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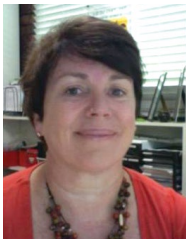
INTERVIEW WITH HELEN GLOVER – RECOVERY ORIENTATED SERVICE CONSULTANT



Helen Glover

Finbar: *Thank you Helen for doing this interview. Can you provide me with some background on the story of how you got to where you are today?*

Helen: The story is a fairly long winding one. A lot of people ask me how I got into this work around recovery and it wasn't by design, it was more about opportunity and that I fell into it.

I was a teacher in a previous life and then I became very unwell, spectacularly unwell and ended up being in psychiatric hospitals and treatment for a number of years.

As part of that process I could not teach any more, they don't employ mentally ill teachers, so I got superannuated out from the Queensland Education Department. With that money I was able to then start a new career. I wanted to study social work. I studied social work and to cut a long story short, then started work in the mental health sector.

I brought with me a number of ideas about learning and education but also my own lived experience knowledge and then started to work with clinical teams. I was very fortunate in those early years to work with a psychiatrist in Caboolture , Dr Kalyanasundaram, from Queensland (known affectionately as Kaly). He has a passion for systems doing thing differently. I had not heard the word recovery and he introduced me to this concept both personally & professionally. He has a big reputation and is one of the leaders in this country around thinking that systems could do things differently. He started putting this into practice with a small team about how do we create an environment for people to live, work and play despite them having a mental illness.

So I learnt a lot from him, but I did not know this concept was called recovery or recovery based practice. What I was learning from him was impacting on me both personally and professionally.

I realised at that stage I wasn't in a recovery space myself. So I had to get that right for myself before I could start thinking about how I could use this in my work.

I worked as a mental health professional before I started falling into opportunities to speak and teach around the world. It was more by opportunity than it was about me saying I am going out to make this a career.

I have been doing this now for probably 2 decades, way before Australia and their mental health policy even thought about the concept about recovery. I have probably had more traction and interest internationally and Australia has only caught on to it in the last couple of years in comparison to other places.

Finbar: *Why do think that was?*

Helen: I don't know, but I think Europe and the US have much more of an interest in the social justice and rights stuff and there was a big push at the time from a lot of the American lived experience groups and a lot of the European people who were really championing this. - closing hospitals, doing things differently and I think systems were listening to them. Where in Australia I felt we were at a stage where there was only a few of us talking and I think it was a very kind of tokenistic response back then.

I also think the northern hemisphere sets the agenda a little bit, and it's a bit like the flu, it comes to the southern hemisphere afterwards.

So I was getting lots of requests to do training and speaking engagements in Europe, before I even was known in Australia for doing this stuff.

I have had a consultancy for nearly 20 years, but in 2005 I decided to bite the bullet and leave full time employment with Queensland Health to start up a consultancy of my own. That then became a company that I now employ people and work with a small team of consultants that can keep this message going and keep working with organisations and helping them with not just training, but in terms of thinking about their whole systems structures around recovery.

Though I don't even like the word 'recovery' for me anymore, I think it's something else.

Finbar: *Tell me about that?*

Helen: Well, I have noticed in Australia and overseas that when you use the word 'recovery' to describe what you are trying to help people 'get', in terms of work practice, they turn off. It's like they have already got it, and that they don't need to know about it. I think it's because people have seen it as a model as opposed to a way of being and a philosophy- an approach that sits underneath their therapy or their treatment or system. I have a sense it's kind of seen now as "oh, we have done recovery so we don't have to pay attention to it anymore".

So I'm reluctant to describe some of the work I do now as recovery-based practice. This has been a huge shift for me probably in the last year or so, to start to describe it, to get underneath it and say well what we are trying to do here without using the word recovery to describe it. I think organisations that are attuned to that will hear it and the organisations that want to just tick a box to say "yep recovery training, we have done it", they won't hear it.

They're not the organisations that I tend to work with anyway.

So how do I describe it if I don't call it recovery? It's kind of like helping organisations, or support the positioning of organisation's so that they can support people to reclaim a life. How can we support people/ organisations to bring out their best? It's much more about a description of changing our services rather than changing the people who access our services.

