in protecting and supporting early child health and wellbeing pays dividends across the lifespan, enhancing whānau ability to provide nurturing care for their children, reducing chronic ill health, increasing the child's capacity for pro social behaviour and learning. (Center on the Developing Child at Harvard University (2016). Further, the articulation by many organisations of the importance of the first 1000 days reflects this growing evidence base of the critical importance of the early years in building the foundation for health and wellbeing across the life span. The 2020 review by the MoH found the current WCTO service contributes positively to health and wellbeing for many tamariki and whānau, but this change is not consistent across all whānau. To read more about what the review found and plans for the future WCTO service, follow the link below.

https://www.health.govt.nz/publication/well-child-tamariki-ora-review-report

Poipoia te kākano kia puawai

Nurture the seed and it will blossom.

**References**


Bryder, L. (2003). *A voice for women*. Auckland University Press. New Zealand

Center on the Developing Child at Harvard University (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families* www.developingchild.harvard.edu.

Ministry of Health, (2013). *WCTO National Schedule*, Wellington.

Ministry of Health, (2013). *WCTO practitioner handbook,* Wellington.

Ministry of Health, (November 2020). *Well Child Tamariki Ora Review Report*. Wellington.

Whānau Āwhina Plunket, (2022). Annual Report.

https://www.plunket.org.nz/assets/Annual-report/Whanau-Awhina-Plunket-Annual-Report-2021-22-Web.pdf

## Breastfeeding matters; a day in the life of an IBCLC in remote rural Tararua.

*By Cherry-Anne Lee, IBCLC, RM, RN, Tararua.*

You would be forgiven for thinking that breastfeeding just comes naturally to most new mothers and requires thinking about only once the baby is born. The reality is that from the moment a woman conceives to the moment she weans, breastfeeding is ever changing and wrought with challenges requiring much negotiation from the woman, her family, and her healthcare providers. With every breastfeeding experience hinging on the next. As a remote rural lactation consultant in the Tararua region I have seen anything but "coming naturally" to the hundreds of women I see in a year; even with women who have successfully breastfed previously. The challenges can be physical, emotional, demographical or a combination of all three; and the breastfeeding rates at 3 months postpartum in our community are worrying. Although I am a private LC, I provide 99.9% of my clients with fully funded breastfeeding services through a contract with Community Birth Services in the Manawatu. Come this April that service will cease to provide breastfeeding support due to financial constraints brought around by a rapidly changing economic environment following a pandemic and ongoing funding crisis in the health care sector.

Te Whatu Ora MidCentral is currently working towards salvaging the services already currently making a big difference and trying to bolster them up to improve breastfeeding rates especially within the Māori population. Inclusive language and use of social media to promote drop-in breastfeeding support groups which aim to pop up in at least four locations along the Tararua; from Eketahuna to Takapau and out to the coastal regions of Herbertville, Akitio and Pongaroa. So far, the groups have been very successful and well received by the grateful women and whānau who have attended, returning weekly in many cases. My day starts like most farming wives, alarm clock, coffee and then panic to get the 1000 things done prior to school bus drop-off. If I'm lucky enough I get a three-minute chat with a neighbouring parent who also drives to the bus stop location six kms away from home. We have just enough time to complain about the weather and laugh about our wild children's antics for that morning. I might even get another coffee in if I had time to get my travel mug out. Then before the bus pulls out, I whizz around past it and wave to the Driver gratefully, and head out so the bus doesn't hold me up for the rest of the six kms on our gravel road. I quickly remind myself which location my breastfeeding drop-in clinic is in for the day – Eketahuna, only 102 kms away. I pop an audio book on and carry on my way for a long hours' drive using all the back roads and shortcuts I've learnt in 13 years of being a local in the district. I pass logging trucks; road works three times and avoid a few cattle beast earlier on in my route. I think about my kids, my husband, my previous life back in Australia. What a big difference 13 years can make. I'm passionate about women's health and

always have been. Naturally that lead to nursing and midwifery in particular and later on an IBCLC and breastfeeding advocate.

I enjoy the remote rural challenges of my job because every person and family I see are so happy and grateful to get any services at all. They often have very low expectations and when I bring a gold standard of care to their remote rural doorsteps, they appreciate the knowing and empathetic smile that I can bring with a myriad of skills from general nursing to midwifery and beyond. Most people just need to feel like someone cares enough to make the pilgrimage to their little neck of the woods, or to bring a drop-in clinic close enough that they can justify using the petrol on the trip and couple it with a grocery shop and veterinary drench pick-up. I always ring my clients when I'm heading out, to remind them of my visit and to ensure they will be home and of any landmarks should I get lost (has happened a few times) and the next thing that always falls out from my mouth is…and do you need any milk brought out? They often laugh and mostly say no…but some say Yes and it's a great connection. Because it's the little things in life that count. People are having to cope with so much these days and to bring a little bit of kindness in any way means a lot to anyone who lives remote rurally. We often discuss the weather, farming hardships and the labour and birth journey; then eventually the breastfeeding issues that have brought me to them. There is a lot of unpacking to be done emotionally for these women and their whānau. Sometimes the visit is predominately a social one with lots of reassurance and guidance around anxiety and sleep deprivation. I am tender and nearly everything is "completely normal", but women need to hear those words, again and again and again. I work with shallow latches and assess for tongue tie and the need for further referral to have that reviewed or treated, cracked nipples and engorgement, low birth weight gains and low milk supplies. Sometimes we fix the issues with one home visit that could last on average of an hour and a half with a follow-up phone call two days later, or we may need to return again in two to three days for a repeat visit, called a Tier 2 visit. Two visits per referral is the limit to the funding and everything is done to avoid a second visit, because there's only one of me and more referrals continue to filter through from all the community midwives, Rangitāne Kaiawhina, Plunket nurses, and district nurses within the elongated region. I love what I do, and I feel privileged to work alongside some excellent services, but good thing I do love it, because otherwise it would be very hard to justify the rising cost of petrol, cost of living, wear and tear on my car, and the emotional toll of trying to raise my own family (aged 9, 7 and 5) in amongst it all and running a farming business with my husband on the side with droughts, pandemics, lock downs, cyclones and the crippling rising costs of inputs into the farming sector. Never before has there been so much evidence as to why breastfeeding your baby is the most economical and safest option all round, and yet at three months postpartum more and more women are deciding to introduce a bottle of formula for varying reasons. Some of the common reasons given and that I try to undo are, ~ "I'm going back to work in six months and need to make sure my baby can take a bottle now" ~ "My husband/mother/sister want to be able to help out with the baby

to let me sleep more" ~ "My baby seems more hungry in the evenings and goes straight to sleep with a bottle" ~ "My supply can't keep up with my baby's demands" ~ "Formula-feeding and/or top-ups help my baby to sleep for longer periods" ~ "I can't get enough expressed breastmilk for whole feeds/top-ups and so we gave some formula that a well-meaning family member dropped off" And the list goes on. The milk bank in the Manawatu has made some ground-breaking increases in exclusive and fully breastfed baby statistics leaving the hospital setting, and that's indicating that there is a real need for the uptake of donor human milk. The problem is, are the full-term healthy babies receiving "donor breastmilk" as top-ups prior to hospital discharge for convenience and routine and to allow mums to sleep better on the ward and then setting the families up for disaster the minute that they attempt to settle into home life away from the milk bank stash and convenience of skeleton staff just a buzzer away. Midwives are thin on the ground, nurses are stepping up to keep maternity wards running and breastfeeding rates are suffering. Now the rates are beginning to rise, with the donor milk uptake, even in healthy term babies. Breastfeeding education is rationed out to those who need it urgently, for everyone else its often picked up too late to reverse some of the common reasons for deciding to introduce a bottle of formula. Even if it can be reversed and righted, fully breastfed is the best we can hope for, but often exclusive breastfeeding has been lost forever and mixed feeding to artificially fed statistics are the only options left to tick. Once the drop-in clinic is done and dusted, there is a home visit to try to fit in on the way home before I return to just catch the school bus in time for pick up at 3:30pm. It's not uncommon to unfortunately run late and need my husband to pick up the slack…but he's out of cell phone coverage for the day as usual on any one of the blocks that he runs 24/7. I then text a neighbour on our road and beg them to hold on to our children until I can arrive. It's a juggle. The struggle is real. Once home I feed ravished kids, try to stop them eating me out of house and home, clean out lunchboxes and then head into the witching hour and prepping dinner still with all my days notes swirling in my head to be finished and scanned and emailed once the children are in bed.

Exhaustion is my new mood. And I have fifty shades of it on a daily basis. When my head hits my pillow around 11pm I am so spent that I wonder why anyone would do this job. But then I think of that beautiful smile from a mum who latched her baby with more ease, or the mum who felt validated, or the dad who felt reassured that he's also doing a great job and how else to support mum and baby. It's rewarding, but the stats aren't yet. There is much to do and much to learn. Connection and kindness are the key with some soulful networking within each unique rural community. I hope to still be providing breastfeeding and midwifery support to this district for many decades to come and welcome the challenge to increase our exclusive breastfeeding rates to a standard that we can be proud of from three months postpartum and well beyond. Every mama and pēpi deserves that!

Ngā mihi Cherry-Anne Lee

## Youth mental health and the ongoing effects of COVID-19.

*By: Lorraine Maxwell RN MN Programme Manager - Enhanced School Based Health Services - Te Puna Manawa HealthWEST*

**Introduction**

There are probably very few people in the entire global population, who have not heard of COVID-19. Three years on, it seems timely to remind ourselves of the events of 2019/2020. As you will recall, COVID-19 is a virus first detected in December 2019. It spread rapidly, and uncontrollably, through the world's population, with the World Health Organization declaring a global pandemic on 11 March 2020 (World Health Organization, 2022). By this point, horrifying and chaotic scenes were being relayed throughout the world's media. Hospitals were struggling to cope as they became rapidly overwhelmed with caring for the dead and dying (Windarwati et al., 2022). At short notice, governments produced and implemented public health measures, based on what little advice they had, in an attempt to protect high-risk populations.

During this period, New Zealand fared well. The government implemented strict lockdown rules, minimising the initial spread of the disease. Once the vaccination became available, the New Zealand population sought herd immunity, achieving one of the highest vaccination rates in the world (Our World in Data, 2022). But while we were all concentrating on the potentially devastating physical effects of COVID-19 on the population, few people were monitoring the rise in adolescent mental distress.

**Youth Mental Health before COVID-19**

Before COVID-19, youth mental health had been declining for years. Youth researchers increasingly painted a concerning picture of declining youth wellbeing and increasing rates of depression (Fleming et al., 2020). Youth suicide rates have been labelled New Zealand's "national shame", (He Ara Oranga, 2018, p50), with youth suicide rates consistently amongst the worst in the OECD (Organisation for Economic Cooperation and Development, 2015). We must recognise that young people are growing up in a difficult world, finding it harder to envision a secure future (Windarwati et al., 2022), citing climate change and lack of job opportunities as two major issues of concern (Fleming et al., 2020; Kiss et al., 2021). They have had to contend with the global rise of technology, becoming the first generation to live in this world.

While technology has some benefits such as increased access to learning and feeling more socially connected, there are certainly some downsides (Fleming et al., 2020). Young people are now exposed to higher rates of cyber bullying, online violence and potential sexual exploitation (Dahl et al., 2018). At the click of a button, there is a risk of accessing unwanted and unregulated, pornographic images, often at terrifyingly young ages (Office of Film and Literature Classification, 2018), leaving young people with images they are ill-equipped to process.

**Youth Mental Health and COVID-19**

Youth researchers all noted that COVID-19 was going to be difficult for our youth populations. It is at this developmental stage of their life that their world increases, and peer support becomes central (Vacaru et al., 2022). Public health measures aimed at minimising physical contact to stop the spread of the virus, were in direct opposition to teenage brain development and normal socialisation processes (Lamblin et al., 2017). This resulted in the isolation of many young people as they were mandated to suddenly cut all physical contact with friends and chosen family, key individuals who were vital to their mental stability (Kiss et al., 2021).

