



## Guest Editorial

### Recovery in New Zealand: Lessons for Australia?

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#### Keywords

*mental health, recovery, recovery process, service users*

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Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach. I was one of a small team of service users who wrote the recovery content in the Mental Health Commission's (1998) *Blueprint for Mental Health Services in New Zealand*. It was the first time 'recovery' had been mentioned in a central government agency document.

There is now wide acceptance of 'recovery' in New Zealand's mental health sector, but we have a long way to go to ensure that professionals understand recovery and that the mental health system is recovery oriented.

People in New Zealand had been talking about recovery for some years before *The Blueprint* and there was a lot of support for the concept. But we knew some service users didn't like the word. 'Recovery takes you back to where you were, but my experience transformed me.' 'I'll always have mental health problems so I'll never recover.' 'I don't believe I had an illness but recovery implies I did have one.' 'I don't see my madness as undesirable, so what is it I need to recover from?' 'To recover means to cover up again, but I don't want to cover up my distress.' We also knew that some professionals regarded 'recovery' as 'esoteric nonsense', as 'hard to grasp' and as lacking an 'evidence base'.

Some people, especially service users, had other concerns about recovery that went deeper than semantics or uninformed criticism: first, that

recovery is an import from America; second, that the Americans, in emphasising recovery as an individual process, have seemed to overlook that it is a social process as well; and third, that recovery in America evolved out of psychiatric rehabilitation and was perhaps driven more by professionals than by service users.

Despite these problems we went with the term 'recovery'. But we were determined to redefine recovery for the New Zealand context and to pass ownership of it to service users.

*The Blueprint* loosely defines recovery as 'living well in the presence or absence of one's mental illness'. It mentions the importance of hope and personal and social responsibility. It states that families, communities and people with mental health problems themselves need to be as actively involved in recovery as mental health services. The Blueprint also asserts that discrimination is the biggest barrier to recovery. Although the Blueprint reflects our early thinking about recovery, it shows some differences in emphasis to much of the mostly American recovery literature around at the time.

The American literature from the 1980s and 90s was strong on the individual process of recovery, especially the view that people with ongoing mental health problems have reason for hope and that recovery is the service user's own unique, self-determined journey. But it was the gaps in the American recovery literature that struck us most, from our perspectives as both New

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Zealanders and as service users. New Zealand is one of the few western countries that has seriously attempted to right the wrongs of white colonialism. The recovery literature was very monocultural and we needed to acknowledge cultural diversity and a connection to one's own culture as a key to recovery. Coming from the most individualistic country in the world, the American literature focused mainly on the individual's process rather than the social, economic and political processes that also enable recovery. Again, we wanted to emphasise citizenship and the breaking down of stigma and discrimination as central to recovery. An emphasis on social as well as personal responsibility for recovery may not sit easily with American libertarianism but it does fit New Zealand's traditions of egalitarianism and collective responsibility.

Much of the American recovery literature accepted, at least implicitly, the biomedical model of 'mental illness'. It did not place a great deal of emphasis on challenging the veracity or the dominance of the biomedical model in mental health services. We wanted the recovery approach in New Zealand to signal that there are many ways of understanding and responding to mental health problems and that no one way should dominate at the expense of others.

We also found that the recovery literature did not necessarily reflect all the values of the user/survivor movement. Yet we believed that user/survivor movement values should drive recovery more strongly than any other movement, such as psychiatric rehabilitation. Indeed, we have described recovery as the approach that service users have been asking for all along. So we put the spotlight on human rights, advocacy and on service user partnerships with professionals at all levels and phases of service planning, delivery and evaluation.

So, we added quite a lot of content to the recovery 'container' that we'd inherited from America. We were confident that New Zealanders would as a result come to associate the label 'recovery' with the fuller 'container'. Some service users in New Zealand still don't like the word 'recovery' but I have not heard one of them object to the way we have defined and interpreted it.

*The Blueprint* was light on detail, so the Mental Health Commission has continued to define recovery and to interpret what it might look like in the world of practice and experience. Our first major publication after the Blueprint was *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2002a). These competencies fall into ten major categories that are elaborated in the text.

