news
AUSTRALIAN COLLEGE OF MENTAL HEALTH NURSES
December 2016 – February 2017

MENTAL HEALTH NURSES MATTER
> CEO wins Australian Mental Health Prize
> New qualification pathway for Credentialing
> Asylum Seeker Trauma and Suicidality
> 2016 Conference wrap-up
Taking the time out to reflect is always important...particularly when it has been a whirlwind of meetings, events, emails, phone calls and College activities! Happily, they have culminated in a few important wins for the organisation, but there have also been substantial challenges.

Despite the implementation of some mental health activities through Primary Health Networks and the election promise of $1.5 Million to the College to build workforce capacity, we are witnessing changes in the MHNIP nursing workforce for some a positive change and for others not so. We will continue to work with the PHN’s over the next 12 months to build a pathway for mental health nurses into primary care.

As we have come to expect, the 42nd International Conference in Adelaide was an excellent conference. There were many highlights - the Oration by Prof Philip Darbyshire challenging us to reflect on our profession and what that may look like to think differently about our work in the future change inspired and challenged us. Janine Mohamed’s keynote regarding Indigenous mental health and the impact of colonisation and the role of mental health challenged the nursing profession to develop an apology to Indigenous recipients of historical mental health nursing services. All keynote speakers were excellent, as were the concurrent sessions. All presenters inspired delegates and delivered sharp and considerate content and prompted passionate discussions. My thanks to College staff, and Prof Eimear Muir-Cochrane and the local Committee on delivering another successful event. Preparations are now underway for #ACMHN2017 in Hobart!

Congratulations to Mental Health Nurse of the Year 2016 – Mrs Agartha Buku and Mr Christopher Patterson the Mental Health Nurse Achievement Award winner. They are outstanding examples of mental health nurses who uphold the ideals of the profession, start thinking about worthy candidates to nominate for next year. Members continue to offer their time and resourcefulness to the many activities of the College. We sincerely value that input – it would not be feasible to achieve all the things we do without your hard work. I am also indebted to the College staff for their dedication to the profession and the organisation.

Finally, my sincere thanks to the many individuals who have contacted me with words of support and encouragement around the UNSW’s Australian Mental Health Prize, which I was (surprised) and thrilled to accept on behalf of every mental health nurse who is passionate and dedicated and working in a profession I love. Have a happy festive season, please all stay safe and look after yourselves – Christmas is joyous for some not so joyous for others.

I look forward to a jam packed year ahead and will keep in touch during 2017!

Cheers,
Kim Ryan, CEO
E: executive@acmhn.org
Special Message from the President

It is with great pleasure that I inform members that our very own CEO Kim Ryan has been selected as the inaugural winner of the UNSW Australian Mental Health Prize!

Announced at an event held at the UNSW on 7th December, Kim was selected by the Australian Mental Health Prize Advisory Group from a group of outstanding finalists – Annette Baker, Betty Kitchener, Ian Hickie, James Prascevic, Joe Williams and John Mendoza.

Kim is committed to improving mental health outcomes for Australians through collaborating with others. We see this in the way she has managed the College to date and in the collaborative relationships she has established across nursing, mental health and the health sector more broadly. Her response to the award was typically Kim – focused on what this Award means for the profession: “I’m incredibly honoured and completely overwhelmed to have won this prestigious Award. I am fortunate to work with some incredible people and I feel exceptionally proud to be representing the profession of mental health nursing. To have been selected from such a high calibre group of finalists is very humbling.”

Ita Buttrose, Chair of the Australian Mental Health Prize Advisory Group said of Kim’s selection, “Mental health nurses are often at the forefront when it comes to working with people who experience mental health conditions in the community. The Advisory Group were incredibly impressed with Kim’s commitment to advancing the profession of mental health nursing, and her tireless work advocating on behalf of mental health nurses. Kim’s work demonstrates the enormous difference that specially trained mental health nurses can make in the recovery of people with mental illness.”

Scientia Professor Phillip Mitchell, Head of the University of New South Wales School of Psychiatry, commented “Reviewing the entries in the first Australian Mental Health Prize has confirmed that Australia’s reputation as a world leader in many areas of mental health is well deserved. Kim Ryan’s work is an outstanding example of Australian innovation in the field of mental health nursing and the positive power of professional collaboration.”

Kim, on behalf of the Board, the Staff, the Fellows, Members and the broader mental health nursing profession, I congratulate you wholeheartedly on your outstanding work and significant contribution. We couldn’t think of a better recipient for this prestigious award and we couldn’t be prouder.

Wendy Cross
President ACMHN E: president@acmhn.org

From the (Guest) Editor

The theme for this edition is ‘mental health nurses matter’ and inside you will find a collection of articles demonstrating how and why what it is that we do makes a difference in people’s lives.

Our very own CEO being awarded the inaugural Australian Mental Health Prize is evidence that what we do really does matter! Thanks to each and every one of you for the amazing work you do.

I hope you find this edition interesting and useful. We have a new Communications Officer starting in January, hence my guest appearance as editor of this edition of ‘news’. I really must take this opportunity to sing the praises of the College staff who so willingly support each other when we’ve got a lot on by helping to pick up the slack!

We are busy planning some great things for next year and I’m looking forward to sharing our ideas with you early in the new year. Wishing everyone a wonderful break over Christmas and looking forward to working with you and for you in 2017 and beyond.

Peta Marks
Professional Development Manager E: peta.marks@acmhn.org
News briefs

What is a Health Care Home?
The Health Care Home is an existing general practice or ACCHS that commits to a systematic approach to chronic disease management in primary care, which supports accountability for ongoing high-quality patient care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services. For more information see www.health.gov.au/internet/ main/publishing.nsf/Content/health-care-homes

Fifth National Mental Health Plan
The Fifth Plan will seek to establish a national approach for collaborative government effort over the next five years, with a focus on achieving a better integrated service system for consumers and carers. Draft copies of the plan and dates for national consultations can be found here: www.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan-consultation-survey

Health plans for vulnerable mental health consumers
The Chief Psychiatrist in Victoria, directed by the Coroner, has issued an advisory notice regarding management of heat stress for mental health consumers – particularly those who find it difficult to make and execute plans, or who are taking antipsychotic medications that can have an effect on the body’s ability to regulate temperature. See www2.health.vic.gov.au/about/publications/policiesandguidelines/ocp-advisory-notice-heat-health-plans-for-vulnerable-mental-health-consumers?ec_contact_id=447FA533D538DA4AB1B82493FA19A6842&ec_message_id=061921CC31F44FE992EEC6392D00EC4

PHN pilot sites announced
The Federal Government recently announced 10 Primary Health Network (PHN) regions that will take a lead role in developing and delivering new models of primary mental health care. • North Coast PHN (NSW) • Central and Eastern Sydney PHN (NSW) • Murrumbidgee PHN (NSW) • Eastern Melbourne PHN (VIC) • North Western Melbourne PHN (VIC) • ACT PHN (ACT) • Brisbane North PHN (QLD) 2 • Tasmania PHN (TAS) • Perth South PHN (WA) • South Eastern Melbourne PHN (VIC).

