Skills Matter

KNOWLEDGE, SKILLS, ATTITUDES. WELLNESS, HOPE, RECOVERY

2018 Follow up Skills Matter interviews report

Second follow up of students from the 2016 Skills Matter cohort

Day to day work helps deepen, consolidate the learnings because you're able to apply the theory into practice. Before taking the course, I had already been doing things but to put a name to it makes it easier to understand and remember. (former CEP student)

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Realising workforce potential

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Te Pou o te Whakaaro Nui

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We would like to thank and acknowledge our 32 interview participants for once again giving their valuable time and insights during this important exercise. It was a great privilege to reconnect with them about their ongoing experiences with course learnings.

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Feedback from students who are funded by Te Pou o te Whakaaro Nui (Te Pou) through the Skills Matter project is important in order to understand the experiences they have during their courses and the benefits of studying. A survey has been administered to all students at the end of each academic year for a number of years. Results are published on the Te Pou website.

In 2017, a sample of 37 students from 2016 were followed up with in-depth interviews to ascertain the longer-term outcomes of the training on students' practice, on their organisations and on people accessing services and their whānau. In 2018, those who were interviewed in 2017 were approached to be interviewed once more in order to understand their experiences in deepening their practice over time. Thirty-two respondents from 2017 were able to be interviewed.

- New Entry to Specialist Practice Nursing (NESP Nursing) (12 participants)
- Clinical Leadership in Nursing Practice (CLNP) (6 participants)
- Coexisting Substance Use and Mental Health (CEP) (6 participants)
- Infant, Child and Youth Mental Health and Addiction (ICAMH&A) (3 participants)
- Cognitive Behaviour Therapy (CBT) (3 participants)
- New Entry to Specialist Practice – Allied health (Allied NESP) (2 participants).

There were 32 interview participants re-interviewed in 2018. Ten of these were able to be interviewed face-to-face. The rest were interviewed by telephone. An information sheet with a copy of the topic guide for the interviews was sent to all participants before the interviews.

The respondents

Four out of every 10 respondents worked in the Northern region (n = 14) with approximately two out of 10 coming from the Midland (n = 8) or Central (n = 7) regions. Two respondents came from the Southern region and one person had moved overseas.

Most of the participants' employers were from 13 of the 20 DHBs in New Zealand with Waitematā and Auckland accounting for over a third of the sample between them. Five employers were NGOs from different parts of the country.

Half the participants worked in adult mental health services. Other service types included addiction (n = 7), community health (n=4), forensic (n = 3), child and youth mental health (n = 2) and community health (n = 2). One person worked in a co-existing problems service. Another was no longer in the sector and worked at Oranga Tamariki. Another person worked with refugees overseas.

Well over half of the sample were nurses by occupation. One in every nine people was a social worker. Four were alcohol and drug practitioners and two were occupational therapists. There were two nurse educators, one clinical team leader and one clinical psychologist in the group.

Ten participants identified as New Zealand European and 10 identified as Pasifika. There were seven people who identified as Māori and three Asian people. There were three other ethnicities in the group, each represented by one person.

A third of the participants were between 41 and 50 years of age in 2016. A third were 30 years old or under at that time. There were seven people between 31 to 40 and four people between 50 and 60 years of age in 2016.

Key findings

Practice had deepened and developed for over two thirds of respondents. As a result, it had become a more nuanced and natural part of peoples' professional repertoires. Respondents also reported they were dealing with more complex cases and/or involved in primary health care activities than last year. Several people had been promoted to more senior roles and some had undertaken further study during the year. There was also evidence that practitioners had more confidence to adapt what they had learnt to their own personal ways of working.

The most significant factor in enabling this development of skills was to have another 12 months' experience in incorporating course lessons into everyday practice. The opportunities to discuss issues with colleagues also contributed. Having endorsement and support from managers and senior staff also helped to consolidate practice.

A third of the respondents did not experience barriers to the deepening of their practice. Those who did report barriers noted lack of time and increased workloads as obstacles. Others came up against staff who had been in the sector for a long time and had fixed ideas about how things were done. The lack of cultural content in courses was also a barrier for some people.

Almost all respondents received favourable reactions from colleagues to their ideas and practice. There were further endorsements as they were asked for advice, given more complex cases to manage and allocated more senior duties.

Two thirds of the respondents regularly asked for feedback from service users and their whānau while another two people obtained informal feedback. Without exception, that feedback was positive about and appreciative of the services received.

Two thirds of respondents reported increased confidence in their practice. The same proportion of people indicated they felt confident in suggesting organisational changes. Their efforts led to a wide range of organisational changes, large and small. Several people said they had adopted useful strategies to try to influence organisational change. For a few people, the development of self-confidence was an ongoing journey.

Only three people did not have some form of regular supervision. All those who did considered it to be valuable at many levels. A wide range of topics were brought to supervision with the one mentioned most often being those cases supervisees wanted to talk over.

A third of respondents received support from other Skills Matter-funded students. Others had support from alternative sources. The same proportion of people gave support to other Skills Matter-funded students. This came in many forms including supervision/mentoring and encouragement to others to do more study.

A long list of essential and/or useful aspects of courses was identified during the interviews. By far, the bulk of these related to the topics covered. Apart from assessment and basic knowledge of mental health and addiction, a key topic was the relationship between mental and physical health. The ways in which courses were delivered was also considered to be crucial. Having the opportunity to learn alongside and network with other students was mentioned most often. More details about this are in the body of the report.

Over half the respondents indicated there were no aspects of their courses they considered to be non-essential or useless. A third of the people identified less useful aspects but no item stood out from the rest.

There was a call for a greater emphasis on cultural matters in the courses. Suggestions were also made for refresher courses and evidence-based courses for those who had been working in the sector for a long time, especially primary care staff. Greater employment of actual service users in role plays instead of actors was suggested.

People expressed gratitude for the opportunity to study and recommended their courses to others. Not only did they enjoy their courses, but they enjoyed the interview process. It had been a useful exercise for them to reflect on their experiences, something they rarely had time to do.

Conclusions

These findings demonstrate the increasing influence of the Skills Matter programme over time and highlight some ways in which improvements could be made.

The highly desirable outcomes of the Skills Matter programme include the development and deepening of knowledge, skills and practice over time and the advancement of respondents to more senior positions. There is evidence that people are capable to take on more complex cases safely.

Much of the foundational knowledge in the courses remained the bedrock of good practice. The core values espoused by Te Pou in *Let's get real* and Equally Well remained present in many respondents' practice.

The continued use of supervision and the support received by and given to others is also encouraging to note as these are critical to safe practice.

However, one disappointing aspect of the programme is the lack of engagement and buy-in from senior staff in the services where respondents work. As this is crucial to successful change management, this should be addressed.

There were indications of the need for refresher courses for former students and for courses aimed at senior, more experienced staff, including primary health care staff.

Our specialist cultural interviewers were once more invited to comment on findings as a whole for all Māori and Pasifika respondents. They concluded:

- There was too little content in the 2016 courses around cultural practices for Māori and Pasifika peoples.
- Cultural tension became an issue when there was only one Māori or Pasifika person on a team.
- Our respondents reported difficulties in finding suitable cultural supervision and some Pasifika people formed their own network to counter this. This is also an issue that may need to be addressed.

The interview process used proved to be very useful to respondents as a time for reflection on their work and practice.

Introduction

Skills Matter is a workforce development programme that funds programme providers to deliver post entry clinical vocational training to mental health and addiction clinicians. The six courses contain clinical and academic components:

- New Entry to Specialist Practice Nursing (NESP Nursing)
- Clinical Leadership in Nursing Practice (CLNP)
- New Entry to Specialist Practice – Allied mental health and addiction (NESP Allied)
- Infant, Child and Youth Mental Health and Addiction (ICMH&A)
- Coexisting Substance Use and Mental Health (CEP)
- Cognitive Behaviour Therapy (CBT).