A competent mental health worker understands recovery principles and experiences, supports service users' personal resourcefulness, accommodates diverse views on mental health issues, has self-awareness and respectful communication skills, protects service users' rights, understands discrimination and how to reduce it, can work with diverse cultures, understands and supports the user/survivor movement, and understands and supports family perspectives.

The recovery competencies have been promoted to people who set the curricula in mental health education, but the document has also been used by services for quality improvement, job descriptions and performance appraisal. Later the Commission produced *Mental Health Recovery Competencies Teaching Resource Kit* (Mental Health Commission, 2002b), a starter kit of recovery articles and teaching aids for educators.

The Commission has also published a research report, *Kia Mauri Tau!* (Lapsley, Nikora & Black, 2002) which provides a thematic analysis of 20 Maori and 20 non-Maori people's narratives of recovery from disabling mental health problems. One of the interviewees led and wrote up the research. This research is unprecedented in New Zealand: it focuses on recovery rather than just illness or distress; it is a bicultural partnership between Maori and people of European descent; and it takes people with experience of mental health problems at their word. The research described people's journeys through mental illness and recovery. Mental illness shattered lives, and so recovery involved not just overcoming symptoms, but also developing personal resourcefulness and receiving support from others. Recovery processes were similar across cultures, but some contributors to recovery were identified that were uniquely Maori. After recovery, people had

changed profoundly, knowing and liking themselves better, empathising with others, and appreciating the important things in life.

Although recovery is widely accepted as a concept by people in the mental health sector in New Zealand, the Commission still has a long way to go to ensure that recovery as we have defined it becomes embedded in mental health services. So far, we've highlighted how individuals can contribute to recovery – both mental health workers and service users themselves. Now we are starting a project to define the features of service systems that support recovery.

Australia has not gone as far down the recovery track as New Zealand has, though Australians appear to be showing an increasing interest in recovery. If the New Zealand experience is anything to go by, there is still time for Australians to adapt recovery for their own circumstances, and most importantly, to ensure that a recovery approach in Australian mental health services is led by service users.

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All these publications can be downloaded from [www.mhc.govt.nz](http://www.mhc.govt.nz) or a paper version can be ordered free of charge from [info@mhc.govt.nz](mailto:info@mhc.govt.nz)

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## Guest Editorial

### Recovery in Australia: Slowly but surely

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#### Keywords

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“Australia has not gone as far down the recovery track as New Zealand has, though Australians appear to be showing an increasing interest in recovery” according to Mary O’Hagan in her preceding guest editorial (O’Hagan, 2004). While Australia may not be as far down the recovery track, we have certainly been undergoing significant and progressive change in mental health service delivery over the past decade and recovery is clearly on the agenda.

Recovery is a major principle of the *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003), where it is stated that “A recovery orientation should drive service delivery”. Recovery is, therefore, a foundation of current mental health policy. Furthermore, while recovery was not a term that was used in the First or Second Mental Health Plans, its intent was evident in the emphasis on mental health promotion within the Second Plan. Mental health promotion is “action to maximise mental health and well-being among both populations and individuals” (Australian Health Ministers, 1998).

*The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (Commonwealth Department of Health and Aged Care, 2000), which was an outcome of the Second Plan, elaborated on this approach and emphasised that mental health promotion applied regardless of mental health status. Mental health promotion is equally relevant across all levels of the spectrum of interventions for mental health and was particularly important in order to maximise the well-being of people with mental illness. Although it applies a different paradigm

and terminology, mental health promotion for people with mental illness incorporates the process of adopting a recovery orientation within mental health services.

Recovery is defined in *the National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003) as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability” (p.11). This definition is taken from William Anthony, who has made a major contribution to incorporating a recovery orientation within psychiatric rehabilitation in Boston in the United States. Our understanding of recovery has, therefore, been derived from the American recovery literature, but is also strongly influenced by innovative work in Canada, New Zealand and also here in Australia.

Like New Zealand, the term 'recovery' is not universally accepted in Australia. It is a term that can be especially contentious for people who have experienced mental illness for long periods of time. “How can I be expected to recover now, I’ve been sick for 35 years, and now you expect me to recover”. Unfortunately, the word ‘recover’ implies, in everyday useage, full recovery to a state of wellness. While this is not part of its definition in the recovery literature, recovery nevertheless has this association for many people, especially people who are not familiar with the literature. It will be an ongoing

challenge to implement a recovery approach while ensuring that people recognise that this does not necessarily mean becoming completely symptom free (although this is an achievable goal for many), but rather that recovery means maximising well-being, empowerment, opportunities and meaning in the lives of people with mental illness.

