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SYMPOSIUM: WHOSE RECOVERY IS IT ANYWAY?
– CAN PERSONAL RECOVERY INFLUENCE CLINICAL PRACTICE?

Framework for Recovery-orientated Practice was launched by the Victorian Health Department in August 2011.

Mental Health Minister the Honorable Mary Woolbridge wrote in the forward to the framework document "that the orientation of service delivery towards recovery involves the need to focus on strong partnerships in decision making between people and providers".

It also requires partnerships with people's significant others. In order to forge genuine partnerships, practitioners must do the work of listening closely to the experiences of people accessing services and their support people.

This necessary work can be very challenging, especially when listening, means acknowledging people's distress associated with accessing services.

Recovery orientation requires that service models and practitioners favour collaborative practices in everyday work. This involves supported approaches to decision making across the full spectrum of service provision, from assessment and acute treatment to therapeutic programs, long-term rehabilitation, accommodation and employment. This requires careful negotiation and collaboration.

A number of efforts are underway across the Victorian specialist service system to work in recovery oriented ways.

This framework is intended to pull these activities and efforts together. As a living document, the Framework for recovery-oriented practice will be adapted over time to suit the evolving system.

This framework presents an invitation of the specialist mental health workforce to continue to develop and enhance practice in line with recovery principles. It offers an opportunity for services and individual practitioners to reaffirm the aspirations they held when entering the mental health sector and, most importantly, to create more positive experiences for people accessing the services.

The Centre for Psychiatric Nursing is hosting a one day Symposium on Thursday 19th April 9.00am – 3.00pm, titled Whose Recovery is it Anyway? – can personal recovery influence clinical practice?

Join us for this symposium that will stimulate thinking and discussion about how services might be transformed toward recovery and how recovery principles can inform clinical practice. Presentations during the day aim to encompass theoretical, policy and practice ideas about recovery.

Six guest speakers with an interest and expertise in recovery and mental health nursing will present their views followed by questions from the audience, facilitated discussion and debate.

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

A registration form and a flyer for the Symposium can be found on the CPN website at **http://www.cpn.unimelb.edu.au/news/whats_new**

Reference: State of Victoria, Department of Health, (2011), Framework for Recovery-oriented Practice, p1

AUTONOMY IN JEOPARDY:
CONTRASTING PARTICIPATORY HEALTH MODELS WITH PATIENT DECISION MAKING UNDER MENTAL HEALTH LAW

ARTICLE SUMMARY

In terms of research, education and knowledge development, the consumer academic program at the Centre for Psychiatric Nursing focuses on two distinct but related domains. These are: consumer perspective education and training in the preparation and professional development of the clinical workforce; and supporting consumer autonomy in legislated contexts. Recently, Cath Roper and Vrinda Edan had an article published in the Journal of Participatory Medicine that uses Victorian mental health law (MHL) as a case study through which to tease out some of the thorny aspects of supporting consumer decision-making under Victorian mental health legislation. The paper adopted an ethical lens to explore these tensions.

Respect for patient autonomy is fundamental to participatory health models where treatment decisions are made through a partnership based on mutually acknowledged expertise between patient and provider. For patients subject to mental health law (MHL) in Victoria, however, autonomy can be overridden on grounds of incapacity to make treatment decisions. In such cases, providers become substitute decision makers and patients may be treated without their consent, presenting a challenge for participatory practices. The overlay of participatory frameworks onto mental health policy and law serves to mask significant ethical issues at stake for patients who are governed by MHL, where patients are not free to make autonomous health care decisions in a voluntary context. Providers may be placed in ethically challenging positions, attempting to establish partnerships and encourage patient participation on the one hand, yet working with a mandated treatment plan that the patient may not have agreed to, on the other.

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ACTION LEARNING AND LEARNING SETS

The Centre for Psychiatric Nursing (CPN) is offering an Action Learning (AL) workshop for clinical supervisors, nurses or nurse managers to introduce them to the action learning approach and to provide experiential learning in the approach.

Action learning sets (ALS)can used for the purpose of group supervision. If you want to explore your interest in action learning and action learning sets, but you are still unsure about what it all means the following overview may be able to help you to decide if the workshop and the ALS would benefit you.

