MENTAL HEALTH REFORM IN RURAL AUSTRALIA - WORKING TOGETHER, INTEGRATING CARE

2 - 4 November 2016
Mantra on Salt Beach, Kingscliff, NSW
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Rural & Remote Mental Health: Mental Health Reform in Rural Australia

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Narratives from the field: Conversations and reflections about social and emotional well-being

**ABSTRACT:** Conversation and critical reflection are significant to the practice frameworks of professionals working in communities to enact change. This paper will share the narratives of the professionals engaged in a project to work with families and individuals living in drought-affected areas in South West Queensland to support sustainable strategies to strengthen community wellbeing.

The approach of the Pathways to Resilience Trust Project team was based on developing social and emotional wellbeing and resilience skills across the lifespan. The narratives of practice from the project team have been gathered and analysed using Most Significant Change methodology (Dart & Davies, 2005) and Circle of Change Revisited Critical Thinking Model (Macfarlane, et al, 2014). The process consisted of four steps: deconstructing, confronting, theorising and thinking otherwise about their practice.

This strategy illuminated the strengths of the practice of the team to create sustainability of skills beyond their work within the community for building capacity in social and emotional wellbeing and resilience.

**Keywords:** community development, reflective practice; narrative

**Introduction**

In partnership with Anglicare Southern Queensland, the Pathway to Resilience Trust (PRT) undertook to deliver a range of services in South West Queensland in the shires of Bullo, Paroo, Balonne, Maranoa, Murweh, Quilpie, Goondiwindi as part of an initiative to support drought affected areas. The aim of the initiative, which became known as the Community Wellbeing Project, was to engage both indigenous and non-indigenous community members as part of the resilience-building process; develop social and emotional wellbeing and resilience skills across the lifespan by building individual and community capacity in order to support and create sustainability of the skills beyond the work of the Pathways to Resilience Trust within the communities of South West Queensland.
This paper will share some of the narratives of the professionals engaged in the project and the changes they noted in the individuals, families, organisations and communities during the six-month delivery phase of the project.

**Background**

Pathway to Resilience Trust (PRT) is a charitable organisation established in August 2007 in Brisbane, Australia. PRT was formed with the objective of building resilience in vulnerable families and communities through the promotion of social and emotional learning. Usually PRT works in schools, however increasingly they are being asked to work in other settings such as children’s services and community organisations to help children and adults understand their social and emotional wellbeing.

In 2016, Anglicare Southern Queensland approached PRT to consider ways in which they could help them to work with drought affected areas in south west Queensland. The Federal Government through the Department of Social Services had engaged Anglicare Southern Queensland to deliver a range of services across seven Drought Declared Local Council Regions in Queensland. Anglicare then partnered with PRT, as they were impressed with the kinds of work PRT had been doing in building resilience. Having established the direct link between climate variability, stress, depression and suicide, it was important to consider possible points of intervention in the communities in the south west of Queensland, so that more detailed prevention strategies could be developed and implemented (Kenny et al., 2008). The PRT team initially called the project - Drought Resilience project but after the first couple of days of looking and listening in the communities, the project changed its name to “Community Wellbeing Project”. This change of name is reflected in the processes and the outcomes of the project.

Pathways to Resilience Trust are guided by the mission statement: Resilient Kids. Positive Families. Strong Communities. The Community Wellbeing project team was gathered from tenured and contract staff for the period of the project. As a researcher, I met with members of the team as they were forming and we discussed a methodology of reflective practice that could be used both within the project delivery and to reflect on the development of the team practices. Underpinning the whole project was the concept of developing the well being of the whole community in order to support the individual members. In the first instance this would...
be achieved by giving individuals knowledge about developing social and emotional well-being to help form the bonds that hold a community together. Figure 1 is a simplified representation of the community development process used by the project team. In actual fact there were multiple cycles of consulting, presenting and celebrating during the period of the project.

Figure 1: Community Wellbeing project - Community development process

Methodology – Gathering the narratives

During the timeframe of the project eleven PRT staff were involved in the delivery of the strategic initiatives that included training programs and community activities. These staff consented to having staff planning and debriefing meetings as a data gathering process about the practices in which they engaged.

The planning and debriefing sessions included segments of reflection that were structured using the Circle of Change Revisited (COCR) model (Macfarlane, Cartmel, Casley & Smith, 2014). This model was a significant process as it was used in PRT project team meetings, and in community consultations and in workshop presentations in each of the shires. It was used
by individuals and within the group processes. This model has been useful to examine change processes allowing for multiple perspectives to inform understanding. It was used by the researcher to gather the narratives from the PRT staff. The model was used to illuminate change in thinking, strategies and practices in relation to emotional and social well-being.

In the process of gathering deep insights to progress the Community Wellbeing Project, verbal accounts and personal stories told in a narrative approach allowed the project team to develop a relational stance with the people in the communities. This conversational strategy allowed the project team to more easily understand points of view and uncover new ways of thinking and possibly a more accurate story about the circumstances in the communities experiencing the consequences of long periods of drought. Conversations can be assumed to be more representative of an individual’s inner feelings as well as the social circumstances behind the stories told and participants are more likely to provide more accurate perspectives about the circumstances (Andrews et al., 2008). Scharmer (2009) suggests that you know when you are in generative listening ‘when at the end of a conversation you are no longer the same person you were when you started the conversation. You have gone through a subtle but profound change’ (p.13). The PRT staff summarized the community stories as they shared their narratives with each other and the researcher. Analysing these conversations highlighted some key points to effective working “in the field”.

The COCR critical thinking model is a conversational strategy, which includes the following four processes: deconstruct, confront, theorise, and think otherwise. Initially within the deconstruct stage, participants clarified their perspectives about their approach and listened to one another to understand the various perspectives that exist. During the second stage, confronting, the participants build on the perspectives of the group and confronted the aspects of practice and their own values and beliefs, highlighting some of the inherent ideas that are accepted and rarely questioned about an issue. The third stage, theorise, involved participants thinking about the source of their ideas and using evaluation data collected from surveys and other instruments. Finally, during the think otherwise stage, participants gathered the variety of perspectives presented about an issue by examining previously marginalised perspectives, and developed a position, solution or idea, while encouraging change. Each of these processes combined assists individuals to articulate change. Space is created for discussing experiences in a setting from multiple perspectives. This model privileges both theory and practice because it works on the notion of developing ‘communities of practice’ by valuing
the tacit knowledge, as well as the relevant and up-to-date knowledge in relation to theory and practice. As previously mentioned in the Community Wellbeing Project, the model was used by the project team in the communities in the shires of south west Queensland in the initial consultation phase and it was used to examine the practices of the PRT staff team in project meetings.

Staff were asked to reflect on an aspect of their practice or the actions of others that had made the most noticeable change as a result of the project strategies. The process of reflection used the COCR model and the Most Significant Change (MSC) methodology. The COCR model highlights the importance of critical reflection and encourages individuals to undertake this critique of practice in a democratic and safe environment. It encourages deep level thinking. It is suitable for young people (Cartmel & Casley, 2010) as well as with practitioners and professionals (Macfarlane, et al, 2014). In the process of reflecting, participants told stories about their practice. The PRT team meetings ended using the Most Significant Change methodology (Dart & Davies, 2005). The staff responses were transcribed and then analysed for common themes about the way in which the staff described their work within the drought affected communities. These narratives from the PRT staff contained information about the strategies used by them and the impact or changes they observed. For the purposes of this paper, the narratives told were about the experiences of the ‘PRT Project team in the Field’.

Findings

The PRT staff became aware that certain ways of working were more effective than others. It was noted that the team placed particular emphasis on talking and listening; building knowledge and understanding for individuals; partnerships and collaboration; and cultural connections. Each of these strategies helped to build trust and respect within the communities and meant that the staff team was more likely to support the communities to build sustainable strategies for maintaining community wellbeing.

Talking and Listening

The staff described how they began their conversations in the initial meetings with community members with the following script.

   Introduction: Who are we? What are we offering and how will we achieve it? What is in it for you and your community?
Deconstruct: Describe the situation in your community? Tell us about your life in this town?

Confront: How does your community cope with the current situation? What are the challenges in the community?

Theorise: Can you provide examples of how this community copes with challenges? How does your background help you cope with challenges?

Think otherwise: What was positive or worked with program like ours in the past? How could we do it differently?

Closing: Reiterate who we are.

* A consistent script was invaluable to opening up dialogue and developing relationships with community members. After this process we came back to the office and planned how we could use our programs to support the community members to have a deeper understanding about their own well being* (Team Member 1)

**Building knowledge and understanding for individuals**

The team were acutely aware of the unique challenges posed by Queensland’s population, the nature of rural and remote communities and the link to the provision of mental health services (Centre of Rural & Remote Mental Health Queensland, 2008). The Pathways to Resilience Trust programs were a proactive rather than a reactive response to an awareness of mental health and well being.

**Partnerships and Collaboration**

After the PRT team began the Community Wellbeing Project by conducting pre-tour visits and listening to the needs of the community, they customized offerings of the PRT programs to meet community need around wellbeing and resilience. Further the team built community capacity by nurturing key people in the community to attend training programs and support them to become wellbeing champions. Sustainability of a community sense of well being was critical to the short term and long term outcomes of the project. Finding individuals or organisations that would champion the messages that PRT was making about social and emotional development was important. It was critical to getting into services and it was critical for the uptake of community based projects that provide the opportunities to continue supporting social and emotional well being beyond the funding period.
As much as possible we tried to link in with whatever was happening already. 
In one town we joined with a presentation about business processes. When we read the feedback from the presentation participants said that our “Building resilience through your life” presentation helped them to feel more positive about attending the presentation about financial literacy. (Team Member 2).

The team was aware that there was a need to move away from a ‘crisis response’ service delivery of mental health services. This concept was difficult to achieve without opportunities for members of the community, including professionals providing support to well being of individuals and families, to know more about what each other was doing. The initiative to build community events was a unique opportunity to help create channels of communication across communities to reduce lack of coordination that had been noted as a barrier to providing mental health support (Kenny et al 2008).

Cultural connections
It was important for the team to value each other as much as it was to value the strengths of each of the individuals they met as they travelled across south west Queensland. Pathways to Resilience Trust place a priority on connecting and respecting the Indigenous perspectives.

Having Pete on the team was critical to broadening the other team members understanding about the land on which they were working and travelling. He was a great friend and generously shared his knowledge about the land as well as introducing us to the people he knew in the Indigenous and nonindigenous community (Team Member 11)
Conclusion
The strategic approaches used by Pathways to Resilience Trust staff made visible differences within the community. Community celebrations supporting and supported by community champions were an integral part of the narratives about the sustainable strategies used to support community wellbeing.