All Australian states and territories have initiatives underway related to recovery, although there is considerable variation evident in the level of knowledge, commitment and implementation. Service providers in some areas have barely heard of recovery, while others are far down the track, adapting the concept of recovery to local needs and developing and implementing a recovery orientation within their service frameworks. The following provides an example of initiatives that are occurring in each of the states and territories:

- NSW has developed a policy document entitled *Framework for rehabilitation for mental health*, which identifies wellness as the focus for psychiatric rehabilitation, and which is in turn linked to consumer participation, empowerment and ownership of the process.
- In Victoria, the peak body for psychiatric disability rehabilitation, Vicserv, has developed a policy paper, *Finding our place: Rehabilitation and support in the spectrum of mental health interventions*. Vicserv is also hosting a conference focused on recovery in April in Melbourne (see [www.conference.vicserv.org.au/](http://www.conference.vicserv.org.au/)).
- Queensland has developed a paper entitled *Recovery - A guide for the future*, which discusses in detail the complex concept of recovery.
- Western Australia has undertaken comprehensive state-wide consultations to develop a *Psychiatric rehabilitation policy and strategic framework*.
- Pilot programs are underway in South Australia to test different rehabilitation and recovery models for diverse target groups.
- Tasmania has recently completed a mapping process to identify the current status of rehabilitation and recovery practices in the state.

- The ACT is trialling a collaborative therapy approach within adult mental health services and funding an external evaluation of this approach.
- The Northern Territory is developing a better understanding of current strategies in psychoeducation for clients and carers and the use of care plans, particularly for remote service providers. The Mental Health Association of Central Australia is implementing a pilot program of a recovery oriented model for consumers in Alice Springs.

These are but a few of the many recovery-related initiatives taking place across the country. Perspectives on recovery are also the focus of a conference jointly auspiced by the Australian Mental Health Consumer Network and the New Zealand Consumer Network to be held in August in Brisbane (see [www.amhcn.com.au/](http://www.amhcn.com.au/)).

Despite these many and varied initiatives taking place across the states and territories and the national policy emphasis on recovery, this orientation has not been widely adopted and implemented. There is a long way to go before a recovery orientation is standard practice for mental health services and there remain significant barriers to changes in service orientation. Many of these barriers were documented in the *Evaluation of the Second National Mental Health Plan* (Commonwealth Department of Health and Aged Care, 2003) and the Mental Health Council of Australia's major report, *Out of Hospital, Out of Mind!* (Groom Hickie & Davenport, 2003). These reports identified continuing problems in implementing several areas of mental health policy, but particularly problems with service reorientation. Consumers are still often unable to access mental health care as and when they need. Service availability does not meet population needs in many places, particularly in rural and remote areas and for some demographic groups (such as older people). The social and emotional well-being of Aboriginal peoples and Torres Strait Islanders remains a source of national shame.

Special emphasis in these reports was given to the attitudes of service providers, which were identified as a major and continuing concern that was impeding mental health service reform and

perpetuating stigma for people with mental illness. A change in attitude among service providers is fundamental to working within a recovery orientation. Many service providers, particularly of clinical services, still hold outdated beliefs that a diagnosis of mental illness is a life sentence to an incurable condition that invariably will have only negative consequences for a person's life course. This view of mental illness needs to be eliminated, and instead, an atmosphere of hope and a belief in human potential and growth must pervade mental health service delivery. Implementing a recovery orientation requires an attitude shift for many service providers in order to support consumer rights and provide the types of services that maximise well-being for people with mental illness.

Workforce training and development is fundamental to the roll-out of a recovery orientation. All sectors of the mental health workforce need to be trained to enable them to operate within a framework that supports the empowerment of consumers and personal capacity building. Also required is better understanding of the factors that impact on recovery, rehabilitation and relapse, along with coordinated provision of the support services that are essential to recovery. Equitable access to and better coordination of support services must be achieved, particularly for accommodation, disability, and employment services.