The closure of schools and other community institutions also contributed towards increasing youth psychological distress (Panda et al., 2021). For some young people, home is not their safe place. New Zealand already had one of the worst rates of family violence and child abuse compared to other OECD countries before COVID-19 (UNICEF Innocenti, 2020). With food insecurity and other family stressors increasing during lockdown periods, the potential for an increase in exposure to violent or abusive situations became enormous (Russell et al., 2022; Jones et al., 2020; Every-Palmer et al., 2020). Sudden closures of schools and the lack of access to places of refuge, combined with an increase in time spent at home, has no doubt, impacted mental wellbeing (Panda et al., 2021).

Not unusually, some young people turned to substance use as their method of coping (Villanti et al., 2022). This may have been role modelled by adults as they also struggled to cope with the stressful climate (Every-Palmer et al., 2021). It seems bizarre now that alcohol was considered an essential item throughout lockdown periods, with many governments ensuring easy and convenient access (Stockwell et al., 2021). This is despite the fact that alcohol consumption is associated with an increased risk of COVID-19 complications (Huckle et al., 2020), and a decrease in youth wellbeing.

**Equity**

The spread of mental distress was not equitable. Those from the LGBTQ+ community reported overwhelmingly poor outcomes, some young people having to stay at home with parents who did not support their gender transition or sexuality (Mitchell et al., 2022). One young person reported their parents using their dead name (Editor note: “dead name” refers to name at birth, rather than their chosen gender affirming name) constantly and sought online support from people they referred to as their chosen family (Mitchell et al., 2022).

Youth previously diagnosed with a mental health condition were inequitably affected (Bailey et al., 2022). Before the pandemic, many young people were able to cope with their mental health condition, having external supports in place to enable this. The pandemic removed these supports and created an environment of instability and uncertainty.

Indigenous youth were identified as being inequitably affected by the pandemic (Thomas et al., 2022; Serlachius et al., 2021). This is a concern with growing evidence of the negative health effects of

colonisation on indigenous populations, a concern identified before the pandemic (Ellison-Loschmann & Pearce, 2006), particularly on the mental health of Māori youth (Fleming et al., 2020; Clark et al., 2018; Clark et al., 2022).

Disabled youth (Ministry of Youth Development, 2020) and neurodiverse youth (Ameis et al., 2020) are other subsets of youth that have been inequitably affected. As you can imagine, the gap between these youth and those from well resourced, stable home environments widened (Mitchell et al., 2022).

**Coping mechanisms**

Youth became very resourceful during this time as they sought ways to cope.

- Connectedness - feeling connected was a major theme throughout the literature with some youth seeking to maintain and improve family connection. Other youth maintained relationships digitally, often making new connections online, upskilling their technological ability to achieve this (Fish et al., 2020).
- Practicing Self-care – this was another useful skill that was practiced during lockdown periods, with youth turning to exercise routines, eating healthy foods, or trying new hobbies to cope (Sinko et al., 2022; Balhara et al., 2020).
- Mindfulness Based Interventions - emerging evidence is supporting the use of mindfulness-based interventions as a tool for young people to cope and regulate their mental health (Yuan, 2021; Miller et al., 2021).
- Mobile health applications (apps) – the use of apps has been shown to be on the rise as young people seek digital tools to improve their mental health. Caution must be advised though as many health apps are not evidence based (Larsen et al., 2016; Terhorst et al., 2020). If they are subjected to a trial, this is often led by the programme developer, with no independent research available (Grist et al., 2019). Both WHITU and SPARX are well researched New Zealand based apps that have evidenced positive outcomes for young people (Serlachius et al., 2021).
- Phone Helplines - many young people utilised Youthline, a youth specific helpline, to support their mental health. Youthline reported a 50% increase in contact with youth during the COVID-19 lockdown periods (Ronald, 2020), with a similar increase in those wanting to use the chat or text function as they sought to maintain their privacy (Fildes et al, 2022).

These are all useful resources to support young people as they learn to cope during a difficult pandemic period. But what about those young people that don't have access to a digital device so they can access a wellbeing app? What about those young people that aren't living in well-connected family homes? It is these young people who are most at risk and must not be forgotten as they struggle to maintain their mental health.

**Conclusion**

There is much to do if we are to be successful in diverting a youth mental health crisis that has the potential to endure for generations to come. Youth specific services such as Youthline, WHITU and SPARX, Youth health clinics must be

given the funding and resources they need to improve and increase their services, enabling them to reach more at-risk young people. Young people must not underestimate the tools they already possess but need support to recognise and strengthen these tools in preparation for times of distress. The key will be to act rapidly and with focused, targeted policy changes that address equity and are developmentally appropriate.

**References**


Ameis, S. H., Lai, M. C., Mulsant, B. H., & Szatmari, P. (2020). Coping, fostering resilience, and driving care innovation for autistic people and their families during the COVID19 pandemic and beyond. Molecular autism, 11(1), 61. https://doi.org/10.1186/s13229-020-00365-y

Bailey, E., Boland, A., Bell, I., Nicholas, J., La Sala, L., Robinson, J. (2022). The mental health and social media use of young australians during the covid-19 pandemic. International Journal of Environmental Research & Public Health [Electronic Resource],19, https://dx.doi.org/10.3390/ijerph19031077

Balhara, Y., Kattula, D., Singh, S., Chukkali, S., Bhargava, R., & Balhara, Y. P. S. (2020). Impact of lockdown following COVID-19 on the gaming behavior of college students. Indian Journal of Public Health, 64, 172–176. https://doi.org.ezproxy.auckland.ac.nz/10.4103/ijph.IJPH_46 5_20

Clark, T. C., Le Grice, J., Moselen, E., Fleming, T., Crengle, S., Tiatia-Seath, J., & Lewycka, S. (2018). Health and wellbeing of Māori secondary school students in New Zealand: Trends between 2001, 2007 and 2012. Australian and New Zealand Journal of Public Health, 42(6), 553–561. https://doi.org/10.1111/1753-6405.12839

Clark, T.C., Ball, J., Fenaughty, J., Drayton, B., Fleming, T., Rivera-Rodriguez, C., Le Grice, J., Peiris-John, R., Bavin, L., Schwencke, A., Sutcliffe, K., Lewycka, S., Lucassen, M., Waa, A., Greaves, L.M., Crengle, S. (2022). Indigenous adolescent health in Aotearoa New Zealand: Trends, policy and advancing equity for rangitahi Māori, 2001-2019. The Lancet Regional Health Western Pacific, 28, 100554, https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(22)00169-9/fulltext

Dahl, R., Allen, N., Wilbrecht, L. & Ballonoff Suleiman, A. (2018). Importance of investing in adolescence from a developmental science perspective. Nature 554, 441–450. https://doi.org/10.1038/nature25770

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Māori population. American journal of public health, 96(4), 612-617. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2005.070680

Every-Palmer, S., Jenkins, M., Gendall, P., Hoek, J., Beaglehole, B., Bell, C., Williman, J., Rapsey, C., & Stanley, J. (2020). Psychological distress, anxiety, family violence, suicidality, and wellbeing in New Zealand during the COVID-19 lockdown: A cross sectional study. PLoS ONE 15(11): e0241658. https://doi.org/10.1371/journal.pone.0241658

Fildes, D., Williams, K., Bradford, S., Grootemaat, P., Kobel, C. & Gordon, R. (2022). Implementation of a Pilot SMS-Based Crisis Support Service in Australia. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 43 (1), 46-52. doi: 10.1027/0227-5910/a000758.

Fish, J. N., McInroy, L. B., Paceley, M. S., Williams, N. D., Henderson, S., Levine, D. S., & Edsall, R. N. (2020). "I'm Kinda Stuck at Home 8.5/9 Online support 64 With Unsupportive Parents Right Now": LGBTQ Youths' Experiences With COVID-19 and the Importance of Online Support. Journal of Adolescent Health, 67(3), 450–452

Fleming, T., Ball, J., Kang, K., Sutcliffe, K., Lambert, M., Peiris-John, R., & Clark, T. (2020b). Youth19: Youth Voice Brief. The Youth19 Research Group. https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/5f3394a2654885
030c051243/1597215912482/Youth19+Youth+Voice+Brief.pdf

Fleming, T., Tiatia-Seath, J., Peiris-John, R., Sutcliffe, K., Archer, D., Bavin, L., Crengle, S., & Clark, T. (2020). Youth19 Rangatahi Smart Survey, Initial Findings: Hauora 69 Hinengaro / Emotional and Mental Health. The Youth19 Research Group. https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/5f338e4cfb539d2
246e9e5ce/1597214306382/Youth19+Mental+Health+Report.pdf

Grist, R., Croker, A., Denne, M., & Stallard, P. (2019). Technology delivered interventions for depression and anxiety in children and adolescents: A systematic review and metaanalysis. Clinical Child and Family Psychology Review, 22(2), 147-171. doi:https://doi-org.ezproxy.auckland.ac.nz/10.1007/s10567-018-0271-8

He Ara Oranga, (2018). Report of the Government Inquiry into Mental Health and Addiction. Inquiry report | Mental Health and Addiction Inquiry

Huckle, T., Parker, K., Romeo, J. S., & Casswell, S. (2021). Online alcohol delivery is associated with heavier drinking during the first New Zealand COVID-19 pandemic restrictions. Drug & Alcohol Review, 40(5), 826–834. https://doiorg.ezproxy.auckland.ac.nz/10.1111/dar.13222

Jones, E. A. K., Mitra, A.K., & Bhuiyan, A.R. (2021). Impact of COVID-19 on Mental Health in Adolescents: A Systematic Review. International Journal of Environmental Research and Public Health, 18 (5), 2470. https://doi.org/10.3390/ijerph18052470

Kiss, O., Alzueta, E., Yuksel, D., Pohl, K. M., de Zambotti, M., Muller-Oehring, E. M., Prouty, D., Durley, I., Pelham, W. E., McCabe, C. J., Gonzalez, M. R., Brown, S. A., Wade, N. E., Marshall, A. T., Sowell, E. R., Breslin, F. J., Lisdahl, K. M., Dick, A. S., Sheth, C. S., . . . Baker, F. C. (2022). The Pandemic's Toll on Young Adolescents: Prevention and Intervention Targets to Preserve Their Mental Health. Journal of Adolescent Health, 70(3), 387-395.https://ezproxy.auckland.ac.nz/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=
JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med20&AN=35090817https://openurl.auckland.ac.nz/resolve?sid=

Larsen, M.E., Nicholas, J., Christensen, H. (2016). A Systematic Assessment of Smartphone Tools for Suicide Prevention.

PLoS ONE 11(4): e0152285. https://doiorg.ezproxy.auckland.ac.nz/10.1371/journal.pone.0152285

Lamblin, M., Murawski, C., Whittle, S., & Fornito, A. (2017). Social connectedness, mental health and the adolescent brain. Neuroscience & Biobehavioral Reviews, 80, 57-68, ISSN 0149-7634, https://doi.org/10.1016/j.neubiorev.2017.05.010.

