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PILLS & PILLOWS

INTERVIEW WITH MARY O'HAGAN,

INTERNATIONAL MENTAL HEALTH INNOVATOR, THINKER AND WRITER WITH LIVED EXPERIENCE OF MENTAL DISTRESS.

Finbar: *What do you think the top issue facing mental health nursing profession is today and why?*

Mary: I don't know if I can be specific to nursing. One thing I've always thought is that we have got the mix of clinical and support services around the wrong way. We should have far more services that help us regain our personal, social and material opportunities and relatively fewer services that provide pills and pillows. Then we would have a chance of creating recovery based systems. Not that I am not totally against pills and pillows but there is a huge focus on the clinical of things in our mental health systems.

My question is if we did have a much more recovery based system what would be the role of nurses, who are the largest workforce in mental health at the moment? If we had a much less clinically focused system would their role be different and would we want to call them all nurses anymore.

I can answer the question about the top issues more generally though. We have two intertwined but contradictory forces at work in mental health services and I think we always have. One of them is about healing and recovery and the other is about containment and control. I believe that those functions should be separated. I don't think that the same people who treat or support you should be the people who contain and control you. In fact I believe there should be virtually no control or containment of people with mental distress anyway.

Finbar: *What research areas in mental health do you think should be prioritised or further developed?*

Mary O'Hagan

Mary: Well if you look at where the resources go into research today around the world, its biological and drug research. I'm sure ninety-five percent of research funding probably goes into this kind of research. But it's not just a matter of what research is done; I think one of the answers to your question is who does it.

I think the evidence base has become skewed; there is a professional hegemony that is reinforced by the self-selected evidence they produce. A lot of evidence that comes out of the drug companies has been shown to be pretty shonky and it's merely a way of maintaining an industry or professional power base. Predictably I am very in favor of service user led research and giving more credence to the evidence that derives from a lived experience knowledge base. But we need to resource people who have a lived experience background to do research and I don't see enough of that happening.

Finbar: *I want to move onto thinking about mental health nursing students. Have you got any ideas about some of the things they should be learning, because I am thinking another generation is coming along and what are your ideas about this?*

Mary: I think they learn some good stuff now but they often go into a toxic work situation which means they have to unlearn it pretty quickly to survive sometimes.

I think the clinical gaze has done a lot of harm despite its benevolent intentions and professionals need to find new lenses through which to look at the life and situation of the people they are working with, to look at them much more contextually and not as isolated individuals who have symptoms that need to be eliminated.

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CLINICAL SUPERVISION AWARD:

MID NORTH COAST LOCAL HEALTH DISTRICT'S (MNCLHD) ANNUAL QUALITY AWARDS: *"WALK THE WALK, TALK THE TALK"*

The Centre for Psychiatric Nursing (CPN) is stretching its tentacles across the border into NSW!

The CPN is pleased to announce that a health service in NSW has been awarded for innovation and excellence in clinical supervision. Last year the CPN conducted two clinical supervision workshops at Port Macquarie and at Coffs Harbour. The workshops and consultations were part of an initiative sought by the Mid North Coast Mental Health Service to establish clinical supervision across the mental health services areas.

The CPN worked with NSW team members led by Ms Tanya Dugard, Clinical Practice Coordinator and Mr Barry Hunter, Network Manager of Mental Health Services for the Hastings Macleay area, over the last year to establish a quality sustainable clinical supervision program.

In June of this year, the clinical supervision program was recognised at the Mid North Coast Local Health Districts (MNC LHD) Annual Quality Awards. From ten categories, the Mental Health Services received an award in category 6: Building the Workforce for their Clinical Supervision Program, titled *"Walk the Walk, Talk the Talk"*. The MNCLHD chief executive, Stewart Dowrick congratulated the award winners and said the awards are held in recognition of the innovative programs that staff across the MNCLHD develop and deliver on a daily basis.

The clinical supervision program will now be nominated for the State awards to be held later in the year. The CPN extend their best wishes to MNCLHD and will continue to support health services locally and nationally who wish to implement sustainable program of clinical supervision within their organisation.

