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representing progress & communication over distance

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INTERVIEW WITH MANDY DONLEY AND BRENT HAYWARD

OFFICE OF SENIOR PRACTITIONER IN DISABILITY SERVICES, DEPARTMENT OF HUMAN SERVICES

Finbar: *I would like to invite Mandy and Brent to introduce themselves, and tell us about their roles within the Office of the Senior Practitioner (the Office).*

Mandy: Hi I'm Mandy Donley, I've been a Psych nurse for about 30 years and I originally trained in the UK in the thousand bed Institution, and since 1998 I have been working in Australia, predominately in Forensic Psychiatry with Forensicare.

In 2007, with the introduction of the new Disability Act, I was asked to come and work at the Office of the Senior Practitioner in Disability Services.

Brent: Hi I am Brent Hayward, I have been practicing as a mental health nurse for a little over 10 years now. I was comprehensively trained and completed my postgraduate studies at Melbourne University.

I have worked in community and inpatient mental health and also at the Victorian Dual Disability Service and some sexual health services across Melbourne. I have been with the Office of the Senior Practitioner now for about 4 and a half years.

Mandy: And we are both credentialed mental health nurses.

Finbar: *Excellent. Can you both describe the background to your current roles?*

Mandy: At the moment I am the practice leader for integrated health care at the Office. I was originally employed to address the issue of chemical restraint within disability services, so the years with mental health services and peak bodies around projects that can look at reducing chemical restraints, mechanical restraint, seclusion or physical restraints throughout the whole of Victoria, has helped me in my role.

I also go out to disability services to do training and audit and to speak to people on the ground as well as divisional executive around how we systemically strategise around the reduction of restrictive interventions.

Finbar: *Can you tell me a bit more about the training and then the strategies for reduction?*

Mandy: What we usually find is that disability support workers have not had any training in medications. Since the mental health and disabilities Acts split in 1986 there have been reduced numbers of clinicians working in disability services because there has been the adoption of a social model where we usually find that the people who support people with disabilities have at the best a Certificate IV in Disability.

So I go out to services and talk about what the drugs are, what they are used for and why when they are prescribed for a person who doesn't have a diagnosis of mental illness that they are defined as chemical restraint. I let them know this is because they are actually used predominately to address behaviors and worldwide research shows that the use of chemical restraint is largely ineffective and doesn't address the behavior in any shape or form and we hope that people will access services within their communities such as behavior intervention.

However there are not a lot of behavior specialists and many are not trained clinicians, rather people who have experience in disability as compared to formal training as psychologists, nurses or speech pathologists.

I also work with peak bodies to look at things like mechanical restraint. What we will find is rather that devices like splints are not being used for a therapeutic purpose, they are being used to address self injurious behavior and because they are not monitored by clinicians they may cause physical injury to the person, for example atrophy. So there are lots of clinical issues, but there is a paucity of clinicians.

Finbar: *Yes indeed. Brent do you want to describe your role*

Brent: Yes but my focus is a bit different to Mandy's. Mine is more around practice improvement of supporting individual people with disabilities. Mandy's focuses a lot on chemical restraint , while I focus more broadly on supporting people with a disability in a more positive manner. Everything from what are contemporary approaches to supporting people with particular type of disability through to how do we accurately assess people's behavior and devise and implement a behavioral intervention as well.

Finbar: *Can I just ask you, when you say assess, what do you mean by assess?*

Brent: That's a good question. My work has to span both a clinical perspective and practice perspective, so it's using established frameworks for analysing people's support needs, for example positive behavior support and what people's skills are, what their weaknesses are. Then we can build their skills by using established standardised review tools. Then we use the results of those formal evaluations to inform their support needs.

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INTERVIEW WITH MANDY DONLEY AND BRENT HAYWARD

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Finbar: *So do you have to be a trained clinician, say a mental health nurse, to use those tools?*

Brent: Some of them yes, for example if you look at autism, you need to be trained to use autism assessments and I have done the training and been authorised to do those assessments.

Brent: Some of them are freely available in the public domain, but some clinicians don't know they exist or how to use them in their work, so if I am working with a clinician for example, it might be about showing them what options are available, where they get them from, how you use them and interpret them together.