The Skills Matter team within Te Pou o te Whakaaro Nui (Te Pou) manages and administers contracts with programme providers on behalf of the Ministry of Health. The contracts are to deliver the training programmes and provide support to students. The Skills Matter team also promotes the availability and purpose of the training to the mental health and addiction sector on the Te Pou website.

Te Pou has quality assurance processes to ensure each programme provider is delivering the core components of the Skills Matter programme and that these are functioning as expected. All students who are funded through Te Pou are invited to complete a survey at the end of each academic year. Providers are also followed up with a brief survey at the beginning of each year. The course providers are:

- University of Auckland
- University of Otago
- Auckland University of Technology
- Waitematā DHB
- Canterbury DHB
- Massey University
- Whitireia New Zealand.

In 2017, it was decided to follow up a sample of students who obtained Skills Matter funding in 2016 to better understand the longer-term outcomes of their training. Thirty-seven people were interviewed.

The same respondents were approached in 2018 to be part of a second round of follow up interviews. Thirty-two people were able to be interviewed.

This report summarises the findings of the resulting interviews.

The evaluation

Method

All 37 people who were interviewed in 2017 agreed at the time to be re-interviewed in 2018. However, a few were unable to be found again and one person decided not to participate this year. This resulted in 32 interviews in total for the 2018 exercise.

The interviews were conducted between late-August and late-October in 2018. Twenty-two interviews were carried out by telephone and 10 were carried out face-to-face.

The specialist cultural evaluators contracted in 2017 returned to re-interview their respondents from 2017. The Senior Evaluator also re-interviewed her group again. Sadly, one interviewer from 2017, Shona Clarke, passed away suddenly during the year. Her interviewees from 2017 were contacted by Alessandra Steenhuis who also has European (as well as Niuean) ancestry and Kellie Spee, the independent Māori researcher.

The interviewers read copies of each respondent's previous interview notes before each interview. It was then possible to reflect on those findings with some respondents, which was very useful.

The topic guide and information sheet

Interviewers sent an information sheet about the study to participants prior to the interview. They also reviewed the sheet with participants at the start of each interview to ensure fully-informed consent was obtained. A copy of the information sheet can be found in Appendix A.

A topic guide was developed with relevant Te Pou colleagues and all members of the interviewing team. It contained 19 questions, some with additional prompts. The topics covered included:

- Ways in which practice had developed and deepened over the last 12 months
- Enablers and barriers to the practice development
- Feedback about practice from service users and their whānau
- Colleagues' reaction to deepening practice
- Ways in which respondents influenced their services
- Details about professional supervision received and how it was utilised.
- Support received from and given to former and previous Skills Matter-funded students
- Reflections on the course and how it could be enhanced in future.

The topic guide can be found in Appendix B.

Participant details

Four people had moved to other services during the 12 months prior to the interviews. One of these was now working with refugees in Asia.

Another respondent was now working with vulnerable children outside the mental health and addiction sector but still found their course learnings useful.

> I think the course helped give me an overall foundation in mental health and although not using it, I feel confident knowing what I know and like to think that it gives me additional tools, knowledge to help the people I work with. (former ICMH&A student)

The others were still working in mental health or addiction services.

Over a third of the respondents had completed the NESP Nursing course. One in five had completed CLNP courses and the same proportion had completed CEP courses. Three people did CBT training and three undertook the ICAMH&A course. There were two former students of NESP Allied in the sample (see Table 1).

Table 1: Courses attended by participants in 2016

Course	No.
NESP Nursing	12
CLNP	6
CEP	6
CBT	3
ICMH&A	3
NESP Allied	2
Total	**32**

Almost half the respondents came from the Northern Region while one in four came from Midland Region. Almost one in five people were from Central Region and two came from Southern Region. One person was now based overseas (see Table 2)

Table 2: Regions in which participants worked in 2018

Region	No.
Northern	14
Midland	8
Central	7
Southern	2
Outside NZ	1
Total	**32**

Half the respondents worked in adult mental health services. One in five worked in addiction and one in seven worked in community health. Three people worked in forensic services and two each in child and youth mental health and community mental health. One person worked in a co-existing problems service and another for Oranga Tamariki. The person working overseas was in a refugee service (see Table 3)

Table 3: Types of services in which participants worked in 2018

Service type	No.
Adult mental health	16
Addiction	7
Community health	4
Forensic	3
Child and youth mental health	2
Community mental health	2
Co-existing problems	1
Oranga Tamariki	1
Refugees	1
Total	**

*** NB: Does not add to 32 as some people worked in more than one type of service*

All but five people worked in an NGO. The rest worked in one of the 13 DHBs listed in Table 4. Waitematā (n=6), Auckland (n=6), Hawkes Bay (n=4) and Lakes DHBs (n=3) had the largest representation with only one person from the remaining DHBs.

Table 4: Names of participants' employers in 2018

Employer	No.
Waitematā DHB	6
Auckland DHB	6
NGO	5
Hawkes Bay DHB	4
Lakes DHB	3
Bay of Plenty DHB	1
Counties Manukau DHB	1
MidCentral DHB	1
Northland DHB	1
Taranaki DHB	1
Waikato DHB	1
Wairarapa DHB	1
Canterbury DHB	1
Whanganui DHB	1
No response	1
Total	**

*** NB: Does not add to 32 as some people had multiple employers*

Almost six of every ten respondents were registered nurses. There were four social workers, and four AOD practitioners. Two people were occupational therapists and another two were nurse educators. There was one clinical psychologist and one clinical team leader in the group (see Table 5)

Table 5: Occupations of participants in 2018

Occupation	No.
Registered Nurse	18
Social Worker	4
AOD Practitioner	4
Occupational Therapist	2
Nurse Educator	2
Clinical Psychologist	1
Clinical Team Leader	1
Total	**32**

Almost one third of the respondents identified as a Pasifika person. The same proportion were NZ European. One in four people identified as Māori. There were three people who were Asian, a Brazilian, a British person and a Dutch person (see Table 6).

Table 6: Ethnicity of participants

Ethnicity	No.
Pasifika peoples	10
New Zealand European	10
Māori	7
Asian	3
Brazilian	1
British	1
Dutch	1
Total	**

*** NB: Does not add to 32 due to multiple ethnicities*

Half the respondents were 40 years or under and half were between 40 and 60 years of age (see Table 7).

Table 7: Age ranges of participants in 2016

Age range in 2016	No.
21 – 30 years	9
31 – 40	7
41 – 50	12
51 – 60 years	4
Total	**32**

Limitations of the evaluation

One of the main challenges for the team this year was the number of times interviews had to be re-scheduled. This extended the time frame over which interviews took place. Some of the re-scheduling was due to illness, emergencies and respondents' forgetfulness. However, the team agreed that the main reason was the greater sense of connection the respondents felt with their interviewers. Respondents felt they could be more casual about the exercise than in 2017. The advantage was faster establishment of rapport and a greater sense of openness from respondents once the interviews began.

There was no contact with respondents during the year except to send copies of the 2017 evaluation findings report. It was suggested that the invitation and topic guide be sent out a month prior for any further interviews with this group, to allow them more time to reflect beforehand.