Postscript: At the time of writing the following events had occurred:

Faces of Cunnamulla Photographic Exhibition 20 October 2016. 600 people attended this event, which was more than half the population of the town. There was a community barbeque and musical performances including the first public performance of 'The Cully Way' a song/anthem that was written by children from the community during the school holidays. The exhibition of photographs included everyone living in Cunnamulla. To our knowledge no one has ever photographed an entire town before

Home Grown Festival Community Garden Goondiwindi 21 August 2106 – Event was attended by 800 people. The event featured home-grown music and Indigenous dance amongst the home-grown veggies, food and market stalls and activities. The Community Garden President reported, “the garden is all about growing friendships and feeding the mind, body and soul”.

In Charleville community choirs are getting ready to perform at numerous community events including a Big Sing in 2017.

References


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‘Making the journey easier’: An evaluation of community- and clinician-targeted rural suicide prevention workshops

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‘Making the journey easier’: An evaluation of community- and clinician-targeted rural suicide prevention workshops

**ABSTRACT:** For more than eight years the Farm-Link program has delivered suicide prevention skills workshops to members of rural communities, particularly to people from sectors such as finance and agriculture who work closely with farmers likely to experience mental distress. In the course of this work it became apparent that if Farm-Link was going to have a role in advising community members on ‘where to get help’, it also had a responsibility to ensure that health professionals providing that help had the skills and knowledge to support people who were thinking about or considering suicide. Farm-Link partnered with Black Dog Institute to roll out their recently developed ‘Advanced Training in Suicide Prevention’ to health professionals, particularly General Practitioners and Psychologists, in the Farm-Link target area. An evaluation, comprising a series of questionnaires and qualitative interviews, is currently being conducted to examine the two complementary aspects of Farm-Link’s suicide prevention work; the delivery of Suicide Prevention Skills Workshops to rural community members, and delivery of Black Dog Institute’s suicide prevention training to rural health professionals. This presentation reports on the preliminary findings of this evaluation. It reports on the experiences of community members and health professionals who have sought to apply mental health and suicide prevention skills in their everyday lives and practices. The findings of the evaluation highlight that Farm-Link’s suicide prevention training has real transformative potential for community members who, sometimes for the first time, have an opportunity to reflect on their role in promoting positive mental health. However, findings also suggest challenges for maintaining and sustaining the momentum that is generated in short-term training approaches. The partnership approach to delivering suicide prevention training to health professionals highlights the importance of collaboration, recognising that multi-tiered approaches are important, that draw on the existing strengths and resources of communities and associated institutions.

**Keywords:** Suicide prevention, training, rural, community, health professionals

**Introduction**

Farm-Link program, part of the Centre for Rural and Remote Mental Health at the University of Newcastle, delivers rural suicide prevention skills workshops throughout the New England North West region of New South Wales. Previously, Farm-Link’s suicide prevention
workshops targeted people from rural communities who work in sectors such as finance and agriculture and who are likely to work closely with farmers who might experience mental distress. In the course of this work it became apparent that if Farm-Link was going to have a role in advising community members on where to get help, it also had a responsibility to ensure that health professionals providing that help had the skills and knowledge to support people who were thinking about or considering suicide. Farm-Link partnered with the Black Dog Institute to roll out their recently developed ‘Advanced Training in Suicide Prevention’ to health professionals, particularly General Practitioners (GPs) and psychologists, in the Farm-Link target area.

This paper reports on the preliminary findings of an evaluation currently being conducted on two components of Farm-Link’s work; the delivery of Suicide Prevention Skills Workshops to rural community members, and delivery of Black Dog Institute’s suicide prevention training to rural health professionals. While the evaluation is at its midway point, this paper offers preliminary insights into the experiences of community members and health professionals who have sought to apply mental health and suicide prevention skills in their everyday lives and practices. The preliminary findings of the evaluation highlight that Farm-Link’s suicide prevention training has real transformative potential for community members who, sometimes for the first time, have an opportunity to reflect on their role in promoting positive mental health. However, findings also suggest challenges for maintaining and sustaining the momentum that is generated in short-term training approaches. The partnership approach to delivering suicide prevention training to health professionals highlights the importance of collaboration, recognising that multi-tiered approaches are important, that draw on the existing strengths and resources of communities and associated institutions (van der Feltz-Cornelis et al., 2011).

A previous evaluation of Farm-Link’s community suicide prevention workshops indicated that participants show improvements in knowledge and attitude regarding suicide after the training. This supports what is already known about ‘gatekeeper’ training programs. However, it doesn’t tell us much about what happens after training and whether the learnings are applied in everyday life. This paper offers some preliminary insights into the experiences of two different rural groups of people who share an interest, and potential role, in rural suicide prevention and response. It reports on a study which seeks to understand what happens after suicide prevention training activities and to examine the value of multi-tiered approaches to suicide prevention training that recognise the value of different professional, personal and community roles.
Background

There is evidence to suggest that ‘gatekeeper’ suicide prevention training programs – those training programs which target key professionals or community members as points of support or referral for people who may be thinking about suicide – contribute to improvements for those directly take part in the training. A systematic review of gatekeeper training as a prevention intervention for suicide found that, of the nine studies examined, there was evidence showing the programs had a positive effect on participants’ skills, knowledge and attitudes (Isaac et al., 2009). Previous internal Farm-Link program evaluations supported this finding, indicating that participants in community-based suicide prevention workshops had experienced improvements in attitudes towards suicide, increased understanding of suicide and increased confidence to assess and respond to people at risk of suicide. There was some evidence that these improvements, while diminished slightly, were mostly sustained for three months following participation in the workshop. However, little is known about the application of the knowledge, skills and confidence gained in this type of workshop activity and whether, and how, participants go on to apply what they have learned.

A systematic review of the effectiveness of a range of suicide prevention strategies, including education and awareness, treatment, and access to means, found that awareness and education programs targeting primary care physicians ‘represent the most striking known example of a therapeutic intervention lowering suicide rates’ (Mann, Apter, Bertolote, & et al., 2005, p. 2067). Internationally, programs which sought to improve physicians’ knowledge of depression and other psychiatric disorders were generally associated with increased provision of treatment and outcomes such as decreases in suicide attempts and suicide ideation. Brunero et al. (2008) found, in a study of health and allied health professionals in one Australian Local Health District, that targeted training on suicide awareness and management resulted in improved attitudes, skills and knowledge. Although now slightly dated, a particularly relevant Australian study examined the impact of training GPs in recognising and responding to psychological distress and suicide ideation in young people (Pfaff, Acres, & McKelvey, 2001). After attending a one-day training workshop, GPs demonstrated increased recognition rates of psychologically distressed patients and identification of suicidal patients, although there were not significant changes in patient management. Pisani, et al. (2011) conducted a review of 11 workshops from various countries that targeted mental health professionals to improve general
clinical competence in the assessment and management of risk for suicide (including an Australian program). They found a lack of research to demonstrate clear impacts or outcomes from these programs, but two studies within their review showed that the programs contributed to improved clinical knowledge and attitudes. There was no evidence to demonstrate whether the programs had impacted upon skills of clinicians.

GPs are often an important source of support and referral for people with concerns related to their mental health (Australian Institute of Health and Welfare, 2015), but particularly so for people in rural areas where there may be limited specialist services. GPs have been found to be, by far, the main professionals contacted by people in rural locations to seek help related to mental distress (Perkins et al., 2013). As such, the Farm-Link staff recognised that engaging with GPs and other health professionals was a key rural suicide prevention strategy. Given that the Black Dog Institute had recently developed an ‘Advanced Training in Suicide Prevention’ program to target GPs, GP registrars and psychologists, a partnership was developed between the two organisations to deliver this training in targeted rural communities. The evaluation of this training seeks to acknowledge the importance of the multi-tiered approach – training community gatekeepers and health professionals – but also recognises that there are substantial gaps in the evidence base to understand the ways in which these types of interventions actually impact upon practice and decision-making regarding suicide prevention amongst those people trained.

**Methods**

This mixed methods, formative evaluation draws primarily on questionnaires and interviews to understand whether participation in a Farm-Link suicide prevention training activity is associated with changes to attitude, knowledge and practice and to understand whether and how different groups of participants apply what they have learned in their everyday lives and practice. Two discrete groups of participants are being targeted in the evaluation which is being conducted between January 2016 to July 2017; those people who have participated in a Farm-Link Suicide Prevention Skills Workshop and those health professionals who have participated in the Black Dog Institute’s Advanced Training in Suicide Prevention as part of the Farm-Link program.

All participants in a Farm-Link Suicide Prevention Skills Workshop are being invited to participate in a semi-structured telephone interview approximately three months after taking
part in the training, to discuss their experiences of applying what they learned in the workshop. The Suicide Prevention Skills Workshop is a four-hour workshop delivered throughout the New England North West region to members of the public and representatives from groups likely to have contact with farmers, such as financial counsellors and agricultural service providers. It aims to develop participants’ knowledge and confidence in helping someone who may be at risk of suicide using the SCARF action plan – Suspect, Connect, Ask, Refer and Follow-up. The evaluation interview asks questions about participants’ perceptions of key learnings, whether and how they have applied what they have learned and their self-care. A brief pre- and post- training questionnaire is also administered to all participants to identify whether participants perceive improvements to their own knowledge and capacity. Previous evaluations of Farm-Link’s community-based suicide prevention skills training activities used the Literacy of Suicide Scale (LOSS) and Stigma of Suicide Scale (SOSS) in pre- and post-training questionnaires, and had already identified that participation in the training was associated with improvements to suicide literacy and attitude, and as such the LOSS and SOSS are not being repeated in this evaluation. This paper reports on data collected to 30 June 2016, at which point five workshops had been conducted.

Health professional participants are those people who have taken part in a Black Dog Institute 'Advanced Training in Suicide Prevention' conducted under the auspices of the Farm-Link program. The Black Dog Institute's ‘Advanced Training in Suicide Prevention’ is a six-hour workshop delivered by a GP and offers accreditation points for a number of professional groups, including GPs and psychologists. It aims to increase health professionals’ skills and confidence in taking a detailed suicide history and developing a collaborative management plan to increase the safety of people planning suicide. For the health professional cohort, a pre-, immediately-post- and four-month-post-training questionnaire have been designed to measure changes in attitude, practice and knowledge regarding suicide and suicide prevention. The questionnaire incorporates two validated tools; the LOSS, which measures changes in participants' knowledge regarding suicide and suicide prevention through a series of true/false statements, and the SOSS, which measures changes in participants' attitudes towards suicide by assessing their level of agreement with a range of descriptions of people who suicide (Batterham, Calear, & Christensen, 2013a, 2013b). The questionnaire incorporates some additional questions to better understand the current practices of the participants and the context in which they work. The questionnaire is administered at three points (before, after and four months after training) with respondents having the option to complete by paper or online.
Participants are also invited to take part in a semi-structured telephone interview to discuss in more depth their experiences of applying the knowledge and skills learned in the training. Two rural GPs were consulted to support the development of the interview guide and to ensure its appropriateness for the target group. To date, two training workshops have been conducted at rural NSW locations, with a total of 37 participants. It is anticipated that three more trainings will be conducted by July 2017.