Finbar: *So you will support nurses on an inpatient unit when there if there is a client with a disability and you will teach them how to use them.*

Brent: Yes I can do and we have done that.

Finbar: *But it's not a major component of your work, is it?*

Brent: It's not a major component, but just the nature of the Office and the work we do, the people we get involved with, the individual people with disabilities are those who experience crisis who can't receive a service, so by the nature of our work we see people at their worst sometimes and there are no mental health services actually involved.

Mandy: And we will usually with a complex case consult with the Office of the Chief Psychiatrist, so they will advise from a mental health point of view and we will advise from a disability point of view. We have lots of those cases so we work closely with the Chief Psychiatrist.

Finbar: *Right, and that's a different way of working, so you feel really supported in the role in terms of what you're doing.*

Mandy: Yes, and in the resultant case conferences where we usually have that interface with mental health nurses or mental health unit managers.

Brent: I think also one important thing that is unique with our roles is that we work across the entire age demographic, so 5 years plus. We're not just working with a CAMHS group, an adult group or an aged group, we are working with the entire spectrum of ages.

Finbar: *Just the two of you?*

Mandy: Three positions, we also have a psychologist part time and a speech pathologist part time in our team in the Office.

The Office of the Senior Practitioner, along with the Office of the Chief Psychiatrist, has a statutory role to monitor all restrictive interventions in Victoria. Whereas the Office of the Chief Psychiatrist only monitors mechanical and seclusion, we monitor mechanical, seclusion, chemical, physical and other restrictive interventions.

The core business of the Office is to protect the rights of people with disability who are subject to restrictive interventions and compulsory treatment. So a locked front door in a house, or a locked fridge or a locked bathroom we would be consider to be a restrictive intervention because we are guided by the Charter of Human Rights and Responsibilities Act 2006 & Convention on the Rights of Persons with Disabilities.

Finbar: *So there is a lot of ethical overlay to the work that you do? Can you tell me about some of those ethical issues you encounter?*

Mandy: We had a huge one recently, where a young man with significant disabilities was misdiagnosed and the Consultant wanted to withdraw life sustaining treatment because they considered his quality of life was so bad. This young man had remained relatively unchanged for the last 10 years and we needed to argue his case and his right to life. We challenged the diagnosis of successfully. We had to be very firm in argument around the diagnosis and support needs. Professionally this case was very challenging, but satisfying.

Finbar: *Well that is fairly sobering.*

Brent: Yes, its one of those cases that will probably stay with you for the rest of your career, well, it is for me. It also shows the nature our work can be very autonomous. We don't have medical support when it comes to backing up our opinions.

We have our peers on our team but you have to be confident in what you do, you have to be evidence based in your approaches and you have to be able to show that you can collaborate, appropriately challenge and follow through on things to ensure that there is an appropriate outcome, a positive outcome for a person.

Finbar: For mental health nurses who are working as case managers, or in inpatient setting, in what ways you work with them to enhance their practice around disability?

Mandy: I think their great difficulty is usually communication. If the person doesn't use speech to communicate, mental health nurses usually don't have the confidence or have had any training in key word signing or the use of augmented communication.

Engaging speech pathologists would be a huge advantage, engaging occupational therapists around sensory issues, because that's where we find a lot of the behaviour stems from as well. A greater understanding of both communication and sensory issues is important, that's certainly been the big learning curve for me coming into the Office from forensic psychiatry.

It's a world that I hadn't been in since I trained in my institutional days and it provides an excellent framework to move forward. It demystifies what the issues are and it shows people a way forward.

Also engaging the multidisciplinary team including OT's and Speech Pathologists can provide significant learning for mental health nurses.

But also as mental health nurses we are not used to the words 'chemical restraint', we would use the word PRN and we would use it at our discretion. Chemical restraint is really something mental health nurses need to read up about and be realistic about its use within Victoria today.

We have over 2,000 people registered on our database and that's only the people who are in disability services. That doesn't include the children who are at home on Risperidone, Catapres, Phenergan and Olanzapine for example who are being chemically restrained on a daily basis, because the families have no alternative or no support with the behavior of their children. And there are alternatives out there, but people just aren't aware of them.

