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Isolated connections: Re-writing the self and social support within online communities

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Isolated connections: Re-writing the self and social support within online communities

**ABSTRACT**: Geographical and social isolation, lack of services, stigma and privacy concerns are just some of the barriers that prevent rural, remote and regional (RRR) residents from seeking mental health (MH) support within their communities. Online peer-to-peer communities may provide an answer to some of these problems. These online spaces offer support, information and advice for people irrespective of time or location. While online communities appear promising, very little research has been done to examine the experiences of such services for RRR residents living with a mental illness (MI). This research aimed to explore the experiences of people living in RRR Australia who seek online support for MH concerns. Using an exploratory approach, this study delved into the experiences of people living in RRR Australia who access the SANE Forums, an anonymous online peer-to-peer support service for carers and people living with MI. Focus groups were conducted and data from these was analyzed using inductive qualitative methods. The results suggested that online peer support offers a very different community space that fosters connection, belonging, and support for people who are otherwise isolated in their RRR communities. Through engaging in online communities users can challenge and re-script stigmatized identities, and engage in social practices where they negotiate their own needs and the needs of others. Such interactions may have the potential to break cycles of isolation if well integrated into offline realms.

**Keywords**: online communities, online peer support, rural mental health

**Introduction**

People who live in RRR Australia face many burdens when accessing support for MH concerns. There are accessibility issues due to a shortage of qualified MH specialists, a lack of affordable services, and difficulties with the distances needed to travel to receive care combined with unreliable transport (Bischoff et al., 2013; Jackson et al., 2007). In addition, the stigma associated with MI and need for MH treatment can negatively influence the acceptability of care (Hoyt, 1997). Adding to
concerns around stigma in RRR communities are issues of privacy, particularly in close-knit communities, which often characterize RRR locations (Thien, 2008). In this, RRR residents may be reluctant to attend a MH service because the provider may be someone who socializes in personal social spheres (i.e., sports, children are friends at school, church).

While RRR localities are often regarded for having a strong sense of community, this strength can also create problems with support seeking. Close-knit communities, such as rural townships, tend to form collective attitudes (Granovetter, 1973), in which they adopt stoic and self-reliant attitudes in dealing with issues, including MI (Fuller, Edwards, Procter, & Moss, 2000; Weinert & Long, 1987). Accordingly, research conducted by Judd, Jackson, Komiti, et al. (2006) indicated higher levels of stoicism and self-efficacy in rural communities were associated with less likelihood of having sought help for MH problems. This may mean that individuals with higher levels of self-efficacy and stoicism are likely to delay help-seeking until symptoms are severe and disabling, which is representative of the ‘rural definition’ of health as a capacity to work or be productive in one’s role (Judd, Jackson, Komiti, et al., 2006). Unsurprisingly people in rural communities are less likely to seek support, despite having higher suicide rates (Caldwell, Jorm, & Dear, 2004; Judd, Jackson, Fraser, et al., 2006), and as high prevalence of MI as metropolitan rates (Caldwell, Jorm, Knox, et al., 2004; Hauenstein et al., 2006).

Such findings are suggestive of stigmatizing attitudes towards MH issues within RRR communities that may hinder support seeking. Individuals may be reluctant to seek MH support as it may be perceived as having a weakness of character within their community, as they do not conform to cultural values of stoicism and self-efficacy. In fact, Jackson et al. (2007) research indicated that perceived stigma among RRR residents was the strongest predictor of non help-seeking behavior, outperforming all other demographic variables (i.e., gender, age, education, income). Here, cultural norms may discourage MH support-seeking behavior within RRR communities.

A promising aspect of MH online forums is that they provide a space that encourages help-seeking. As previous research has noted, online forums seem to be particularly appropriate for ‘stigmatized identities’ and MH issues (Johnson, Rosevinge, & Gammon, 2002), given that help-seeking in ‘real life’ can be associated with stress and stigma (Berger, 2005). Parr (2008, p. 136) argues that “fostering
virtual geographies of communality” between people with MH concerns offers “an innovative solution to what some might call a crisis in real-space community”, giving RRR residents access to social support that is lacking in their offline communities.

Research on MH online forums in RRR communities is fledgling. However, there are systematic reviews on online MH forums conducted by Griffiths, Calear, Banfield, and Tam (2009) and Eysenbach, Powell, Englesakis, Rizo, and Stern (2004), which are helpful in understanding how online forums may benefit RRR residents. Both these reviews revealed that online forums provide an outlet for expression, where users can discuss subjects they were unable to elsewhere, helping users feel supported and less isolated. There is a growing body of literature that similarly explore MH outcomes (e.g., S. Fox, 2011; Handley et al., 2014; Ziebland & Wyke, 2012) However, to the best of our knowledge, no research has specifically investigated the experiences of RRR residents who access online MH forums.

Thus, using an exploratory approach, this study delved into the experiences of people living in RRR Australia who access the SANE Forums, an anonymous online peer-to-peer support service for carers and people with lived experiences of MI. This study sought to bring to the fore the voices, lives, and capacities of people with MH problems as well as the difficulties they encounter living in RRR localities. The critical question this research sought to address was, ‘What motivates, or deters, RRR residents to access online peer support?’ This perspective is important because it provides a step toward understanding how online MH forums may provide an alternative space for social support.

**Methodology**

This study employed a qualitative design using online focus groups for data collection. Focus groups were particularly useful in obtaining data to understand online support communities, because they allowed investigation into group dynamics that surround an individuals’ perception and understanding of such phenomena (Stewart, Shamdasani, & Rook, 2007). Moreover, in an online environment, research has shown that the level of disclosure, ideas, answers, and preference to participate in online focus groups setting is higher compared to face-to-face to focus groups (F. Fox, Morris, & Rumsey, 2007; Reid & Reid, 2005). Due to the anonymous nature of online focus groups, it is possible that the exchange was not hampered by appearance-related clues that might characterize face-to-face encounters. Moreover, synchronous online
communication can influence the power dynamics associated with conventional methods, allowing the group to a greater degree to ‘take control’ of the discussion (F. Fox et al., 2007).

Participants

Respondents were invited to participate via advertisements that were placed on SANE Forums website, and newsletter. This meant that respondents in this study were SANE Forums members who had participated in the Forums. Due to the exploration nature of this study, the sample size was purposively small \((N = 5)\), to allow for greater depth of conversation between the group. The focus group comprised four respondents who lived in rural Australia, and one living in an outer regional area \(^1\).

Procedures

The focus group was conducted in a setting that was familiar, and thus conducive to creating a comfortable atmosphere in which the participants could reflect and openly share their thoughts and experiences with one another (Hays & Singh, 2012). The online focus group was conducted within a password protected hidden space on the SANE Forums that could only be accessed by the respondents and investigators. To access this online space, the respondents were required to use their SANE Forums login and membership details. Accordingly, the respondents’ avatars in the focus group were the same profiles used on the SANE Forums. This meant that the respondents’ real life identity remained anonymous, however the respondents might have been familiar with each other through other interactions that have taken place elsewhere on the forums.

This focus group was open 24 hours a day for a 10-day period, allowing for asynchronous communication between the group, mirroring similar communicative interactions that typically take place on SANE Forums. A SANE Forums moderator worked behind the scenes at all times to monitor any posts published by the respondents. The SANE Forums moderator did not facilitate the focus group

\(^{1}\) The focus group contained two people living in rural Victoria, one lived in Far North Queensland, and one lived rural South Australia, however this particular respondent had recently relocated from remote South Australia. The remaining respondent lived in outer regional area of the Northern Territory.
discussion, however viewed and approved posts, ensuring that the content and respondents remained safe. The respondents were aware of the SANE moderator viewing their posts, and could contact the SANE Forums moderation team via email if they had any concerns during the course of the focus group.

There were two focus groups moderators, however, the principle investigator (CB) acted as the primary moderator. The researchers used a set of questions to guide the group discussion, and address the core research question (refer Appendix A for list of questions). Flexibility was permitted, however, to deviate from these questions to allow expansion and exploration into areas that might have otherwise been overlooked through strict adherence to structured questioning. As Stewart et al. (2007, p. 61) points out, it was essential that the discussion did not become a “version of a survey questionnaire”. With this in mind, the researcher used an active approach to elicit the respondents’ perspectives. This approach encouraged participants to freely express their perspectives, and allowed the researcher to further probe and explore the group’s views and experiences of online peer-to-peer support. The use of set questions ensured that the core research areas were examined.

All data was then transferred into Nvivo, and analysed by the principle investigator using a grounded theory approach. This involved a systematic comparison and analysis of the data, which drew out common themes. From these themes, categories were formed, which were then validated against the data set that they were grounded in (Strauss and Corbin, 1990). These categories were examined in relation to existing literature as outlined in the discussion.

Results

The analysis of the data revealed three prominent themes. Firstly, the respondents experienced social and geographical isolation in their RRR communities. Secondly, the respondents used the SANE Forums and other online communities as means to respond to the emotional support and connection that was lacking in their RRR communities. Thirdly, through such online interactions, the respondents could re-visualize stigmatized self-identities, in which their self-conceptions of illness was normalized. In addition, through engaging in online social practices they learned to negotiate their own needs as well as the needs of others, which initiated self-care
strategies and boundary setting. These three themes are discussed in detail in the following sections. An analysis of these themes follows in the discussion.

**On the outside: Social and geographical isolation**

Geographical location posed significant difficulties with accessing both support services and specialist MH treatment. Due to a shortage of services in their communities, the respondents reported that they were required to either wait and/or travel lengthy distances to find appropriate and affordable treatment. Kelly’s statement below describes some of the hardships she experienced with finding accessing services.

I really struggled with only being able to have 10 sessions in a year. After the fires I saw a bushfire trauma counsellor for about 12 months, which was free. Thankfully when she retired I had just changed GPs and when I asked my new GP she recommended a psychiatrist who is about an hour & a quarter away by car. I'm really incredibly lucky as she is not only very supportive and encourages me to find my own strength & grow, but also after a while when she saw how much I was struggling financially to pay the gap between her fee (which was already discounted because I'm on a pension) & the Medicare rebate she offered to bulk bill me and has ever since. I usually see her weekly, or fortnightly if I'm quite well and stable. It took looking for about 5 years to find her.

Like Kelly, all respondents concurred that finding a clinician who was willing to bulk-bill was uncommon. Yet, it was highlighted as a crucial factor that determined the accessibility of treatment even if the respondents were required to travel some distance.

As well as service shortages, all of the respondents reported issues around privacy and stigma in close-knit communities, which further impeded on accessing support within RRR locations. This is demonstrated with Lori’s statement:

I was a teacher in the local school and most of the nurses in the hospital were parents of children that I had taught, were currently teaching or possibly would teach! For

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2 Please note that all quotes were taken directly from transcripts, alterations were only made to correct grammatical errors and to protect anonymity.
instance when i fell pregnant with my second child, i went to the hospital one morning because I was concerned I was miscarrying and saw a nurse (who was a current parent of a child i was teaching) before I went into see the on duty doctor. I went back to school afterwards and finished teaching for the day. At home time i walked my children out to the pick up area and the sister of the nurse that I had seen that morning congratulated me on my pregnancy... in front of my students and a co worker all of who knew nothing about my pregnancy! So privacy was always a major concern for me... as well as the stigma.

Due to a lack of privacy and stigma, there were difficulties with being accepted into their close-knit communities, particularly because the respondents’ deviated from cultural norms. Kris’ statement below illustrates this:

Breaking into the community when I first came here was very difficult and took 5 years to even get partially accepted. My area is very close knit and is only accepting if you fit within a certain criteria. I am on the fringes of this so don't get included or excluded. The problem living in such a small community is that once you get tagged with something, you are tagged with it for life. Most people here have a very poor impression of MI and are very suspicious of anyone with it. Most think it is characterized by violence and unacceptable behaviour.

