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# Editorial
## On rural services for mental health

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Sometimes it helps to go elsewhere and see other clinical services; on reflection you can gain perspectives on your own service or state, which can then lead to positive change. In the last few months I have had the privilege to be part of a team reviewing an interstate child and adolescent mental health service. As part of this we travelled to country areas and spoke not only with clinicians within the service, but administrators and others from connecting services. I suspect that much of what we were told is typical of rural services across the country, although some may wish to challenge what I am about to say, and perhaps clarify my ignorance about what is done in other states.

First (and it seems banal to mention it) distance is a real problem. One clinician travelled over 400 kilometres by car to present some of the issues. Because she was a sole practitioner for an area, she was based in a group of not very connected services, and had to fight to get, and maintain, sufficient infrastructure to do her job. She had to plan well ahead for her interview, argue cogently why she was needed to be present, and then sign several forms to gain access to a car. Similarly she had to sign forms and argue her case to get hold of a mobile phone with distance coverage. Strangely, she actually did not need to arrange for cover because she did not have a direct clinical role. Someone had been creative in gaining funding from a new statewide pot of funding for health promotion officers in remote areas, and so our colleague was placed in position as a 'body' – big tick in a bureaucratic box somewhere! It did not seem problematic that what the community wanted was a 'jack of all trades' clinician who could meet local need in terms of crisis intervention, and provide early intervention and some therapy, as well as very much needed local education in mental health. Because of distance, this sole clinician had few colleagues with skills in the mental health of young people, so supervision was a problem. A local supervisor was not available, so face-to-face supervision was limited, and although telephone supervision was possible, because of limited local technology, videoconferencing was rare. My previous experience tells me that if you create this sort of situation, then professionals burn out very quickly, whatever their commitment, experience and skill; and if they are primarily not meeting the community's expressed needs, then this happens much more quickly. A minimum for a rural team in a region with, say, about 15,000 people seems to be 3 clinicians with a skilled and knowledgeable advisor visiting on a regular basis. The primary focus of such a group should be the community's expressed needs, but mental health promotion is often a part of the job for at least one clinician.

This issue to do with sole practitioners was not the only problem, of course. Over half the positions in the regional child and adolescent service (as a whole) were empty. People left after a relatively short time, and replacements were hard to find, particularly those with seniority and experience. Younger clinicians often took the jobs because they could gain

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experience, and because they were often given a post at a level above what they might have been able to gain in a city. But rural work was only a stepping stone to return to the city as soon as possible. Under pressure of clinical referrals, remaining clinicians had naturally adopted a siege mentality, and attempted to manage the workload by providing access to only a limited number of new cases who could be managed in office practice with the skill mix available. There was not really the capacity to meet crisis intervention needs, and so, with much resentment, acute cases had been managed by local adult mental health services and/or paediatric services, as appropriate for age. Of course the pressure often fell on psychiatric and paediatric registrars in training whose experience with young people and mental health problems was rather limited.

There are some underlying issues here. First, it seems to me that rural workers are an interesting mix. Many are often committed to rural practice because of prior experience. They are often those who grew up in the country, and go away to gain qualifications mainly to bring the knowledge and skill back 'home'. Then there are those somewhat older clinicians who seek a pre-retirement change to a quieter environment. Finally, there are the younger clinicians I have mentioned above, out to gain rapid experience and seniority. I am not sure that administrators necessarily think through the targeting of advertisements to attract these differing groups. Clearly more stability in rural services could be gained by targeting the first two groups, and I am sure that many more creative ideas would emerge from a strategic planning session.

Then there are the issues to do with salaries, infrastructure and special inducements. I have already mentioned the younger on-the-move clinicians who gain seniority early. But there are precious few other reasons to work in rural areas; you really do have to be committed, and you can expect your commitment to be used against you. Very few clinical mental health services offer salary enhancements, there are few in the way of infrastructure perks, and few special inducements. However, other systems do offer these. For instance many education services offer free housing (or at least rental or housing assistance), good infrastructure, and salary enhancements - which increase annually the longer you stay in the area. If we are serious about a mental health service commitment to rural and remote Australians why do we not positively discriminate to enable a stable, committed, highly skilled, well-supported and well-supervised workforce?