Finbar: *So you see a role for mental health nurses in becoming advocates and also educating themselves?*

Mandy: Definitely because I know even as a mental health nurse and working in forensic psychiatry, if somebody with a dual disability came to our door it would be "Oh they go next door they are not our business".

Brent: I think that along those lines, mental health nurses in particular, don't have the knowledge about the service system in Victoria.

There is an assumption that people with disabilities live in supported accommodation, supported by nurses and trained clinical staff and that people with disabilities don't exist in mental health services, or that there are specialty health services for people with disabilities.

But specialty health services for people with disabilities don't exist in Victoria either.

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BOOK REVIEW:
THE WHITE COCKATOO

The White Cockatoo; Diane Brown (2012) Poseidon Books: Burleigh Queensland

The White Cockatoo is a compelling account of the four years after a suicide, from the perspective of a mother whose adult son died.

The author notes that it was written as part of a healing process, and also to show others in such distress that there can be a future beyond the deepest grief.

There is a distinctive Australian flavor to the reminiscences of family life from the 1970s to 2000s, including moves from regional and metropolitan settings and the rights-of-passage travels of young adults in the family.

In contemporary service models we recognise the value of first person experience and recovery stories from all perspectives to enrich understanding both of workers and the people we support.

Written as a letter to her son, this heartfelt account does not gloss over deep despair, complex emotions and enduring fallout of suicide for many people.

Readers will be rewarded with useful insights.

By Dr Brigid Hamilton
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There are two consulting services, but there are no specialty health services for people with disabilities.

So there is a view within mental health nursing that people with disabilities shouldn't access their mental health service, but should go to a specialist disability service, but specialist disability services don't exist in Victoria.

Finbar: *Yes I see. That compartmentalised thinking has been a challenge for you two as clinicians and advocates.*

Brent: Yes

Mandy: Yes

Finbar: *Do you do much work with families?*

Mandy: Certainly on a case by case basis and we encourage disability services to always include the family when it comes to decision making and looking at alternatives.

We always have a case conference including the family, if we send an email we include the family in the email.

Brent has been out and done education sessions for parents at special schools.

We just look at every avenue, every gap we see we try and fill, but we are limited in what we can provide.

This is why a lot of my time is spent looking at strategic projects because we want to capacity build and that's what we want to do with mental health.

Finbar: *Thank you. As we are coming to the end of our interview, what kind of message would you like to give to mental health nurses in order to advance the current issues and difficulties you are having in the role that you are working in?*

Mandy: If people don't have any experience in working with people with disabilities, please call us or call the Victorian Dual Disability Service and access training. That's what we would love people to do, start the conversation.

Brent: I would like to take it back to the broader issues around human rights. I think you can apply human rights to every scenario that you could possibly face. We are talking about a very vulnerable group of people here who often have no one advocating for them, or who are put in situations where people are not necessarily looking after their best interests.

Nurses have an obligation there to be looking at the persons whole support needs, what rights they have to access services, what type of services are they receiving and how a service is being provided to them.

And as Mandy has mentioned before "why would we do something to someone with a disability when we would not do it to someone without a disability"? Let's think about that.

Mandy: And as I used to say to the office of the Chief Psychiatrist "people with a disability are entitled to the same over-stretched over -worked mental health service that the rest of us are".

Finbar: *Mandy and Brent thank you for giving us your time and sharing your views with us.*

INTERVIEW WITH HELEN GLOVER – RECOVERY ORIENTATED SERVICE CONSULTANT

PART 2 – CONTINUED FROM LAST ISSUE

Finbar: *I am going to move on and ask you what a recovery learning circle is.*

Helen: This is hard to explain. If I could describe it as a space where you would have 8 – 10 people come together to use that circle and use the support of the group, being prepared to put their thoughts, ideas, challenges in, ask for help, and think through their practice. It's probably a reflective space but with a bit more structure. The mentor provides a focus or an exercise or a conversation piece they want to have dialogue around, but at the same time not to set themselves up as the tutor or the "I've got the answers. So it's a much flatter hierarchy and it's really the mentor's role to create the invitation to the conversation, maybe ask provocative questions, maybe push and invite a different way.

