

**Investigating and enhancing rural communities' existing
mental health service networks.**

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Abstract

Mental illness is a growing concern throughout the world. The burden of mental illness is increasing globally, currently representing 7.4% of the total years of life either lost due to premature mortality or lived with disability.

In New Zealand, the estimated life-time risk of meeting the criteria for one or more mental illnesses is 46.6%. It is therefore essential to have a secure and effective mental healthcare system throughout the country. This can be particularly challenging to deliver in rural communities due to the unique circumstances that they face.

Previous studies have found that rural residents have decreased access to mental health specialist services, and increased exposure to mental health risk factors. However, there is ongoing dispute as to rurality's overall effects on mental health status. Further research is required.

Despite the urgent need to better understand the interactions between rurality and mental health, there is a severe paucity of research in the area on a national and global scale.

This action research project helped investigate the impact of rurality on mental health within New Zealand by interviewing mental health and wellbeing service providers operating in Wanaka and Balclutha.

The information gathered from these rural providers included their difficulties with interagency collaboration, the effects caused by rural providers working beyond their role descriptions, rural community characteristics that impact on service access, and service deficits within rural communities.

This data was used in conjunction with established literature in order to help understand several of the issues that are important to mental healthcare in rural New Zealand communities.

From this background, attempts were made to help improve Balclutha's existing mental health service network. These attempts included facilitating networking between services, creating a community-specific service information package, and encouraging the use of minimal-contact guided self-help therapies in a community-appropriate manner.

By investigating issues that are pertinent to rural mental health in New Zealand, this project helps address a major gap in current knowledge. The feasibility testing and process evaluation of enhancing an existing mental health service network will also serve to greatly benefit ongoing research and action in rural New Zealand.

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To my supervisors and my colleagues,

To my family and my friends,

To Balclutha and to Wanaka,

To those that made this year possible,

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Chapter One

Project Overview: From Conception to Completion

1.1 Introduction to the Project

This action research project helped explore the impact of rurality on mental health in New Zealand. In particular, it focussed on rural mental health service provision and the connections that exist between service providers. My work followed on from the 2011-2012 COMHEART Wanaka summer studentship and built upon the work that was started during that project.

To help understand rural mental health services, I investigated the views of service providers operating in the Clutha region. These views were used in conjunction with national and international evidence to examine some of the issues relevant to rural residency and mental wellbeing. The synthesis of these information sources informed my attempts to facilitate improvements in Balclutha's existing mental health service network.

My work tested the feasibility of enhancing a community's existing mental health service network and piloted several processes that could be used in future research and action.

1.1.1 Study Conception

The project was initially conceived of during discussions between my supervisors; Drs Jim Ross and Shyamala Nada-Raja. They recognised that many New Zealanders with mental health and wellbeing issues present to their general practitioners for support and treatment. They felt that general practitioners often had very few therapeutic options to offer these patients.

My supervisors believed that the lack of readily available brief intervention and therapist services meant that general practitioners were often forced to resort to using antidepressant medications as a first line treatment despite national guidelines that discourage this.⁽¹⁾ Their experience in rural areas was that the service deficits and associated issues were even greater than those found in urban settings.

In light of these beliefs, they designed COMHEART Wanaka: a 10-week summer studentship that sought to identify Wanaka's wellbeing service network and detect the gaps that existed within it. They hoped to understand how the community actively worked to mitigate these deficits and then explore how their research team could supplement Wanaka's efforts in this regard.

A community assessment tool was developed for COMHEART Wanaka which used interviews with local service providers to examine the community's situation. COMHEART Wanaka also piloted the process of creating a community-specific wellbeing service information package.

This honours-level project sought to extend the work in Wanaka, deepen the understanding of the effects that rurality has on mental health, and test the processes that developed during COMHEART Wanaka in a new rural location.

I became involved in this project as I am naturally inclined to work in rural areas. I find the connection, collegiality, and shared drive of rural community members creates a supportive and appealing environment. I have always enjoyed working and living in small communities as I find them more personable than larger ones and believe it is easier for one person to have a tangible impact on a small community. I also find mental health fascinating, stimulating, and an important element of overall health and well-being.

The work I carried out for this Bachelor of Medical Science with Honours is meant to complement the work that was carried out in Wanaka and work towards the wider goal of understanding rurality's impacts on mental health in New Zealand. Additionally it examines in more detail some of the steps we can take to improve the delivery of mental healthcare in rural New Zealand.

1.1.2 Aims

- 1 To provide feedback to Wanaka on the findings of the COMHEART Wanaka Summer Studentship (2012) project, which identified the community's service network and partially disseminated this information.
- 2 To update the disseminated information package from COMHEART Wanaka and evaluate its format, usability and potential avenues for maintenance.
- 3 Using information gained from COMHEART Wanaka, identify the current mental health service network within Balclutha and disseminate this information among providers and potential consumers of mental health services.
- 4 To investigate how Balclutha's existing community service network can be improved upon, including through the facilitation of an increase use of evidence-based online and guided self-help treatment modalities in the region.
- 5 Using data collected from both Wanaka and Balclutha, to document and evaluate the process of identifying a community's service networks and facilitating the enhancement of said network.

1.2 The Impacts of Rurality on Mental Health

There is a paucity of New Zealand-specific information regarding the impact on healthcare provision and the mental health effects of living in a rural location. Although more has been written on the subject internationally, it has been argued that there is a lack of evidence in the subject globally.(2)

This section examines the literature around rurality, the effects it is thought to have on mental health, and briefly summarises what is known about rural mental health in New Zealand. The literature that explores New Zealand's situation is elaborated upon further in Chapter Five (*Alike but not identical: Heterogeneity in rural New Zealand*) which discusses local research and how this project contributes to the growing pool of knowledge in New Zealand.

1.2.1 Defining Rurality

Perhaps the largest factor that affects the interpretation of rural mental health literature is the lack of an agreed upon definition of 'rurality'. Studies generally apply *ad hoc* definitions of rurality(3) making the interpretation of results, comparisons of studies and meta-analysis of data difficult.(4)

In addition, most studies only examine the differences between 'rural' and 'non-rural' centres despite the extreme heterogeneity within the rural category.(2) While common elements can be found between rural centres, they are distinct entities from one another and "few...would agree that their town is the same as...[a] similar sized one".(5) Differences in historical funding, founding principles, and variations in the "geographical, environmental and sociodemographic characteristics" of rural communities cause the rural category to be a "complex mosaic" as opposed to a single entity.(6)

It is believed that inconsistent definitions of rurality and the imprecise combination of several heterogeneous communities into a single entity has caused an underestimation of the effects of rurality of health status.(3-9)

These issues related to the definition of rurality mean it is difficult to draw conclusions from international research. This is true even of Australian data, despite residents being relatively comparable to New Zealanders.(10)

Australian studies and data sourced from the Australian Bureau of Statistics tend to use the Accessibility/Remoteness Index of Australia (ARIA) which defines a community's rural status

entirely on remoteness. ARIA+ (the most widely used index) is “a purely geographic measure of remoteness” and does not take into account factors such as socio-economic status or population size.(11)

In contrast, New Zealand recognised in 1983 that “although it may have been tenable in the past to regard the rural population as homogeneous, recent trends in migration have changed the character of this group... it would be useful to divide the rural population into groups which reflect this diversity.” The current Statistics New Zealand Urban/Rural Classification scheme attempts to divide rural areas into these groups based on the “comparison of a person’s usual residence address with their workplace address.”(12)

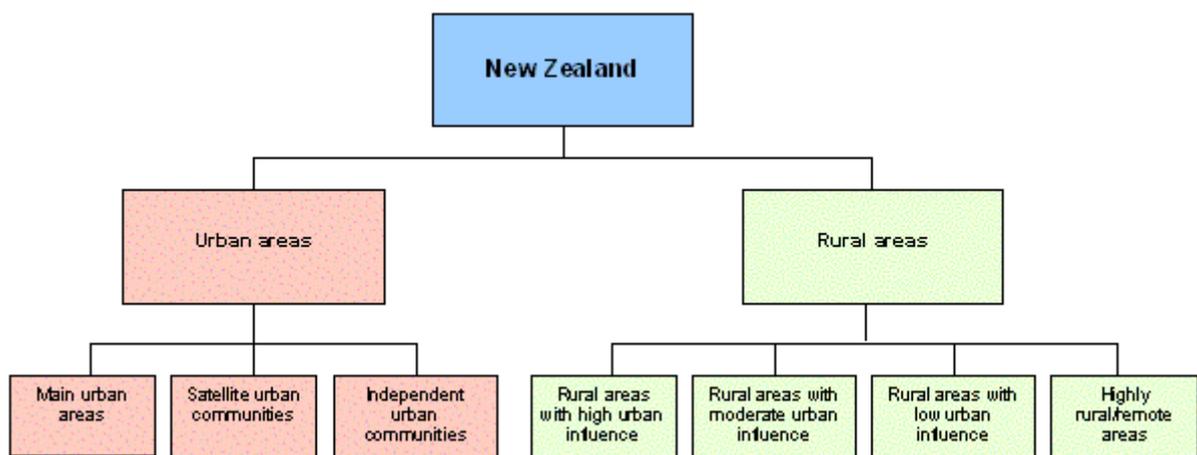


Figure 1.1: Statistics New Zealand’s Urban/Rural Classification System.

Statistics New Zealand’s classification system attempts to highlight the importance of factors beyond geographical location or population size that affect rural residents. However, the New Zealand research that has previously explored the effects of rural mental health has not used this classification system, perhaps due to the difficulty applying the system to situations that extend beyond discrete “meshblocks” of geographical area.

For this project, I similarly chose not to use the Statistics New Zealand classification system due to the difficulties applying it in a real world situation. If I had done so then Balclutha, the main community of interest, would have been categorised as an “independent urban community” as “less than 20 percent of the usually resident employed population's workplace address is in a main urban area”. The surrounding area where a large proportion of clients seen by Balclutha services reside, however, would fall into the “rural area with low urban influence” and “highly rural/remote area” categories as they have “minimal dependence on urban areas in terms of employment, or... a very small employed population.”

The difficulty that would be created during fieldwork by using this classification scheme, the conflicting nature of this scheme compared to that in the established literature, and the local consensus that all of the Clutha region was 'rural' meant I defined rurality on an *ad hoc* basis, similar to other rural researchers.

For the purposes of my literature reviews, I used studies' own definition of rural. I classed the locations I studied as rural based primarily on population size and relative isolation from a major urban centre.

1.2.2 The Significance of Mental Illness

Recent evidence has shown that there is a large and underappreciated global burden of mental illness. In 2010 mental illness accounted for 7.4% of all disability adjusted life years (the sum of years of life lost due to premature mortality and years lived with disability) worldwide. This figure that had increased 38% since 1990 representing mental health's growing impact on health and wellbeing.(13)

The New Zealand Mental Health Survey estimated that the local life-time risk of meeting the criteria for one or more mental illnesses is 46.6%. Major categories of disorders within this were anxiety disorders (28.8%), mood disorders (28.4%), substance-use disorders (13.8%), and eating disorders (1.9%).(14)

As nearly 47% of New Zealand residents are expected to experience some form of mental illness in their life, it is imperative that there is a stable and secure mental health service present throughout the country. Delivering this is thought to be particularly challenging in rural areas, however, as residents tend to have reduced access to services.(15-20)

1.2.3 The Mental Health Implications of Rural Residency

In general, rural residents access mental health services less frequently than their non-rural counterparts.(19, 21) The New Zealand Mental Health Survey reported that those "in rural centres and areas had...the lowest rates of mental health specialty sector visits."(22 p129)

There is on-going contention as to whether this diminished access mental health speciality services has significant implications on the mental health status of rural residents. Several studies have found no significant differences in the prevalence of mental health disorders between urban regions that have readily accessible specialist services and rural regions that do not.(3, 23-25)

Although there is debate as to the differences in mental health status between rural and non-rural settings, it is generally agreed upon that those in rural communities have increased exposure to mental health risk factors.(25) An increased suicide rate for young males in rural areas has also been recognised.(9)

Current thinking is that it is not 'rurality' *per se* that affects mental health and wellbeing, but a multifactorial effect of the characteristics and circumstances within a particular rural community.(25) This multifactorial, site-specific aetiology is in keeping with the established evidence of rural heterogeneity and previously discussed impacts of an inconsistent definition of rurality.

To improve a rural community's wellbeing, one must recognise how its unique characteristics and individual circumstances align and negotiate solutions within that framework.(26) There are, however, some themes that are thought to be common to most rural and remote locations that are also important to understand.

Risk factors for mental illness are magnified by the isolation, the effects of economic restructuring, and the unpredictable ecological conditions commonly found in rural and remote areas.(25) Many rural residents, particularly males, are thought to believe that sickness and injury are socially unacceptable as they convey weakness.(27) This rural stoicism(5, 28) and a culture of self-reliance(29) decrease the acceptability of seeking professional help for mental distress.

Rural residents are often thought of as being geographically distant but socially proximate; they may be separated from one another by large distances, but have an intimate knowledge of each other's personal circumstances.(28) This social proximity can create a supportive environment that bolsters mental resilience, but can also lead to a lack of confidentiality and the formation of a rural 'gossip network.'(30, 31) It has been argued that the stigma of being seen seeking help in a rural community has a greater detrimental effect on service use than the stigma of mental illness itself.(21)

Managers and providers of mental health related services in geographically isolated areas have repeatedly expressed difficulty recruiting and retaining qualified professionals in geographically isolated areas. This leads to a high turnover of staff.(16, 17, 32) Other difficulties in service provision include inappropriate funding models which are based on historical needs,(5, 16) confusion over the nature of other providers' roles,(29, 33, 34) and inadequate communication between services.(15, 18, 33-35)

Understanding the interplay of these common factors and other, site-specific factors is crucial to implementing meaningful change within a community.(4)

1.3 Assumptions of Research

During my research year, I also served as the Academic Senior Resident at Selwyn College. This position involved me living with many first year students and supporting them in their first steps into tertiary education.

Talking to junior science students about my studies, it became evident that many of my students felt researchers start in a state of *tabula rasa* when they begin their project. They believed that researchers begin as 'blank slates' and only draw conclusions through rigorous, objective experimentation and scientific enquiry.

Similar to my students, I once held scientific research in this regard. Early in my academic career I believed that research was impartial, unbiased and spoke in absolutes; research didn't just discover information, it discovered truths.

As I moved through my studies, I moved from this naïve and idealistic belief of scientific objectivity to the widely accepted view that researchers have numerous assumptions and biases that inform how and why they carry out research. Similarly, I moved away from the concept of an 'absolute truth.'

A single, universally experienced, 'true' reality now seems farfetched to me. We experience our own individual interpretations of the events that occur to, around, and because of us. Two individuals can experience the exact same event and come away with drastically different impressions; a phenomenon I often witnessed with the first year students I mentored. The meaning we give to, and take from, situations largely depends on our pasts and our individual experiences.

The closest concept to the 'truth' or a shared 'reality' is an artificial construct that synthesises people's individual experiences of a subject even when these differ from, or conflict with, one another. 'Reality' cannot be objectively measured as it is made up of people's subjective experiences and interpreted by the person 'measuring' it.

Assessing a community therefore becomes less about seeking an objective answer and more about working to understand the subjective experiences of the people, including yourself, that make up that community. Looking for elements of consensus and uniqueness within these experiences then

helps you understand which aspects are important to the community as a whole, and how individuals within the community experience these common elements. However information is only beneficial when it generates change in some way, so developing this understanding should not be the endpoint of research.

To bring about change in a community, you must acknowledge the individual 'realities' that exist within it. It is these individually experienced realities that you are ultimately attempting to change. Involving community members throughout the process of change is crucial as they are the ones who experience, interpret, and give meaning to that change.

With this in mind, the views I took when approaching this project are best thought of as stemming from constructivist and participatory paradigms.

The constructivist paradigm acknowledges that humans innately perceive, interpret and construct reality. It states that 'truth' is a "matter of consensus among the informed...not of correspondence with objective reality."(36 p98)

The participatory paradigm emphasises the importance of bringing these individual realities together and extols the positive effects that congruent realities have on action and change. The participatory paradigm highlights the critical role that research 'participants' have in generating knowledge and enacting change.(37)

The remainder of this chapter briefly outlines some of the ontological and epistemological assumptions of these paradigms, and then examines how these paradigms and assumptions impacted upon the study design including the chosen means of enquiry, analytical processes and points of action that occurred throughout the study.

1.3.1 Ontological Assumptions

Ontological assumptions are those assumptions that we make about reality. They underpin our fundamental views on the world and are the lenses that colour our views of life, including our views on research. They centre on the question "what is reality?" Here, they specifically revolve around the question "what is the reality in which I carried out my research into community service networks?"

The core assumptions I took as part of my wider constructivist and participatory paradigms were those of relativism.(38) The concept of relativism was put forward by Protagoras who believed that reality is what is purely what experienced; there is no reality without the measurement and perception by man.

For example a gust of wind feels, and therefore is, cold to one person. This same gust of wind may feel, and therefore be, warm to another. Protagoras argued that there is no absolute reality that could describe whether the wind is objectively 'cold' or 'warm'; the reality of the wind is entirely contextual.

Relativism often conflicts with the traditional positivist assumption that a situation can be defined, quantified, and predicted. Holding a relativist ontological stance tends to make a traditional positivist study design that seeks to measure and objectively understand a situation inappropriate.

1.3.2 Epistemological Assumptions

Epistemological assumptions are those assumptions that relate to knowledge, and the roles of the researchers and the research subjects. These assumptions have significant implications on the nature of research as they determine what results will be generated by a project.

As previously discussed, I take the assumption that our knowledge about reality is subjectively generated. I believe that we are incapable of developing knowledge that is not influenced by our individual circumstances.

It is therefore impossible to discount somebody's knowledge of a situation as 'incorrect' as they have experienced it in this way which makes it true to them. Each voice carries weight and meaning, regardless of its relationship with other voices. Our knowledge is dependent on our individual circumstances so it cannot be ignored purely for being different to the majority opinion.

My epistemological assumptions are rooted in subjectivism;(37) the assumption that the only knowledge we can be assured of is our experience of reality. Our knowledge of reality is generated by our personal interpretations, and not of an objective measurement.

1.3.3 Methodological Assumptions

I felt a qualitative methodological framework was the most appropriate approach for my project given my constructivist and participatory paradigms, and the relativist ontological and subjectivist epistemological assumptions that form these.

During the departmental protocol review process, action research was raised as a methodology within this qualitative framework that would align with these paradigms. At this point I was unfamiliar with the methodology, despite it being well established in education fields and increasingly used in nursing and health research.(39)

As I created my study protocol, I reviewed the information around action research to determine its suitability for my project. From my readings, I agreed that the methodology was well suited for my project given the direction I wanted to take with it.

Here I explore the key elements of the methodology as they applied to my research.

Action research is a dynamic form of research developed in the 1940s as a means of linking social change to research.(40) It is a more adaptable form of research than traditional positivist designs and therefore lends itself well to highly situational issues. As Cohen and Manion (1994) describe:

“Action research is a small-scale intervention in the functioning of the real world and a close examination of the effects of such intervention... [it] is situational... concerned with diagnosing a problem in a specific context and attempting to solve it in that context... Action research is appropriate whenever specific knowledge is required for a specific problem in a specific situation; or when a new approach is to be grafted onto an existing system.”(41 p194)

Since action research’s inception it has undergone many ‘generations’. Its core principles remain relatively static, however, as outlined by Kemmis and McTaggart.(42) These principles are that...

1. Action research has a self-reflective framework that is more fluid than those found in traditional, positivistic research styles;
2. Action research is a social process, acknowledging the complex interaction between individuals and society;
3. Action research is participatory, engaging participants in examining their practices and situation;
4. Action research is practical and collaborative;
5. Action research has an emancipatory nature; it explores how practices are shaped by social, cultural, political, and economic structures and seeks to minimise or overcome these constraints;
6. Action research is critical and seeks to identify and appraise the ideologies and assumptions behind activity;
7. Action research is a reflexive, recursive process of implementing change and evaluating the effects of that change; and
8. Action research seeks to transform both practice (action) and theory (research).

The importance that each of these principles holds within a project varies depends on the nature of the researcher, research subject, and overarching research institute. Like others before us,(43) my supervisors and I believed that implementing a completely fluid, adaptive, and reflexive project

would be infeasible within the confines of a single year honours project. To do so would require us to engage with participants in the study conceptualisation and design phases which would significantly delay and complicate the department protocol review, university ethics approval and regional locality assessment processes.

This project, like all action research projects, became *“a matter of balancing opportunities and constraints while operating flexibly within a set of guiding principles.”*(44)

Although these guiding principles are key elements that define action research, many action researchers choose to define the methodology purely by their use of so-called “action-reflection cycles.”

These cycles are formally defined by Stringer as a *“process of rigorous inquiry, acquiring information... and reflecting on that information...[this information] is then applied to plans for resolution of the problem (action), which, in turn, provides the context for testing hypotheses derived from group theorizing (evaluation)”*(45 p11) and are often expressed diagrammatically as in Figure 1.2 below.

Each cycle consists of issue identification, investigation, analysis, planning, action, evaluation and reflection upon the previous steps.(46) New issues and points of action are identified throughout the analysis, evaluation and reflection phases which then form the basis for another cycle.

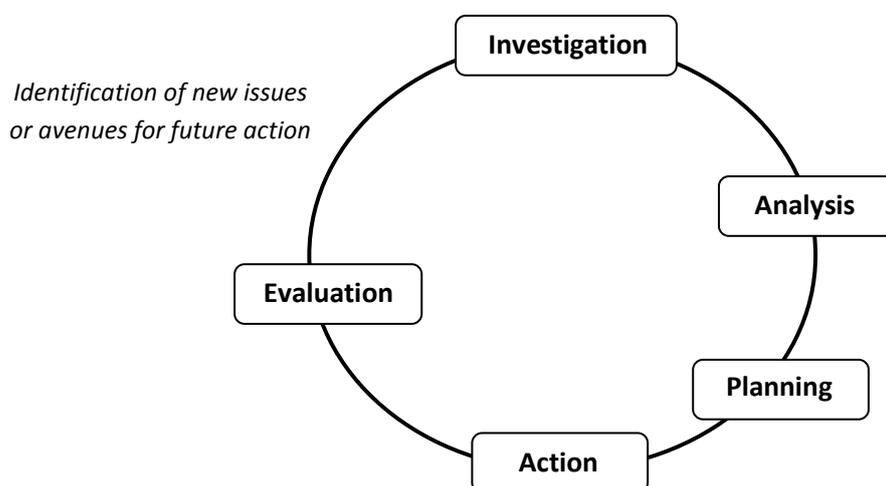


Figure 1.2: The principles of an ‘action-reflection’ cycle.

The ongoing cycles of action, evaluation and new action means research does not conclude with each completed cycle or project. Instead, study continues with a stronger evidence base, more focussed objectives, and a range of recommendations for extension and improvement.