Following the workshop, an introductory action learning set (ALS) group will be organized and take place at the CPN for participants, who are interested in developing learning action sets in their workplace. The ALS will be offered every 4 weeks on a half a day basis for six months. Ms Finbar Hopkins will act as an ASL advisor and facilitate the ASL.

The ALS will focus on work based issues, problems or questions that relate to professional development, team working, managing staff, managing change, consulting or any other professional issues that are of concern to them.

INTRODUCTION

Action learning has become a key approach to enable professionals such as mental health nurses to grapple with the competing demands of their busy work lives. It does this by engaging their strength and dedication on how to work out problems, questions, interpersonal issues and difficulties that occur at various junctures in their working lives.

Action Learning teaches professionals about how to:

1. be more imaginative in their work

2. get the most out of staff

3. work with people who are difficult

4. interact more productively with each other, in groups and across disciplines using all their abilities and expertise

WHAT IS ACTION LEARNING?

There are two key components to an action learning set that are important to understand.

An action learning set it involves a group of people working together (called a set) on their 'doing' and their 'learning' .This requires regular and purposeful meetings of the group to provide space and time for questioning, understanding and reflecting.

Several definitions of action learning recognise that action learning is a process of learning and reflection supported by colleagues, with the purpose of getting things done. Another definition suggests that it is an educational process by which a person studies his or her own actions and experience to improve performance. Through action learning, people learn from each other by working on real problems and reflecting on their own experience.

WHAT IS AN ACTION LEARNING SET?

An action learning set is a structured process for working in small groups to address complex issues.

The main elements in an action learning comprise a small group of five or six people (set)who meet regularly, ideally once a month for a day or a half day to work together in a supportive yet challenging way. At the commencement of the ASL there is a 'checking in' exercise to draw all group members together. The ALS commences with individual members 'presenting' work on a problem. The group will then help the 'presenter' work on the problem through supportive, but challenging questioning in order to encourage a deeper understanding of the issues involved, a reflective assessment of the 'problem' and an exploration of the way forward. An ALS is not a self-discovery group or counseling group, but members will become aware of their learning and reflection which may enhance their personal insights.

WHO CAN BE IN AN ALS?

Anyone who can benefit from the experience, action learning is for everyone.ALS are selected so that people within them are able to help one another, even if they come from different disciplines or different organizations.ALS are normally made up of people from the same level of responsibility.

WHEN ARE ALS'S USEFUL?

When we are facing a new situation we have not dealt with before or when we are working with a new group of people who we have never worked with before. ASLs are also helpful for managing staff, relating to colleagues, and working in teams and when the organisation we work for is undergoing change. Action learning is effective for organisational development, team development and personal development.

This overview has provided you with a brief account of action learning and action learning sets to whet your appetite. This may encourage nurses and other interested professionals to discover something about themselves and about their learning through action learning and action learning sets.

WHO SHOULD ATTEND?

This workshop could be beneficial to nurse unit managers, clinical educators, project managers, nurses who provide group supervision, case managers and team leaders.

NEXT WORKSHOP:

23rd May 2012 – Info and application form available at

http://www.cpn.unimelb.edu.au/education_and_practice_development/practice_development_workshops/action_learning_sets

Reference
McGill, I. & Beaty, L. (2002). *Action learning: a guide for professional, management & educational development*. London: Routledge Falmer

Finbar Hopkins, Lecturer, CPN

STATISTICS IN NURSING LEVEL OF MEASUREMENT AND STATISTIC

In research we collect data on a variable(s) of interest from one or more respondent(s). To describe the variable, the data collected need to be summarised. Understanding the level of measurement is important before summarising the data. The level of measurement of a variable limits the set of logical and arithmetic operations that can appropriately be applied to scores which, in turn, limits the choice of statistics. For nominal and ordinal variables, scores serve merely as labels for group membership, and hence for these variables mathematical operation is not logically meaningful. However, scores in interval or ratio variables refer to specific amounts of some quantity measured. For these variables, performing mathematical operations such as calculating average are appropriate. Therefore, understanding how a variable is measured is important in order to appropriately analyse and interpret data.

Data collected on a variable is often examined by looking at three major features: distribution, central tendency and dispersion. The distribution of a variable is the count of individual scores. For a nominal or ordinal variable, the distribution of a variable includes the count of all of its scores. For interval or ratio variables, scores will be grouped and the distribution of the variable is the list of counts of scores for each group. Percentage share of each group out of the total can be computed and a percentage distribution can also be presented to examine a variable.