Finbar Hopkins, Lecturer, CPN

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INTERVIEW WITH MARY O'HAGAN

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Nurses need to be educated in recovery but recovery has become such a broad church that you have people on one side who just want to delete 'treatment plan' and replace it 'recovery plan' and just change a few words, then you have people at the other side who think the system needs to be dismantled and built up again. Obviously I would prefer nurses to get the version of recovery that demands a major paradigm shift.

Anyone who works in this area needs a keen sense of social justice and an analysis of discrimination against people with mental health problems, including the myriad of ways the mental health system can discriminate. They need to learn about the role of nurses and other mental health workers in helping to overcome the effects of that stigma and discrimination. That is really important to me.

Finbar: *If you were to wake up in a world where people's emotional and mental wellbeing was attended to, what will have changed?*

The mental health system and a society need to focus primarily on the well being of people with mental distress instead of focusing primarily on eliminating symptoms and controlling behavior. At the moment we've got a system that is mainly about reducing symptoms and reducing risk. And this drive comes back to the standard belief that madness is a tragic and dangerous pathology that renders people incompetent and unpredictable.

But in order to disrupt the prevailing drivers we need to develop very different attitudes to madness. Whether these attitudes are couched in unsophisticated community ideas like dangerous axe murderer or in clever pathologising professional jargon, we need to replace them with a view that madness is a legitimate human experience. It is often disruptive, it can be difficult and terrifying but it's still a legitimate human experience that meaning and value can be derived from, not just for the person themselves but the whole community. Madness also needs to be seen as an experience that we can get through and grow from.

We've really got to tackle the discriminatory bedrock beliefs both within mental health services and our general communities if we want any profound change. Then we'd have a society and a mental health system that respond quite differently to people with major mental distress. Services would foster hope for people, respect their self-determination, offer them a range of options and ensure they stay connected in with their communities. If we had more positive, respectful views about madness, people who use services would be encouraged to be much more actively engaged in their recovery; they would not be sitting back waiting for the pills to work, and they would not be locked up in places and paternalistically controlled. We would also have professionals who related to people as expert resources rather than expert authorities. And we would have communities that did not discriminate. Then we would start to get a flowering of different kinds of responses for everyone who needs them, such as peer support, recovery education, support to get employment, support to get housing, support with your social networks, advocacy and reliable service navigation. The idea of personal budgets might facilitate that process too.

We have got a lot of these types of supports available at the moment, but if only a tiny percentage of people with access to them. Ninety nine percent of people who use services have access to drugs, even when they don't want them, but probably about 2% of people have access peer support. I would say that a very small percentage of people have access to supported employment in Australia.

We've got a vast clinical system that is soaking up most of the resources for the kinds of interventions such as medications and hospital based services that have very mixed outcomes for people - much more mixed than supporting someone to get a job or providing peer support and education that helps people believe in themselves again and to manage their lives. We know the medication can do as much harm as good; the research shows that when you ask people who use medications or are subjected to compulsory treatment about whether they help or not, you get very mixed responses. But people know that humans respond well to intentional practices that help restore their self belief, to learn from their experience and to self manage for instance. They know that jobs and houses and social networks are helpful to recovery.

We know all this and yet we have so few resources in our system going towards these ends and humungous resources going to containing people in crisis and filling them with drugs that have very mixed efficacy.

Finbar: *Well coming to the next question which is kind of related….If you had control of the mental health budget how would you spend the money? I think you have kind of given us some of the answer.*

Mary: Most mental health systems spend well over 80% of funds on clinical services and less that 20% other kinds of services. In Victoria it's about 90% clinical and 10% of for other kinds of services. I would reverse that. We need to put 20% of the funds into clinical services and expend the rest of the funds helping people in these other areas of life. I'm not suggesting that all clinical services are bad and all the community based support services are good but we've got the balance totally wrong. Not all the funds needed for support needs to come out of the mental health budget. We need to be plugging much more into other sectors and ensuring they're effective at delivering services to people with mental health problems.