Indeed MI was often stigmatized in RRR communities, which contributed the social isolation experienced by the respondents. Lori reported:

Country/rural areas do seem to hold on to myths and misconceptions about mental illness, domestic violence and immigrants. When things happened between my husband and I, our local church stepped up to help support my ex husband and still do, and the community rallied around him while I was or felt like, i became an outcast in the community. And a few people that i ran into told me that was because it was me who had chosen to 'leave'.

These results suggested that stigmatic attitudes formed the basis of social inclusion or exclusion. In the cases described above, the respondents were pushed to the fringes of their RRR communities.
Re-writing the self and belongingness

The respondents described their use of the SANE Forums, as a response to the social isolation and exclusion that they experienced in their RRR communities. This is illustrated with Kris’ comment below:

Loneliness and isolation was a driving factor to join [SANE Forums] as was the need to connect with other MI people under the watchful eye of a moderator of course. I don't think people not living in remote areas understand how difficult it is to start up relationships, even on line ones when you have the culture of isolation where you live.

Through their interactions on the SANE Forums, the respondents reported that they felt less alone, as they could express themselves in an upfront and honest manner. The text-based asynchronous nature of the online environment allows the respondents time to carefully and thoughtfully construct their posts. This is reflected in Lori’s remark:

… you have time to read what has been written and then plan out your response based on what you've read. I think its the time that you have to prepare and edit what you're writing that makes it feel safer. And the slightly anonymous nature of it.

Through this they could connect with others who were non-judgmental, and who could relate to their experience. Kris’ statement below reflects this:

I like the way you can talk about your crazy antics and no one seems to judge you… I do appreciate having a safe place to talk about my MI experiences. I also like reading other peoples comments, which makes you feel connected.

Through such interactions, the respondents reported that they were able to re-visualize themselves as normal, suggesting a sense of decreased self-stigma as well as a greater degree of social support and acceptance. For instance, Dorothy wrote:

Reading about other's similar (or even different but not "normal" - hate that word) experiences helps a lot in making you feel less like some kind of unique alien, out of
place in a "normal" world. Contributing to the conversations is what helps me feel connected to others…

As Dorothy’s statement suggests, the ability to connect with others who share similar experiences challenges stigmatized notions of the self as it normalizes experiences of MI.

**Breaking isolation: connecting the online to the offline**

The respondents commonly discussed the ways in which the SANE Forums and other online communities or spaces, posed challenges in which they were required to establish boundaries for self-perseveration. Lori discussed how she has learned to establish distance from interactions on the SANE Forums that cause her distress. She wrote:

> I've had to realise for myself that I can step away from topics that get difficult for me or that are bothering me. I’m also able to feel like I’m able to leave those threads because I know that there are active moderators on the site all of the time, which in turn makes it feel like a safer place.

Lori’s statement suggests that she been able to establish boundaries for self-care and can to minimize potentially harmful interactions. With the understanding that moderators are present on the Forums, Lori is able to initiate self-care. Interestingly, Lori advised that while she joined the Forums due to difficulties connecting with people offline, she now feels more equipped to participate in real world interactions:

> I do wish now though.. that there were groups available in 'real life' here though, because I think i’m more ready now to work on my social stuff!

Kelly, similarly reported, that her self-confidence has grown, and that she was feeling more confident to connect with others offline, and talk openly about her MI. While she acknowledges that the SANE Forums had a part in this, she also highlights the Forums limitations with breaking isolation offline:
One thing about Sane forums which I have recently found very debilitating personally was a flow-on effect from the mandatory anonymity. I think the option of anonymity is essential. However I have grown the confidence to be much more open about my MI, in part fuelled by the forum. I don't want to have to be anonymous anymore. I want to be able to offer REAL friendship to the wonderful folk who are part of the forum. Of course they must be completely free to say "no thanks".

Both Kelly and Lori’s statement point out that the SANE Forums can offer a space of connection through which they can learn skills to communicate and interact with others. However, the capacity to break isolation is limited if users are unable transfer a sense of connection and social practices gained online to offline spaces.

**Discussion**

This study sought to explore what motivates and/or deters RRR residents to access online support. The results suggested social and geographical isolation acted as a primary motivator to seek online peer support. That is, RRR residents purposively sought out social connection and emotional support online as it was identified as lacking in their offline communities. Through online interactions, the respondents were able to challenge and re-visualize stigmatized self-identities, and develop social practices to address their own needs as well as the needs of others. These findings call into question how social networks are generally understood.

The importance of social networks is well documented in the literature as an important factor in an individual’s immediate proximal social environment that promotes well-being (e.g., C. Cohen, I. & Sokolovsky, 1978; Feld, 1981; Kawachi & Berkman, 2001). The assumption here within traditional social network models is that social support acts a stress relief or ‘buffering’ function, provided that there is no conflict within a network (Jackson et al., 2007). Having physical contact with ‘friends’ is therefore typically equated with more tangible social support, a stronger sense of identity and self worth, which is understood as beneficial for MH (C. Cohen, I. & Sokolovsky, 1978; S. Cohen, 2004). In this context, it may be tempting to assume that RRR residents who belong to intimate and close-knit communities have a strong social support system (Thien, 2008). However, as Kalish, Robins, Pattinson, and Jackson (2006) argue there is a need for a more nuanced understanding of how MH status in RRR communities is related to the **structure and characteristic** of social
networks and regular interactions. Thus while there might be frequent contact with ‘friends’ in RRR communities, such close-ties may also act as an impediment to seeking support.

In the present study, the respondents spoke of difficulties they encountered living within close-knit RRR communities. A strong sense of community was paradoxically accompanied with a sense of isolation and exclusion. Consistent with previous research (e.g., Jackson et al., 2007; Judd, Jackson, Komiti, et al., 2006; Kelly et al., 2010), a shortage of support services impeded on an individual’s capacity to access professional support. Furthermore, there were privacy concerns due to overlapping relationships. As one respondent pointed out, “everybody knows each other’s business”. This posed significant issues with accessing support within their community. Here, the social networks that contributed to a sense of community, also contributed to a lack of privacy. In addition, the RRR communities in this research seemed to harbor negative attitudes towards MI, resulting in the respondents feeling unaccepted in their communities.

Negative community attitudes towards MI may be a result of strong-tie social networks, which has a consequent effect of conformity on opinions and behaviors. It is well established that strong-tie partners within close-knit groups tend to form collective attitudes and beliefs (Jackson et al., 2007). Within rural settings, in particular, seeking support may be discouraged due to a culture of stoicism and self-efficiency. The notion of the ‘Aussie battler’ who perseveres in the face of adversity promotes the idea of health as the capacity to be productive or the ability to work (Weinert & Long, 1987), and it assumes a high degree of self-responsibility for health problems (J. C. Fox, Blank, Rounyak, & Barnett, 2001). This culture, in turn, implicitly views MI and the need for support as a character deficit. Unaspiringly, perceived stigma predicts non help-seeking behavior (Wrigley, Jackson, Judd, & Komiti, 2006), and higher levels of stoicism and self-efficacy are negatively associated with help-seeking behaviors in rural communities. This may suggest that strong-tie networks within RRR communities, depending on their cultural norms, may discourage seeking support for MH concerns (Jackson et al., 2007), as people are likely to conform to what their community expects of them (Thien, 2008).

Online MH forums, in contrast, offer social networks with cultural norms that encourage support seeking. In this study, offline isolation motivated respondents to seek out social support online. In contrast to feeling like an outsider in their RRR
communities, they were very much on the inside of their online community. This sense of connection was fostered through the ability to discuss MH concerns. Consequently, bonds were formed as the respondents could receive and provide social support.

The respondents reported that their engagement within their online communities normalized experiences of MI. Unlike offline communities that can fuel self-concepts of self-stigma and abnormality, Madge and O'Connor (2006, p. 90) point out that a benefit of belonging to an online community “comes from the desire to have your thoughts and feeling confirmed as being “normal”’. Though there are obvious dangers here with reifying virtual sociability, it is important to consider how the textual and anonymous nature of online environment may encourage a greater degree of disclosure, while also permitting individuals time to think about how “they want to represent themselves” (Valentine & Holloway, 2002, p. 308). In this, the virtual writing – or the ‘righting’ - of the self (Wright & Chung, 2001) may empower individuals to re-script how they understand and articulate the self (Karnieli-Miller et al., 2013; Parr, 2008). The telling of their story within a peer-to-peer network, can serve to validate, or challenge understandings of the self. Parr (p. 140) argues:

… the emotional relationability [sic] that constitutes online self- and peer-help can provide insight into the more diverse social revisionings, ones that may challenge ascribed identities. For the most part, people who access discussion forums are geographical disparate and only virtually networked into textual environments through which nuanced emotional and social ‘work’ assists both the (ill) self and the collective community.

The online ‘work’ within online communities enables users with MH issues to take on roles as competent and effective social actors (Parr, 2008). If online communities are considered online-support groups, then actors within these groups will typically take on self-help and/or supportive roles (Fahy, 2003). In self-help roles, users exercise agency in addressing an issue by conversing with others, or seeking out information contributed by other members. Users who take on supportive roles will offer new insights, share experiences, and provide emotional support to other users (Iriberri & Leroy, 2009). Similar to offline support groups, users enact and demonstrate their capabilities in dealing with and managing challenging experiences,
offering an alternate self-construct to their ascribed offline personas (Finn, Bishop, & Sparrow, 2007).

However, unlike offline support groups, constant exposure and access to virtual discussions regarding MI can create challenges for online users. The respondents spoke about times when they had experienced distress, witnessing difficult situations and tense conversations. In this, daily discussions about emotional hardships establish an unusual sense of proximity among users. The online environment enables users to both share achievements and struggles in virtual real time, creating a sense of emotional closeness between users, particularly among those whom come into frequent contact with each other. As a result MH forums can invoke a heightened sense of responsibility between users. This can present challenges, particularly during times of illness or stress, when users are unable to provide support, but also in need of support for themselves. While this can deter online participation, the tension between self-help and support-giving provides users with an opportunity to practice negotiating and balancing their own needs with the needs of their peers.

Indeed, the respondents spoke about how they had developed strategies to manage stress on the Forums. Some spoke about leaving the Forums, while others described ways that they distanced themselves from particular conversations by going elsewhere on the site. Thein (2005: 93) refers to this as ‘flexible intimacy’, wherein individuals establish ‘elasticity’ negotiating proximity foster emotional closeness in relation to the self and others. This intimacy allows for practice in boundary setting and self-care. According to Thein, the evolving digital space confronts users with new social challenges because it unsettles assumptions of intimacy that typically rely on close geographical proximity within social networks. Instead, the online terrain requires users to develop and practice social skills within closely-knit and physically distant social networks.

Establishing competencies oriented towards articulating selves and emotions may be useful for offline life. As one user reported, “I have grown the confidence to be much more open about my MI’, which was, in part fuelled by the forum”. Conversely, this respondent explained that she felt at odds with her online interactions, as she wanted them to evolve into a “real friendship” offline. This suggests that if users are unable to transfer online social practices to the offline world, users may remain isolated within the real world communities. These findings are consistent with Parr’s (2008) research, which revealed that online MH forums users reported that they
had improved social contact in the offline world as a result of regular forums participation. However, they reported online social practices could result in difficulties socializing elsewhere. Too much online socialisation could potentially decrease social skills needed for face-to-face interaction (Kraut et al., 1998). This could result in dependence on virtual social interaction, where the very technology that creates sociability also has the potential to isolate people (Young, 1996). Parr argues that although people with MH problems can re-vision selves and become socially skilled actors in online communities, there are also barriers to how these gains might be fully realised in other parts of offline life.