The cyclical model encourages reflection upon actions that are taken, and ensures that knowledge gained is utilised throughout the study. The process is rarely as cleanly divided into discrete phases

as the pictorial representation would imply. Parts of the cycle often overlap throughout the project, and a single cycle may involve several smaller cycles of self-reflection and alteration.

Rather than defining my project through the use of action-reflection cycles, I defined it as action research due to the importance I placed on the guiding principles of the methodology. I did not purposefully attempt to divide the project into the discrete phases of an action-reflection cycle as it was the principles of action research, not the illustrative representation of the process, which resonated with my approach to research and helped address the unique challenges rural research.

The principles of action research lend themselves well to rural research due to the heterogeneity and situation-dependent nature of rural centres. The situational focus and adaptable nature of action research is a far more appropriate study design than a pre-determined 'one-size fits all' positivist approach when it comes to developing a meaningful understanding of a rural centre.

I felt that an action research methodology would encourage more meaningful change than other study designs would because the action research principles prioritise empowering the researched community. This empowerment would promote community dedication and help sustain change once our external research group left the area.

I also felt the action research framework was appropriate for my project as it was not designed to be a standalone investigation. My research forms only one part of an ongoing exploration of rurality's impact on mental health and the actions that can be taken with regards to this.

1.4 Project Overview

This project's goals were to complete the COMHEART Wanaka project, investigate another community (Balclutha) and explore how a community's existing mental health service network could be enhanced.

At the beginning of the project I drafted a rough outline to guide my work in Wanaka and Balclutha. I elected not to refer to this outline as my 'methods' as this implied a level of definitiveness that was not in keeping with the adaptable and reactive nature of my research. I instead referred to this initial outline as my 'means of enquiry and action.'

This means of enquiry and action is described below. The exact methods taken in each aspect of the project are explored more definitively in the relevant chapters of this thesis.

1.4.1 Means of Enquiry and Action

To carry on from the COMHEART Wanaka studentship, I had to understand of the project and assess its methods, findings, and developed products. From this assessment I then had to decide which elements I would incorporate into my own work, and how I would do so.

My initial field work would involve re-engaging with Wanaka, and beginning the engagement process with Balclutha.

I would re-engage with Wanaka participants in order to hold a feedback forum to gather their views on COMHEART Wanaka. This feedback forum would also serve as a means of introduction between the community and me, allowing me to more easily continue work in the region if appropriate.

The Wanaka feedback forum would be geared towards understanding how to streamline and improve the processes that I intended to use in Balclutha.

To engage with Balclutha I would first develop a baseline understanding of the area, and then identify potential participants to interview.

Interviews would be derived from those used in COMHEART Wanaka and again be semi-structured and qualitative. They would involve key points of discussion, but remain adaptable to participants' individual circumstances. I would only involve service providers in this project and would not discuss specific clients.

These interviews would allow me to understand how members of the community perceived the region's current service network. From these perceptions I hoped to understand how I could help participants enhance the connections and collaboration between local services.

Based on COMHEART Wanaka, I would develop a community-specific wellbeing service information package. I would tailor the content, structure and delivery of this package to the based on my field observations and the provider interviews.

I would modify the Wanaka information package based on the Wanaka feedback forum and the lessons I learned from my initial work with Balclutha.

Finally, I would test the feasibility of introducing new treatment modalities to an existing service network by developing a support framework for evidence-based guided self-help interventions and encouraging community providers to use this. The support framework would be developed to

be community appropriate, but would also be grounded in established evidence regarding supporting self-help treatments.

I would evaluate all aspects of this project through a feedback forum in Balclutha, as well as another in Wanaka if appropriate. If particularly important elements of feedback were raised in either forum, I would interview relevant people further to explore these issues.

I would document my actions and comprehensively evaluate all steps of the project to help inform future research.

1.4.2 Thesis Structure

This chapter has explored the overview of the research project, as well as the assumptions and methodological framework that underpinned its execution.

Chapter Two (*Wanaka: A Lesson in Community Engagement*) describes the COMHEART Wanaka studentship in more detail and explores the work in Wanaka that I completed. It focuses on the lessons about community engagement that I learnt through my work with Wanaka.

Chapter Three (*Balclutha: Investigating the Community*) describes the engagement process with Balclutha. It goes on to outline the interview process and most of the results generated from participant interviews.

Chapter Four (*Balclutha: Understanding the Community*) examines the results from Balclutha fieldwork at a deeper level. It explores my understanding of, and insights into, the community to a much greater extent than the previous chapter did. It also describes how these results were reported back to the community, the community's reaction to the community assessment process, and their views on the results I generated.

Chapter Five (*Alike but not Identical: Heterogeneity in Rural New Zealand*) examines what is known about rural communities in New Zealand and describes the effects of rurality on mental health issues in New Zealand. It compares and contrasts the two communities studied, highlighting the site-specific and common elements found between the two.

Chapter Six (*Balclutha: Enhancing the Service Network*) covers my attempts to enhance the existing mental health service network in Balclutha. It discusses the relative impact of these and evaluates the processes taken to enact change. Chapter Six also outlines the evidence behind guided self-help and describes the novel support framework I developed for guided self-help therapies.

Chapter Seven (*Continuing the Cycles: Current Conclusions and Future Suggestions*) briefly summarises my project and gives recommendations for areas of future research.

1.5 Chapter Summary

This chapter has explored the overall purpose and structure of my research year, the rationale behind its inception and my involvement, the philosophies and assumptions behind the project and the methodological framework in which the project was carried out.

The chapters that follow explore the project in greater detail, and contain the relevant literature and methods taken through each phase of investigation and action.

Chapter Two

Wanaka: A Lesson in Community Engagement

2.1: Introduction

Community Oriented Mental Health Evaluation, Action, Research and Training (COMHEART) Wanaka was a 10 week studentship project conducted in the summer of 2011 – 2012 by student researcher Shinayd van Rooy.(47) It was a scoping and networking exercise that had aimed to compile a list of available mental health service providers within the community.

As part of the project, an investigative framework for assessing a community's mental health service network was developed and piloted. This framework involved semi-structured interviews with service providers and formed the basis of the work done in Balclutha.

At the end of the project, an information package that outlined services operating in the region was created to facilitate understanding, networking and collaboration between providers. This was sent to study participants for their consideration and input, but was unable to be completed or fully distributed due to time constraints.

This chapter describes the COMHEART Wanaka work completed by Ms van Rooy, how I continued this work, and the lessons I learned about community engagement in the process.

2.2: COMHEART Wanaka

Wanaka is a small rural community in Central Otago. It was selected for the site of study due to its population size (7014 as per the 2006 census),(48) its established links with the supervising department, and reports from third year medical students' community contact projects which suggested that the community's residents were facing mental health stressors that were inadequately provided for by existing services.(49)

Particular emphasis was placed on taking a holistic and culturally sensitive approach throughout the project

2.2.1 Understanding the Community

The COMHEART Wanaka research team's primary aim was to develop an understanding of Wanaka's service network and explore the interactions between providers. A semi-structured

interview was developed that consisted of six open-ended questions. These questions assessed the strengths and weaknesses of the region’s current mental healthcare system, and investigated the degree of networking that occurred between providers.

Interview schedule used during COMHEART Wanaka
Background information regarding participant
What is your/your organisation’s role in mental health care? <i>Prompts: Challenges, Contributions.</i>
What are the relevant strengths of the current local mental health care system? <i>Prompts: Treatment outcomes, Collaboration, Patient satisfaction.</i>
How well do relevant providers/organisations integrate and network? <i>Prompts: Who are you involved with? Who would you like to be involved with? How well does everyone know about each other’s services/abilities? Contact, Referrals.</i>
What are the barriers for consumers in terms of receiving treatment from your perspective? <i>Prompts: Service availability, Accessibility, Affordability.</i>
Where do you think the gaps between services lie? <i>Prompts: Skill underutilisation, Lacking services, Lacking collaboration.</i>
What are some suggestions for improvement of the system in the future? <i>Prompts: Training in therapies, e-Therapies, Service integration, Information package.</i>

Table 2.1: The 2011-2012 COMHEART Wanaka studentship interview schedule

A ‘local champion’ (a general practitioner) was consulted in order to provide insight into the community and identify local service providers who would suit the study. A snowballing technique was used during interviews to identify and recruit further participants.

In total Ms van Rooy interviewed 19 participants (three male) from 15 services.

2.2.2 Key Results

Important themes from interviews were identified through a general inductive approach.(50) These themes reflected the overall impressions Ms van Rooy took from the community and were categorised under the broad headings of ‘Strengths’, ‘Networking’, ‘Barriers for Consumers’, ‘Gaps’, and ‘Suggestions.’

They are summarised in Table 2.2 below.

Key Results from COMHEART Wanaka	
Strengths of the Local System	<ol style="list-style-type: none"> 1. The Southern Primary Health Organisation's Primary Mental Health Service for mild to moderate problems. 2. The Dunstan Community Mental Health Team who had just started to see clients at the Wanaka Lakes Health Centre at the time of interviews. This was seen as increasing service range and availability, and encouraging networking between local practitioners and the Mental Health Team. 3. The then recently-introduced 'Books on Prescription' program.
Networking between Providers	<p>Opinions on networking differed between providers. Overall, it was felt that</p> <ol style="list-style-type: none"> 1. Some providers were unaware of each other's services or to have false assumptions about roles in the community. This was suggested to be especially true of local general practitioners with regards to alternative therapies. 2. Networking was difficult in the community due to high turnover of staff, 3. More established providers felt significantly more aware of other services and were more comfortable referring to these than their newer counterparts, 4. Bimonthly networking meetings occurred in the community, although attendance rates were said to be poor.
Barriers for Consumers	<ol style="list-style-type: none"> 1. Funding and the cost of treatment; particularly when clients couldn't use free services such as the Brief Intervention Service due to access criteria. 2. Travel to and from services. Travel for providers. 3. Maori in the community were noted as potentially being disinclined to engage with services due to previous poor experiences.
Gaps in the Local System	<ol style="list-style-type: none"> 1. A local Community Mental Health Team 2. Specialised treatments for cases such as eating disorders and drug abuse 3. Designated providers for Maori Mental Health
Suggestions for Improvement of the Local System	<ol style="list-style-type: none"> 1. Training local Practice Nurses in simple evidence-based interventions 2. More transparent sharing of information 3. Greater numbers of Maori General Practitioners 4. Social services targeting families 5. Group workshops on stress-management and maintaining 'wellness' as opposed to treating 'illness'

Table 2.2: Key results from the 2011-2012 COMHEART Wanaka studentship

2.2.3 Compiling a Community Information Package

COMHEART Wanaka participants were also asked about their views on the creation of a community-specific list of mental health and wellbeing services. This idea was met with "great enthusiasm", and several practical matters were raised by participants.

Participants emphasised that a broad and holistic approach should be taken when considering which services should be included. It was felt that descriptions should be brief and basic for quick reference, and that online therapeutic options would be a welcome addition to the list. It was cautioned that such a list would need constant updating, particularly in light of the high turnover of staff in the region.

From these suggestions, a draft version of a Wanaka information package was created as seen in Figure 2.1.



Wanaka Mental Health Package



Local Resources

<i>Name/Organisation</i>	<i>Contact</i>	<i>Roles</i>	<i>Services</i>
Aspiring Medical Centre http://www.aspiringmedical.co.nz/	Sally Battson (Practice Manager) (03) 443 1226	General Practitioners and Practice Nurses	First port of call for mental health issues, both immediate and long-term. Act as an advocate for the patient in the system. Assess patient and evaluate interventions.
Wanaka Medical Centre http://www.wanakamedical.co.nz/	Jan Gillespie (Practice Manager) (03) 443 7811		
Southern Primary Health Organisation Brief Intervention Service http://www.southernpho.health.nz/community.php	Tina Simmonds Tina.Simmonds@southernpho.health.nz 0800 488 887	Clinical Nurse Specialist – Brief Intervention Service	Free PHO funded service provided for individuals with mild to moderate issues such as depression, anxiety and stress and adjustment. Brief intervention services include initial assessment and up to five sessions. Referrals must come from GP or Practice Nurse.
Mental Health Team	Lesley Forbes lesley.forbes@southernpho.govt.nz	Community Mental Health Team member	A multidisciplinary community mental health service covering Central Otago, for more severe mental health problems. 24 hour emergency service.
'Books on Prescription' Southern PHO	Sarah Berger sarah.berger@southernpho.health.nz	Health Promotion Coordinator	The 'Books on Prescription' scheme is a joint initiative between the Southern PHO and the Wanaka Library. Self-help books are offered to patients with mild-moderate mental health issues. Referral is gained through GPs, nurses, counsellors and other health professionals.

Figure 2.1: The first page of the COMHEART Wanaka studentship Information Package

The information in this package was generated by Ms van Rooy, based on the interview question *“What is your/your organisation’s role in mental health care?”* and public sources of information. This first draft was then sent to participants with a brief email survey about the package and study.

All 19 participants were sent this survey, of which seven replied (37% response rate).

Generally respondents believed that the study was helpful in identifying gaps, bringing relevant information about services into a single resource, and encouraging networking between providers.

Participants were generally pleased with the “calibre and variety” of the services contained in the information package, although some noted there were additional organisations that could have been included. Only four respondents answered the question that asked them to rate the information package on a scale of 1 (not useful) to 5 (very useful); the average was 3.5.

Three participants volunteered to write their own role description in lieu of the one written for them.

Respondents generally felt that the established Community Networks Wanaka facility would be the most appropriate organisation to maintain the information package. Respondents felt the Community Networks website would be the best place to host an online version of the information package, should one be created.

2.3: Re-engaging with the Community

Despite the time delay and change in student researcher since the 2011-2012 COMHEART Wanaka studentship, my supervisors and I made the decision to incorporate Wanaka into my project. We felt it was important to feedback the results to the community, receive feedback on the validity of the project’s findings, offer closure to participants and, if possible, include them in the network enhancing aspects developed for the Balclutha arm of the study (see Chapter Six - *Balclutha: Enhancing the Service Network*).

I contacted Community Networks Wanaka as a means of re-engaging with the community. Working alongside the agency, I organised for myself and my primary supervisor Dr Jim Ross to attend the networking meeting held on June 12th, 2013. The purpose of our attendance was to present COMHEART Wanaka’s findings and discuss the project with community providers.

I was most interested in people’s thoughts on the draft information package as I intended to create a similar resource for Balclutha. The idea of an information package had been discussed during COMHEART Wanaka interviews but there was little feedback on the product itself. I was

interested in what practical aspects would be required for providers to make use of the resource, so I examined the document and researched the organisations included in it.

While investigating the organisations in the community, I discovered that Community Networks Wanaka already had an extensive online directory of community services operating in the region. This directory was broken into categories, several of which related to health and mental wellbeing.

The information about each service that was included in this directory was quite limited, usually only listing the organisation's name and contact details. Some organisations had additional notes such as the qualifications of the provider or a brief description (5-10 words) of the types of cases the service worked with.

The existence of this directory raised several important points with regards to the COMHEART Wanaka information package and its role in the community. The most interesting point to me was that it had not been mentioned by participants which suggested they were either unaware of the list or did not view it as a useful mental health resource despite meeting a similar idea with "great enthusiasm."

I suspected that a key reason that participants did not use the directory as a mental health resource was that it had a far broader focus than mental health and wellbeing. The directory included a large number of organisations which would have been irrelevant and frustrating if attempting to use it as a mental health and wellbeing resource.

Additionally, while organisations were grouped into broad categories such as 'counselling', there was no overall category dedicated to mental health and wellbeing. In order to find all mental health services within the directory, you needed to search through multiple categories which I found time consuming and often unintuitive.

The directory's use in understanding which organisations would be appropriate for an individual was limited it only including basic contact details and the occasional brief additional note. While minimising excess information would be helpful for those only looking for an organisation's contact information, it significantly reduced its usefulness for those who were unsure of what services were available in the community or how they could be accessed.

Because of these issues, I felt the COMHEART Wanaka information package could still have a purposeful role in the community provided it maintained its focus on mental health and wellbeing, conveyed key points of service information clearly and logically, and gave people the ability to quickly understand the mental health service options in the region.

The directory was already a valuable resource given its scope, up-to-date information and oversight by a community organisation that was thought to be the most appropriate to coordinate a community information package. It therefore seemed logical to work to complement this resource rather than attempt to replace it. When investigating how this could be achieved, I noted several organisations in the existing directory that would have been appropriate in the COMHEART Wanaka information package that were not in the initial draft or participants' feedback. I also noted several discrepancies between the contact details in the directory and those in the information package.

This led me to examine the information package content more closely. In doing so, I discovered that the information package had often used the contact details of the COMHEART Wanaka participants themselves which identified the study participants and gave their personal contact information.

In preparation for the Wanaka meeting I redacted this identifiable information and used the generic contact details found on the Community Networks Wanaka site instead.

2.4: The Community Networks Wanaka Forum

Community Networks Wanaka had provided us with 30-45 minutes to present at their June 12th meeting. The COMHEART Wanaka project and my study were briefly explained at the start of this time. Following this, written consent to take part in the feedback process was obtained from all those in attendance as not all taken part in the original studentship.

Dr Jim Ross and I presented an adapted version of a PechaKucha slideshow Ms van Rooy had created which gave an overview of COMHEART Wanaka and its key findings. I presented the further work on the information package that I had begun, and highlighted some of the points that had come up in preparation for the networking meeting/feedback forum including the implications of the Community Networks website.

People at the forum found the draft information package a very helpful resource and described the benefits of keeping it specific to mental health. It was thought that making the package available to the public was a good idea and descriptions of each service were particularly helpful in light of this. Descriptions were thought to be helpful for the region's newer professionals as well, as established providers would often get calls asking "*where do I actually go for this?*"

Practical aspects regarding its usability were highlighted. It was felt that a web version linked through the Community Networks website would be helpful, but that there was still a need for a printed copy. One participant stated,

“With the likes of general practices, [they] don’t have time to look up websites.”

One person who had experience maintaining printed copies of a list emphasised that

“The minute you do a hard copy it’s out of date”

although noted that

“There’s no solution [to this].”

The tendency for printed lists to rapidly fall out of date was demonstrated in the meeting as several of the organisations and practitioners included in the COMHEART information package had left the community in the intervening eighteen months.

People generally felt descriptions should be written by the organisations themselves, albeit with strict guidelines to length and content. The example descriptions written during COMHEART Wanaka were thought to be around the right length, although one person felt there was room to condense some information with bullet points to make it *“less wordy.”*

The layout of services was also noted as being somewhat haphazard. It was recommended that services that are the most likely to be needed in an emergency should be listed first, followed by services categorised in a logical manner.

We raised the idea of handing over the resource to community and how it would best be maintained and used. Participants still felt that Community Networks Wanaka would be the best organisation to oversee the document and a representative from Community Networks Wanaka was happy with this arrangement.

Through the course of discussions, it was mentioned that two independent networking endeavours were being undertaken in the community.

The first was that Community Networks Wanaka was in the process of overhauling their service directory and establishing a ‘Family Services Directory.’ This directory would have a formal process that services would follow in order to be included in it or have their details updated.

The family services directory would be broken into ‘chapters’, the specifics of which had not been finalised at the time. A Community Networks Wanaka representative stated that these chapters

could potentially include a 'mental health' heading given the positive feedback we had received. They indicated that the directory was unlikely to include service descriptions.

The second initiative being undertaken in the community was the establishment of a social support group for mental health providers to encourage networking between mental health and wellbeing service providers. Details on this group were scarce, but the group's chairperson mentioned that they had been collecting self-written descriptions of services from its members. They hoped to be able to pass these descriptions on to us once they had been collated.

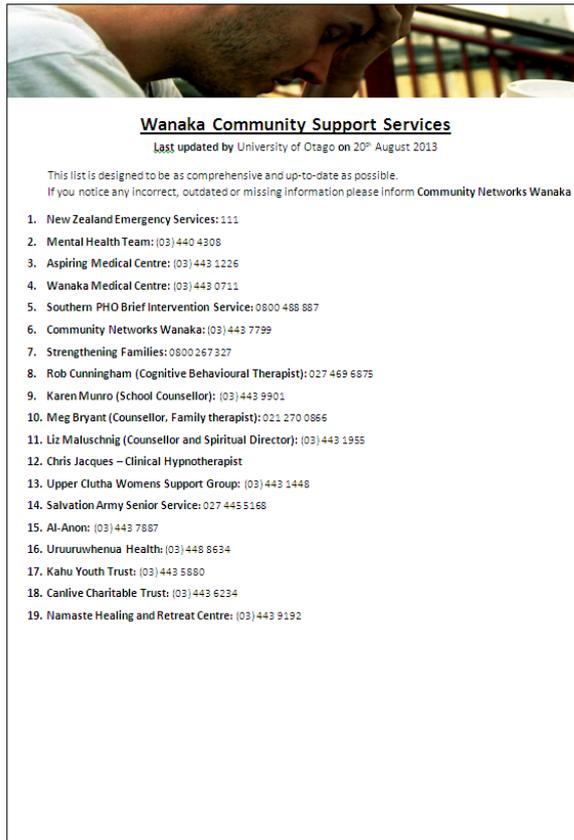
After the feedback forum, I discussed my future plans with Community Networks Wanaka and the chair of this provider support group. We decided that I would update the COMHEART information package with some of the layout changes suggested in the forum, liaise with the support group co-ordinator to obtain their collated service descriptions and, once these were incorporated into the COMHEART Wanaka resource, hand oversight of the document over to Community Networks Wanaka.

2.5: Updating the COMHEART Wanaka Information Package

The counsellor in the mental health provider support group who was responsible for compiling the descriptions of services was not present at the feedback forum. The social support group had a meeting scheduled for July, however, so the chair and I elected to remain in contact in the interim until the chair had the chance to discuss the COMHEART Wanaka project at this meeting.

In the meantime, I updated the information package based on the formatting suggestions raised in the Community Networks Wanaka meeting. As I had yet to receive the self-written service descriptions, I continued to use the researcher-generated ones from the draft document. The new format meant that there was some information missing from certain services. In these cases, I left those sections blank.

The updated version of the COMHEART Information Document is included in Appendix A.