All lead sites are in the early stages of implementation and are working with the Department of Health to refine the scope of activities and evaluation framework.

Healthy Communities: Report released 22/9/16
The Australian Institute of Health and Welfare (AIHW) latest Healthy Communities report contains data on intentional self-harm hospitalisation at the local level, saying it will help communities plan suicide prevention responses.

Key report findings:
• The age-standardised rate of hospitalisations for intentional self-harm varied from 83 per 100,000 people to 240 per 100,000 people.
• Across regional and remote local areas, hospitalisation rates for intentional self-harm increased with remoteness.
• Self-harm is associated with a number of mental health conditions and about 70% of those admitted to hospital had either a principal or secondary mental health diagnosis in 2013–14.
• The age profile is similar to the profile on persons who died by suicide – 30% are youth/young adult, more than 50% are middle aged and the remainder are older persons.

In 2015, 3,027 people died from intentional self-harm in Australia. In 2015, the standardised death rate was 12.6 deaths per 100,000 people. This compares with a rate of 10.2 suicide deaths per 100,000 persons in 2006. The ranking of suicide as a leading cause of death has also changed over time; it is now the 13th leading cause of death in Australia, compared to the 14th leading cause in 2006. Deaths from intentional self-harm occur among males at a rate three times greater than that for females.

The standardised death rate for suicide in 2015 was 12.6 deaths per 100,000 persons. This was the highest rate recorded in the past 10 years. All states and territories except South Australia reported a stable or increasing suicide rate from 2014 to 2015. In 2015, suicide was the leading cause of death among all people 15–44 years of age, and the second leading cause of death among those 45-54 years of age. The median age at death for suicide was 44.5 years. This compares to a median age of 81.9 years for all deaths.
Oration 2017 bought to you by twitter!

Professor Philip Darbyshire Ch-ch-ch-ch-changes: Mental health services and nursing in an ever more uncertain world. Changing how we change.
Supporting mental health of the community: a nursing solution

An important strategy for improving the mental health and wellbeing of all Australians will be developing and sustaining a nursing workforce that is responsive to the mental health needs of the community, across the spectrum of illness and over the lifespan.

Nurses are critical to the provision of timely, effective and appropriate treatment services to people experiencing mental distress, people with mental health problems, mental disorder or mental illness (World Health Organisation, Investing in Mental Health, 2003). Yet mental health nursing has been identified as experiencing existing and predicted significant future workforce shortages. This is indicative of a future mental health service provision crisis (Australia’s Future Health Workforce – Nurses Overview Report August 2014). The proportion of the mental health nursing workforce nearing retirement age – aged 55 and over – has increased from 25% in 2009 to 30% in 2013. Expanding the mental health nursing workforce is one part of the solution, but we can’t do it alone – a whole of nursing response is required.

The National Mental Health Commission (NMHC, 2014) has also recognised the importance of ensuring a sustainable and flexible mental health workforce that is adequately prepared to identify and manage people’s mental and emotional wellbeing, is therefore essential to increasing the mental health and wellbeing of the community.

The shift in care provision from acute care settings to primary health care means that increasingly, nurses are taking up roles in community and primary health care settings. General Practice nurses work at the front line of primary health care provision, and will be a key workforce to support mental health care, yet an Australian Primary Health Care Nurse Association Workforce Survey (2015) identified that 84% of respondents never undertook mental health assessments and 82% never provided mental health education or management. This suggests General Practice nurses require a more detailed understanding of mental health issues, and the nursing skills to undertake nursing care, related to mental health, relevant to their scope of practice. General Practice nurses also need supported to make appropriate referrals to, and provide integrated and coordinated care with, mental health nurses (MHNs, CMHN, MHNPs).

New pathways for transitioning into the mental health nursing workforce must be developed for graduates and existing registered nurses with an interest in specialising in mental health. Opportunities to foster an interest in mental health amongst the future workforce should be harnessed through student placements and innovative workforce engagement models.

The ACMHN is working with Government to present a comprehensive plan to develop the nursing workforce and we look forward to providing members and other nurses with information about this work in the coming months.

(Endnotes)


Meet ACMHN’s Policy and Stakeholder Engagement Manager

Alexandra Anderson has recently joined the College from the Department of Social Services where she worked on policy associated with the implementation of the National Disability Insurance Scheme (NDIS).

Alexandra is passionate about mental health and other health and social issues affecting disadvantaged people. She has previously worked as a policy officer on the Mental Health Nurse Incentive Program at the Department of Health, and also brings her experience from having worked in clinical environments, both as an Office Manager in the Psychiatric Services Unit at the Canberra Hospital, and as a trainee neurophysiology technician at the Royal Children’s Hospital in Melbourne.

Alexandra moved to Canberra from Melbourne six years ago and married her partner of nine years in the Dandenong Ranges in March 2015. She enjoys reading, traveling, sharing delicious meals with her family and friends, and lists Turkey and Vietnam as the destinations she would most like to visit again one day.

Alexandra is looking forward to engaging with you all and enjoyed meeting some of you recently at our International Conference in Adelaide. She is more than happy to be contacted if you have any questions or issues you wish to discuss. Alexandra can be contacted via email at alexandra.anderson@acmhn.org

“It has been really great to move into such an interesting and challenging position…”

Make the MOVE to Australia’s first world class regional hospital

The new Bendigo Hospital will have an 80 bed psychiatric inpatient unit, which includes a parent infant unit, adult inpatient unit, older persons unit and an extended care unit.

To make your next move visit: www.bendigohealth.org.au/careers/
Once again the annual International Mental Health Nursing Conference provided delegates with a range of social and networking opportunities, top caliber keynote speakers, a provocative orator and the opportunity to hear from other mental health nurses talking about what they do best!