Miller, Reagan L, Moran, Megan, Shomaker, Lauren B, Seiter, Natasha, Sanchez, Natalia, Verros, Megan, et al. (2021). Health effects of COVID-19 for vulnerable adolescents in a randomized controlled trial. School Psychology, 36, 293-302. https://doi.org/10.1037/spq0000458

Ministry of Youth Development. (2020). Youth Plan 2020-2022. Turning Voice into Action – rebuilding and recovering. https://www.myd.govt.nz/documents/young-people/youthplan/youth-plan-2020-2022-turning-voice-into-action-rebuilding-and-recovering.pdf

Mitchell, K. J., Ybarra, M. L., Banyard, V., Goodman, K. L., & Jones, L. M. (2022). Impact of the COVID-19 pandemic on perceptions of health and well-being among sexual and gender minority adolescents and emerging adults. LGBT health, 9(1), 34-42. https://www.liebertpub.com/doi/pdf/10.1089/lgbt.2021.0238

Office of Film and Literature Classification. (2018). NZ Youth and Porn: Research findings of a survey on how and why young New Zealanders view online pornography. https://www.classificationoffice.govt.nz/resources/research/nz-youth-and-porn/

Organisation for Economic Cooperation and Development. (2015). Teenage suicides (15-19 years old). https://www.oecd.org/els/family/CO_4_4_Teenage-Suicide.pdf

Our World in Data (2022, April 29). COVID-19 vaccine doses administered per 100,000 people. https://ourworldindata.org/covid-vaccinations.

Panda, P.K., Gupta, J., Chowdhury, S.R., Kumar, R., Meena, A.K., Madaan, P., Sharawat, I.K., Gulati, S. (2021). Psychological and Behavioral Impact of Lockdown and Quarantine Measures for COVID-19 Pandemic on Children, Adolescents and Caregivers: A Systematic Review and Meta-Analysis, Journal of Tropical Pediatrics, 67, (1), fmaa122, https://doi.org/10.1093/tropej/fmaa122

Ronald, S. (2020). Youthline. Supporting Youth through challenge and change. Annual Report 2020. https://www.youthline.co.nz/uploads/2/9/8/1/29818351/youthline_annual_report_fy20_-email_version.pdf

Russell, J., Rajanaidu, S., Anderson, P., Best, E., de Lore, D., Jansen, R., Leversha, A., Percival, T., Sinclair, O., & Webb, R. (2022). Schools and COVID-19 in Aotearoa New Zealand: Keeping schools open as safely as possible. https://cdn.auckland.ac.nz/assets/auckland/news-andopinion/2022/01/Russell%20et%20al%20%202022%20Schools%20and%20COVID19%20Keeping%20schools%20open%20(002).pdf

Serlachius, A., Boggiss, A., Lim, D., Schache, K., Wallace-Boyd, K., Brenton-Peters, J., Buttenshaw, E., Chadd, S., Cavadino, A., Cao, N., Morunga, E., Thabrew, H. Pilot

study of a wellbeing app to support New Zealand young people during the COVID-19 pandemic (2021). Internet Interventions, 26, art. no. 100464

Sinko, L., He, Y., Kishton, R., Ortiz, R., Jacobs, L., & Fingerman, M. (2022). "The Stay at Home Order is Causing Things to Get Heated Up": Family Conflict Dynamics During COVID-19 From The Perspectives of Youth Calling a National Child Abuse Hotline. Journal of Family Violence, 37(5), 837–846. https://doi.org.ezproxy.auckland.ac.nz/10.1007/s10896-021- 00290-5

Stockwell, T., Andreasson, S., Cherpitel, C., Chikritzhs, T., Dangardt, F., Holder, H., Naimi, T., & Sherk, A. (2021). The burden of alcohol on health care during COVID-19. Drug & Alcohol Review, 40(1), 3–7. https://doi.org.ezproxy.auckland.ac.nz/10.1111/dar.13

Terhorst, Y., Philippi, P., Sander, L. B., Schultchen, D., Paganini, S., Bardus, M., Santo, K., Knitza, J., Machado, G. C., Schoeppe, S., Bauereiß, N., Portenhauser, A., Domhardt, M., Walter, B., Krusche, M., Baumeister, H., & Messner, E. M. (2020). Validation of the Mobile Application Rating Scale (MARS). PloS one, 15(11), e0241480. https://doi.org/10.1371/journal.pone.0241480

Thomas, A., Bohr, Y., Hankey, J., Oskalns, M., Barnhardt, J., Singoorie, C. (2022). How did nunavummiut youth cope during the covid-19 pandemic? a qualitative exploration of the resilience of inuit youth leaders involved in the isparx project. International Journal of Circumpolar Health, 81, 2043577. https://dx.doi.org/10.1080/22423982.2022.20435 77

UNICEF Innocenti. (2020). Worlds of Influence: Understanding what shapes child wellbeing in rich countries. Innocenti Report Card 16, UNICEF Office of Research. https://www.unicef-irc.org/publications/pdf/Report-Card-16-Worlds-of-Influence child-wellbeing.pdf

Vacaru, S.V., Beijers, R., & de Weerth, C. (2022). Internalizing symptoms and family functioning predict adolescent depressive symptoms during COVID-19: A longitudinal study in a community sample. PLoS ONE 17(3): e0264962. https://doi.org/10.1371/journal.pone.0264962

Villanti, A.C., LePine, S.E., Peasley-Miklus, C., West, J.C., Roemhildt, M., Williams, R. & Copeland, W.E. (2022). COVID-related distress, mental health, and substance use in adolescents and young adults. Child and Adolescent Mental Health, 27 (2). 138-145. https://doi-org.ezproxy.auckland.ac.nz/10.1111/camh.12550

Windarwati, H.D., Lestari, R., Supianto, A.A., Wicaksono, S.A., Ati, N.A.L., Kusumawati, M.W., Humayya, A., & Ekawati, D. (2022). A narrative review into the impact of COVID-19 pandemic on senior high school adolescent mental health. Journal of Child and Adolescent Psychiatric Nursing, 35 (3), 206– 217. https://doi.org.ezproxy.auckland.ac.nz/10.1111/jcap.1237

World Health Organisation (2022). Timeline: WHO's COVID-19 response. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive timeline#!

Yuan, Y. (2021). Mindfulness training on the resilience of adolescents under the COVID-19 epidemic: A latent growth curve

analysis. Personality and Individual Differences, 172, Article 110560. https://doi.org/10.1016/j.paid.2020.110560

## Cancer Society – Te Kāhui Matupukupuku o Aotearoa Supportive Care Services – Te Waka Hau Ora

*By Hiliary Graham-Smith – Supportive Care Contractor – Waikato/Bay of Plenty Cancer Society*

In my article in September 2022, I wrote about a planned change to the Cancer Society Model of Care for our supportive care services. At present not all services are available everywhere, so we are working on identifying the services that are most valued by our clients and developing a new Model of Care that offers multiple entry points, choices to support self-care and offerings that support the whole whānau. We also want to partner with a range of providers in particular Māori/Iwi service providers to ensure clients have access to the most appropriate care for them.

Our aim in this work is to grow our reach and achieve equity by ensuring all people experiencing cancer and their whānau have access to our services early in their journey, through treatment and beyond. We know that currently we are only reaching about 25% of people with a cancer diagnosis and that some of these people are well down the track with treatment before they are referred to us.

Referral to the Cancer Society supportive care service can occur in a variety of ways. They come from hospital oncology services, usually from clinical nurse specialists or nurses working in the chemotherapy unit, some are self-referrals or the referral is made by a family member. Very few referrals come from general practice so we have a small side project in progress which we hope will assist you with involving the Cancer Society in working with you to support your patients with a cancer diagnosis.

At the moment, you can refer by going to www.cancer.org.nz **click on** how we can help then **click on** Health professional referral on the left side bar, **scroll down and click on** the area you are located in then **click on** referral form for health professionals and start the referral. If by now you are thinking this is very clunky you are right but please don't let that put you off because there is a solution coming. In the short term we will start by putting the link to the referral page on the front page of the website.

The long-term solution is for you to be able to generate the referral from your Practice Management System. We are about to launch a small e-referral pilot in general practice in the Midland region which will provide an opportunity to iron out any kinks, then with the support of your e-referral platform providers we will roll it out across the country.

Thank you to the LOGIC team for providing space for this update. I look forward to updating you further as we progress the development of the new Model of Care.

If you have questions or ideas you would like to share please email me hilarygraham-smith@cancersociety.org.nz

Ka kite

*Nicky Cooper RN/MN*
*Public Health Nurse/Hauora Tūmatanui Nēhi – First 1000 days Practitioner & Hepatitis C Community Services*

## Hobbiton Medical conference

Sometimes I just really need to learn how to say no, when my best friend asked me if I would be interested in going to Hobbiton, I jumped at the chance. There was only one condition, she then chipped in. You will need to present at the medical conference, but don't worry, you'll be great!

For Us, By Us: Medical Conference in The Shire

What: Conference for us & by us
Vision: Food, Fun, Fellowship and perhaps learn something
Why: Because Winter is dark and it is something to look forward to
Venue: Hobbiton Conference Centre The Hub and Banquet Tour, Matamata NZ
Who: *Healthcare Professionals and their guests
When: Saturday Sept 3rd, 2022

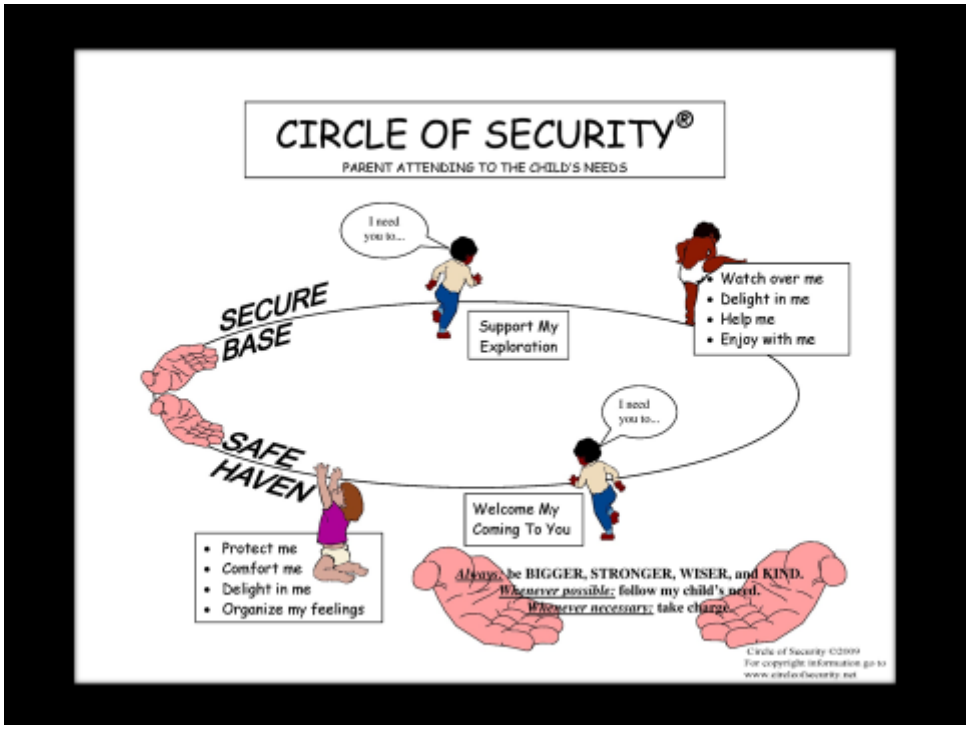
1200-1230 Registration, Meet & Greet1230-1630 Medical Conference
1645-2100 Hobbiton Banquet Tour with conference attendees and guests
*Keeping in mind a broad audience of medical specialties and careers (Emergency, GPs, Paediatrics, Medicine, Nurses, Doctors, Ambulance officers, Allied health)
*Costumes on the Tour & Banquet are mandatory
*Prizes for Best Costume and Best 'Geeky-Hobbiton' Teaching Session
*Our Attendees: Medical professionals from all over New Zealand that are passionate to teach and learn, and perhaps a little geeky towards the 'The Lord of the Rings'.
*Once the lectures have concluded, conference attendees and their guests will enjoy The Hobbiton Banquet Tour. The tour consists of a guided twilight tour of Hobbiton followed by a warm delicious meal at the Green Dragon Inn.

Just do it on blah blah blah…instant panic, "what the heck do I do in my world as a Public Health Nurse that's remotely linked to the 'Lord of the Rings' or the 'Hobbit'"?