Findings

Ways in which practice was different over the last 12 months

More than two thirds of the respondents reported they enhanced and deepened their practice over the last 12 months. Many of them indicated this was due to being able to put their course lessons into practice

> I still use the recovery approach and ensuring people are making choices about their own lives. I'm developing an appreciation for working with families and the barriers they face making changes. I have a deeper understanding of the wider social and personal issues and reasons for change or no change. This is due to more experience and being involved in more cases. I have also had exposure to certain types of issues and mental health issues. (former NESP Nursing student)

> More of a sometimes-acute focus now. More of a front line where the police or the client is the first contact. … Seeing the whole process through now from first contact to the end of their treatment, I have a wider lens than last year. More focused on looking in-depth at the back story and what happened before they came to us. I now have more experience in the occupational therapist role – diagnosing different clients etc. and I am able to resolve things quicker myself. (former NESP Allied student)

> The sessions are a lot more focused and I feel like we are achieving something. The clients feel they've got something to take away as homework – something solid to do. It feels more effective. On the group side of it, I use the models of depression, anxiety and addiction diagrams over and over again. They are very useful – especially with the addiction side. People start to look at look at it as a pattern of thoughts rather than the individual substances they're using. It gives people a much better understanding of addiction and their thought processes. They get to see that it's not the addiction that's the problems, but the particular pattern of thoughts and beliefs they have. People get a much clearer understanding of addiction and why they have those thought patterns. (former CBT student)

Other aspects of enhanced practice over the last 12 months included:

- Managing risk better
- Being more thorough with assessments
- Being more confident
- Doing more talking therapies
- Able to challenge service users more comfortably

Respondents described their enhanced practice as more organic, more natural. They felt this came from greater confidence and more experience during the year. They were now translating the learning from the courses in their own words.

> With every passing year comes more experience and a better feel for the work you do. I still work heavily with Māori and Pacific, and because of my lived experience coupled with my experience in the field and the learnings from upskilling through the programme work, I continue to feel more natural with each passing year. But I wouldn't call it different again, just more refined. (former CEP student)
>
> I am using my learning all the time. The difference might be what you're learning – there is always a local flavour, the need to tailor all the information you've learned to your local practice. It's never straight-forward to apply the learning directly to our needs. The university research is not readily applicable to your everyday local practice. (former CLNP student)
>
> More consolidated now. It feels like it comes from a more natural place. (former CBT student)

Several respondents were now dealing with more complex cases. They had moved past the foundational side of their courses into deeper practice – finding other dimensions to their work.

> Clients are different to those from last year. Their cases are more complex, they have more issues. There are more things to consider. I am more senior now and the organisation is happy to give me more complex situations – more than just the regular input – more social issues. (former NESP Nursing student)
>
> I've been able to add to what I know. I now am able to understand that there are certain ways of working with people with autism and how to keep myself safe and how to keep my clients safe so they're not hurting themselves or others. So, I've learned how to read the situation. (former NESP Nursing student)

Four respondents had been doing further study and/or professional development over the last 12 months and another three were planning to do so. They agreed they were life-long learners. *"The more you know, the more you know you don't know."*

> I am still recovery-focused – that is still intact in my practice. My practice has evolved over the year – through professional development stuff. For example: Doing training on ACT, DBT informed care and trauma informed care, I gained extra knowledge that I combined with the recovery focus. (former NESP Nursing student)
>
> … someone in our team organises different topics on Tuesdays so that we can continuously upskill. … I also put myself out there when they ask for volunteers to run programmes for our clients. It's another way of upskilling. (former NESP Nursing student)
>
> I am also doing Duly Authorised Officer training at the moment because we are required to carry out restrictive legislation which is not a natural therapeutic role of being a nurse. It's a real tension for me, a moral journey. (former NESP Nursing student)

Four people had taken on more senior roles (including two who were now nurse educators) during the past year and many others had greater responsibilities within their roles. Their Skills Matter-funded courses had helped this progression.

> My whole role is different and because of that I suppose I practice quite differently. The course really helped me transition into a leadership role, becoming more confident with working in a new team. I had been in inpatients for a long time, really comfortable with that, really close with the team there. So, the course helped especially with me realising what kind of leader or what kind of leadership style I liked and then being able to manage things like that. (former CLNP student)

A few respondents indicated they were much more involved with primary health care activities than 12 months ago.

> I have developed so much more in primary health care and also have a greater passion about working in mental health. Really know it is what I want to do. I have got more confidence to try new things and look at ways to support the clients I work with. I have started a metabolic monitoring programme for youth who have just started on anti-psychotic medication. (former NESP Nursing student)

> I am getting some primary care providers in my courses, when I invite them. I'm doing some credentialing with them at the moment – once a month we have study days. I'm providing training and supervisions for everyone. The risk side is more mental health focused. That's the other cool thing. I've been talking to the service manager for orderlies and security staff about them needing some supervision where they can reflect on what's happening and how that affects them. It will be more of a group process for them. (former CLNP student)

Some issues with self-care were reported. With greater responsibility and seniority, came longer hours and less support from supervisors.

> With regard to looking after myself, It's OK but not as good as it could be. Probably worse off: more hours, less supervision than I used to have. Also, general busyness and not as engaged in training and upskilling as I was 12 months ago. (former NESP Nursing student)

Respondents are giving more thought to what kind of practitioner they want to be. There is increased confidence in being able to make changes and a greater self-awareness.

> … the leadership paper and the research paper has given me a great basis for my new role in the community which also now includes a lot of data collection and interpretation, clinical oversight of the team and caseload management. It also reminds me often that I need to be aware of my style of communication, leadership and data collection to ensure I utilise my strengths and identify any weakness areas that I may need to work on while acknowledging the other persons way of working. (former CLNP student)

> My own sense of awareness about myself and what's coming up for me when I'm working with someone. With the addiction sector, there's often transference for residents and the therapists. I am able to recognise that triggering when it happens. I can identify that, and it doesn't become counter-therapeutic. (former CBT student)

> The trauma informed care that we did on course was also really good and obviously working in crisis it is part of my practice. Again, making sure that clients are part of their recovery, not just dictated to. It's strength-based approach acknowledging their experiences and are really important, so they don't get re-traumatised. I think what's becoming clearer to me in crisis is the sense that people just want their problems fixed which I get but need support there's more to it than that and that's what I want my practice to be about. (former NESP Nursing student)

Several respondents were now more confident to speak up to their colleagues than the previous 12 months.

Others are working more effectively within their multidisciplinary teams.

One person indicated that an inclusive, open team environment that encourages constructive criticism plays a significant role in determining the extent to which new graduates have confidence to call out more experienced people for unsafe practice.

Some change in practice related to respondents moving to different services.

> The difference from last year is that the cultural support [in the previous service] was more reachable. In a larger organisation, it is more widely spread so it takes a little longer to get them. If my client is Māori, they have to travel to West Auckland for treatment. The support workers are fewer to take people there for treatment. I learn more and get support from the large team or the manager or the kaumatua etc. I can pass information from them to my clients if they need help. (former CEP student)

Experiences in trying to develop/deepen practice

Enablers to deepening practice

Over a third of all respondents mentioned that incorporating course learnings into practice was the greatest factor in helping them consolidate those learnings.

> Just the on the ground experience and the more assessments you do or talanoa [sharing stories] you have, the better you become at it. Their experiences help me, because they'll say something, and I'll remember it was covered in the course, like metabolic screening and things like that. (former NESP Nursing student)

> A lot of group work with clients. We ask them about some of the interventions/ techniques we use. What do they find useful about the models we use. The idea is to help people reflect

on what's going on for themselves. This also helps us improve what we do. (former CEP student)

Personally, I feel like you can only gain so much from the course learnings because it's mainly theory. Like I said, it was helpful in guiding my nursing practice particularly at the start of my career, but it was the clinical experience that helped me understand the theory and it was on the job that I got to experience whether it was effective or ineffective in my everyday nursing practice. So, it was the clinical experience that consolidated course learnings. If that makes sense. (former NESP Nursing student)

Case study

Having the attitude that allowed me not to do it purely. There [are] some people you can do it with and also have psychology interns who will do pure CBT but I find that quite difficult because it is not practical. There is a young man I see who can't get into the office and needs to smoke cannabis before he sees me. This is like the opposite of what clients or the space they need to be at for CBT to work in the pure sense. They need to be ready to set goals, do lots of homework, really work towards change. If you're not flexible, especially with Māori clients, you will lose them. Working with Māori there is so much engagement and rapport needed, and I think that CBT doesn't allow for this. So, having experienced and being a senior therapist has helped me take what I want to take from the course. (former CBT student)

Discussions with and working alongside (often like-minded) colleagues was another important way in which respondents consolidated their learning into practice.