Within days of getting back home, I was visiting Mount Isa, a mining town of about 20,000 people about 2 hours flying time northwest of Brisbane. I visit to do some face-to-face supervision and clinical work about every 4 months to enhance fortnightly videoconferencing to the clinicians there. This arrangement is similar to many colleagues in my service who each service a rural or remote area in the same kind of way – a minimalist supportive service, but the best that can be managed within current resources. At the time of my visit, 9 of the 14 adult mental health service positions were empty, so the one and a half co-located child and youth mental health clinicians were left with no back-up, no capacity to manage crisis cases, and not many colleagues with whom they could discuss difficult cases in emergency. This has changed recently with 3 new people appointed including a full time adult psychiatrist (which is a miracle in a community like this) so things are looking up. Six other positions have been advertised, and we live in hope. However, on the second day of the visit, I was talking with a group of school counsellors, and one mentioned she had previously worked with Child and Youth Mental Health Services (CYMHS) in the Mount. I asked why she had left and got an answer I should have expected. In education, she gets a better salary, free accommodation, better perks, and a bonus for each year she stays with the service. Mmmm.

Last week I was teaching 35 CYMHS workers from around Queensland, many from rural areas. In the second session, I was talking about the need for a supportive environment in the work we do, how important our own mental health and resilience can be, and just how crucial supervision is. A young person at the back of the room appeared to be wiping away tears, so at the break I tentatively tried to see what she was experiencing. There was relief that I was asking, but also more tears. She is a sole worker in a rural town, and my comments had sparked a flood of regret at moving there. At times she is unable to cope with debt, based in part on the

costs of moving to the country area. She feels very unsupported, and is coping with a large caseload and the kind of serious problems with which many experienced practitioners would struggle. She is on a second level salary, but having to do administrative tasks in excess of her experience and ability. And guess what? She is not getting anything extra financially for what she sees as her commitment, and sacrifices. I would give her town a couple of months before they are scratching their heads to work out why professionals leave so often.

The need for mental health services and support in rural areas is immense. In a previous editorial I referred to Ann Dunning's work on Social Exclusion in Australia. I was intrigued by her ability to measure the stark differences between rural and city people. But over the last few years, the rural downturn as a result of the drought has begun to bite really hard, and made it even more difficult for those with fewer personal, family and community resources. Several rural towns I have visited to speak at Rotary meetings have mentioned the numbers of suicides they are experiencing in young to middle aged males, and this was brought sharply home to me in Warwick a couple of weeks ago. The Southern Downs in Queensland has experienced a marked increase in suicides over the last 18 months, and interestingly with no one under the age of 25. Four out of five of the suicides are male, and again of interest, the vast majority would appear to have had a clearly diagnosed mental illness. This was not a spurious diagnosis made post hoc to assist the relatives to grieve; several of those who had died had been admitted to hospital in prior years. What it might say to us is that in hard times we all struggle, but those who have had mental health problems in a context of social exclusion, and under the severe pressure of unchangeable events like the drought, may get to despair more deeply, and for longer than the rest of us. My presentation was meant originally to be with 15 or so general practitioners. When it was opened up to the local professional community, more than 80 people turned up, some from over a 100 kilometres away. Not only do the problems seem overwhelming, but local professionals all recognise them as such, and are desperate for input, ideas, possible solutions, and support.

All of these examples suggest to me that we must give urgent consideration to the plight of rural communities. In particular we must give thought to those with mental illness within those communities. We cannot simply work away at our everyday lives, keep our heads down, and say that 'life is hard in the bush'. Rural people have the right to mental health services every bit as good as those for city people. To achieve this, we must seriously analyse the way we go about providing these services, and develop a range of appropriate strategies to entice and retain good quality clinicians. As previously noted, I believe we need to positively discriminate for rural services, and of course it is going to cost us more.

And so to this issue, the first of 2007, and the beginning of our 6th volume, once again ably, caringly produced by our Editor, Anne O'Hanlon. In the first paper, Judith Fairlamb and Eimear Muir-Cochrane describe the development of a rural Community Health Service Health and Wellbeing Team with a mix of clinicians, and the development of a common philosophy and values base. The model takes a primary health care approach and works towards practical outcomes in people's lives which concur with the PHC determinants of health, secure housing, employment and social connection, while reducing more traditional mental health assessment processes, and less of a focus on case management practices. The outcomes appear to be a consistent paradigm shift toward a consumer focused approach.