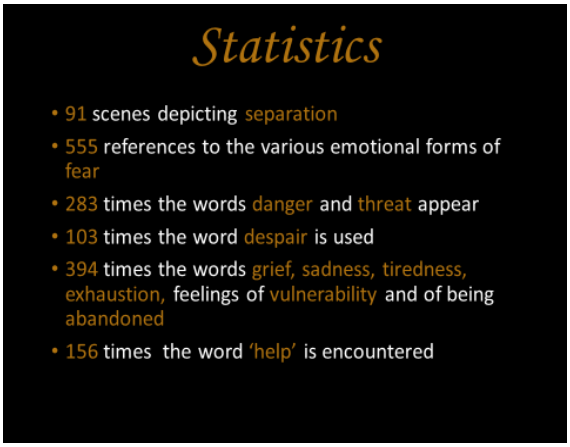
I had to dig deep and dig fast. But eventually I came to my favourite thing which is the 'Circle of Security', a psychology tool for a parenting course to enhance attachment.

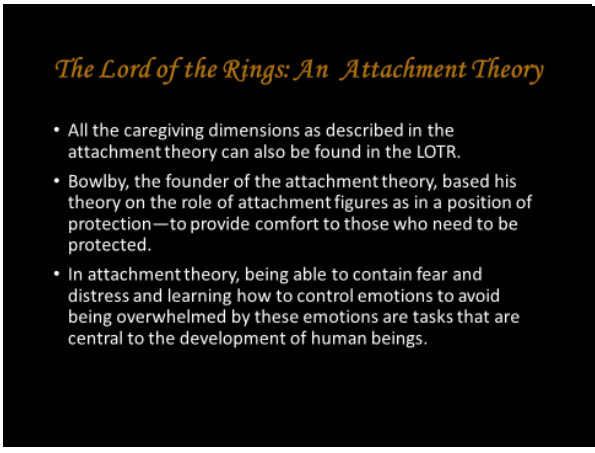
To start with I introduced myself to this room of strangely dressed medical hierarchy as a 'Public Health Nurse' and I apologised that Covid had made us a bit busy lately, and that it had been a very long journey……. which got thunderous applause (gush).


I then went to talk about the Circle of Security and gave them a very basic concept of how it works. How my work in the first 1000 days of life is so important for building positive infant mental health and attachment.



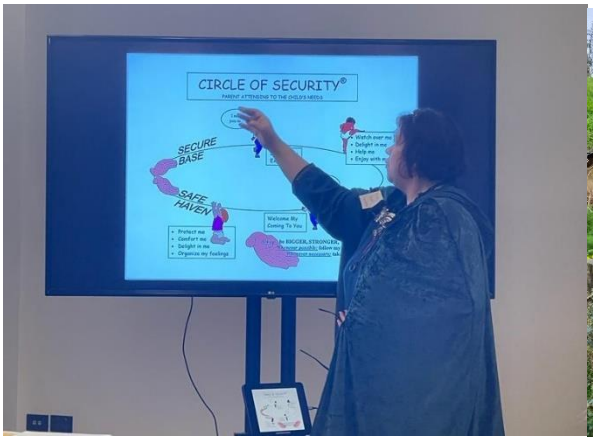

I was then able to suggest and link research on attachment theory to the Lord of the Rings/Hobbit books/movies phenomenon into my presentation, I even found scholarly articles doing exactly that.



It was received surprisingly well, and there were a lot of questions, mostly by parents about how to make critical changes in their relationships. A theme that would continue funnily enough throughout the rest of the day, I guess you could say I became 'camp mother' at Hobbiton.




## Rallying together for rare disorders

*By Angela Nielsen, Rare Disorders NZ*

During the month of March, Aotearoa was called on to Glow up and Show up for the six percent of the population living with a rare disorder. The Rare Disorders Month campaign was initiated by Rare Disorders NZ, as a way to extend Rare Disease Day, 28 February, into a longer advocacy and support period to maintain a spotlight on rare disorders.

It's not rare to have a rare disorder. In Aotearoa, more than 300,000 people live with one of the more than 6,000 rare disorders - that's similar to the population of a big city like Wellington. Around half of those affected are children. Unlike most OECD countries, New Zealand currently does not have a national strategy for rare disorders, leaving this sizeable population group to navigate the health and social care systems on their own with little guidance or support. With no official data registry on the prevalence of rare disorders in New Zealand, those affected often feel invisible - slipping through the cracks for not fitting a 'tick box'.

The Glow up and Show up for Rare campaign has provided an opportunity for the 300,000 strong community of rare patients, as well as friends and whānau, to rally together and call for urgency in the health reform that has been promised. Events have been held in local communities all around the motu, showing a strong collective spirit and drive from the rare community to call for meaningful change.

Rare Disorders Month has also been an opportunity for the wider community to show those affected by a rare disorder that they are valued, and the support has been felt. Kindergartens, schools, workplaces, and community groups have rallied behind the cause – hosting morning teas, organising fundraisers, setting up displays and raising awareness through newsletters and social media. The reach of these events demonstrates just how common it is to either have a rare disorder or know someone who does. This in itself is a powerful indication to those affected that they are not alone on their journey.

There has also been a sustained media campaign which has enabled the rare disorder community to get their voice heard; to feel visible and understood. Individual stories have been featured throughout the month, providing an insight into the challenges patients and their whānau battle with every day. A #GlowUpShowUp social media campaign, featuring temporary tattoos as a way to show support, has made it possible for anybody anywhere in the country to get involved.

The highlight of the month, which also marked the very beginning of this campaign period, was the launch of a new parent and caregiver guide by Rare Disorders NZ. This guide was developed to help parents and caregivers navigate the path in caring for a child with a rare disorder in Aotearoa New Zealand. It is also

hoped that health professionals will share this guide with rare patients and their whānau, so that families can begin their journey with a rare disorder knowing that support is available.

*Raising a child with a rare disorder: A guide for parents and caregivers living in Aotearoa New Zealand*, was launched at Government House with Rare Disorders NZ's patron Her Excellency, The Right Honourable Dame Cindy Kiro. Invited guests included families of children with rare disorders, patient group representatives and other key stakeholders, and the atmosphere was warm and very special for those attending.

Raising a child with a rare disorder: A guide for parents and caregivers living in Aotearoa New Zealand can be downloaded from Rare Disorders NZ website here: https://www.raredisorders.org.nz/patient-support/parent-and-caregiver-guide

As the campaign draws to a close, the work continues. There is still a long road ahead to achieve equitable access to health and social care for people living with a rare disorder.

Sustainable funding for Rare Disorders NZ, the only national organisation supporting all New Zealanders who live with a rare condition and the people who care for them, is uncertain. If you would like to get involved and help make a difference for the rare disorder community in New Zealand, visit https://www.raredisorders.org.nz/ to learn more.

For more resources and advice for health professionals on rare disorders visit Medics4RareDiseases https://www.m4rd.org/daretothinkrare/

*Rachael Evans – Associate Nursing Director, Primary Health Care, Te Whatu Ora Waitemata*

Rachael Evans is a strong advocate for nursing professional supervision having seen nurses grow in confidence and capability as a result of their participation in sessions. Offers Professional supervision via www.baysupervision.com, or email rachael@baysupervision.com

# Making sense of Professional Supervision for nurses

**(Safety-Growth-Hope)**

## Why have Professional Supervision

"…Professional supervision really helps breakdown your thinking and actions in your practice… and develop plans for similar future situations ... it can help by highlighting your strengths and in building confidence in your practice…" (DN)

"…it helped, is helping and will help me work through sticking points with a new clear outlook and strategy…" (PHN)

"… It's unbiased and supportive……From being uncertain, giving it a go, till now being addicted!" (PHN)

"I look forward to my monthly session and always feel energised and motivated afterwards to tackle the next day with new insights…" (PHC Nurse Leader)

## What is it?

Professional supervision provides monthly, one on one, protected time and investment in nursing roles and responsibilities. It can offer learning, insight, and time to explore, challenge, and reflect on practice in a safe space. It can additionally enable nurses to focus on their

professional growth and understand themselves and their professional identity. Supervision will enable nurses to develop critically conscious practice, as well as develop strategies to manage workplace stress.

It is not surveillance, management checking up on you, therapy, a chat or judgement session (Davy's, 2007)

***"Supervision is a relational conversation where supervisees reflect on their work and their work experiences in order to learn how to practice better"*** **(Carroll, 2014, p.18)**

***"Supervision is a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users' health outcomes and safety"*** **(MoH, 2006, p. 22)**

### How is it helpful to nurses?

Supervision is recognised as an important aspect of quality nursing practice and access for all nurses is encouraged (New Zealand Nurses Organisation, NZNO, 2015). The professional bodies, New Zealand Nurses Organisation (NZNO) and College of Nurses Aotearoa Incorporated (CONA) recommend that organisations advocate for supervision with clear policies and processes needing to be in place.

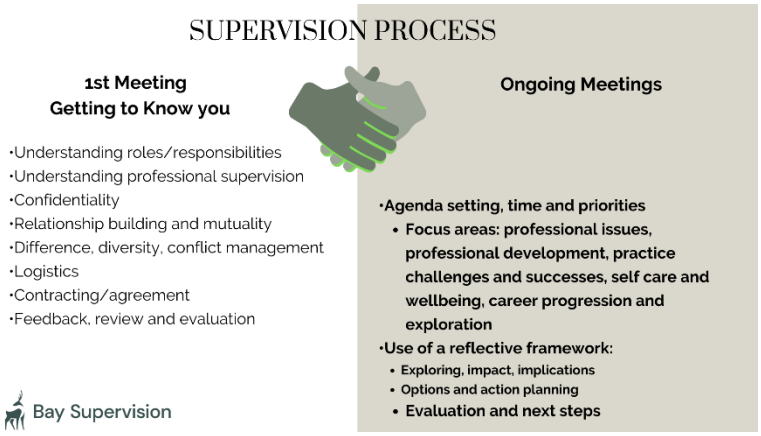
The gains are acknowledged throughout the literature (Dilworth et al., 2013) and more supervision support is recommended. In addition, the recent years, of health system review alongside response requirements for many nurses to Covid-19 has accentuated the risk and realities of anxiety, stress, exhaustion, and burnout (Bell et al., 2021).

According to Jamieson et al. (2021) high levels of stress, stigmatisation as well as redeployment, border work, Managed Isolation Quarantine (MIQ) nursing demands and community outreach have created an unprecedented toll on nurses at this time. Martin et al (2021), report on the positive benefits of effective supervision and supervisors through both quantitative and qualitative analysis. Resulting outcomes were aligned with lower staff burnout and greater staff retention associated with job satisfaction. Work environment improvements reported by healthcare professionals receiving adequate supervision additionally helped to avoid stress in the workplace.

Now is the time to address some of these issues. Advocating for and building professional supervision into organisational learning frameworks as integral to professional development is the investment districts and organisations need to consider offering for nurses. Opportunity for nurses to engage in good quality professional supervision, will go some way to assuring quality service to our patients and whānau and keeping our nursing workforce well, long into the future.

Supervisee nurses bring their agenda or topic to the session which may include aspects such as: competing priorities; an incident or issue that they keep thinking about or has caused feelings of worry/distress; a situation which is approaching and may be challenging; team

worries or collegial dilemmas; stress management, work-life balance and wellbeing concerns affecting professional practice.




## What are the benefits?

**For the individual nurse -** a place to grow knowledge and insight. A chance to find your professional identity and understand your responsibilities, especially when advancing your practice and building your capability, such as prescriptive authority. Time to reflect on policy and practice as well as attend to your own wellbeing can be incredibly enabling for new grad nurses through to senior nurse roles, whether clinical, cultural, leadership, managerial.

**For patients & whānau** - the eye of supervision is focused on their care, what you do and what you don't do when providing nursing care. Critically conscious nursing care, practice and service is explored to ensure you are always meeting their needs.