Organisation:	Contact:	Description:	Notes:
New Zealand Emergency Services	Phone: 111	If there is an immediate risk or health concern, call 111 for urgent response and guidance.	No referral required. Free service.
Mental Health Team	Phone: (03) 440 4308 Fax: (03) 440 4318 Email: centralotagoemht@southernhb.govt.nz	A multidisciplinary community mental health service covering Central Otago, for more severe mental health problems. Includes a 24 hour emergency service.	
Aspiring Medical Centre	Phone: (03) 443 1226 http://www.aspiringmedical.co.nz/	First port of call for mental health issues, both immediate and long-term. Act as an advocate for the patient in the system. Assess patient and evaluate interventions.	No referral required.
Wanaka Medical Centre	Phone: (03) 443 0711 http://www.wanakamedical.co.nz/		No referral required.
Southern PHO Brief Intervention Service	Phone: 0800 488 887 http://www.southernpho.health.nz/community.php	For individuals with mild to moderate issues such as depression, anxiety and stress and adjustment.	Referral from GP or Practice Nurse required. Free service up to six sessions
Community Networks Wanaka	Phone: (03) 443 7799 www.communitynetworks.co.nz	Assessment and referral, advice and guidance on various issues (financial etc). One-stop shop for information on local services, including mental health options.	
Strengthening Families	Phone: 0800 267 327 Email: strengtheninfamilies@coreap.org.nz http://www.strengtheninfamilies.govt.nz/	Works with families who are linked with mental health issues, improving services for vulnerable families through local collaboration.	No referral required. Free service.
Rob Cunningham: Cognitive Behavioural Therapist	Phone: 027 469 6875 Address: 699 Aubrey Rd., Wanaka	Uses a psychotherapeutic approach to manage stress/anxiety/depression, control fear and anger, enhance performance and improve relationships.	
Karen Munro: School Counsellor	Phone: (03) 443 9901	Guidance and support for students, staff and families.	No referral required. Free service.
Meg Bryant: Counsellor, Family therapist	Phone: 021 270 0866 megbryant1@yhcoc.co.nz	Privately consult with people on various issues. This may include marriage, relationships, family/whanau issues, stress etc.	
Liz Maluschnig: Counsellor and Spiritual Director	Phone: (03) 443 1955		
Chris Jacques – Clinical Hypnotherapist	Email: contact@hypnotherapyandme.co.nz http://www.hypnotherapyandme.co.nz/	Helping individuals rebalance their beliefs/thoughts, reduce self-limiting and negative behaviours and working towards goals. Supporting people in any way.	Chris Jacques – Clinical Hypnotherapist
Namaste Healing and Retreat Centre	Phone: (03) 443 9192 Email: namastewanaka@slingshot.co.nz http://namastewanaka.co.nz/	Offers the opportunity to deeply immerse oneself into a holistically based healing environment. Services include guidance and counselling, alternative healthcare, residential retreats, spiritual development and workshops and courses.	

Figure 2.2: The first pages of the updated Wanaka Information Package

Unfortunately the person overseeing the descriptions did not attend the July support group meeting and, despite the chair and I continuing to be in contact through the latter half of the year, I was unable to ever obtain the collated service descriptions.

As the year progressed, Community Networks Wanaka overhauled their website as they had indicated. In late November 2013, they launched their Family Services Directory through this site. This directory had incorporated several of the ideas that had been raised in the networking meeting, although it still had a broad community service focus and did not have a mental health category.

In light of the updated Family Service Directory and the increasing time pressures on my project, my supervisors and I decided not to continue our attempts to oversee the integration of the COMHEART service information package into the community.

I updated the package to the most complete form I could produce using the information available to me and incorporated some usability elements I had learned from Balclutha in the interim (described in Chapter Six – *Balclutha: Enhancing the Service Network*). I then sent this updated information package to Community Networks Wanaka and the community providers' support

group with the understanding they could use it in whatever way(s) they felt would most benefit them.

The image shows two pages from the Family Service Directory. The left page features the directory's logo and a 'Selected Results' section. It lists three organizations: @Heart - Central Otago, Access - Central Otago, and Adaptive Snowsports New Zealand. Each listing includes contact information, availability, charges, and referral requirements. The right page shows results for Adventure Development Counselling and Age Concern Central Otago Inc, also with contact details and service information.

Figure 2.3: The first pages of the Family Service Directory.

2.6: Discussion

The work in Wanaka benefited both the community itself, and my ongoing work in Balclutha.

The issues that were raised by COMHEART Wanaka participants were fed back to the community for their consideration through Ms van Rooy's studentship report and the June 12th Community Networks Wanaka meeting.

At this meeting, several new points were raised regarding the role and implementation of a community service information package. Many of the content and layout suggestions were incorporated into Community Network Wanaka's Family Service Directory as evidenced in Figure 2.3.

The work in Wanaka developed and piloted a rapid community assessment framework which was essential for the work in Balclutha. On evaluation, the questions were deemed appropriate as they allowed researchers to quickly and easily develop an understanding of a community and the strengths and weaknesses of an existing service network. As discussed in Chapter Three (*Balclutha:*

Investigating the Community) the interview schedule remained largely unchanged as it was felt that it had worked well in Wanaka.

Exploring how to implement an information package in a community was invaluable for my work in Balclutha. The suggestions from meeting members were helpful in guiding my efforts, and several practical issues were identified. Working with Wanaka demonstrated the need to identify existing service lists and work to complement these and highlighted the importance of maintaining confidentiality throughout the whole project. It was essential that only generic contact details were included for services so as not to reveal participants. Similarly, it was essential that the information package be developed and distributed in a timely fashion while community engagement is still high.

Continuing work from a previous research project proved somewhat difficult, particularly given the level of community understanding and engagement required. Having to do so generated valuable data with regards to the need to maintain community engagement and the need to develop and distribute products of research in a timely fashion. Continuing from another researcher also tested the project's ability to convey an understanding of a community.

The time delay between the 2011-2012 COMHEART Wanaka project and my work in Wanaka provided direct evidence of the changing nature of the community that had been identified by participants. In the short time between studies several new services and initiatives had been established. Similarly, several services had left the community. This emphasised the need for an up-to-date directory for providers and consumers to refer to. The Community Networks Wanaka directory, whilst not specific to mental health, is an excellent resource in this regard.

2.7: Chapter Summary

Although the end product of the work in Wanaka (the Community Networks Wanaka family services directory and the dissemination of selected results from COMHEART Wanaka) was not entirely as intended, the community still directly benefited from research project. Many important lessons were also learned that benefited our ongoing research. The following chapters explore how these lessons were incorporated into my work in Balclutha.

The results from Wanaka are also considered in Chapter Five (*Alike but not Identical: Heterogeneity in rural New Zealand*) which compares the two centres in the context of rural New Zealand as a whole.

Chapter Three

Balclutha: Investigating the Community

3.1: Introduction

In the previous chapter we discussed COMHEART Wanaka, a project that developed and piloted a framework for investigating a community's mental health service network based on interviews with local service providers. The interview process developed for COMHEART Wanaka heavily informed the initial stages of work done in Balclutha.

The overarching goals in Balclutha were to develop an understanding of a community's existing mental health service network, explore how this network could be enhanced and added to, and to begin this process.

In order to understand the community and be able to make specific recommendations to it, I conducted interviews with providers of services that supported mental health and wellbeing in the Clutha region. A particular emphasis was placed on the results of these interviews as they formed the basis of future parts of the project.

This chapter describes the interview process in Balclutha and the initial results that were obtained from these interviews. The results outlined below were analysed further to develop a more complete understanding of the overall community and the issues underpinning participants' responses. The process and outcomes of this further analysis are covered in Chapter Four (*Balclutha: Understanding the Community*) as is the overall reflection on the interview process.

This chapter outlines the key differences from COMHEART Wanaka in the interview and analysis processes. These differences are returned to in Chapter Five (*Alike but not identical: Heterogeneity in rural New Zealand*) which compares the results from COMHEART Wanaka and Balclutha and explores the lessons derived from working with two communities.

3.2: Methods of Investigation

As in COMHEART Wanaka, a local community member (a 'community champion') was used to gain an oversight of the community and to identify key initial contacts to take part in the study. Dr Branko Sijnja acted as my community champion. Dr Sijnja is a General Practitioner working part-time in Balclutha and part-time as a Senior Lecturer at the Department of General Practice and Rural Health (University of Otago) where I was based.

I sought participants that worked in a service providing any form of mental health, wellbeing or community support service. By having Dr Sijnja facilitate introductions, I was able to make contact with several key Clutha services in this category including the local Community Mental Health Team and Clutha Health First, the organisation which encompasses the hospital and general practice.

I took an initial site-surveying trip to Balclutha where I became familiar with the town and talked to information site workers to help understand the region. While in town I made direct contact with services I had been liaising with, physically located services I had identified online such as Child Youth and Family, and made identified several new appropriate services such as Anglican Family Care. With my initial list of relevant services compiled, I invited providers to take part in a semi-structured interview for the study. Potential participants were sent information sheets about the overall project and a simplified invitation brochure. Based on feedback from the COMHEART Wanaka project, providers were also sent copies of the questions in advance.

The interview questions were based off the COMHEART study and aimed to examine role of the various services provided by participants as well as the strengths and weaknesses of the community as assessed by participants.

The designated 30-minute interviews were semi-structured, with standardised prompts that were rarely required. The interview schedule, as compared to the Wanaka schedule, is outlined below in Table 3.1.

Question 5 (*“What services related to mental health are you aware of? Please list all of these”*) was designed to be a source of data and part of a snowballing technique to identify further participants.

Where possible, a further three questions were discussed with participants in order to inform future avenues of research; these are outlined in Table 3.2 below. The rationale, results and implications of these are discussed in Chapter Six (*Balclutha: Enhancing the Service Network*) and Chapter Seven (*Continuing the Cycles: Current Conclusions and Future Suggestions*).

COMHEART Wanaka	Balclutha
Background information regarding participant	Background information regarding participant <i>Prompts: Age, Ethnicity, Qualifications, Years in profession, Years in Balclutha</i>
What is your/your organisation's role in mental health care? <i>Prompts: Challenges, Contributions.</i>	What is your/your organisation's role in mental health care? <i>Prompts: Specific contributions</i>
	What challenges do you face working within your organisation?
What are the relevant strengths of the current local mental health care system? <i>Prompts: Treatment outcomes, Collaboration, Patient satisfaction.</i>	What are the strengths of the current local mental health care system? <i>Prompts: Treatment outcomes, Collaboration, Patient satisfaction</i>
How well do relevant providers/organisations integrate and network? <i>Prompts: Who are you involved with? Who would you like to be involved with? How well does everyone know about each other's services/abilities? Contact, Referrals.</i>	
	What services related to mental health are you aware of? Please list all of these. <i>Prompts: Which do you refer to/recommend regularly?</i>
What are the barriers for consumers in terms of receiving treatment from your perspective? <i>Prompts: Service availability, Accessibility, Affordability.</i>	What do you think are the barriers for Balclutha consumers in terms of receiving treatment? <i>Prompts: Service availability, Accessibility, Affordability</i>
Where do you think the gaps between services lie? <i>Prompts: Skill underutilisation, Lacking services, Lacking collaboration.</i>	Where do you think the gaps between services lie? <i>Prompts: Skill underutilisation, Lacking services, Lacking collaboration.</i>
What are some suggestions for improvement of the system in the future? <i>Prompts: Training in therapies, e-Therapies, Service integration, Information package.</i>	What are some suggestions for improvement of the system in the future? <i>Prompts: Service integration, Information package.</i>

Table 3.1: A comparison between the Wanaka and Balclutha interview schedules.

Additional Questions in Balclutha
<i>[After explaining briefly what was meant by e-Therapies]</i> Do you feel there is a role within Balclutha for e-Therapies?
Are there any skills you, or your organisation, have that you would be interested in training other healthcare providers of Balclutha in (should they express interest)?
In the interest of informing future studies what, if any, routine data do you currently collect regarding users of your service? Note that we will not collect these data. <i>Prompts: Client numbers, demographics, waitlist time, referrals, re-presentation rates</i>

Table 3.2. Additional questions asked of Balclutha participants.

Participants had the opportunity to discuss the interview phase of the study, or project as a whole before interviews. Written, informed consent was obtained before interviews began.

I personally interviewed all participants. With the exception of one participant who elected to be interviewed over Skype, all interviews were conducted in person. Interviews were based on the principles of the Calgary-Cambridge model(51, 52) which I had been taught through medical school. This model encourages techniques such as developing rapport and using minimal encouragers and an open-to-closed questioning framework to gather meaningful information from participants.

Whenever possible, I incorporated into interviews elements of the Hui Process(53) that I had been taught by the Maori and Indigenous Health Institute (MIHI) through the Christchurch School of Medicine. The Hui Process is designed to establish meaningful connections and promote greater understanding and connection between people in a brief contact setting. By establishing a shared connection ('whakawhanaungatanga') I hoped to increase engagement with participants and to encourage a closer connection than 'researcher' and 'research subject.'

I recorded detailed field notes(54) of interviews as they progressed and afterwards I briefly noted my personal thoughts about the interview style, content and tone. Where possible, appropriate and permitted by participants, I made audio recordings for future analysis.

I listened to key sections of audio recordings shortly after each interview in order to enhance the notes I had taken. This ensured I had understood each of the participant's key points and also provided further insight into my interview technique and the accuracy and appropriateness of my notes. This encouraged more substantive interaction with future participants..

At the conclusion of the interview phase, I listened to each recording in its entirety. I did this to ensure all elements of the recorded interviews were accurately documented in my master document that I would later use for analysis. At this point, I also fully transcribed the quotations

from each participant that related to the main points they had made. This allowed me to work from their exact words when analysing data, rather than relying on my interpretations that formed the notes I had taken during interviews.

In total, I conducted 31 formal interviews with 38 participants (10 male). Participants worked in various roles of 23 key services and audio recordings of 22 interviews were made. The average length of these recorded interviews was 28 minutes 44 seconds (range 13 minutes 21 seconds – 48 minutes 42 seconds). The other nine interviews were not specifically timed but were not appreciably different in their length and range.

Several discussions outside of these 31 interviews were held with participants and relevant stakeholders in the community, such as the Books on Prescription service. These were not included in analysis as formal interviews as they did not follow the interview structure or have the same structure of enquiry. Instead they informed the study process, helped enhance my understanding of the community and maintained my connection with the community.

Once my master sheet of interview material and quotes was complete, I used a general inductive approach(50) to analyse the data. I formed categories based on the interview questions, identified main themes in these categories and selected quotes to demonstrate and explore participants' views around these themes.

The results of this general inductive approach are below.

3.3: Interview Results: A General Inductive Approach

I was primarily interested in three key areas when considering the interviews; the perceived strengths of the service network, the perceived weaknesses of the service network, and providers' suggestions on how to improve the service network.

The strengths of, and suggestions for, the Balclutha mental health, wellbeing and community support network were asked about directly through the questions "*What are the strengths of the current local mental health care system?*" and "*What are some suggestions for improvement of the system in the future?*"

Weaknesses were identified indirectly through three exploratory questions:

1. "*What challenges relating to mental health service provision do you face in your organization?*"

2. *“What do you think are the barriers for Balclutha consumers in terms of receiving treatment?”*
3. *“Where do you think the gaps between services lie?”*

The intent in dividing the discussion on weaknesses was to encourage participants to consider multiple and varied viewpoints, and to promote more robust discussion of the areas that required attention. It did tend to place a negative focus on interviews, however. In addition, having three separate questions to examine one aspect meant there was significant overlap in answers between questions. For example, one participant may have identified an issue as a barrier for consumers, whereas another may have seen it as a gap in service provision.

During analysis I classed responses to the three ‘weakness’ questions under the heading I felt was most appropriate given the context and overall discussion around that point, choosing to define the headings as:

1. **Challenges**
Points that addressed the difficulties experienced by providers attributed to working within Balclutha or the wider mental health service industry.
2. **Barriers**
Points that impacted Balclutha residents’ ability to receive help when required. A lack of service options was often cited during the interviews as being a barrier. For the purpose of analysis this was considered a gap.
3. **Gaps**
Points that highlighted the absence of specific services or needs of the community that were not adequately being met.

I was able to find more consistency between participants’ responses by classing responses in this way.

3.3.1 Strengths

Range of Services:

The range and quality of the services in Balclutha was highly regarded. Most participants praised the services available in the region itself or through Dunedin and the Southern District Health Board.

The Community Mental Health Team (CMHT), local non-governmental organization (PACT), and the Primary Health Organisation's Brief Intervention Service were highlighted most frequently by participants, emphasizing their importance.

"We are incredibly lucky in Balclutha...we are of a size where we do have a local mental health team, we've got CYFs, we've got the police..."

"I'm quite impressed. [Balclutha has] got a lot of things...great resources."

Working Relations:

Liaison and communication between services, the willingness of services to work in conjunction with one another, and established networking opportunities such as the youth interagency meeting were generally seen as strengths of the region.

"We have great networking with other services, it's a small community. We know each other; we all turn up at the same meetings."

"My experience is that [the CMHT] really want to... involve you in decision making, which is really good."

"[We] work to complement each of those supports, rather than working against each other."

Collaborative working relationships were particularly important to providers, and described as a recent area of improvement in the region.

"[We] work very cohesively now [there are] less people falling through the gaps."

"The agencies are working really well together, compared to what we used to"

Some participants did still difficulties with collaboration, however.

"Collaboration and understanding where each other's coming from is one of the biggest challenges."

"There's not a lot of collaboration between agencies. There's a lot of professional sort of jealousy and territorialness about sharing information which is negative...there's information that they allude to that would be helpful...everybody's bound by their own privacy issues, but for the benefit of the person you're trying to support it would be really positive to have a heads up on some things."

Service Approachability:

Participants explained that services were very approachable, even in the absence of formalized working relationships.

"I can go...into [the] mental health service and go 'who's this?' and 'what's that?'"

"[The CMHT] are very approachable and there's not an issue around having discussions around cases, and they will get back to us and they will reconsider [their decisions]."

"We feel comfortable talking to each other."

Very few participants felt intrusive when approaching other services and no recurring barriers were reported for providers who were seeking guidance or information.

Location:

Helping contribute to the collaborative working relationships and approachability of services was the close proximity of many services. This allowed easier communication and partnerships, and many participants expressed a desire to work in even closer proximity if possible. The idea of co-locating services as a single 'health campus' or 'one-stop shop' was raised by several participants.

"Everything's really close... it's just round the corner."

Having local services was seen as a strength for the community. This was most frequently described with regards to the locally based mental health team.

"Having somebody who can prescribe on site makes a world of difference."

"[Having the CMHT on site is] absolutely exquisite. We're so lucky... [we] can walk straight over with the file and have a chat."

"[Having the CMHT] in town is a really big strength... [we're] very fortunate to have the services they provide."

Community Support:

Most participants felt there was a culture of holistic care and support in Balclutha that did not arise solely from organisations. Many felt that the community had characteristics that encouraged health and help-seeking in its residents.

The most common characteristic reported was the small size of the community which gave providers a greater understanding of its residents. The size of the town meant providers could

appreciate the history and surrounding circumstances of client, and meant there was a greater awareness in the community of people who required support.

"[Providers] usually know the client anyway; know where they're going and what they're doing."

"In a small community you have a lot more knowledge of people...of the demographics and the community profile...and the clients, and their backgrounds. It's more personable."

Participants also acknowledged that services took this holistic, supportive view of health, and often went 'over-and-above' to support residents. This was generally described in relation to local services, again highlighting the benefit of proximity.

"In a rural area [you] do cover everything holistically."

"The important thing is that these people get help."

3.3.2 Weakness: Challenges

Many unique challenges were raised by participants. This was expected given the wide array of difficulties that arise when supporting mental health, and the wide range of services included in the study. Every service interviewed faced their own individual challenges based on their role and types of clients. During analysis, focus was only placed on challenges that related to the overall service network, or challenges common to many services.

Client Factors

One of the most frequently described challenges was managing clients in difficult and complex situations which extended beyond the client themselves. Client-centric challenges were often the first and most pressing issues described by participants. Although the nature of these client factors was unique to each service, the concept was important to all interviewed providers..

"Challenges? Constantly. Daily."

"People's expectations are usually quite high, especially in rural community."

Encouraging clients and their immediate supports to engage with services could be challenging, particularly with young people who relied on their parents for structure, support and consent.

"We work with complex families with complex issues."

"Some of the children that we deal with- the parents can have mental health issues as well which can be quite a hindrance to us... trying to get the best outcome when you're working with a parent with [mental health problems]...[it] can be a real stumbling block."

Some providers noted that maintaining a trusting, therapeutic relationship when there were concerns about safety was difficult, particularly given the lack of secure facilities when required.

"[It's challenging] keeping the trust with [the client] yet also being aware of their safety."

"We're mindful that we can't hold anybody... [they might] walk off and we think they really shouldn't do because they're going to walk off onto a main street."

Resources

Limited resources were almost universally acknowledged as challenging. These may have been funding related,

"Resources are historic."

"All the money is spent in [Dunedin]... if you look at the expenditure into areas [in Clutha] they're probably about, per head, about 20% of what Dunedin's is."

or due to a lack of staff and time,

"[There's a] limited amount of staff and a lot of people [who need help]."

"It's well known across mental health that the rural teams run lean on staff."

or due to having to balance client work with other activities, such as attending community meetings or continuing education.

"I often can't go. I chose not to go because it's two [clients] I could have seen in that time. It's a real challenge for me."

"Getting everyone in the same room hearing the same story is really challenging..."

"Everybody just gets so busy with their own roles that it becomes difficult to find time."

Overall it was felt that

"The need out in the community is greater than what we can provide."

Going beyond role descriptions:

Frustration and tension arose when the desire to provide holistic care for the community came into conflict with time constraints, staffing limitations and rigid funding models.

"I do notice, whether it's a good thing or a bad thing, that this service picks up things that Dunedin wouldn't. There's a much clearer division of who sees what in Dunedin."

"Resources are so stretched in all of the organizations...everybody's workload is so high...it's left agencies without the ability to [provide extra services beyond their scope]."

"We don't have the luxury of a structured work environment... you never know from one day to the next what's going to present... [we] have to offer quite an element of flexibility."

Finding a balance between serving the community and running services sustainably was particularly challenging. Participants often described going beyond their role parameters as an obligation, or in a frustrated manner.

"We're not funded for [providing support for over 65 year old clients] but we do it anyway...someone needs to."

Some participants tempered their comments by noting that no system could allow completely open access, however.

"I think it's probably because they're under pressure as well and can't pick everybody up, but we're the same...I appreciate that they do have to set limits."

Service Network Awareness

Some participants felt they were unaware of the range of services available to the community. This was often attributed to the fragile nature of services, or as a result of working either as a sole practitioner or within a niche area.

"I am always discovering more about who's around so probably I don't have a very exhaustive list...[because of] the scope of what I'm doing [it's been hard] nailing down who's actually in Balclutha."

"Everybody knows everybody in the district and knows what everybody's doing and yet there seems to be a brick wall between that and providing social services... it's like people don't know that there are other social services in town or if they do know they're there they're not quite sure what they provide."

“Working on your own has a certain disadvantage...it takes longer to learn some of these things...”

The reported level of unawareness was reinforced by responses to the question that asked participants to list all of the services that were accessible to Balclutha residents that they felt were related to mental health and community wellbeing.

Participants working from memory recalled an average of 9.5 services. Participant responses ranged from 4 to 22 identified services which suggested that there was a wide variation of knowledge in the community. Four participants used lists of services that they had already compiled in order to answer the question.

A breakdown of services listed by participants is included below in figure 3.3. Broad categories of frequency were used as several issues in data collection limited in-depth analysis. The types of study participants meant some areas of mental health were overrepresented. For example, several participants worked exclusively with youth, so youth services were more likely to feature on their lists. Additionally, conditions between participants were not standardised; some participants had read the question in advance and some participants spent longer thinking and answering this question. The breakdown is not intended to describe the precise awareness of particular services in the community, but to give insight into the types of services that participants considered related to mental health and wellbeing and the differing levels of awareness of these services.