The paper by Amanda Harris and Gary Robinson draws on 3 years' experience of evaluating the Northern Territory's Aboriginal Mental Health Worker Program. The authors stress the critical impact of support for mental health workers on program sustainability, and go on to describe the factors which undermine. They outline many of the problems that the program has faced in differing and complex communities, and note the tensions in views about what the role of the AMHWs should be. 'Should it be culturally informed, clinically-related mental health work or community 'wellbeing work', and how should each role be supported?'

The next paper focuses on the role of an Indigenous health worker in contributing to equity of access to a mental health program in a

youth detention centre. Stephen Stathis and his colleagues provide a retrospective and descriptive account of the development of the role, and the strategies used to assist Indigenous young people. Overall the program has been shown to bring Indigenous access to mental health services and drug and alcohol services up to a level comparable to non-Indigenous young people in detention. Close clinical and cultural supervision play an important part in the development and maintenance of such programs.

The paper by Malkanthi Hettiarachchi is a single case report, and describes a treatment which has had quite a contentious history. The case study, telling a very moving story, describes a young female university student traumatised by the 2004 Asian Tsunami. The three sessions of combined CBT and EMDR are described in detail and a number of reliable scales are used to track progress. The combination of treatments appears to provide the opportunity to evoke painful memories and place them in context. The result challenges us to consider the use of brief focused novel treatments, and particularly in resource poor contexts.

The next paper relates to our ongoing struggle to help those with emotional problems in the most efficient and effective way. Fiona Green and John Malouff add to the literature on self-help books in a study exploring the impact of such books in the community. They stress that the more closely a book is read, and the more changed behaviour that occurs, the more likely the improvement in psychological problems. Their preliminary work raises several issues that warrant further investigation.

Working mothers as a construct has provided challenge and discussion for many years. Work, of course is a right; but does it enhance personal identity and enable family management and does it improve personal energy or simply add a burden to the family system. In a tightly written paper, Karen Elgar and Andrea Chester provide a critique of the literature to date, examine two major models which have led to somewhat oversimplified arguments, and suggest that the benefits for maternal psychological wellbeing need to be explored in a more complex way if we are to truly understand them.

Peer support programs have been operating for many years but, as noted by John Dillon and Anne Swinbourne in their paper on ‘Helping Friends’ (a peer support program for senior secondary schools), few have evaluated their effectiveness beyond satisfaction levels of participants. This is in part because schools are complex environments, and research in the real world is hard to set up and complete. The peer support program reported has been continuing for many years, but has only recently been subject to evaluation, which does appear to show significant increases in knowledge of helping behaviours and perceived social support within and across peer groups. ‘Helping Friends’ is a welcome addition to our efforts to improve mental health of young people in schools.

The final paper in this rich issue of AeJAMH also describes efforts to improve mental health in schools, in this case a collaboration between child and adolescent mental health and the school. CAST is an evidenced-based program treating children with emerging disruptive behaviour disorders in primary schools, and Denise Corboy and John McDonald here report on the implementation and the satisfaction of school personnel. They utilise an adaptation of an American model of process evaluation, which appears to transfer well to Australia. Despite the complexity and multiple levels of the school environment, the CAST program appears to have been acceptable to staff, and well implemented in Victorian primary schools.

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# A team approach to providing mental health services in a regional centre using a comprehensive primary health care framework

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## Abstract

This paper discusses innovative mental health work being provided in a regional community health centre where values, setting and a wellbeing model have challenged traditional understandings of specialised mental health care. Comprehensive primary health care is a universal approach that transcends traditional boundaries; however, its value is often not appreciated in developed countries where technology and economics can limit its potential. Indigenous Health workers and Women's Health workers have long understood that psychiatric diagnosis is not always helpful for some of the people who access their services, and have developed ways of working that are respectful and empowering without the use of diagnostic labels. In Murray Mallee Community Health Service (MMCHS), a Health and Wellbeing Team was established, combining Aboriginal Health workers, Women's Health workers and Mental Health workers. Through strategic planning, a common philosophy and values base was developed. Some of the outcomes have been programs within limited resources and partnerships across health disciplines. Workers' skills and confidence have increased in every area with the resulting understanding that 'mental health is everybody's business'. This paper presents a brief historical overview of primary health care, outlines the MMCHS model, and calls for policy to be formulated and implemented in the comprehensive primary health care framework.