**For the organisation -** an investment in your nursing workforce to foster safe, high-quality care that is sustained. A recruitment and retention strategy to grow and nurture the next generation of new nurses to serve your communities which is supported in the literature.

## What are the functions?

Inskipp and Proctor's (1993) formative, normative and restorative phases derived from counselling and cited by Davys and Beddoe (2020) provide a solid baseline for exploring reflective practice within professional supervision sessions, see below. All areas can be

explored based on the supervisee nurse's agenda and needs at the time. Models used are reflective and seen to challenge and enhance practice. There are many available as well as cultural models for those nurses seeking Kaupapa Māori supervision approaches or other culturally amenable support. In addition, educative elements and the process of learning often captured through professional supervision aligns well with PDRP and sessions count towards professional development hours.

| FORMATIVE (learning & development) | NORMATIVE (accountability) | RESTORATIVE (support) |
|---|---|---|
| •Skill development via regular reflection<br>•Innovative practice development<br>•Insight and ''aha'' moments<br>•Discussion of specific work aspects<br>•Professional pathways | •Clarity around roles and responsibilities<br>•Professional and regulatory requirements<br>•Organisational policy/procedure/practice<br>•Code of rights and ethical obligations<br>•Specific legislative accountabilities | •Safe space & protected time<br>•Self care and emotional wellbeing<br>•Response to stressors, coping and ability to bounce back (resilience)<br>•Relating attitudes, values and beliefs to response<br>•Managing conflict/challenge/distress in the workplace |

### Who will provide it?

Many organisations run Professional Supervision internally. New Zealand Nurses Organisation has an available list of Professional Supervisors, contact, nurses@nzno.org.nz

College of Nurses Aotearoa NZ (Inc) provide profiles of quality available Professional Supervisors you can access, https://www.nurse.org.nz/supervisor-profiles.html

Check in with your organisation or district provider to explore what options are available.

**References**

Bell, C., Williman, J., Beaglehole, B., Stanley, J., Jenkins, M., Gendall, P., Rapsey, C., & Every-Palmer, S. (2021). Challenges facing essential workers: A cross-sectional survey of the subjective mental health and well-being of New Zealand healthcare and 'other' essential workers during the COVID-19 lockdown. *BMJ Open*, *11*(7), e048107. https://doi.org/10.1136/bmjopen-2020-048107

Carroll, M. (2014). *Effective supervision for the Helping Professions* (second edition). London. Sage Publications

Davys, A. (2007). Active participation in supervision: A supervisee's guide. In D. Wepa (Ed.), *Clinical supervision on Aotearoa/New Zealand: A health perspective*. (pp.26-42). Auckland: Pearson Education New Zealand

Davys, A., & Beddoe, L. (2020). *Best practice in professional supervision: A guide for the helping professions* (2nd ed.). Jessica Kingsley Publishers.

Dilworth, S., Higgins, I., Parker, V., Kelly, B., & Turner, J. (2013). Finding a way forward: A literature review on the current debates around clinical supervision. *Contemporary Nurse*, *45*(1), 22-32. https://doi.org/10.5172/conu.2013.45.1.22

Jamieson, I., Andrew, C., & King, J. (2021). Keeping our borders safe: The social stigma of nursing in managed isolation and quarantine border facilities during the COVID-19 pandemic. *Nursing Praxis Aotearoa New Zealand*, 53-61. https://doi.org/10.36951/27034542.2021.035

Martin P, Lizarondo L, Kumar S, Snowdon D (2021) Impact of clinical supervision on healthcare organisational outcomes: A mixed methods systematic review. PLoS ONE 16(11): e0260156. https://doi.org/10.1371/journal.pone.0260156

Ministry of Health. (2006). *Mental Health Nursing Framework and its future: A discussion framework.* Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2014). *The Role of Health Workforce New Zealand*. Wellington: Ministry of Health.

New Zealand Nurses Organisation. (2015). Practice Fact Sheet. Supervision. https://www.nzno.org.nz/LinkClick.aspx?fileticket=d7IqZCfjC_M%3D&portalid=0#:~:text=Supervision%20is%20recognised%20as%20a,supports%20initiatives%20to%20achieve%20this.

Nursing Council of New Zealand. (2016). *Competencies for nurse prescribers*. https://www.nursingcouncil.org.nz/Public/Nursing/Nurse_prescribing/NCNZ/nursing-section/Nurse_Prescribing.aspx?hkey=091ed930-56ca-4f25-ae9e-52b33decb227

## Pregnancy immunisation is baby's first immunisation.

*Immunisation Advisory Centre, Auckland, New Zealand*
*Dr Anna Howe, Research and Policy Analyst & Research Fellow*
*Dr Cayley Ingham, Public Health Medicine Registrar*
*Sue Rogers, Regional Immunisation Advisor*

Promoting understanding about the value of immunisation during pregnancy and sharing actionable strategies to improve equitable coverage.

### Why immunise in pregnancy?

Immunisation during pregnancy is essential to **reduce risk to the pregnant person and the risk of adverse pregnancy outcomes, and to provide significant protection against vaccine-preventable diseases in infants at their most vulnerable time**, when they are too young to have full protection from their own immunisations. In New Zealand vaccination is free during pregnancy for pertussis, influenza, and COVID-19 in order to help provide protection equitably.

Pertussis epidemics tend to occur every three to five years in New Zealand, with young infants being the most severely affected group. During the 2011–2014 epidemic, hundreds of infants required hospitalisation and three infants aged less than six weeks old died. Approximately 60% of infants with pertussis require hospitalisation and of these, 1 in 10 are admitted to the Paediatric Intensive Care Unit (PICU); 1 in 6 infants admitted to PICU with pertussis will either die or have ongoing brain or airway/lung damage (Grant, 2014). The good news is that immunisation more than 7 days prior to delivery is over 90% effective at preventing pertussis in infants under 3 months old (Ministry of Health, 2020).

Pregnant people have increased morbidity and mortality due to influenza compared with non-pregnant people, and influenza is also associated with poorer infant outcomes (Immunisation Advisory Centre, n.d.). Pregnancy immunisation with influenza vaccine confers protection to both the pregnant person and their infant (Ministry of Health, 2020).

Whilst pregnant people were not initially included in the trials for Covid vaccine (another story…) it became very clear very quickly that pregnant people had significantly higher morbidity and mortality outcomes with Covid infection. Immunisation reduces the likelihood of severe COVID-19 infection in pregnancy, and also provides a degree of infant protection (Ministry of Health, 2020).

### Pregnancy vaccines

**Funded pregnancy immunisation is available with no cost to pregnant people** through general practice (GP), contracted non-government health providers, hospital antenatal clinics, some midwives, and, since 2017, pharmacies.

**Tdap (Boostrix- pertussis-containing vaccine) is recommended and funded for women during every pregnancy,** from 16 weeks' gestation, preferably in the second trimester. **Timing is important** as infant protection is limited if the pregnant person is not immunised at least two weeks prior to birth (Ministry of Health, 2020). Immunisation from 16 weeks of gestation allows time for antibodies to be transferred and accumulate in the fetus (Ministry of Health, 2020). Immunisation during the

second trimester also provides protection for more preterm infants than does immunisation later in pregnancy (Ministry of Health, 2020. A Tdap booster is recommended but not funded up to 10 yearly for close family contacts of newborns such as partners and grandparents.

**Influenza** vaccine is typically available from April to September annually and is recommended and funded for administration at any point during every pregnancy.

**Covid** vaccines are the third funded pregnancy immunisation. Currently all pregnant people are recommended to have their primary course of Covid immunisations and a booster (if timing requires) during pregnancy. Refer to the Immunisation Handbook and latest guidelines for the recommended booster guidelines.

### Current coverage in NZ

Since 2013, coverage of influenza and pertussis immunisations in pregnant people has increased by 19% and 33%, respectively. However absolute coverage levels remain disappointingly low and equity gaps are evident. Asian and European people had the highest rates of vaccination in pregnancy, while Māori and Pacific people had the lowest, with these gaps increasing over time (Pointon et al., 2022). For more data on coverage please visit https://geohealthlab.shinyapps.io/hapumama (Howe et al., n.d.).

### Different places pregnancy vaccines can be accessed.

Pregnant Māori women are pro-active and engaged early with primary health services to confirm their pregnancy but are let down during the transition to their lead maternity carer (Makowharemahihi, 2014). Healthcare provider bias and failure to provide vaccination recommendations to Māori and Pacific women could be a contributing factor for ethnic inequities in maternal vaccination coverage. Proximity to basic amenities, including GPs, does not necessarily reflect high vaccine uptake (Pointon, 2022). Research has shown that physical access to a GP has little effect on increasing coverage for pregnant people, despite GPs being the almost exclusive providers of pregnancy pertussis immunisation and the lead provider of pregnancy influenza immunisation, with pharmacy only providing funded pregnancy influenza immunisation vaccination since 2017. Research from a New Zealand study found that pertussis immunisation to pregnant people increased with funding of maternal pertussis immunisation in community pharmacy (Howe, 2022). Importantly, whilst pharmacy-delivered immunisations increased, this was in addition to, rather than as a replacement for, the immunisations delivered by other providers.

## Understanding pregnant peoples' thoughts and beliefs towards the health system

NZ research has shown that pregnant people would like information and support to help them make the decision to be immunised during pregnancy. A clear recommendation for immunisation from a trusted health professional is an important factor in choosing immunisation, thus a chat with their trusted health professional including pharmacy staff, nurse, GP, or midwife increases awareness and results in increased pregnancy immunisation (Gauld, 2022). Pregnant people also want to know the benefits and risks of vaccine-preventable diseases to give them confidence in immunisation, and for this information to be provided face-to-face and with resources to take home for further thought and discussion with whānau (Young et al., 2022).

A recent study (Brown et al., 2021) explored pregnant Māori Māmā attitudes, beliefs and perspectives about childhood vaccines and immunisation service and delivery for their pēpi and tamariki. Recommendations for policy, practice, service delivery and communications for Māori Māmā around childhood immunisations include:

1. Mo Mātou – find out who we are, what we want and how we can work together.
2. Te Taonga – provide opportunities for us to tell our stories.
3. Tūhonohono – connect to our culture, mātauranga (knowledge systems), rongoā (healing practices) and ensure unfettered access to choices in care.
4. Mātauranga Whakakoranga – learning and training opportunities to share knowledge.
5. Pūtea tautoko – resource Māori Māmā to participate and engage; and
6. Hanga Mahere – develop tools and models of engagement.

## Practice systems and processes to support

While it can be difficult for practices to monitor the pregnancy status of their patients, every interaction with a pregnant person is an opportunity to review their immunisation status. Tools exist to assist with caring for pregnant people in accordance with best practice, including for immunisations. For example, Best Start Kōwae (modules) are innovative pregnancy assessment tools available to all Primary Health Care organisations and Lead Maternity Care Providers. The tools can be integrated into the PMS (Practice Management System) or can be accessed via a web browser. The tools can be used with all pregnant people across the pregnancy journey (National Hauora Coalition, n.d.).

Knowing your patients, building trust, and providing culturally appropriate support that involves the whole practice environment and staff, will allow us to increase immunisation coverage for pregnant people to protect them and their infant at a critical time in their lives.

## References

Brown, S., Toki, L. & Clark, T. C. (2021). *Māori Māmā views and experiences of vaccinating their pēpi and tamariki: A qualitative Kaupapa Māori study*. WotMatters Consulting contracted by NZ Work Research Institute, Auckland NZ.

Gauld, N., Martin, S., Sinclair, O., Petousis-Harris, H., Dumble, F., Grant, C.C. (2022). Influences on Pregnant Women's and Health Care Professionals' Behaviour

Regarding Maternal Vaccinations: A Qualitative Interview Study. *Vaccines*, 10(1), 76. https://doi.org/10.3390/vaccines10010076.