It's hard to explain, but it's a space that is not supervision, not about accounting for your practice. Someone might say they are really struggling to support service change and wondering has any one has any ideas to help me. Or it might be about this article has really challenged me and I wonder whether we all can read it and discuss it next time. It's about how we learn together opposed to individual as if you are in a tutorial group.

Finbar: *Sounds like an action learning set. Where an individual brings a problem and then the other people in the group come to tease it out and unpack it.*

Helen: Yes, but it may not be a problem, but it also could be that the stimulus for the discussion may come from the mental health service setting, an exercise or a question or something like that. As they get into their project work more the conversations shift around that. Once they design their projects the coming together won't be so much about the individual kind of journey and learning, but the collective learning.

Finbar: *What have you learned from the approach, from using it yourself?*

Helen: (Laughs) That it's easier for me to run a learning circle face to face rather than over the web. That's hard.

I call this space the mud space and it's a space that is not about, as a mentor or leader, trying to get people out of their discomfort and comfortable. I am looking at all the ROMP projects I have done and all the learning circles I do, and I actually find people will take themselves to that challenge or difficulty and they get stuck in the mud. It's not about pulling them out of the mud; it's actually helping them explore that and over time; they hate it, they fight, they kick, they get themselves out of it. As a leader or as a mentor it's important for me to be comfortable to hold a difficult space. As an educator you would probably appreciate that.

I might ask a question such as "I notice that you are struggling with this issue at the moment. What are you noticing? What's coming to you from that struggle, what's the learning that you're getting, otherwise you wouldn't be there. Is there a learning here that you think is important to focus on at the moment?

Finbar: *So the struggle is the work?*

Helen: The struggle is the work; but also it's the mud space where it happens. So we don't learn when we are comfortable. I have become attracted to two sorts of approaches. The transformational leaning theory which talks about create the space, create the opportunity for people to struggle, it's no good working outside the resistance point.

That's why I don't have a set training program that I repeatedly roll out for every group. If I facilitate a group I try to come in as a tool and work with their agenda and any resistance that they may have. If I can find that resistance and hold that space for long enough and not get scared from that space then something happens.

I have had people fight what is being presented around the concepts of supporting people in their efforts of overcoming and go "this is crap, this is wrong… rah rah rah"– you just gently hold it and you will notice over time that they will reposition themselves around that.

Going back a few years there was this ADON in a hospital who only told me the story a few years later who came to the first training very prepared. He had done the pre reading and he was on this and yep, yep, yep and he said the 1st day of training, everything he stood for in his 30 years of being a nurse, I was challenging him. He was getting more and more angry, and apparently at home that night his wife asked how his day was and he responded "don't talk to me, I have to go back to her tomorrow". He said he drank a bottle of red wine and went to bed and he woke up in the morning and he said everything had changed. He realized something had shifted.

It's around getting at the heart level, so there are two types of learning, experience far and experience near. Experience near learning, it transforms it within us as who we are, that we can't unlearn that, no one can take that away from us, it's not about forgetting it, it's about I have fundamentally shifted something. So this space, this learning space, is different from a knowledge space for me. It's about how do I invite people into the discomfort to consider what are they prepared to give up.

My biggest learning is as a leader, as a facilitator; don't be scared of that space, because that's the only space I have ever seen experience near learning happen within.

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Finbar: *How do you think the staff has responded to the change?*

Helen: I don't really know. I only speak to the mentors that I get to work with. I have seen their shift. Their ability to pick up on what's getting in the way is quicker and that's what I said to them the last time we met. They are able to name stuff quicker; they're not fighting it as much. Their recognising some stuff some time before I recognise it. So that's useful.

Last time they started to share some of their project ideas and my feed back to them, when we went around the table was, every single project design was about shifting themselves as services and service providers and not trying to shift the person.

And that would be the first group of leaders that I have not had to come back, and gently remind them this is not about changing people.

They are really strange indicators, but for me it told me they got this, their getting this. This is not about 'OK, how we make Billy, Freddie, Mary better?" There has been a shift.

Finbar: *How have psychiatrists responded?*

Helen: (Laughs) In Barwon Health or overall?