Quantitative data were analysed using IBM SPSS (version 23). One-way ANOVA with post-hoc analyses were used to compare SoSS, LoSS and confidence and knowledge scores across the three time points (baseline, midline and endline). Qualitative data were analysed using QSR International NVivo (version 11). A thematic content analysis was conducting drawing on the evaluation questions as a coding framework. Content was analysed to identify frequently reported themes and also the variations in participants’ self-reported experiences.

All data collected is de-identified to protect the anonymity of participants and pseudonyms are used for interview respondents. Participation in the evaluation is voluntary and a decision not to participate in the evaluation does not in any way affect a person’s eligibility to participate in the Farm-Link training activities or any other part of Farm-Link’s work. This study has gained approval from the University of Newcastle Human Research Ethics Committee.

Community suicide prevention skills workshops

To date, 43 participants in the Farm-Link Suicide Prevention Skills Workshops (SPSW) have completed the paper-based pre- and post-workshop questionnaire and five workshop attendees have participated in interviews.
Table 1: Suicide Prevention Skills Workshops pre- and post-workshop questionnaire preliminary results

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<th>Statement (indicate level of agreement)</th>
<th>Pre-training</th>
<th>Post-training</th>
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<td>I could identify someone experiencing signs and symptoms of a mental health problem</td>
<td>53.5</td>
<td>81.4</td>
</tr>
<tr>
<td>I would feel comfortable talking to someone about seeking help for a mental health problem</td>
<td>76.7</td>
<td>93.0</td>
</tr>
<tr>
<td>I could link someone in need to mental health services and information</td>
<td>69.8</td>
<td>90.7</td>
</tr>
<tr>
<td>I understand the risk and protective factors associated with suicide</td>
<td>44.2</td>
<td>90.7</td>
</tr>
<tr>
<td>I feel confident with identifying someone at risk of suicide</td>
<td>30.2</td>
<td>81.4</td>
</tr>
<tr>
<td>I feel confident to ask someone directly about their suicidal thoughts</td>
<td>41.9</td>
<td>83.7</td>
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Prior to the training most respondents did not feel that they could understand, recognise or ask about suicide. After the training, most participants agreed that they had skills and confidence to recognise and respond to someone experiencing signs of a mental health problem and/or someone experiencing suicidal thoughts. This reinforces earlier Farm-Link evaluations which indicated that people who participated in the training experienced increased knowledge and confidence to recognise and respond to someone thinking about suicide.

Of the five people who took part in interviews, four people had attended the workshop in some kind of professional capacity. Their jobs meant that they had regular contact with farmers, or other rural community members, who may be experiencing hardship and distress and as such they had identified that this training would be relevant and useful. Three of these participants worked with financial institutions.

The main thing for me was if I did identify someone who needed assistance, how I went about offering them assistance and what was available. … So for me just having those contacts and being able to you know, pass that onto someone who needs them, was something I really took away from the workshop. (Cara, SPSW participant)
These participants each identified important changes in their attitudes towards suicide and their own capacity to recognise and support people who may be at risk of suicide. There was some element of transformation experienced as a result of the workshop. All four of these participants saw that they could use these skills in their individual interactions with groups such as farmers, to recognise distress, inform their communication strategies and to offer referral information to support services where relevant and appropriate. However, the kinds of skills and knowledge gained in the workshop hadn’t translated into any ongoing changes to their workplaces and there wasn’t an ongoing or identified role for them in utilising these skills in their work. Some respondents had shared information about the training with their colleagues. For Debra, who had found the training very informative and powerful, the reaction of her colleagues when she tried to share information about the workshop was disappointing because,

They weren’t very interested actually. I think that some of those people don’t share the same personal relationship as I do… they don’t see their role as developing strong personal relationships.

For other people, such as Cara, the training seemed to align well with the philosophy of her workplace, which was increasingly encouraging employees to take preventative actions regarding their physical and mental health.

One participant attended because she wanted information to help her in supporting a particular family member who had been experiencing mental distress, noting that “I was just hoping to get some more insight into how to handle it and how to approach it” (Belinda, SPSW participant). She did note that most people in attendance had been there in some kind of work capacity and she wished that more people from the general community had attended.

When asked to recall the most important things they’d learned in the workshop, respondents were not generally able to recall specific details about the content. However, all were able to identify at least one service that they would refer someone to if they thought they needed assistance and reflected on important parts of the workshop such as role playing conversations about suicide.

In the few months since taking part in the workshop two people had had contact with someone they considered to be experiencing, or at risk of experiencing, mental distress. Belinda had continually encouraged her family member to seek professional support, drawing on information from the workshop, but noted that her family member was reluctant to seek help.
and that taking part in the workshop had done little to resolve her particular situation. In the course of her work, Cara had passed on information about support services to a farmer who had been experiencing severe hardship and felt that this had been well received. She paid attention to the distress or potential distress of all of her clients and noted that this particular farmer “was very comfortable opening up with myself, but he probably wouldn’t be, you know, if it was a counsellor or in a workshop situation”.

For Alan and Debra, while they hadn’t had direct contact with someone they considered to be experiencing symptoms of mental distress or to be at risk of suicide, they had experienced the relevance of the workshop in other ways. Driving home from the workshop with a colleague, Alan had learned about this colleague’s personal experiences of mental illness. This, in combination with the workshop, had really changed his attitude towards mental illness and suicide, and he noted that understanding people’s personal experiences of mental illness and suicide provided an opportunity to help others to make their “journey” “easier”. Where previously he’d perceived conditions such as depression as a situation where people should “suck it up and get on with it”, he now strongly advocated that:

It’s not a stigma, it’s more the medical condition. It’s because that’s who they are. It’s just, unfortunately, it’s a treatable thing that they can get help with, treatment – medical treatment. So I guess that was an eye opener for me.

He perceived that he could have a valuable role in recognising and supporting clients, particularly farmers, who may be having a difficult time. For Debra, the self-care component of the workshop had been very powerful and she had really become attuned to improving her own mental health, stating that it was useful:

…in terms of looking after my own mental health. And even if it’s just the basics of you know eating well, drinking water, getting plenty of sleep, finding other outlets outside of work to get enjoyment from… It was a good reminder of those different aspects that are important.

**Health professionals suicide prevention training**

From the two Advanced Training in Suicide Prevention workshops conducted to date, 22 participants completed pre-workshop questionnaires, 20 completed questionnaires
immediately after the workshop and 7 completed questionnaires four months after the workshop (noting that participants in the second workshop hadn’t been invited to complete the endline questionnaire yet as it has not been four months since training was completed). No interviews have been conducted yet. The 20 participants who completed the midline questionnaire identified their professions as psychologists (n=10), GPs (n=5), GP registrar (n=1), medical student (n=1), social worker (n=2), and not identified (n=2).

Table 2: Preliminary Literacy of Suicide Scale and Stigma of Suicide Scale data for health professionals

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOSS total</td>
<td>Baseline</td>
<td>22</td>
<td>10.59</td>
<td>1.26</td>
</tr>
<tr>
<td></td>
<td>Midline</td>
<td>20</td>
<td>11.55</td>
<td>0.60</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>7</td>
<td>11.29</td>
<td>0.95</td>
</tr>
<tr>
<td>SOSS isolation</td>
<td>Baseline</td>
<td>22</td>
<td>3.99</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>Midline</td>
<td>20</td>
<td>3.99</td>
<td>1.17</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>7</td>
<td>4.04</td>
<td>0.86</td>
</tr>
<tr>
<td>SOSS glorification</td>
<td>Baseline</td>
<td>22</td>
<td>2.70</td>
<td>0.58</td>
</tr>
<tr>
<td></td>
<td>Midline</td>
<td>20</td>
<td>2.78</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>7</td>
<td>2.18</td>
<td>0.95</td>
</tr>
<tr>
<td>SOSS stigma</td>
<td>Baseline</td>
<td>22</td>
<td>1.48</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Midline</td>
<td>20</td>
<td>1.31</td>
<td>0.63</td>
</tr>
<tr>
<td></td>
<td>Endline</td>
<td>7</td>
<td>1.18</td>
<td>0.37</td>
</tr>
</tbody>
</table>

While the sample sizes to date are quite small, these preliminary results identify trends which will be monitored closely over the coming months. Importantly, these participants reported fairly high levels of literacy and low levels of stigma associated with suicide at the baseline. It should be noted that 13 out of the 22 participants reported that they had taken part in some form of suicide prevention training prior to this workshop, including activities such as online trainings, workplace-based sessions and Applied Suicide Intervention Skills Training (ASIST).

There was an overall significant difference in LOSS scores between the three time points, $F(2,48) = 5.02, p = .011$. Post-hoc analyses indicate that immediately after taking part in the training there was a significant increase in participants’ literacy regarding suicide compared to baseline scores ($p = .003$). Four months after training there was no significant difference between endline scores and either baseline or midline scores. There were no
significant changes to the SOSS scores across baseline, midline or endline points. Stigma scores related to suicide tended to be quite low for most participants prior to training, suggesting that there was little stigma towards suicide amongst this group from the outset.

Table 3: Preliminary confidence and knowledge in regard to recognising and managing suicide risk data for health professionals

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
<td>Baseline 22</td>
<td>6.50</td>
<td>1.26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midline 19</td>
<td>8.21</td>
<td>0.713</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endline 7</td>
<td>7.86</td>
<td>0.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL 48</td>
<td>7.38</td>
<td>1.28</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>Baseline 22</td>
<td>6.23</td>
<td>1.48</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midline 19</td>
<td>8.16</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endline 7</td>
<td>7.86</td>
<td>0.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL 48</td>
<td>7.23</td>
<td>1.48</td>
<td></td>
</tr>
</tbody>
</table>

The findings show that respondents’ reported an overall difference on both their levels of confidence \( (F(2,47) = 15.69, p < .001) \) and knowledge \( (F(2,47) = 15.15, p < .001) \) regarding recognising and managing suicide risk across the three time points. Post-hoc analyses showed that for confidence, both midline \( (p < .001) \) and endline \( (p = .003) \) scores were significantly higher than baseline. There was no significant difference between midline and endline scores. These findings were similar for knowledge, with both midline \( (p < .001) \) and endline \( (p = .002) \) scores being significantly higher than baseline, and no significant difference between midline and endline scores.