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SAFETY AND QUALITY LESSONS TO BE LEARNED

INQUEST INTO THE DEATH OF A BARWON MENTAL HEALTH CLIENT – FEBRUARY 2013

On Thursday 21 February, I and a number of our staff members were summonsed to give evidence at the inquest into the death of our client.

The client had been a patient in the Swanston Centre for less than 24 hours in 2011 when she took her own life in between routine observations and while her primary nurse was off the ward. Our client was undergoing chemotherapy for cancer at the time of her death.

Her death and our subsequent investigations revealed a number of weaknesses in our care systems that left both patients and staff unprotected. These included:

- The lack of a system for recording observations at intervals of no more than 15 minutes. Failing to record the observations allowed more than 15 minutes to pass between us sighting the client.
- The lack of a system for formally handing over observations from one nurse to another. While the clients's care was informally handed over, the nurse taking over had no way of knowing when the last observation had occurred, allowing up to 30 minutes to pass between observations.
- The failure of our systems to intercept and search belongings as they are brought into the acute unit. This allowed a dressing gown and cord to end up in the client's possession without us knowing.

An inquest is a public process in which the Coroner attempts to ascertain the identity of the person who died, their cause of death and to address other matters of concern to public health and safety.

Prior to the inquest and throughout the process both I and all of the staff involved were very well supported by both Barwon Health and the lawyers appointed to represent us.

Despite this, attending an inquest and giving evidence under oath is stressful and daunting process. All of our guidelines are made public and the legal team representing our client's family was intent on cross-examining us on both our actions and behaviours, and on our compliance with the guidelines we have all agreed to.

What was written in the clinical file, what boxes were (or were not) ticked on assessments forms, and the presence or absence of signatures on key documents were examined in detail.

Very significant pieces of work to improve our systems occurred shortly after our clients's death, and these along with safety improvements at the entrance to Swanston centre have all addressed the key failings in our systems since 2011. We were also able to present a series of detailed audits demonstrating that we are now complying with our responsibilities around visual observations of high risk patients.

As part of the inquest process Barwon Health fully admitted significant failings in our systems and offered a public and unreserved apology to the family.

The Geelong Court House

The inquest has now concluded and we will receive a formal summary from the Coroner in 6-8 weeks time.

I feel that there are a number of critically important messages that we need to take away from this incident:

- Our everyday actions and interactions with clients have the potential to be examined very closely, publicly and under oath. Coronial Inquests are open to the public, hence media reporters do attend the hearings and may name individual clinicians who are called to give evidence.
- Fully and accurately completing paperwork is of critical importance. If you fail to complete defined paperwork, or complete it in an ambiguous way, you must be prepared to explain why.
- Your best defence is to comprehensively document with dates and times exactly what you did and why. If something is not documented, or is inadequately documented it is going to be very difficult for you to explain or defend what has happened, especially if the inquiry comes years after the event.
- All clinical staff must be familiar with the clinical guidelines that relate to their area of practice and be sure that they are complying with them. To practice outside of an organisational guideline places individual clinicians at significant risk of criticism. For MHDAS the ACE Guidelines in 'Prompt' provide the overview.
- If staff are aware of policies, guidelines or even just 'custom and practice' that we are not complying with, or that are inadequate or dangerous they must report these to their manager or via RiskMan.

Having said all of that, it also clearly of great importance that we balance high quality paperwork with having enough time to genuinely engage with clients as this is the activity that is most likely to lead to clinical improvement and recovery.

One really positive outcome from these sad events has been the establishment of a psycho-oncology service within our consultation-liaison team, which we are hoping will provide the psychological support to patients undergoing treatment for cancer that might have prevented this whole incident.

I believe that as an organisation we have learned a lot from this experience. We have certainly improved our systems and hopefully the care we deliver is now safer.

A/Prof Richard Harvey
Clinical Director; Mental Health, Drugs and Alcohol Services Barwon Health

SYMPOSIUM – TRAUMA INFORMED CARE

THURSDAY 9 MAY 2013

Trauma-informed care is an approach to engaging people with histories of trauma that recognises the role that trauma has played in their lives.