In summary, at a national level, Australia has explicitly adopted recovery as a basic principle for mental health services. Change can be frustratingly slow, however, especially for people – consumers and their families and carers, as well as many service providers – who are currently involved in the mental health system. These people need an effective and mental health promoting service response *now*. Nevertheless, if we look back at the mental health system as it was just over 10 years ago, at the commencement of the *National Mental Health Strategy*, we can see that major and significant changes have been achieved. There has been a total shift in orientation and attitude from locking up and stigmatising people with mental illness toward recognising their rights and enabling their integration within communities.

There is still a long way to go, change is slow, and the barriers can at times be considerable, but Australia is slowly but surely moving toward a mental health service system that empowers and promotes the well-being of people with mental illness – adopting and adapting a recovery orientation to Australia's unique needs. However, it needs to be said that an adequate resource base for mental health, commensurate with its health burden, would considerably hasten this process; commitment at the policy level has not been supported by mental health funding.

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## Guest Editorial

# Globalisation and interdisciplinary activity in mental health: A time for innovations in higher education

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### Keywords

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### Introduction

Along with the current movement towards economic globalisation, as well as increasing cultural and social globalisation, the globalisation of education is also taking place. In turbulent, constantly changing national and world circumstances, challenging questions are being faced by professional health care disciplines as well as mental health professionals and the universities that teach them, questions that consider such issues as:

- the interface between professionals and the universities and health services;
- the learning environment for health professionals;
- the sorts of alliances that will be in place to support learning and innovation; and
- the scope and range of possibilities available to advance national and international dimensions to learning.

And, as a subset to these broad strategic and philosophical issues, there continue to be fundamental issues that will have an uncertain impact on the practicalities of mental health care and health care in general, as well as health education, such as global nursing shortages and the steady increase in mental and neurological disorders as part of the global disease burden.

### Fundamental issues: Ageing and the crisis of confidence

One of the main challenges facing the health professions in countries such as Australia,

Canada and the United States is the situation of an ageing health professional workforce which is caring for steadily increasing numbers of other ageing people (Global Nursing Partnerships: Strategies for a Sustainable Nursing Workforce, 2001). For example, in Australia, if present trends continue, the proportion of people aged from 20 to 39 years will increase by only 2% between 2001 and 2051. In the same period, the proportion of the population aged 60 to 79 years and 80 and over will increase by 122% and 307%, respectively. By 2051, one in three Australians will be aged 60 and over. Never before have such proportions been reached in large human populations (Australian Bureau of Statistics, 1999).

The health workforce challenges of an ageing Australian population are, therefore:

- how to replace the many health professionals (especially nurses) who will retire over the coming decade;
- how to identify the skills and roles needed to meet recognised and anticipated service needs; and
- how to plan for the health and social care that will be required for people who are surviving into older ages at unprecedented rates due to advances in biomedical sciences (Hassan, 2000).

Nursing shortages (for example) can only increase the current crisis of confidence in world health care systems. In a recent survey published in *The Economist* only 15% of Americans said

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they had a great deal of confidence in their health care system. Electricity companies (which deliver blackouts) enjoy double that level of support (Fishburn, 2002). In Australia no week in politics is complete without reference to waiting lists, medical misadventure, or staff shortages.

Health education, in such a climate of concern and confusion, faces challenges not previously experienced. What new skills and attitudes, understandings and behaviours will nurses, doctors and researchers need during the next two or three decades? How will health professional educators interpret those needs and respond to them?

### **Global developments in mental health and mental illness**

Among the predictions for the future of global health and healthcare systems, the prediction that mental illness will increase is one of the most concerning in terms of the use of national healthcare resources, both financial and human. While mental health and mental illness have never been easy to quantify and catalogue, it is generally agreed that mental and neurological disorders currently form 11% of the global disease burden (Murray & Lopez, 1996). By 2020, this burden is expected to rise to 14.6%. In addition, the WHO estimate that approximately 450 million people worldwide have mental or psychosocial problems, and most of those who turn to health services for help will not be correctly diagnosed or get the right treatment (World Health Organisation, 2001).

Five mental disorders – unipolar depression, schizophrenia, alcohol abuse, bipolar and obsessive-compulsive disorders – are among the diseases causing the highest disability ratings in the world (Mitchell, Brodaty & Copolov, 2002).