A central tendency measure estimates the central score of a distribution of a variable. There are three common central tendency measures: mean, median and mode. A mean is an average of scores which is computed by adding up all the scores and dividing by the number of scores. Median is the score found at the exact middle of the set of scores which are listed in numerical order. A mode is the most frequently occurring value in the set of scores. For interval and ratio variables, mean, median and mode are appropriate measures of central tendency. For a nominal variable, only mode, and for an ordinal variable, median and mode all the time and mean sometime are used as measures of central tendency.

Dispersion refers to the spread of scores around the central tendency. Two common measures of dispersion are the range and standard deviation. Range is the difference between the highest and lowest value. Standard Deviation measures how much scores of a variable spread out from the average score. Both measures of dispersions are appropriate only for interval and ratio variables.

Dr Zewdu Wereta & Roshani Prematunga

CARILLON – now an eNewsletter

The Carillon will is now only available as an e-copy publication via email or from our website: **http://www.cpn.unimelb.edu.au/**
If you want to receive an e-copy please email us at **cpn@nursing.unimelb.edu.au** to provide us with your current email address.

AUTONOMY IN JEOPARDY
ARTICLE SUMMARY

Continued from page 1

We argue that in the case of people subject to MHL, autonomy should be accorded intrinsic and independent value. Autonomy is the ethical principle most at stake for people subject to MHL where providers become substitute decisions makers. We argue that providers need to clearly understand their roles as substitute decision makers and learn to be transparent about and accountable for the statutory powers conferred on them. Any departure from respecting patient decision making needs to be considered an aberration rather than a norm.

But new practices are also needed to promote patient self-determination and affirm autonomous decision-making on the part of patients. First, capacity should be assumed so that any paternalistic intervention needs to establish which specific decisions are not able to be made and the reasons why. 'Conversation models' are one way to encourage participation, rendering clinical thinking transparent to the patient and then tailoring information to the individual. The model requires clinical skills such as sharing one's thought processes; encouraging the patient to ask questions; and finding out how much the person wants to participate. Flowing from this, practice needs to be always directed toward facilitation of autonomous decision-making, and provision of opportunities for consent. We further suggest all of these practices could form the substance of therapeutic alliance. The goal of service use would need to shift to voluntariness. Service quality standards and professional guidelines would need to reflect directives aimed at taking responsibility for creating environments supportive of patient decision-making and voluntariness.

The paper concludes by arguing that the first step must be to recognize loss of patient autonomy under MHL as an ethical problem worthy of attention. Only then can the impact this may have on patients and providers alike be appreciated and faced and ethically grounded practices affirming patient autonomy, consent, and voluntariness be developed. In an age where national and state mental health policy directs services towards a recovery orientation, tensions between paternalism and patient autonomy need to be overted.

To read the full article, go to:

http://www.jopm.org/evidence/case-studies/2011/09/12/autonomy-in-jeopardy-contrasting-participatory-health-models-with-patient-decision-making-under-mental-health-law/

Cath Roper, Consumer Academic

VOICES, CONVERSATIONS & TRANSFORMATIONS

STOREY HALL, RMIT, MELBOURNE, 23RD & 24TH FEBRUARY 2012

This was the second annual conference organised by Voices Vic, the voice hearer's network at Prahran Mission. Finbar Hopkins was a member of the conference organising committee, involved in the months of planning and securing speakers leading up to the event. It is the only consumer run conference in Victoria aimed at an open audience, where voice hearers, consumers, clinicians, academics and support workers can come together to continue having important conversations about healing approaches in mental health.

About 350 people attended the conference over the two days. The conference attracted people from across the spectrum, voice hearers, carers, social workers, academics, counsellors, occupational therapists, nurses, doctors, community support workers, researchers, writers and art therapists.

It was heartening to see many mental health nurses at the conference. Interstate and international delegates attended. Keynotes speakers included guests from the UK, Eleanor Longden and Ron Coleman who talked about the correlation between voice hearing and trauma and Dr Lewis Mehi-Madrona from Vermont, US who talked about narrative medicine.