Discussion

For both groups – community members and health professionals – who have engaged in suicide prevention training activities delivered through the Farm-Link program, there are reported increases in confidence, skills and knowledge associated with recognising and responding to suicide and improvements in attitudes towards people who think about or die by suicide. During interviews, participants described a transformative process, in which their confidence to have discussions about issues related to suicide and their perceptions of people experiencing mental distress or thinking about suicide had changed. The willingness of participants to engage with these workshops, and the gains in confidence and knowledge, suggest that is a reasonable
expectation of people to engage as gatekeepers and that suicide awareness and suicide prevention are areas in which community members and health professionals see that they can make a valuable contribution. The low levels of stigma amongst health professionals prior to (and the sustained after) training, and the fact that many health professionals had undertaken some previous suicide prevention education or training, suggest that this program is engaging people with an existing, and strong interest in, and professional commitment towards, suicide prevention. Fundamentally, this illustrates that health professionals and members of the broader community (including key professional groups such as the finance sector) represent potentially important resources for rural suicide prevention and response and that these training workshops are valuable steps in engaging these people.

These preliminary findings show that gains in knowledge, skills and confidence, as well as already positive attitudes tend to be maintained after the training. However, interviews with community workshop participants suggest that there may be missed opportunities to reinforce what people have learned in training sessions and to continue building knowledge and engagement after the workshop. Farm-Link has not claimed to be the stand-alone solution to any rural community’s complex and multi-faceted issues related to suicide. Rather, Farm-Link’s training workshops are offered as tools to support broader suicide prevention and response mechanisms. However, it is unclear how the cohort of newly trained health professionals and community members might make an ongoing contribution within those broader mechanisms. At present, their roles as ‘gatekeepers’ are focused on their individual interactions with people who might be thinking about or at risk of suicide, largely in their workplaces, but also in their personal lives.

**Limitations and strengths**

It is important to note that these findings are presented as a ‘work-in-progress’, with the expectation that ongoing data collection and larger sample sizes may result in quite different final evaluation outcomes than those presented here. The intention is to highlight the importance of evaluating this type of intervention and the potential areas of interest for further exploration. In addition, it should be noted that recruiting participants in evaluation activities, such as questionnaires and interviews, are substantial, particularly when potential participants working in busy jobs with numerous demands on their time.
While the evaluation has been able to identify whether improvements in confidence, knowledge and attitude take place, it is difficult to attribute these changes directly to the Farm-Link suicide prevention training activities without having a control group for comparative purposes.

The key strength of this study is that it offers insight into the experiences of applying the knowledge and skills learned in suicide prevention training activities in a rural context, drawing on quantitative methods to identify overall changes and qualitative methods to understand what these changes mean.

Conclusions

These preliminary findings are promising, indicating that appropriately designed and delivered suicide prevention training workshops have the potential to improve skills, confidence and knowledge amongst health professionals and community members in rural settings. Ongoing study will provide further depth of understanding regarding people’s experiences of applying their newly acquired knowledge, skills and confidence.

Partnership has been an important factor in the design and delivery of programs, particularly the partnership between the Centre for Rural and Remote Mental Health and Black Dog Institute. It is an example of organisations working together to use existing strengths and resources in new ways, rather than duplicating existing training activities. This is certainly an approach to continue building upon.

To date, there has been little crossover between the activities targeting health professionals and those targeting community members. They have tended to be treated as two discrete groups. However, an opportunity to build on the gains in knowledge, skills and confidence and ensure ongoing, multi-faceted support mechanisms within rural communities, may exist in bringing these two groups together in some way. As yet it is unclear how these trained health professionals may support community-based gatekeepers in their role as referral and support points or how community-based gatekeepers may support health professionals in their role as practitioners.

Ongoing evaluation of the Farm-Link program, and ongoing innovation within the program, offer opportunities to ensure that this newly developed asset - rural health
professionals and community members with increased skills, confidence and knowledge regarding suicide and suicide prevention – is supported and engaged for maximum impact.

Acknowledgements

Farm-Link gratefully acknowledges the current funding support of the Hunter New England Central Coast Primary Health Network and previous support of the Australian Government’s National Suicide Prevention Program.

References

Use of innovation to recruit, train and support an NDIS ready workforce in rural and remote communities.

Dr. Jodie Goldney
Professional Practice Academy,
Aftercare, and
Charles Sturt University

Paper Presented at the
8th Australian Rural and Remote Mental Health Symposium
2-4 November 2016 | Mantra on Salt Beach, Kingscliff, NSW
Use of innovation to recruit, train and support an NDIS ready workforce in rural and remote communities.

**ABSTRACT:** The roll out of NDIS brings with it the prediction of a significant shortfall in the national workforce necessary to implement this legislated change (Hall, 2013). Due to difficulties accessing necessary training and education resources, hardest hit will be rural and remote communities (e.g. National Rural Health Alliance, 2008). To address this, the Professional Practice Academy (PPA, Australia’s largest industry led professional organisation for the community services sector), and a consortium of industry providers, have built an innovative, and world first online platform, which provides an avenue via which anyone with internet, can access a diverse range of industry approved and administered recruitment tools, and education and training relevant to the community services sector. PPA have also worked closely with Exemplar Global to build a comprehensive, and internationally recognised certification system. Our certification allows individuals at all levels of education and training within the community services sector to capture their current level of skill, and extend that, such that they are able to develop professionally in an ongoing and supported manner. Moreover, drawing on an extensive social media platform, our solution facilitates the building of community irrespective of location. This presentation will provide an overview of the need for such a solution, and using a case study approach, provide a practical demonstration of how the platform can be utilised within rural and remote communities in Australia.
The roll out of the National Disability Insurance Scheme (NDIS) heralds a time of unprecedented reform for the community services industry. Such change is forecast in key policy documents encompassed within the overarching National Mental Health Strategy, including the National Health Workforce Planning and Research Collaboration’s (2011) “Final Report,” and Health Workforce Australia’s (HWA, 2014) “Mental Health Peer Workforce Study.” Whilst the roll out of NDIS is a potentially liberating and empowering policy change for those with a lived experience (e.g. Richardson, 2016), for the industry primarily responsible for servicing that change, it heralds a time of both excitement and unease as we move into its largely unchartered waters. Inherent with this change is a predicted national shortfall of approximately 70,000 support workers (Hall, 2013; Williams, 2016). Already facing difficulties in recruitment and service provision (e.g. National Rural Health Alliance, 2008), the rural and remote community is set to be further challenged in finding and training appropriate staff. To address this, and in the absence of a suitable platform from which to recruit and train prospective employees, the Professional Practice Academy (PPA), in collaboration with Aftercare, and a consortium of industry providers, have built an industry informed online platform. The PPA is Australia’s largest industry led professional organisation for the community services sector (PPA, 2016). Aftercare, are one of Australia’s leading not-for-profit providers of mental health services. The online platform provides an avenue via which anyone with internet, can access a diverse range of industry approved and administered education and training relevant to the community services sector, including internationally recognised certifications, job specific attributional tools, and access to an online, national, workforce community.

There is arguably an ethical, best practice and abuse prevention component to this response both for the participant and the provider (e.g. Faulkner & Sweeney, 2011; NSW Department of Family and Community Services, 2016; Productivity Commission, 2011). The Disability Services Commissioner (2012) comments:
Our learnings tell us that systematically, when people who provide services do not have as their key driver a person centred and rights based approach to their work, less than optimal and sometimes adverse outcomes result for people with a disability (p. 4).

Furthermore, historically, within the mental health sector, front line staff, are oftentimes drawn to this profession, due to their own lived experience (Malone, 2016). Thus there is a dual responsibility for any organisation recruiting, and providing participants with direct service, or any sole-provider of NDIS approved care. Firstly, to ensure that staff are well matched with, and supported to carry out that role. Secondly, to ensure that staff adhere to person-centred codes of conduct when working with clients.

Working Philosophy Driving our Solution

The solution has a number of key components. Core is the philosophy that networking, employment opportunities, and pathways to access professional development and learning occur real time, anywhere. The technology that we have sourced and used to build the PPA brings all of these aspects together into one digital response to the challenges posed by NDIS. Having a place to go to network, recruit staff, find work and to access professional development and learning opportunities real time may also be an important unifier for our sector given the spate of reform. For the rural and remote workforce, access to such tools through an online platform allow them to both contribute to, and source what is best practice. I will now outline the first of the tools built as part of the PPA, the mental health support worker attributional tool (Goldney, 2016a). In expanding on this example, I will provide the reader with greater insight into the types of tools being developed by the PPA, and how they can be applied.

The Mental Health Support Worker Attributional Tool

The mental health support worker role has received increasing interest at the national and international level, and been identified as efficacious to positive health and wellness outcomes for clients (e.g. HWA, 2014; Slade & Longden, 2015). The role is generically defined as “providing support and services to individuals and families experiencing mental health issues” (Government of Western Australia Department of Training and Workforce Development, 2016). More specifically the role may be defined as
A person who is employed on an individual basis to foster independence and provide assistance for a service user in areas of ordinary life such as communication, employment, social participation and who may take on secondary tasks in respect of advocacy, personal care and learning (Manthorpe & Martineau, 2008).

However, whilst there is relative agreement around what constitutes the mental health support worker role, to date, there exists no suitable, rigorous, assessment and recruitment tool able to determine whether an individual will be a good fit with this role (Beale, 2016). Yet, the capacity to do exactly that is the foundational currency necessary for survival within the world of NDIS for both the individual, and organisation, wishing to participate in direct service provision. Moreover, it is this capacity which is arguably the cornerstone of the NDIS reform (e.g. Richardson, 2016).

The PPA mental health support worker attributional tool seeks to capture what is the ‘x-factor’ which allows one individual to facilitate a wellness and recovery outcome for another. Moreover, the tool differentiates between those who are a good fit for this role, and those who may be better placed, or educated in, and for other roles. For the latter, the tool can be used as a diagnostic, ethically channeling them into targeted education and training, alternate employment, or volunteer options, in keeping with the tenets of person-centered care.