The approach was initially used in working with war veterans and later, with victims of domestic violence. A basic working definition of trauma is: exposure to extreme stress that overwhelms someone's ability to cope.

Trauma should be thought of as an experience, not a diagnostic category. Studies show that up to 98% of people who come to the attention of mental health services have experienced trauma in their lives. It is possible that a diagnosis formed on the basis of presenting symptoms such as hallucinations, sleep disturbance, hyper vigilance and paranoia could overlook an underlying trauma.

A trauma informed approach tells us: Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences. In a trauma informed approach, the focus is on 'what happened to you' rather than 'what's wrong with you'? Since this experience is about being unsafe and powerless, interventions are directed at restoration of safety and power.

The Centre for Psychiatric Nursing is hosting a one day Symposium on Thursday 9th May 2013, 8.45am – 3.00pm, titled "Trauma Informed Care"

Join us for this symposium that introduces trauma informed care in mental health services and explores how mental health clinicians can work with clients who have experienced trauma.

Six guest speakers with an interest and expertise in trauma approaches and mental health nursing will present their views followed by a 60 minute workshop that will assist participants to work in a trauma informed way and will raise the question of how organisations can support trauma informed approaches.

This symposium is of relevance to mental health nurses and mental health communities.

A REGISTRATION FORM AND FLYER FOR THE SYMPOSIUM WILL BE AVAILABLE IN EARLY APRIL 2013 ON THE CPN WEBSITE: http://www.cpn.unimelb.edu.au/news/whats_new

MILDURA MENTAL HEALTH SERVICE

One of the main issues that come up when talking about rural mental health, and rural health care generally, is isolation. Isolation when others think about rural services and for staff working in rural areas. Issues such as access to specialist secondary service providers in mental health and general medicine, and staff recruitment abilities and alternatives are some of the concerns from the services isolation. News stations will even occasionally leave Mildura off the top of state maps, unless they are pointing out how hot it is here.

Mildura Base Hospital

The engagement with the community through collaboration and connection with community services is one of the ways that the service will attempt to work with the issue of isolation. This is not something that people from a rural area will find as new information as rural communities have for years looked to the connections of community members and collaboration of community services as the ways that rural areas have used to survive and flourish.

Mildura Mental Health Service forms part of the Mildura Base Hospital, which is located in Mildura, 550kms north of Melbourne. It is a specialist, integrated mental health service covering the Department of Human Services, Northern Mallee sub-region, having a weighted population of around 60,000 and covering an area of 25,000 square kilometres. Programs include Aged Persons Mental Health Service (APMHS), Adult Mental Health Service (AMHS), Acute Response Service (ARS), Primary Mental Health Service (PMHS) including peri-natal and homeless youth services, Child and Adolescent Mental Health Service (CAMHS) including autism spectrum assessment service and youth early psychosis service, a 12 bed Acute Inpatient Unit (IPU) and Mental Health Education Team (MHET). The Community Programs provide outreach support to people living up to 230km away from Mildura. The majority of the Mental Health Services are located within the Mildura Base Hospital, however PMHS and APMHS are located off campus. Mildura is also a border town, on the Murray River, with the New South Wales Far West Community Mental Health Service at Dareton being one of the most remote services in New South Wales to Sydney. Mildura Mental Health Services and Dareton Community Mental Health Services also have a connection with a Cross Border Policy as Dareton CMHS does not have an inpatient service.

As part of our training and professional development for staff our service fosters close collaboration with the general nursing education team through our combined education sessions with our graduate year programs and in staff training. Our general nursing and mental health graduate year programs share orientation and competency topics during the graduate nurses first month of work and mental health have featured in the general graduate nurse program Quality Improvement Project as part of their overall assessment. The Mental Health Education Team also presents at the general graduate nurse program study days and has an annual Mental Health Awareness Month on the Mildura Base Hospital education calendar in October to coincide with and extend on the activities of Mental Health Week. These activities have included awareness campaigns of Mental Health First Aid, staff education on Management of Challenging Behaviour, and Dual Diagnosis topics.