There are limitations in this study that require consideration. The respondents recruited in this study were SANE Forums users; therefore their perspectives carried a bias. This, combined with the small size is not an accurate representation of the larger RRR population, nor can it assume that it was representative of the broader SANE Forums registrants. Moreover, three of the respondents were ‘super users’. These are online participants who create vast amounts of content. Super users and active users account for a very small portion of online users in health forums. Approximately 90% of online health community users are ‘lurkers’, people whom observe, and do not participate. Within the remaining 10 per cent, nine per cent contribute sparingly (‘contributors’), and only one per cent are ‘super users’ (van Mierlo, 2014). In line with this, the super users respondents contributed the majority of discussion in the online focus group. They may have felt more confortable, and may have had a greater degree of ownership of the discussion, given that the focus group was conducted in an online space, which they were familiar with. Their contributions, therefore, may have influenced the other two respondents’ opinions. Despite the investigators attempts to elicit conversation and potentially diverging perspectives in the group, the investigators were unable to pick up on non-verbal cues that may have been able to facilitate more conversation from other respondents. Potential future research, therefore, could investigate experiences of online MH forums users who access an array of online forums and examine various levels of participation.

This research sought to address the question: what motivates and deters RRR residents to participate in online MH forums? The results suggested that social and geographical isolation was key motivator to seek out online support. Offline, RRR residents may encounter barriers and social networks that discourage support seeking. However, online MH forums may provide an online community that promotes
support seeking, and provide social support. Online interactions within MH forums can normalise experiences of MI, and develop social interaction that can contribute to self-care practices and boundary setting. These skills may build confidence in social relations offline. However, if users are unable to transfer such experiences to the offline world, users may continue to experience social isolation within their communities. While online communities can provide social connection for isolated populations it is important to question: how can such online social interactions cultivate social connection offline?
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Appendix A

List of core questions

The core questions used in the focus group were:

1.) Please indicate your age, gender, and whether you live in regional, rural or remote. More specifically we are very keen on understanding what it’s like living in rural, remote or regional areas with a mental illness or caring for someone who does?

2.) How effective and accessible do you feel treatment and/or support is, and what barriers do you encounter (eg: privacy in a small town, privacy issues, geographical issues etc) in accessing services and/or support?
3.) Is there anything specific about your geographical locations that led you to use the Forums or other online support? What forms of online support/services do you use?

4.) How did you come across the Forums and what motivated you to use or participate in the forums. If you haven’t posted in the Forums before, why haven’t you, and what might encourage you to contribute?

5.) What has your experience been using **online** mental health services and/or the Forums?
Stress Associated with Commencing University: A Comparison of Metropolitan and Rural and Regional Students

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Poster presented at the
7th Australian Rural and Remote Mental Health Symposium
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Stress Associated with Commencing University: A Comparison of Metropolitan and Rural and Regional Students

ABSTRACT: Most people find times of transition stressful, such as commencing a new job or moving house. In this study, our aim was to investigate stress reported by students as they commenced university. Specifically, we aimed to investigate whether stress levels and perceived social support levels differed among students (i.e., metropolitan and rural and regional) who moved house to commence university and those who did not. Results from 551 students (144 males) indicated that 88% of all students rated the level of stress associated with commencing university as being above the mid-point on a 5-pt Likert scale. The stress of commencing university was higher among rural and regional students who left home to study than it was among metropolitan students who shifted house. In addition, the stress associated with moving house significantly predicted both metropolitan and rural and regional students’ ratings on the stress of commencing university. There were no group differences in perceptions of available social support when commencing university. Results of this study, especially for rural and regional students, are discussed in terms of student welfare, and ways to ameliorate the potential stress and depression associated with commencing university and shifting house.

Keywords: Transition, Stress, Regional, University, Relocation

Introduction

Acceptance into a university program is an exciting opportunity which fulfills students’ years of scholarly efforts and allows them to embark upon their chosen path of study. For some students, however, this transition also involves feelings of anxiety. Commencing university is a major life transition where students face a range of potential stressors, not the least of which is the move from a structured secondary school environment to the more open milieu of tertiary education. For some, commencing university also involves moving from their family home to some other form of accommodation, especially for students from rural and regional areas. While there may be a great deal of excitement around these events, which in Vinokur and Selzer’s (1975) terms makes them desirable, any change can involve some degree of stress. Aside from the typically more distal commitment to tuition fees faced by students, the more proximal financial aspects of moving house are confronting for many rural and regional students. In addition, there are also personal sacrifices that rural and regional students might
experience, not the least of which is distance from their social support networks. Distance from social support is potentially more problematic for students moving from, or into, rural and remote regions than say metropolitan students, who might choose to live in ‘digs’ but not be so far from home.

Significant life transitions, whether negative (such as loss of a job or a relationship) or positive (for example, the birth of a child, commencing university), are not only stressful but can also have a deleterious impact upon one’s mood and health (Holmes & Rahe, 1967; Moore & Burrows, 1996) as they involve substantial adjustment to one’s lifestyle. The cumulative effect of several life changes experienced within finite periods of time has been related to subsequent illness (Holmes & Rahe, 1967; Moore & Cooper, 1996); however, the perceived availability of social support can act to mediate their negative impact (Kaniasty & Norris, 2009; Vollmann, Antoniw, Hartung, & Renner, 2011). When these mediators are impoverished, research from the organisational sector has demonstrated a range of negative outcomes including poor mental or physical health (Moore, 2001), a lack of job satisfaction, increased absenteeism (Greenglass, Burke, & Moore, 2003), and an intention to quit one’s job (Firth, Mellor, Moore, & Loquet, 2003). With the risk of over-generalisation noted, it could be argued that similar outcomes are expected when students undertake university studies without adequate social support (defined as emotional, informational, or instrumental assistance from others; Baumeister & Bushman, 2014).

Universities typically provide students with an academic mentor and offer various formal and informal supports to students. Unfortunately, students are often not cognizant of these services and/or fail to utilise them. If university students’ stress is unmediated, it may affect not just their health, but also their academic performance. In some cases, unmediated stress may even contribute to student ‘drop-out’ (which can be considered students’ operationalisation of an employee’s intention to quit). It is important, therefore, to understand the stress experienced by commencing students, most particularly among those who have to shift home from, or to, regional areas in order to study. It is also important that an attempt is made to understand the factors which may exacerbate or mitigate this stress.

The aim of this study is to conduct an exploratory assessment of the stress and perceived social support associated with commencing university between metropolitan and rural and regional students who did and did not shift house to commence university. In addition, any deterioration in students’ living conditions (i.e., less comfortable home) and financial situation will be explored. Finally, stress associated with commencing university for metropolitan and
rural and regional students who shifted house will be predicted from the variables of stress of shifting house, deterioration in living conditions, and deterioration in finances.

**Method**

**Sample**

Five hundred and fifty one students (407 women and 144 men) with a mean age of 19.37 years ($SD = 4.34$) participated in the study. The sample was not random but was recruited from volunteers in undergraduate classes at an Australian University.

**Procedure**

Notices inviting first-year students to participate in an online study related to their stress associated with commencing university were placed on the student learning portal of the university and on noticeboards outside lecture and tutorial rooms. The notices contained a link to an anonymous online survey. Data were collected during the 4th to 6th weeks of the first semester. The majority of student participants (65%) were undertaking a psychology course, although the programs in which they, and other students, were enrolled varied.

**Instruments**

All participants provided demographic data and indicated whether or not they had shifted house to commence university. Participants all rated the stress associated with commencing university on a 5-pt Likert scale (0 = No Stress to 4 = Extremely Stressful). In addition, participants who shifted house indicated the type of accommodation in which they currently resided and rated any deterioration in their living conditions and finances on 5-pt Likert scales (0 = None at All to 4 = A Great Deal).

Participants also completed the Social Support Scale (Sarason, Sarason, Shearin, & Pierce, 1987), which is a 12-item scale with two factors: number of supporters and satisfaction with social support. The current study used only satisfaction with social support, which has six items rated on a 6-pt Likert scale (1 = Very Dissatisfied to 6 = Very Satisfied).

Students who had shifted house to commence university were invited to provide any additional comments they chose related to their move.

**Results**

Data were analysed using SPSS (Version 21). There were less than 1% of missing data spread non-systematically across the variables. These cases were excluded from the relevant analyses.

**Details Regarding Shifting House**
Twenty-eight per cent of students (154/551) reported making a change in their residence in order to attend university. Full demographic details about change of residence are shown in Table 1.

Table 1: Demographics Regarding Students in Current Study Shifting House to Commence University

<table>
<thead>
<tr>
<th>Normally Live</th>
<th>No</th>
<th>%</th>
<th>Yes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne &amp; Metropolitan</td>
<td>328</td>
<td>85.64%</td>
<td>55</td>
<td>14.36%</td>
</tr>
<tr>
<td>Rural &amp; Regional Vic</td>
<td>66</td>
<td>42.86%</td>
<td>88</td>
<td>57.14%</td>
</tr>
<tr>
<td>Interstate</td>
<td>0</td>
<td>0%</td>
<td>11</td>
<td>100%</td>
</tr>
</tbody>
</table>

A chi-square analysis revealed a significant association between participants’ normal residence and whether or not they changed residence to commence university \(\chi^2(2) = 124.36, p < .001\), Cramer’s V = 48%. Specifically, the majority of rural and regional students, as well as all interstate students, moved house.

Of these students, 33% (50) stated that they were renting accommodation, 31% (47) were in Halls of Residence, 16% (24) were boarding with family members, 7% (12) were boarding with strangers, and 13% (21) were housed in various other temporary accommodations.

**Stress Associated with Commencing University**

A 2x2 factorial ANOVA showed no main effect for shifting house (yes vs. no) on stress of commencing university \(F(1, 520) = .79, p = .374\). However, results did show a main effect of student classification (metropolitan vs. rural and regional) on stress of commencing university, \(F(1, 520) = 4.31, p = .038\). The main effect showed that rural and regional students \((M = 2.73, SD = .91)\) reported greater stress commencing university than metropolitan students \((M = 2.49, SD = .99)\). Finally, there was no significant interaction between shifting house and student classification on stress of commencing university, \(F(1, 520) = .53, p = .467\). See Table 2 for descriptive means and standard deviations.
Table 2: Means and Standard Deviations by Shifted House and Student Classification on Stress of Commencing University

<table>
<thead>
<tr>
<th>Shifted House</th>
<th>Metropolitan</th>
<th>Rural &amp; Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2.49 (.99)</td>
<td>2.64 (.82)</td>
</tr>
<tr>
<td>Yes</td>
<td>2.51 (.99)</td>
<td>2.81 (.98)</td>
</tr>
<tr>
<td>Total</td>
<td>2.49 (.99)</td>
<td>2.73 (.91)</td>
</tr>
</tbody>
</table>

Potential Deterioration of Living Conditions and Finances

The data file was split by whether participants had shifted house, as students who had changed residence to commence university were of interest for the following analyses.

An independent-measures t-test showed no significant differences between metropolitan students who had shifted house ($M = .70$, $SD = 1.10$) and rural and regional students who had shifted house ($M = .61$, $SD = 1.03$) on their ratings for deterioration of living conditions, $t(135) = .49$, $p = .625$. An independent-measures t-test showed no significant differences between metropolitan students who had shifted house ($M = 1.17$, $SD = 1.42$) and rural and regional students who had shifted house ($M = .91$, $SD = 1.38$) on their ratings for deterioration of finances, $t(137) = 1.07$, $p = .285$.