By choosing to focus on attributes, defined here as causal beliefs, and philosophical frames (Angelova, Konig, & Proksch, 2016; Kassner, 1990; Williams & Smalls-Glover, 2014), the PPA made a deliberate philosophical and ethical decision to position experiential wisdom as inherently valuable, and necessary to the facilitation of wellness. Whilst at odds with some understandings of “best practice” (e.g. the science versus practice debate in the discipline of psychology, Goldney, 2016b), this is a stance well supported by policy documents and associated recommendations at the national and international level as outlined above; the scholarly literature (e.g Goldney, 2016b; Slade & Longden, 2015); and as evidenced in the effectual rise of the support worker role (Health Workforce Australia, 2014).

Attributes included in the test have been reverse engineered through analysis of data thrown up by an intensive interview process of incumbents and their managers, using main tenets of Hollway and Jefferson’s Free Association Narrative Interview technique (FANI, 2013). Out of this process, the following attributes emerged, and include whether a potential employee has the capacity to be: reflexive (to learn from one experience, and apply that learning to a comparable experience); a chameleon (able to be adjust their personality to the
needs and interests of their client); able to build rapport (ability to get on with their client, and build trust); person-centred (ability to facilitate for the client what they would like—at times reading between the lines); able to suspend judgement (ability to keep your own belief sets and values at bay); able to solve problems in diverse ways; professional (ability to be on time, to keep accurate notes etc.); an advocate (ability to advocate the needs of the client to varied stakeholders such as psychologists, psychiatrists, or family members); safe when working with clients (ability to look out for your own safety in the work environment); and sit in the space of discomfort (ability to hear at times distressing stories, without feeling the need to always provide a solution) (Goldney, 2016a). For more detail regarding the methodology, ethics and review process employed in the build of this tool, but beyond the scope of this paper, please contact me directly. Alternatively, more detail regarding the mental health support worker attributional tool is viewable online at https://profpracc.com/product/ppa-mental-health- attributional-tool/.

Application of the Attributional Tools

Each of the attributional tools has, or will have multifaceted application. They can be used by: workforce development teams to identify workforce strengths and weaknesses in incumbents, and/or teams; internal and external recruiters to aid decision making during the selection process; managers responsible for staff induction; learning and development specialists to support development planning processes and allied learning and development programming; organisations involved in job support programs; and the individual wanting to drive their own career journey. Moreover, once we have completed the full attributional build for our industry, we will be able to clearly view the individual’s potential to move into and through varied roles within an organisation, allowing individuals to be easily ‘ear-mark’ for ‘advancement.’ In providing this level of insight, the PPA is able to facilitate the minimization of costs for organisations associated with employee movement out of an organisation, loss of corporate knowledge, loss of excellent staff, and costs associated with recruitment and training in a new financial landscape.

In addition to the mental health support worker role, the PPA is currently in the research and build phase of attributional tools targeting the aged care support worker, the disability support worker, and the team leader role. We anticipate these tools will be released in the early part of 2017.
Online Certification and a Community of Practice

In addition to the attributional tools, our industry collective have researched, benchmarked and launched a series of 18 sector informed, and internationally recognized certifications. The complete selection of certifications is viewable here [https://profpracc.com/search/certification](https://profpracc.com/search/certification). I will expand on the content of these below. In providing this service, we are actively seeking to address the shortfall between the idea of the roll out of the NDIS, and the pragmatics of providing an empowered, excellent, and compliant workforce to those with a lived experience of mental illness or disability.

The PPA commenced the design and development of our certification in January 2015. Our process involved a comprehensive review of the literature, including for example, the Community Services and Health Industry Skills Council’s environmental scans (2013-2015). Moreover, our process involved extensive discussions with varied stakeholders representative of the mental health and disability services.

These courses provide new and existing staff with the opportunity to submit via an online portal, evidence toward certification in one or more of six certification categories. Each certification is reflective of targeted areas encompassed by the community services sector including mental health, disability, aged care and community living and supports. Additionally the certifications target operational, supervisory and business leader personnel.

Each category of certification provides learners with a career pathway to demonstrate skills and knowledge relative to operating, managing and leading businesses in roles across the Community Services Sector of which they have relative experience. Successful completion results in the learner gaining an international certification through the PPA in the applicable category and level.

Learners are encouraged to complete the course within a six month timeframe. However, the course is open for learner completion up to a maximum period of 12 months. Course intakes are dependent on uptake, but are currently offered monthly on or near the 20th of each month. Certification expires three years from completion. Through an online course including an ‘avatar’ coach, the student is able to select, collect and upload evidence of their skills and knowledge, thereby demonstrating their capacity against the course aims. These themes assess the capability of learners to work effectively in their chosen area.
In addition to the certification, the PPA also provides an online community of practice. Using this platform, the innovator, or entrepreneur within our sector, irrespective of location, has access to a vehicle from which to share their wisdom, insights, and solutions at the national and international level. I will now provide a case study example of one instance of the PPA supporting innovation through our ‘Support Launcher.’ In providing this example, I offer further insight into how the PPA may be applied to varied environments, including the rural and remote setting.

Support Launcher

Jenny (pseudonym used to preserve anonymity), an employee of Aftercare https://community.profpracc.com/new-south-wales/lilyfield/service-providers/aftercare, one of Australia’s leading providers of mental health services, is a peer support worker. She is particularly skilled in this role, and marries that with her capacity to mentor and guide other less experienced support workers. At Aftercare’s recent industry conference “My Career: Pathways to Practice” (2016), a number of peers identified the need to develop a national mentoring resource to support this key position within the mental health sector. Learning of the capability of the PPA, and giving consideration to her already existing skill-set, Jenny has decided that she is both able to, and willing to address this need. Using the PPA’s versatile online platform, Jenny is in the early stages of set-up for the launch of her national mentoring service for peer support workers. Jenny is able to advertise her concept on the PPA’s marketplace https://profpracc.com/courses-publication, and through her personal PPA webpage https://community.profpracc.com/join. Jenny is also able to use the PPA’s support team (info@profpracc.com) to carry out a targeted marketing campaign, only directed at individuals and organisations who have a substantive interest in developing and supporting the peer support worker role. Using the PPA, Jenny is able to share her wisdom and expertise with her broader community, and develop her own personally unique skill set, and capability.

In another organisation, a team of support workers led by Dr Isabelle Meyer (2016)

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1 This scenario is in process development due to the relative youth of the PPA (launched in July of this year). I am using it here to illustrate some of the possibilities made available to individuals and organisations in the new world of NDIS through the PPA online platform. It is not yet a fully developed and operational concept.

2 Please note, to view this page, you need to create a PPA login. You are able to do this free of charge. The login ensures the security of our online professional membership and community.
https://community.profpracc.com/new-south-wales/lilyfield/staff/isabelle-meyer have developed a comprehensive pre-assessment guide to help support clients with psycho-social disabilities to access the NDIS. The tool functions as a guided checklist, supported by attractive visuals, helping to make it easily accessible to a client group with varied literacy levels. Other organisations (including a State Health Department) when viewing the tool have commented on its usefulness, and requested access for their own client groups. To facilitate this, using the functionality of the PPA, Dr Meyer is in the process of using the PPA marketplace to distribute this product to the broader sector. Moreover, in sharing her and her team’s wisdom in this way, other organisations are not required to reinvent the wheel as they respond to the challenges thrown up by the NDIS roll out.

I will now briefly outline the PPA’s online Hub, explaining how one organisation uses the platform to provide diverse education and training to a national audience. In providing this offering, we are actively seeking to provide a vehicle to facilitate social enterprise and collaborative ventures within the community services sector.

**Spotlight on the Centre for Disability Studies**

The Centre for Disability Studies (CDS) https://community.profpracc.com/new-south-wales/camperdown/learning-providers/centre-for-disability-studies-28cds29-an-affiliate-of-university-of-sydney, are one of Australia’s leading providers of person-centred, and disability focused education and training. As one of the PPA’s priority members, they use the PPA marketplace to advertise all of their courseware to a national community. They are able to use the site to advertise the full details of their courses, and to allow their clients to both register interest, and hold their place in a course. For example, https://profpracc.com/product/working-together-to-build-social-connections/. Moreover, CDS are able to use the PPA’s support team (info@profpracc.com) to advise the sector of specials they are offering, upcoming courses they are running, or that time to register is coming to a close. They can also use the PPA as a litmus test to see whether there is interest in a new course offering that they would like to provide to the community.

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3 Please note, to view this page, you need to create a PPA login. You are able to do this free of charge. The login ensures the security of our online professional membership and community.

4 Please note, to view this page, you need to create a PPA login. You are able to do this free of charge. The login ensures the security of our online professional membership and community.
Conclusion

Whilst the roll out of NDIS heralds a time of change for the community services sector, it also brings with it the opportunity to develop new initiatives, and to work collaboratively in new and exciting ways. For the rural and remote population, it brings the additional challenge of how to access industry benchmarked education and training, and also how to access and recruit staff of excellence. The PPA provides an online platform via which any individual or organisation with internet availability can participate in quality education and training, access rigorously developed recruitment and screening tools, and promote their unique skill-sets at the national level. Through the privileging of practice generated, and industry informed knowledge, the community services sector is able to benchmark their industry, facilitate industry informed standards of excellence across the workforce, and maximise employment stability, and quality of care provision within a changing landscape.
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Consumer-Driven, Recovery-Oriented Practice:

Using Feedback-Informed Treatment to Improve Consumer Participation

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Paper Presented at the
8th Rural and Remote Mental Health Symposium
2-4 November 2016 | Mantra on Salt Beach, Kingscliff, NSW
ABSTRACT: 70 years of outcome data has not led to improved outcomes for social work and psychology services. During this span, mental health services have become process-oriented, relying on the use of empirically supported treatments (ESTs) and the diagnosis of mental disorders all while the largest variability in outcomes lies within the person of the therapist, consumer, and the therapeutic alliance. This paper explores the implications of Feedback-Informed Treatment (FIT) and the use of Routine Outcome Management (ROM) to increase participation, reduce dropouts, and improve outcomes for consumers of mental health services in Australia. A case illustration will also be provided to explore the process and lessons learned from implementing FIT into an adventure therapy program for adolescents living in rural South Australia.

Keywords: Feedback-Informed Treatment, Adventure Therapy, Outcome Management

Introduction

The end of World War II led to an influx of veterans in need of mental health support (Albee, 2000). This resulted in the burdening of caseloads for psychiatrists across America and the recruitment of psychology students to provide psychiatric services in hospital settings. Here, mental health services took a turn towards training students to privilege the medical model’s view of mental disorders in order to deliver much-needed interventions for the veterans in need. Fast forwarding seventy years, there are now nearly 400 listed mental disorders in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) and empirically-supported treatments have become the norm for both the funding and reimbursement of mental health services (Hubble, Duncan, Miller, & Wampold, 2010). This, however, has not led to an improvement in consumer confidence, therapeutic outcomes, or a reduction in client dropouts (Brown, Dreis, & Nace, 1999; Garcia & Weisz, 2002; Lambert & Bergin, 1994; Miller, Hubble, Chow, & Seidel, 2013; Wampold, 1997).

