



## **Editorial**

### **On rural services for mental health**

**Professor Graham Martin, OAM**

*Director, Child and Adolescent Psychiatry, University of Queensland, Brisbane, Australia*  
*Editor in Chief, AeJAMH*

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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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- Contact:** Professor Graham Martin, OAM, Director, Child and Adolescent Psychiatry, University of Queensland, Brisbane, Australia. [graham.martin@uq.edu.au](mailto:graham.martin@uq.edu.au)
- Citation:** Martin, G. (2007). Editorial. On rural services for mental health. *Australian e-Journal for the Advancement of Mental Health*, 6(1), [www.auseinet.com/journal/vol6iss1/martin.pdf](http://www.auseinet.com/journal/vol6iss1/martin.pdf)
- Published by:** *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)* – [www.auseinet.com/journal](http://www.auseinet.com/journal)

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.