Since the study I did, I have always worked and always found that my management and staff were always really supportive of people doing study and that sort of thing. People have been quite open to discussing if I had done some research and found something interesting or something. There is usually somebody around that wants to listen and discuss different ideas, most colleagues. (former CLNP student)

Time spent working alongside lots of experienced clinicians. The certificate in Child and Adolescent Mental Health definitely helped my confidence in this work. (former ICAMH&A student)

Talking to others has also been really good and sharing things with colleagues. I continue to build on the foundations made in the course especially through networking with past students. At the time there were six of us who did it and we all started in new roles after so have kept in contact and supported each other. (former NESP Nursing student)

Organisational support and senior management backing were further enablers described by respondents as being important in helping to translate course learnings into practice.

> We have a flat hierarchy in the team, everyone's a leader of sorts. The team has really grown into that space. I have brought a different set of skills in my leadership [compared] to our past leadership. This has really encouraged growth across the team and I'm very proud of what we're achieving and managing ourselves. (former CEP student)

> Organisational support to do what I do. I have the autonomy to be able to do that within my position. I have this because I have support and trust from my direct line manager. (former CLNP student)

> We have a culture that is hot on continuing professional development so that helps us all be reflective, inquiring. I think having an attitude as well about lifetime learning and the importance of that to continue growth also helps to take what you learn and use it. (former CEP student)

Other enablers mentioned included:

- Self-reflection on practice
- Supervision
- Having a life-long learner attitude
- Looking for evidence
- Seeing things from service users' points of view
- Being flexible to better suit individual service users
- Trying new things without being afraid to make mistakes
- Being motivated as service users make positive changes
- The study being directly relevant to the work
- Being invited to talk to other staff about the work
- Being a mentor or a mentee
- Discussing ideas with university lecturers

Barriers to deepening practice

Over a third of the respondents reported there were no barriers to the consolidation of their learning into practice.

> To be honest, I don't see any barriers. I love what I do. (former NESP Nursing student)

> Nothing really, it was kind of perfect because the new role let me explore the papers, try different things, because it was all new in a way I was open and looking for things to fit with it. If anything, it was a challenge, a good one, to get the new team to trust me but that's understandable. (former CLNP student)

Lack of time and having too much to do was a considerable issue for some.

> Time, workload, responsibility is probably the barrier. (former CLNP student)

> Understaffing with heavy client numbers mean less time and too much paper work and referral stuff that takes us away from our patient. Taking care of things that if we had a social worker they could take care of. Especially in the AM shift. Like accommodation and stuff. I get really frustrated because I feel like I've sat on the phone or behind a computer all day rather than give patients the care they need. You get caught up with mundane things, it makes me feel guilty, because you can see they want to talk to you. Then they get frustrated and start playing up on the ward so it's a bit of a Catch 22. (former NESP Nursing student)

A few people reported some staff who had been in the sector for a long time had deep-rooted practices and were resistant to new evidence-based ideas.

> … I've found that there are nurses who are entrenched in their ideas. They have a set way of thinking and doing things. We're talking about people whose practice might not have changed in 20 years. And that's when the challenges come. They're the ones who are not really open to change which makes it hard introducing new ideas that we've had through the course. (former NESP Nursing student)

> *Most* people were supportive of implementing learnings in the workplace. Always some that weren't interested, they like the way they do things and not interested in learning a way of doing things differently. (former CLNP student)

> … What I am also learning is that there is still quite a lot of prejudice out there and people still think they can punch out assessment in under two hours. Comprehensive assessments should really take 3 sessions with the client, then around 4 hours to write up. I think about it as paying homage to people, what I write sits on their files for a long time. Someone's life I'm writing and it's frustrating when people think they can punch that out in 1 to 2 hours. I am real vocal in regards to that. I had that whakaaro (thought) the whole time, but the course really confirmed and affirmed it for me. (former CEP student)

Lack of enough appropriate cultural content in the courses was a barrier for some.

> For me, the course material was predominantly a western approach to nursing, so I felt like they missed the mark when it came to understanding the way other ethnic groups, minority groups like mine being Tongan, interpreted things, despite being taught about cultural safety. For example, the links to the supernatural, and breaches of tapu and how that sometimes needs to be addressed in the healing process of not only the patient but also whānau. (former NESP Nursing student)

> As a part-Māori raised in a Pākehā world, I can see how people have difficulties. In prison, I work with a lot of Māori. They are in prison for things most Pākehā are not in there for. Sometimes, there's lip service paid to cultural learning and that's how it goes. I find that a lot of Māori have resentment towards the majority of Pākehā (and the government in general) but they haven't yet worked out why. A lot of guys I work with in prison can't communicate

what's going on verbally. What we do is give them a name and a word for what they're experiencing. (former CEP student)

Other barriers mentioned included:

- Poor communication between mental health and addiction agencies to help service users experiencing issues in both domains
- Lack of senior management support for new ideas
- Lack of appropriate policies and procedures
- No opportunities to follow up course learning with further study
- Working alongside people from other professional groups who see matters through a different lens
- Not being part of a 'normal' service structure
- Increased number of referrals
- Greater complexities in cases presented
- Lack of qualified staff
- Self-talk (internal barriers)
- Stress
- Implementation issues

Colleagues' reaction to respondents' practice

All but four respondents reported favourable reactions from colleagues to their ideas and practice in the last 12 months. Almost half mentioned how supportive and positive their colleagues were.

> No concerns but a lot of praises. I have done the role I was going to do – clinically attaining good outcomes for my client caseloads. (former NESP Nursing student)

> I have been given some good positive feedback from the trainees about the training I deliver. For example: Someone said it was it was great training and it felt safe. It was amazing how people open up. Cool that you can add that [learning] to the training. (former CLNP student)

> Generally, have very positive feedback from my colleagues and I suppose, being newer, whenever I had questions, they were supportive of answering those questions and provided suggestions of how practice can be improved. (former NESP Allied student)

> The team's support and encouragement to share and to continue to upskill acts as motivation when I am working. Overall, feedback is generally positive. I continue to share with my colleague's key learnings and ask for advice when required. (former CEP student)

Some respondents talked about the greater level of confidence their colleagues had in their skills and practice. This led to being allocated more cases as well as more complex ones. They were also being given greater responsibilities.

> Well it feels like they're pushing more onto my plate in terms of clients so that to me is a sign that they recognise how well I work. (former CEP student)

> I generally get positive feedback from my colleagues and my line managers. I have been given more authority to widen my scope of what my job includes also [with] regards to clinical co-ordination and oversight of projects. (former CLNP student)

Others indicated their colleagues came to them for advice.

> By and large, they hold my practice in reasonably high regard. They are very positive. I took an acting supervisor's role. The new role I am about to take is a clinical supervisor. People see I've done study and practice and ask me for suggestions and advice around their own practice. (former CEP student)

> I think they react positively, they ask for my opinion and they compliment me when they think I've done well which is nice. (former NESP Nursing student)

A few explicitly reported ways in which their colleagues had learnt from them and changed their practice.

> … Sometimes I've influenced some of my colleagues especially the ones that were trained in the 80s, by introducing the metabolic screening stuff for example. (former NESP Nursing student)

> Very respected by my colleagues in what I do. We have some really good conversations and reviews about our practice. I feel like they learn from me too – without sounding too big headed. They make me feel I have something to offer because they come and ask questions and because in our reviews, they ask advice. Yeah, it feels good. It feels like I can comfortably share what I know. (former CBT student)

A few respondents felt their ideas and practice had been *less* well received, mainly by more colleagues from other disciplines and were older. Some expressed frustration about inflexible organisational systems getting in the way of the introduction of new ideas.