Many participants said that they believed a particular service existed in the community, but were unaware of any specifics. This was most common with counselling services, carer services, and home help services.

Frequency mentioned by participants	Name of Organisation
Very commonly ($\geq 50\%$)	Anglican Family Care Clutha Health First Community Mental Health Team (including Child Adolescent and Family Service and Community Alcohol and Drug Service) Pact Group
Commonly (40 - 50%)	Child Youth and Family Services Dunedin Hospital and Related Services Primary Health Organisation's Brief Intervention Service Salvation Army SF Otago
Quite commonly (30 - 40%)	Adventure Development Counselling Services (as a general term) Police Public Health Nurses Relationships Aotearoa School Supports Work and Income New Zealand (including Budget Advice)
Sometimes (20 - 30%)	Bill Rout Counselling Catholic Social Services Pathway Counselling Carer Support Services Churches Home Help/Home Support Services IHC Services Miramare Needs Assessment Plunket Presbyterian Support Southern Support Eating Disorders St John's Women's Refuge Victim Support
Uncommonly (10 - 20%)	Dunedin Arts Centre Duly Appointed Officers Family Violence Support Holmdene Rest Home and Hospital Jenny's Companion Group Special Education Services Telford Tokomairiro Waiora

Table 3.3: Community wellbeing services identified by interview participants

Most of the participants that felt that there was good service range awareness in the community still described a lack of depth in understanding about services' roles. It was felt that service priorities and purposes tended to change significantly over time, particularly given the 'contract

era' of service provision. Many participants reported that there were incorrect assumptions made about services in the community.

"We don't really understand each other's roles and responsibilities enough. They probably have expectations of us and we have expectations of them...there needs to be a bit more discussion and understanding about what they can do...we need to understand and respect what they can do, their limitations to what they can do. And they similarly need to understand what we can do because sometimes they have unrealistic expectations."

"[It's been a] learning curve for us as to what they [The Community Mental Health Team] require [in referrals] ...I don't think they make it that clear as to what they expect."

"We're not always clear why a client's denied which creates more workload for us."

Some participants said the approachability and informal connections between providers compensated for any lack of understanding that may have existed in the community.

"Everyone knows everyone. I don't know whether [the network] needs to be more regimented."

"[It's] easy to find somebody who knows the information you want."

Several participants noted that service clarity had greatly improved in recent years.

"Providers are a lot clearer now about what needs to [be sent to the CMHT]...[it's] a lot clearer about what each agency does."

Fragile nature of services

Services provided in Balclutha were described as being inconsistent over time. Many organisations either did not provide continuous support to the community, frequently changed staff, changed available programs, or else ceased service provision all together. This was difficult for providers who relied on having those options for their clients.

"If you lose something, it's very hard to get it back. Once it's gone, it's gone."

"It's quite hard to keep up with what's available...one minute you have it, the next minute you don't."

“They come in with barrels blazing but then it just fizzles and the client’s left hanging.”

Local services often relied on the passion and dedication of a single person, leaving them vulnerable to collapse if that person moved on from that role. This was compounded by a high staff turnover reported in the area.

“When you lose someone out of the pool it feel like...you’ve got a bit less to work with. Less options.”

“It’s a big brief, a big client base. Probably the reason why the rate of burnout is pretty high.”

“There’s been a change of staff...there just seems to have not been the continuity there.”

Services were also vulnerable when funding was granted for a particular purpose without plans to sustain it in the future. This was particularly noted for services that travelled from Dunedin.

“Sometimes [services are] available and sometimes...it’s just random, like Seasons for Growth – they ran it once and it’s like ‘Oh yeah, they’re coming’ and then...I don’t know...they come once and they don’t come again. It’s not consistent.”

“Quite often these services might be around for a year or two and then they just go. Y’know they haven’t got funding, or they’ve decided they’re not going to come back to Balclutha anymore.”

“Everyone has a bit of a turn at coming down to serve Balclutha and then buggers off again.”

It was cautioned that in a small community professionals needed to be high quality, as they often are the only option for consumers.

“The calibre of facilitators has been questioned [in the past] – that’s the other aspect, you can get. You might get service provision but rurally it’s got to be done by the best.”

Location

Balclutha’s rural location caused difficulties for providers, particularly those that had strong connections to Dunedin due to travel requirements between the two centres.

“To go that far you wanna have numbers [of clients to justify services].”

"We're an hour away [from Dunedin Emergency Psychiatric Services] and they want to have a reasonable idea of the patient's state of mind. Sometimes there's quite a debate as to whether this patient needs to be seen."

Patients and clients based in regions such as Tapanui caused difficulties due to the politics involved with duty of care and organizational boundaries. This was noted to cause disputes and delays in assessment and treatment. The responsibility for transport back from Dunedin after emergency referrals was often unclear and unfunded.

3.3.3 Weaknesses: Barriers

All participants could identify barriers that hindered or prevented consumers receiving care. The majority of identified barriers were systemic issues associated with living and working rurally and were consistent with the international literature outlined in Chapter One (*Project Overview: From Conception to Completion*). Some reported barriers were either specific to, or particularly important within, Balclutha's network configuration. These barriers are outlined below.

Cost

Cost was the most commonly cited problem identified for residents. Many participants noted the lack of free counselling as a key financial barrier.

"This does seem to be a poorer demographic here."

"Our clients...they're not affluent, and trying to get them a disability allowance for counselling through WINZ is hopeless."

"Cost is a huge barrier, if everybody could just get some counselling for free like they kind of do in Canadian models...it would be a lot easier."

People were quick to note, however, that costs are not restricted to a service's fees. Time off work, transport, and accommodation all contribute to financial strain for the client.

Transport costs were seen as a major barrier for consumers. Travel to Dunedin for specialist services was acknowledged in this regard, but the issue was more commonly raised with regards to transport within Clutha itself.

"There are people here who struggle to get transport to centres. Clutha district's a huge area... [residents outside of Balclutha] can't afford or aren't available to get to services."

“For people who live actually in Balclutha it’s not so bad, but for people who live in the outskirts, like there’s no bus services or taxi services or anything like it...[transport’s] quite a big issue for people.”

Meeting criteria

The second most commonly identified barrier for consumers was the need to meet service criteria. Clients often would not meet the diagnostic criteria required to access many support services in the region, and be left with little support options as a result. Participants highlighted the moderate-to-severe threshold of the Community Mental Health Team.

“People just having chaotic life styles, but they don’t have a diagnosis. That’s a big gap, because who does work with them?”

“[Criteria’s] always been a bit of an issue... [clients] often feel it is severe when it’s not”

“Not meeting the criteria- like you’ll only see moderate-to-severe. Sometimes when you’re referring in you don’t know where that person fits on that line so they have lots of discussion about whether this person is moderate to severe. Sometimes you think ‘would you just see them, do that assessment and then decide?!’”

It was acknowledged that the mental health team were often flexible in their decisions around acceptance criteria when compared to services in larger areas. One participant explained that the close relationships between services may play a large role in this flexibility.

“We tend to get them in because... we’ve got that collegial relationship. But I have heard general public say ‘man alive it’s hard to get seen in that place.’”

Oversubscription to services

It was felt that services in the region had long waitlists that prevented community members receiving appropriate care. Several services noted that their own waitlists were unduly long, and had concerns about other services for similar reasons.

“How do we manage them while we wait?”

“We don’t advertise. We simply can’t. We’ve got a waitlist, it wouldn’t be ethical. We’re always in a dilemma around whether we promote our service or not.”

“It’s the wait time...do we send them home? We’ve got families saying ‘you can’t send them home.’ Well we can’t hold them here.”

A few participants reported that the length of time to be assessed or accepted by a service occasionally meant people experiencing a crisis had “settled just enough” that they would no longer meet criteria for the service. This frustrated participants as the client was left unsupported until they reached another crisis.

Community Characteristics

The size of the community and its character negatively impacted help seeking and engagement with services. Many participants described community members as stoic and conservative..

“[There’s an] element of the small community stuff. Rural communities are typically not great at putting their hand up for help.”

“[There’s a] rugby, racing and beer culture here... [People think] ‘I’m not going there’ [or] ‘I’m not one of those’... They don’t want to be classed as nutters.”

“People down here are very conservative...they don’t like anybody who’s too different.”

The close nature of the town also led to confidentiality concerns.

“[People] haven’t wanted to go in [the Community Mental Health building] because they’re scared somebody’s going to see them... to some degree, people quite like it that you’re not based [in Balclutha], that you’re not going to see them in the pub.”

“People have long memories in that respect in the community. [They’re] not given the same chance, they’re not as anonymous as they are in the big city.”

Participants believed that past experiences with mental health issues and mental health services had impacted on Balclutha residents’ current behaviours.

“People hold very long memories here...people talk, so there’s a lot of suspicion [about professionals].”

“People have been burnt too, with previous practitioners who haven’t been professional.”

A few participants felt the level of stigma in Balclutha was higher than that in other similar communities,

“My experience in [another rural location] was similar, but not [as bad] as down here.”

“[Balclutha] is a difficult place to live if you’re mentally ill.”

although one participant felt that stigma wasn’t noteworthy in the area.

“I certainly haven’t experienced much in terms of stigma attached to services. People come in here off the street all the time. No one seems to have a problem with accessing a mental health service.”

Community Knowledge

A common theme was the lack of knowledge in the community about support services and the impact this had on one’s ability to seek help. It was felt that consumers lacked information about the services available in Balclutha and how to access them.

“[There’s a] lack of knowledge...people need to have awareness of what’s out there and how to- how the referral system works. Does the GP refer them over? Can they self-refer?”

“People only find services at crisis points... [when] there’s been this huge amount of damage done.”

“I actually think Joe Blogs’ general knowledge on [mental health services] is pretty limited on what they do and what’s available and what their criteria are... The average person in the community probably really doesn’t know what the mental health team is about. Maybe partly that’s to enable a bit of discretion for people that access it...but at the same time if you really need the service some people just might not know where to turn.”

3.3.4 Weaknesses: Gaps

Beliefs about absent or undersupplied services were less consistent between participants than in other areas in the survey. It was difficult to identify roles felt to be lacking by the community as a whole because participants tended to describe gaps within their own field of work only. For example agencies that worked with mothers identified a lack of caregiver services whereas agencies that worked with the elderly noted a lack of respite care.

Although the specifics varied, there was an overall belief that some support services were lacking, understaffed or prohibitively difficult to access in the community.

“[We] haven’t got as many things here as in Dunedin.”

“There are things you can’t access...some services you might not be able to access down there...limitations on what’s available there.”

It was felt that the limited number of service options in Balclutha meant there was little choice for the consumer within a particular field

"If it doesn't happen to work with that particular person...in those places there's not much option... [you're] limited to one or two people."

While it was not possible to identify clear positions desired by the community as a whole, there were some common areas of concern to participants.

Mild-to-Moderate Services

A lack of early intervention services was described as a shortfall of Balclutha's service network. Some participants described this gap as the "mild-to-moderate" area, reflecting diagnostic severity, whereas some chose words like "primary care" or "general support."

The Primary Health Organisation's Brief Intervention Service was acknowledged as an excellent service, but the length of engagement with clients was seen as being too short to cater to everybody's needs, and concerns were raised about staff turnover and a lack of community presence. It was felt that other services were needed in the region.

"There tends to be a bit of turnover with [the Primary Health Organisation's Brief Intervention Service] and it's a bit of a faceless service. They don't have their own rooms and they just sort of float around. They don't have a clear identity and the referral process is murky."

"It would be great to be doing a bit more [early intervention] but because we're not... [we're] dealing with stuff that's a lot further down the track."

"[The Brief Intervention Service] goes some way to addressing that bit of a gap [but] six sessions isn't really enough."

An organisation that worked with people when they were discharged from severity-dependent services was desired.

"When they are supposedly well they get signed off but then they feel like they're left in limbo with no support... [They're] still quite fragile. That's where we are lacking in our community, [supports for] those people before they get to crisis."

There was a call for more counselling services in the area, particularly low cost or free options.

"There's a real need for some group work or counselling. We don't have a local grief counsellor available ...I think there's a really big need for something like that here; grief in the broadest sense."

"Supported positive stuff like suicide prevention, depression in teenagers, school counselling - all of that stuff needs to be beefed up."

Specialist Services

While there was no consensus on what types of specialist services would best benefit the community, participants did desire more specialists in the area. Specialist services that commuted regularly were appreciated, but weren't seen as sufficient as it was impossible for them to be on-site "as things evolved."

Participants often acknowledged that services such as Youth Alcohol and Drug workers or Psychogeriatric support were accessible through Dunedin, but still described these as gaps as they were not in Balclutha often enough to meet the perceived needs of the community.

"[We] have to wait...the psychiatrist's not down very often."

"You can't be in Balclutha and immediately access a specialist in say eating disorders."

"I really think it's useful if they've got some sort of connection to the community."

Psychological Services

Some participants noted that the loss of Balclutha's psychologist, employed 12 years previously, was particularly damaging to the community's ability to manage mental health issues.

"We probably struggle... We're used to having a psychologist on site. The skill level's not what it was."

"We haven't got a psychologist [and] we've been banging on about it for two and a half years... When you're getting into [things like] severe anxiety disorders you're not going to get [adequate support] from the brief intervention service. You need quite skilled people working with that."

Skills Programs and General Support

Many participants felt general life skills programs would encourage wellbeing and prevent mental distress in the community. This was seen as preferable to the current reactionary focus on mental illness.

Example of absent life skills programs included anger management, assertiveness, and parenting programs. Work skills programs were also seen as needed in the community to help prevent unemployment and underemployment stresses.

“Training opportunities, up skilling opportunities that these people could benefit from...some of these people would like skills with computers and stuff that would be really helpful...there’s nobody doing that. That’s a huge gap really.”

“[People] all want work, but it’s not happening.”

More flexible employment opportunities for clients whose mental illness made it difficult for them to work full time were also desired. Similarly, it was felt that a dedicated home support service would benefit mental health as it would address life stressors that contribute to mental health problems in the community.

“People tend to get themselves into a bit of a crisis situation... [we know] that they need some help to put some structure into their home...but there’s nobody.”

One participant was concerned increased home support may delay the referral of people who require more intense management.

3.3.5 Suggestions

Despite marked variability in identified challenges and service deficits, there was a strong consensus as to how Balclutha’s wellbeing service network could improve itself.

Enhancing Interagency Collaboration

The majority of participants gave their views on the current level of collaboration between services; while the recent work in this area was praised, many participants felt this area required on-going attention.

There were calls for agencies to better inform one another of their role descriptions and limitations.

“We have to keep talking to each other about what we can and can't do.”

“What would really help, really really help, is for them to hold a workshop or something on who they are and what they do as there have been changes.”

“If you're supporting somebody it's good to have all parties on board knowing. [To know] what each other's doing so you can be a bit more cohesive in what you provide.”

A frequently expressed method of achieving this was establishing a regularly occurring professional networking meeting.

"I don't know how you'd do it but that would be the ideal though, wouldn't it? That you all get in a room once in a while, even if it was once a month... It'd be helpful just to even meet without clients; to know other agencies and what they can provide so then you are able to offer it to anybody that you see might need it."

"One of the models that I particularly like in Southland is they have a network meeting. Key people from all the different areas, including NGOs, sit around the table once a month and review how things are. It's a really good interdisciplinary overview between mental health and other services...A deliberate attempt to sit in the same room at the same time."

"Even if it was once a year there was some sort of forum or half a day or whatever that just purely focussed on mental health as an opportunity for networking and being refreshed about what [each service provides]. Having available referral forms or pamphlets or if there's been new counsellors come in that they're introduced...once a year that meeting and greeting and networking would be quite useful because it's very easy to make assumptions about what services provide."

Several participants felt co-locating services would encourage collaboration and networking between services, as well as make things simpler for clients. Services based outside of Balclutha frequently expressed a desire to run their clinics in the Community Mental Health Team building.

"[It would be nice to have a] one stop shop...the hospital has everything but mental health."

"The primary mental health brief intervention service is great because it's filling a gap but it's just creating again another layer of services. You've got your general practice, your GP, your nurses and then you've got this one and that one. It'd just be great if it was a community mental health team - everyone just gets referred in and you've got counsellors and therapists and you just provide it."

Joint training programs and shared screening and treatment tools were seen as ways of helping services work more effectively individually, as well as increasing networking opportunities for services.

"It would be really good to hear about [training opportunities]. Occasionally they have let us know when they've got training they think may be of interest to us, but I'm sure there's lots of other things we don't hear about... It's really good any chance we get together."

Public engagement

Some participants pointed out that engaging the public could be an effective way of reducing the perceived stigma and lack of knowledge in the community. Previous community events such as the Women's expo and the Wellness program were given as a proof of concept.

"It would be great for the community to see [providers] out of the work that they actually do... To be seen in the community, because often they're not... [They should] get out there and sell themselves a bit more."

"There needs to be more talk about what it means to be professional... as a community we need to talk about that more... One client has come to [the participant's service] because of people talking in another organisation."

"I think that the district health board could do better with their marketing."

One participant believed information evenings could be a potent means of informing the community, clients and their close supports about mental illness and avenues for support.

Funding

Although many participants highlighted resource limitations as a challenge, comparatively few mentioned increasing funding as a solution to the problems they faced.

It may have been that participants felt the suggestion was implied by prior discussions, or else elected to focus on more readily implementable suggestions. The study was not affiliated to a funding body so participants may have seen little merit in raising the idea. Alternatively, it may have been that participants didn't see increasing resources as the most relevant solution to the issues facing community wellbeing support in Balclutha.

"It's not about money. It's probably about looking at how you might have more integrated systems between mental health and the medical services."

The participants who did suggest increasing funds to the region as a means of enhancing community wellbeing services felt that distribution would have to be carefully considered.

"[Funding] doesn't need to go into the mental health teams, it needs to go into the GP practices and health promotion... generally supportive services and schools and stuff like that... [It] needs proper distribution."

3.4: Reporting Results Back to the Community

The results of the interviews provided an insight into Balclutha's service network and revealed a number of strengths, weaknesses and unique facets of the community. By compiling these results, I was aware that many providers shared viewpoints on number of issues in the community. I felt that making these shared views known to the community could encourage dialogue and action on some of these issues, particularly as several key community figures and organisation heads had been involved in the interview phase. .

I consulted with my supervisors, and we agreed that presenting preliminary results to the community at this stage was sensible. We decided to incorporate discussion regarding results into the information package feedback session we intended to hold in Balclutha. I placed far greater emphasis on the interview results for this feedback session than we had done in the Wanaka feedback session given the timeliness and level of investment from providers.

When considering how I could present my results, it became clear that the results formed by a general inductive approach were not able to clearly and appropriately convey the complex interplay of concepts. While it the means of data collection meant it was logical to categorise results in to strengths, weaknesses and suggestions, the formulaic approach failed to acknowledge the interactions ideas and was too unwieldy for an oral presentation.

I was concerned about the length of time a categorical approach would takes I still wanted to gather feedback on the information package I had compiled for Balclutha in the feedback session. I was aware that participants had already been generous in giving up their time to be interviewed for the study and did not want to encroach on them further by running multiple sessions, or by hosting an overly long seminar.

It was suggested that I carry out a further level of analysis that would connect concepts in a flowing narrative, as opposed to categorical format. By linking concepts by common themes, causes and effects I hoped to develop and convey a more comprehensive understanding of the community. I felt a theme-linked narrative would allow me to incorporate important ideas that

connected issues but appeared inconsequential in a categorical general inductive approach due to the low number of participants who discussed them, or difficulties categorising them.

The process of developing this narrative, the results generated from this process, and the feedback forum are explored in Chapter Four (*Balclutha: Understanding the Community*). Because the feedback forum provided valuable information about the appropriateness of the investigatory and analytical framework for community assessment introduced in this chapter, discussion around these points is considered there.

3.5: Chapter Summary

This chapter outlined the methods used to investigate community providers' thoughts on the current mental health service network in Balclutha.

The general inductive approach to analysing these providers' thoughts generated a great deal of valuable data that identified strength and weaknesses of the community's service provision. Presenting the results in this categorical manner was seen as impractical, however, and it was felt that attempting to do so would fail to appreciate the underlying connections between concepts.

It was decided that interview data would be reanalysed in a way that encouraged a better understanding of themes, a more robust exploration of causes and effects, and reported these in a more coherent means than a categorical approach. The next chapter (*Balclutha: Understanding the Community*) explores the creation of this narrative and the feedback on it; it also discusses the means of community assessment outlined earlier in this chapter.

Chapter Four

Balclutha: Understanding the Community

4.1 Introduction

As described in Chapter Three (*Balclutha: Investigating the Community*), there were many strengths, weaknesses, and unique elements of providing mental health support in Balclutha. Given the significant overlap between answers given by participants, I felt it was important to feed these back to the community in a concise and logical way.

To that end, I reanalysed interview data in a way that would connect concepts and be easier to convey in an oral feedback session.

This chapter examines how this narrative form of results was created, and the feedback forum in which they were presented. It also discusses the means of assessing the community and generating the results presented in this chapter and Chapter Three.

4.2: Preparing for the Feedback Session

After consulting my supervisors and the Community Mental Health Team, a one hour feedback seminar was arranged in Balclutha. This was felt to be enough time to cover the key results of the study and receive input on the initial draft of the information package generated for Balclutha (See Chapter Six – *Balclutha: Enhancing the Service Network*)

To prepare for this seminar, an immersion/crystallisation technique(55) was used to connect concepts in a narrative format. By carefully considering all the data I had gathered on the region, I began to develop a picture of the connections between the results reported in Chapter Three. From this, a more complete picture of the community's situation was established and by linking concepts by cause and effect I better appreciated the intertwined nature of the service network. The immersion/crystallisation analysis also allowed me to bring in important aspects that were less evident in a categorical report or were only evident when considering multiple interviews and themes.

I elected to divide the sixty minute session into rough quarters, with three quarters allocated towards exploring and discussing the results I was forming. The final quarter was dedicated to the information package and future avenues of research. With this in mind, I created a three point narrative to explore my findings.

- 1) Investigating the levels of connection and collaboration in the region
- 2) Exploring the holistic nature of the region and the urge to go 'above and beyond'
- 3) Describing the characteristics of the region and its residents

Participants and their respective agencies were invited to attend the feedback seminar where I presented these results as an oral seminar with a supplementary handout containing key points and supporting quotes.

4.3: Interview Results Part I

Results were presented to Balclutha providers with an emphasis on 'Connection and Collaboration', 'Going Above and Beyond', and 'Community Characteristics.'

Within these three topics were elements that related to the unmet needs of the community. This topic was so heavily emphasised in participant discussion, however, that I have considered it as a separate point in the chapter. This additional topic 'Unmet Needs in the Community', as well as the original three presented topics, are explored below.

4.3.1 Connection and Collaboration

Most participants were positive about the interpersonal and interagency connections in the community. It was often the first point raised by participants, highlighting its relative strength and importance.

Participants were quick to note the strength of current working relationships and the approachability of services when relationships were not as formalised.

"We have great networking with other services, it's a small community. We know each other; we all turn up at the same meetings."