## Keywords

*primary health care, mental health services, mental health promotion, consumers, recovery*

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# The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context

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## Abstract

This paper draws on our experience as evaluators of the Aboriginal Mental Health Worker Program that has been operating in eight remote communities across the Top End of the Northern Territory, Australia, for over four years. The program aimed to fund the placement of Aboriginal Mental Health Workers (AMHWs) in remote community health centres, to work under the clinical leadership of General Practitioners and to contribute to development of a culturally appropriate community based mental health care service for Indigenous people. In this paper, we examine the key features of the AMHW program and the originating partnership, the degree of integration of AMHWs in health centre processes and the provision of support for the development of the AMHW role in community mental health work. While there are many examples in this program of AMHWs providing highly valued services within their communities, the evaluation showed that the program did not achieve clear commitments to develop mental health practice around the AMHWs' role. In addition there was variability in levels of local managerial support for the AMHWs, vulnerability to staff turnover and other discontinuities, as well as tensions in views about what the role of the AMHWs should be. Should it be culturally informed, clinically-related mental health work or community 'wellbeing work', and how should each role be supported? Together these factors undermined the sustainability of positive achievements within the program.

## Keywords

*Aboriginal Mental Health Worker, primary mental health care, remote, remote community health centre, program support, role development, sustainability*

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# The role of an Indigenous Health Worker in contributing to equity of access to a mental health and substance abuse service for Indigenous young people in a youth detention centre

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## Abstract

Indigenous youth in detention have been identified as a priority category in national and state policies in relation to their mental health and drug and alcohol service needs. This article describes the development of the role of Indigenous Health Worker in the Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS) at a youth detention centre. It provides an account of the process as well the outcomes achieved to date. A retrospective and descriptive account is given of the development of the role, and of strategies aimed at improving access to MHATODS for Indigenous young people. Over a one-year period, data were compiled on all young people admitted to a Queensland youth detention centre, which was then cross referenced with MHATODS' own service records to determine the proportion of Indigenous young people who had been referred and subsequently received a service. The Indigenous Health Worker has decreased barriers to access for Indigenous young people who require treatment for mental health or substance abuse problems while in detention. There was no significant difference in referral or service provision rates for Indigenous compared to non-Indigenous youth. Indigenous young people were statistically more likely to refuse an assessment by MHATODS, though given the low rates of refusal the clinical significance was small. MHATODS' use of an Indigenous Health Worker significantly contributes to the needs of Indigenous young people in youth detention by reducing barriers to access for the assessment of mental health problems and substance misuse. MHATODS has achieved equity in referral and service provision between Indigenous and non-Indigenous youth admitted into detention. Clinical and cultural supervision play an important part in the development and maintenance of the Indigenous Health Worker role.

## Keywords

*Indigenous mental health, substance misuse, youth detention, youth, Indigenous, equity*

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# Brief intervention for Post Traumatic Stress Disorder with combined use of Cognitive Behaviour Therapy and Eye Movement Desensitisation Reprocessing

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## Abstract

This case study is of a 23 year old female diagnosed with Post Traumatic Stress Disorder (PTSD) in Sri Lanka, six months following the Asian Tsunami of December 2004. The intervention was conducted in a village clinic on the southern coast of the country. Treatment involved the use of Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation Reprocessing (EMDR). The Beck Anxiety Inventory (BAI) was used to monitor levels of anxiety. The Impact of Event Scale (IES) was administered to assess level of intrusion and avoidance (Horowitz, Wilner & Alvarez, 1979). Subjective Units of Distress Scores (SUDS) were obtained to assess level of distress and the Validity of Cognition Scale (VOC) used to assess accuracy of positive beliefs (Shapiro, 2001). A significant reduction in trauma symptoms, levels of distress, intrusion and avoidance were noted at post-treatment. Treatment gains were maintained at one month and nine month follow-up. The combined treatment protocol may be an effective brief intervention to use in situations that require rapid treatments to alleviate personal psychological distress in the aftermath of large scale disasters.