For consumers and providers in Australia, the Fifth National Mental Health Plan: Draft for Consultation (2016) calls for a person-centred system involving consumers in the co-production of case planning and service delivery. For Sparks and Muro (2009, p. 72), the before mentioned reliance on the medical model is at odds with Australia’s plan for mental health reform as “relationships of helper/helped and expert/impaired that typically define medical intervention render unlikely other kinds of partnerships, specifically those where clients lead and know best”. This paper will present Feedback-Informed Treatment (Bertolini
& Miller, 2012), or FIT, as a means for ensuring the accountability of service outcomes, routine outcome management, and the privileging of the consumer’s voice and choice in the field of mental health.

The following section will review the literature informing FIT and explore studies providing clinicians with real time measurements of both outcome and alliance measures. A case illustration will explore the process of implementing FIT as well as the lessons learned on an adventure therapy program funded by the Department of Education and Children Development and a local Rotary Club for 8 adolescents living in rural South Australia.

**Review of Literature**

Over 60 years of outcome research has found psychotherapy to be effective for treating a wide range of populations, ages, genders, and diagnoses (Asay & Lambert, 1999; Brown et al., 1999; Miller et al., 2013; Orlinsky, Grawe, & Parks, 1994; Wampold, 2001). Asay and Lambert (1999) cite that psychotherapy has a robust effect size of 0.8 in randomised clinical trials (RCTs) compared to a 0.2 effect size in no treatment control groups. This deems psychotherapy to be four times as effective as groups receiving no treatment. Although most outcome research resolves to uncover the specific healing ingredient leading to improved outcomes, this effect size exists across numerous empirically supported modalities. Additionally, a group of general therapeutic factors, known as the *Common Factors*, seem to be responsible for the outcomes and are considered to be the known elements contributing to variance in outcomes (Asay & Lambert, 1999; Duncan, Miller, & Sparks, 2007; Hubble, Duncan, & Miller, 1999; Smith, 2002; Wampold, 2010). These factors will be presented below.

*Client/Extratherapeutic Factors*

According to Bertolini and Miller (2012, p. 6) in the International Center for Clinical Excellence’s Feedback-Informed Treatment (FIT) Manuals, the *Client/Extratherapeutic*
Factors are “independent of treatment and include clients’ readiness for change, strengths, resources, level of functioning before treatment (premorbid function), social support systems, socioeconomic status, personal motivations, and life events”. Exploring the relationship of therapeutic processes and outcomes, Orlinsky et al. (1994) conducted a meta-analyse of 132 outcome studies. The authors found 11 variables contributing to change, such as client cooperativeness, expressiveness, suitability, and the participant’s contribution to the therapeutic relationship. They emphasise further that “The quality of the patient’s participation in therapy stands out as the most important determinant of outcome” (Orlinsky et al., 1994, p. 360). Wampold (2001) estimates these factors to make up 87% of the variability when evaluating the difference in those who engaged in a service and who did not. The remaining 13%, presented below in subcategories, comprises of the specific aspects to the service. While these factors are presented with percentages that make up the effects of treatment, Hubble et al. (2010, p. 34) emphasise that “the role and degree of influence of any one factor are dependent on the context: who is involved; what takes place between the therapist and client; when and where the therapeutic interaction occurs; and ultimately, from whose point of view these matters are considered”. In this way, most quantitative research is unable to capture the subjective experience between the therapist and client. These include the Therapeutic Relationship, Therapist Effects, and Model/Technique.

The Therapeutic Relationship

Bordin (1979) defines the therapeutic alliance as being comprised of three components. There must be a relational bond and agreement of the goals and tasks of therapy. Garcia and Weisz (2002), while surveying the parents of adolescents who had dropped out of therapeutic treatment in California, found that relational issues including concerns about therapist’s competence and the relational bond were more widely referenced by consumers than any other issue except cost as leading to the decision to disengage. For Bachelor, Meunier, Laverdiere, and Gamache (2010), the therapeutic alliance and the client’s contribution to that relationship are critical to successful treatment.
Australian social worker Smith (2002) acknowledges that in many cases research on the therapeutic alliance is psychotherapy focused while many Australian social workers are working in multidisciplinary settings delivering short-term interventions where the therapeutic alliance may seemed irrelevant. Smith (2002), however, argues that research in practice settings has found positive relationships between the therapeutic alliance and outcomes using the example of problem gambling and counselling services in rural Victoria. The author stresses the importance of social workers taking a consistent trusting, open approach to working with consumer in case planning and the service delivery.

Hannan et al. (2005) investigated how effective therapists in outpatient settings were at predicting client deterioration and dropouts. Administering a self-report outcome questionnaire at each session, therapists were asked to predict which clients were improving or deteriorating. Therapists correctly identified 5 of 26 clients who were deteriorating under their care and only 1 who did not achieve a positive outcome. Tryon, Collins, and Felleman (2006, August) meta-analysed therapeutic alliance ratings at the third session of service finding consumer and provider ratings correlated only 33% of the time. Additionally, Bachelor and Horvath (1999) found consumer ratings of the alliance to be better predictors of outcomes than ratings by the provider. These findings, along with the Hannan et al. (2005) study, emphasise the importance of privileging the consumer’s experience and the relational bond. This alliance is both fluid and reciprocal and encourages providers to collect feedback on both the delivery of the service and the therapeutic relationship.

**Therapist Effects**

*Therapist Effects* is the newest addition to the *Common Factors* as there is consistently “greater variance in outcomes between psychotherapists in a given study than between the types of therapy they are practicing” (Miller et al., 2013, p. 89). Baldwin, Wampold, and Imel (2007, p. 849), while attempting to untangle the alliance-outcome relationship, found that “therapists who, on average, formed stronger alliances with their patients showed statistically significant better outcomes than therapists who did not form as strong of alliances”. In terms of therapeutic approaches, *Therapist Effects* acknowledge that “who provides the therapy is a
much more important determinant of success than what treatment approach is provided” (Miller, Hubble, & Duncan, 2008, p. 74).

A challenge with Therapist Effects is that there is little known about what leads to some therapists achieving higher outcomes, stronger alliances, and less dropouts (Bachelor et al., 2010; Miller et al., 2008). It is estimated that 47% of adult consumers will disengage from mental health services regardless of the provider’s recommendation while it is estimated that upwards of 85% young people will do the same (Duncan et al., 2007; Garcia & Weisz, 2002; Sparks & Muro, 2009). Because the relationship and consumer experience seems to be referenced by consumers disengaging from mental health services, the person of the provider should be taken into consideration as an active ingredient in the change process.

Model/Technique

A meta-analysis by Wampold (2001) assigns 13% of variance to the specific technique or model used by the service provider. To achieve status as empirically supported treatments (ESTs), specific approaches must go through the test of two Randomised Control Trials (RCTs). For mental health services, this randomly assigns participants to a group receiving a specific ingredient, such as cognitive-behavioural therapy or psychiatric medication, or to a control group receiving either no treatment or a Treatment-As-Usual (TAU), such as supportive counselling. Traditionally, control groups receiving no treatment do not pose much strength for measuring effective therapies. As earlier referenced, an effect size of 0.2 for those in control groups would seldom bat up against a bona fide therapy with a 0.8 benchmark. It is not common that ESTs are measured against each other yet a few studies below are presented to discuss the findings.

The Treatment of Depression Collaborative Research Project (Elkin et al., 1989) randomly assigned 250 participants diagnosed with depression to four groups: (1) Interpersonal Therapy, (2) Cognitive Therapy, (3) Antidepressants, and (4) Placebo Pill with Case Management. While this research design was perceived as state of the art, the results
indicated similar results for each of the four conditions. Further analysis of these findings by Blatt, Zuroff, Quinlan, and Pilkonis (1996) found that the quality of the therapeutic relationship during early stages of treatment was a significant predictor for overall outcome no matter which service the consumer was provided. The authors go on to suggest the “the extensive efforts to compare different manual-directed treatments need to be balanced to commensurate attention to interpersonal dimensions of the therapeutic process” (Blatt et al., 1996, p. 162).

A large study led by Human Affairs International included 2000 therapists and 20,000 clients using thirteen different treatments in real world settings. Approaches included psychiatric medications and various individual and family therapies. The findings revealed no statistical differences among the approaches. Beginning in 1989, Project MATCH was a $33-million dollar study investigating different treatments for alcoholism and if certain types of consumers responded to specific treatments (Project MATCH Research Group, 1998). The researchers explored whether participants should be assigned to specific treatments based on specific characteristics. While the study’s design was criticised for lacking a control group, the results were also unfavourable showing no improvement in outcomes when participants were matched to specific treatments. In the end, all three of the treatment conditions were equal in effectiveness.

In 1996, Howard, Moras, Brill, Martinovich, and Lutz (1996) raised concerns about treatment-focused research. That is, researchers were focused on the effectiveness of specific interventions for exclusive criterion. The authors put forth that a new paradigm of patient-focused research “concerned with the monitoring of an individual’s progress over the course of treatment and the feedback of this information to the practitioner, supervisor, or case manager” (Howard et al., 1996, p. 1059). The factors presented in this section illustrate the components common to various therapeutic approaches that contain the greatest variance in outcomes. Providers using specific models or interventions, while designed to intervene with particular mental health concerns, should acknowledge that the quality of participation and feedback from the consumer on the working alliance and outcome stand as two strong predictors for outcomes. This literature is used to inform the use of FIT, a way for providers
to routinely and systematically collect feedback from consumers about the therapeutic relationship and benefit of their service. The following section will present FIT and present a case illustration with lessons learned from implementing FIT into an adventure therapy program in rural South Australia.

**Feedback-Informed Treatment**

Feedback-Informed Treatment (FIT), established as an evidence-based practice in 2013, is defined as

“a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery” (Bertolini & Miller, 2012, p. 2).

FIT applies two ultra-brief, easy-to-interpret measures for tracking outcomes and consumer reports of the therapeutic alliance, the Outcome Rating Scale (ORS, See Appendix A) and the Session Rating Scale (SRS, See Appendix B) (Miller, 2011). The ORS was developed for providers to administer at the beginning of each session, or the start of each week for those in residential care, in order to quickly calculate the consumer’s experience of wellbeing (Bertolini & Miller, 2012). The SRS intends to measure the therapeutic alliance using the framework put forth by Bordin (1979) previously discussed. The SRS is administered at the conclusion of each therapeutic encounter. Longer surveys, such as the Outcome-Questionnaire 45 (Lambert et al., 1996), which the ORS is informed by, have issues of adherence as providers tend to feel that these are administrative tasks instead of clinical tools which can be completed in the first few minutes of the session (Miller, 2011).