Finbar: *Maybe you can speak to both.*

Helen: Well in Barwon Health I had asked Dr Kalyanasundaram from Queensland to join me in delivering a workshop to the psychiatrists. Some of them were receptive to what we had to say but like all professional groups they struggle to think what this asks of them to consider differently. I think the concept they are still stuck with is that recovery equals clinical recovery, rather than going beyond that to extend the invitation to people so that their mastery and self management and self direction and other things come as outcomes as well. This is where this word" recovery" is just not useful for us in any shape or form.

Since then we have had a second lot of training and registrars and other psychiatrists that came who weren't in the initial day of training. They were fantastic. If anything they were the major promoters of this and could see ways this could work or could see ways they could change their practice. Now I have not had many follow up conversations with the psychiatrists so I am not sure.

But one of the things I appreciate is that around the world, if you look at the people that are promoting recovery based practice and championing, writing about it and researching it, they are psychiatrists. Outside people with the lived experience which is your major group, the next group out of your professional groups, I would be saying are psychiatrists.

Finbar: *You mean internationally.*

Helen: Yes internationally, not Australia. People like Glen Roberts, Roberta Mazzini, Michaela Ammering , John Strauss, Richard Warner and I probably only know a handful compared to those out there. There are many people in psychiatry. Internationally I think they get the concept this is not about what we do to people it's about how we work with people.

Finbar: *Is that push coming from the USA?*

Helen: USA and UK. So the UK has the first professional body of the Royal College of Psychiatrists to put out a position paper around recovery.

And it's a strong paper. I think what you had in the UK and USA is that in The AMA and the Royal College you have has some strong leaders who have come out with their own experience of overcoming. They can be a psychiatrist and have had a lived experience and so the two aren't either or. I am yet to see in anyone Australia hold that space, in a public space, and come out and say, yes I have been diagnosed with a serious mental illness and I also happen to be a psychiatrist.

People like Dan Fisher for example, from the USA. He's a Professor of Psychiatry diagnosed with schizophrenia. He influenced strongly *The President's New Freedom Commission on Mental Health: Transforming the Vision the Freedom Report*[1], around changing the mental health system. There are lots of people there now that are drawing upon their own experiences to inform their practice and vice versa.

I think we are still struggling a little bit around that. A lot of my friend or colleagues are professionals without a lived experience; I feel like I have to defend them when I people say in workshops "Oh yeah but the psychiatrists, they are the ones that need to make the difference here." Probably that's not what you expect to hear from me.

Finbar: *No, we need to hear it all. We need to dispel some of the myths that are out there.*

Helen: I have a friend, a colleague, psychiatrist Professor Michaela Amering, who I first met while she worked in the UK but she now works in Vienna. She asked me to write the forward for the textbook around recovery. It got the prize for medical textbooks two years ago. She is a person that I have so much respect for because she will say to me "Helen, I don't have lived experience of mental illness, but in order for me to be effective with my patients, I need to immerse myself in relationships that can teach me what this is about. My teachers are people like you".

You'll have bad apples out there in any professional group and you will have people there that want to manage people and be power over. But that's different from their profession and I think that's what we need to separate out. Show me a profession that says I must you control you, I must manage you. That's our interpretation of it.

Finbar: *What have you learned from this work?*

Helen: I think it's never finished. I'm talking about the knowledge base, if I go back to thinking what I used to understand by this concept I feel like" Oh my god how embarrassing". I used to think it was this…. So I think the knowledge base is constantly changing, constantly emerging, and part of my contribution to it is never to rest on its truth, never to think we understand this beast called 'recovery'.

To keep thinking about what else can you do to help organizations, services, workers, people with lived experience, family members understanding the possibilities of living a good life despite having a mental illness.

And I think that will be an ongoing quest for me, but I also think an ongoing quest for everyone in this movement, about keeping questioning, keep thinking.

So one of the things it's taught me is "what's the next question to ask". How do we do that?

I think the other thing for me is I have learnt training is such a small part of this process.

And if I go back on my 20 years of doing this is to take an Appreciate Inquiry approach to our service transformation and not just to the people who come to services for assistance. If we work with workers as if they can't do this, if we work with systems as if they can't do this, that's what we will prove. But if we look for where they are already upholding good work around recovery oriented practice, and they will be doing it, we can shine a light on those areas and those practices that bring out what's already there, then that grows. What we focus on gets bigger.