See you all in Hobart 2017!
Projects update

Project Report: C4N Stage 2 Complete
The C4N stage 2 project ran from 2 Feb 2015-30 June 2016 and was funded by Queensland Health, via the Nursing and Midwifery Office, Queensland (NMOQ). Key achievements included:
• Endorsement of the C4N common qualifications framework that guides the credentialing of all specialist nurses, and the application of specialist-nuance of that common framework to reflect the professional standard within each specialty.
• Development of the C4N website which provides an accessible credentialing system, based on the common framework, setting the standard for specialist nurse professional credentialing for Australia.
• Building the capacity of the four participating professional associations’ understanding and competencies in preparing the specialist workforce and supporting credentialing roll-out for specialist nurses working in their specialty areas.
• Accepting credentialing applications from the first 100 specialist nurses from four different specialty areas – Cancer nursing, Emergency nursing, Children & Young People’s nursing and Palliative Care nursing.

In addition, a most significant achievement of the C4N project was the very collegial collaboration between the five professional nursing organisations involved in the C4N project (ACMHN, Australian Children & Young Peoples Nurses, College of Emergency Nurses Australasia, Cancer Nurses Society of Australia, Palliative Care Nurses Australia), which resulted in the successful roll-out of the C4N project across the four nursing specialty areas in Queensland, and is ongoing in support of rolling out C4N nationally.

New Project: C4N Stage 3 – Includes CPD App!!!!
The NMOQ have agreed to fund the ACMHN to develop a CPD App that interfaces with the C4N online credentialing application system. This means that we are only six months away from offering members a comprehensive App that can be downloaded onto your smart phone. The app will enable you to record all of your CPD activities and evidence, categorise activities as professional development or education activities, and then, if you are seeking credentialing or re-credentialing, translate this information directly to your application within the C4N system! Yahoo!

The project will also include ongoing support of the C4N system and development of an online peer-reviewer training program.

New Project: Supporting MHNs towards ongoing seclusion and restraint reduction
Seclusion and restraint reduction and ultimate elimination are policy goals of all Australian Government Departments. Mental health nurses (MHNs) have a crucial role in this process, however, in support of this goal, there are many contributing factors that need to be considered and addressed, with staff, consumer and visitor safety of the utmost importance.

Nursing leadership is required – not only in demonstrating commitment to the use of de-escalation principles and implementing recovery-oriented approaches, but also in understanding the experience and attitudes of front line MHNs, who are, above all other mental health professionals, key decision makers when it comes to using, or not using, seclusion and restraint.

The ACMHN has received funding from the National Mental Health Commission for a six month project that responds to the need to further facilitate cultural change towards reduction and ultimate elimination of restrictive practices in Australian mental health services. We seek to ensure that the experiences of MHNs are fully explored and understood by policy makers and service managers. We will investigate the thoughts, feelings and attitudes of MHNs towards issues of safety, care and protection and we will seek to understand the barriers and enablers that MHNs face in regard to clinical, cultural and individual change – with the aim of ensuring that MHNs are appropriately supported to further promote this policy directive into the future.
Clinical skills for treating posttraumatic stress disorder (Treating PTSD)

This two-day (8:30am-4:30pm) program presents a highly practical and interactive workshop (case-based) for treating traumatised clients; the content is applicable to both adult and adolescent populations. The techniques are cognitive behavioural, evidence-based, and will be immediately useful and effective for your clinical practice. The emphasis is upon imparting immediately practical skills and up-to-date research in this area.

11 - 12 May 2017, Brisbane CBD
18 – 19 May 2017, Melbourne CBD
25 - 26 May 2017, Sydney CBD
8 - 9 June 2017, Adelaide CBD*
15 - 16 June 2017, Perth CBD*
22 - 23 June 2017, Wellington (NZ) CBD*

*$600 Super early-bird rate applies when you pay more than six months prior

Clinical skills for treating complex traumatisation (Treating Complex Trauma)

This two-day (8:30am-4:30pm) program focuses upon phase-based treatment for adult survivors of child abuse and neglect. In order to attend, participants must have first completed the 'Treating PTSD' program. This workshop completes Leah’s four-day trauma-focused training. The content is applicable to both adult and adolescent populations. The program incorporates practical, current experiential techniques showing promising results with this population; techniques are drawn from EFTT, Metacognitive Therapy, Schema Therapy, attachment pathology treatment, ACT, CBT, and DBT.

13 - 14 July 2017, Brisbane CBD*
20 - 21 July 2017, Melbourne CBD*
27 - 28 July 2017, Sydney CBD*
3 - 4 August 2017, Wellington (NZ) CBD*
19 - 20 October 2017, Perth CBD*
26 - 27 October 2017, Adelaide CBD*

Program fee for each activity

Early Bird $690 or $600 each if you register for both (or with a colleague) more than three months prior using this form.

Normal Fee $780 or $690 each if you register for both (or with a colleague) less than three months prior using this form.

Program fee includes GST, program materials, lunches, morning and afternoon teas on both workshop days.

For more details about these offerings and books by Leah Giarratano refer to www.talominbooks.com

Please direct your enquiries to Joshua George, mail@talominbooks.com

2017 Trauma Education Registration Form for ACMHN Members

Please circle the workshop/s you wish to attend above and return a copy of this completed page via email

Name:
Address:
E-mail:
Mobile:
Dietary Requirements:

Payment method (circle one): Visa Mastercard Electronic Funds Transfer. An invoice containing our banking details will be emailed to you

Name of card holder:
Card Number:
Card Expiry MM/YY:
Signature of card holder:
Card Verification Number

EFT or credit card payment is preferred. Simply complete the information above, scan and email this page to mail@talominbooks.com

A receipt will be emailed to you upon processing. Note: Attendee withdrawals and transfers attract a processing fee of $55.

No withdrawals are permitted in the seven days prior to the workshop; however positions are transferable to anyone you nominate.
Asylum Seeker Trauma and Suicidality: Understanding and Responding

By Professor Nicholas Procter, University of South Australia, Associate Professor Mary Anne Kenny, Murdoch University
Professor Carol Grech, University of South Australia

Between August 2012–December 2013 a group of asylum seekers – numbering approximately 30,000 – who arrived by boat have become known in public policy as the ‘legacy caseload’. As asylum seekers, many will have been subjected to psychological and potentially physical trauma in their home country. Waiting up to four years to have their claims for refugee protection assessed in Australia further impacts on their individual mental health. In the last 24 months, there have been several suicides and reports of many more ‘near misses’ in the legacy caseload group.