I know that there have been many attempts to put more money into support services, but there are huge interests in keeping these very expensive hospitals and hospital beds open. In New Zealand we provide community based crisis houses for people who would otherwise be admitted to hospital and they cost 40% of the cost of a hospital bed. You've got to ask why more of these services aren't being established and it's all to do with vested interests as well as a lack of courage and imagination.

Finbar: *So you're saying the situation in New Zealand is less focused on clinical?*

Mary: Yes it is. It's still far too focused on clinical, but less than Australia.

2012 VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE UPDATE

Preparation for the 13th Victorian Collaborative Psychiatric Nursing Conference to be held at the Moonee Valley Race course on 9 & 10 of August are well underway.

Early bird registrations ended on the 25th of May 2012 with over 130 delegates registering early to gain the early bird rate and the chance to have their conference fees refunded.

This year's conference program has new and innovative presentations, so make sure you visit the conference website to view the draft program

The conference organising committee is pleased to announce that the two individual keynotes for this year will be **Dr Rufus May**, Clinical Psychologist and internationally renowned speaker and

Professor Bernadette McSherry, Professor of Law at Monash University and the Director of the Centre for the Advancement of Law & Mental Health.

Rufus May has worked as a clinical psychologist in the NHS in England for 17 years. He has a special interest in recovery based approaches to powerful states of confusion and distress.

His interest in how to facilitate people's recovery is rooted in his own experience of psychosis and recovery in his late teens. He has facilitated *Hearing Voice* groups for eleven years. His work was featured in the channel 4 film *The Doctor who Hears Voices*. He teaches internationally about holistic approaches to mental health and recovery. Rufus will also be delivering two workshops for the Centre for Psychiatric Nursing (CPN) whilst he is in Victoria and information on those workshops can be found on the CPN website.

Bernadette is a legal member of the Mental Health Review Board of Victoria and has acted as a consultant to government on criminal law, sentencing and mental health law issues.

The final keynote spot at the end of the conference will be a panel of Victorian Senior Psychiatric Nurses being involved in a moderated question and discussion session on current and innovative practice within the mental health services in Victoria. This keynote session is designed to allow active participation by conference delegates into the discussion.

So if you have not registered, and wish to do so, you will need to ensure that you register before registrations close on Friday 20th July 2012.

The registration form and all conference details can be found on the conference website at : **www.cpn.unimelb.edu.au/conferences/vcpnc**

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to provide us with your current email address.

Finbar: *Right, but there would be lessons for Victoria from that?*

Mary: The big lesson is that it's very hard to get rid of hospital services and of course you have to replace them with something, you can't just get rid of them. But it's very hard to shift the acute end into a much more community based response, because there are a lot of vested interests in keeping things the way they are. New Zealand closed down all its psychiatric hospitals in the 1990s. We have one of the most deinstitutionalised mental health systems in the world which is great but it's only the first step in a long journey.

Finbar: *Yes indeed, so Mary what would your policy vision be?*

Mary: Well broadly speaking, I think we have ghettoized mental health conceptually, and in policy, in funding and in delivery. And we've ghettoized them in our communities. We need to break that down. The recovery approach is really mental health promotion for people who have mental health problems. We need to think of recovery for people with mental health problems as just a part of the general community well being agenda.

Most of the things that enhance community well being, will enhance the well being of people who have mental health problems. Things like loving relationships, jobs, not too much income inequality, early support for families in distress and things like that. These are no brainers and they're as useful for people with mental health problems as for anyone in the population. So once we start thinking in terms of the general well being agenda we see that people with mental health problems are just like other people in the community. They may have some additional needs related to their problems, but they have basically the same well being needs as everyone else.

When you start thinking this way you're looking at a whole of government responsibility for people with mental health problems because they're just a part of the community. And you're collapsing the traditional division between mental health promotion and mental illness services. In doing so you're opening up opportunities for much more joint funding and much joint delivery across sectors.

The other policy challenge is mental health legislation. Our compulsory treatment regime is worryingly unquestioned in our system. My own belief is that mental health legislation is discriminatory. We should not be taking people's rights away on the basis of danger to self, because you can't do that in a general health setting, or danger to others when the danger has not been enacted yet, because you can't do that in the criminal justice system.