So my biggest shift is about, if I go back I am probably guilty as charged, at bashing services and giving the impression you're not really doing this. I feel shameful around some of that. I think now it's about how do we shine the light on existing good practice. And it's everywhere; if we look for it it's there. You will find really good recovery orientated practice or practices that supports recovery orientation. The question is how do we help t is to row and spread.

I have started shifting some of my conversation to that: "Tell me a story as a worker where you felt you have been able to hold the space for another person who is in distress that has helped them reclaim their life." This question brings so much energy, ideas and recognition of their practice, and how do we take that intention and build upon it?

Finbar: *It sounds kind of solution focused.*

Helen: I would not call it solution focused, because it's not a problem to be fixed. It's kind of working with an organisation as if it is designed to work well. Rather than this is an organisation that's broken, that needs fixing, this is an organisation that's designed to work well, let's highlight where it is working around recovery orientation before we go and slap it down and say "no, you are not doing this you are not doing that" etc.

So if I was invited to review of an organisation, the first question I would ask is "let's find lots of examples of what we are looking for already is in existence". And then let's find areas to strengthen to support this. Instead of going "no that's wrong, you're not doing that" etc.

For me that's been a big shift.

Finbar: *Do you have a vision of what a recovery oriented service would look like?*

Helen: It would be a reflective service; it would be one that was questioning. It would be one that would constantly be thinking about its position it's adopted in someone's life. Whether that will be organisational or workers, it will be constantly questioning if the service has taken up too much space, have we not taken enough space, have we gotten in the way.

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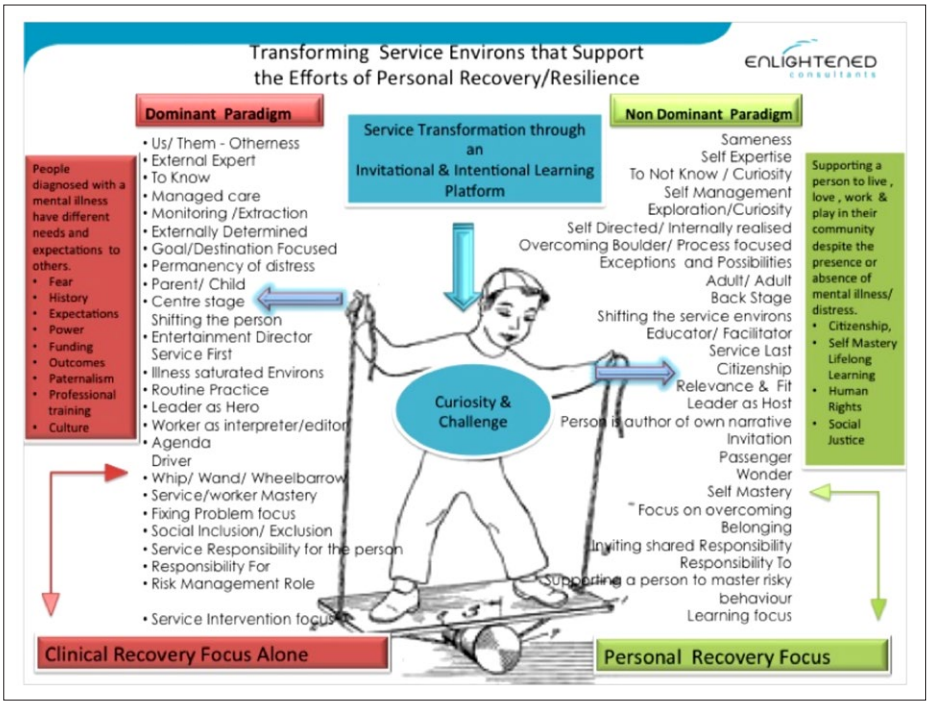


I have a diagram that shows this. (see above)

So this is a service when I think about it is about the tensions we hold. If I explain this, the dominant paradigm is the one that is driven by our fear, our history, our expectations, our power, our funding, our outcomes, professional training, sense of paternalism and our culture.