"I can go...into [the] mental health service and go 'who's this?' and 'what's that?'"

"We all feel that we feel comfortable talking to each other."

It was clear that connection and collaboration had been an area of recent focus for services, as this had substantially improved in recent years.

"[We] work very cohesively now...less people [are] falling through the gaps."

Despite the perceived strength of connections there was a lack of clarity around services' existences and roles. This came across in several ways such as logistic difficulties described when referring clients to other services...

"[It's been a] learning curve for us as to what they [The Community Mental Health Team] require [in referrals] ...I don't think they make it that clear as to what they expect."

...and the limited recall participants had when asked to list services related to mental wellbeing in the region. On average participants listed nine and a half services, with a range of 4 to 22. This showed there was a wide range of knowledge between providers in the community and highlighted the fact that many providers lacked a deep understanding of locally accessible services.

"It's hard isn't it? Like anything, you know what you use."

Some participants acknowledged they had little insight into the community's services and attributed this to the limited section of the community they personally worked with, the low number of other providers they regularly interacted with, or the difficulty keeping up with services whose role often changed.

"I am always discovering more about who's around so probably I don't have a very exhaustive list."

"We don't really understand each other's roles and responsibilities enough. They probably have expectations of us and we have expectations of them...there needs to be a bit more discussion and understanding about what they can do...we need to understand and respect what they can do, their limitations to what they can do. And they similarly need to understand what we can do because sometimes they have unrealistic expectations."

The fragile nature of services in a rural setting was thought to contribute to this lack of understanding. Because of Balclutha's size, local agencies often relied on one or two key people to function. These people had to be highly motivated, dedicated and skilled to establish and maintain a service in the region. When this isn't feasible, the region depends on Dunedin services coming down on an unpredictable and often unreliable basis.

When local champions moved on, funding models changed, or Dunedin services ceased their community outreach programs, it tended to leave a greater deficit than it would have in an urban centre.

"If you lose something, it's very hard to get it back. Once it's gone, it's gone."

Keeping track of who was still operating in the region, and what they were funded for, was a challenge because of the fragile and ever-changing nature of services.

Another potential factor contributing to the lack of service awareness was the existence of a local Community Mental Health Team. Having an on-site mental health team was universally recognised as an asset to Balclutha but limited people's awareness of other local services. This effect was increasingly evident with successive interviews.

Unless prompted to consider mental health broadly, participants would focus their responses on the Community Mental Health Team and their relationship to the service. While some participants naturally broadened their focus, many required study questions to be reframed with words such as "wellbeing" and "community support" instead of "mental health" before a wider view of community support was taken. In later interviews I found myself prefacing questions with statements such as *"looking beyond just the local mental health team..."* or *"looking broadly at community supports as a whole, including things like volunteer groups..."* as I knew I would otherwise receive answers with a very limited focus.

Responses from participants when asked to list every service related to mental health and wellbeing also provided insight into this issue. The Community Mental Health Team was the only service mentioned in every interview. The next most frequently mentioned agency (the local hospital: Clutha Health First) was only mentioned in two-thirds of interviews.

My overall view on Balclutha's community collaboration was best put by one participant who stated

"Everybody knows everybody in the district and knows what everybody's doing and yet there seems to be a brick wall between that and providing social services...it's like people don't know that there are other social services in town or if they do know they're there they're not quite sure what they provide."

This quote resonated with me as it recognised the strong interpersonal connections between community providers but acknowledged the disconnect between the strength of these

relationships and the lack of understanding between agencies. Although services generally found it easy to informally interact with one another, there were muddled and unclear professional links between agencies.

Several participants suggested formal networking opportunities as a means to address this disconnect by purposefully enhancing connectivity and collaboration. The specific timing and logistics did not always align between participants, but consensus was that a regular meeting for wellbeing support providers would benefit Clutha's mental health service network. This was seen as a way of addressing the perceived lack of interagency understanding, and mitigating the effects of service fragility in the region.

"Even if it was once a year there was some sort of forum or half a day or whatever that just purely focussed on mental health as an opportunity for networking and being refreshed about what [each service provides]. Having available referral forms or pamphlets or if there's been new counsellors come in that they're introduced...once a year that meeting and greeting and networking would be quite useful because it's very easy to make assumptions about what services provide."

"In Southland they have a network meeting. Key people from all the different areas, including NGOs, sit around the table once a month and review how things are. It's a really good interdisciplinary overview between mental health and other services."

Logistical issues were quickly identified with this suggestion regarding the resources required to establish and sustain such a meeting. Providers were also wary about the time and resources required to attend on a regular basis.

"[There's a need] for community network[ing]...[a] monthly get together with regular email contact between...[although] most people are so busy in their own jobs and this is in addition to that...it's probably why it hasn't happened. It needs funding to make it happen and make it worthwhile."

"I often can't go [to meetings with similar purposes as the proposed mental health meeting]. I chose not to go because [that's] two [clients] I could have seen in that time."

Examples of successful collaborative meetings for wellbeing related issues were often used by participants to illustrate their suggestions.

"From time to time we have called specialist meetings. There was a suicide prevention group for a wee while... At the moment there's a partner violence group and we [have] had a synthetic drug group."

Overall it seemed that the community had strong personal links with one another and these would be enhanced by implementing formal interagency collaboration opportunities. These opportunities would have to be purposeful but practical given resource constraints.

4.3.2 Going Above and Beyond

An area that interested me was the blurring of role boundaries in Balclutha as it was brought up both positively and negatively by participants, sometimes within the same interview. It seemed more common in Balclutha than in the urban centres that study participants and I had worked in previously. Blurred role boundaries directly impacted the ability of agencies to understand each other's roles and contributed to providers' frustrations with the service network.

I felt there were three points crucial to understanding the community's holistic view of health, and tendency to go above and beyond their role description.

The first was the familiarity of the region. As a small centre, there was a stronger sense of community and connection to residents than that in larger centres like Dunedin. Providers often knew residents outside of their jobs and there was a sense of connection to the region.

"In a small community you have a lot more knowledge of people... It's more personable."

"[Balclutha is a] closer knit community, and people do seem to all know each other."

This close-knit aspect of Balclutha generated a personal desire for providers to support members of the community, as they were more than just clients.

"The important thing is that these people get help."

"In a rural area [you] cover everything holistically."

The second key reason for the community's holistic view also related to the small size of the town in that there was a lack of local service options. While most participant responses praised the range of services on offer to Balclutha...

"We are incredibly lucky in Balclutha...we are of a size where we do have a local mental health team, we've got CYFs, we've got the police..."

"I'm quite impressed. [Balclutha has] got a lot of things...great resources"

...the majority still identified gaps within the service network. These gaps were sometimes impractical to fill, but were still frustrating for providers.

"There's things you can't access [in Balclutha]...some services you might not be able to access...limitations on what's available."

"[We] haven't got as many things here as in Dunedin."

The final element revolved around the funding models and systems in which local agencies operated. A lack of finances was infrequently mentioned by participants, despite the view that funding is more scarce in rural centres than in their urban counterparts.

"All the money is spent in town...if you look at the expenditure into areas down there [in Clutha] they're probably about y'know per head about 20% of what Dunedin's is."

The effects of a relatively inflexible and underfunded system did come through during interviews, however. Several participants expressed a desire for more staff, or greater ability to contribute to community initiatives, or for more agency assets like cars, computers, and office space. All of these desires reflected a lack of adequate resourcing for providers.

The combination of these three factors created the tension witnessed when participants described going beyond their agency's job description. The three points explain why the blurring of role boundaries occurs more frequently in Balclutha and other small areas: because there are absent services, it falls to existing services to "fill the gap" in order to support members of the community with whom providers have a greater connection. However due to a lack of funding, these providers are not being appropriately compensated for their work and are placed under extra pressure as a result. This generates negative feelings towards the action.

Participants would often describe their work outside of their 'required role' as being an 'obligation' rather than appreciating the selflessness, dedication and compassion for the community 'they were displaying by going beyond their required role.

"Two of us [provided an extra support service to a client] for over a month every morning... That drained us [and] our resources hugely, but there was no-one else to do it."

As with the prospect of running networking meetings, resources such as time weighed heavily on people's mind when considering the issue.

“Resources are so stretched in all of the organizations...everybody’s workload is so high...its left agencies without the ability to [provide services beyond their scope].”

While these resource draining aspects had a clear impact on people’s views, they still were willing to go to such lengths which showed they place greater emphasis on the benefits than the financial strain. Balclutha providers continued to go outside their role boundaries despite feeling overworked and under resourced because they valued the positive effects it had on the community and themselves.

Services reaching outside their role boundaries had negative impacts on service network clarity, however, which had already been identified as a problem in the community. As services accept additional clients outside of their parameters and undertake extra jobs on an *ad hoc* basis, it becomes difficult for other agencies to understand their limits, purpose, and acceptance criteria.

“I do notice, whether it’s a good thing or a bad thing, that [the Community Mental Health Team] picks up things that Dunedin wouldn’t pick up. There’s a much clearer division of who sees what in Dunedin.”

Services supporting clients that fall outside of their role description may make it unclear as to why somebody wasn’t accepted into a service. Balclutha’s culture of going beyond role definitions may have exacerbated the frustrations that occurred when a referral was denied because a client did not meet a service’s criteria.

“Probably the biggest challenge for us with health is just for the referrals we do to meet the criteria for them to accept them ... I don’t think they make it that clear as to what they expect.”

“We’re not always clear why a client’s denied which creates more workload for us.”

Services going beyond their role descriptions also has long term implications for funding and planning. While services ‘hold together’ the gaps in service provision there is a less evident and urgent need to address the issue. Despite the strain placed on agencies by operating beyond their capacity, there is little incentive for funding bodies to provide new resources to the region when current services address issues without financial compensation. A lack of co-ordinated funding efforts that identify how services are being provided and whether they are being provided

sustainably decreases a community's ability to provide an integrated, cohesive and well defined service network.

No participant offered a clear suggestion of how to address the problems caused by blurring role boundaries (strain on providers, decreased role clarity, and implications for funding) which likely reflects the complexities of the underlying causes (closer connection to the community, inappropriate funding models, and service deficits).

Any solution that would be able to make a significant impact on the matter would require increasing funding or adopting a more flexible funding model. As both of these would depend on high level organisation and support, it is understandable that ideas were not raised by participants in this University project.

4.3.3 Community Characteristics

The unique character and physical features of Balclutha had many direct and indirect effects on service provision in the area. The size of the community was generally seen as a strength as it encouraged collaboration and collegiality between services. Many participants highlighted the physical proximity of services.

"Everything's really close, like Link... it's just round the corner."

The small community also afforded a familiarity with clients and the community as a whole.

"In a small community you [as a provider] have a lot more knowledge of people...of the demographics and the community profile...and the clients, and their backgrounds. It's more personable."

However, this familiarity between providers and clients could sometimes be a barrier for clients.

"Often it could be that they know somebody who works there."

"People quite like it that you're not based [in Balclutha], that you're not going to see them in the pub."

The location of services was also problematic as several services were located along the main street, or in other highly visible areas.

"[People] haven't wanted to go in [the Community Mental Health Team building] because they're scared somebody's going to see them and know that they're going."

"[Balclutha's residents are] not as anonymous as they are in the big city."

The visibility of services and familiarity of community members were compounded by traits thought to be common among residents.

"[There's an] element of the small community stuff. Rural communities are typically not great at putting their hand up for help"

"People down here are very conservative...they don't like anybody who's too different"

The rural nature of the town also caused logistical barriers such as transportation issues. The Clutha region extends well beyond Balclutha and many community members had to travel to get to services located in the central town. Transport from outlying areas to services was a problem for both providers and consumers.

"For people who live in the outskirts there's no bus services or taxi services or anything like it...[transport's] quite a big issue for people"

"We find lots of people living out in Kaitangata...can't get to appointments here, they've got to be picked up"

Prior to interviews I had anticipated transport to Dunedin would be an issue for services. However, transport within the district was seen as a greater issue by providers. When participants did refer to difficulties regarding transport to Dunedin, it focussed less on the distance itself and more on related elements such as accommodation within the city.

Dunedin based services had more stringent criteria for accepting clients and patients, and meeting these criteria could sometimes be difficult as the service could not assess the client without transporting them.

"It's quite difficult because we're an hour away and they want to have a reasonable idea of patient's state of mind. Sometimes there's quite a debate as to whether this patient needs to be seen..."

It was often unclear as to who was financially responsible for return transport in these circumstances.

It was felt that community members lacked an understanding of the support services available.

"[There's a] lack of knowledge...people need to have awareness of what's out there and how to- how the referral system works. Does the GP refer them over? Can they self-refer?"

"I actually think Joe Blogs' general knowledge on [mental health services] is pretty limited on what they do and what's available and what their criteria are...the average person in the community probably really don't know what the mental health team is about... if you really need the service some people just might not know where to turn"

Service providers believed they could actively work on this in the hopes of increasing service awareness and reducing stigma in the community.

"It would be great for the community to see them out of the work that they actually do. To be seen in the community, because often they're not...[they should] get out there and sell themselves a bit more"

"I think that the district health board could do be better with their marketing"

This proposed solution had several potential problems, however. One participant felt that publicizing thorough, concrete information about services would restrict the discretion that allowed agencies to take on clients outside of their role description.

In addition, local services were already experiencing oversubscription issues without advertising. This problem would presumably increase if there was an increased engagement of the public.

"The need out in the community is greater than what we can provide"

"We don't advertise. We simply can't. We've got a waitlist, it wouldn't be ethical. We're always in a dilemma around whether we promote our service or not"

Any process that engaged the community would have to take careful steps to minimise the increased burden on providers that could result.

4.4: The Balclutha Feedback Session

The Balclutha feedback session was attended by 10 people in total, including some who had not been involved in the interview phase.

The findings were well received which lent credence to them. Nobody disagreed with the points raised, and several people wanted to know more about them. There was a sense that people viewed me as an expert on the region's services, despite not working within the service network.

The Community Mental Health team were very interested in obtaining full copies of the results of as they were set to begin a review of their own services. They felt that the interviews had comprehensively explored a number of issues which focussed their own service review.

There was a great deal of support for the formation of a mental health stakeholders meeting. Discussion highlighted that networking meetings worked well for similar fields such as child health and family violence. There was some discussion about the logistics and purpose of a 'wellbeing' meeting. I emphasised my support for the idea.

There was interest in the mild-to-moderate gap that had been described. At times these discussions were tense as several members in attendance were from the Community Mental Health Team which had a moderate-to-severe mandate. The discussion on this point prompted me to expand on the theme of unmet needs in the community below.

4.5: Interview Results Part II

4.5.1 Unmet Needs in the Community

Most participants readily identified gaps in the service network. The gaps varied in nature and were often dependent on the service being interviewed itself. There was a consensus among participants, however, when it came to the need for more options for managing life stressors, subclinical conditions, and mild-to-moderate conditions.

"People just having chaotic life styles, but they don't have a diagnosis. That's a big gap, because who does work with them?"

"Shortage? Its primary mental health services. I mean its secondary, secondary, secondary, secondary...there's a whole bunch of people probably getting antidepressants from GPs, but no other interventions."

"[Balclutha] has totally dropped mild to moderate."

Discussions around disease severity tended to involve the Community Mental Health Team's moderate-to-severe threshold which emphasised the central role they had in the community.

“There’s always that discussion [with the Community Mental Health Team] as whether it’s behaviour or whether the person has a mental health disorder, or whether it’s mild-to-moderate, or moderate-to-severe. It’s just getting access in those situations.”

“[They’ll] only see moderate-to-severe. Sometimes when you’re referring in you don’t know where that person fits on that line so they have lots of discussion about whether this person is moderate to severe. Sometimes you think ‘would you just see them, do that assessment and then decide?!’”

It was felt that a lack of early intervention options meant clients experienced greater distress as their conditions were more likely to progress in severity. This placed greater pressure on services as they were dealing with more complicated cases.

“It would be great to be doing a bit more [early intervention] but because we’re not... [we’re] dealing with stuff that’s a lot further down the track.”

One of the most commonly desired services in the region was low cost counselling services. It was interesting to note, however, that participants often did not mention the counsellors that were already established in the community. ‘Counselling services’ as a concept was thought to be available by around one fifth of participants, but details about specific services were only mentioned by around 10% of participants.

National helplines or free-to-access websites for subclinical or mild-to-moderate illnesses were only mentioned by one participant, although this may have been due to the regional focus of the interview schedule. The wording of the question which asked about ‘services’ as opposed to ‘supports’ may have also contributed.

The “Books on Prescription” scheme was only mentioned by one participant despite being recently introduced to the region and heavily promoted as a support for subclinical and mild-to-moderate conditions during the interview phase of the study. In general, participants only considered supports that involved face-to-face contact with a provider.

There was a lack of awareness of services in the community and participants who worked from memory only named an average of 9.5 services. Only four participants made use of a list they had prepared independent of the research project. Most participants were surprised at the initial draft of the information package due to the number of services I had identified that supported the region.

I felt there was a strong influence of the Community Mental Health Team on people's perceived needs. Because the central organisation did not cater for mild-to-moderate conditions, there seemed to be an inflated perception that the network as a whole did not cater for these conditions..

My observations of the region were that there was a need for increased mild-to-moderate supports as evidenced by waiting lists and absent services. However, this need seemed to have been overrepresented when subjectively described by participants.

4.6: Discussion

The interviews were designed to quickly and simply provide an insight into the community's perceived service network, identify agencies that operated within this network and provide data that would inform future research and action to enhance the community. In all of these aims the interview schedule excelled.

While there were varying levels of investment and enthusiasm from participants, all had a good understanding of the purpose of the study and sought to assist where possible. This suggests that the amount of work required by participants in the interview and analysis phases is not overly cumbersome. This could potentially be increased in future endeavours to encourage greater community ownership of the project.

The interview schedule could benefit by redressing the balance of strengths, weaknesses and suggestions. The current schedule is skewed towards difficulties experienced when operating within the system. While this comprehensively covered areas of weakness within the region, it tended to place a negative spin on the interviews. Suggestions to improve these areas of weaknesses were not as thoroughly explored, and further information regarding which particular roles were absent in the community would be of benefit.

The results that were formed from the interview process created a good understanding of the community's situation and a number of potential mechanisms behind this. The results were validated in the community feedback forum, and were seen as more comprehensive than the knowledge of any one resident in the community. The discussion from those present at the feedback seminar guided the evaluation process.

Both the general inductive approach and the immersion/crystallisation approach to analysing data provided invaluable information for understanding the community and how it could be enhanced.

As in COMHEART Wanaka, the general inductive approach provided clear responses to the question “what are the strengths, weaknesses and suggestions for improvement of the current community service network?” This helped create strategies to enhance the current network (See Chapter Six – *Balclutha: Enhancing the Service Network*) but had limitations for presentation and validation of emerging themes.

The immersion/crystallisation approach to analysis had not been used in the earlier COMHEART Wanaka project but provided a useful way of reporting information back to Balclutha. It acknowledged areas that would have otherwise been missed and was an asset to the analytical process in this study.

The immersion/crystallisation technique allowed discussion to be presented alongside the results which deepened the understanding of those results and allowed greater insight to be considered and critiqued by the community.

Seeking comment and insight from the community about the results in a timely fashion was an asset to this study; it validated and prioritised aspects that were used as the basis of further action within the project.

4.7: Chapter Summary

This chapter and the previous chapter, explored the key findings of interviews conducted in Balclutha. These identified a number of current strengths and weaknesses of the region’s mental health service network and explored the suggestions of local service providers as to how to address these.

The results covered in these chapters were invaluable to the ongoing research and underpin most of the continuing work on the project.

The next chapter compares the Balclutha results with those obtained in Wanaka. It uses this comparison to explore the under-researched concept of heterogeneity between rural New Zealand communities.

The understanding of Balclutha’s current situation that was developed through interviews and explored in these chapters was crucial to designing ways to enhance the service network as described in Chapter Six (*Balclutha: Enhancing the Service Network*).

Chapter Five

Alike but not identical: Heterogeneity in rural New Zealand

5.1: Introduction

It is generally accepted that the term 'rural' encompasses an diverse, heterogeneous mixture of communities. Broad classifications of 'rural' and 'urban' fail to appreciate differences within or between communities.(3-5, 7-9) Despite calls that such classifications are "unacceptable for all but the most general investigations of urbanization and health", (4) research into New Zealand mental health services still tends to use this over-simplified dichotomous division.

There is very little research into the state of mental health service provision in rural New Zealand, let alone within specific communities. The research that is available generally focuses on the medical profession and rural residents' access to physicians. Research into primary care services has a focus on general practitioners and there is a paucity of knowledge regarding other rural practitioners and providers.(56)

This chapter examines the current literature regarding rural mental health service provision in New Zealand and explores the similarities and differences found between Wanaka and Balclutha. As the views of a wide range of primary care service providers were examined in both centres, it offers an important insight into a poorly understood area.

5.2: The New Zealand Background

The New Zealand Mental Health Survey found that "participants in rural centres and areas had...the lowest rates of mental health specialty sector visits"(22 p129) but did not explore this effect in individual communities or regions.

This low rate of attendance may be partly explained by the circumstances of rural life. A national study by Rural Women New Zealand found that rural service access was hampered by distance, cost, hours of availability, quality of service and complex situations experienced by clients and patients. 39% of respondents were more than 30minutes drive from a mental health care service and 37% reported problems accessing mental health services because of this distance.(57)

An evaluation of Primary Mental Health Initiatives in New Zealand recognised that this distance combined with a general lack of public transport in rural New Zealand was a barrier to service access. Some contributors to the evaluation felt that inadequate information regarding available

services in rural areas was an even greater barrier than physical distance, supporting the notion that rurality's impacts on service access are not explained by location alone. It was suggested that there is a greater need for mental health services in rural communities than in urban centres due to the additional stress of living in isolation.(58 pg74)

Access to specialist psychiatric services is difficult in New Zealand regardless of rural status due to the "chronic shortage of psychiatrists" across the nation. Rural areas are thought to have even further reduced access to psychiatric staff due to being unable to recruit and retain professional staff.(59) Psychiatrists in New Zealand have identified a number of reasons for not wanting to practice in rural areas including being professionally isolated, having to work as a generalist, managing risk in clients, being on-call frequently and a general resource shortages.(20)

A study examining the medical profession showed that New Zealand-trained doctors were less likely to practice in rural New Zealand than internationally trained doctors. Only 9.2% of New Zealand trained doctors worked in rural New Zealand, compared with 15.6% of doctors trained in other developed English-speaking countries and 12.2% of doctors trained elsewhere.(60)

The only study I found that delimited their investigation to communities within Otago was a study of the region's rural and urban general practitioners' perceptions of mental health services. This reported specific problems thought to exist when managing mental disorders rurally including time pressure, poor liaison with psychiatric services, difficulties accessing other services, inadequate funding, and inadequate training.(35) This did not explore particular communities within the region, nor did it explore the positive impacts of rurality on mental health services in the area.

The work done in Balclutha, coupled with that in Wanaka, begins to identify some of these specifics across two communities in the region.