Perceptions of Social Support

A 2x2 factorial ANOVA showed no main effect of shifting house on satisfaction of social support, $F(1, 485) = .98$, $p = .322$. Results also showed no main effect of student classification on satisfaction of social support, $F(1, 485) = 1.47$, $p = .226$. Finally, there was no significant interaction between shifting house and student classification on satisfaction of social support, $F(1, 485) = .35$, $p = .555$. See Table 3 for descriptive means and standard deviations.
Table 3: Descriptive Means and Standard Deviations by Shifting House and Student Classification on Satisfaction with Social Support

<table>
<thead>
<tr>
<th>Shifted House</th>
<th>Metropolitan</th>
<th>Rural &amp; Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>5.28 (.86)</td>
<td>5.33 (.60)</td>
</tr>
<tr>
<td>Yes</td>
<td>5.31 (.71)</td>
<td>5.47 (.53)</td>
</tr>
<tr>
<td>Total</td>
<td>5.28 (.84)</td>
<td>5.41 (.56)</td>
</tr>
</tbody>
</table>

Predicting Stress Associated with Commencing University

A multiple regression was run to test if the stress associated with shifting house, deterioration in living conditions and deterioration in financial conditions could predict the stress associated with commencing university for those students from metropolitan and those from rural and regional areas who shifted house.

For metropolitan students, results of the regression indicated that the three predictors explained 33.3% of the variance in stress associated with commencing university, $F(3, 44) = 8.82, p = .001$, Adjusted $R^2 = .33$. Results showed that the stress of shifting house significantly predicted the stress of commencing university ($\beta = .59, p = .001$). However, deterioration in living conditions and deterioration in finances did not significantly predict the stress of commencing university ($\beta = .11, p = .374$ and $\beta = -.01, p = .918$, respectively).

For rural and regional students, results of the regression indicated that the three predictors explained 20.8% of the variance in stress associated with commencing university, $F(3, 78) = 8.07, p = .001$, Adjusted $R^2 = .21$. Results showed that the stress of shifting house significantly predicted the stress of commencing university ($\beta = .37, p = .001$). However, deterioration in living conditions and deterioration in finances did not significantly predict the stress of commencing university ($\beta = .11, p = .277$ and $\beta = .18, p = .078$, respectively).

Open Question

Metropolitan and rural and regional participants who indicated that they had shifted house to commence university were also given the opportunity to make further comments. Responses to this open-ended question revealed additional stressors experienced by these students, including: Not seeing old friends, break-up in relationships or distance from partner due to the move, missing home, car problems, lack of familiarity with the new environment, the amount of work required for their studies, and for some, living alone.
Discussion

Results of Current Study

The aim of this study was to examine the stress and perceived social support associated with commencing university between metropolitan and rural and regional students who did and did not shift house to commence university. Deterioration in students’ living conditions and financial situation were also explored, and stress associated with commencing university was predicted from the variables of stress of shifting home, deterioration in living conditions and deterioration in finances.

From the current data, it seems that around 28% of the students in our sample shifted house in order to commence university. Furthermore, a greater proportion of students who shifted house were from Rural and Regional areas, along with all interstate students. Those students who shifted house reported living in a range of accommodations from rented houses, Halls of Residence, to boarding with either family or strangers. There were no significant differences on these factors among students from the three regions (Interstate, Rural and Regional, or Metropolitan).

Although no differences in stress associated with commencing university were shown between students who shifted house and students who did not shift house, over students from rural and regional areas reported significantly more stress associated with commencing university in comparison to students from metropolitan areas. The reasons for this reported stress may vary; however it is reasonable to assume that rural and regional students, in comparison to metropolitan students, might be travelling further to commence university. It is possible that this distance from home might induce additional stress as their support network is no longer nearby and, it might also be, that engagement in previous social or sporting activities is curtailed by the time constraints associated with attending university.

In addition, due to geographical constraints, rural and regional students may not be as familiar with university campuses/structures as metropolitan students, as their location may have limited access to university campuses. In an attempt to decrease stress associated with commencing university, it would be worthwhile having rural and regional students attend university open days and orientation weeks before semester begins, so they are familiarised with their campus of choice.

There was no difference between students who did and did not shift house and perceptions of social support. Further, there was no difference between metropolitan and rural and regional students and perceptions of social support. This suggests that, although rural and regional students reported experiencing significantly more stress associated with commencing
university than metropolitan students, they still perceive their social support network as accessible and satisfactory. This is a positive result, as effective social support may act as a stress buffer for rural and regional students, making the stress they experience when commencing university manageable. Future research might also consider students received support and the impact that this might have upon their stress levels.

Results showed no differences between metropolitan and rural and regional students who shifted house regarding deterioration in living conditions and finances. This result suggests a comparable transition of living conditions and finances among these students and, further, the low mean ratings on each of these variables indicates students’ new circumstances were approximately comparable to those at home.

Finally, the study assessed if the stress associated with moving house, deterioration in living conditions, and deterioration in financial conditions could predict the stress associated with commencing university for both metropolitan and rural and regional students who shifted house. Results showed that for both metropolitan and rural and regional students, the stress associated with moving house predicted higher university commencement stress (33% and 20.8%, respectively). It is unclear from the current data why a difference in explained variance exists. Among the many possible reasons, might be that metropolitan students experienced great dislocation that is, they may have expected to be offered a place at an institution near their home. These and other possible reasons need to be addressed in future studies.

**Implications of the Current Study**

Results of this study suggest that easing the stress associated with shifting house prior to commencing university might be beneficial for overall stress associated with university commencement, for both metropolitan and rural and regional students. This is an important consideration, as stress of commencing university might be indicative of absenteeism and even, in some cases, drop out. Clearly a longitudinal study is required in order to assess this possibility. The stress associated with shifting house might be alleviated with additional financial support. Additional social support might also be beneficial during this transition, so students are settled before university commences.

Clearly the costs associated with commencing university are more complex for metropolitan and rural and regional students than fiscal. In particular, rural and regional students are separated from friends and family. Statistically, they still perceive their support as not different from those students who remained at home, but qualitative comments suggest they do experience loss. Loss of proximity to their friends, loss of relationships, and loneliness in a new and unfamiliar location are clearly among the less tangible costs these students pay to
commence university. University initiatives, such as orientation week and ‘meet and greet’ seminars, might be beneficial for these studies as a mechanism to aid establishment of new social ties.

The current results are somewhat limited in their overall generalisation to all students, due to the results being collected from one Australian University. Future research should endeavor to collect samples from a range of Australian Universities (both metropolitan and rural). In additional, further qualitative data could be collected where students express, if any, university initiatives they found particularly helpful during their transition (i.e., orientation weeks, ‘meet and greets’).

While the findings from this study are informative, and support the need for universities to continue to provide support and advice groups for students in general, little is known regarding how students from other states or countries cope with the stress of commencing university in a strange city or country, and how they cope with adapting to their new life. The issues associated with language and customs, with isolation and depression, may be even greater among these cohorts and future research should address these issues.
References


Influences on women in rural and regional areas help-seeking behaviour during the perinatal period

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Influences on help-seeking behaviour during the perinatal period

ABSTRACT:
A substantial level of depression and anxiety is experienced by women in the perinatal period. This distress might be exacerbated for women in the Northern Territory who reside there temporarily as a function of family-work circumstances and hence may have a limited local social support network; while other women, most notably Indigenous women, who live remotely, might experience issues because of distance, culture, and language. There is limited research concerning depression and anxiety in the perinatal period among women living in these rural and remote areas or in Aboriginal and Torres Strait Islander communities. It is generally considered however, that the incidence will be at least on a par with the general population. Many women no matter their cultural or social circumstances fail to seek help from primary care professionals for emotional distress during the perinatal period and indeed, such distress often is not detected even during routine health visits. These low detection and help-seeking rates can lower the quality of life and increase the morbidity rate among these women in later life, and potentially have an impact on their offspring and partners. Women in rural and remote regions who do seek help may face additional barriers in accessing and/or completing a sequence of treatment. In this paper, we propose a model of help-seeking which is specific to women in the perinatal period taking account of rural and remote factors. The model remains to be validated but the importance of determining factors which influence women’s decision to seek help for psychological issues during this time cannot be overemphasised.

Keywords: Perinatal, Help seeking, Mental Health, Rural and Remote

Introduction

Research indicates that between 8 to 15% of mothers experience depression post-partum (Milgrom, Ericksen, Negri, & Gemmill, 2005; O’Hare & Swain, 1996) with the incidence of perinatal depression increasing to as much as 38% among first-time mothers of low socio-economic status (Seguin, Potvin, St.-Denis, & Loiselle, 1999). It is also clear that
approximately 7 to 20% of women suffer from depression prenatally (Bennett, Einarson, A., Raddio, Koren, & Einarson, T.R., 2004; Gavin, Gaynes, Lohr, Meltzer-Brody, Gartlehner, & Swinson, 2005). The incidence of prenatal depression is particularly concerning given the findings of Evans, Heron, Francomb, Oke, and Golding (2001) that 50% of women detected with prenatal depression also developed postnatal depression. Anxiety, as both a precursor to depression and co-morbid with depression (Misri, Kim, Riggs, & Kostaras, 2000), is also common before delivery as well as postnatally (Buist, 2006). Goodman and Tyler-Viola (2010) reported that 23% of participants recruited from a large urban teaching hospital screened positive for an anxiety disorder or depression or both prenatally, and 17% of women were positive at 6 weeks post-delivery. Of particular concern, especially among Australian Indigenous communities, where 18% of Indigenous mothers are teenagers compared with mothers 3.4% overall (Australian Bureau of Statistics (2014), is the finding that adolescent mothers are nearly three times more likely to experience postnatal depression than older mothers (Swann, Bowe, McCormick, & Kosmin, 2003).

On the basis of Goodman and Tyler-Viola’s findings, it can be argued that many young women who experience prenatal distress do not receive treatment for this distress. An emerging body of research suggests that perinatal depression and anxiety might also adversely affect the child’s development (Anhalt, Telzrow, & Brown, 2007), the mother’s subsequent morbidity, as well as her relationship with her partner. These findings are particularly concerning as not only is the child’s secure attachment to the mother under threat but also their economic and psychosocial security if the parental relationship breaks down.

It is unclear why these high rates of morbidity exist when there are effective interventions available, particularly if the anxiety and depression is detected and treated in the early stages. Screening procedures can, especially where culturally sensitive (Ferguson-Hill, 2010), identify women experiencing emotional distress and facilitate treatment. Yet
according to Austin and Lumley (2003) extant screening measures to identify or predict who might become depressed or anxious during the perinatal period lack both sensitivity and specificity. While this screening is important an equally concerning issue is why many women who experience emotional distress during this period fail to seek help.

Several health models have been developed to predict people’s adoption of health behaviours or behaviour change. In a review of health help-seeking models, Armitage and Conner (2001) classified them into three categories (1) motivational, (2) behavioural enaction, and (3) multi-stage. Motivational models focus on the motivational factors (e.g., protection, motivation, threat) that underpin individuals’ decisions to perform (or not to perform) health behaviours. Such models include the Health Belief Model (HBM; Hochbaum, Rosenstock & Kegels, 1952), Protection Motivation Theory (PMT; Rogers, 1983), Social Cognitive Theory (SCT; Bandura, 1986), The Theories of Reasoned Action (TRA) and Planned Behaviour (TPB) (Ajzen & Fishbein, 1980; Ajzen & Madden, 1986).