Grant, C.C., & Williams G. (2014, October 1). *Pertussis.* Starship. https://starship.org.nz/guidelines/pertussis/.

Howe, A.S., Gauld, N.J., Cavadino, A.Y., Petousis-Harris, H., Dumble, F., Sinclair, O., Grant, C.C. (2022). Increasing Uptake of Maternal Pertussis Vaccinations through Funded Administration in Community Pharmacies. *Vaccines*, 10, 150. https://doi.org/10.3390/vaccines10020150

Howe, A.S., Marek, L., Young, A., Willing, E., Dawson, P., McIntyre, P., and Hobbs, M. (n.d.). *Examining spatial variation for immunisation coverage in pregnant women: a nationwide and geospatial retrospective cohort study in Aotearoa New Zealand*. UC GeoHealth Lab. https://geohealthlab.shinyapps.io/hapumama.

Immunisation Advisory Centre. (n.d.). *Recommended and funded vaccines during pregnancy.* https://www.immune.org.nz/factsheets/recommended-and-funded-vaccines-during-pregnancy.

Makowharemahihi, C., Lawton, B.A., Cram, F., Ngata, T., Brown, S., Robson, B. (2014). Initiation of maternity care for young Māori women under 20 years of age. *NZ Med J*, 127(1393), 2010–9.

Ministry of Health. 2020. *Immunisation Handbook 2020*. Wellington: Ministry of Health.

National Hauora Coalition (n.d.). *Best Start Kōwae*. https://www.gen2040.co.nz/best-start-kowae

Pointon, L., Howe, A.S., Hobbs, M., Paynter, J., Gauld, N., Turner, N., Willing, E. (2022). Evidence of suboptimal maternal vaccination coverage in pregnant New Zealand women and increasing inequity over time: A nationwide retrospective cohort study. *Vaccine*, 40, 2150-60. https://doi.org/10.1016/j.vaccine.2022.02.079.

Young, A., Charania, N., Gauld, N., Norris, P., Turner, N., Willing, E. (2022). Knowledge and decisions about maternal immunisation by pregnant women in Aotearoa New Zealand. *BMC Health Services Research*, 22, 779. https://doi.org/10.1186/s12913-022-08162-4.

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# *NZCPHCN, NZNO Leadership (Haututanga) and Innovation (Tangongitanga) Award - Awarded to Fiona Murray in October 2022*

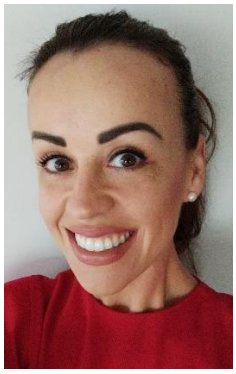

Nursing, for me, is all about connection and building trust - and it's different in every type of nursing area. I started my Primary Health Care (PHC) nursing in general practice in 2009. I found this environment rewarding as I built relationships with patients, getting to know their health needs and circumstances enabling me to provide continuity of care over the lifespan. From providing babies with their six-week vaccinations and then their shots before they head off to school four years later. For some older adults, a trip to the GP is their chance for social connection that week, so it was important to take the time to connect and listen to them.

I'm really passionate about health education and growing a robust, knowledgeable, engaged PHC nursing workforce for the future. In 2014 I started my role as a nurse educator for PHC nurses. I enjoy supporting new graduate nurses as they transition from new graduate nurse to competent registered nurses. Watching these nurses develop their confidence and transition their knowledge into practice as they develop their clinical reasoning is very rewarding for me as an educator. It is like watching a light bulb go on when they realise, they have the skills and knowledge to provide best care.

I was so humbled to recently win the 'New Zealand College of Primary Health Care Nurses Leadership (Haututanga) and Innovation (Tangongitanga) Award.' I have been a member of the college for several years. This award recognises positive role models and excellence in primary health care nursing. I was blown away to receive two nominations for this award. They recognised the voluntary work I have undertaken on the National Executive committee over the past 4 years, alongside my day-to-day work." I am currently researching professional development opportunities on PHC or Nursing Education, that I can use my award to attend.

Being a member of one of the college committees is rewarding in many ways. Meeting amazing nurses from a range of PHC settings and hearing the challenges and successes in the individual areas. Being a part of a group of passionate people who have a voice on professional nursing issues and contributing to discussions and

consultations affecting the health of the people of Aotearoa. If you have some time to spare, are passionate about PHC nursing and contributing to the future of nursing and the health of Aotearoa then put yourself forward for one of the three committees for the NZCPHCN.



*Katrina Coleman*
*Whānau Āwhina Plunket*

## Looking back to move forward- Researching maternal adverse childhood experiences (ACE's) and maternal mental health in the New Zealand context.

**Introduction.**

The perinatal period presents a high-risk time for disruption to maternal mental health and well-being. Poor maternal mental health can lead to reduced sensitivity to infant cues and a limited capacity for mothers to meet their baby's physical and emotional needs. This is particularly important in the perinatal period as the infant relies on 'serve and return' style interactions with their primary attachment figures to build the early neural connections that will inform their health and development over their lifetime. International studies have identified an increased incidence of maternal mental illness in mothers who were affected by adversity in childhood. This association between maternal childhood trauma and later maternal mental illness has not yet been explored within the NZ context. Screening for maternal childhood adversity has the potential for the early identification of whānau, most likely to be affected by poorer maternal mental health, providing opportunities for services working with NZ whānau to tailor care pathways for parenting through trauma. This article will provide evidence to support the universal screening for Adverse Childhood Experiences of NZ mothers, early in the perinatal period.

**Perinatal mental health.**

The definition of the perinatal period is the time of pregnancy, through the first postnatal year (Ministry of Health, 2011). This period presents an increased risk of both new and recurrent mental illness/distress which both compromises maternal well-being and can result in a cascade of lifelong consequences for her developing child. Although it is recognised in the literature that, like general mental illness, maternal mental illness does not stem from one single cause, the disruption to maternal mental health is commonly attributed to the significant physiological and psychosocial changes and adjustments that occur for women in the perinatal period (Garcia, 2017). Studies have identified additional risk factors that increase a mother's risk of mental illness in the perinatal period, including a history of previous mental health problems, a lack of social support, previous trauma including physical, emotional, or sexual abuse, isolation (physical, mental, cultural), stressful life events, and a history of drug or alcohol abuse (Ministry of Health, 2021).

Maternal mental distress/illness are broad terms that include perinatal depression, anxiety, stress, and psychosis (Garcia et al.,

2017). Despite the range of symptoms that can be experienced with these disorders, depression and anxiety are the most prevalent mental disorders in NZ and the focus of most research studies (Berry et al., 2021). Depression in the perinatal period is defined by the DSM IV as a period of at least two weeks during which there is either a depressed mood or a loss of interest or pleasure in nearly all activities (Segre et al., 2013). The incidence of perinatal mental illness described within NZ research studies is variable in its prevalence rates (Ministry of Health, 2021). In 2016, the New Zealand Health Promotion Agency undertook a cross-sectional study of 805 new mothers assessing the prevalence of postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS) (Health Promotion Agency, 2017). Their findings identified 14% of all respondents met the criteria for EPDS-PND. The prevalence was not distributed equitably varying significantly across NZ ethnic groups. PND was reported by 12% of Māori, 13% of the European/Other group, and 23% of participants who identified as Asian (Health Promotion Agency, 2017). Pacific participants were excluded from the analysis due to insufficient participant numbers. Pacific PND prevalence was however reported in a well-known New Zealand study in 2006. This study focussed on the prevalence of EPDS-PND across Pacific ethnic groups within New Zealand. Samoan mothers reported the lowest rates of PND prevalence at 13.6% and Tongan mothers reported the highest prevalence of PND at 30.9% (Abbott et al., 2006). Despite these high rates, Abbott et al. described a likely underrepresentation of PND reporting in this study due to ongoing societal stigma against mental illness, with these negative fixed beliefs about mental illness held strongly by many in Pacific communities (2006).

**Why maternal mental health really matters.**

In NZ, the leading cause of maternal death in the perinatal period is suicide. These rates are often minimised as the mortality rates are low however, when compared internationally, NZ rates are reported to be five times higher per capita than the UK with Māori and Pacific māma significantly over-represented in the data (Health Quality Safety Commission New Zealand, 2021). As well as the significant impact perinatal distress has on mothers, it is important to understand that the consequences of poor mental health extend beyond the individual to have measurable, negative repercussions for the children of affected mothers, with recent studies describing the effects of maternal mental illness as being intergenerational in nature (Letournou, et al, 2019; McDonell, et al, 2016; & Schickedanz, et al., 2021).

Good mental health and well-being are essential for the development of the attachment relationship between a mother and her infant. The architecture of the developing brain of the infant relies on the effective cue reading of their primary attachment caregivers, as the foundational neural pathways are built and then streamlined by ‘serve and return’ style interactions with primary caregivers (Center on the Developing Child at Harvard University, 2016). Mothers who experience mental illness are described to have a decreased capacity to engage in ‘serve and return’ with mental distress impacting the mother's ability to notice/interpret her baby’s cues limiting the emotional availability of the mother to respond to those cues. Research studies have identified that mothers experiencing mental illness have been associated with less successful attachment relationships

with their infants with an increased incidence of anxious/ambivalent, disorganised, and avoidant relationships (Berthelot et al, 2020; Cooke et al, 2019; & Erickson et al, 2019). Insecure attachment styles have been linked to poorer outcomes for children in the areas of development, emotional/mental health, and well-being, as well as decreased educational attainment.

**Current nurse practice to identify maternal mental concerns.**

All Well Child Tamariki Ora nurses in NZ are directed by the Ministry of Health to screen for postnatal depression at the first and third core contacts with māma/whānau and thereafter, as required. The screening tool prescribed in the Well Child Tamariki Ora Schedule (MoH, 2013) is the Patient Health Questionnaire-3 (PHQ-3). Despite more than two decades passing since the original ACE's study was conducted (Felitti et al., 1998) and several international clinical models using maternal ACE screening as a predictive risk tool for the early identification of perinatal mental illness (Racine et al., 2021), the routine/universal screening of maternal early life adversity has not yet become established in NZ.

**Adverse childhood experiences can directly shape child and adult health.**

It is widely reported in health literature that the experiences of early life form the foundation for health and development across the lifespan (Centre on the Developing Child, 2016). Adverse childhood experiences (ACEs) are defined by the World Health Organisation as "some of the most intensive and frequently occurring sources of stress that children may suffer" in their first 18 years of life (2018, p.1). The term ACEs was first described in 1998 in the seminal ACEs research study conducted by the Centre of Disease Control in Kaiser, Permanente. This large-scale study described for the first time, the graded relationship between the experiences of early life trauma, and poor physical, psychological, and social health consequences in adulthood (Felitti et al., 1998). The survey instrument developed from the study, the ACE-10 assessment tool, retrospectively measures the ACE scores of adults from their first 18 years of life. The ten categories of ACE are psychological, physical, or sexual abuse; physical or emotional neglect; violence against the mother; or living with household members who were substance abusers, mentally ill, suicidal, or ever imprisoned. For each measure of experienced adversity, participants score one ACE (Felitti et al., 1998). Felitti & Anda then compared the ACE scores of participants against measures of adult risk behaviour, health status, and disease. The results identified that 64% of participants had been exposed to one or more of the ACEs measured and, as the total ACE score increased, so too did the incidence of adult physical, psychological, and social dysfunction (Felitti et al., 1998).

The mechanisms for ACE harm to the brain and body are believed to be a consequence of a maladaptive stress response system. Experiences of early life adversity that are severe, prolonged, or repetitive cause hyperarousal of the sympathetic nervous system's fight or flight response (Franke, 2014). This maladaptive stress pathway results in dysfunction of the neuro-endocrine-immune response system, allowing for prolonged cortisol activation and a chronic state of inflammation, with failure of the body to normalise these functions once the stressor has been removed (Franke, 2014). This is particularly significant in the first 18 years of life as the developing brain is more plastic and permeable to the potentially neurotoxic

endogenous mediators of the stress response system. This risks permanent damage to the development and function of the systems of the developing body and brain (Danese, 2019).