Following the need for collaboration and connection with services, the education team also has developed relationships with the local tertiary providers of registered nursing and enrolled nursing courses in Mildura. La Trobe University and Sunraysia Institute of TAFE has offered opportunities for experienced staff to take up teaching positions with the courses mental health topics. These opportunities have provided engagement with staff of the tertiary providers, access to their resources and professional development activities, and connection with the nursing students which provides a better informed clinical placement and is an area of recruitment to the mental health graduate nurse program through general information to students and with the annual Graduate Nurse Program Panel Discussion to third year students which happens before the commencement of Computer Match program.

One of the Mildura Mental Health Service initiatives promoting working with collaborative approaches is the Northern Mallee Critical Incident Support Team (NMCIST). The team developed from the work of collaborating organisations involved in the Community Services Engagement framework to launch a 12 month trial program for critical incident support within the greater Sunraysia area. Critical incident support and its interventions aims to restore the effective functioning of the individuals and groups involved in unusual events/incidents.

People accessing the team are advised that critical incident support would not be used as an operational critique to review and evaluate the effectiveness of procedures and services ability to respond and that it is not used as a crisis response to the incident. The NMCIST response is provided 1 – 2 weeks after the incident as a trainer-facilitated group or individual session to process affected individual's personal perspective with a view to support and linking in with community services when needed.

Sharing rural perspectives on physical distance from metropolitan services and experiences of isolation as a health service is in it self a way of connecting with others. Rural areas have to continue to develop these connections and foster collaboration with other Victorian Mental Health services to continue what our older generation of rural workers would agree is a way to survive and flourish.

Stephen Butler
Clinical Nurse Educator
Mildura Base Hospital, Mental Health Service

CONFERENCE, SYMPOSIUM & WORKSHOP REGISTRATIONS GO ONLINE

As from the 1st of January 2013 all registrations for conference symposiums and workshop run by the Centre for psychiatric Nursing will be done on line.

The new system allows you to select the event you wish to attend, register and pay the registration fees on line.

Once you have completed your online registration you will be able to print out your own tax receipt and a confirmation letter the event you have registered for. The confirmation letter will detail where the event will be held and provide any other information you may need to attend the event.

You can go to the relevant area of the Centre for Psychiatric Nursing website to locate the event you wish to register for and the by clicking on the register now icon it will take you to the registration and payment online system.

Should you have problems with this new system please do not hesitate to contact our office on 03 8344 9626 for assistance.

Greg Mutter, Centre Administration Manager

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INTERVIEW WITH HELEN GLOVER – RECOVERY ORIENTATED SERVICE CONSULTANT

Continued from page 1

Finbar: *Tell me about your thoughts on 'recovery'?*

Helen: I think Australia is still struggling to get that concept that recovery based practice is not about changing that person who walks through the front door to ask for help. They are still thinking about changing people as constituting recovery based practice , rather than thinking about what is it that we as service providers or an organisation have to change or let go of, so as to invite people to work with us? It's a huge difference in those two interpretations.

This is the challenge - recovery base practice has nothing to do with the person; it's got everything to do with the environments we create, and if those environments are conducive to well being, people will naturally want to use them and they will naturally be useful in helping people to self right and thrive.

The analogy I normally use is when I go to a gym. Is that gym conducive to helping me get what I need from it? It might be the best gym in the world, but it might not necessarily be for me. So it's that fit that is important. A gym never says we are a better gym if we have fitter people, it says we are a better gym if we can offer more relevant things for people to use to get fit.

I don't think we are looking at ourselves as to what do we have in the service environments that brings out the best in people.

So for the last 5 or 6 years, I have been working with organisations that are only interested in shifting and thinking about their own shifts, as opposed to shifting people.

Finbar: *Yes, it is where the answer lies, isn't it?*

Helen: In Australia if you look at the national and state writings, it's still heavily based on fixing people. And if you think the person is not broken to fix then the thing you have to fix is our system in the places where it butts up against people. Is it conducive?, is it useful?, is it something that people will go:-"wow that was a really helpful experience; it helped me to get back into a really good space".