These models have commonalities in terms of their inclusion of social cognitions, such as perceptions of illness seriousness and illness severity, and of the ‘pros and cons’ of engaging in behaviour change as well as control beliefs. According to Sheeran and Orbell (1998) motivational models of health behaviour have generally been shown to be successful in predicting health related behaviours. Nevertheless, researchers using these models often use intention as a dependent or mediating variable, implicitly hypothesising near-perfect correspondence between intentions and subsequent behaviours (Armitage & Conner, 2001). Yet studies which have used both intention and behaviour show a significantly larger amount of variance is explained in intention than in behaviour (Conner & Armitage, 1998). It is also important to note that intention is future oriented while behaviour is typically assessed in the present.
The behavioural enaction models are social cognition models which aim to explain intention formation. In Gollwitzer’s (1993) Implementation Intention Model there is a clear distinction between goals as intentions and implementation intentions where the person is asked when and where the intention will be put into action. Another behavioural enaction model is Bagozzi’s (1992) Goal Theory, which is basically a theory of goal attainment that suggests motivational influences affect goal intentions and efforts.

Among the multi-stage models which describe the course of behaviour modification and the factors that might influence behaviour change at the different stages are Prochaska and DiClemente’s (1992) Transtheoretical Model of Change (TTM) and Schwarzer’s (2001) Health Action Process Approach (HAPA). In the TTM change is said to occur over five stages: precontemplation, contemplation, preparation, action, and maintenance; while in the HAPA model, Schwarzer argued that the adoption, initiation and maintenance of health behaviour is a process involving two separate stages: a motivational stage and a volitional stage which occur progressively over: ‘Preintenders’, ‘Intenders’, and ‘Actors’. It can be argued that these three stages are, in fact, analogous with those of Proschaska and DeClemente.

However, none of these models are behaviour specific, rather they are general in nature and vary in the amount of variance they explain in people’s intent to change a behaviour and/or their actual behaviour change. Researchers have used several of these models to predict help-seeking for mental illness, often with the addition of specific variables (e.g., stigma) however, there does not appear to be any specific help-seeking model for women with perinatal depression. It is important therefore to consider a more behaviour specific model, as Bandura (1986) and others have argued with respect to self-efficacy: in this instance, a focus on the particular issues that might preclude women in the perinatal period from seeking help.
Our aim here is to present a model which reflects these factors. Clearly, significant life changes occur during the perinatal period which can be classified as biological such as sleep and appetite disturbances; psychological including changes to body image and feelings of stigma associated with not coping; and social issues related to perceptions of and actual social support. Demographic factors also influence women’s intention to seek help at this time and may include the mother’s age, education level and whether or not she is a member of a minority. Furthermore, for some, feelings of shame, remorse, or even guilt associated with the circumstances surrounding the pregnancy might also exist. Even when a change is ‘positive’, for instance the joy of a long awaited pregnancy, change is known to contribute to stress and anxiety and may lead to depression (Holmes & Rahe, 1967).

The population in the Northern Territory (NT) is unique: it includes large Indigenous communities as well as many migratory Australians, that is ‘ex pats’, from other States as well as those from overseas who have few sources of family support available to them to buffer the impact of change through either instrumental or emotional support. This gap may be important given the widely acknowledged value of social support (e.g., Kaniasty, 2011; Umberson & Montez, 2010).

In many rural and remote communities in the NT, pregnant women are required to leave their home, and hence their potential support network, two weeks before their due date to be monitored in a health facility in the nearest large centre. They are hospitalised at a distance from home for the delivery of their child. While birthing centres and hospitals are cognisant of these factors and attempt to provide women with an appropriate environment (e.g., family accommodation, and for some Indigenous women and their babies smoking ceremonies post birth) this level of displacement and giving birth largely among strangers, can be a source of extreme distress. For Indigenous women who have strong connections to country this separation at such a crucial time could have deleterious effects on their social and emotional wellbeing. Such distress can also be experienced among other women in the NT where the population is largely migratory, and women often have no family and few supports other than their partner. As maternal distress during the perinatal period can also affect the child and possibly other relationships it is important therefore, as emphasised in the National Perinatal Depression Plan (Australian Government DoHA, 2008), to understand the factors which promote or hinder women seeking help.

From the literature in general, we understand that cultural issues (Hsu & Alden, 2008), satisfaction with the mental health service (Knipscheer & Kleber, 2001), self- and perceptions of public-stigma, distress around disclosing, as well as attitudes towards counselling (Pederson & Vogel, 2007) influence willingness to seek help. Vogel, Wade, and Haake
(2006) developed a scale to assess self- and public-stigma associated with seeking help for mental illness. In their assessment of over 500 students, stigma differentiated between those who would seek help for a psychological concern and those who would not; furthermore, self-stigma uniquely added to the variance beyond public-stigma and the anticipated risks and benefits of help.

Other research has indicated not wanting to be controlled, not overreacting to the problem, financial difficulties, embarrassment, not liking to talk about feelings (Mansfield, Courtney, & Addis, 2005), lack of belief that it would help (National Rural Health Alliance, Inc, 2011) as well as being less educated, part of a minority (Horgan, 1985), and past use of services (Leaf, Bruce, & Tischler, 1986) predicted low levels of help-seeking behaviour. Clearly, these as well as issues of access, culture, and language, and perceptions of the ‘system’ might contribute to a diversity of reasons as to why women across Australia and notably women in the NT might fail to seek help.

These factors may also influence women’s ability to access and complete treatment. In Darwin (a remote, tropical city in what is termed the Top End of Australia) for example, women who were referred to a series of funded local perinatal depression groups had to navigate issues of childcare (for the new baby and his or her siblings if not of school age); travel; and in many cases exhaustion from the role of primary caregiver. Despite the fact that many of the women referred were socio-economically stable and had engaged in help-seeking via their General Practitioner, the lack of extended family support; limited if any, other supports; an ‘absent’ partner (due to shift work, fly-in fly-out [FIFO] schedules, defence and para-military employment), meant that committing to and completing the program was challenging. Those who had only recently relocated to the Top End stated they were still adjusting to Top End living and were feeling overwhelmed.

In addition to individual factors, several external factors may also influence women’s decision to seek help at this time. Among these are their knowledge of available services and their accessibility; their relationship with possible service providers and their satisfaction with these services in the past.

We have attempted to synthesise these elements into a model of help-seeking behaviour specific to women in the perinatal period (see Figure 1) taking into account cultural and geographic factors. It is important that women living in urban, rural, and remote regions both in the NT and elsewhere who are at various stages in the perinatal period participate in studies to validate this model. In addition, input and feedback from midwives and medical practitioners is vital to determining the biopsychosocial reasons women seek help and, more
importantly, why they choose not to seek help. Such a model is in line with the National Perinatal Depression Plan (Australian Government DoHA, 2008) which emphasised the need to assess women’s psychosocial wellbeing in the perinatal period, educate health professionals about perinatal depression, and develop pathways of quality care for women with or at risk of depression.

Figure 1. Model of help-seeking behaviour for perinatal women

It is argued that the proposed model offers a richer, more specific and comprehensive understanding of the issues involved in women’s help-seeking motivations and behaviours and the barriers to this, than can be found in more generic models. Such specificity is in accord with Bandura (1986) who, although referring to self-efficacy and not help-seeking, argued that specific as well as general explanatory models are essential.
Empirical support for the elements of this model will provide rich information to include in health promotion strategies, information sheets for women in the perinatal period and their families, as well as factors that may alert health care practitioners to the distress felt by women at this time. The ultimate aim of such research is to reduce this distress for the woman, and as a result, her child, and the family by facilitating timely care.

We also offer a model to be considered from the health carer’s perspective as often this side of the equation is neglected or the focus is primarily on the biological aspects at the cost of holistic care (see Figure 2). In this model we suggest that, aside from the importance of biological factors which may be a first indicator of depression for some women and is often the primary focus of practitioners, the woman’s psychological and socio/cultural circumstances also need to be considered as possible primary indicators of her need for help. It might also be that observation of these factors by staff at the various Maternal and Infant (Child) Health Services in the States and Territories can lead to recommendations to the woman to seek professional help. Whether this help is of a clinical, practical or support nature is less relevant; the fact that a need for help is identified and acted upon are what is paramount.

While much research has addressed depression in the perinatal period, and recommendations for drug, cognitive, and other therapies are available, it is imperative that all trainees and health care practitioners are aware of the broad issues that might affect women in the perinatal period and after, as depicted in these models.

In sum, identifying help-seeking behaviours and providing perinatal mental health services for women, especially those in rural and remote regions, needs to take into account the unique demographic and socio-environmental aspects of their lives as well as external factors related to health services generally and health providers specifically. In addition, relevant pathways to participation: flexible and multimodal delivery; costs; options to include partners or significant others; and childcare, which were issues which emerged from our Darwin experience need to be considered. While our proposed model is comprehensive, it is not and cannot be exhaustive. However, it does take into account the specific factors which may identify help-seeking behaviours among women in more remote locations, such as in the NT, including Aboriginal communities.
Figure 2: Practitioners recognising need for help

- **Demographics**
  - Younger
  - 1st pregnancy

- **Biological**
  - Difficult pregnancy
  - Sleep issues
  - Appetite issues
  - Separated from infant
  - Infant fails to feed/thrive

- **Psychological**
  - Irritable
  - Guilt over infant’s health
  - Low mood
  - False positive

- **Social/Cultural**
  - Lack of partner
  - Lack partner support
  - Away from family
  - Language difficulties

Recognising need for help
References


Rural and Remote Mental Health:

Reconnecting the Circle:
Returning to Stillness
Through Mindfulness and Yoga

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Rural and Remote Mental Health:
**Reconnecting the Circle:**

**Returning to Stillness**

**Through Mindfulness and Yoga**

**ABSTRACT:** There is an emerging body of scientific evidence, developing through fields of neuroscience, molecular biology, psychiatry, medicine and psychology, that parallels traditional wisdom, in recognising the importance of restoring balance to social, emotional, physical and inner wellbeing. The effects of trauma can be addressed via therapeutic interventions integrating evidence-based western, eastern and traditional healing practices through a secular framework of mindfulness-based interventions and yoga. Our western paradigm of health and wellbeing can benefit from the integration of traditional wisdom for the benefit of all beings and the environment. Underpinning the need for change is immense human suffering through an exponential rise in stress related disease and the unprecedented and significant divide between Indigenous and non-Indigenous health and wellbeing that is well documented and can be traced back to the far reaching effects of trauma (Atkinson, 2002). The potential for existing paradigms of healthcare to adapt and move toward a global humanity that combines knowledge from the world’s wisdom traditions and science may offer hope and bring about change for the future.

Keywords: *Mindfulness, Yoga, Trauma, Indigenous, Wellbeing.*
Introduction

There are many kinds of medicine, but most medicine only eases the suffering in our bodies and minds temporarily. It doesn’t heal the source of our illness. Mindfulness, however, is a truly healing balm that can help put an end to our sense of alienation and help us heal both ourselves and our planet. If we can ground ourselves, become one with the Earth and treat her with care, she will nourish us and heal our bodies and minds. Our physical and mental sicknesses will be cured and we will have wellbeing in body and spirit.

While the energy of our thoughts, speech and actions is powerful, this energy is infinitely more powerful when we join together with others. When we come together as a group, with a common purpose and commitment to mindful action, we produce an energy of collective concentration far superior to our own individual concentration. This collective energy can lead to collective insight and to a collective awakening. Our collective compassion, mindfulness, and concentration nourishes us, but it also can help to reestablish the Earth’s equilibrium and restore balance. Together we can bring about transformation for ourselves and for the world.

Thich Nhat Hanh (2014 p.35)

Zen Master, Teacher, Author, Poet and Peace Activist

An emerging body of scientific evidence, developing through fields of neuroscience, molecular biology, psychiatry, medicine and psychology, parallels traditional wisdom and ‘the healing balm’ that Thich Nhat Hanh (2014 p. 35) refers to, in recognising the importance of restoring balance to social, emotional, physical and inner wellbeing. The effects of trauma can be addressed via therapeutic interventions integrating evidence-based western, eastern and traditional healing practices through a secular framework of mindfulness-based interventions and yoga. This approach contributes to the coming together of a common humanity. Developing science increasingly supports the notion that our western paradigm of health and wellbeing can benefit from the integration of traditional wisdom for the benefit of all beings and our planet. Underpinning the need for change is immense human suffering through an exponential rise in stress related disease and the unprecedented and significant
divide between Indigenous and non-Indigenous health and wellbeing that is well documented and can be traced back to the far reaching effects of trauma (Atkinson, 2002).