> When I think about my older colleagues, they have a lot of issue with my practice. They possibly perceive me as being inexperienced and naïve compared to them and that is an issue. It relates mainly to the recovery and partnership approach. Colleagues are a lot more directive. I do see some merit in their ways sometimes – but not all the time. They have not changed their ways as a result of talking to me. (former NESP Nursing student)

> Positive. The counsellors are really good, the nurses are the barriers really. The counsellors are interested and there are good discussions about what I learnt, they are really open to it. We are a stable core group that has been here for 15 years working together. The nurses come from a medical model what they've been trained at is about that. I am generalising I know but from what I've witnessed the medical model approach is their focus. I have been

encouraging them to do the post grad study to do the course but old dogs, you know what they say. (former CEP student)

Service users' feedback about practice

Almost two thirds of the respondents regularly asked service users for feedback about their treatment and four did not. Another two people received informal feedback. Without exception, the feedback from service users about respondents' practice was positive.

> In the group, people like the clarity a diagram brings. There's an awful lot of talking going on and sometimes people aren't in the head space to process it yet. The diagram gives them something to hang all those words on and make sense of. It's also something I've used in family meetings. Sometimes families struggle with the understanding addiction. (former CBT student)

> For me, the feedback I received has been overly positive in terms of incorporating family in treatment decisions and discussions. I've been better at building a rapport with whānau and the service user, but again this comes from experience. Drawing on cultural knowledge also helps and being fluent in Tongan helps when working with Tongan whānau. (former NESP Nursing student)

> There is nothing specific that I can think of as it's such a holistic approach that incorporates lots of knowledge and experience, but feedback is normally positive. When working with young people and their whānau [I am] constantly asking how things are going for them, what we can be doing more of, is the support they are getting what they need. (former CEP student)

Two respondents were in leadership or educational positions and had no direct contact with service users. However, they were working with staff to ensure course learnings were embedded in practice. The following case study demonstrates the kind of impact good practice can have on service-users' lives.

Case study

I integrate *Let's get real* attitudes through all the training we do. The staff report that it makes a big difference to the outcomes that they get with people that use their services. For example: I was talking to a nurse this morning who's just gone from inpatient to community and managing a caseload. I often have a chat with her about what she's doing.

There's one particular client that she's working with – a young Pākehā male, early 20s who has spent a lot of time very unwell in an inpatient unit. Just that engagement she has with him, that honest, open engagement has meant he has really taken on board that it's his goals that need to be his own and what it is that he wants to do. Just having that acceptance from his key worker has meant he hasn't been an inpatient except for once this year – which was big for him. Even attending a day programme on a daily basis - him feeling he had to do that – it was almost his job.

They talked about having a break, having a holiday and a holiday from his key worker where he could just do his stuff. They did that for two weeks and he came back and said how great that was and talked about what he'd done.

It all came out of the SPEC (Safe Practice Effective Communication) training and the de-escalation and break away – person-centred care and trauma-informed care. And really integrating all those values and attitudes into those principles. (former CLNP student)

Changes in respondents' confidence

Confidence in own practice

Two thirds of the respondents reported increased confidence in their practice over the last 12 months.

> More confident all the time and put in leadership roles a little bit more often and have to be confident to be effective in those situations. (former CLNP student)
>
> I think I am quite confident now and have been using it naturally and without any barriers and I think I have internalised the model, so I am familiar with that now and it is a part of my practice. (former CBT student)
>
> I have become more confident in working with whānau and my approach, how I practice. I think I have become more comfortable with not knowing everything, and knowing my limits asking for help, getting advice. The course gave me the ability to apply for my new role in mental health and without the foundation from that I wouldn't have been able to. (former NESP Nursing student)

For other people, the development of confidence is still a work in progress.

> Being young, Pacific and in mental health affects my confidence. I'm shy and sometimes it's hard for me to stand up to adults. But I'm beginning to become more assertive, the new work environment helps. (former NESP Nursing student)
>
> Since moving, I feel a lot more valued and confident to speak up. But I have learned that there are diplomatic ways of putting things across. I'm putting a lot more effort to thinking things through before offering my opinion and that's helped with my confidence. (former NESP Nursing student)

The following case study provides an example of the impact increased confidence had to speak up on the well-being of service users.

Case study

For example, we had a night shift and one of our girls, she's done her post grad and there was a patient who couldn't sleep, and she said we'll give him this particular drug, and I said "Hasn't he got anything else. It's charted here only for agitating and he's not agitated so I'd be reluctant to give it". She said, "That's what we've been giving him", and I said "I have to say I don't agree with him having it, so what we can do is ring for a second opinion because I'm not comfortable giving it because he might get reliant on it". So, I'm confident to speak up when I feel it is needed. She was a bit taken back but these are the little things that we need to be careful that we're not giving things just because it's there, but we have to have the rationale behind it. (former NESP Nursing student)

Confidence in making suggestions for service improvement

Almost two thirds of all respondents indicated they were confident to suggest service improvements.

> Our organisation has always been open to suggestions for improvement so usually when we share. If there is an idea I put forward that the rest of the team thinks will benefit our practice they're open to the idea of us trialling it. Like I said, it's a great environment to work in, and I think that makes the world of difference. (former CEP student)

> Yeah. Really confident to express my opinions and views. (former ICAMH&A student)

> I am confident to do that. I looked at starting a group for clients with personality disorders, it would have been a new thing for our service, but it didn't happen. I also work closely with the GP service with clients who are mild to moderate but can flip to severe. They often fall between the cracks. I feel really confident in talking with GPs about changes that could be made to assessment, referral etc. (former CBT student)

Several people strategised the way in which they made suggestions.

> I'm confident that I can suggest and put things out there, but it's knowing when to suggest it or hold it off for another time. I take advice from people who have been there for a long time, so I'll bounce an idea and they give me feedback like when to bring it up, if I need to work on an idea and when to table it. (former NESP Nursing student)

> I'm more confident in putting forward ideas. But that's a time thing because I know my colleagues, I've built relationships with them and I'm aware of my own strengths and weaknesses. So, where I feel like I can make a contribution, I will and where I think I can learn I'll ask for help or guidance. It's good. (former CEP student)

A few people had not yet developed their confidence to make suggestions for change.

> … I don't really make suggestions. I learn what to change through experience and observing what others are doing, but I'm not fully confident yet to feel like I can make suggestions that will be taken on board. (former NESP Nursing student)
>
> I guess I feel quite new and not ready to make suggestions for service improvements. (former ICAMH&A student)

Service changes made as a result of respondents' suggestions

Respondents listed many changes resulting from suggestions they had made.

> What I have seen is where I have been discussing detox services and the homeless population and why they're homeless and what goes on for them. There was a lot of negative stereotyping when I took on that job a couple of years ago. I've seen a lot of change there and that's been really good and very positive. There's a lot of understanding now around empathy. There was a lot of judgement coming before from the medical side of the service. (former CEP student)
>
> The best part is we had two [region name] practice nurses credentialled last year. Six out of the ten credentialled. Their practices have set up wellness clinics in primary care to provide services for mild to moderate mental health conditions. Bulk funding through the PHO is used to set the services up. We've set up packages of care to suit the cohort of patients that come to those practices. Me and my colleagues provide clinical supervision to give that follow up with them. It's good. We get to have that ongoing follow up with them. That's the biggest outcome that we've seen. It so fits for the DHB and a good fit for the Ministry of Health. That was my thesis topic. I'll have lots of evidence for when I do start writing that. (former CLNP student)

Examples of numerous other changes to services are listed below:

- Changes to the whānau assessment process
- New services (Hepatitis C)
- Increased number of internal supervisors for the NESP programme
- The introduction of credentialing for primary care nurses
- Closer working with primary care workers
- Introduction of a metabolic screening service
- More planned and structured admission process – followed by more intensive treatment
- Change of forms (treatment plan, assessment)
- Running additional exercise groups
- A new model of care working more closely with GPs
- Introduction of a peer support model

A couple of people considered that the uptake of their suggestions was slower than they would like, or non-existent.