5.3: Comparing Wanaka to Balclutha

As discussed in Chapter Two (*Wanaka: A Lesson in Community Engagement*), COMHEART Wanaka involved interviewing 19 participants from 15 services. The interviews provided an insight into the community and piloted the investigative and analytical framework adapted for Balclutha.

In Balclutha, 38 participants were interviewed from 23 services. As the interview process had already been piloted, more emphasis was able to be placed on developing an understanding of the community and exploring recurrent themes that were raised by providers.

While neither study proclaims to understand every aspect of the study community's service network, both developed considerable insight into local providers' perceptions. This insight is discussed here.

5.3.1 Community Characteristics

Wanaka and Balclutha are towns within the Otago region of New Zealand. The healthcare of both communities is overseen by the Southern District Health Board. The tertiary referral hospital for the Southern District Health Board is the Dunedin Public Hospital.

The two centres share a number of geographic similarities. However there are a number of key differences as described below and summarised in Table 5.1.

Wanaka is the largest town in the Queenstown-Lakes District, with 'usually resident' population of 6474 as per initial results from the 2013 census (3.2 percent of the Otago region's population). The town's population had drastically grown in recent years, having a 'usually resident' population of 3330 in 2001. The growth in population makes interpretation of statistics from previous years difficult.(61)

As per the last reported census (2006), the population of Wanaka was 5040. The median income for peoples aged 15 years or older was \$28,900. 19.5 percent of people aged 15 years or over had an annual income of more than \$50,000.(48) The 2006 NZ Deprivation Score for Wanaka was 2, indicating that it is relatively not deprived when compared to New Zealand as a whole.(62)

Wanaka's population was skewed towards the working age (15-64 years old) compared to the Otago region as a whole. 13.2 percent of residents were 65 or older compared to the total Otago Region of 13.8 percent. Only 15.9 percent of Wanaka residents were under the age of 15 (Otago Region 17.6 percent).(48)

The 2006 Census(48) also found that 52.4 percent of Wanaka residents aged 15 years and over had a post-school qualification. Only 15.0 percent of residents aged 15 years and over had no formal qualifications. Unemployment was 1.9% and the most common occupation in the town was 'Occupational Manager'

5.1 percent of Wanaka residents were Maori; 20.1 percent were born outside of New Zealand.

Like Wanaka, Balclutha is the largest town of its district; Clutha. Its 'usually resident' population was 3918 as per the 2013 census (1.9% of the Otago region's population). Balclutha's population has remained relatively static in recent times with a 2001 'usually resident' population of 4107.(61)

In 2006 the population of Balclutha was 4062. The median income for peoples aged 15 years or older was \$22,300.(63) Only 11.4 percent of people aged 15 years or over had an annual income of more than \$50,000. The 2006 New Zealand Deprivation Score for Balclutha was 6, indicating it is slightly more deprived than New Zealand as a whole.(62)

The 2006 Census(63) found that Balclutha's population was skewed away from the working age (15-64 years old) when compared to the overall Otago region. 19.8 percent of residents were 65 or older (Otago total 13.8 percent) and 20.4 percent of residents were under the age of 15 (Otago total 17.6 percent).

Only 31.7 percent of Balclutha residents aged 15 years or older had a post-school qualification; 37.5 percent had no formal qualifications. Unemployment in the town was 2.6% and the most common occupation was 'Labourer'

7.7 percent of Balclutha residents were Maori and 8.3 percent were born outside of New Zealand.

From these statistics it appears that Wanaka is less deprived than Balclutha. In addition to its less deprived NZDep2006 score, Wanaka has a higher median income, a lesser proportion of people earning less than \$20,000 and a greater proportion earning more than \$50,000. Both centres earn a higher income than the regional average. A smaller proportion of Balclutha residents earn over \$50,000 when compared to Otago as a whole.

More residents in Wanaka are of 'working age' (15-64) and have greater qualifications. This difference in qualifications is reflected in the most common job in each region; Wanaka being 'Occupational Managers' compared to Balclutha's 'Labourers'.

Wanaka has undergone significant growth in the past twelve years, with its population nearly doubling since 2001. Balclutha, on the other hand, has remained relatively stable with only a slight decrease in this period.

Key Community Characteristics*			
	Wanaka	Balclutha	Otago
Location:			
Region	Otago	Otago	N/A
District	Queenstown-Lakes	Clutha	
Distance from Dunedin hospital	277km	81km	
Population:			
2013 Usually Resident (% Otago)	6,474 (3.20%)	3,918 (1.94%)	202,470
2006 Usually Resident (% Otago)	5,040 (2.60%)	4,065 (2.10%)	193,803
2001 Usually Resident(% Otago)	3,330 (1.83%)	4,107 (2.26%)	181,542
Aged under 15 or over 64 years	29.1%	40.2%	31.4%
New Zealand born	79.9%	91.7%	84.4%
Maori	5.1%	7.7%	6.6%
Skillset and Occupation:			
% with a post-school qualification	52.4	31.7	40.2
% with no formal qualifications	15.0	37.5	23.7
Unemployment Rate	1.9%	2.6%	4.5%
Most common occupation	Managers	Labourers	Professionals
Income:			
Median Income	\$28,900	\$22,300	\$21,600
% with annual income ≤\$20,000	33.8	45.5	47.4
% with annual income ≥\$50,000	19.5	11.4	13.9
NZDep 2006 Score	2	6	N/A

Table 5.1: A summary of Wanaka and Balclutha's community characteristics

*Statistics from 2006 unless stated otherwise

Balclutha is significantly closer to the major hospital of the Southern District Health Board, the Dunedin Public Hospital. This has effects on service provision as reflected in participants' responses in the two studies.

5.3.2 Identified Similarities

Both communities highlighted strengths in the current mental health service network, including characteristics of being rurally located. Both described the benefits of a working within a smaller community and having services located close to one another..

The Southern Primary Health Organisation's mental health service was praised in both regions, Wanaka more so than Balclutha.. Balclutha participants found the service beneficial, but noted there had not been continuity in the service over the years and felt the service was somewhat "faceless" in the community. The service had only recently restarted in Balclutha at the time of the study.

Differing levels of service awareness between providers was noted in both communities. In Wanaka this was attributed to the turnover of personnel within services, whereas in Balclutha it was felt more to do with the service availability itself. Both regions described being unaware of other services (particularly alternative treatments) and having faulty assumptions about services and both had informal means of overcoming this. In Wanaka, newer providers tended to rely on established colleagues to supplement their understanding. In Balclutha, providers relied on informal connections between services and the approachability of other staff.

Perceived barriers to each region's residents were similar and tended to involve cost, service criteria and travel. A lack of community awareness and previous poor experiences with services was noted as a barrier in both towns, although this was raised in a context of Maori health in Wanaka.

Specific Maori mental health support was mentioned as a gap in Wanaka, and a similar need for Maori support services was voiced by some participants in Balclutha. Services in general were felt to be lacking by participants in communities, as was adequate resources to meet the needs of the region.

Participants in both communities strongly felt there was a need for more "transparent sharing of information" between existing services. In Wanaka there were calls for a liaison person to purposefully integrate information for providers, whereas Balclutha participants felt that services should be less 'territorial' with their information for the good of the patient or client and suggested a more general approach to collaboration.

Both centres thought a mental health service information package would be beneficial for providers and consumers alike, despite Wanaka already having an established service directory. Both centres felt there should be an increased community focus on maintaining wellness in residents.

5.3.3 Identified Differences

One of the largest differences between community service networks was the role of the Community Mental Health Team. Wanaka did not have its own mental health team, instead being covered by the team based in Dunstan. This group had recently begun to see clients at the Wanaka Lakes Health Centre when COMHEART Wanaka was conducted, and the close proximity was praised and predicted to encourage networking between providers. The lack of a local team was still the most commonly raised gap by COMHEART Wanaka participants, however, emphasising the community's perceived need for one.

In contrast, Balclutha had a local Community Mental Health Team that was seen as essential to the service network. The team's presence was described as a key strength of the community and had far reaching effects on the region. One effect of the local team in Balclutha was that service providers tended to focus on it when considering referral options for clients and patients.

There was a strongly perceived need for more mild-to-moderate options in Balclutha as the Community Mental Health Team did not support people in this range. However, services were often unaware of the wide range of services outside of the mental health team which included a number of mild-to-moderate options for patients.

Wanaka, on the other hand, lacked a specialist mental health centre and had a perceived need for more specialist services that catered for moderate-to-severe cases. They found the local primary mental health brief intervention service a greater strength than participants in Balclutha did, likely reflecting the centrality of that service in Wanaka.

The difference in desire for specialist services may have also reflected the proximity to a main centre. Balclutha's close proximity to Dunedin meant numerous specialist services either came down from the city, or were readily available to residents. Although there were a number of logistical, emotional and financial issues associated with this, Balclutha residents were still more likely to use Dunedin services than their Wanaka counterparts.

Whilst Wanaka participants highlighted on the need for travel specifically with regards to the Dunstan-based Community Mental Health Team, Balclutha participants focussed more on the financial and emotional costs for consumers when traveling for any appointment or service.

Service awareness difficulties and informal workarounds were noted in both regions. Wanaka had formalised networking opportunities for providers, something that many providers in Balclutha had called for. Balclutha providers felt this would be an excellent way of encouraging networking although organisers of Wanaka's bi-monthly network meetings reported they could be poorly attended.

A comparison of the two service information packages created during the study demonstrates the marked differences in services available in Wanaka (Appendix A) and Balclutha (Appendix B). It is difficult to compare the two information packages directly as neither reflects a complete list of services available to residents in their region. It appears, however, that the two communities have very different available services despite sharing a governing District Health Board.

5.3.4 Summary

In addition to the differences in communities themselves, there were a number of differences found in each community as explored in Table 5.2 below.

Key Comparable Results		
	Wanaka	Balclutha
Primary Mental Healthcare	Strength of the community. Strong PHO Service.	Some good services, but lack of options in community. 'Faceless' PHO Service.
Secondary Mental Healthcare	Improving ties with Dunstan CMHT, but strong preference for a local team. Specialised services lacking in community.	Strength of the community. Strong local CMHT.
Provider's Network Awareness	Differences attributed to high turnover of staff within services. Newer providers relied on more established colleagues to overcome gaps in knowledge. Faulty assumptions about services common. Not enough sharing of information. Established networking meetings.	Differences attributed to fragile nature of services in region. Providers relied on approachability of other services to overcome gaps in knowledge. Faulty assumptions about services common. Not enough sharing of information.
Current Network Shortfalls	Lack of local CMHT. Lack of specialised treatment options. Emphasis on Maori health. Inadequate resources.	Lack of primary care options. Acknowledgement of Maori health. Inadequate resources.
Perceived Barriers to Access	Cost. Travel. Meeting service criteria. Community knowledge.	Cost. Travel. Meeting service criteria. Community knowledge.

Table 5.2. A comparison of the key results found in Wanaka and Balclutha

5.4: Discussion

The data gathered from Statistics New Zealand and the information gained from the Balclutha and Wanaka interviews gives valuable insight into each community's characteristics, their perceived strengths and weaknesses, and the differences between the two centres.

It is clear that, despite sharing several traits, there are a number of differences between the two towns. Each centre operates in unique circumstances with a different client base and different resources available to them. Even challenges faced by both communities, such as travel difficulties for consumers, expressed themselves in different ways.

Caution has to be taken when comparing the results of the interviews due to the background in which those interviews were conducted. COMHEART Wanaka sought to develop an understanding of the community assessment process, and test the appropriateness of a developed interview schedule. The interview phase of Balclutha was able to be more streamlined because of the work in Wanaka and more emphasis could therefore be placed on understanding the community's characteristics and exploring the themes raised by providers.

Some aspects of each study's results were unable to be compared as they were only raised in one community. It is certainly possible those matters were unique to one community; however it is also possible that this was an artefact of the interview and analysis processes in each centre. For the purpose of this comparison, only aspects that arose in both projects were considered. A potential avenue for further study is asking around the aspects present in only one community in the other to see how it affects them.

Repetition and streamlining of the community assessment process in other areas is required in order to understand rural New Zealand. It is clear from this preliminary comparison that there is no 'universal' model of communities or mental health service delivery in rural New Zealand. The two communities studied shared a number of geographical and logistical similarities, yet differed in many ways including services available, perceived importance of these services, service provision issues, and community providers' suggestions for improvement. Deeper investigation into the two communities would likely uncover even more differences, such as the impact of population change in Wanaka compared to the static population in Balclutha, or differences in fields beyond mental health and wellbeing.

It is likely that communities that have fewer similarities than the two Otago towns investigated here would show more pronounced differences in service networks. Towns in different regions, towns that are not central to their district, and towns with greater differences in socioeconomic characteristics would likely demonstrate greater heterogeneity. Investigating the differences and consistencies between these heterogeneous areas is essential to understanding areas for development in rural New Zealand.

The lack of a 'universal' approach to service delivery likely precludes a 'universal' approach to resolving all mental health and wellbeing issues in rural New Zealand. There may, however, still be some problems that are common throughout the country which could be addressed through standardised means. For example, further community assessment may reveal that travel costs and transport difficulties affect consumers regardless of their particular community. This could be addressed through a common approach such as improving intra- and inter-district public transportation across rural New Zealand.

Having a well-developed 'universal' approach to rural community assessment would benefit rural communities regardless of their individual circumstances. A standardised approach that quickly assesses a community's unique aspects, identifies potential solutions to their problems, and tailors support packages to that community would allow site-specific interventions to take place in a quick and efficient manner.

This project contributes to the knowledge base of rural New Zealand by identifying some of the similarities and differences between two rural Otago communities. It continued the development and refinement of a community assessment tool which will benefit future research in this area. While these early results cannot describe the similarities and differences found across all of New Zealand, they certainly demonstrate that there is heterogeneity between two superficially similar rural communities.

This identified heterogeneity highlights the need for further investigation into rural New Zealand community configurations and circumstances.

5.5: Chapter Summary

Wanaka and Balclutha share several superficial traits such as their region, overseeing District Health Board and status as largest town in their respective districts. Despite these similarities, there were many differences between the two centres as explored in Tables 5.1 and 5.2.

The work carried out in these regions offers a number of further avenues for research including a deeper exploration of issues raised in either community, refinement of the interview and analysis phases, and investigation of more distinct rural communities.

Much can be gained from continuing this work. By identifying commonalities between rural communities a regional or national approach could be taken to enhancing mental health service provision. Streamlining the community assessment and analysis models used in this project would allow future researchers to quickly and accurately develop an understanding of unique issues in

rural communities. This in turn would highlight those issues that require site-specific issues that require intervention..

The following chapter explores the feasibility of implementing site-specific interventions in Balclutha.

Chapter Six:

Balclutha: Enhancing the Service Network

6.1: Introduction

The results of interviews conducted in Wanaka were compared to those in Balclutha in the previous chapter. This comparison was possible because the interview schedule remained relatively static between the two studies. In this chapter, I discuss an aspect of my work in Balclutha that was not present in the Wanaka cycle; the process of adding to, and enhancing the service network.

As discussed in Chapter Two (*Wanaka: A Lesson in Community Engagement*), COMHEART Wanaka's primary goal was to identify and document the mental health service network in Wanaka. At its conclusion, an information package was compiled that outlined the community's wellbeing services to help raise awareness of the mental health organisations in the community and strengthen the connections between them. The package was made available to study participants as part of the feedback process.

In Balclutha, we sought to further emphasise the goal of enhancing the service network and explore different methods of improving community identified shortfalls. This aspect did not have as great an experiential backing as the interview phase did and therefore we focused on understand the process of enhancing an existing service network and the factors important to this.

We assumed that the community would benefit if organisations were able to supplement their existing care options with evidence based treatment modalities, or if interagency collaboration in the community was made easier. We defined 'enhancing the service network' as these positive effects on service provision.

As with the COMHEART Wanaka project, there was likely a positive effect on service provision because organisations were taking part in a research project. This effect, known as the Hawthorne effect,(64) may have been amplified in this project as the interview phase invited participants to critically examine their local service network and working relations.

The Hawthorne effect is difficult to separate and quantify, however, so I placed little emphasis on it during the process analysis. I chose to focus on how the study's deliberate attempts to enhance the service network were carried out and accepted that the study itself may have played a role in

any changes that occurred in the community. Indeed, one participant described the benefit of having an external “*set of eyes*” looking at service provision in the community.

At the beginning of the project, we planned to help enhance Balclutha’s service provision by...

1. Producing a service information package for the community,
2. Exploring ways in which connections between agencies could be strengthened, and
3. Providing information about evidence-based self-help treatment programs and developing a community-specific means of implementing these based on provider interviews.

This chapter covers these attempts to enhance the Balclutha service network and discusses the relative strengths and weaknesses of the processes used for each one.

6.2: Creating a Balclutha Service Information Package

COMHEART Wanaka participants felt that the information package that had been created for them was a useful resource. In light of this, and as the participant selection in Balclutha had generated the beginnings of a similar information package, I created another information package for Balclutha community.

The interview phase had suggested there was a lack of awareness of services and a lack of clarity between services within the community. Only four interviewees had used a hard copy of service list when asked to name all organisations that they were aware of and each of these lists had been compiled by them specifically. This suggested that a uniform list given to all providers may be beneficial as no such resource currently existed. Alternatively, it may have suggested that participants didn’t see a benefit in having such an item.

To maximise the potential benefits of the information package and encourage participants to use it, I again reflected on the lessons learned from the Wanaka feedback forum.

COMHEART Wanaka had generated role descriptions based on public sources of information, and the survey question “*What is your/your organisation’s role in mental health care?*” Doing so allowed a consistent writing style across all organisations, without bias toward any service in particular. Providers were sent copies of these descriptions to check as part of feedback on the study.

Of the seven providers who responded; one identified a spelling mistake and three volunteered written descriptions for their own role, suggesting the description written for them did not best encapsulate their role description. The COMHEART Wanaka information package contained

several content issues as a result of the research-led creation process. I therefore had Balclutha participants generate their own role descriptions and contact information by filling in a standardised form attached in Appendix C.

Self-written role descriptions often required minor edits to be consistent with the rest of the document. Occasionally providers were unable to fill in the form, or did not complete it despite multiple attempts to contact them. In these instances, I generated a role description in a manner similar to COMHEART Wanaka; using only publically accessible contact details for these descriptions.

As in COMHEART Wanaka, the information package's purpose was to provide a broad overview of the whole community's services as opposed to an in-depth document about any one particular area. The information package included any agency that worked in a wellbeing capacity and had a holistic view to health and wellbeing.

Based on feedback from the Wanaka forum, the Balclutha information package listed services so that those whose contact details might be needed in an emergency (the New Zealand Emergency Service, the local Community Mental Health Team and the local Hospital and Health Centre) were placed at the beginning of the document. Services were then grouped by their roles to create a logical flow through the list.

Organisations that operated outside of Clutha but still supported residents due to a lack of a local equivalent (e.g. Gore Women's Refuge) were included towards the end of the package. National and international agencies that were accessible in the community (e.g. helplines and selected websites) were also included.

On reflection of the document I had created, I decided to add an additional cover page that listed services' names and contact phone numbers for quick reference. I also separated out cost and referral information so these could more easily be identified.

The completed document is attached in Appendix B.

As identified in Wanaka, a printed document has benefits and drawbacks. A printed copy allows instant access but requires providers to keep it somewhere readily available, can be lost and quickly becomes out of date rapidly I therefore wanted to provide the community with an online version as well.

An online database would provide open-access to an up-to-date copy of the information package. The interactive medium could allow users to tailor the focus and depth of information they

accessed, rearrange information based on referral criteria, cost or diagnosis, and search for keywords across services. An online source would also encourage the use of other services' websites through the use of hyperlinks and would allow separate pages for providers and consumers, with different descriptions and priorities for each.

While creating such a website was certainly possible, its maintenance would be problematic. The purpose of the information package was to be a living document, updated as the service network changed. Inherent in this was the need for somebody with an on-going role in the network to oversee and edit it as required. This work would continue for an indefinite amount of time without any foreseeable compensation. I felt that requiring a high level of technical proficiency to edit the site could prevent motivated community members from taking up this role.

A more limited online version was conceived of that would rely on user-friendly tools such as WordPress (<http://www.wordpress.com>) Weebly (<http://www.weebly.com>), or Wiki software such as MediaWiki (<http://www.mediawiki.org/wiki/MediaWiki>). A proof-of-concept was created using Weebly as shown in Figure 6.1.

It was my hope that these user-friendly interfaces would allow somebody without extensive technical knowledge to be able to oversee the website while still incorporating interactive features only possible in an online medium. However, even this reduced form had implementation issues.

As discussed in Chapters Three (*Balclutha: Investigating the Community*) and Four (*Balclutha: Understanding the Community*), many providers were already overburdened by clients and related work. Participants had described a lack of capacity to take on extra duties. I was concerned that a labour intensive task such as consistently updating multiple pages on a website, as well as a hardcopy document, would quickly be stopped in favour of other tasks more directly related to client care.

Short of developing a database system from scratch, I was unsure how to provide a website that could display a list of services in multiple forms across multiple pages that could be easily edited without requiring high levels of dedication and time.

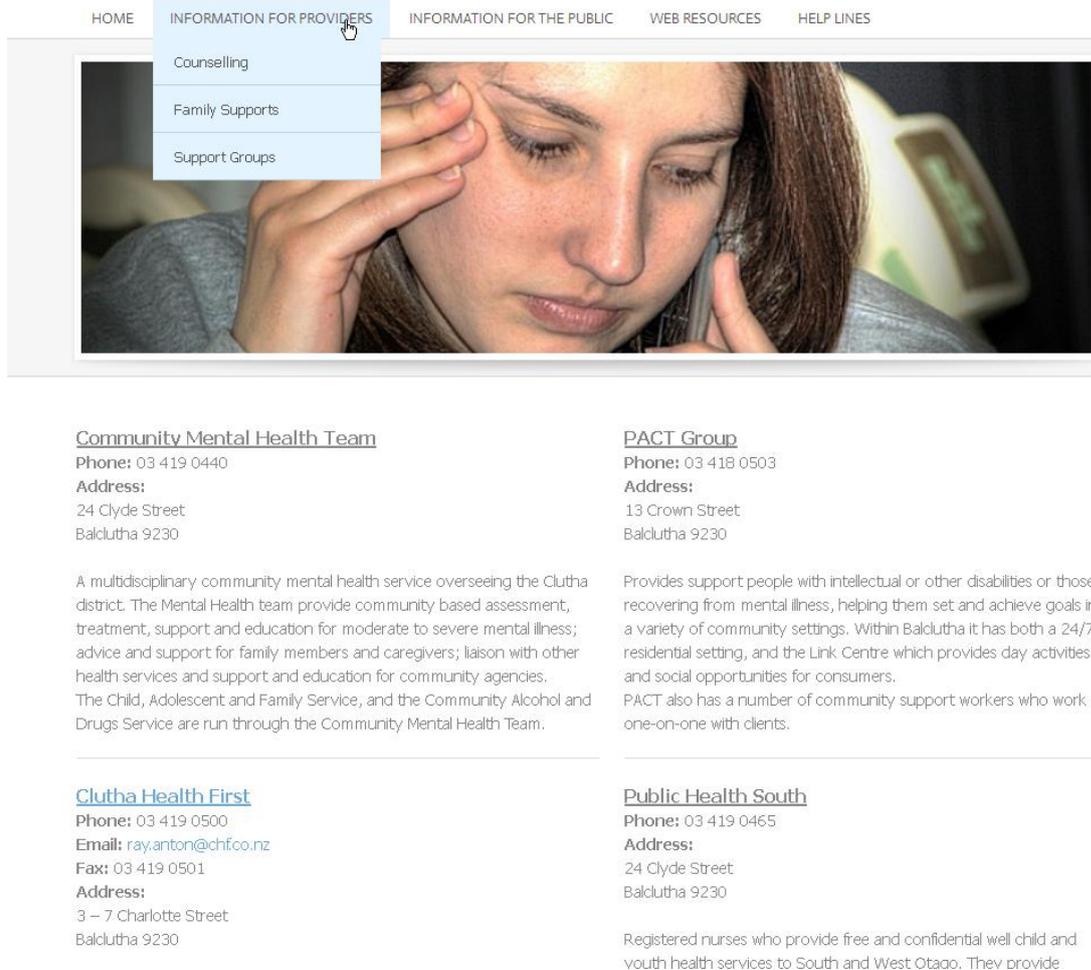


Figure 6.1: A screenshot of a draft website created using Weebly.com

After consulting with my supervisors, I decided that the sustainability of the information package was more important than the interactive features that could have been incorporated into a website. We felt that a single document that could be printed as a hardcopy, uploaded to an existing website and emailed to interested providers was more sustainable.