If we want to take people rights away in the mental health system at all, we should do it via generic legislation that deals with treatment without consent for all health consumers. Some commentators say that we should only treat without consent in the mental health arena if there is a loss of capacity to communicate or make a decision, as we do in the general health arena. There's research evidence that just about as many people who are deemed to be incompetent in physical hospital settings as in mental hospital settings.

The problem with the explicit capacity test in mental health is that some psychiatrists see this as a good way to get people into treatment earlier before the traditional danger criteria come into play. If there was capacity testing under general legislation, it would need to be applied equally with other health consumers and the testing should be taken out of the hands of psychiatrists.

Under these conditions I think you would see very little compulsory treatment in mental health because it would not be tolerated in general health services.

Not a lot people support my views on compulsory treatment but the suffragettes and slavery abolitionists didn't have a lot of support to start with either. I do think attitudes about compulsory treatment are starting to change and I think it's very significant that the 2006 UN convention on the Rights of Persons with Disabilities states that people should not be deprived of their liberty on the basis of disability.

So the two big policy challenges - increasing wellbeing and drastically reducing compulsory interventions – are both about getting us out of the mental health ghetto into a broader community context where we are treated like other citizens.

Finbar: *Just to come to our final question and thank you so much for your vision so far. What do you think is more important, the process or the outcome?*

Mary: Oh they are both important. If you are talking about what goes on with people in mental health systems the process actually helps to determine the outcome. They are totally intertwined. But I think outcomes are important. The kind of outcomes of people who use mental health services at the moment are appalling - we die 10 to 25 years younger than the rest of the population, we have 80% unemployment, 80% who have no de facto or married partner. Those are terrible outcomes for any group of people in the population.

We have got to be very mindful of those awful outcomes, but also mindful about how our processes contribute to those terrible outcomes. The process of giving someone a 'fading life chances' prognosis, the process of diagnosis, of treatment, of compulsory interventions, hospital admissions, the process of being given low expectations, they feed on these outcomes. They help to create the poor outcomes to happen.

So you have to give process and outcomes both equal attention and you have to be thinking what outcomes are we looking for and then what processes are we wanting to assist achieve these outcomes?' I'm sure there are people running the system at the moment who think the processes that contain risk and control people will achieve adequate outcomes. They may do their best to maintain a safe locked acute unit, and ensure people are tucked up in their lonely little houses taking their medication and collecting a benefit. But actually these are lousy outcomes if you think of our lives in terms of the level of wellbeing and participation other people in the population expect.

Finbar: *Well that brings us to the end of our interview and I wanted to thank you Mary for giving us your time and your views and the inspiring articles you have written.*

Finbar Hopkins, Lecturer, CPN

STATISTICS IN NURSING

CENTRAL TENDENCY

Central tendency is the centre or the middle of a distribution that is used to describe a set of data. Common measures of central tendency includes: Mean, Median and Mode. When the data set is normally distributed, mean, median and mode are the same. The most appropriate measure of central tendency is determined by the type of data you're analyzing, such as whether the data is nominal or continuous and also the distribution of the data.

Mean is commonly referred to as the average as it is the average score of a distribution. It is computed by taking the sum of all the scores and dividing by the number of scores. For example, the average test score of an exam could be computed by adding up the exam scores of all students and dividing by the number of students who sat the exam. The mean is computed using all of the scores in a given set of data; however the mean can be heavily influenced by outliers.

Outliers are values that are extremely small or large in comparison to all the other values in a data set. If a data set contains outliers, the mean would not be an accurate measure to represent central tendency as outliers can distort the overall measure.

Median is the middle score found in a set of scores that has been arranged in numerical order. For example, the wages of staff at a company could be represented well using the median if there are a few staff members earning extremely high wages. The median is a good measure of central tendency when dealing with data sets that are skewed in distribution. However if a data set has extreme values, the median would not accurately represent the full set of scores.