Trauma initiates immense suffering through heightened activation of the body’s innate alarm systems, reducing the potential for flourishing across many domains of health including the acceleration of aging and the triggering of genetic vulnerability to disease. Experiences of trauma can mean that we never truly feel relaxed or at ease as reactivity resonates deeply through the body’s fear response or limbic system, impacting on sleep, ability to concentrate, and our innate capacity to trust in the goodness of the world and feel connected. Trauma can produce a deep sense of disconnection from self and others and has the potential to initiate maladaptive coping responses including substance abuse, self-harm and suicide (Van der Kolk, 2014).

In traditional psychotherapy, the relationship between thought and emotion is often the primary focus, overlooking the complex interplay mediated by stress hormones of our inner sensory world, internal organs and muscle contraction of the limbs, face, throat and abdomen. Emmerson & Hopper (2011) describe the consequences of trauma are that the body becomes “a kind of alien force….unknown, unpredictable, unreliable” (Emmerson & Hopper, 2011, p. xv). The impact of trauma on health and wellbeing is highlighted through the Adverse Childhood Experiences (ACE) study linking adult health status to physical, emotional and sexual abuse experienced in childhood, with cumulative effects of trauma associated with significantly higher risk of developing serious substance abuse or dependence, depression and suicidality in adulthood (Felitti, 1998). Such cumulative effects are also related to an increased risk of the leading causes of adult death including obesity, heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Felitti, 1998).

Throughout the world, the experience of colonisation has resulted in large groups of Indigenous People experiencing overwhelming intergenerational trauma. These effects can be seen through rates of homelessness, involvement with the justice system and child protection agencies, and also violence, suicide, accidental death and drug and alcohol problems (Linklater, 2014). Linklater (2014) highlights the importance of viewing the complex effects of trauma as a collective or shared problem arising through the process of colonisation, as opposed to individual issues. Healing practices that calm and balance body, mind and spirit
through reconnection to self, the community and culture are based on a model of wellness instead of symptoms of illness.

Practices that encourage a reconnection to inner stillness founded on clear value systems are inherent in many Indigenous wisdom traditions and not always explicit within western culture, and may be related to increases in rates of stress related illness and mental health problems. Cultural practices for example, story-telling, rhythmical dance and music, sharing of food, interconnectedness and relational experience of group activities, encourage somatic experiences that directly influence neural systems and regulate the expression of trauma, neglect and abuse while simultaneously reinforcing cultural values (Linklater, 2014).

The symbol of the circle relates to life and a universal connectedness from which balance and harmony arise. In many healing traditions, the circle is a symbol of spiritual, physical, mental and emotional connection. Broomfield (1997) suggests that modern science can do well to “lay aside the driven symbol of the straight line and adopt once more the ancient symbol of the circle which represents harmony, moderation and balance - optimization rather than maximisation” (p.139) in order to support people to once more uncover an internal ‘knowing’ and innate capacity for healing of body, mind, heart and spirit. Conceptualising health as being inseparable from inner wisdom and culture can highlight barriers to wellbeing in adapting therapeutic approaches.

Healing wounds involves cultivating an awareness of the physical and sensory processes playing out in the body, and importantly, formulating skillful responses of befriending and tolerating sensations and inner experiences. The ‘stepping out’ of automatic reactivity and responding with kindness, compassion and curiosity to our felt sense of what is arising in the present moment can contribute to a sense of mastery. It can provide new internal resources, which allow us to recognize what is happening, be curious, observe and make choices about responding. Within mindfulness circles a practice referred to as ‘attending and befriending’ is a skillful and conscious response to our internal experience of trauma, and seemingly paradoxical to the automatic and reactive fight and flight related behaviours. The body’s response to trauma can be mediated through body-based interventions targeting the alarm system, toning down the limbic system and mediating biochemistry that elevates oxytocin, enabling us to self-sooth and to form significant relationships with others (Van der Kolk, 2014).
In looking to a new paradigm that focuses on supporting individuals to flourish through developing and reconnecting with stillness and balance, Van der Kolk (2014) suggests the importance of healing approaches that have foundations in safety affect regulation, coping, and self-management skills, as well as the therapeutic relationship itself. Mindfulness-based interventions and yoga offer a paradigm of learning from the ‘inside out’ that can address human suffering through restoring balance to the body, mind and heart, and differ from traditional modes of learning from the ‘outside in’. Both are grounded firmly in ethical value systems that include for example non-judging, non-striving, patience, trust, compassion, letting be and letting go.

Mindfulness is an inherent part of our capacity as human beings, and as such is a deeply embodied element in traditional Indigenous cultures. Mindfulness involves paying attention to the present moment with non-judgmental awareness to whatever thoughts, feelings and sensations are arising within our conscious awareness. Mindfulness-based training supports people to pay attention to thoughts, feelings and body sensations and through increased awareness to make better health-related choices. Neuroscientific studies have found people who participate in mindfulness-based training can experience changes in areas of the brain associated with decision-making, attention and empathy. The studies show increases in the area of the brain linked to regulating emotion, improved attention, job performance, productivity and satisfaction. Further, people who participate in mindfulness-based training experience increased blood flow, reductions in blood pressure, and protection for people at risk of developing hypertension. The risk and severity of cardiovascular disease is reduced, and also the associated risk of death (Kabat Zinn, 2003). Furthermore, there is evidence that people who have participated in mindfulness-based training programmes report long-lasting physical and psychological stress reduction, discover positive changes in wellbeing, are less likely to experience relapses in depression, and are better able to manage addictive behaviour.

The interest in applications of mindfulness-based interventions from disciplines including neuroscience, psychiatry, psychology, molecular biology and education suggests that there is much mindfulness can offer to benefit health care and education systems in Australia. Mindfulness-based Stress Reduction (MBSR) was developed by Professor Jon Kabat-Zinn and his colleagues in 1979 at the Center for Mindfulness in Medicine, Healthcare and Society at the University of Massachusetts Medical School. MBSR has a focus on cultivating physical and emotional balance. More than 20,000 people worldwide have completed the program, and
over 250 similar programs have been set up at other major medical institutions. In the past 30 years, MBSR has been well researched and found to be effective for alleviating a wide range of both psychological and physical symptoms (Kabat-Zinn, 2003).

In focusing on supporting flourishing – as opposed to treating symptoms – the potential to transform wellbeing and save money simultaneously is within reach. Mindfulness-based training and interventions have the potential to bring about change and deeply profound healing. The Mindfulness-based Stress Reduction program in Australia has traditionally been offered in the private sector, while in parts of Europe, the United Kingdom and the United States of America, MBSR is offered through the health systems in many of the major hospitals making it available and inclusive for people who are socio-economically disadvantaged. In a progressive step during 2014, an All Party Parliamentary Mindfulness Group in the United Kingdom has been formed to bring mindfulness into public policy as a means of reducing costs in the rising health budget, and improving the nation’s health and wellbeing. To date approximately 95 UK politicians have participated in the 8-week mindfulness-based Stress Reduction program. Arising from the Mindfulness Initiative, a coalition of academics from Oxford, Bangor and Exeter Universities, the model has the potential to considerably change the face of healthcare in the UK and more broadly throughout the world.

Implicit in mindfulness-based interventions is an understanding that we have an innate capacity to heal through harnessing the wisdom of the body, mind and heart. This view is echoed through the ancient tradition of Yoga which, at its core lies the implicit understanding that the cause of suffering emanates from the mind, and understanding the causes of suffering enables self-determining choices toward rebalancing health and wellbeing. The importance in shifting perceptions related to health and wellbeing are highlighted by Atkinson (2002) who suggests that humanity remains united by the need to know who we “are at deep structural levels of being” (Atkinson, p.245).

The effects of traumatic experiences can trigger both sense of disconnection from self and others, and maladaptive coping responses addressing our need for connection. Yellowbird (2014) argues the need for conceptualizing rising rates of depression, anxiety, addiction and stress related disease (diabetes, heart disease, some cancers) as coping responses to trauma, and recommends the antidote to stress being a reintroduction of our capacity for stillness
through stories, songs, meditation and creativity. Many Indigenous traditions develop strong protective connections to culture through practices that support the return to inner stillness and healing through activating parts of the brain is associated with wellbeing (Linklater, 2014). Engaging with practices that encourage and interrupt pathways of emotional reactivity can be supported through mindfulness-based interventions, as changes associated with neuroplasticity in the brain can mediate stress, increase empathy and promote memory (Kabat-Zinn, 2003). Increases in empathy have significant implications for humanity and the environment.

A return to stillness represents infinite possibilities for the future of our fragile planet, “the way we harm the earth affects all people, and how we treat one another is reflected in how we treat the earth.” (Hawken, 2007). The potential for change is felt through a wave of acknowledgment that some of our western clinical models are not always helpful, and there is much to be learned from Indigenous cultures and traditional ways of healing and wisdom. For example, in Australia, Aboriginal people traditionally practice deep listening in cultivating inner stillness, based on respect that involves still awareness and waiting (Atkinson, 2002). In many Indigenous traditions there is implicit acknowledgement that the heart and mind have the capacity to heal through connection with self, community and the environment. The words of the Native American Elder, Chief Seattle (1854) offer a way to understand the intricacies of interconnectedness:

*Humankind has not woven the web of life.*
*We are but one thread within it.*
*Whatever we do to the web, we do to ourselves.*
*All things are bound together,*
*All things connect.*

One of the significant issues in changing paradigms integrating traditional wisdom practices including mindfulness and yoga involves the development of teachers embodying qualities such as authenticity, authority and friendship (McCowan, 2013). Core characteristics of effective healers have been identified by The Canadian Aboriginal Healing foundation as including a background and solid understanding of ethical conduct and well established personal boundaries that are protective against harm and burnout (Kishk, 2003). They suggest healers are respected members of the community, are able to be present, listen deeply and
hear with clarity and acceptance, engage in clinical supervision and reflective practices, have humility, positive energy, can understand professional limitations and are spiritually grounded (Kishk, 2003). Deep inner listening is important for both the therapist and client in cultivating compassion and stillness.

It is well recognised in circles of teacher training for mindfulness-based interventions that “the teaching has to come out of one’s practice” (Crane et. al., 2010). Santorelli (2001b) argues that the importance of personal practice is not so much to improve pedagogical skills as to develop presence and the ability to fully meet the moment with participants by offering “an authentic embodiment of this commitment to be awake in one’s life no matter what is occurring” (p.11), and developing possibilities for the participant feeling “the same warm connection with themselves” (p.11). In Mindfulness-based Stress Reduction the teacher’s embodiment of mindfulness is congruent with conveying authenticity, and as Crane et. al. (2010) argue “the depth of experience that teachers have in exploring their own personal process through their mindfulness practice and through other personal development processes is thus held to be directly related to their ability to ‘meet’ the participants in a mindfulness-based class in this radically new way, thus creating a space in which participants can inquire into the actuality of their experience with compassion and free from the constraints of the inevitable ideas that arise about what could or should be happening” (p.78). As a clinician, knowledge of our own heart, mind and body facilitates supporting clients in practices that allow the realization of our innate potential as human beings.