These are the sorts of the practices we would see in a service that was just purely focusing on "our job is to get you from point A to point B "and kind of not interested in the process so much but much more on the outcome.

The non-dominant paradigm is driven by knowledge bases that want to support citizenship, self mastery, lifelong learning, human rights social justice and self determination.

It is non-dominant, but it's natural. It's the one in all our lives that we live in. This is what brings out the best in us.

But something happens. And this is the bit I would love to understand more, and if I ever was masochistic enough to do a PhD, it would be something around this.

If, as workers, we live in the green space ourselves. What invites us when we go to work into a system to take on the red space? Because our systems have built and created structures that have invited workers to work out of that red space. So I explain to workers who are thinking about a transformational shift, that because the red side is dominant, and it comes from a created structure outside of us, as individual workers we would actually get pulled to the left. Our structures will support that. A good recovery orientated service will recognise that that's the natural tendency, but will have developed protocols and procedures to resist practices falling back to the dominant side.

So it's not above creating the non-dominant side (right), because that naturally occurs. It's about resisting the pull to the dominant side (red space). This is all dichotomy work. We have set up service systems around creating parent / child relationships with people coming in for help, whatever the age they are. In a recovery orientated space we would hold an adult to adult relationship.

And so we have got to be aware of all of our practices, our processes, policies and our tendencies to go back into parent-child relationships and structures and how we resist this to stay with an adult/adult focus to our work.

For example down at the bottom instead of seeing our role to risk manage (the second item in the left column) we could so easily do that we are so easily doing that in services. Our job is to resist just falling into that, and goes beyond it; to stretch it to how do we support a person to master risky behavior. And those two positions are very different to each other.

One of my irks is when an organisation says "oh yes we do recovery". That statement alone tells me that they don't. Because they not aware because these tensions, regardless of how focused, how committed we are to recovery orientation, we will get zapped back into that dominant red space.

So if I heard an organisation say that we are an organisation that are aware of the tensions of getting in the way of people's lives and are constantly reflecting and negotiating that, then that would tell me your on, you have got it. That would be a strong indicator of recovery orientated practice.

Another big shift for me is moving from a service intervention focus to a learning platform. I have learnt this from some of the European services. A recovery oriented service framework would be about learning, because my personal recovery is about making learning, so how do we create an environment, that through my participation I go, yeah I can do this, I've learnt, it's my agency, thank you very much but I am the protagonist of my life. That would be an outcome rather than, "thank you very much you did it for me and I couldn't have survived without you." This statement tells me that a service has positioned them in the dominant side (red zone), because they haven't created that opportunity or invitation for someone to recognize their own ability to self right.

This diagram is a piece of work that is still getting shaped. Workers like it. I use it as a supervision tool and they say things like "I just got zapped across there". And that's nothing to be ashamed of; it's only if we don't recognise it, that we should worry. It's dynamic.

I think Australia still has a long way to go, because we are still seeing it as a static thing that we can access whether a service is recovery orientated or not. And we are not even assessing it on the right things. We are assessing it on how well people are as opposed to how does it create environments around negotiating these tensions.

Finbar: *If you were to have any information for others working with this approach, how could they contact others working in this area?*

Helen: Australia or internationally

Finbar: *Both*

Helen: A colleague of mine, Dr Anne Markwick from the UK has just finished her PhD on transforming recovery orientated environments. She was the Operations Director for Hertfordshire Partnership Foundation Trust and her whole PhD was about how you bring an organisation to a recovery orientation. Probably her greatest learning has been in how not to do it rather than how to do it.

I recommend organisations that would be interested in the whole shift stuff to talk to Anne

In Australia I think its knowledge outside of mental health sector that we need.

Some of the organisation change and development thinking from other areas I think helps.

I use people like Andrew Wu out of Sydney. He is an organisational consultant, but he has done a lot of work around the service culture and service environments.

That's a good question and I am trying to think of who I know even that is doing this kind of work.

There a couple of international people who come here like Ron Coleman, Rufus May, Arana Pearson, Mary O'Hagan, but in terms of visiting a regular basis there aren't many.

There are some smaller NGO's that are trying to think through service structures for their staff and how to do they hold that space.