Finbar: *You have started some work here in Victoria. We have spoken to the people at Barwon Health and they are happy for you to tell us about that work. That could be a nice example of fixing the system.*

Helen: One of the things I have moved away from and it probably touches how I work as well, is not just doing training because I don't think just training works by itself as a individual one off thing. It serves no one: - the organisation says we did recovery training but nothing changed, and everyone loses around that.

I say to organisations that you may as well just throw a good staff party, because you will get more out of that than you would out of just doing one off training.

So how I have worked with Barwon Health and a number of other organisations, is through offering some service transformational projects. How do we support the organisation to create that culture or that environment that brings out the best in people? This has been a fairly complex project. The project I have introduced to Barwon is ROMP – Recovery Oriented Mentoring Project. This is an action learning project design that originally was conceptualised with leaders in Queensland in 2009.

The Queensland Government took it on first in the Department of Communities. It was a way that combining training and action learning, ongoing learning circles, opportunities for people to connect with each other in these learning circles. It was also a way for them to do some transformational work in their teams, in their service, as a part of their learning.

This is what I have offered Barwon but in a different shape. Because I am not physically down there every month to run learning circles we are doing learning circles using web based technolog. It is also not a pure leadership program, so they are trying to work with the whole organisation to bring about that culture change.

So we have done some training, two lots of three day training and had 100 staff go through that.

And from that people put up their hand to be mentors. But that didn't mean that they had to have it all and know it all. It was about they were willing to guide their teams in conversations around these concepts. We have been having monthly mentoring groups that have been happening for nearly a year now, where I support the mentors. Mentors and I meet once a month and then they go and support the teams.

My design around this is that I am interested in supporting the sustainability of change within the Barwon Health. If I can strengthen or support the core of the organisation to strengthen, then I can disappear after a year and hopefully this will still continue. If it has to rely on me, then it's a failed design and it's not going to flourish.

I always look at how is this going to be sustained and is there enough energy to sustain it. One of the key things when I started working with Barwon Health was to have conversations with some of the key leaders to understand their intention to bring about change. The questions that I asked this leadership group was about; why do you want this?; what hopes you have for this to be different?; how do you think you're going to need to support it, kind of getting buy in at the initial stage.

They came to me, rather than me trying to sell them something, and I think that is a big difference. They said, "we want to do this well, we know we have got some struggles and how can we think about doing it differently"? The appreciated that the difference that they were seeking would not come about by just about sending people to training. They appreciated the need to offer support afterwards.

The other things around the original ROMP structure that I haven't done with this group as much as I have with other groups is a set structure with learning activities and exercises. The mentor group and I have created those specifically as we have gone along as opposed to other Romp groups were they have been pre set..

This has been a much more about hearing the need and thinking about how I can support those mentors having the conversations with people in their teams. It's only now that they have started to design their team projects and they will go through until November and hopefully in November they will be able to come back together and really witness and learn from each other about what is we have done to make that environmental change and what impact it how has that had impact on people who use our service?

Finbar: V*ery empowering and liberating. It's taking it from a different perspective*

Helen: Yes and it's also about supporting the staff that want to do something different .I think about it the same way as you do when supporting an individual. I think - "If they could have done it, they would have – so what is standing in their way?" How do I support you as leaders, as an organisation, as workers here? I fundamentally believe they want to create a different space, but there are lots of structural things and lots about our expectations that get in the way of that. There are many things about our professional training, about our history, about our systemic routines and about our expectations of others and ourselves that will pull us constantly away from our intentions. Part of this is how do we hold that tension and negotiate it with a strong core as opposed to going "oh no, we can't do this - we have to go back and do this "to" people.

They have been looking at their language, their documentation, the way they use existing outcome measures as a useful process, the way they ask questions; the way they invite people into this process. It's a big process, it's a big change orientation, but I don't know if we are going to see massive change at the end of a year. What I do think we will see is a group of leaders that have more confidence raising the questions and conversations and being sensitive to the nuances and recognising when they are being pulled away from their focus.