Mode is the most frequent score found in a set of scores. For example, in a bookshop that sells different types of books, the mode would represent the most popular book. The mode is less affected by extreme values. However if the data set does not have scores that appear more than once, then the mode would not be very useful.

For interval/ratio variables where the data set is normally distributed, mean is typically used as a measure of central tendency while the median is commonly used for distributions that are skewed. When dealing with ordinal data, median is generally used. For nominal variables, only mode can be used as a measure of central tendency.

Roshani Prematunga, Research Assistant, CPN

REPORT ON THE VICTORIAN MENTAL ILLNESS AWARENESS COUNCIL (VMIAC) CONSUMER WORKFORCE CONFERENCE: *RAISING THE STANDARD*

28th & 29th May 2012, Treacy Centre, Parkville

This two day consumer workforce conference brought together over a hundred consumer workers in diverse roles and settings. The conference theme was: *acknowledging the critical role that consumer leadership plays in moving towards a truly consumer-centred mental health service system through the unique and diverse expertise of lived experience*. Consumer leadership occurs in a range of ways: representing consumer views and perspectives, advocating for systemic change, improving the quality of services, providing peer support, and implementing rights-based, recovery and wellbeing-oriented practice.

Keynote speaker on the first day was living legend Janet Meagher who as usual, spoke with wit, passion and talked a great deal of common sense. She spoke about the consumer workforce needing to be in control of its own future, the need to be able to access organisations that will support us when we speak out, and the very human need to have pride and respect in our work. Janet reminded us that we are part of a much broader movement whose long history does indeed encompass the passions and energies of those who have come before and on whose shoulders we stand.

On day two we were introduced to Anne Beales, keynote speaker from the UK. She is the current Director of Service User Involvement at the organisation *'Together: Working for Mental Wellbeing'*, a mental health charity and service provider. Anne received an MBE for services to healthcare for her work in setting up and co-ordinating the Capital Project Trust, a service user led group in West Sussex which offered training and support so that people with lived experience could positively influence local developments. Anne too was a very inspirational, witty, down to earth and passionate speaker. In a tour de force speech, she shared a wealth of learning gained from her experience of working with peers, organisations and governments. These included the dangers of recovery becoming unrecognisable from its origins in the user/survivor movement – for example when it becomes synonymous with gaining employment, practical techniques for how consumers can form productive partnerships in change efforts without compromising on principles that have been agreed to and adopted by service users. Rumour has it that Anne may well be coming back to Melbourne next year for the Themhs conference. If so, don't miss it.

Other highlights were attending a presentation by Neil Turton-Lane and David Pedlar on Advance Directives (ADs), during which three consumer actors told life narratives while the audience was asked to listen and then feedback some of the specific issues that could be written up in an AD. This was a very moving educational technique. Will we soon have services in which the first person who greets you will say, *"Hi, my name is so and so, and I want to let you know I have read your AD, let's take some time to go through it now together"?*

Indigo Daya, project manager of Voices Vic at Prahran Mission gave an inspirational presentation about her work with the Voices Vic team which was delivered with characteristic irreverence and optimism. Principles underpinning the work are always asking: 'what is the respectful way to do this?', reinventing the workplace and the work, constant reflection and learning, speaking the truth, and being open to doing things differently.

Vrinda Edan, Director of Consumer and Carer Relations at Southern Health Mental Health Program presented with senior consumer consultant, Joanne Sheedy on a pilot program that uses Ipads to undertake 'real-time' satisfaction surveys on inpatient units. The survey tool was developed locally, response rates have been above 80% and the service is able to respond quickly and systemically to concerns. Among other innovations, the data has been used to inform nurse led inpatient groups, gender sensitive practice and the introduction of peer support onto wards.

There were numerous other wonderful presentations (only some of which I saw) and the proceedings were closed by the Honourable Minister for Mental Health, Women's Affairs and Community Services, Mary Wooldridge. Overall, the conference was an eye opener. It was very evident that our work has moved from the realm of participation to providing leadership in the mental health specialist and community managed sectors. Congratulations to VMIAC for providing a fantastic professional development opportunity for and by the consumer workforce.

Cath Roper, Consumer Academic, CPN