### **Answering the challenge: Making the most of the phenomenon of *glocalisation***

In such a situation, involving a chronic shortage of health professionals and an acutely increased demand for them, the health professions need to consider new models of higher education to provide a more efficient and innovative use of scarce resources. Such new models would help define the learning environment for health professionals, the future interface between professionals, universities and health services.

They could establish alliances that will support learning and innovation, as well as the range of possibilities to advance national and international learning in the health professions.

These challenges can be answered successfully if a subtle and significant feature of globalisation is taken into account: that the compression of the world (globalisation), as Robertson (1995) observes, “increasingly invokes the creation and incorporation of locality processes which largely shape the world” (p.25). That is, the local helps shape the global in a process Robertson refers to as “**glocalisation**”.

Holton (1998) sees Robertson’s notion of **glocalisation** as something beyond the idea of globalisation as a large-scale, world-centred process that is distinct from and antagonistic to smaller-scale processes that occur within the nation or locality. He argues that the ‘global’ and the ‘local’ interact, often to the point of drawing particular synergies from each other, rather than being locked into perpetual conflict in which, according to the “most demonic versions of globalisation theory, local difference and particularity will be obliterated by global homogenization” (p.16).

Far from people’s lives being more integrated and their cultures and societies being more blended in the wake of expanding telecommunications, regulated and non-regulated people movements and the increasing global influences over personal and social life, an increasing diversity of connections is appearing among phenomena once thought disparate and worlds apart. These connections involve ideas and ideologies, people and goods, images and messages, information technologies and techniques that are inevitably interrelated (Apparduari, 1999), but not homogenous.

**Glocalisation** depicts different lives and disparate phenomena as being drawn together in unexpected ways. **Glocalisation** is, in this sense, the interpenetration of the global and the local, as the defining feature of global society.

### **Interdisciplinary research, education and action**

A focus on a local need for early detection and intervention in mental health, therefore, could involve a global solution and vice versa. Developments locally could have significant

implications for interdisciplinary research and the education of health professionals globally; for example, increased attention by professional disciplines to their commonalities and possible integration. Psychosocial and pharmacological treatments in the management of mental illness could be blended to good effect, for example, providing an educational challenge to such disciplines as psychology, pharmacology and mental health medicine and nursing. Another example of the potential for interdisciplinary management of mental illness is in the development of the concept of 'mental health literacy' – community knowledge of mental disorders – which is now recognised as a major determinant of the effectiveness of any intervention (Jorm, 2000).

Occurring at the same time will be growth in research and education surrounding program and policy development in ageing and disease eradication and management. There are likely to be demands in the future for education programs in health and mental health for individuals and communities not directly connected with the health sector (community education), as well as for generalist health professionals in the areas of destigmatisation, advocacy skills, information about illness, mental health and suicide prevention, and service availability and early help seeking for mental and other health problems.

With the incidence of psychological morbidity expected to rise between now and 2020 there will be increased demand for new initiatives for people whose professional and personal lives have been drastically changed due to the unwanted effects of ill health, ageing and mental illness and whose attempts to resume a career or other meaningful activities have been unsuccessful (Ronningstam & Anick, 2001).

*Research.* Such research and education into the meaning of work and the psychosocial impact of role and job loss as a consequence of physical or mental ill health are likely to involve the disciplines of education, nursing, occupational therapy, psychology, psychiatry, economics and human resource management (among others).

Typical of the advances that will be looked for from research are the significant observations in Alzheimer's disease that have revealed the

specific molecular defects underpinning the rare familial early-onset form of this condition (Watson, 2001) and the major advances in pharmacotherapy that have led to dramatic shifts in treatment - particularly for depression and schizophrenia - but also for dementia and bipolar disorder (Australian Bureau of Statistics, 1997).

While studies in Melbourne of early intervention in schizophrenia have received considerable international attention (Schaffner & McGorry, 2001), this is a goal that is yet to be realised. Nevertheless, promising avenues include early intervention for schizophrenia, and the (more distant) possibility of vaccination as primary prevention for Alzheimer's disease.

Typically the disciplines of education, nursing, occupational therapy, psychology, psychiatry and medicine are involved in discoveries like these either through their own research or through their application of the results of the research. Ideally the disciplines work together for the desired outcome; and it is in the area of education that this multidisciplinary collaboration can most effectively take place.