We are engulfed in an era of unprecedented change and uncertainty that requires existing systems of healthcare to adapt and new training programs to support and reflect the dynamics of change. Importantly, we need to question existing paradigms and understand better the antecedents of barriers to health and wellbeing in order to support people to flourish and be self-determining. The diversity and unique important contributions of different cultures, provide a platform for us to step beyond traditional western approaches of viewing health toward a vision of a global humanity that combines the knowledge and wisdom from both the world’s wisdom traditions and science to offer hope and bring about change for the future.

*To come together as one, we must know our place in a biological and cultural sense, and reclaim our role as engaged agents of our continued existence. Concern for the wellbeing of others is bred in the bone, endemic and hardwired. We became human by working together*
and helping one another. According to immunologist Gerald Callaahan, faith and love are literally buried in our genes and lymphocytes, and what it takes to arrest our descent into chaos is one person after another remembering who and where they really are.

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A whole-community service delivery model for strengthening the mental health of drought-affected Northwest NSW

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A whole-community service delivery model for strengthening the mental health of drought-affected Northwest NSW

ABSTRACT

Aims: This paper aims to outline a service delivery model implemented in drought-affected communities in Northwest NSW. With continued federal government funding, the program hopes to strengthen the resilience of individuals experiencing mild to moderate mental health issues as a result of the pressures of drought. A unique approach was employed in order increase access to the available counselling & psychological service and aimed to strengthen the community as a whole not only the individuals within it.

Contents: The program was designed to overcome many of the typical challenges faced with help-seeking in rural areas: stigma, perceived lack of services, lack of privacy, high suicide risk and long wait lists. Whilst there were challenges associated with this, contact with over 7000 people was provided through psychological counselling services or attendance at community events and over 200 people were provided with psychological counselling services. This suggests that the delivery model allowed a significant amount of access to services and showed some success in overcoming the barriers mentioned above. Integral to the service delivery model was use of media and promotion, consultation with community leaders, flexible modes of delivery, varied referral pathways and an informal approach to intervention in order to be culturally sensitive and appropriate. Presenting issues were commonly seen concerns such as anxiety and depression, however also followed themes unique to rural lifestyles and farming.

Conclusions: The approach to delivery of mental health services in drought-affected Northwest NSW has been novel and effective in reaching rural communities. Further quantitative research is required to evaluate the effectiveness of interventions in terms of strengthened resilience of individuals and communities. The model outlined in this paper has implications for rural psychological practice in general, not only for those communities affected by drought.

Keywords: Rural, Mental Health, Community, Psychology, Service Delivery, Australia, Drought, Northwest NSW

Introduction

It is generally accepted that a person’s mental health is affected by an interaction between genetic predisposition and environmental context. Arguably, environmental context includes the natural physical environment as well as socio-cultural factors. Environmental factors may have a protective impact upon a person’s mental health or exacerbate underlying genetic vulnerabilities. During prolonged stressful events such
as drought and the associated impacts of drought, even the most resilient person would struggle to remain mentally unaffected.

Australia is the driest inhabited continent in the world and therefore Australian farming and agriculture has always been, and will continue to be, affected by periods of drought. Drought, in comparison to other natural disasters such as earthquakes or floods, is a subjective experience, insidious in its onset and tends to have a more prolonged nature. Key to the effect of drought on mental health is the associated financial strain and, regardless of the cause, financial pressure generally contributes to mental health issues. Drought therefore has an effect on mental health similar to any prolonged stressful event, although there are unique cultural factors involved in relation to rural, farming and agricultural lifestyles. See Rennie (2010) for some of the unique factors associated with the stressful effects of drought in Australia. Presenting issues such as anxiety, depression, trauma, grief & loss, relationship conflict, substance abuse and domestic violence were common.

In January 2014, the Federal Government of Australia announced a Drought Assistance Package of $280 million for initiatives in drought-affected parts of Queensland and New South Wales. A significant portion of these funds was allocated towards free mental health programs covering counselling services and community events. Centacare New England North West (NENW) was granted funding in Local Government Areas (LGAs) across Northwest NSW to provide community events and counselling in eight LGAs: Tamworth Regional Council, Gunnedah Shire Council, Uralla Shire Council, Walcha Council, Armidale Dumaresq Council, Guyra Shire Council, Narrabri Shire Council and Moree Plains Shire Council, and to provide only community events in one LGA: Walgett Shire Council (another organisation was granted the funding for counselling in this LGA). The funding to provide community events was shared between several organisations, whilst only one organisation was responsible for providing counselling in each LGA. Although the funding was for a counselling service, many staff members at Centacare NENW are psychologists and therefore able to provide psychological intervention.
There are a number of challenges associated with providing psychological care to people in rural and remote regions. These typical barriers to treatment will guide principles of practice and service delivery. For a detailed summary of research on this topic, please refer to Jameson and Blank (2007):

1) **Isolation.** There is greater time, cost and effort associated with greater travel distances to mental health services.

2) **Stigma.** There tends to be a negative connotation associated with help seeking for mental health issues.

3) **Lack of services.** There is generally less availability of services. There may also be a perceived lack of services which impedes people from viewing psychological care as a viable option.

4) **Waiting lists.** Fewer services generally result in longer waiting lists.

5) **Lack of privacy.** In small communities, it may be difficult to maintain confidentiality and privacy in accessing psychological care, and there are fears around these issues.

6) **Lack of belief in the need for treatment.** Perhaps even with knowledge that a service is available, treatment is not seen as necessary.

7) **Cost.** There are often costs associated with psychological treatment. Additionally, the cost required for outreach to rural areas impedes services from being accessible.

8) **Self-reliance.** A general preference for taking care of problems themselves, and pride in not requiring help is a characteristic born out of necessity when geographically isolated.

Many of these barriers to treatment are factors implicated in explaining the high rates of suicide in rural areas relative to urban areas. The profound impacts of drought upon mental health combined with these issues sets a significant challenge to service providers to effectively implement a program within the funding framework.

As noted by Jameson and Blank (2007), research efforts have tended to focus more on identifying the challenges associated with psychological practice in rural areas and less on creating novel solutions to these problems. The value of this paper is its aim to outline an innovative service delivery model that provides a practical and immediate solution to overcome these challenges.
The design and implementation of this program was broadly guided by principles of Community Psychology. This required consideration of the following ecological (Kelly, 2010) and general principles (Levine, Perkins, & Perkins, 2005):

1) The context of the social environment interacts with individual issues and has implications for treatment. There is a focus on the person-in-environment, as well as a focus on the community as a larger unit than the individual or family. It involves trying to improve the interaction between persons and environments, as opposed to simply trying to change individuals. This author argues that the context of the physical environment also plays a considerable role, especially in regards to farming lifestyles.

2) Treatment requires providing methods of intervention that are congruent with the culture of the community. This requires service delivery to be culturally sensitive and appropriate.

3) A relationship of respect and trust with the community at large is integral. This involves leaving familiar settings, developing working relationships with other agencies in the community, aiming for local empowerment, reducing bureaucracy and a collaborative approach.

4) Limiting the power and prestige of the psychologist allows an approach that is non-threatening and non-confronting. This involves acknowledging that many groups are suspicious of, or intimidated, by professionals.

5) Prevention is more effective than treatment. Promoting healthy environments and lifestyles, and adopting preventative measures that are more proactive than traditional psychology are more likely to be effective than therapeutic measures. This involves modifying environmental conditions or strengthening the person, and considering intervention in the early history of a problem.

6) It is more effective to emphasise community and personal strengths and competencies than weaknesses. This requires focusing on health, rather than illness, avoiding labelling people as abnormal in order to provide less stigmatising services and searching for resources instead of psychopathology. This principle may be particularly important given the already very present stigma in rural areas.

The implementation of this program was also guided by the principles and ethos of our organisation. Centacare NENW’s vision is for a society in which there is
recognition of individual and social rights and responsibilities, a society that promotes
dignity, equality and participation for all its citizens. Again, this required adapting
traditional approaches to psychological intervention in order to make services more
equitable to rural populations.
Method

The three key elements of the service delivery model are media & promotion, community events and counselling, as seen in Figure 1. At each of these points, a form of intervention is delivered. The three key elements feed into each other to create an integrated approach and to provide intervention at all levels of the community ranging from the whole region, to smaller communities and more specifically, couples, families and individuals.

Figure 1: The Whole-Community Service Delivery Model

Media & Promotion

The use of media and promotion is fundamental to our service delivery model for two reasons. Firstly, advertising is crucial in order to ensure people are informed of the
availability of our service. If the community were not aware of the existence of our service, they would not be able to access it. This aimed to overcome the perceived lack of mental health services available in rural areas. Secondly, the advertisements themselves contained important messages about mental health issues in the same way as a national public health campaign might. The important difference is the direct link to a trusted local service as opposed to general increased awareness of mental health issues. Examples of phrases used in television, radio and newspaper advertising included:

- Doing it tough in the drought? You’re not alone.
- The earlier you ask for help, the sooner you’ll be back on top of things.
- “Asking for support was the hardest part, but these days my only regret is that I didn’t do it sooner…” Lachlan, Narrabri
- Don’t let it snowball, we all need to talk.

These phrases aimed to highlight the importance of seeking help for mental health issues and the positive effects that can be gained from talking about your experiences. They also focus on prevention of issues by suggesting seeking help sooner rather than later. Casual and inclusive language seeks to reduce the stigma and normalise the experience of mental health issues. In this sense, seeing the advertisement may be interventional, as well as providing validation and informing that there are people who care and have the skills to help. Advertisements also emphasised the confidential nature of our service in order to address concerns around lack of privacy and addressed the perception that psychological services can only be provided in office-based settings. Local community leaders were used for appearances in advertising to strengthen a local connection. We also carried a wide range of promotional materials such as stress balls, tape measures, travel mugs, pens, notebooks and other items to hand out at community events. All media and promotional materials clearly used our organisation name and had contact details for ease of access.

Media and promotion allowed for multiple referral pathways to counselling. We accepted referrals from general practitioners (GPs) or other service providers as they may have seen advertisements themselves and or received our flyers in the mail. We were able to identify eligible clients who had been linked with our organisation through other referrals. Clients themselves were able to make a phone call or visit the
office in person to sign up for counselling. People could refer friends and family members as long as they were aware of our requirement to inform the potential client where we had acquired their contact information.

**Community Events**

Community events played an important role in strengthening the community, and were therefore important in their own right, not only as a promotion opportunity or referral pathway to counselling. Events provided opportunities for people to connect and participate in community life and experience the socialisation required to overcome isolation, as well as enjoyment and relaxation. Events were wide ranging and might also include elements of education on mental health issues. Presence at community events may have provided validation, and again had an interventional effect in this way. Planning of events engaged local people and involved consultation of community leaders and members in order to determine the unique needs and wants of that particular community. Local organisations were employed to take ownership over their events and were empowered to make the event a success for their community.

Some events were entirely run by Centacare NENW, while others were made possible through joint efforts between organisations or having a presence at pre-existing events. Everybody from the community was welcome to attend community events, although the events were designed to attract drought-affected populations. Examples of community events run by Centacare NENW were:

- Family fun days
- Pamper days
- Music concerts
- Outdoor cinema screenings
- Men’s health talks

Community events also included training for community leaders and others with primary contact with drought-affected people such as priests and ministers, local government members, hall committees often involved in hosting community events, P&C associations, Lions Club groups, agribusiness workers, bankers, financial
counsellors and veterinarians. This values the key role community leaders play in reducing the stigma associated with help-seeking and in referring clients to mental health services when required.

One of the most unique aspects of our service delivery model is the follow up process following community events as a referral pathway to counselling. At many events, there were lucky door prize forms, feedback forms or registration forms which contained “Yes” or “No” check boxes for the person to indicate if they would like to be contacted by our service. Providing this follow up within one to two weeks of the event, we were able to make referrals to financial support, provide immediate counselling or sign clients up for regular counselling. Where unable to make phone contact, we were often able to send an email or letter outlining available drought support.