As the project concluded, I handed control of the document over to the local Community Mental Health Team. I chose the Community Mental Health Team as they had the largest number of mental health workers of any service in the region, were integral to the service provision network, had ties to a wide variety of mental health and wellbeing organisations, and had a waiting room filled with information for the public about common mental health and wellbeing conditions that would supplement the information package. The Mental Health Team had also expressed an interest in keeping the document up-to-date for their own purposes.

When I handed the document over to them, I requested that they keep updated copies available for the community. I also suggested they link to a PDF of the document on their subpage of the Clutha Health First website (<http://www.cluthahealth.co.nz/index.php?pageLoad=36>) although

they have yet to do so. All study participants received an electronic copy of the document via email.

While handing the document over the Mental Health Team had a number of advantages, it did place its control in the hands of a specialised mental health service rather than a more broadly focused community organisation such as Community Networks Wanaka or a more holistic health and primary care centre such as Clutha Health First. Additionally, the level of collaboration and interaction between services and the Community Mental Health Team had been called into question by some participants.

Whilst I believe the Mental Health Team was the best suited in the community to take ongoing control of the information package, it will be interesting to see how their position within the service network affects the use of the document in the community.

6.3: Strengthening Interagency Connections

This aspect of enhancing the service network was the least fleshed out during study design. Our research group was keen to improve connections between agencies as this had been a point of difficulty expressed by COMHEART Wanaka participants. We were unsure how relevant this issue would be in Balclutha and how the issue might be best addressed in the community if it was present. The attempted method of strengthening interagency connections was therefore largely guided by the interview phase of the study.

One of the most common suggestions given by participants was forming a regular, purposeful wellbeing service network meeting. While the specifics of this varied between participants, it was generally felt to be a simple and effective means of encouraging collaboration between services.

I presented, emphasised and endorsed this suggestion at the Balclutha results feedback forum (See Chapters Three and Four – *Balclutha: Investigating the Community* and *Balclutha: Understanding the Community*). The suggestion featured first in my presentation due to the enthusiasm from interview participants regarding the idea.

I did not personally give a view on how I felt a network meeting should logistically occur. The hard copies of the immersion/crystallisation generated results explored several participants' views on how the network meeting might take place, however, and I highlighted this fact during the feedback session.

This suggestion was the most discussed topic by people present at the feedback forum. Initial progress was made at this time, with most people agreeing it should be started in the community, be themed around wellbeing as opposed 'mental health', and have a networking focus rather than one specific to patients, clients or cases. It was evident that further thought and discussion would be needed before the meeting could be implemented in a meaningful, sustainable way.

To my knowledge, little-to-no progress instigating any form of interagency meeting was made between the feedback forum on the 19th of August and the e-Therapy seminar held on the 26th of September. A participant who was present for both sessions asked me whether this network meeting was likely to occur and at this stage I made it more explicit that, while I thought it was a good idea, the community would have to take the central role in its creation. I explained that our research group would not be attempting to establish it ourselves. There was another brief discussion into the logistics of a potential meeting between providers present during the e-Therapy seminar.

There were several reasons I had decided to take this 'hands-off' approach. Firstly establishing a networking meeting to enhance service connections was not something we planned for prior to the interview phase. It was only after understanding Balclutha's current situation that we could appreciate the potential role for networking meetings in the region, which highlighted the need to develop insight into a community before recommending actions.

Balclutha providers had already demonstrated their ability to form and sustain similar meetings, something that we ourselves did not have experience in. At the time of interviews, semi-regular meetings around child health and family violence were being held by providers, and the community had a history of calling one-off meetings regarding community issues such as synthetic cannabis.

Given the community had experience in chairing similar projects; I felt it would be possible for existing providers to create recurring network opportunities without overt researcher input. I believed a community-led approach to establishing the meeting would be better as it would give the community a sense of ownership around these meetings, be substantially easier for a member of the community to organise such a meeting given their knowledge of scheduling conflicts, and would circumvent the need to later hand over the organisation and co-ordination to a Clutha provider once my involvement was finished. I hoped that the sense of ownership and community development would aid in making the meeting sustainable, purposeful and keep it in the spirit of local providers coming together.

Despite initial enthusiasm from people at the results feedback forum and e-Therapy training seminar, the decision was made in the Community Mental Health Team not to actively pursue the idea. It was felt that current efforts to encourage networking through meetings such as the Family Violence meeting were sufficient, and that a networking specific meeting was not needed enough to justify the required time and resources. There were also concerns that the meeting would face attendance issues from providers. The Mental Health Team chose to make more of an effort to have staff members attend existing meetings so that they could get to know other providers and vice-versa.

It was somewhat disappointing that the Mental Health Team elected not to support the idea as a community networking meeting would not be effective without their involvement. The Mental Health Team would have likely been the best to co-ordinate such a meeting given their central role in the community.

Their decision for not involving themselves was well considered, however. As described in previous chapters, participants were concerned about the sustainability of a network meeting given the time requirement involved. The well-established Balclutha Child Health focus meeting had begun to lapse demonstrating sustainability issues with such meetings. Wanaka's Community Networks team had also reported attendance difficulties for a similar endeavour.

Although several participants had called for a recurring networking meeting, there was no clear champion willing to bring about one. Like the wellbeing services themselves, there was a need for somebody with the passion and drive to enact the meeting. At the time of the project, nobody seemed willing or able to do so.

Future work may wish to revisit this idea, with more guidance and support from a research team in the initial set-up.

6.4: A Structured Approach to Guided Self-Help in Balclutha

The method of enhancing service provision in Balclutha that I had the most central role in bringing about was promoting of the use of evidence-based self-help treatment modalities. Doing so piloted the process of introducing a new modality into an existing service network.

6.4.1 Rationale in the study design

As discussed in Chapter One (*Project Overview: From Conception to Completion*), rural centres are thought to have less comprehensive health services than their urban counterparts. COMHEART Wanaka findings were consistent with this and we therefore believed that Balclutha would lack support services.

A practice nurse who took part in COMHEART Wanaka suggested training nurses in simple, brief, evidence-based interventions to benefit the community's support network. We felt that training local general practitioners as well would be beneficial, as it would give practices an alternative to prescribing antidepressants which are currently "not recommended for the treatment of mild non-melancholic depression" in New Zealand.(1 p88)

During study design, it was clear that in order to train participants in practitioner-centric interventions we would require highly skilled, certified educators. This was not feasible and a focus was instead placed on how guided self-help modalities could be integrated into existing services with providers acting as a support person rather than a therapist. After reviewing the literature and considering the logistics, we chose to focus our attention on online self-help programs ('eTherapies'). This was consistent with suggestions that online therapies are way of supporting rural and remote residents,(1, 65-67) and align with local and international recommendations to integrate online therapies into a stepped care approach to managing mental illnesses.(68, 69)

For departmental protocol and ethics review, we proposed the use of four programs; the online cognitive behavioural therapy program 'MoodGYM' (<https://moodgym.anu.edu.au/>), the online depression literacy site 'BluePages' (<http://bluepages.anu.edu.au/>), the online problem solving therapy program 'The Journal' (<https://myjournal.depression.org.nz/>) and selected self-help booklets published by the Northumberland Tyne and Wear NHS Trust available online at <http://www.ntw.nhs.uk/pic/selfhelp/>.

These programs were selected because they were freely accessible, had been created on backgrounds of evidence-based treatment and were appropriate for New Zealand residents. We

hoped that, by having four programs, we could offer a range of choices from which providers could then select in a way that best suited their individual preferences and practice requirements.

6.4.2 Surveying the community

The currently accepted view on guided self-help programs, particularly e-Therapies, is that they are only appropriate for subclinical and low severity disorders(65, 70, 71). The four programs we had selected were specific to mood and anxiety disorders and would therefore be inappropriate for moderate-to-severe disorders, or for other mental health diagnoses such as eating disorders.

This limited therapeutic niche made it essential to understand what role, if any, they could play within Balclutha's existing service network and how they might best be used by the community. The interview schedule was adapted to explore the potential use of online modalities in Balclutha provided the line of questioning was appropriate given time and participant factors.

Because the term "online therapy" can encompass a wide range of ideas that are only connected by their delivery medium,(72) I first described what I meant by online therapies before asking the question "*Do you feel there is a role within Balclutha for eTherapies?*"

Of the 16 participants asked, most were supportive of the suggestion provided there was evidence behind eTherapies.

"That sounds like a good idea... developing the awareness of people- within the role- to have those sorts of things in their favourites... to have a wee kitty of resources so when there's a presenting concern they can work alongside them"

"I've referred people to [The Journal, asking them] 'have you ever looked at that?', 'have you ever been on that site?'... Those self-help things have been very good"

"People often like to self-help first and then if they find that's not enough then they go to the next level...I say try it, go for it"

Several participants expressed concerns about logistics, particularly around the computer access and literacy levels required for clients to meaningfully undergo e-Therapies.

"Things need to be simple enough for people... when you're depressed things are hard enough anyway, so if it's a really complex thing people don't want to know about it"

There were concerns around the process of engagement and ongoing role of the support person...

"They'd have to know who to refer onto, and be good at assessing...and then documentation, how would you do that? There's lots of things to think about. Storage of documentation and that sort of stuff. Sometimes they [clients] tell you more than you want to know and then what do you do with that information?"

"When [clients] do those assessment tools, it's knowing where [they can] get local help afterwards. If they score really high in a depression thing and they're in the boondocks...its knowing what to do with that and where to get to help"

...and one participant was opposed to self-help therapies entirely.

"I don't know whether it will work full stop. It's the relationship with the therapist that actually does most of the work...it doesn't seem to matter what modality you use, it's the actual warmth of that relationship...you're not going to get that online"

My overall impression was that the modality could be appropriate for members of the community particularly as a lack of mild-to-moderate service options had been identified in the region.

Caution had to be taken in the use of online therapies however, and consideration had to be given to when and how guided self-help should be used in the region.

Those points of consideration raised by participants were that...

1. As much as possible, recommendations should be based in established evidence,
2. There should be a clear process of engagement for support people,
3. There should be a clear role of the support person on an on-going basis,
4. There should be a clear process of disengagement for support people, and
5. There should be clear guidelines for when and how to refer to 'higher' treatment options.

There were further aspects to consider, however, based on other elements that arose during the study.

An aspect that surprised me was the type of agencies most interested in guided self-help as a treatment modality. Based on my medical background and the COMHEART Wanaka findings, I

thought that general practitioners and practice nurses would be the most likely to incorporate guided self-help into their practice. The Balclutha participants who showed the greatest interest, however, worked in non-medical support services. There was less enthusiasm than I had expected from the local general practice. There was, however, more interest from the Community Mental Health Team than I had expected given their moderate-to-severe threshold

Providers had described substantial time and workload pressures in the current system. While using guided self-help programs would require less contact time per client than traditional provider-centric approaches, it would not necessarily reduce workload or time constraints if the support framework required a large amount of client contact or associated work. A poorly conceived model may even increase workload if providers took on clients that they would not normally come into contact with which carries the expectation of continued support and oversight. There was a potential for contact to be prolonged or significantly more intensive than initially thought.

Therefore the following points had to also be taken into account...

6. The model needed to be easily implementable in a non-medical, primary supportive agency,
7. The model had to be adaptable to different organisations' values, structures and clients,
8. The model should focus on existing clients under the care of an agency, and
9. The model had to involve minimal, but purposeful, effective contact time.

Given how difficult it would be to incorporate these nine points into a support framework, I felt it was prudent to focus on a single eTherapy program rather than using all four programs we had identified earlier. This would allow me to provide more targeted and relevant information about that program, and tailor a support framework specifically to it. I hoped that a concrete recommendation would encourage providers to become familiar with a program and be more likely to use it.

I decided to centre the model around MoodGYM as it had the largest and highest quality evidence base. My supervisors and I felt that the Australian-based program would be appropriate and acceptable to New Zealand residents.

We recognised that 'The Journal', a New Zealand-based program, could have potentially been more relevant than MoodGYM as it was the focus of a national campaign and the only program mentioned by participants. However, there was no published evidence specific to 'The Journal'

published at the time of study so I chose not to promote its use as a first line option. I suggested it for clients who failed to engage with MoodGYM or for agencies that weren't able to provide any additional support, but heavily cautioned that it had yet to be validated as a treatment program. I advised participants that there was greater evidence for MoodGYM as a therapy.

6.4.3 Evidence behind MoodGYM and Online Therapies

MoodGYM is an interactive, online program based on the principles of cognitive behavioural therapy (CBT) and interpersonal therapy (IPT). It "consists of 5 interactive modules that use diagrams and online exercises. It demonstrates the relationship between thoughts and emotions, examines issues related to stress and to relationships"(73) by making use of fictional characters who model patterns of dysfunctional thinking. A multitude of studies have demonstrated MoodGYM's effectiveness and acceptability in reducing symptoms of mild-to-moderate depression and for people with anxiety.(10, 74-78)

Information on the effectiveness of psychological programs such as MoodGYM is often reported by analysing changes in standardised depression scores and calculating effect sizes based on this data. Effect sizes quantify the size of differences between groups and give an indication as to the strength of the intervention compared to the control group. An effect size of 0.2 is generally considered 'small', 0.5 considered 'medium', and 0.8 considered 'large'.(68)

Based on intention to treat analysis, MoodGYM has an overall effect size of 0.4 compared to an attention placebo which places it between a 'small' and 'medium' sized effect. For people who complete the whole program, there is an effect size of 0.6 ('medium').

The program had an effect size of 0.9 ('large') for completers of the program who had an initial Centre for Epidemiological Studies Depression score of 16 or higher which represents clinical depression.(79) The effect size on this subset is "comparable, although smaller than brief cognitive therapy assisted by a therapist, self-directed manualised computer therapy, and bibliotherapy."(75)

Symptom reducing effects have been shown to be retained beyond the duration of the program, with statistically significant reductions present 12 months after intervention.(77) Recent evidence suggests that MoodGYM also promotes mental well-being in healthy members of the general population.(73)

Reductions in depressive symptoms have been found in both trial participants and spontaneous users of the website.(74, 76) No significant differences in effect size have been found between trial

participants and spontaneous users who complete two or more modules of MoodGYM (the “minimum dose of treatment”). Differences in the proportion of people who complete this many modules have, however, been found between the two groups. Spontaneous users are significantly less likely to reach this minimum dose of treatment when compared to research participants.(76, 80)

Poor rates of completion are a feature of all online therapies and eHealth programs.(65, 80-83) Dropout rates in online programs are higher in spontaneous users than in trial participants.(82) Trials of MoodGYM specifically have found dropout rates between 25%(75) and 74%(84). A 2008 study of spontaneous, open access users found that 63% did not complete any modules; 27% completed only one module and only 10% completed two or more modules. (80) An earlier study found that only 15.6% of the public completed two or more modules.(76)

Adherence and the number of modules completed by a user is important as there is a greater treatment effect associated with greater exposure to the website(74) and number of modules completed.(76) Low adherence may also cause an underestimation of a program such as MoodGYM’s overall effect size.(72)

The higher drop out in the general public is thought to be due to users’ ability to ‘opt-in’ and ‘opt-out’ of treatment with a single click. Individuals with low levels of commitment can try the site without any real belief in the program, commitment to therapy, or expectation of benefit.(78) Clinical trials are thought to provide infrastructure, expectation of effect and external motivation (78, 85) which promote adherence in trial participants.

Adherence promoting factors of research projects are not unique trial settings. These factors form the rationale for a clinical support role.

6.4.4 Evidence for Support People in Guided Self-Help

Many believe that a clinical support role is an essential part of any self-help therapy.(86) The literature has not unequivocally demonstrated this however due to the large heterogeneity in study design, program content and a lack of consensus on the type and duration of support.(70, 82, 87, 88)

Scientific consensus is that drop-out rates are reduced when people are supported in their use of internet interventions.(10, 65, 72) This has been demonstrated in research specific to MoodGYM(80, 89) and is consistent with the proposed mechanisms behind differences between trial participants and spontaneous users. It also aligns with clients’ views on the adherence

promoting benefit of having a non-judgemental support person and external reminder system.(85, 90, 91)

The impact of a support person on the effectiveness of self-help is less established than that of adherence(70). Several meta-analyses have demonstrated a greater effect of treatment when support was offered alongside the intervention.(70, 87, 92, 93) Trials reviewed tended to minimise discussion on the content and effect of the support person role, affecting the quality of literature in this area(70, 88, 93) and each review highlighted the need for further research and more clear data in this area.

The 2013 review by Farrand and Woodford(70) attempted to separate out types of support based on contact time and content in order to analyse effect. It found that “overall effect size did not significantly differ” between therapist-intensive guidance and minimal contact guidance; this challenged “the assumption that the higher amount and type of support...necessarily results in greater effectiveness.”

Farrand and Woodford recommended that support be “restricted to provision of a rationale in the use of self-help alongside regular brief check-ins”(70) which had supported the suggestions of a 2010 systematic review that recommended “support given by the therapist should primarily be of supportive or facilitative nature, and is meant to support the patient in working through the standardized psychological treatment.”(94)

Farrand and Woodford noted that support delivered by telephone had a significantly greater effect than other contact modalities, including face-to-face. They suggested that phone calls reduce the ‘therapeutic drift’ found in face-to-face support where discussions drift away from a supportive role towards a “less effective combination of ‘talking therapy’ and support for the self-help materials.”

Taking into account the evidence for online therapies, the impact of a support person, recommendations for support, and the key points of consideration regarding the role of guided self-help in Balclutha; I developed a novel support framework for the region.

Source	Points of consideration
Participant interviews	Recommendations should be based in established evidence. Support people need clear processes for engagement, continued management and disengagement. There should be clear guidelines for when and how to refer to 'higher' treatment options.
Fieldwork generated beliefs	The model needed to suit non-medical, primary supportive agencies. The model must be adaptable to different organisations. The model should focus on existing clients. Support had to involve minimal time while still being effective.
Literature – efficacy	MoodGYM is the most evidenced model. eTherapy effective for subclinical and mild-to-moderate conditions. Dropout rates problematic.
Literature – support	Support known to increase adherence. Role of support on effect size poorly understood. Minimal contact support thought to be effective. Support should be focussed on motivation and facilitation. Support should be delivered via telephone.

Table 6.1: Points of consideration when developing a guided self-help support framework

6.4.5 A Framework for Support

I took a pragmatic approach to the development of the model given the unclear literature around the role of a support person, the strength of evidence behind MoodGYM even whilst unsupported, and the importance of creating a framework for an existing service network in a real world setting.

Where possible, I based the model on evidence from meta-analyses, recommending a minimal contact, facilitative approach by telephone. For less established elements, such as the timing and content of each contact, I took inspiration from sources such as the 'Oxford Guide to Low Intensity CBT Interventions'(65) and studies which did not directly examine MoodGYM but were explicit in their support models.(85, 95-97)

It was essential that any education on regarding supporting eTherapies conveyed the evidence base behind the practice, outlined the role of a support person, and appeared to integrate into practice. I felt it was essential to demonstrate the integral role Balclutha had played in the creation of a support framework in order to encourage a sense of community ownership.

I drafted a document that outlined the support framework for MoodGYM (Appendix D.) This document was designed to be a stand-alone document so that any provider could facilitate the use

of the program based only on its instructions, but was also meant to complement the community information package which provided alternatives for higher severity and inappropriate clients.

I organised two seminar sessions to provide an opportunity for me to present the framework, supply additional information, take participants through the support document, demonstrate the interventions, and answer providers' questions about the support process. The sessions were designed to be interactive, with deliberate points of discussion included throughout. The structure of these seminars was based on an openly published pilot study of a workshop that educated clinical psychologists in how to deliver therapist-assisted internet cognitive behaviour therapy.(98)

The first seminar was held in Dunedin on the 25th of September. Several Dunedin-based services had expressed interest in attending this, though only two participants were able to make it on the day. Both of my supervisors attended this session. The seminar ran for 60 minutes.

I made some slight changes to the structure of the session after discussion with the two Dunedin participants and my supervisors. These changes were made to better gauge the understanding of eTherapies in the group, encourage deeper discussion around the concept and eliminate a small area of confusion in the Dunedin discussion.

I presented the updated version in Balclutha the following morning (26th September). This session was attended by 14 people from six organisations. Three people who arrived late opted to leave for space reasons; their manager stayed behind for the presentation and took associated resources back to the others. The seminar ran for 90 minutes.

The key area of discussion encouraged at both seminars was how practices and practitioners might incorporate the support framework into their work.

6.4.6 Exploring Providers' Views on the Support Framework

One participant at the Dunedin seminar found MoodGYM and the framework "very interesting", and indicated their desire to incorporate the MoodGYM into practice once they had tried it themselves. The other didn't see a role for online therapies within their practice.

Neither participant felt there was a particular risk in using the programs as neither MoodGYM nor The Journal claimed to be able to diagnose disorders or were being recommended in place of proper risk assessment.

One participant felt strongly that any new support had to be introduced to a service network "properly or not at all." They felt that an organisation or community would need a standardised

protocol for a guided self-help support people to follow and all staff in that network would have to be aware of this procedure to make the support program viable and effective.

The other felt that MoodGYM had the potential to reach and support a large number of people and could easily be advertised and encouraged to clients in a range of ways.

Both agreed that there was the potential for online therapies to play a much greater role as part of a whole community approach to addressing mental health issues.

Participants at the Balclutha seminar were generally positive about online therapies. Nobody present had used MoodGYM or The Journal to any great extent in the past. The Journal was familiar to some participants and one provider who worked with youths had previously recommended 'The Lowdown', a site run in conjunction with 'The Journal.'