*Education.* In the area of higher education, globalisation has meant an increase in competition for the research dollar and student numbers, accompanied by the need to make the most of uncertain financial resources. Paradoxically, this means finding new ways of international engagement with others in applied research, teaching and learning in an environment where competition is rife while global success depends on collaboration. In mental health this means the development of programs (alone and in partnership with others) that remain deliberately and convincingly relevant in the local context, practical, accessible, but of a world standard.

In this sense, globalisation, with its underlying communication infrastructure, offers educators, including mental health educators, the potential to share ideas and knowledge with a worldwide collegiate community and a worldwide student body. As broadband internet services become more accessible and less expensive, the way in which software is distributed, updated and maintained and the way in which knowledge is disseminated will transform current educational models.

The sheer volume of information, for example, that derives from biomedical and clinical evaluative sciences and is increasingly available to clinicians and patients through the World Wide Web (Eysenbach, 2000) has to be managed. Educators and their students need to process information, derive knowledge, and disseminate the knowledge into clinical practice in ways unanticipated before the introduction of computer technology and the internet.

This is particularly challenging for clinical health professionals in the context of health/illness assessment and consultation. Information often highlights uncertainties, including collective inter-professional uncertainty, which can be addressed with more and better research; individual professional uncertainty, which can be addressed with professional education and support for decisions; and stochastic uncertainty (the irreducible element of chance), which can be addressed with effective risk communication about the harms and benefits of different options for treatment or care.

Within the scope of these possibilities, how can information be used without losing the benefits that are traditionally associated with the art, rather than the science, of nursing and health care? The answer is that the concept of **glocalisation** implies that local research culture ought naturally be focused on the local community while being innovative and world-competitive; and that the art of nursing and health care ought to be nurtured at the same time that new knowledge is garnered. In this way research will continue to be progressed in areas of identified need and neglect, and there will be scope for research that will be applied and interdisciplinary into priority and/or neglected areas. Additional emphasis will be placed upon notions of reciprocity (giving in return) ensuring new, or improved partnerships across communities, sectors, organisations and jurisdictions.

*Educational structures.* Could it be that in order to meet the challenges of an interdisciplinary future, a single organisational structure is needed within individual universities – perhaps in partnership with other universities?

Could interdisciplinary scholarship (broadly defined) operate, for example, as some kind of coherent system or set of structures? Or will its development be situational and lacking in enduring patterns?

If interdisciplinary scholarship is regarded as systemic in form, what is the logic in support of an academic profile that underlies such a system? Or are there several underlying types of logic rather than a singular master process?

And within these various scenarios, what scope, if any, remains for (1) a single discipline to retain its loyalty and identity and, (2) a single university to maintain its competitive interests?

Robertson's (1995) concept of **glocalisation** implies that once some activities have been initiated in a local context, there is potential for many crosscurrents – global and otherwise – of thought and scholarly connections without losing local identity. The value of an interdisciplinary research structure as a model for educational institutions is that it would ensure research program and service delivery activities were coherent and complementary. Interdisciplinary education and research would also help avoid problems of communication between the various components (both internal and external to a university environment) and would allow for better (uniform, really) measurement of effectiveness.

This interdisciplinary structure would by its nature embody the concepts of globalisation and **glocalisation**, with each discipline operating within and without itself simultaneously. Such activity should have the effect of boosting medical discovery and encouraging experimentation with and adoption of novel methods for dealing with complex health issues.

### **Relationship capital in the context of education**

The notion of globalisation in higher education and an increase in multidisciplinary activities can be compared to the idea of relationship capital – “a relationship based upon intellectual and emotional communication, where the rewards derived from such communication are the main basis for the relationship to continue” (Giddens, 1999, p.61). This idea recognises that there is an affinity among people that does not stop at national borders, and which may have

some potential in the higher education environment (World Bank & Oxford University Press, 2002).

While the marketplace changes daily – and innovations in technology are emerging faster than we can keep pace with – some organisations will simply hold on tight to what they have always done and seek comfort in the status quo. Yet in this age of discontinuity the organisations that last through the coming decades will be those that can respond effectively to the changing demands of their environment (Kets de Vries, 2001). Organisations with good, and perhaps novel, local and then international relationships will be competitive. Efforts at creating and managing interdisciplinary educational structures will be rewarded with success in the newly and highly competitive field of education, as well as with success in terms of intellectual, philosophical and behavioural contributions made both locally and globally to the disciplines involved.