Community events provided an opportunity to promote our service, through banners and distribution of flyers and promotional items. An example of co-ordination between community events and promotion is the travel mugs with the phrase “Never underestimate the power of a cuppa and chat” which were taken to sale yards to use for farmers having their tea or coffee. Events also played an important role in building a trusted relationship with the community. Sometimes support was provided through the planning of events as it involved liaising with community members and hearing about their situation and needs. Counselling staff were always present at community events in order to provide immediate assistance.

**Counselling**

The counselling element of our service delivery model allowed for more specific intervention with individuals, couples and families. In terms of eligibility criteria, anyone of any age affected by the drought was eligible for counselling and support. This included people indirectly impacted such as contractors, small business owners, those supporting others affected by the drought and almost anybody living in small rural communities. In recognition of the widespread and often indirect effect of drought, drought had to be an exacerbating factor in the client’s issues, though not necessarily their largest stressor, as sometimes people were coping with the drought while other areas of their life suffered. Community leaders were eligible for
counselling themselves in recognition of the stress involved with supporting others with mental health issues. Individuals with mild to moderate mental health issues were eligible, as opposed to high needs or acute patients. Sometimes counselling was more supportive and social, and sometimes it was more formal psychological intervention.

Outlined below are some particular features of our approach to counselling:

1) *Flexibility of treatment delivery mode.* Clients could access face-to-face sessions at one of our six offices, at their property or another location that suited them such as a park or café. Clients could also access services through telephone or video technology, and use these options in combination with each other.

2) *Flexibility of treatment duration and frequency.* Some clients appreciated a 15-minute phone call every month, while others came into the office for hour-long appointments every fortnight. Outreach to properties could often take two hours. Some clients (mostly where it was telephone support) did not require fixed appointment times, in order to accommodate for the variability of farm work.

3) *Immediacy of treatment.* Counselling was provided immediately wherever possible, for example at community events or at the time of receiving a referral, phone call or visit from a potential client. Occasionally, this involved elements of crisis counselling such as suicide risk assessment and safety planning.

4) *Informality of approach.* Wherever possible, forms were discussed verbally. There was more direct contact with the clinician when possible and appropriate, for example, through email. Manner of dress tended to be more casual in order to challenge typical perceptions of psychologists.

5) *Referral to financial support.* Strong links were maintained with service providers such as Centrelink and the Rural Financial Counselling Service, and clients were frequently referred for financial support.

We also conducted a short two-week initiative to provide drop-in counselling at locations where we did not already have offices. These locations tended to be smaller,
more rural communities and clients could arrive for immediate counselling, as well as sign up for continued support.

Counselling clients were informed of local community events, and could also invite us to have a presence at community events with which they were involved. Promotional items were given to counselling clients to use themselves, or give to others and possibly told others about our service which served to promote it.
Results

It is estimated that this program has provided contact with over 7000 people in Northwest NSW across a period of 12 months between July 2014 and June 2015 inclusive. Of this group, over 200 people were provided with counselling services whether it was immediate, or more regular and ongoing. The following case studies anecdotally describe how the service delivery model functioned in practice:

Karen* became aware of our service after we contacted her to organise an event in her local community. Following this event, she signed up for counselling and made her first appointment. She initially attended weekly, hour-long, face-to-face sessions at our office, and over time reduced these to monthly. Whilst receiving counselling, she continued to be involved with the organisation of events.

Julie* saw our advertisement on television and rang us in distress. A psychologist was available to speak to her immediately for approximately an hour and a half. She attended an appointment at our office, however mostly received counselling through telephone appointments. These appointments were often scheduled using email, with resources also provided in emails. After a year, she felt she no longer required support, however later visited us at a community event.

Craig* attended a community event in his local area where we had a stall. He signed up for counselling and was able to talk to a psychologist immediately about what was going on. The same psychologist contacted him later to schedule face-to-face appointments and outreached once to visit him at his local service station and café. When unable to attend face-to-face appointments, Craig changes his appointments to telephone appointments.

*Names have been changed to protect the confidentiality of clients. Some scenarios have been combined in order to illustrate all aspects of our service delivery model and to further protect confidentiality.
Norman* contacted our office after seeing our advertisements on television and coming across one of our promotional notebooks. He attended face-to-face sessions at one of our offices, for approximately 45 minutes every month. Norman invited us to attend events run by his local community group in order to reach out to others. More recently, he has not required sessions, however calls us occasionally to maintain contact, as well as to inform us of other upcoming events.

Beverley* visited her GP, who sent a referral for psychological intervention. We identified her issues were related to drought, and she was therefore eligible for our service. She was able to make an appointment at one of our drop-in counselling locations during this initiative and the psychologist continues to provide general support and social contact to Beverley through monthly visits to her home.

Mr. and Mrs. Smith* rang our office after their minister directed them to our organisation. They were linked with a psychologist who comes out to their farm every month to provide couples counselling. In between sessions, support is provided through email.

Paul* heard our radio advertisement several times while driving the long distances required to operate his properties. He recognised our name and visited one of our offices while he was in town to visit his banker for more information. A psychologist was available and could see him immediately for a counselling session. The psychologist continues to support him through unscheduled telephone calls, which vary in length, and when he is able, Paul attends a face-to-face session.

William* attended one of our community events and requested a follow up phone call on his lucky door entry form. Multiple voicemails were left for William, as well as an email with further information about our service and referrals for financial support. Two weeks later he returned our call and a psychologist was available to chat to him immediately for 20 minutes. Following that conversation, he signed up for face-to-face counselling at our most convenient office. After several sessions, William felt that a short unscheduled monthly phone call was all the ongoing support he required.
Elizabeth* attended one of our community events and requested a follow up phone call on her lucky door entry form. A psychologist rang her and provided general support for approximately 15 minutes, as well as referrals for financial support. Elizabeth agreed to further supportive phone calls, and the psychologist calls every month to check-in.

The volume of people reached suggests that the service delivery model allowed for significant access to our service and showed success in overcoming the typical barriers associated with help seeking for mental health issues in rural areas. The case studies illustrate how the three key elements to this service delivery model interacted in effective ways to allow access to services, as well as highlighting the flexibility of service delivery mode, duration and frequency, various referral pathways available and ability to provide immediate support.
Discussion

The lack of quantitative or comparative data means that it is not yet possible to conclusively state that this model is effective in increasing access to support services or improving the mental health of individuals or communities. The author suggests this model should therefore be seen as a proposed model.

The elements of our service delivery model that seemed to work well include the ability to provide intervention during all three key elements, the way in which these three elements fed into each other, the multiple referral pathways to counselling, the flexibility of service delivery mode, duration and frequency, and the ability to provide immediate support and psychological intervention over and above the funding for counselling. It is worth noting that this service delivery model could be effective in rural areas not only during times of drought, and could also have some validity for use in other sectors of society that are difficult to engage in treatment such as severe mental illness, disabilities and indigenous populations. There are, however, aspects of our service delivery model which did not work as well, and these are evaluated in more detail below.

Firstly, managing so many different referral pathways can be difficult, including allocation of a clinician and determining the best approach to treatment given so many options. This required organisational flexibility. The short initiative of drop-in counselling did not appear to be effective in increasing access. This may have been because it was difficult to promote and required a significant amount of resourcing for a short initiative. It may be more effective to establish an ongoing day per week, for example, as opposed to a short two-week initiative.

The event follow up, one of the most innovative aspects of our service delivery model had some difficulties, but was overall found to be effective. As some people ticked a box without necessarily reading the form, follow up phone calls could seem like telemarketing and it was very common to not hear back from voicemails and letters. The information provided such as referrals to financial support may have been highly valuable, although this is difficult to gauge and not captured by the data. For others, it provided a very important private avenue that removed some of the responsibility and
fear involved with help seeking. As follow up phone calls often did not result in ongoing psychological services, this may highlight a potential barrier to treatment in that rural people may identify that they are stressed and appreciate a phone call showing our concern, but not necessarily recognise the need for treatment. In many cases, immediate support was valued even when people did not sign up for regular counselling. Although follow up phone calls, presence at community events and advertisements may have had an interventional effect in their own right, these approaches would be difficult to justify funding-wise without the provision of counselling.

We found that our video technology options were not a popular method of service delivery, with the vast majority preferring face-to-face or telephone options. This may be embraced in the future, however clients seemed to value a personal connection, perhaps given the personal nature of counselling and psychological support. There may have been limitations such as client skills and knowledge, as well as concerns with Internet service capability and reliability. Clients sometimes had a preference for office-based counselling instead of outreach, whilst others enjoyed the convenience of outreach to their properties and this emphasises the importance of providing multiple service delivery modes to suit the client. Future directions on the basis of this paper may involve making video technology options more attractive to rural people, as well as exploring manualised eHealth treatments for use in combination with personal connections.

There were some dangers associated with a more informal approach with clients, which required a heightened awareness of personal and professional boundaries, for example, in regards to seeing clients at events and planning events with clients. This could mostly be avoided. There was some difficulty in gauging at what point to discuss confidentiality during a conversation that begins informally and becomes counselling.

Eligibility criteria were quite broad and due to the general lack of psychological services in rural areas, this sometimes made it difficult to determine who was indirectly impacted by the drought and who was simply living in the town of a drought-affected area. In smaller communities, it was presumed everybody was
impacted by the drought, but in some slightly larger towns, this could be difficult to distinguish and highlighted the general need for more services in rural locations.

The program described in this paper clearly requires a considerable amount of resourcing and we were fortunate to have a budget that allowed provision of a free service, finance potentially large community events, provide outreach with short waiting periods and run a substantial media campaign. As an established organisation, we were also fortunate to have multiple office locations in order to provide these options to clients. In particular, the cost of promotion and media could be very expensive, but it is clear to us that this plays a vital role in our service delivery model. The author recognises that private psychologists and many organisations will not have these luxuries and this emphasises the importance of government support for programs such as these.

There were some difficulties associated with the funding model provided by the government. Firstly, the lack of guaranteed continued funding means that it is difficult to a reliable ongoing service. Continued funding is important given the long-term impacts of drought and general need for permanent mental health programs in rural areas. Long-term funding allows organisations to establish trust within the community and provide continuity of service.

Another challenge in implementing this service delivery model within the provided funding framework was that funding in the one LGA for only community events made it impossible, unfortunately, to make direct connections between community events and counselling, as we could in our other LGAs. In this LGA, we were generally required to refer to the organisation with counselling funding and this caused the access to service to become more cumbersome. It seems to be more logical to fund one organisation for both events and counselling in each LGA. It was also sometimes difficult to share community event funding with other organisations. The promotion of counselling services could easily get lost amongst different service providers where only one local organisation was able to provide counselling through the funded drought assistance package. It also seems logical for only one organisation to provide the community events in each LGA. There were also some difficulties with media & promotion in that regional television networks do not necessarily align with
LGAs and this creates confusion where multiple counselling services are advertising in the same region.

While this paper has potentially outlined an immediate solution to barriers to treatment for rural populations, long-term solutions do need to be the subject of focus. Largely, the solution seems to involve attracting more psychologists to rural areas through training programs and placements, as well as working towards cultural and structural change where resilience continues to be valued, but the stigma associated with help seeking is decreased.

**Conclusion**

Centacare NENW’s approach to delivery of mental health services in drought-affected Northwest NSW has been novel and effective in reaching rural communities. This is demonstrated through a significant level of access to the service and suggests that many typical barriers to help seeking have been overcome. Further quantitative research is required to more precisely evaluate the effectiveness of interventions in terms of strengthened resilience of individuals and communities. The model outlined in this paper has implications for rural psychological practice in general, not only for those communities affected by drought.

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