**Adverse Childhood Experiences in New Zealand.**

There are limited studies investigating ACEs in the NZ population. The 1977 Christchurch Health and Development Study is a longitudinal cohort study that has informed prospective investigation into childhood adverse experiences, and their relationship to poor health and social dysfunction in adulthood (Swain-Campbell et al., 2003). The ACE prevalence for this cohort reported that approximately 65% of the participants experienced one or more ACEs while 15% reported four or more ACEs, findings comparable to the original 1998 ACEs study in the United States (Felitti et al., 1998; Reuben et al., 2016). An evolving critique of this internationally acclaimed study is that the findings from the research are becoming dated with children in this cohort born between 1972-1973. The sociodemographic characteristics of the study participants no longer reflect the increasing diversity of the NZ population today (Walsh et al., 2019).

In 2019, a research team using data from the longitudinal *Growing Up in New Zealand* [GUINZ] study applied an ACE assessment tool to the existing GUINZ data sets (Walsh, et al., 2019). The GUINZ birth cohort of over 7,000 children were born between 2009 and 2010. The sociodemographic characteristics of the cohort are described as being broadly generalizable to the children being born in NZ today (GUINZ, 2010 as cited in Walsh et al., 2019). Walsh et al. (2019) investigated ACE prevalence by retrospectively applying an ACE tool that measured 9 out of 10 conventional ACEs, the ACE of childhood sexual abuse was omitted from the original GUINZ data collection. In this population, by the 54-month study wave, when the children were around four and a half years old, the prevalence of at least one ACE was 52.8% with 2.6% of children experiencing 4 or more ACEs (Walsh et al., 2019). These prevalence findings are high when you consider that ACE assessment is designed to be measured across the first 18 years of life. The four-and-a-half-year-old children of the GUINZ study reported prevalence rates of adversity that are comparable with international prevalence findings of ACEs measured over 18 years of life (Walsh et al., 2019). The reduced ACE measuring tool (9 out of 10 items) coupled with a considerable non-response of surveys resulted in the assumption that the reported GUINZ ACE prevalence scores were an underrepresentation of the actual ACEs experienced by this birth cohort and thus nationally within NZ (Walsh et al., 2019).

**Intergenerational consequences of ACES.**

Over recent decades, a growing body of ACE research has focused on the intergenerational transmission of ACE consequences from parents to their offspring (Lang et al., 2010; Lomanowska et al., 2017; Meltzer-Brody et al., 2017; Plant et al., 2017; Zalewski et al., 2013). In both animal and human models, the ACEs of mothers significantly outweigh the negative effects of a father's ACEs on their offspring (Folger et al., 2018; Light et al., 2019; Schickedanz et al., 2018). Maternal ACEs are associated with poorer physical, emotional, psychological, social, and developmental outcomes for their children (Lomanowska et al., 2017). Mental illness in the perinatal period of ACE-affected Mothers has been identified as a potential mediator of ACE risk (Khan & Renk, 2018; Lang et al, 2010; Lomanowska et al, 2017).

Recent studies involving ACE-affected mothers experiencing mental illness have reported an increased incidence of maternal risk-taking behaviours, increased self-reported parenting stress, a decrease in emotional availability to their children, increased risk for insecure infant-mother attachment relationships, and an increase in maladaptive parenting practices (Khan & Renk, 2018; Lange et al., 2019; McDonald et al., 2019). There are currently limited studies investigating the association between maternal ACE prevalence and MMH outcomes, particularly within ethnically diverse or indigenous population groups. There is, however, growing evidence from screening programs and intervention studies describing the success of universal screening for maternal ACEs, as a successful approach to identify families with a higher risk of intergenerational harm. This has allowed for the offering of targeted education and prevention strategies to reduce the risk of ACE transmission (Wade et al., 2017).

**Maternal ACE screening in primary care settings.**

There are currently limited studies investigating the association between maternal ACE prevalence and MMH outcomes, particularly within ethnically diverse or indigenous population groups. There is, however, growing evidence from screening programs and intervention studies describing the success of universal screening for maternal ACEs, as a successful approach to identify families with a higher risk of intergenerational harm. This has allowed for the offering of targeted education and prevention strategies to reduce the risk of ACE transmission (Wade Jr et al., 2017).

The benefits of maternal ACE scoring within primary healthcare settings are two-fold. Firstly, it provides an opportunity to address identified ACE consequences of affected mothers through health education and therapeutic intervention. Secondly, identifying whānau who are most at risk of ACE-related harm allows for preventative care pathways to be developed to reduce the risk of intergenerational trauma (Khan & Renk, 2018; Lê-Scherban et al., 2018: Letourneau et al., 2018; McDonald et al., 2019; Plant et al., 2017; Racine et al., 2018). There is currently limited NZ-based research to inform ACE-focused practice changes within organisations that work alongside NZ mothers and whānau.

**Conclusion.**

Despite the perinatal period representing only a short time in the perspective of a lifetime, this time represents a significant window to support the foundation of early neurodevelopment that shapes the future learning, health, behaviour, and mental well-being of children across their lifetime. This article highlights the significant role that maternal mental health and well-being play in promoting positive outcomes for children, particularly for women who have experienced early life adversity. Despite the significant body of literature describing the deleterious effects of early life adversity on the health and well-being of individuals and their children, there remains an untapped, evidenced-based opportunity for the early screening of childhood adversity of NZ mothers to provide tailored care pathways for those most affected by trauma. My Doctoral research project that considers the prevalence/characteristics of NZ māma affected by childhood adversity, and the associations between that adversity and later maternal mental health consequences will strengthen this argument, providing NZ-specific data for the first time in this research space.

**References**


Abbott, M., & Williams, M. (2006). Postnatal depressive symptoms among Pacific mothers in Auckland: Prevalence and risk factors. *Australian and New Zealand Journal of Psychiatry, 40*:230–238. https://www.researchgate.net/profile/Max-Abbott-2/publication/7301118_Postnatal_Depressive_Symptoms_Among_Pacific_Mothers_in_Auckland_Prevalence_and_Risk_Factors/links/5a5d1a4c0f7e9b4f783972b0/Postnatal-Depressive-Symptoms-Among-Pacific-Mothers-in-Auckland-Prevalence-and-Risk-Factors.pdf

Berry, O. O., Babineau, V., Lee, S., Feng, T., Scorza, P., Werner, E. A., & Monk, C. (2021). Perinatal depression prevention through the mother-infant dyad: The role of maternal childhood maltreatment. *Journal of Affective Disorders, 290*, 188-196. https://doi.org/10.1016/j.jad.2021.04.068

Berthelot, N., et al. (2020). Prenatal attachment, parental confidence, and mental health in expecting parents: The role of childhood trauma. *Journal of Midwifery & Women's Health*, 65(1): p. 85-95. https://doi.org/10.1111/jmwh.13034

Centre on the Developing Child at Harvard University (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families.* 1-52. https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/From_Best_Practices_to_Breakthrough_Impacts-4.pdf

Cooke, J.E., et al. (2019). Maternal adverse childhood experiences, attachment style, and mental health: Pathways of transmission to child behaviour problems. *Child Abuse and Neglect*, 93: p. 27-37. https://doi.org/10.1016/j.chiabu.2019.04.011

Danese, A. (2019). Annual research review: Rethinking childhood trauma-new research directions for measurement, study design and analytical strategies. *Journal of Child Psychology and Psychiatry, 61*, 236-250. https://doi.org/10.1111/jcpp.13160

Erickson, N., M. Julian, & M. Muzik. (2019). Perinatal depression, PTSD, and trauma: Impact on mother–infant attachment and interventions to mitigate the transmission of risk. *International Review of Psychiatry,* 31(3): p. 245-263. https://doi.org/10.1080/09540261.2018.1563529

Felitti, V.J., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine,* 56(6): p. 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

Folger, A, Eismann, E, Stephenson, N, Shapiro, R, Macaluso, M., Brownrigg, M., & Gillespie, R. (2018). Parental adverse childhood experiences and offspring development at 2 Years of Age. *Pediatrics, 141*(4). https://doi-org.ezproxy.aut.ac.nz/10.1542/peds.2017-2826

Franke, H. (2014). Toxic stress: Effects, prevention and treatment. *Children, 1*(3), 390-402. https://doi.org/10.3390/children1030390

Garcia, E.R., & Yim, I.S. (2017). A systematic review of concepts related to women's

empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy Childbirth 17*, 347. https://doi.org/10.1186/s12884-017-1495-1

Health Promotion Agency. (2017). *2016 Health and Lifestyles Survey Questionnaire.* Wellington: Health Promotion Agency Research and Evaluation Unit.

Health Quality & Safety Commission New Zealand. (2021). *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee | Te Pūrongo ā-Tau Tekau mā Whā o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki.* https://www.hqsc.govt.nz/resources/resource-library/fourteenth-annual-report-of-the-perinatal-and-maternal-mortality-review-committee-te-purongo-a-tau-tekau-ma-wha-o-te-komiti-arotake-mate-pepi-mate-whaea-hoki/

Khan, M., & Renk, K. (2018). Understanding the pathways between mothers' childhood maltreatment experiences and patterns of insecure attachment with young children via symptoms of depression. *Child Psychiatry and Human Development,* 49(6), 928–940. https://doi-org.ezproxy.aut.ac.nz/10.1007/s10578-018-0808-6

Lang, A., Gartstein, M., Rodgers, C., & Lebeck, M. (2010). The impact of maternal childhood abuse on parenting and infant temperament. *Journal of Child and Adolescent Psychiatric Nursing, 23*(2), 100–110. https://doi-org.ezproxy.aut.ac.nz/10.1111/j.1744-6171.2010.00229.x

Lange, B., Callinan, L., & Smith, M. (2019). Adverse childhood experiences and their relation to parenting stress and parenting practices. *Community Mental Health Journal, 55*(4), 651–662. https://doi-org.ezproxy.aut.ac.nz/10.1007/s10597-018-0331-z

Letourneau, N., et al. (2019). Intergenerational transmission of adverse childhood experiences via maternal depression and anxiety and moderation by child sex. *Journal of Developmental Origins of Health and Disease*, 10(1): p. 88-99. https://doi.org/10.1017/S2040174418000648

Lê-Scherban, F., Wang, X., Boyle-Steed, K., & Pachter, L. (2018). Intergenerational associations of parent adverse childhood experiences and child health outcomes. *Pediatrics,* 141(6). https://doi-org.ezproxy.aut.ac.nz/10.1542/peds.2017-4274

Light, A., Holt-Lunstad, J., Porter, C., & Light, K. (2019). Early life trauma: An exploratory study of effects on OXTR and NR3C1 gene expression and nurturing self-efficacy in mothers of infants. International *Journal of Psychophysiology: Official Journal of the International Organization of Psychophysiology*, *136*, 64–72. https://doi-org.ezproxy.aut.ac.nz/10.1016/j.ijpsycho.2018.03.018

Lomanowska, A., Boivin, M., Hertzman, C., & Fleming, A. (2017). Parenting begets parenting: A neurobiological perspective on early adversity and the transmission of parenting styles across generations. *Neuroscience, 342*, 120–139. https://doiorg.ezproxy.aut.ac.nz/10.1016/j.neuroscience.2015.09.02

McDonald, S., Tough, S., Madigan, S., Racine, N., Tomfohr, L., & Benzies, K. (2019). Maternal adverse childhood experiences, mental health, and child behavior at age 3: The all our families

community cohort study. *Preventive Medicine, 118*, 286–294. https://doi-org.ezproxy.aut.ac.nz/10.1016/j.ypmed.2018.11.013

McDonnell, C.G. & Valentino, K. (2016). Intergenerational Effects of Childhood Trauma: Evaluating Pathways Among Maternal ACEs, Perinatal Depressive Symptoms, and Infant Outcomes. *Child Maltreatment*, 21(4): p. 317-326. https://doi.org/10.1177/1077559516659556

Meltzer-Brody, S., Larsen, J., Petersen, L., Guintivano, J., Di Florio, A., Miller, W. C., … Munk-Olsen, T. (2017). Adverse life events increase risk for postpartum psychiatric episodes: A population-based epidemiologic study. *Depression and anxiety, 35*(2), 160–167. https://doi-org.ezproxy.aut.ac.nz/10.1002/da.22697

Ministry of Health. (2011). *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand.* Wellington: Ministry of Health.