Most mental health nurses will encounter asylum seekers in the legacy caseload living in the community on bridging visas while they await assessment of their protection visa applications.

Processing of applications has been protracted and subject to several government policy changes.

Social support services for the majority of the legacy caseload in the community are limited. A reduction in government funding for legal assistance has also led to lengthy delays in accessing no-cost assistance in preparing visa applications.

An asylum seeker whose application is successful will only be granted either a three year Temporary Protection visa (TPV) or a five year Safe Haven Enterprise visa (SHEV). At the expiration of those terms current policy is that a refugee will likely only receive another temporary visa and will only have access to Permanent Protection in limited circumstances.

Projections on future government policy for this group are difficult, but it is clear that this group will be facing a minimum of ten years on a temporary visa and are thus facing long periods of uncertainty, including ongoing separation from family, thus creating a particular subclass of ‘outlander’ (i.e. an alien/foreigner who likely will never ‘belong’) that service providers have not previously experienced, nor have the means to effectively assist.

Available options for supporting people in such deteriorated mental states are further complicated by the scale of perceived burdensomeness, self-blame, alienation and aloneness. While asylum seekers with previous suicide or self-harm distress may be more likely to value support from individuals within their own social or cultural network (for example, family and friends) than the support of health and social professionals, the nature of worsening distress and trauma is such that the immediate family and social group is becoming a diminishing protective factor against deteriorating mental health.

With worsening uncertainty comes worsening hopelessness and deteriorating mental health.

An additional complexity in this situation is frustrated belongingness, purpose and identity. This has significant inter-subjective consequences for asylum seekers; such as adversely impacting upon relationships between, for example, husband and wife, neighbours, among siblings and other immediate family members who are also under significant strain.

Individuals who are experiencing disconnectedness from others who they have had previous close relationships with are more rather than less likely to become increasingly socially and culturally isolated, internalise mental distress and ruminate over how life could or should be.

This is of particular concern; it makes for a complex set of circumstances contributing to vulnerability of family and intimate partner violence, alcohol and substance use, self-harm and suicidal behaviour.

It may become increasingly difficult for such individuals to trust others and seek help during a period of crisis. If this situation worsens, so too will the corollaries of hopelessness, futurelessness and being a perpetual outlander.

The focus of a therapeutic response with vulnerable asylum seekers in the Australian community should be guided by the very real need to find a way to decrease the lethality associated with their feeling hopeless, disenfranchised and trapped.

This means taking active account of knowledge that many asylum seekers have experienced extremes of threat, violence, distress and despair. Acknowledging that violence and threat teaches withdrawal, anxiety, distrust, overreaction, hypervigilance and aggression coping behaviours is important in trauma informed practice.

Deeper dialogue and engagement between individuals leading to a redefining of the problem in alternate terms, for example, of a need to do something to stop excruciating psychological pain and anguish is a strategy worthy of consideration. The aim of this work will be to begin trying to diffuse the source of the person’s focus on one single outcome or solution (death), thus creating a space for the person to discuss their inner suicide struggle. For some individuals this may be a helpful shift – albeit temporarily – from their experience of unbearable injustice, enough to help them think about alternatives to ending their life.

A trauma informed approach would look something like this, “When you say I can’t live like this, I can’t take this anymore, what is the this?”

External observers can always interpret the behaviour of asylum seekers in excruciating distress from their own viewpoint, but they will not be able to understand the crucial individual context behind such distress, anger or suicidality without the active assistance of the person concerned.

The focus of therapeutic engagement with asylum seekers who in suicide related distress should be guided by the twin process of developing a therapeutic alliance and understanding the person’s explanatory model and conceptualisation of suicidality. Such activity relies on a ‘person centred connection’ and seeks collaborative understanding of the drivers for intense suffering.

A trauma informed practitioner guide for working with asylum seekers in the legacy caseload is available from mentalhealth@unisa.edu.au
ACMHN transition to online credentialing and additional education pathway to meeting qualifications criterion

Peta Marks, C4N Project Manager

At the ACMHN International Conference, College President Prof Wendy Cross, announced that the Credential for Practice Program (CPP) will become part of the Credential for Nurses (C4N) consortia.

The College developed the CPP starting in 1999, and since opening the program to all in 2004, we have become the leader in the nursing profession in establishing clarity around what it means to be a specialist nurse. Based on this expertise and knowledge in the credentialing of mental health nurses, the College was selected as the Project Lead for the Nursing and Midwifery Office Queensland funded Credentialing for Nurses (C4N) project in 2014.

In this project the College worked collaboratively with four other professional nursing organisations: the Australian College of Children & Young People’s Nurses; College of Emergency Nurses Australia; Cancer Nurses Society of Australia; and Palliative Care Nurses Australia to establish the national credentialing framework. This framework was somewhat adapted, but essentially built on the ACMHN’s credentialing framework, and utilises a common set of standards to complement the diverse roles of nurses within their respective specialties.

C4N has now become a program which has implemented a nationally standardised professional credentialing mechanism, by which registered nurses can be recognised as specialist nurses within their area of practice.

From 1 March 2017 all ACMHN applications for Credentialing and Re-credentialing in mental health nursing will be available and processed entirely through the online portal. This will provide a more streamlined and accessible process for all applicants and for peer reviewers.

In transitioning to C4N, the College has reviewed our eligibility criteria for credentialing and brought it in line with that accepted by the broader profession. As a result, from 1 March 2017, in addition to the currently accepted qualifications criterion pathways, we will accept applications under a new pathway (known as Pathway 2). The new pathway will not compromise the very robust standard we have set, but it will enable more mental health nurses to apply for Credentialing.

Pathway 1: Graduate Diploma or higher degree in mental health/psychiatric nursing (100 points)

Pathway 2: Graduate Certificate in Mental Health Nursing (must include content on mental health nursing theory and practice, and mental health theory and practice, which is clearly evident in a minimum of 75% of the program of study) (50 points) AND a qualification from a cognate course in a complementary mental health practice and/or specialty (e.g. Child & Adolescent Mental Health) (50 points).

Pathway 3: Post Basic Hospital Course recognised by the specialty organisation / college (100 points) (not a Transition to Mental Health Nursing program) OR a Hospital Certificate in the specialty area of nursing; or specialist pre-registration course; or specialist registration (100 points) OR a pre-registration Specialist Nursing Bachelors degree or diploma; or specialist pre-registration course; or specialist registration (100 points).