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## Help-seeking behaviour and the Internet: An investigation among Australian adolescents

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### Abstract

The purpose of this study was to evaluate the effect of a brief school-based intervention on help-seeking behaviour among Australian adolescents. The aim of the intervention was to encourage adolescents to seek help, focusing on the use of the *Reach Out!* website ([www.reachout.com.au](http://www.reachout.com.au)) as a help-seeking source. Male and female adolescents were compared. The evaluation involved 243 students from ten government and non-government schools across rural and regional Victoria. They received a presentation that contained information on *Reach Out!*, what to do if they or a friend was going through a tough time, and help-seeking options. Questionnaires assessing help-seeking knowledge, intentions, behaviour, and use of *Reach Out!* to seek help were administered six months following the presentations. The majority of participants, with more females than males, knew where to go for help and who they could talk to. Almost half of the participants had been to the *Reach Out!* website following the presentation, and approximately two-thirds reported that they would use *Reach Out!* to seek help if they were going through a tough time. There were no significant gender differences in visiting *Reach Out!* or in intending to visit it. The results demonstrate that young people in Australia are likely to use the Internet, and especially *Reach Out!*, to seek help when they are going through tough times.

### Keywords

*help-seeking, internet, adolescents, gender differences, mental health, mental health literacy*



## Services for adults with intellectual disability and mental Illness: Are we getting it right?

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### Abstract

There is increasing evidence to support the high prevalence of mental illness in adults with intellectual disability and some studies suggest that the prevalence of mental illness may be higher than that of the general population. It is not uncommon for adults with intellectual disability to be referred to local community mental health centres or psychiatric hospitals because of the presence of challenging behaviours, such as aggression or criminal offending behaviour. Despite the emerging research in the area of diagnosis and treatment of mental illness in adults with intellectual disability, many are often not provided with appropriate and adequate mental health services. Two case studies illustrate the difficulties in accessing mental health services for this 'invisible' group of individuals with intellectual disability, and demonstrate the gaps in service delivery and clinical practice. The paper argues that mental health concerns should be considered when challenging behaviours are present in persons with intellectual disability. There is an urgent need for mental health services to re-examine their understanding of and clinical practice with adults with intellectual disability and mental illness.

### Keywords

*intellectual disability, mental illness, dual diagnosis, forensic, challenging behaviours*



## **An exploratory study of crime and brain injury: Implications for mental health management**

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### **Abstract**

There is emerging evidence to link criminal offending and brain injury, but there is still limited research in this area, in particular for people with brain injury and psychiatric disorders. To explore this issue, we reviewed 276 individuals presented to the New South Wales Mental Health Review Tribunal (MHRT), an independent agency that reviews people who are deemed not guilty of offending by reason of mental illness. Nine individuals (3.3%) were identified with brain injury and psychiatric disorders, the majority as a result of non-traumatic brain injury related to alcohol and substance abuse. All of them were male. They were diagnosed with serious psychiatric disorders such as paranoid psychosis and schizophrenia and had committed serious offences such as murder, intent to murder, sexual assault and physical assault. Most had previous psychiatric, criminal, and alcohol and substance abuse histories. Two case studies suggest a lack of treatment follow-up. The study suggests an urgent need to consider early intervention and how services are offered post-rehabilitation, and the importance of collecting and maintaining data to ensure appropriate mental health management and policy formulation.

### **Keywords**

*brain injury, mental illness, substance abuse, treatment, forensic*

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## Parent group treatments for children with Oppositional Defiant Disorder

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### Abstract

This study compared two group intervention strategies aimed at parents of primary school-aged children with Oppositional Defiant Disorder. One group focused on parent management training; the second used a cognitive approach, which focused on parental stress and problem solving skills. Both interventions were effective with a clinic-referred sample showing overall improvements in post-treatment child behaviours and parenting stress levels. Parents who attended the parent management training reported the larger reduction in conduct problems in their children, whereas parents who attended the parenting stress group showed a reduction in their reported level of stress. The results emphasise the importance of specifically targeted interventions.

### Keywords

*ODD, oppositional defiant disorder, parenting, parent management training*