Ministry of Health. (2013). *Well Child Tamariki Ora National Schedule.* Wellington: Ministry of Health.

Ministry of Health. (2021). Maternal mental health service provision in New Zealand: Stocktake of District Health Board services. Wellington: Ministry of Health.

Plant, D., Jones, F., Pariante, C., & Pawlby, S. (2017). Association between maternal childhood trauma and offspring childhood psychopathology: Mediation analysis from the ALSPAC cohort. *The British Journal of Psychiatry,* (3), 144. Retrieved from http://search.ebscohost.com.ezproxy.aut.ac.nz/login.aspx?direct=true&db=edsovi&AN=edsovi.00002405.201709000.00008&site=eds-live

Racine, N., et al. (2021) Adverse childhood experiences and maternal anxiety and depression: A meta-analysis. *BMC Psychiatry,* 21(1): p. 28. https://doi.org/10.1186/s12888-020-03017-w

Reuben, A., Moffitt, T. E., Caspi, A., Belsky, D. W., Harrington, H., Schroeder, F., & Danese, A. (2016). Lest we forget: Comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health. *Journal of Child Psychology & Psychiatry,* *57*(10), 1103-1112. https://doi.org/10.1111/jcpp.12621

Schickedanz, A., et al. (2021). Intergenerational Associations between Parents' and Children's Adverse Childhood Experience Scores. *Children*, 8(9): p. 1-14. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=edb&AN=152665395

Segre, L. S., & Davis, W. N. (2013). *Postpartum depression and perinatal mood disorders in the DSM.* https://www.postpartum.net/wp-content/uploads/2014/11/DSM-5-Summary-PSI.pdf

Swain-Campbell, N., Fergusson, D. M., & Horwood, L. J. (2003). Ethnicity and criminal convictions: Results of a 21-year longitudinal study. *Australian and New Zealand Journal of Criminology, 36*(3). https://eds-a-ebscohost-com.ezproxy.aut.ac.nz/eds/detail/detail?vid=4&sid=7896b986-753d-4389-98ab-a876dfc086f0%40sessionmgr4008&bdata=JnNpdGU9ZWRzLWxpdmU%3d" \l "AN=rmitplus20041091&db=edsapt

Wade Jr, R., Becker, B. D., Bevans, K. B., Ford, D. C., & Forrest, C. B. (2017). Development and evaluation of a short adverse childhood experiences measure. *American Journal of Preventive Medicine, 52*(2), 163-172. https://www.ncbi.nlm.nih.gov/pubmed/27865652

Walsh, M., Joyce, S., Maloney, T., & Vaithianathan, R. (2019). Adverse childhood experiences and school readiness outcomes: Results from the Growing Up in New Zealand study. *The New Zealand Medical Journal, 132*(1493), 15-24. http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=30973856&site=ehost-live&scope=site

World Health Organization (2020). *The Adverse Childhood Experiences International Questionnaire ACE-IQ.* https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq)

Zalewski, M., Cyranowski, J., Swartz, H., & Cheng, Y. (2013). Role of maternal childhood trauma on parenting among depressed mothers of psychiatrically ill children. *Depression and Anxiety, 30*, 792-799. https://doi-org.ezproxy.aut.ac.nz/10.1002/da.22116

*Lee-Anne Tait*
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**Capturing the Voices and thoughts of Our Retired Nurses**

Lee-Anne Tait Nurse Prescriber and member of the Logic Committee has started to do a series of interviews capturing the voices and thoughts of our older retired nurses in primary health care. This is to acknowledge that their voice and wisdom continues to influence our thoughts and practice.

Our first interview is with Maria Travers who is 87, she is now a retired with over 50 years of nursing experience as a Midwife, Plunket, General, Sexual and Public Health Nurse, also a senior Nurse Lecturer. We met to discuss her thoughts just after the cyclones and the devastation across the North Island of Aotearoa.

**Maria** – I have experienced a cyclone in my personal life which was extremely frightening. I was trying to recall if I had a similar event related to my nursing but I hadn't actually except for the Tiniu flood (1991) and I was only on the very periphery of that event and wasn't doing anything worthwhile initially in a nursing capacity, until the recovery phase.

I was thinking the other day about the worst thing that has happened to New Zealand in my time was the earthquake in Christchurch and the devastation that that caused. Now the people all along the East Coast, Hawkes Bay, and Auckland and also Wairoa -we always forget Wairoa will be having very similar feelings because everything that is known to them has been taken away. They will be having that feeling of insecurity. That they have got no safe haven anymore their home has gone, or their home is broken, and sometimes in some situations they don't even know if their home is liveable any more or not, so they are still in limbo over that, so they will be facing very similar feelings to those the people who were in Christchurch at that time.

But when we look at Christchurch today what a difference it has made to that city and the people have been resilient and recovered and can survive and thrive. I was reading in here actually (points to her paper? the Dominion) that Christchurch or at least Canterbury is the only region in New Zealand that has surplus housing because they had such determination to rebuild, with such determination that they moved forward with that. I know it is hard for people in Hawkes Bay or any of these affected cyclone areas to try and look forward to that time… So, it is so important in the meantime for people like us and those in surrounding communities to use positive language and I don't mean to say to be happy clappy or lovey dovey about it, but to avoid getting into the negatives and maintain more of a positive attitude and take bite sized amounts of that problem at a time. You are not going to be able to rebuild your house next week but we have got a safe place for you to stay in the Marae or someone's home for the time being, we are going to much sure you are fed and warm- now what's that old saying – nobody can eat an elephant in one bite, so if only for the children's sake try to take one step at a time and deal with the manageable sized problem each time.

*So, you would encourage the nurses to deal with the most immediate need they see and put a positive stance on the next situation?*

Yes, I mean Maslow's hierarchy of needs is really very appropriate in this situation isn't it?

*Absolutely…*

So as long as you address this and for the children's sake, I think to be able to maintain some measure of calm, some measure of optimism, so the children are not getting that feeling of dread and helplessness that can happen when people all around them are falling apart.

*Absolutely… well when you look back at the floods in Tiniu what did you Nurses do for those Children and their families to help with their rebuilding?*

Well, I think it was the case of maintaining the services we always did and to show that that hadn't changed, that we were still there for them and always ready to listen. And the other thing that was important was ensuring that people had the resources to go forwards. That people had the skills to go through the process of claiming for their insurance *and* guiding them to like the community lawyers or the Citizens Advice Bureau, to get the kind of advice they needed for their lives rather than feeling totally helpless, that there were steps they could take –

*Yes, this isn't a nursing procedure but a nursing action to direct people to the places where they need to be?*

Absolutely, the old referral business – 'I can hear what you are saying I'm not the person who can answer that, but this person can' - that kind of thing. That's the great thing about working in the community we are part of a network of support. As well as individual and family health needs we know our areas and resources "

*Yes, I think that as nurses we want to be that all-encompassing blanket, but we are so limited in our scope, but really that is actually fantastic- as we put them to the person who is the best to help-*

Yes, what you can do is put them on to somebody else with to best knowledge to help. The other thing we can do in any community is to support those social structures, what's it called – the social capital - the people that have come together to help people in times of trouble – this has been absolutely amazing. The Maraes of course, as Maraes always do they open their hearts and their arms and take people in. So have many other people - just individuals have given, you know shared their homes with people or said I've got a batch or a granny flat or whatever else and people will have offered these. People from all walks of life have just picked up wheelbarrows and shovels and got in and helped one another. I think that reinforcing that is the most important thing that we and governments can do at the moment, is to support that and resource that, as so many groups as well as individuals have already got together and are sorting things, we need to be behind them and help them as best we can at this time. Along with the nurses working locally in all those areas, let's support them. And that story about the Three Māori boys is just absolutely wonderful and so typical, so typical, and this has happened time after time after time after time. So, you know not all heroes wear capes by any means, but we've certainly have seen some tremendous heroes over this sad business haven't we?

*We certainly have*

(Maria chuckles) And sooner or later they are all going to be discovered and you know no matter how anonymous they want to stay they are going to get recognized….

*I think those three Māori boys are going to be legends in their lifetime.*

Yes, I think they will one day make a movie out of it (Maria smiles and chuckles with delight at this thought, at the celebration of these three humble men, their amazing heroic antics, along with their tenacity kindness and laughter over many long hours - all reaching the big screen

Sue Gasquoine is the Nursing Policy Adviser/Researcher in the Professional Services Team. She has worked at NZNO since March 2017 and in addition to her work in the Policy and Research Team, she supports the Nursing Education and Research Foundation (NERF) Board, Chairs the Publications Team and is a member of the recently convened Green Team exploring ways to introduce sustainable practices into NZNO.

Maranga Mai!

Diversity and understanding all groups in society.

Recently in my role as advisor to the Nursing Education and Research Foundation Board (NERF) I have been helping to establish a new scholarship for undergraduate nursing students. The donors, entrepreneurs whose business is in the men's health and wellbeing sector, are keen to support more men into nursing and other health careers. They believe that men talking to men about their health will be beneficial. As part of scoping how we could set up such a scholarship successfully, I facilitated a conversation between one of the donors and some of the students identifying as men who are in NZNOs National Student Unit (NSU). Afterwards the donor commented on how affirming that kōrero was for their business and social aspirations for men's wellbeing – they had found a team they could support!

Discussion with the NERF Board emphasised the importance of clear criteria for the scholarship which is primarily about acknowledging that the profession and care recipients would benefit from supporting male nursing students to succeed. They cautioned, that while recruiting more men into our profession is clearly within the Maranga Mai! remit, we needed to consider the 'exclusion' of female or non-binary applicants carefully so that the Human Rights Act (1993) wasn't breached. After legal opinions that explored the potential for breaching human rights and that other 'categories' including age and ethnicity already exist in the undergraduate scholarship, the Two Dudes male nursing undergraduate scholarship is available. https://www.nzno.org.nz/support/scholarships_and_grants

Along with members of the NERF Grants Assessment Committee I have also been assessing applications from student members of NZNO for undergraduate scholarships which are offered 2 to 3 times a year. One applicant identified themselves as being a member of the LGBTQIA+ (Rainbow) community and describes personal and professional experiences of the significance of gender-affirming care for recovery and supporting individuals' wellbeing. They describe the role of a nurse in them feeling 'comfortable' with accessing care and now identify that nurse as a role-model for their

professional aspirations. All nursing students need role models in whom they see their future selves. Suliman and Warshawski (2022) conclude that it has a significant positive effect on nursing student success and retention, an issue of significant concern for the profession globally. Effective role-modelling is therefore a significant contribution to sustaining our profession.

The 'how' of gender-affirming care needs to be part of nursing practice development as we authentically partner with diverse groups needing and deserving of high-quality nursing and healthcare. This begins with ensuring nursing and healthcare is accessible and all of us able to role-model inclusion for our tauira.

https://www.tandfonline.com/doi/full/10.1080/26895269.2021.1933669
https://www.clinicalkey.com.au/nursing/#!/content/playContent/1-s2.0-S026069172200140X?returnurl=null&referrer=null