All information regarding credentialing on the ACMHN website will reflect these changes soon. Further information is also available on the C4N website at http://www.c4n.com.au/credentialing.
Presently posted to the Members section of Australian College of Mental Health Nurses Inc [ACMHN] website is the 2013 version of the Clinical Supervision [CS] Background Paper. It represents the latest version¹ and contains 23 references. Also posted to the same webpage is a 2016 Joint Clinical Supervision Background Paper; it contains 62 references. The latter document is similarly posted to Australian College of Nursing [ACN] website. Thirteen references are common to both 2013 and 2016 Background Papers. Ten references are cited in the stand-alone 2013 ACMHN paper [mostly international mental health-related texts] are not found in the 2016 joint ACMHN/ACN paper. Forty-nine references have been added to the latter [many Australian-based and generalist in content], which do not appear in the 2013 ACMHN paper.

It can be assumed that the co-branded joint Background Paper is the narrative summary to show how the authors arrived at their six recommendations in the Joint Position Statement on Clinical Supervision. The writing team comprised [un-named] individuals, drawn from the ACMHN and the ACN². Feedback on the final draft version was invited from [again, un-named] individual members of the ACMHN CS Special Interest Group³, before the Joint Position Statement was signed-off by the Boards of Directors of both Colleges in August 2016. It, too, has been posted to the websites of both Colleges. Unlike the ACMHN, the ACN had not previously developed a stand-alone policy position on CS; indeed, is ‘not intending to publish’ one.

Since the sign-off, the Joint Position Statement on Clinical Supervision has been lodged for buy-in from the Coalition of National Nursing and Midwifery Organisations [CoNNMO], comprised of more than 53 organisations, and from the Council of Deans of Nursing and Midwifery [CDNM], which represents 42 University Schools of Nursing and Midwifery throughout Australia and New Zealand.

Discounting possible duplications⁴, it is hard to imagine what the line of best fit will eventually look like, which will satisfy all 95 component entities, in the resultant Position Statement. It is also difficult to imagine how the upshot of a review of the 2013 ACMHN-specific CS Background Paper and Position Statement, due ‘sometime in the new year [2017]’, will harmonise with the already jointly agreed versions of both documents AND also craft something distinctive for mental health nursing. This, because the process of producing the Joint Position Statement appears to have been the rather perfunctory removal of the words ‘mental health’ from the 2013 ACMHN Position Statements and then to co-badge the remains as a Joint [ACMHN/ACN] Position Statement on Clinical Supervision. It is also noticeable that, in substantive terms, the references chosen for inclusion in the Joint Background Paper revealed very little [if anything] that was not already known and, therefore, it carried limited weight to steer the tenor of the Joint Position Statement.

Thus, a fresh and more convincing relationship must now be established between the content of the 2017 ACMHN Background Paper [aka, the conceptual and empirical basis] and the content of the 2017 ACMHN Position Statement [aka, the publicly-adopted policy position]. This will be a somewhat more challenging scholarly endeavour. In so doing, it is vital that such a linkage is mindful of the risks associated with the selective use of CS literature and the influence of external political drivers, which may innocently/intentionally overreach claims to the benefits of Clinical Supervision [White 2016]. Moreover, the author[s] of such future documents should identify themselves [see Falander et al 2016, for a recent exemplar] and each document should be date-stamped, to increase transparency and avoid any confusion about the currency of successive versions, respectively.

Having been early adopters of Clinical Supervision [White and Winstanley 2014], mental health nurses should also guard against becoming increasingly marginalised from the narrative around CS in any/all forthcoming publications...”
this may be a function of an apparent widespread reluctance of mental health nurses to publicly engage any discourse around Clinical Supervision, which continues to dance on the head of a pin [White 2014]

Edward White PhD, FACMHN, FACN
E: edwardwhite@osmanconsulting.com.au

1 It is identical to the 2011 version, which is presently posted to the Public area of the ACMHN website, save one word; viz, ‘demonstrable’ was added as a prefix to ‘benefits’ in the 2013 version, found in the Members section.
2 For the ACMHN, this was a member of the Board of Directors and a National Office staff member. The ACN declined to identify the name[s] or role[s] of contributing author[s].
3 Any feedback given has not entered the public domain.
4 For example, it is possible for a single individual to be a Dean of a University Department of Nursing, and a Senior Officer of the ACMHN, and to be a representative on the CoNNMO.

References:


White E [2014] Clinical Supervision in Australia: dancing on the head of a pin. The Hive, 7, pp14-15


White E [2016] Claims to the benefits of Clinical Supervision: a critique of the policy development process and outcomes in New South Wales, Australia. International Journal of Mental Health Nursing [In Press]

Dr Edward White is Director, Osman Consulting Pt Ltd. He is also Conjoint Professor, School of Psychiatry, University of New South Wales, Sydney, Australia and Honorary Reader, Personal Social Services Research Unit, The University of Manchester, England. He is the former Director, Board of Research, Australian College of Mental Health Nurses Inc.
2016 AWARD WINNERS

2016 Mental Health Nurse of the Year
Agartha Buku (A)

Ms Buku was nominated for the MHNOTY by the Manager of Nursing Services at the Kimbe Provincial General Hospital in Kimbe PNG. She holds the Senior Specialist Mental Health Officer position and her nomination letter states:

‘Agartha has made an exceptional commitment to mental health nursing, mental health nursing education and to the health and wellbeing of people requiring admission to a mental health inpatient facility in PNG. As a registered mental health nurse in PNG, Agartha has taken every opportunity to improve her own education and practice. She has attended workshops, conferences and other education opportunities in PNG and overseas. On return to PNG and to her facility, she has used the knowledge and practices gained to enhance the standard of education of nurses at the facility and to improve the care of consumers wherever possible. In fact, Agartha has worked tirelessly to enhance the educational opportunities for mental health nurses and consumers by the introduction of contemporary practices observed at overseas institutions.’

Congratulations to Agartha for this wonderful achievement.

Thank you to Wiley Blackwell which co-sponsors the award with the College.

2016 Mental Health Nurse Achievement Award
Christopher Patterson (B)

Christopher Patterson is a RN and has a Master of Nursing (MH) from UoW. His principal practice has been mental health nursing and his career has included work in the areas of adult high dependency, acute adult inpatient and rehabilitation, and in unit management, education and nurse consultant positions. Most recently, he’s been working in academia and is currently undertaking a PhD in Mental Health Nursing under the guidance of Prof Nicholas Proctor at UniSA.