## Keywords

*trauma, tsunami, impact of events, Post Traumatic Stress Disorder, Cognitive Behaviour Therapy, CBT, Eye Movement Desensitisation Reprocessing, EMDR*

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# A preliminary investigation of processes involved in improvement associated with reading self-help books for psychological problems

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## Abstract

This study is a preliminary examination of the effects of reading a self-help book on overcoming psychological problems. Adding to prior research findings on self-help books prescribed as part of psychotherapy, this retrospective, community-centred study collected data on whether reading a self-help book helped individuals. The study, in which 71 women and 16 men participated, found that the more closely individuals read the book and the more they made recommended changes in thoughts, behaviour, and situations, the more they reported they had improved. The study also found that making changes in thoughts, behaviour, and situations mediated the association between reading the book closely and improving.

## Keywords

*self-help, self-help books, psychological problems, bibliotherapy, behaviour change*

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# The mental health implications of maternal employment: Working versus at-home mothering identities

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## Abstract

Past research exploring the effect of employment on mothers' mental health has largely constructed maternal employment as a problem of identity and energy supply within the theory of multiple roles. Specifically, maternal employment has been investigated as either beneficial (role enhancement hypothesis) or detrimental (role strain hypothesis) to women's psychological wellbeing, with little consideration given towards a more complex relationship. As such, despite three decades of research, there is inconsistent support for both the role strain and role enhancement hypotheses. The few trends to emerge from this research suggest that while maternal employment may be associated with better psychological functioning, this effect may be mediated by the over-absorption of one's time and resources within a particular identity role. Future research would benefit from revising the manner in which maternal employment is constructed as a variable in order to yield more consistent and usable findings.

## Keywords

*employment, maternal employment, mother, mothering identities, multiple role theory, role strain, role enhancement*

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# Helping Friends: a peer support program for senior secondary schools

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## Abstract

Peer support is used frequently in addressing the health of young people. *Helping Friends* builds on the existing peer helping networks in schools to improve the availability, accessibility and appropriateness of social and personal support. It increases young people's knowledge of and access to referral options (in and out of school) and assists in the development of a safe and supportive school environment. Twenty-two schools in North Queensland, Australia participated in the program with many participating on several occasions. An evaluation of the *Helping Friends* program using the Social Provision Scale (Cutrona & Russell, 1987) was undertaken to determine whether there was an increase in perceived social support as hypothesised. Results revealed small yet significant increases along subscales of the Social Provision Scale. Pre and post measures of helping skills and knowledge of helping topics also revealed a significant increase following students' participation in training workshops. The results are discussed in terms of the efficacy of peer support programs for addressing the health needs of young people. The findings can be used to guide secondary schools in making decisions on the value of peer support programs and their application in school and out of school settings.

## Keywords

*peer support, social support, schools, connectedness, school mental health program, help seeking, program evaluation*

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# An evaluation of the CAST program using a conceptual model of school-based implementation

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## Abstract

Therapeutic prevention and/or early intervention programs for children at risk of developing disruptive behaviour disorders are increasingly being implemented in schools. One such Australian school-based program is CAST: CAMHS (Child and Adolescent Mental Health Service) and Schools Together, an evidenced-based program treating children with emerging disruptive behaviour disorders in the early primary school years. The current evaluation examines the process of implementation of the CAST program in primary schools. By using a conceptual model of school-based implementation (developed by Greenberg, Domitrovich, Graczyk & Zins, 2005) the wide array of factors that can affect successful implementation at the school level were identified, and those elements critical to implementation quality were examined. Semi-structured individual and group interviews were conducted with a sample of 69 school personnel across 16 schools in the City of Ballarat and wider Grampians region of Victoria, in both government and Catholic primary schools. Results showed that schools were highly satisfied with the quality of CAST resources and personnel, and the implementation and delivery of sessions as planned. Aspects that impacted negatively on the implementation process were the lack of parental engagement; the lack of classroom follow-up in some schools; the level of readiness and pre-planning by the schools; and the availability of technical support. Greenberg's conceptual model appears to be a useful framework to utilise in examining the implementation of the CAST model, as it allowed close examination of how the program was implemented within naturally occurring constraints. It allowed the identification of elements within the CAST model and the associated support system that must be maintained and nurtured by the collaborating parties, in addition to the factors at a school level that are potential barriers to effective implementation. Identification and examination of such factors assist in ensuring quality outcomes for school-based interventions in the future.

## Keywords

*program evaluation, implementation quality, schools, school mental health program, disruptive behaviours*

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