There is Centacare in Cairns is doing some work through their Mental Health Resource Service.

There's the Benevolent Society in NSW & Queensland who have done a project similar to Barwon Health.

There is Anglicare Tasmania, which is trying to do it as a "whole of" organisation, even across non mental health areas like disability, housing drug and alcohol, youth & protection.

Finbar: *The final question is do you have any take away messages for clinicians interested?*

Helen: That it's "ongoing".

There is a selling point around this.

If you ask yourself why would clinicians want to do this, why would they want to work different?

Concluded over page >

It's not like they are going to get more pay. And what I hear back from clinician when they get this is it's "lighter"; it's a constant word they say "I feel lighter", and that it bring them more energy and creativity to work.

If we as clinicians feel heavy and constantly feel that "I can't do this" and that "I am holding this big boulder of all my clients" then it's probably time we need do some recovery work about letting go and repositioning ourselves.

There is something in it for clinicians.

As to the why I think it doesn't come in a model. And so many people will want to promote a model. Here, come and do these two days and you can ….!!!!

It's a commitment to letting go of learnt practices that no longer serve us and then adopting practices that do serve us.

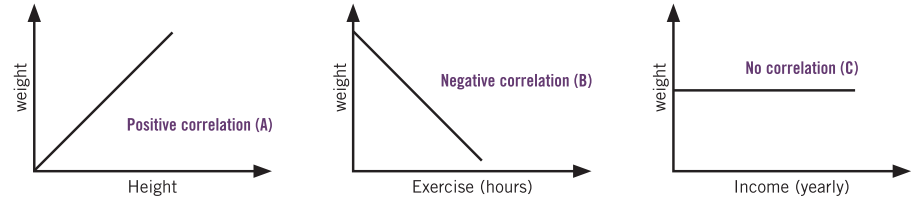
Finbar: *It's been a real privilege to talk to you, can you send us your contact details? If any Victorian services and clinicians are interested in working with you, we would be happy to pass your details onto them.*

Helen: That would be great thank you.

STATISTICS IN NURSING RESEARCH: CORRELATION

Correlation is a statistical technique used to measure the relationship between two or more variables. The existence of an association between two variables can be illustrated graphically on a scatterplot. Figure 1 (A) suggests a positive linear relationship between height and weight; where when height increases, weight also increases. Figure 1 (B) suggests a negative linear relationship between hours spent exercising and weight gained in a month; where when the number of hours spent exercising increases, weight gain decreases. Figure 1 (C) shows no relationship between weight and yearly income.

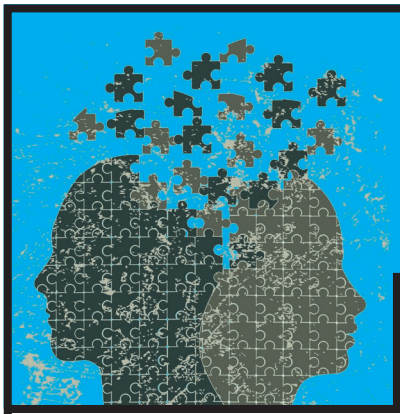
Figure 1: Scatter Plots



Correlation is measured by the use of a Correlation Coefficient. Correlation coefficient can vary between -1.00 and + 1.00 and provides an indication of the magnitude and the direction of the relationship. A correlation coefficient of +1.00 indicates a positive linear relationship between the variables; -1.00 indicates a negative linear relationship, and a correlation coefficient of zero indicates no relationship between the variables. A negative correlation coefficient indicates a negative relationship and a positive correlation coefficient indicates a positive relationship.

Different approaches are used to examine relationships between variables based on the different types of variables. The most commonly used correlation coefficient is the Pearson product-moment correlation coefficient. This is used to measure correlation between interval and ratio variables. Spearman's rank-order correlation is another common test statistic used to examine association between ordinal variables. Pearson's Chi-square with Phi coefficient or Cramer's V can be used when examining relationships between nominal variables. Correlational analysis is a statistical technique used to measure whether a relationship exists between variables. However, correlational analysis cannot be used to infer causality.

Roshani Prematunga
Researcher, Centre for Psychiatric Nursing



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