‘Christopher is exactly what our profession needs. He is young, passionate and completely committed to mental health nursing. This commitment began as an undergraduate student and has not waned. Always looking for opportunities to promote mental health nursing, Christopher has a regular line up of students wanting to find out more about the passion he holds for mental health nursing. This passion ‘infects’ students with an inquisitorial approach and sparks their interest in mental health nursing.’

Congratulations Christopher! Long may you continue to ‘infect’ and recruit new mental health nurses into the profession!

Thank you to Curtin University and Wiley Blackwell for co-sponsoring the MHNAA.

Stan Alchin Award
Katie Bleus and Antony Mullen (B)

Research Award
Phillip Maude (H)

General Award
Robert Trett (C)

First Time Presenters Award
Rebecca Lofts and Jo Ryan (co-presenters)

Poster Award
A tie between Josephien Rio and Anita Cregan
Expression of Interest - South Western Sydney PHN

Are you a mental health nurse with an interest in providing an exciting, dynamic and mobile range of services in the areas of Liverpool, Fairfield and Campbelltown in South Western Sydney?

South Western Sydney PHN are looking to hear from accredited Mental Health Nurses that are interested in being part of a mobile service that will have a focus on the following population groups:

- People with mental health issues experiencing homelessness, accommodation issues and sustaining tenancy
- People transitioning from adolescent to adult mental health services
- People with a mental illness currently involved in the justice system

While these groups represent a focus of the mobile service within the region, the scope of the services that could be provided will not be limited to these areas.

Additionally MHNs involved in this mobile service would be expected to partner and develop relationships with GPs, other allied health providers and mental health NGOs to ensure that effective and integrated approaches to people’s mental health care are offered.

To find out more or express your interest please contact Chris Jones on 4632 3066 or chris.jones@swsphn.com.au
Andrew Denton is known to many mental health nurses for his documentary Angels and Demons, in which he interviewed people who live with mental illness about their experience of mental health care, of hearing voices, of feeling suicidal, and of stigma. His address to the National Press Club in August launched his organisation, “Go Gentle Australia”, to lobby for the legalisation of assisted dying, and to “galvanise the support so that politicians can no longer ignore it”. The launch included a book, The Damage Done, which is a collection of testimonies by the dying and their relatives.

In a related address to the recent Australian Nursing and Midwifery Federation’s (ANMF) Victorian branch delegates’ conference, he sought the continued support of nurses for the laws. He noted that polls in Australia consistently show support of over 70% for the introduction of voluntary euthanasia laws.¹

When asked about whether the lack of progress on the legislation might be based in our own psychology and the rational fear of dying, Mr Denton replied: “I’m fiercely pro-life. The group that struggles the most is doctors.” Even this is changing. The Australian Medical Association’s (AMA) recent position statement² acknowledges for the first time “that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.”

Mental health nurses care for people in many contexts. Mental Health Nurses (MHNs) have therapeutic relationships with people in primary health care, in the management of chronic disease and co-morbid physical illness, in case management of people across the life span and of people with terminal illness. MHNs are recovery-focused and work with people making life choices, but many of us have also attended the funeral of a client.

Mr Denton reported that in Victoria one elderly person per week with irreversible disease-related deterioration of physical health is dying a violent death by their own hand. Coroner John Olle has said it is a clear case of the need for law reform. Mr Denton said the golden rule the world over is that people don’t want to die.

The chairman of the Black Dog Institute, Peter Joseph, believes the suicide rate (of people with terminal illness) would drop significantly if assisted dying were seen as assisted living.

Australia enacted the world’s first assisted dying law in the Northern Territory 20 years ago, but that law was soon repealed. Presently, the South Australian Parliament’s 15th attempt to legalise voluntary euthanasia was narrowly defeated by a casting vote in November, in spite of a support campaign by the ANMF.³ Victoria, Tasmania and NSW can expect Bills within a year.

Opposition to assisted dying legislation takes many forms in Australia. Mr Denton noted that palliative care in Australia is among the best in the world, and it should be brought to the discussion table. However, the leadership of Palliative Care Australia opposes assisted dying laws, as does the Catholic Church hierarchy and a number of traditionalist politicians. Labor’s Tony Burke was the director of the Euthanasia No! group at the time of the NT legislation repeal. The disability community has its own unique concerns and divided opinions, some strongly opposing assisted dying, based in the perception that the lives of people with disabilities are of less value. Both sides of the disability discussion demand safety.

Mr Denton has produced 17 podcasts (Better Off Dead) in which he interviewed Australians who have taken matters into their own hands, and doctors and nurses who have admitted to assisting patients to die.⁴

He travelled to Oregon in the USA, to Belgium and to The Netherlands, where laws exist for assisted dying. He interviewed family members of people who have used the laws and health professionals who have worked within them. He found that rigorous safeguards and regulatory frameworks mean that, by and large, the laws work well.

“But it is a life threatening disease” The Belgian legislation is regarded as the most liberal in the world. It allows euthanasia for children and for people on grounds of psychological distress.

“Psychiatric euthanasias” are the most disputed of all forms of assisted dying. Mr Denton visited the Ulteam in Brussels, a specialised medical unit that deals with the most complex and difficult end-of-life requests. For the psychiatric patient, they say, the pain is not visible.

In cases of what the Belgians refer to as “psychiatric suffering”, three doctors, one a psychiatrist, must independently come to the same view that the case is so intractable that the request for euthanasia can be granted. The person must also be mentally competent.

In an interview with a psychiatrist on the Ulteam, Mr Denton asked what kind of psychiatric illnesses are considered. Dr Lieve Thienpont, who with colleagues has published on this issue,⁵ said the illnesses must be chronic, therapy resistant, unlikely to be a psychosis, and involve unbearable suffering. Mr Denton asked what concept of “unbearable suffering” looks like. Dr Thienpont said more work needs to be done on this, as it has not yet been defined adequately. The Ulteam aim to develop guidelines and protocols, including objective criteria, the consequences of the illness on the patient’s quality of life, the exclusion of coercion, the need for “a

high chance of success in the judgement”, and acceptability to the patient. Sometimes the multidisciplinary team of oncologists, psychiatrists and nurses can discuss difficult cases for a month, and assessments can take much longer.