CATH'S HIGHLIGHTS

"Thorns in the spirit"

Eleanor Longden gave an horrific account of experiencing systematic childhood abuse, through to her eventual breakdown and involuntary hospitalisation where she was diagnosed with schizophrenia. Eleanor is now a psychologist with an interest in the relationship between voice hearing and trauma, reframing this as a dissociative rather than psychotic disorder. She drew a distinction between 'maintenance' as the clinical paradigm in mental health, and 'recovery' in which meaning and its discovery is central. The presentation was a tour de force on the need to take account of trauma in approaching voice hearing.

Dr Mehi-Madrona facilitated a guided meditation where participants were invited to engage in conversation with an inner voice – such as that 'inner critic' (the voice that's always telling you you're not good enough or you should/shouldn't have said/done that…). We then took turns in pairs to role play those voices in dialogue. Ron Coleman also facilitated a workshop in which voice hearers gathered in a circle and spoke about their experiences of voice hearing.

One highlight for me was Louisa Dent's presentation of her book: "The Little Girl That Nobody Wanted: A story about the origin of voices". Louisa used powerpoint slides of her story with text and drawings, reading it aloud. The story contained powerful ideas about belonging, being good, being rejected, rebelling, but told through the style of a children's folkloric story along the lines of a Grimm's tale. Louisa followed the reading with a fascinating analysis of some of the themes in the story.

FINBAR'S HIGHLIGHTS

Last year I had the privilege of being one of the conference organisers so it was an absolute pleasure to see it coming together in 2012 as a very successful and well attended event.

It was difficult to choose any particular presentation as a highlight because I viewed the whole conference was a theatre of ideas and amazing discoveries.

"Letting others hear you voice"

Judith Drake is a mental health trainer, writer and advocate from Melbourne. Judith spoke about the growing trend in mental health services for consumers with a lived experience of mental illness to share their stories of recovery. However, the implications of this for the consumer are rarely discussed. She discussed the benefits of disclosing to the community such as education and reduced stigma. She explored the reasons why people choose to share their personal story, the benefits and the potential risks involved, the different degrees of disclosure that can occur, how to limit disclosure if the person changes their mind and the value of humour. She also spoke about different ways in which stories can be shared. Judith's approach would be really useful to mental health clinicians who wish to work with personal stories.

"Hearing voices group"

Ron Coleman is a mental health trainer and hearing voice group facilitator. He is world-renowned for his innovative recovery-based practice, training and service designs in psychosis prevention and resolution. Ron spent 13 years in and out of the psychiatric hospital system in the UK. A fundamental part of Ron's approach is that there is great value in forming meaningful partnerships between the consumer and the mental health professional. Ron is currently director of Working to Recovery Limited and holds a seat on the board of Intervoice, the international hearing voices network.

Ron facilitated a hearing voices group in action. About ten members of the audience volunteered to participate in a hearing voices group in action. The remaining workshop attendees were observers. Ron was very skill full developing the trust of the group he also used a narrative approach to listen to the experience of voice hearers. Most of the group members had previous experience of working with voices approach and engaged very positively with his style. On completion of the group in action the workshop opened up for a general discussion and several of the audience members commented on the empowering nature of the workshop. Ron's approach is ideally suited to mental health professionals who are interested in recovery and voice hearing approaches.

Cath Roper, Consumer Academic, CPN

Finbar Hopkins, Lecturer, CPN

13th VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

Thurs 09 & Fri 10 August 2012

Moonee Valley Racecourse

As joint hosts the **Centre for Psychiatric Nursing, The Australian College of Mental Health Nurses (Vic Branch), The Health and Community Services Union** and the **Australian Nursing Federation** invite you to attend this exciting conference.

The aim of this conference is to focus on the practice of psychiatric nursing and how this practice contributes to better health outcomes for the consumers of services.

The registration form is available on the CPN website: **www.cpn.unimelb.edu.au**

If you require further information please contact **Greg Mutter** at the CPN:

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F: (03) 8344 7733

THEMES

- Psychiatric nursing across the life-span
- Rural issues
- Cultural and indigenous issues
- Dual diagnosis
- Dual disability
- Recovery
- Innovation in practice
- Sustainability of psychiatric nursing
- Consumer perspectives
- Carer perspectives
- Clinically-based research and evaluation

Earlybird registrations close: Friday 25 May 2012
All other registrations close: Friday 20 July 2012

Register today and don't miss out on this important event in the Mental Health calendar

The registration form is available on the CPN website: **www.cpn.unimelb.edu.au**

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