> Quite confident that I can talk to people – Happy to discuss and bring it up. But to what point we get change, happening, that's another matter. Implementing change can be very frustrating to get anything happening in a hurry. The DHB is a massive organisation and slow-paced moving to make any changes. Nothing happens very fast. (former CEP student)
>
> It hasn't changed. I happy to suggest change but it is quite hard to make change when working largely with a medical model like a GP service. Perhaps the best you can do is make the change on individual level? (former CBT student)

Experiences with professional supervision

Frequency of professional supervision

Half the respondents had monthly professional supervision and five, fortnightly. Almost a third of the people mentioned they went to informal supervision when they needed it.

Two people attended group supervision consisting of peers meeting to discuss common organisational issues.

Three respondents did not go to any professional supervision, mostly by their own choice or because they had not taken the time to organise it. One person was struggling to find a suitable supervisor.

Topics brought to professional supervision

A wide range of topics was brought to professional supervision. One person explained that the topics brought to supervision tended to be supervisee-driven rather than supervisor-driven.

Over a third of the respondents mentioned specific cases they were struggling with during supervision. A similar number talked about clinician-related issues like self-care, stress, risk to themselves and managing workload.

Reflecting on practice during supervision was reported by a third of the respondents.

Other topics brought to supervision were mentioned by fewer people. They are bulleted below:

- Things that are going well
- Things that aren't going well
- Risk to service users
- Recovery focus
- Confidential issues
- Evaluation feedback
- Barriers

- Role
- Personal issues
- Transference of emotions
- Engagement with whānau
- Professional development
- Staff issues
- Supervision provided by respondents to others
- Organisational matters
- Staff leave
- Organisational culture
- Clarifying the Mental Health Act
- Issues specific to being in a new country

Usefulness of professional supervision

Over three quarters of respondents reported supervision was very valuable.

> Supervision is critical without which I wouldn't have a dedicated space to reflect and think about the job I'm doing and the impact on my clients and whānau … My supervisor has been with me since I started here, through the course and everything so she has a real good idea of who I am and what makes me tick. (former ICAMH&A student)

> Very useful to externalise and get feedback – also from someone with a wider frame of reference. (former CLNP student)

> Very useful when you're carrying a lot of risk in your caseloads, when you discuss it with your supervisor, some of the risk is mitigated. You discuss safety plans. It's almost like you're handing over some of the responsibility when things become overwhelming. I find it really useful for that. (former CEP student)

Others reported that the relationship with the supervisor was very important and therefore it was vital that the right person be chosen to provide it. One person was also undertaking private therapy which they also found very useful.

No-one said professional supervision was not useful.

Support received from other Skills Matter-funded students

A third of all respondents reported they received support from other Skills Matter-funded students.

> Heaps of support from past students as I mentioned they are my bedrock, support crew. We talk, compare, challenge and acknowledge each other. It's really good because of our similar experiences we can understand what each of us went through with studying, working and

> how scary it can when you really have so much to learn still even after finishing the course. (former NESP Nursing student)
>
> I received a lot of support from my old team leader who had also done the course. Mainly motivation to keep going and I was able to talk to him when I found it hard to connect to the Māori part of the programme. This was strange because I work in a kaupapa Māori approach and had just finished another course that was kaupapa Māori based. I'm not sure if that was it but it was good to be able to talk to my boss about that at the time. (former CEP student)
>
> I still keep in contact with a few of the other nurses that I went through the programme. There are a few that have gone off because they've had kids. It hasn't been professional support, just moral support and friendships. (former NESP Nursing student)

Although they did not get support from other Skills Matter-funded students, some respondents reported they had sufficient support from other sources.

> Not really from previous students but as I said I did my masters the last couple of years, more support from lecturer at Auckland Uni... (former CLNP student)
>
> I do still get support from them from time to time. I still keep in touch with my preceptor who encourages me to keep upskilling, getting professional development and to keep communication lines open. (former NESP Nursing student)

Five people indicated they received no additional support from previous Skills Matter students.

Support given to other Skills Matter-funded students

More than a third of the respondents had provided a great deal of support to other Skills Matter students.

> I get students to mentor who are on their placements. … Showing them how to do assessments, engagement, establishing rapport. … Reflecting on that, the application of a knowledge base to practice. It's about extending students' capability in them. The mentoring also includes recording and documentation, the therapeutic use of self, boundaries, safe clinical boundaries. (former CLNP student)
>
> We've had a number of new clinicians come on board. I often try to promote to them about how to build engagement and push home the lessons I learnt in the course. People, in all likelihood, will only take away one or two things. I tell them: "Bring who you are to the group and bring that to the process". (former CEP student)
>
> … I've been able to offer support to graduate nurses who are doing the course by discussing what is expected of them (in terms of their academia and practice) and speaking from my own experience. I think that's the only input I could give. (former NESP Nursing student)

One in every five people provided some form of supervision or mentoring to other Skills Matter students.

> This year, I've taken on student nurses to precept and support them in their placements. … So far, I've had students who are keen to learn so it hasn't been so hard. And they've come from the tech I've studied [at] so I know what they're going through. Plus, I haven't been out too long, so [my experience] is still relatively fresh. It only becomes a problem when there are age gaps, and we're much younger than them. (former NESP Nursing student)

One in five respondents specifically mentioned providing encouragement to do further study.

> Encouraging my staff to do more study especially for "credit" (recording) study or Master and previous other trainings that they are working for. In previous years in nursing we asked for more evidence-based practice and we didn't know why we were doing that for patients, but that is best for the patient. I do believe the more study they do they can reflect on their own practice better and probably provide better care to the patient and family… (former CLNP student)

Other ways in which respondents supported other Skills Matter students included:

- Showing them how to manage their time and juggle work and study
- Telling them what to expect in the role in the first year
- Helping with assignments
- Providing guidance around exams
- Sharing their own experiences as a student
- Being a sounding board for any issues the emerge
- Providing structured supervision
- Inviting them to sit in on group and one-to-one sessions
- Encouraging them to take part in running groups (providing they were ready)
- Getting them to do one-to-one assessments (providing they were ready)
- Giving general professional advice.

Eight people had not provided support to other Skills Matter students, primarily because they did not have contact with any.

Reflections on the course

Most essential/useful aspects of the course

The topics covered

Respondents identified a very wide range of essential and/or useful aspects of the courses they had completed. The range of topics covered below dominated in the feedback.

A few people considered every topic to have been useful.

> All of it was quite good. The content was relevant so it's hard for me to fault. (former CEP student)

Learning about conducting assessments was mentioned by one in every four respondents.

> Learning about assessment, a starting point for journeys into addiction recovery and really understanding the importance of it has been critical in how I connect with clients, the information that I am interested in getting and how it paves the way for support they will get. (former CEP student)

> This is very difficult. Everything is so interrelated when providing mental health care. Mental health assessment is the most important thing. (former NESP Nursing student)

A solid foundation in mental health was essential to one in every six respondents.

> The ability to get mental health knowledge in general so a broad foundational base and then being able to focus on two specific diagnoses and really go more in-depth. It was a great starting point for me. The course led to a senior role. It provided the foundation and planted the seed. I watered it. (former ICAMH&A student)

> The course gave me a good foundation in mental health and I wouldn't know what I know now if I hadn't done it. (former NESP Nursing student)

A better knowledge of addiction was useful to others.

> The module we did on addiction – the model we used. I was new to this area of work and it gave me heaps of confidence. (former CBT student)

Understanding the relationship between mental health and addiction was important for several respondents.

> It also is recognition of the kinds of problems in relation to each other. It helped practice to see the connection between things and how they might be impacting on each other. A young person who has social anxiety and using lots of alcohol, what's the relationship is alcohol being used to help the social anxiety or is it causing the anxiety. Thinking about the whole landscape and the interrelationship between issues helps to understand and then plan recovery. Importantly it also means that you are able to consider relevant risks for the young person. (former CEP student)

The relationship between physical and mental health (and metabolic screening) was particularly useful for some respondents.

> I think it would be the AOD and metabolic screening. I'm still very much interested in the metabolic screening especially for Māori and Pacific about how to budget and get healthy food and how that helps with mental well-being. (former NESP Nursing student)

The recovery approach was mentioned by a number of people.