Importantly, more than 50% of the people asking for euthanasia are helped to find other ways to live and do not proceed with their euthanasia application. The Ulteam says this is in part because they can help the person to speak in a “totally different context to suicide about their wish to die”. In Oregon, 40% of people given a prescription for life-ending medication do not take it.

What might an Australian law look like?
Based on overseas laws, Mr Denton’s proposed laws would have three bedrock principles:

• To access it, you must be a competent adult, thereby excluding children and people with advanced dementia.

• Your request must be voluntary.

• You must have a physical illness, thereby excluding people with “purely psychiatric suffering”.

• If any psychological disorder is impairing your judgement, a psychiatrist’s opinion is sought.

Better Off Dead
The 17 podcasts include heart-wrenching interviews, a discussion of palliative care in Australia, controversial discussion by ethicists such as Peter Singer and Anthony Fisher, links to resources, and compelling interviews with nurses.

Andrew Denton summarises:
To those doctors who are sitting on the fence because you think it’s all being taken care of, or because you don’t understand how these laws work, educate yourselves. To the politicians—I urge you: Do your duty. Better Off Dead is not an impartial report. It is a campaign. It has the support of the ANMF. Mr Denton says “we don’t argue for a ‘right to die’. Death is not a right. Death is a fact at the end of life”.

Links
Go Gentle Australia website: www.gogentleaustralia.org.au/
Andrew Denton podcasts: www.wheelercentre.com/broadcasts/podcasts/better-off-dead

5 Australian Nursing and Midwifery Federation, “National campaign on voluntary euthanasia launched as support for legislation grows across country” http://anmf.org.au/media-releases/entry/media_160923

“We don’t argue for a ‘right to die’. Death is not a right. Death is a fact at the end of life”
Mental Health Nurses Matter: The Evidence

The theme of this issue of news mag is ‘Mental health nurses matter’. The following (edited) abstracts from the most recent editions of the IJMHN speak to this theme and may be of interest to readers:


Staff reactions to psychiatric complaints have been linked to their comfort dealing with these types of service users as well as their competencies understanding the illness. It is therefore vital to understand which skills increase confidence in treating psychiatric emergencies. Participants reported several non-technical skills which developed from exclusively serving people with psychiatric emergencies. Participants also reported several other clinical skills which they gained during training, including teamwork, de-escalating techniques and risk assessment.


This editorial discusses the importance of mental health nurses working alongside Indigenous mental health workers to ‘make a difference’.


Australian mental health policy is focused on providing mental health care in the community setting and community mental health teams provide services to clients in a shared model with primary care. This paper reports on research conducted at one Australian public mental health service to identify the components of the community mental health nursing role and to quantify the time nurses spent in each component during the study period. Internal coordination of care was identified as the top workload item followed by clinical documentation and national data collection responsibilities supporting the complexity of the community mental health nursing role. The high rating attached to the internal coordination of care role demonstrates an important contribution that community mental health nurses make to the functioning of the team and the delivery of quality mental health care.

Gabrielson, S., Sävenstedt, S., Olsson, M., (2016) Taking personal responsibility: Nurses’ and assistant nurses’ experiences of good nursing practice in psychiatric inpatient care. IJMHN DOI: 10.1111/inm.12230

Therapeutic nurse–patient relationships are considered essential for good nursing practice in psychiatric inpatient care. Previous research suggests that inpatient care fails to fulfill patients’ expectations in this regard, and that nurses might experience the reality of inpatient care as an obstruction. The aim of the present study was to explore nurses’ and assistant nurses’ experiences of good nursing practice in the specific context of psychiatric inpatient care. The findings suggest that taking personal responsibility is integral to good nursing practice. If unable to improve poor circumstances, nurses might be forced to promote their own survival by refuting or redefining their responsibility. Nurses need to prioritize being with patients and gain support in shaping their own nursing practice. Nursing leadership should provide moral direction and defend humanistic values.


Nurses working in psychiatric hospitals need to acquire the skills of therapeutic communication and empathy, and have higher levels of caring. The present study aims to investigate the level of caring and empathy among nurses working in psychiatric hospitals. Specialized training in mental health nursing, having organizational and managerial support, and empathy were found predictors for caring.


When mental health crisis situations in the community are poorly handled, it can result in physical and emotional injuries. The purpose of this study was to ascertain the experiences and opinions of consumers about the way police and mental health services worked together, specifically via the Alfred Police and Clinical Early Response (A-PACER) model, to assist people experiencing a mental health crisis.


This paper reports on results from a survey conducted in a large Australian public mental health hospital to examine nurses’ perceptions of their practice environment, and identifies interventions that could be implemented to improve the practice environment.


An important part of inpatient treatment for adolescents with anorexia nervosa is to restore normal eating behaviour. Health-care professionals play a significant role in this process, but little is known about their interventions during patients’ meals. The purpose of the present study was to describe nursing interventions aimed at restoring normal eating behaviour in patients with anorexia nervosa. The findings of the present study can be used to assist health-care professionals, and improve multidisciplinary guidelines and health-care professionals’ training programmes.
Every mental health nurse knows the significance and importance of undertaking a mental health risk assessment. Conversely every mental health nurse knows that on occasions they are subjected to time restraints and workload pressures which curtail and negatively impact on their ability to properly and fully undertake the same. A recent coroner’s court hearing, whilst related primarily to a psychiatrist, has direct relevance to mental health nurses undertaking mental health assessments under ‘pressure’.

Background

On 20th February 2013 ‘N’, aged 43 years, was found hanging by his neck in a public playground. Earlier that same afternoon N had been discharged from hospital whilst originally being detained under a mental health detention order, made the day before.

The day before Ns’ suicide, a number of behaviours occurred which indicated suicidal intent. N held a kitchen knife to his throat in front of his ex-partner and their daughter, made statements that he no longer cared about himself and did not want to feel that way anymore, the ex-partner found in his bag a rope with a shackle attached to it and he attempted to jump out of a moving vehicle and walked down the middle of a road in a dangerous and reckless manner. A highly relevant ‘history’ to any mental health nurse.

The assessment

Once N was categorised and assumed the status of a ‘level 1 inpatient treatment order’ an examination by a psychiatrist was required within 24 hours. The examination was to determine whether the order should be confirmed or revoked. If confirmed, N would have had to remain in hospital for seven days. Dr L’s examination of N took approximately 45 minutes and concluded with the revocation of the order based on “a change in risk status”. This decision was based primarily on two factors; an acceptance of Ns’ statements that he no longer desired to end his own life, and Dr L’s (false) assumption at the time, that a full and proper assessment could be completed in the community.