Finbar: *What were the obstacles perceived by the organisation in implementing this process?*

Helen: I think there are some structural and logistical constraints. You have got a big organisation, so how do we get this to everyone? I was recommending that they start smaller than what we actually did, but the thought was trying to influence as many as possible in the change process. My hope was to work with their leadership group and just spend some time helping them feel strong about the transformational direction of recovery based practice and then go to the next layer of the organisation. This way would have been slower and would have also had different limitations. We worked with what is and the resources available.

I don't know if all the psychiatrist members of the team were on board with the direction as much as the rest of the team were. There was a separate session held with the psychiatrists of the organisation. One of the challenges for the psychiatrists in Barwon Health is that most of them are only part time psychiatrists to Barwon Health. On the whole I sensed that they could see possibilities for incorporating more direction towards self direction and self management within the service intention. Like all groups you will have those that are encouraged by such a direction and those that remain doubtful. This group of professionals was no different to other groups in that aspect.

One of the structural challenges to the Barwon ROMP is to bring diversified knowledge bases into the discussions. I only found out, down the track a little bit, that the majority of Barwon's work force is from a nursing discipline. Although this is great and some of the great ROMP leaders are the nurses, we may benefit more from learning from other diversified voices such as other disciplines and people who access services. Some of the teams stretched themselves to hear the voice of those that they provide services to in some of the learning activities. This led to some great reflection and discussion on how things are being delivered. We could strengthen both of these aspects a little more in the design of any future transformational projects.

I think one of the obstacles for the learning circle is the mentors have their jobs as well as trying to support the service transformation project. So it's on top of their duties. You are always going to have those that are dedicated that will do it, but when it becomes stressful you are going to have the ones that fall off. I really respect the executive and the program managers of Barwon Health who have really held the expectation that this is something important to do.

There is really good intent there and there are not people saying "Yeah, yeah, but we are not going to do this".

There is an interesting phenomenon emerging that I don't really make a lot of sense of at this stage. It is completely the opposite of what I expected. The inpatient staff have grabbed and run with this more than the community based staff.

I would have thought it would have been the opposite way around. To the point the last time I was down at Barwon Health we had a face to face mentoring group and the mentors were giving feedback to each other because they don't necessarily get to meet as one group. The mentors from the community team were giving feedback to the inpatient units, 'we know you are doing something different in the work on the inpatient unit because the people we support who have an inpatient unit stay are coming back and telling us how much better and how much more stronger they feel around their self direction. So that tells us it's not just one person in the inpatient unit doing it, but it's a collective doing something different.

I think that's a nice enquiry to follow somewhere, because I would have thought that the community teams would have embraced it more than the inpatient teams?

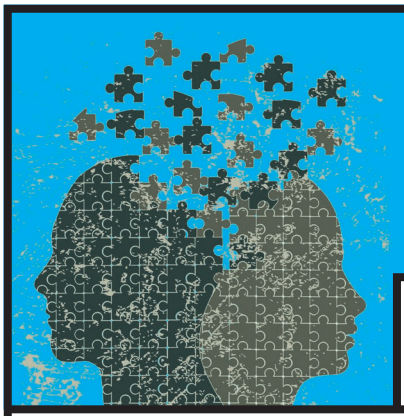
Finbar: *That would have been my hunch as well, because they are out meeting people as guests in their homes and as less as a nurse patient relationship and more in a collegiality relationship.*

Helen: Yes and they are not just necessarily meeting them in a risk or an acute situation. I had a discussion with one of the Community Team Managers and she proposed that maybe the community teams think that they are already doing it and the inpatient teams realise they have some work to do around this shift in service direction. Maybe the community teams are more complacent around it. This isn't for us – we have already got it, they are not talking about us when they say we need to shift to a recovery orientation.

At one stage we were doing cross mentoring where community mentors would come and mentor with an inpatient mentors, but I am not sure how that is going. I think some of it is still going well, but some have fallen apart and they are just mentoring by themselves. The ATOD's (Alcohol and Other Drugs) team seems to be doing well because supporting self management and self direction is not such a foreign concept to them.

Finbar Hopkins, Lecturer CPN

Continued in the June Edition of Carillon



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