> The recovery process. I could relate everything I was doing in the course with what I was doing at work. (Nursing Allied student)

The pharmacological aspects of mental health were an important topic for more than one person.

Other topics, identified by one respondent each are bulleted below:

- Practical application of evidence-based theory
- Theory of CBT
- How to implement research in everyday practice
- People's functioning with mental health illness
- Diagnosis
- Formulation
- Treatment plans
- Self-care
- A better understanding of oneself as a practitioner

The following case study demonstrates the difference made when there was a good understanding of the ways in which mental health and addiction affected a service user and their whānau. It also shows the effectiveness of adopting the values of *Let's get real* and safely bringing one's personal experience into the therapeutic relationship.

Case study

The co-existing co-morbidities and addictions helped broaden my understanding on the ward and taking away the judging and the stigma. We had …. a gay young Māori, who tried to overdose. Quite a serious one. He had criminal charges pending, he was waiting to be sentenced and he tried to take his life. He was quite isolated, and I was lucky just the way the shifts had fallen I managed to nurse him six days in a row. That made a huge difference, I felt like we made some ground work there. And we talked about his fears and what he wanted out of it and that was it. He didn't know what was going to happen, so we talked about worse-case scenario and we did some problem solving and a bit of goal setting and about the strengths that he had because he felt low. Talked about the consequences if he wasn't here. And sometimes when it comes to sharing your own experiences you pick and choose. With him I asked if I could share, and he said yes, and it was about the impact of losing my son to suicide. I said to him, it doesn't matter what you've done and how terrible you feel it's going to be a life sentence for the rest of your family if you take your life and I'm talking from experience. He appreciated hearing that. We built a rapport and when he got discharged, he came looking for me with his mum, he started crying saying thank you so much and you think it's worth it. It may not be straight by the book, but its whatever works for that patient at the time. It's not always the same for everybody. (former NESP Nursing student)

Course delivery processes

Aspects of the way courses were delivered were considered useful by numerous respondents. Several people mentioned the importance of studying alongside fellow students from other parts of New Zealand.

> Networking has been great – connecting and re-connecting of colleagues from other DHBs. This is very useful as staff often move – as do our service users. It maintains consistency across the regions. (former CLNP student)

> The most useful aspect of the 2016 course was being able to openly discuss the challenges or obstacles or difficulties we had during clinical experience in a classroom setting. So, interaction with other students and networking was great. Just knowing that everyone was at the same level reassured me that I wasn't alone. So, it was good to hear what others had to say about it, you would discover whether they'd do the same as you or if they'd deal with it differently and they'd justify why. So, the most essential wasn't necessarily the context but the relationships formed and maintained. (former NESP Nursing student)

Doing role plays was mentioned by two people.

> In terms of the process, the ability to do role plays and practicing what we've learnt in the moment. I'm a kinaesthetic learner so that's helpful to me. (former CBT student)

Other characteristics of course delivery appreciated by people are listed below.

- The group sessions, a good learning process
- Block courses
- Rotation of placements - because the way in which services operate
- The use of real-world cases for assignments

> The assignments were reflective … which really helped to ingrain what we were learning because when evaluating patient care and recognising the importance of professional supervision, you realise how important reflective practice is. It's really a key way to learn from your practice, consider how to change it if it doesn't go well and if it went well what are the steps to making that happen again. (former NESP Nursing student)

Other essential/useful aspects of the course

For a several respondents, the opportunity to refresh and enhance academic learning skills was essential.

> It really enhanced/improved my ability to be able to find the evidence for doing what I do and to be able to articulate that and share it with others. (former CLNP student)

A number of people considered the quality of guest speakers to be useful.

> The talk by the ex-service user – Debra Lampshire. (former NESP Nursing student)

> The most beneficial part for me though would have to be the Māori psychologist who came and discussed their work. It was through this that I could kinda of see how I could use CBT specially with Māori. It culturally fitted with me and my work more. (CBT student|

Course presenters were also highly valued by respondents.

> The facilitators were fantastic. It was organised and professional. The content obviously provided me with a good foundation and I am really looking forward to working in child and adolescent mental health. [Although no longer in mental health] I think the skills or knowledge is transferable with the youth I see now… (former ICAMH&A student)

Other aspects of the course considered to be essential and/or useful were:

- Getting a post-graduate qualification – opens doors
- Text books – referred to a lot
- Papers on specific topics
- Funding support to study

Least essential/useful aspects of the course

Almost half the respondents could not identify any aspects of their courses that were least essential/useful. The following quote echoes the sentiments of others in this category.

> Actually, I can't think of anything that wasn't important. The training I was getting was pretty much what we were doing at work, so it reinforced the practical. It worked hand and hand. For example, we did motivation interview and I'm at CADS in 2016 and there one of their main tools was motivation interview. Again, when I was at ADHB, they wanted to send us off to do motivational interviewing course, so it was really relevant to my practice. (NESP student)

A number of people identified aspects of their courses that were least essential/useful. They each raised different characteristics. These are listed below:

- Lecture styles that were too academic or monotone - especially for students working long shifts
- Lecture styles that did not relate to learning styles of students - more sharing between students needed
- Not being able to cross-credit qualifications from other tertiary education providers
- Having to repeat study topics/activities that were part of under-graduate study and/or regular practice within services
- Role plays
- Teaching students how to talk to service users.
- Having a mismatch between assignments and placements
- Not being able to use block course time to do assignments
- Cultural components
- Teleconferences and webinars – too hard to contribute

Suggestions for redesign of the course

There were several calls for greater emphasis on cultural matters.

> I guess, if I could have more input … just add some more cultural elements – because when you're working in the field, those world views really are important for us to grasp. (former NESP Nursing student)

> … There was no linking with Māori health models. I think they tried to use examples of Māori clients but that felt a bit tick boxy too. It could be incorporated in course way more. I think the tutors tried but they don't really get it, don't really get the realities for some Māori whānau. (former CBT student)

> Bring some understanding of CBT for Māori into course. e.g. when it may work. Otherwise a new practitioner runs off doing CBT with Māori and maybe it's not appropriate. (former CBT student)

Several people proposed that a follow up course would be very useful in helping to further integrate learnings into practice.

> I feel the course learnings will eventually go out of date so what you do on the job is what will change your nursing practice. I guess this is why it would be a good idea to have a phase two maybe once you've had a few years' experience. (former NESP Nursing student)

There were suggestions that courses teaching evidence-based practice be provided for senior practitioners and/or doctors.

> When you go into practice, it's different from Uni – it confuses you. "Here's what you should be doing" and what the organisation asks you to do is at odds. The course message should be aimed more widely to include more experienced workers. (former NESP Nursing student)

> Anti-psychotic medications that we use – the harmful effects – aware of that – it's a bit at odds with our job – it's used all the time. You get conflicting ideas. The research says don't use long-term, but the practice is different. A bizarre course to do – telling you to be change agents. Puts quite a lot of pressure on a new graduate. There's a review of clients about what they need and what they want. A lot of decisions come from doctors who work from a very medical model – and they aren't changing. (former NESP Nursing student)

The employment of actual service-users in role plays was recommended.

> Use the recovery population, those people out there with lived experience, not actors. In the role play … the actors stayed in their role too much it was difficult to connect with them in a real way. Then they gave us feedback on our counselling which was bloody funny. (former CEP student)

One respondent suggested that there could be more client-centred practice.

Another asked that it be made easier for people outside the main cities to get to courses.

More acknowledgement that CEP is a specialist area was requested.

There was a question around the timing of the courses in relation to the beginning of practice.

> The only thing I've given thought to is "should it be done in the first year or the second year?" It would give people time to get the hang of things – they'd be more settled into their jobs and then do the course. But then, you'd have to undo what you've been practicing. It's reasonably about right. (former NESP Nursing student)

Final thoughts about the course

A few of the final thoughts were already covered in previous sections of this report.