The court concluded that Dr L’s assessment was “sub-optimal” and the decision to discharge N was flawed for three reasons;

Dr L did not attach sufficient weight to Ns’ recent plan to hang himself, his behaviour in acquiring a rope and placed too much weight on Ns’ denials of suicidal ideation, particularly in deciding whether the denials were motivated to avoid further detention.

Dr L failed to make proper enquiries and check collateral information. The court found that Dr L should have spoken with N’s GP for background information and to ascertain N’s current treatment plan, spoken to relatives or the former partner and did not check the discharge accommodation arrangements (which had no certainty).

Dr L did not factor into his assessment any reference to Ns’ previous diagnosis of major depressive disorder. In fact, Dr L gave evidence that the reason for this was that he had been rushed in the examination and was an hour late for his outpatient clinic.

The court found that the examination and revocation of the detention by Dr L “…was premature and conducted with unnecessary haste” and that there was sufficient time for the necessary collateral enquiries to have been made if the examination had been delayed for that purpose.

One disturbing aspect, for the coroner, related to an initial mental health assessment clinical record which was meant to have been completed prior to Dr L’s examination. Disturbingly it was only

“...the task of undertaking a mental state examination should not be undertaken in a perfunctory fashion...”
partially completed and no staff member of the hospital took responsibility for its completion (or lack thereof). The court heard that the document was designed to “ensure pertinent questions and issues were addressed in respect of a patient in the hospital”. The incomplete part of the document addressed general topics that included background risk factors and current risk factors, including the presence of suicidal ideation. In order to complete this initial document, collateral information would have required enquiries being made from N’s GP, former spouse and relatives. Of course this never took place and hence an opportunity to obtain collateral information or examine N’s mental state was lost.

Coroner’s recommendations
The coroner made a number of recommendations arising out of the facts and findings of the hearing;

• A mental state examination to confirm or discharge an initial order for dentation should be regarded as an exercise designed to bring about the “best therapeutic outcome” for a detained patient and that it is not merely a statutory forensic exercise.

• In N’s case, with his suicidal ideation on presentation, the best therapeutic outcome would have been to confirm the level 1 inpatient treatment order detaining him even though this would conflict with the principle of least restrictive treatment.

• For the purposes of an inpatient treatment order being confirmed, or discharged, on the basis that the patient has a mental illness, the existence of a strict DSM-IV diagnosis is not necessarily the determinative consideration.

• An examination should be conducted not at the first opportunity that suits the commitments or convenience of a psychiatrist or other mental health staff, but at a time which is “clinically and therapeutically appropriate, having regard to the presentation of the detained patient and the information that has been gathered to date”

• N’s examination should not have been undertaken until all necessary collateral or corroborative information had been sought and obtained, until the initial mental health assessment clinical record has been completed and an examination of the detained patient or the revocation of the inpatient treatment order should not occur until the original medical practitioner who imposed the inpatient treatment order has been consulted.

• Psychiatrists [and mental health nurses] should assess with a critical mind any denials of suicidal ideation by a detained patient, by taking into account the gravity and probity of any previous statements in respect of suicidal intent and plans to carry out the same. Further psychiatrists [and mental health nurses] should carefully consider the fact that “denials of suicidal intent may be engendered by a desire to be released from detention so as to enable the patient to act upon the undisclosed suicidal intent”.

The hearing, coroner findings and recommendations are a salient reminder to all mental health nurses that the task of undertaking a mental state examination should not be undertaken in a perfunctory fashion. Easily stated and a nice sentiment, but perhaps difficult for those on the ‘front line’ and working in acute sectors of mental health service delivery; the pressures to compromise on occasion make it difficult to resist.

UNE offers a range of postgraduate mental health practice and counselling degrees and some can even be completed entirely online. With our flexible study options you can obtain a professional mental health or counselling qualification while balancing your work and family commitments.

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You will have an opportunity to undertake specialised units in substance use, child and adolescent mental health, Aboriginal and Torres Strait Islander mental health and mental health of older adults and develop professional counselling skills to work with a range of clients including those dealing with grief and loss and trauma.

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September 2016
• Meeting with Adelaide PHN – Adelaide
• Meeting with the Chief Nurse and Midwifery Officer for SA Health – Adelaide
• ACMHN Credentialing Committee meeting – teleconference
• Membership Strategic Planning Meeting – Canberra
• Nursing & Midwifery Strategic Reference Group (NMSRG) meeting – Canberra
• Health Care Homes Initiative Briefing – Canberra
• The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) Stakeholder Dinner – Canberra
• Meeting with the Royal Australian College of General Practitioners (RACGP) – teleconference
• Digital Services CEO Group meeting – teleconference
• Meeting with North Western Melbourne Primary Health Network (NWMPHN) – teleconference
• Meeting with Went West – teleconference
• Meeting with South West Sydney Primary Health Network (SWSPHN) – teleconference
• Meeting with the Department of Health regarding MHN programs – Canberra

October 2016
• Meeting with Central & Eastern Sydney Primary Health Network (CESPHN) – teleconference
• Coalition of National Nursing & Midwifery Organisations (CoNNMO) Member meeting – Sydney
• Presentation at the Cancer Nurses Society of Australia (CNSA) Board meeting – Brisbane
• ACMHN Board of Directors Meeting – teleconference
• Australian College of Nursing (ACN) Parliamentary Breakfast – Canberra
• Presentation at the World Federation Mental Health Conference – Cairns
• Mental Health Professionals Network (MHPH) Board meeting – Melbourne
• Victorian Primary Health Network – discussion on severe and complex mental health activity – Melbourne
• ACMHN Board of Directors meeting – Adelaide
• International Mental Health Nursing Conference – Adelaide
• ACMHN Finance, Audit & Risk Committee meeting – Adelaide
• ACMHN Professional Issues Committee meeting – Adelaide
• ACMHN Credentialing Reviewers meeting – Adelaide
• ACMHN Council of Branches meeting – Adelaide
• Presentation at Australian Healthcare and Hospitals Association (AHHA) Workshop on Stepped Care Model – Sydney
• Prime Ministers Office meeting – Canberra

November 2016
• The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) International Health Workforce meeting – Melbourne

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