The ORS is a visual analog with four 10cm lines asking consumers to provide a tick on each line in areas of Individual, Family, Interpersonal, and Overall wellbeing. Using a ruler, the provider can quickly add up each tally to provide a score out of a possible 40. With the client, the score is plotted on a graph and interpreted with both the provider and consumer. Based on
a sample of 35,790 service users over the age of 13, the ORS has a clinical cutoff of 25, which “defines the boundary between a normal and clinical range of distress and…provides a reference point for evaluating the severity of distress for a particular client or client sample” (Bertolini & Miller, 2012, p. 4). The SRS, with a clinical cutoff 36, is also four-item visual analog measuring the relational bond, agreement on goals, agreement on the tasks, and the overall approach of the provider.

While these measures require additional tasks for providers and consumers to complete, these forms can be administered and scored in under a minute (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Research suggests a few benchmarks to look for when interpreting consumer scores. These alarms are to be addressed directly with the participant in order to see if a change in service, provider, or frequency is needed. Firstly, the longer a consumer engages in a mental health service without positive change is a warning sign for negative outcomes or dropout (Hubble et al., 2010). Secondly, more than 60% of clients show improvement by the sixth session (Orlinsky et al., 1994) meaning that “early response in therapy is a strong indicator of eventual outcome” (Bertolini & Miller, 2012, p. 13). Alliance scores under the clinical cutoff of 36 are also cautionary as only less than a quarter of consumers score below this range. Finally, seeing improvement in the consumer’s alliance rating throughout the course of the service tends to generate improved outcomes. A meta-analysis conducted by Miller (2011) explored the use of routinely monitoring outcome and alliance data of 12,374 consumers from 13 RCTs. The findings demonstrated that outcome management doubled the effect size for these consumers, decreased dropouts by half, and reduced deterioration, hospitalization stays, and costs of care when compared to control groups without feedback conditions.

Although the ORS and SRS are used with ages 13 and over, a Child Outcome Rating Scale (CORS) and Child Session Rating Scale (CSRS) may also be used with younger service users. Additionally, the Group Session Rating Scale (GSRS) (Quirk, Miller, Duncan, & Owen, 2012) can be used with facilitators of group therapy programs. Licensing for these measures is available for free from the International Centre of Clinical Excellence and available in over 20 different languages. Below, a case illustration will present the process of
an adventure therapy program implanting FIT with adolescents in a rural South Australian community.

**FIT and Adventure Therapy: A Rural and Remote Case Illustration**

In collaboration with a rural South Australian high school’s alternative education program, called Flexible Learning Options (FLO), this author, a masters level qualified social worker co-led an 11 day expedition along with two case managers from FLO for a group of 8 participants (5 male, 3 female) aged 15 to 17. Funding for the program was provided by a local Rotary Club and the South Australian Department of Education and Child Development. FLO provides the opportunity for participants to voluntarily engage on the adventure therapy program. A month prior to the program, participants were introduced briefly to the process of FIT during a preliminary meeting with the social worker and the participants’ parents.

The case managers at FLO invited participants struggling with issues of self-confidence, bullying, family conflict, disadvantage, and learning differences. For this pilot program, the students struggling with histories violent and aggressive behaviours, severe and persistent mental illness, and substance abuse issues at the extreme end of the spectrum were not invited to participate. Because one of the case managers of FLO had previous experience in adventure therapy, she elected to choose participants whom she assumed would receive the most benefit.

The adventure therapy program was broken into three distinct phases (Individual, Team, Leadership), each being viewed as a specific therapeutic encounter for service. The ORS was provided at the start of each phase and on the final day of the program (Days 1, 4, 8, 11) while the GSRS was administered on the last day of each phase (Days 3, 7, 10, 11) in order to assess how each adolescent participant perceived the value of the service. The GSRS was administered to each participant individually but addressed the feedback as a group to ensure it was attended to. Throughout the program, participants reported issues with teamwork,
communication, lack of therapeutic goals, and the need for the social worker to provide strategies for the participants to work on issues of anger management, self-confidence, and mindfulness upon returning home.

Following each administration of the ORS, a Progress Note (See Appendix C) was completed to explore changes in scores and determine if any improvement occurred while inviting a conversation between the program leader and participant about what modifications could improve the delivery of the service and ensure that any gains were sustained throughout the program and upon the participants returning home.

The table below illustrates the ORS and GSRS of each participant through the adventure therapy program. To protect confidentiality and anonymity, participants were coded by an Initial, Age, and Sex. For example, a female participant, aged 18, named Renee would be coded R18F.

Table 1: ORS and GSRS Scores for Each Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Individual Phase</th>
<th>Team Phase</th>
<th>Leadership Phase</th>
<th>Final Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>P16F</td>
<td>ORS=31.2 GSRS=33.9</td>
<td>ORS=32.5 GSRS=36.1</td>
<td>ORS=39.2 GSRS=37.6</td>
<td>ORS=39.2 GSRS=38.1</td>
</tr>
<tr>
<td>S16M</td>
<td>ORS=15.4 GSRS=31.2</td>
<td>ORS=39.2 GSRS=31.2</td>
<td>ORS=39.3 GSRS=39.1</td>
<td>ORS=40 GSRS=40</td>
</tr>
<tr>
<td>S16F</td>
<td>ORS=15.8 GSRS=33.3</td>
<td>ORS=24.3 GSRS=38.1</td>
<td>ORS=33.8 GSRS=37.6</td>
<td>ORS=35.5 GSRS=39.6</td>
</tr>
<tr>
<td>D16M</td>
<td>ORS=34.9 GSRS=34.9</td>
<td>ORS=40 GSRS=40</td>
<td>ORS=38.6 GSRS=38.5</td>
<td>ORS=40 GSRS=40</td>
</tr>
<tr>
<td>J15M</td>
<td>ORS=30.8 GSRS=40</td>
<td>ORS=38.8 GSRS=40</td>
<td>ORS=38.4 GSRS=40</td>
<td></td>
</tr>
<tr>
<td>M15M</td>
<td>ORS=27.1 GSRS=26.8</td>
<td>ORS=36.4 GSRS=39.4</td>
<td>ORS=36.8 GSRS=40</td>
<td>ORS=37.8 GSRS=40</td>
</tr>
<tr>
<td>J17F</td>
<td>ORS=16.4 GSRS=23</td>
<td>ORS=26 GSRS=28.5</td>
<td>ORS=33 GSRS=34</td>
<td>ORS=39 GSRS=39</td>
</tr>
<tr>
<td>L17M</td>
<td>ORS=24 GSRS=28.1</td>
<td>ORS=33.3 GSRS=36.4</td>
<td>ORS=35.5 GSRS=37.7</td>
<td>ORS=38.8 GSRS=39.5</td>
</tr>
</tbody>
</table>

The graph below shows mean ORS and GSRS scores for the group across the 11-day expedition. As illustration, the group entered the program with a mean ORS score of 24,
below the clinical cutoff for adolescents of 28. No participant left the adventure therapy program below this cutoff. Regarding initial scores of the GSRS, a mean score of 28.1 demonstrates that some participants were not satisfied with the first few days of the expedition.

![Figure 1: Mean ORS and GSRS Scores](image)

**Lessons Learned**

Implementing FIT into any agency or practice is challenging and an outdoor environment can add to this. Tilsen and McNamee (2015) recommend providers create a culture of feedback where consumers are comfortable to discuss their outcomes and perceptions of the alliance with their providers. The scores above show that half the participants scored above the clinical cutoff on their initial ORS measure. While young people traditionally score the ORS higher than adults, it is essential that a provider work with consumers above the clinical cutoff to ensure that there is a reason for engaging in this service. Because the FLO case managers had invited these particular young people, this social worker could have spent time with the referrer and the young person to establish an ORS measure more akin to what their therapeutic goals. Consumers entering a service scoring a 40 out of 40 on their ORS are
considered to be at-risk as it is clear that there will be little agreement on goals. This is common with young people and mandated clients and the FIT manual (Bertolini & Miller, 2012) presents techniques for obtaining a more accurate measure.

In the future, this author would prefer to meet the participants individually prior to the program in order to work with him or her to establish an ORS rating more akin to their unique situation. Additionally, with no follow-up data presented at this stage, it is unclear how these gains were sustained over time. Because this social worker will be working with this community for the coming months, that information will be obtained each session to detail the alliance and benefit of the service.

Conclusion

This paper has presented the means for implementing Feedback-Informed Treatment so as to privilege the consumer experience and honour outcomes over process (Brown et al., 1999; Miller et al., 2013; Wampold, 2010). Because the quality of each consumer’s participation weighs heavily on outcome, this paper argues that privileging specific treatments over consumer feedback will continue leading mental health services down the same path, which has led to no statistically significant improvement since World War II (Asay & Lambert, 1999; Miller et al., 2013; Tilsen & McNamee, 2015; Wampold, 2010; Wampold, Mondin, Moody, & Ahn, 1997).
References


Outcome Rating Scale (ORS)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age (Yrs):</th>
<th>Sex: M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session #</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Who is filling out this form? Please check one:</td>
<td>Self</td>
<td>Other</td>
</tr>
<tr>
<td>If other, what is your relationship to this person?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

**Individually**  
(Personal well-being)

[ ] [ ] [ ]

**Interpersonally**  
(Family, close relationships)

[ ] [ ] [ ]

**Socially**  
(Work, school, friendships)

[ ] [ ] [ ]

**Overall**  
(General sense of well-being)

[ ] [ ] [ ]

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To download free copies of these measures please register online at:  
http://www.scottmiller.com/?g=mode/0
Appendix B

Session Rating Scale (SRS V.3.0)

Name _____________________ Age (Yrs): _____________________
ID# _____________________ Sex: M / F
Session # ______ Date: ____________

Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. [ ]
I felt heard, understood, and respected. [ ]

Goals and Topics

We did not work on or talk about what I wanted to work on and talk about. [ ]
We worked on and talked about what I wanted to work on and talk about. [ ]

Approach or Method

The therapist’s approach is not a good fit for me. [ ]
The therapist’s approach is a good fit for me. [ ]

Overall

There was something missing in the session today. [ ]
Overall, today’s session was right for me. [ ]

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Appendix C

Progress Note
<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORS Score:</th>
<th>Progress:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Score:</td>
<td></td>
</tr>
</tbody>
</table>

Progress addressed in session by:

Between session plan:

<table>
<thead>
<tr>
<th>SRS Score:</th>
<th>[] Above 36</th>
<th>[] Below 36</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[] Increasing</td>
<td>[] Same</td>
</tr>
</tbody>
</table>

Was the SRS addressed directly? [ ] Yes  [ ] No

| Clinician Signature: | Consumer Signature: |
Collaborative approach to addressing access to mental health services

Ms Margaret Kuhne & Ms Cassie Moore
Royal Flying Doctor Service Victoria

Paper presented at the
8th Australian Rural & Remote Mental Health Symposium
2-4 November 2016; Mantra on Salt Beach, Kingscliff, NSW
Collaborative approach to addressing access to mental health services

Abstract
The Gippsland Psychology Collaborative, a partnership between the Royal Flying Doctor Service (RFDS) Victoria, the Gippsland Primary Health Network (PHN) and Gippsland Lakes Community Health (GLCH) aims to address inequity of access to mental health services in small rural communities in Far East Gippsland. Access to both mental health services and general practitioners for these communities is extremely limited and therefore receiving services through funding models such as ATAPS is problematic. Some communities are over an hour from their nearest GP, urgent care or primary health service. Their only access to any services is through their local Bush Nursing Centre (BNC), run by dedicated generalist nurses who, in many cases, also undertake the role of first-responders in an emergency situation.