Those who had other comments about the course expressed gratitude for the opportunity to undertake courses – and to share their experiences with the interviewing team.

> Again, thank you I guess for the opportunity to share and to have been part of that course. (NESP student)

Several people indicated they often/always recommended the course to others.

> Great learning opportunity that validated what I was doing and in what ways I was on the right pathway. I recommend it especially for nurses and especially because it seems to be who DHB is employing at the moment to work in addiction. (former CEP student)

Others reported they had enjoyed their courses.

> I really enjoyed it because it was specific to mental health. … you could be a lot better nurse if you do it because everyone takes something out of that course. (NESP student)
>
> I have to say I really enjoyed the learning. (former CLNP student)

More than one person mentioned the usefulness of conducting the follow up interviews with previous students.

> Touching base with students [a] year after [the] course is important because that's when they probably have the least support after all their studies and more likely to be struggling with things. Also able to reflect on the course more fully. (NESP student)

Conclusions

These findings demonstrate the increasing influence of the Skills Matter programme over time and highlight some ways in which improvements could be made.

It is clear respondents had been developing their knowledge, skills and practice at new levels two years on from their courses. They held more senior positions and took on greater responsibility and complex cases. They integrated learning and experience so that their practice became more natural, more fluid. These are highly desirable outcomes for the Skills Matter programme.

We found evidence that much of the foundational knowledge in the courses remained the bedrock of good practice – even in the light of some resistance. The core values espoused by Te Pou in *Let's get real* were still present in many respondents' discussions. The concepts of respect, manaaki, hope, partnership, wellbeing and whanaungatanga were all spoken of - using different words. The relationship between mental and physical health was recognised and discussed by several respondents and this ties in very strongly to the work Te Pou does in the Equally Well domain. This result is very good.

The continued use of supervision and the support received by and given to others is also encouraging to note as these are critical to safe practice.

However, the programme performs less well in terms of engagement and buy-in from senior staff in the services where respondents work. Our understanding about current evidence-based implementation science is that this engagement is crucial to successful change in organisations. This is a disappointment and should be addressed, perhaps as part of the funding contract process.

There were indications that the topics covered in the courses were well received but that further training types were needed. These were refresher courses for former students and courses aimed at senior, more experienced staff, including primary health care staff.

Our specialist cultural interviewers were once more invited to comment on findings as a whole for all Māori and Pasifika respondents. They concluded:

- There was too little content in the 2016 courses around cultural practices for Māori and Pasifika peoples. It was only if workers already had a strong sense of culture that appropriate cultural ways of working (or culturally responsive approaches) could be integrated into everyday practice.
- Cultural tension became an issue when there was only one Māori or Pasifika person on a team. This was unsafe practice according to our specialists. Whānau engage a lot more quickly with services if workers have a high level of cultural competence. This is an indication that future courses should include more in-depth teaching about cultural matters.
- Only one person received cultural supervision and that was conducted for all staff in a group setting. Our respondents reported difficulties in finding suitable cultural supervision and

some Pasifika people formed their own network to counter this. This is also an issue that may need to be addressed.

About the interview process

Several people commented that the interview process we used was very useful. It helped them reflect on their year more deeply. It was a time of reflection for them – especially as they were so busy at work.

Appendix A: The Information sheet

Second Skills Matter follow up of students from 2016

Why we are doing these interviews

The aim of this second round of follow-up interviews is to understand the longer-term outcomes of Skills Matter-funded training and for you to reflect on the course content and process from a more distant perspective.

This also provides an important opportunity to understand the outcomes of any changes in practice on your experiences and how those changes have impacted on your colleagues and your organisation.

The topics

Some of the topics to be covered in the interview include:

- Ways in which your practice has changed or deepened over time
- How your colleagues, your service and your clients responded to your practice and suggestions over time
- How useful professional supervision has been for you over the last year
- The type of ongoing support you gave and received from others
- Your views on any changes needed to the course

Your rights

This interview is entirely voluntary. Your individual comments will be kept confidential and you will not be identified in any report.

It will take approximately 30-60 minutes (depending on how much you have to say) and be conducted on the phone at a time that suits you.

The notes from your interview will be added to an electronic file that is password protected. Paper notes will be shredded immediately after that. The electronic file will be deleted after five years.

Your interviewer

If you have more to add to your interview or you want to contact your interviewer for any reason, please do so.

Interviewer's name: _____

Interviewer's email address: _____

Appendix B: The topic guide

2018 Topic guide for interviewers

Obtain fully-informed consent to participate in the interview
Interviewer, re-read last year's notes: Mainly to discover this respondent's answer to the **key learnings** they took away from their course and any changes in practice?
QA. Please **describe the organisation** in which you work now? *(Probe: NGO/DHB, type of service (mental health and/or addiction), size of the organisation, focus of services/type of service users etc.)* QA1. Are you still in the same organisation you were in last year? *(skip next question if yes.)* If not, where are you now?
QB. Only for people who have left the mental health and/or addiction sector. QB1. What are your reasons for leaving? *(Probe: What could have stopped you from leaving?)* QB2. What are you doing now? *(Probe: are you using your course learnings?)* QB3.Do you think you might return to the mental health and addiction sector in the future? *(Probe: You may have to think about skipping to QM. now)*
QC. In what ways is your **practice different** from what you learnt in your 2016 course? Please describe or give an example *(Probe: we are looking for evidence of further development/ deepening of practice)*
QD. Do you regularly ask service users and their whānau for feedback? QD1. What **feedback have you had from service users** and their whānau when you use your course learnings in your practice? Please give an example.
QE. What assisted you, if at all, in consolidating/**deepening your course learnings** in your everyday practice? *(probe: time, organisational culture, management and/or collegial support etc.)*
QF. What were the barriers, if any, to you **using course learnings** in your everyday practice? *(probe: time constraints, organisational culture, pressure from colleagues etc.)*
QG. How have **your colleagues reacted** to you and/or your practice over the last 12 months? *(Probe for examples*
QH. How has your **confidence in your practice** changed over the last 12 months?
QI. How confident do you feel about **suggesting service improvements** related to your course learnings to others in your organisation?

QI1. How has your service changed in relation to your suggestions over the last 12 months? *(Probe for examples)*
QJ. How often are you having **professional supervision?** QJ1. What topics do you bring to supervision? QJ2. How useful do you find supervision? *(Please give examples)*
QK. What **support, if any, have you had from previous students** (e.g. preceptors, mentors) who have completed Skills Matter training*?*
QL. What **support, if any, have you given to students** who are now doing Skills Matter training? *(please give examples of any support provided)*
QM. Thinking back, what have been the **<u>most</u> essential/useful aspects** of your 2016 course? *(probe cultural processes/learning, content, academic learning/process, placement learning/process, mentors/preceptors/supervisors, management/organisational support, processes to obtain Skills Matter funding etc.)*
QN. Thinking back, what were the **<u>least</u> essential/useful aspects** of your 2016 course? *(probe cultural processes/ learning, content, academic learning/ process, placement learning/process, mentors/ preceptors/supervisors, management/ organisational support, processes to obtain Skills Matter funding etc.)*
QO. If you were **redesigning the course** you did in 2016, what would make it easier for others like you?
QP. Please make any **further comments** about the course you took in 2016?
QQ. Would you like a copy of the **summary** of the resulting evaluation report?
QR. Would you be **prepared to be contacted** around this time in 2019 for a further follow up interview – if we are able to do them? Update contact details here.
QS. Thank you for taking part in the interview – get address to send thank you gift

Https://Wisegroup434.Sharepoint.Com/Sites/Tepou/Programme/Tepou_Programme/Fileshare/Skills Matter/Evaluation - Skills Matter/Student Follow Up/2018 Student Follow Up/2018 Nov Re-Follow Up Of Students From 2016.Docx

Skills Matter

KNOWLEDGE, SKILLS, ATTITUDES. WELLNESS, HOPE, RECOVERY

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