The Gippsland Collaborative has developed a bespoke model of care which sees BNC nurses trained in mental health triage using a recognised triage tool. Patients with mild to moderate mental health issues will be referred to a team of psychologists located within the region. Patients who are not appropriate for referral to this model would be referred on as part of the Stepped Care model for the region.

Consultations will occur via a mixed model of drive-in/drive-out and telehealth, using the Flying Doctor Telehealth platform. The initial one or two consults will be face-to-face at the local BNC, with subsequent consultations via telehealth.

This model integrates well with other mental health services already existing within the East Gippsland region and has a high degree of scalability to other isolated communities throughout Australia. The Gippsland Collaborative, including a Steering Group with consumers and mental health experts, is an excellent example of how organisations from different spheres (Gippsland PHN – federal; GLCH – state & RFDS Victoria – NFP) can take an integrated, innovative and inclusive approach to the provision of health services in rural communities.

Keywords: Access, Telehealth, Collaborative, Integrate
Background

While Victoria is a relatively populated state with few areas considered to be remote, the communities of Far East Gippsland are significantly isolated with an average population of around 230. Many do not have reliable interconnecting roads - in some cases it is one road in, and one road out – and they are, on average, 64 kilometres from the nearest town with a population greater than 1,000. The roads are winding and generally surrounded by bush. The communities include Gelantipy, Cann River, Ensay, Buchan, Dargo, Tubbut and Bonang.

East Gippsland has been identified as one of the significantly at risk areas in relation to mental health (Population Health Information Development Unit (, 2014)). Five of these isolated communities have a Bush Nursing Centre (BNC) which is run by one or two (in most cases one) nurses, who perform a multitude of roles from point of referral to first responder in an emergency. Most of these communities have limited access to a General Practitioner (GP), as well as other primary care services. For example, Cann River have a GP visit once every two to three weeks and in Ensay the GP visits for three hours every week. If there is no imminent GP visit, or for those communities where there is no such service, community members are required to travel up to 2 hours to see a GP. Additionally the only location that has a regular visit from a psychologist is Cann River, which is provided from Orbost Regional Health periodically, located 75 kilometres away. There is clearly inadequate opportunity for members of these communities to access reliable, consistent mental health services.

The organisations involved in this project have come together after recognising the significant need and gaps in mental health services in this area, with a plan to create a bespoke model of care specifically for these communities. The intent of the collaborative is to test aspects of the service model so that it may be transferrable to other communities and/or disciplines.

Royal Flying Doctor Service (RFDS) Victoria started providing optometry services to four of these communities in partnership with OneSight, in October 2015. The organisation also provides a range of other primary health services throughout Victoria including dental screening, oral health promotion and treatment via a mobile dentistry model; female GPs to communities that only have a male GP; and a telehealth service that links rural communities to endocrinology services in Melbourne. The organisation will apply the learnings from providing mobile and telehealth services to the planning and implementation of this program.
The Gippsland Primary Health Network (PHN) is one of six PHNs in Victoria, three of these being solely rural. It has a focus on supporting general practice, health planning, health system integration and commissioning services in line with national and local health priorities. All PHNs are charged with implementing the Stepped Model of Care for mental health services suitable for their region.

The Gippsland Lakes Community Health service provides primary and community health services in East Gippsland and is based in Lakes Entrance and Bairnsdale. The organisation delivers Alcohol and Other Drug and counselling services to a few of the BNCs, but recognises the scarcity of services for these communities and thus the inequity in health outcomes.

For these communities it is difficult to ascertain the real need for a service that has never been provided i.e. ‘we don’t know what we don’t know’. However it has been established that East Gippsland has significantly higher psychological distress than the state or national levels (PHIDU, 2014).

**Consultation**

The three organisations came together following the launch of the Mobile Eye Care at Gelantipy in February 2016, each identifying the access and inequity issues in relation to mental health services. Planning commenced and a loose Program Logic was developed. From the initial conversations, there was a commitment to ensuring this program would be both person and community centred. Consultation commenced almost immediately with both stakeholders and the community.

Stakeholders include regional mental health services, Monash School of Rural Health, surrounding larger health services such as Omeo District Health, Orbost Regional Health Service, Gippsland Lakes Community Health and Bairnsdale Regional Health Service and the BNC’s themselves. This consultation identified the following issues that needed to be considered in the development of the proposed model:

- A significant need to focus any interventions around culture change within the communities to reduce the stigma and other barriers to accessing mental health services
- Addressing the geographical challenges and needs of the communities is of particular relevant
The adoption of flexible funding models will assist with tailoring the programs to suit the needs and of the communities, as opposed to existing models of mental health care.

For many of the communities in question, there is little infrastructure and limited opportunities to engage with others. The BNCs and organisations such as the Country Fire Authority (CFA) are the life-blood and social hub of these communities. A survey was distributed to those living in the target population via the BNCs requesting information on the services they felt were important for the community and, more directly what they saw as the mental health needs of their community.

The response rate has been positive with services such as audiology and podiatry being highlighted as important. In relation to mental health, almost 85% of respondents confirmed that a lack of mental health services was an issue for the communities.

Additionally, nearly half of respondents in the community survey indicate that they would not travel to access mental health services, with others indicating that they would only travel if they had to, further reinforcing that service models need to reflect the needs of communities and reduce barriers in accessing health services.

**Methodology & Discussion**

From the information provided during the consultation phase, a Program Logic was developed - see Fig. 1 below. Within that, it was important to consider the following aspects:

- Any new service needs to integrate into the existing services provided at Cann River and in the surrounding health services as noted above
- The service must assimilate with the mental health ‘Stepped Model of Care’ as shown below in Fig. 2. Thus, it needed to involve all existing services and providers
- The very limited access to GPs mean that access to ATAPS is also limited and an alternative assessment and referral process will be required
- The program needs to ensure that, while it complies with other services and models, it also must be person-centred; driven and owned by the communities it is intended to benefit
- While on their own these communities do not have the critical mass to warrant a location specific service, combining the resources to benefit all of them is a cost-effective and efficient model of service provision
Given the distances between each of these services (the time required to travel between Gelantipy in the far east and Dargo on the western end of the proposed catchment is approximately three hours), a mobile face-to-face service is not necessarily the best use of limited resources.
Taking all of the requirements and variables into account, a mixed model of service provision was devised, using both face-to-face and telehealth service provision. Governance is to be achieved through the establishment of two committees to oversee program. The first is an Executive Steering Committee (EST) whose members will include executive representation from the three lead organisations, representatives from the regional mental health service, School of Monash Rural Health, BNCs and consumers. There is also an Operational Committee that includes representatives nominated by the organisations and groups listed above and whose role is to develop, implement, monitor and evaluate the program.

The service involves the provision of mental health services via a psychologist, using both face-to-face and telehealth services. Patients will be assessed and referred by the BNC nurses using a recognised assessment tool e.g. SQUARE risk assessment tool and then, if appropriate, referred into the service. Following the principles of the Stepped Model of Care, any patient who is not appropriate for this service will be referred to other, more appropriate, services within the catchment area, as per the developed referral pathway.

To achieve accurate and informed referrals, training will be provided to all BNC staff, as well as staff within the surrounding larger health services, including GPs, to ensure adequate support. This training will be provided by a recognised training provider and will be developed in conjunction with regional mental health service providers and the Monash School of Rural Health.

The psychologist/s will be located centrally at either Lakes Entrance or Bairnsdale. They will visit each of the target locations to provide face-to-face consultations on a regular basis e.g. once per month; it is anticipated that this will be required more frequently in the early stages of the program. Each patient can have a maximum of two face-to-face consultations before moving to telehealth. Telehealth services will, initially, require the patient to attend the BNC. This is to ensure adequate IT infrastructure and also the safety of the patient during these initial stages of the program. Where a patient is assessed by the psychologist as not being suitable to move to telehealth service provision, they will then be referred to the most appropriate alternative local or regional service, as per the Stepped Model of Care.

**Evaluation**

As a new and innovative model of mental health service provision, it is anticipated that evaluation will be a joint initiative undertaken by the three original partners with the support
of the Monash School of Rural Health. The evaluation will assess the three elements of the program.

- Firstly, the value and effectiveness of the provision of mental health services via telehealth. This will be achieved through collection of clinical and patient outcome data for this program and comparing that with a data set from a similar face-to-face only psychology service.
- The effectiveness of the collaboration itself; this partnership has been a unique undertaking with only one other mental health service currently being developed between an RFDS section and a PHN within Australia. Having the inclusion of a lead local health provider ensure appropriateness of service provision and workforce development
- Finally the effectiveness of the service itself from a multi-faceted perspective, utilising both quantitative and qualitative data from clinical data sets, stakeholders, patients and the wider community.

Conclusion

With scarce resources and increasing demand, partnerships and collaborative delivery of services are the way of the future. The delivery of a mixed model is an excellent opportunity to determine the effectiveness of telehealth as a vehicle to providing mental health services to isolated rural communities. This program demonstrates a model that is receptive to stakeholder and community needs and integrates into the existing mental health systems across a region. It is anticipated that this will be scalable to other rural locations as well as other disciplines in both the Victorian and wider Australian context.

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1 Population Health Information Development Unit (2014)