Participants again wanted to first familiarise themselves with the program and understand it before beginning to use it in their practices. They were encouraged by the brief run through I had delivered, and by the brevity of the first module of MoodGYM. One participant stated "I'd quite like to go have a look at it."

People at the Balclutha session felt the most appropriate clients would be farmers in outlying regions, youth, and otherwise unsupported mild-to-moderate cases. One participant raised the idea that the modality would also be appropriate for prisoners who tended to have easy access to computers but not psychological services.

Members of the Community Mental Health Team thought that there could be role for online therapies within the practice despite their moderate-to-severe threshold. One suggested that family members of clients could benefit from it, and another that felt it could be recommended when discharging clients from the service or declining referrals due to severity criteria. A member of the Mental Health Team recommended other services indicated on their referrals whether the client had tried using an online therapy to help understand the severity and status of the person.

One service was "quite keen" on using program to supplement their current options. They felt that it would suit their organisation as they worked with their clients on an ongoing basis so could introduce it and incorporate it over time. They believed it would "fit well with them" and indicated they were likely to use it once they had explored it themselves.

Two services that worked with youths indicated their interest in MoodGYM. There was interest in incorporating the program into a health class at the local high school, potentially around exam

time given the higher levels of stress. One service felt it would be a good addition to the “maturing package” they were developing for clients who transitioned out of their service.

Participants reiterated the view that the programs couldn’t be used as a substitute for proper clinical assessment and care and felt that patient selection was important.

Overall people were interested in the concept, and several seemed like they could incorporate it in some form into their individual practices. It was difficult to follow up on use in people’s practices as the seminars were held late in the year and the potential client base was limited.

On reflection, I feel the model itself has great potential as the basis for future work. Being a minimal contact, relatively simple model it has the potential to be adapted and utilised in multiple ways. As suggested in the Dunedin session there is the potential to use it as a community or organisation wide treatment option. It is flexible enough that organisations within an existing service can incorporate it in different ways such as the Community Mental Health Team using it for family members or as part of a service’s extended care plan or transition plan. It could also be incorporated in the development of a new service.

While the training seminars received positive initial feedback, there is a need for more comprehensive evaluation. More thorough feedback and follow-up is required to assess the impact of training on the use of eTherapies in practice. This could be done by holding a similar seminar with another cohort and auditing provider practices following education. It may also be possible to work with the makers of MoodGYM to gather quantitative data on the number of users in the region before and after the training seminar.

Alternatively, greater emphasis could be placed within interviews to better understand the role of providers within each service to allow the model to be individualised to services. Training could then occur at an agency level to integrate guided self-help into their existing roles.

6.5: Discussion

The three attempts to enhance the existing Balclutha service network provided a number of key insights into the process of working to improve an existing community system as explored throughout this chapter.

The biggest difficulty facing all three attempts to enhance the community’s service provision was time constraints.

Engaging the community, assessing the current situation within that community, and developing a community-specific framework for improvements were essential in helping support and work alongside Balclutha's existing community providers. These processes left very little room for encouraging, implementing, and evaluating attempts to enhance the service network, however.

The engagement and assessment processes provided insight into what areas required work and how this might be realised. The engagement phase helped identify key community figures that would be essential in developing and sustaining change in the community. Interviewing these community members provided the basis of the service information package and helped attempts to improve networking in the community.

Working with participants at a distance was difficult. As I was living and working outside of the region, my communication with participants usually occurred through emails and phone calls. Not being physically present in the community complicated attempts to organise and monitor the project as I was less able to discuss things with stakeholders in person or make collective decisions instantaneously. Liaising with multiple people and organisations through phone calls, answering machine messages and emails was a slower process than working on-site would have been, particularly as participants were volunteering their time to take part in the project without compensation or leniency in their work schedules.

Living in the community for some, or all, of the project would minimise time spent on organisation and allow greater time on enacting change and evaluating this. It would allow greater engagement with community members, increase opportunities to improve the service network, and give the ability to work alongside community champions to facilitate change.

Although living in the community has these benefits, it will not always be feasible in future research. If future research looks to expand throughout rural New Zealand there will be a greater need for research groups to work from a single location. Other means of minimising the effects of time constraints must therefore be considered.

This project helps mitigate time constraints in future work. This project engaged many key organisations and stakeholders within Balclutha. Future work in Balclutha could extend on, or evaluate, the work started here to increase the depth of knowledge regarding the process of enhancing existing mental health service networks.

Research done in other communities will also benefit from this project as the process evaluation and methodological refinement provides a platform from which future research can begin. The community assessment and information package creation processes streamlined in this project

can be readily utilised in other communities. Similarly the literature reviews detailing the impact of rurality on service provision, the effectiveness of eTherapies, and the role of support people in guided self-help therapies are transferable to other projects.

Because of this project, future work will be more efficient, have a tighter focus, and begin with a greater understanding of the elements that are essential to working with communities to bring about change.

6.6: Chapter Summary

In addition to streamlining the process of creating a community information package, this project piloted the process of enhancing an existing service network in several ways: it identified community-appropriate means of improving networking, attempted to implement these, and encouraged the use of supported eTherapies by existing services.

These attempts were met with varying degrees of success. Whilst evaluation was difficult due to time constraints, initial feedback was positive. The work completed in this project will reduce the work required to begin action in future studies, and therefore maximise the time available to enact and evaluate change within a community.

Chapter Seven

Continuing the Cycles: Current Conclusions and Future Suggestions

7.1: Summation of the Project

This action research project aimed to contribute to the understanding of how rurality residency effects mental health service provision and mental health status within New Zealand. It then sought to explore ways to enhance rurality's positive impacts on mental health and minimise its negative aspects.

In conjunction with the COMHEART Wanaka studentship, it explored the views of mental health service providers in two rural locations (Wanaka and Balclutha). These views were interpreted in the context of wider issues affecting the mental health status of rural New Zealand such as service delivery in these communities.

I attempted to translate the shared concerns of Balclutha providers into community-specific action that would support and enhance their existing service network. There were three ways I did this...

- 1) by creating a local information package,
- 2) by encouraging increased networking between providers, and
- 3) by introducing a community-orientated means of supporting clients through minimal-contact guided self-help programs.

These attempts showed promise, but were confined by time constraints of a single year, honours-level framework for action. The lessons learnt from this project will help mitigate these time constraints for future areas of research.

Here I summarise these key lessons and possible avenues of research to conclude my project and offer guidance for future cycles of investigation and action.

7.2: Key Lessons for Future Work

7.2.1 Engagement

Both COMHEART Wanaka and my work in Balclutha involved the identification of a 'community champion' that provided an overview of the service network and helped with initial introductions to community members.

Although further fieldwork was required to identify further organisations within the local network, both projects benefited from having this 'community champion' as they provided a structured means of approaching providers. It also offered a shared connection between the research group and participants which was helpful in developing trust and rapport with the community.

In both Wanaka and Balclutha the community contact was a general practitioner with ties to the department overseeing the research. These close ties will not be present with all rural communities in New Zealand, so it is worth considering how else a community champion may be obtained.

From my project and COMHEART Wanaka, it would seem that local general practitioners have a good overview of key organisations in the service network and are well-known by local service providers. They would therefore make good candidates to initially reach out to in order to act as a community champion in an unfamiliar community.

If a town has a local Community Mental Health Team, this would also be a good initial point of call as evidenced by the central role held by Balclutha's team.

Towns that lack a local Mental Health Team should still fall under the care of one in the surrounding region, as demonstrated in Wanaka. It may be possible to approach a region's team as an initial contact for several towns in that area. For example, the Balclutha Community Mental Health Team has a broad understanding of the services available in the nearby town of Milton and could likely act as a community champion for the town if needed.

7.2.2 Community Assessment

The core interview schedule used in Balclutha (Table 3.1, page 30) provided a way of rapidly and comprehensively assessing the community with minimal extraneous data collected. It required relatively little time investment from local service providers, and was flexible enough to be adapted and extended when required. I believe the core schedule does not require further

adaptation. The benefit of the additional questions (Table 3.2, page 31) that were asked in Balclutha to guide the study is less certain.

Assessing the community's opinion of e-Therapies may be required if attempting to roll these out in a community wide manner once again. If attempting to encourage the use of e-Therapies on an individual service basis, then this question would not need to be asked of all organisations and participants. Only organisations that are interested in guided self-help therapies would need to be questioned regarding their views on the programs. Further questioning would be required of these organisations to determine what they would require within their organisation-specific support framework.

The other two additional questions regarding each organisation's skills and routine data did not yield much beneficial data in this project. Most organisations did not have skills that they felt willing, able, or skilled enough at to teach other providers. The process in which 'teacher' organisations and 'student' organisations could be paired and quality assured has also not been piloted. There was no viable consensus of answers to the question concerning routine data; studies assessing impact of interventions would likely have to record pre- and post-intervention figures.

Extra questions could be added in place of these additional questions depending on the research being undertaken.

7.2.3 Enacting Change

As discussed in Chapter Six (*Balclutha: Enhancing the Service Network*), the biggest barrier to enacting change in Balclutha was time constraints. The chapter raised a number of suggestions to mitigating these constraints (living in the community for some, or all, of the project and using the background work from this project to more quickly begin action in the community) as well as lessons learned specific to each individual attempt.

The core message I took from attempting to enact change in Balclutha is that during study design you must carefully consider the change you wish to bring about, the actions you feel will support this change, and the evaluative process you feel will measure the relative success of these actions. Once these points have been established, you must allow ample time within your study design for them to occur.

7.3: Future Avenues for Research

As described in Chapter One (*Project Overview: From Conception to Completion*), the cyclical nature of action research means that the overarching research does not conclude with each completed project. A ‘finished’ research project should always act as a springboard for further work, providing a greater foundation for investigation and action and identifying further avenues to explore.

The work I have completed in Balclutha does not signify the completion of the research as a whole and there are many facets of community engagement, exploration and enhancement that have not been covered here. These areas will be more easily researched because of my project.

Of all the decisions to be made about future research projects, perhaps the most fundamental is whether to look more broadly at rural New Zealand communities and involve communities that have yet to be researched, or whether to look more deeply into Balclutha and/or Wanaka.

Looking at other rural communities would allow a third cycle to test, refine and evaluate the process of community engagement and assessment using the key lessons described above. It would also further the understanding of rural New Zealand as a whole, and provide a clearer picture of rural heterogeneity at a national level. Future communities could vary in core aspects such as size, socioeconomic status, and their role within their region. They could also come from regions outside of Otago, including those in the North Island.

Exploring future communities would allow streamlining of the entire process from investigation to action, as well as offer the chance to evaluate the impact of a research group’s intervention. Working with new communities would also allow researchers to test the feasibility of working simultaneously in multiple communities with a view of making the process easier to implement on a national scale.

Looking more closely at Balclutha would directly benefit from the initial work done within this project. Due to the high levels of understanding and engagement that currently exist in the community; a new project would be able to move rapidly from study design to action.

Working within Balclutha would allow a more comprehensive evaluation of the enhancing aspects of this project as well as the chance to more thoroughly explore some of the issues raised here. The community would be ideal for further exploring how an existing service network can be added to by looking to implement other low-intensity mental health interventions, or looking to extend the work into eTherapies that I have begun.

Continuing work in Balclutha could also involve developing a greater understanding of how to enhance existing aspects of a community network such as how to best encourage the use of an information package or how to meaningfully increase interagency collaboration.

Further consideration of the action taken in Balclutha would strengthen the knowledge base that I have developed which could in turn be used in other communities as more cycles of research are conducted.

Within any of these future projects and research cycles, there is the potential to include the views of service users or the general public. This would provide a different perspective on the impacts of rurality on mental health.

Regardless of the path taken with future research, the work in Wanaka and Balclutha will provide an essential background for it. These initial centres have already developed a sizeable amount of data and form a solid foundation for future research and action in rural New Zealand.

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Appendix A – Modified Wanaka Community Service Information Package



Wanaka Community Support Services

Last updated by University of Otago on 20th August 2013

This list is designed to be as comprehensive and up-to-date as possible.

If you notice any incorrect, outdated or missing information please inform **Community Networks Wanaka**

1. New Zealand Emergency Services: 111
2. Mental Health Team: (03) 440 4308
3. Aspiring Medical Centre: (03) 443 1226
4. Wanaka Medical Centre: (03) 443 0711
5. Southern PHO Brief Intervention Service: 0800 488 887
6. Community Networks Wanaka: (03) 443 7799
7. Strengthening Families: 0800 267 327
8. Rob Cunningham (Cognitive Behavioural Therapist): 027 469 6875
9. Karen Munro (School Counsellor): (03) 443 9901
10. Meg Bryant (Counsellor, Family therapist): 021 270 0866
11. Liz Maluschig (Counsellor and Spiritual Director): (03) 443 1955
12. Chris Jacques – Clinical Hypnotherapist
13. Upper Clutha Womens Support Group: (03) 443 1448
14. Salvation Army Senior Service: 027 445 5168
15. Al-Anon: (03) 443 7887
16. Uruuruwhenua Health: (03) 448 8634
17. Kahu Youth Trust: (03) 443 5880
18. Canlive Charitable Trust: (03) 443 6234
19. Namaste Healing and Retreat Centre: (03) 443 9192

Organisation:	Contact:	Description:	Notes:
New Zealand Emergency Services	Phone: 111	If there is an immediate risk or health concern, call 111 for urgent response and guidance.	No referral required. Free service.
Mental Health Team	Phone: (03) 440 4308 Fax: (03) 440 4318 Email: centralotagocmht@southernhb.govt.nz	A multidisciplinary community mental health service covering Central Otago, for more severe mental health problems. Includes a 24 hour emergency service.	
Aspiring Medical Centre	Phone: (03) 443 1226 http://www.aspiringmedical.co.nz/	First port of call for mental health issues, both immediate and long-term. Act as an advocate for the patient in the system. Assess patient and evaluate interventions.	No referral required.
Wanaka Medical Centre	Phone: (03) 443 0711 http://www.wanakamedical.co.nz/		No referral required.
Southern PHO Brief Intervention Service	Phone: 0800 488 887 http://www.southernpho.health.nz/community.php	For individuals with mild to moderate issues such as depression, anxiety and stress and adjustment.	Referral from GP or Practice Nurse required. Free service up to six sessions
Community Networks Wanaka	Phone: (03) 443 7799 www.communitynetworks.co.nz	Assessment and referral, advice and guidance on various issues (financial etc). One-stop shop for information on local services, including mental health options.	
Strengthening Families	Phone: 0800 267 327 Email: strengtheningfamilies@coreap.org.nz http://www.strengtheningfamilies.govt.nz/	Works with families who are linked with mental health issues, improving services for vulnerable families through local collaboration.	No referral required. Free service.
Rob Cunningham: Cognitive Behavioural Therapist	Phone: 027 469 6875 Address: 699 Aubrey Rd., Wanaka	Uses a psychotherapeutic approach to manage stress/anxiety/depression, control fear and anger, enhance performance and improve relationships.	
Karen Munro: School Counsellor	Phone: (03) 443 9901	Guidance and support for students, staff and families.	No referral required. Free service.
Meg Bryant: Counsellor, Family therapist	Phone: 021 270 0866 meebryant1@yahoo.co.nz	Privately consult with people on various issues. This may include marriage, relationships, family/whanau issues, stress etc.	
Liz Maluschnig: Counsellor and Spiritual Director	Phone: (03) 443 1955		
Chris Jacques – Clinical Hypnotherapist	Email: contact@hypnotherapyandme.co.nz http://www.hypnotherapyandme.co.nz/	Helping individuals rebalance their beliefs/thoughts, reduce self-limiting and negative behaviours and working towards goals. Supporting people in any way	Chris Jacques – Clinical Hypnotherapist
Namaste Healing and Retreat Centre	Phone: (03) 443 9192 Email: namastewanaka@slingshot.co.nz http://namastewanaka.co.nz/	Offers the opportunity to deeply immerse oneself into a holistically based healing environment. Services include guidance and counselling, alternative healthcare, residential retreats, spiritual development and workshops and courses.	

Upper Clutha Womens Support Group	(03) 443 1448 http://www.communitynetworks.co.nz/support.html	Free and confidential service of advice, education and practical support to women of Wanaka and the surrounding district.	
Salvation Army Senior Service	Phone: 027 445 5168	Organises and provides voluntary friendship and support to elderly community members.	No referral required. Free service.
Al-Anon	Phone: (03) 443 7887 http://www.al-anon.org.nz/	Al-Anon helps families of alcoholics to cope. First responder/referrer to appropriate agency	No referral required. Free service.
Uruuruwhenua Health	Phone: (03) 448 8634 0800 878 087 Email: uruuruwhenuahealth@xtra.co.nz	Whanau ora and primary care focused services for the rural Māori population of Central Otago.	
Kahu Youth Trust	Phone: (03) 443 5880 Email: kahu.youth@xtra.co.nz http://kahuyouth.ning.com/	Kahu Youth provides programs, activities and events for youth (11-24 years) and their whanau in the Upper Clutha region.	
Canlive Charitable Trust	Phone: (03) 443 6234 http://www.canlive.org/	Offers courses in Meditation and Healing and Wellbeing Cancer Programmes for people with cancer and their supporters focussing on meditation, diet, life stressors and ways to handle cancer	

Youthline	Phone: 0800 376 633 Text: 234 Email: talk@youthline.co.nz http://www.youthline.co.nz	A national telephone counselling helpline run by youth, for youth. Provides counselling, information and referral.	No referral required. Free service.
LifeLine	Phone: 0800 543 354 http://www.lifeline.co.nz/	A national telephone counselling service run by trained volunteers. Provides counselling, information and referral.	No referral required. Free service.
Age Concern	Phone: 04 801 9338 Fax: 04 801 9336 Email: national.office@ageconcern.org.nz http://www.ageconcern.org.nz/	Promotes the rights, wellbeing and quality of life of older people. Promotes healthy, active ageing to people of all ages.	Is not a counselling or advice service
Otago Rural Support Trust	Phone: 0800 787 254 http://otago.rural-support.org.nz/	Part of a nationwide network of Rural Support Trusts. Members are local rural people with a wide range of experience and knowledge in dealing with challenging rural situations.	No referral required. Free service.
Rural Women New Zealand	Phone: 0800 256 467 http://www.ruralwomen.org/	A charitable, membership-based organisation which supports people in rural communities through learning opportunities, advocacy & connections.	No referral required. Free service.
Mental Health Foundation	Phone: 09 300 7010 http://www.mentalhealth.org.nz/	Provides information and training, and advocate for policies and services that support people with experience of mental illness, and also their families/whanau and friends.	Is not a counselling or advice service
The Lowdown	http://www.thelowdown.co.nz	An interactive website that aims to help young people recognise and understand depression. This site encourages and enables them to seek appropriate help, or puts them in touch with trained professionals.	Free Online Support Service
Depression.org.nz	http://www.depression.org.nz	Information and an online self-help programme "The Journal". John Kirwan leads individuals through self-tests, various treatment options and advice.	Free Online Support Service
MoodGYM	http://moodgym.anu.edu.au	An evidence-based interactive web program designed to prevent depression. It teaches the principles of Cognitive Behavioural Therapy is associated with decreased symptoms of anxiety and depression.	Free Online Support Service
BluePages	http://bluepages.anu.edu.au/	Provides information on treatments for depression based on recent scientific evidence. The site also offers screening tests for depression and anxiety and has links to other helpful resources.	Free Online Support Service
CALM (Computer Assisted Learning for the Mind)	http://www.calm.auckland.ac.nz/	A motivational tool for students struggling with depression, anxiety, stress, and other factors that contribute to poor study. Includes information, advice and tips on mindfulness	Free Online Support Service

Appendix B – Balclutha Community Service Information Package



Balclutha Community Support Services

Last updated by University of Otago on 27th September 2013

This list is designed to be as comprehensive and up-to-date as possible.

If you notice any incorrect, outdated or missing information please inform Nick Erskine on ersni405@student.otago.ac.nz

1. New Zealand Emergency Services: 111
2. Balclutha CMHT (Community Mental Health Team): 03 419 0440
3. Clutha Health First: 03 419 0500
4. PACT Group: 03 418 0503
5. Southern PHO Brief Intervention Service: 0800 477 115 (*Dunedin Office*)
6. Books on Prescription: 03 418 1677
7. Public Health South: 03 419 0465
8. Catholic Social Services Pathway Counselling: 03 418 4089
9. Bill Rout Counselling: 021 513 995
10. Salvation Army Community Missions Centre: 03 418 3871
11. Anglican Family Care: 03 418 2530
12. SF Otago Supporting Families: 03 455 5973 (*Dunedin Office*)
13. Royal New Zealand Plunket Society: 03 474 0490 (*Otago Area Office*)
14. Child Youth and Family Service: 0508 326 459
15. South Otago High School Guidance and Counselling Service: 03 418 0517
16. Adventure Development: 03 470 1691
17. Relationships Aotearoa: 0800 735 283
18. Southern Support Eating Disorder Service: 0800 328 744
19. Sport Clutha: 03 418 3046
20. Shine Massage Therapy: 027 424 7808
21. Osteopathy Works: 03 418 2226
22. Miramare Ltd: 03 474 5555
23. Gore & Districts Community Counselling Centre Inc: 03 208 5366
24. Gore Women's Refuge Inc: 03 208 9333 (*Crisis Line*) or 0800 00 43 43
25. Tokomairiro Waiora Incorporated: 0800 769 648
26. Te Oranga Tonu Tanga: 03 476 9510 (*Dunedin Office*)

Organisation:	Contact:	Description:	Notes:
New Zealand Emergency Services	Phone: 111	If there is an immediate risk or health concern, call 111 for urgent response and guidance.	No referral required. Free service.
Balclutha CMHT (Community Mental Health Team)	Phone: 03 419 0440 Address: 24 Clyde Street Balclutha 9230	A multidisciplinary community mental health service overseeing the Clutha district. The Mental Health team provide community based assessment, treatment, support and education for moderate to severe mental illness; advice and support for family members and caregivers; liaison with other health services and support and education for community agencies. The Child, Adolescent and Family Service, and the Community Alcohol and Drugs Service are run through the Community Mental Health Team.	No referral required, though other services can refer. Free service.
Clutha Health First	Phone: 03 419 0500 Email: ray.anton@chf.co.nz Fax: 03 419 0501 www.cluthahealth.co.nz Address: 3 – 7 Charlotte Street Balclutha 9230	An integrated Family Health Centre. It houses an inpatient service, a range of community services and outpatient clinics and a GP practice. Clutha Health First's professional staff work cooperatively with all mental health services and refer as necessary.	Cost and referral requirements depend on service used.
PACT Group	Phone: 03 418 0503 Address: 13 Crown Street Balclutha 9230	Provides support people with intellectual or other disabilities or those recovering from mental illness, helping them set and achieve goals in a variety of community settings. Within Balclutha it has both a 24/7 residential setting, and the Link Centre which provides day activities and social opportunities for consumers. PACT also has a number of community support workers who work one-on-one with clients.	Referral requirements depend on service. Free service.
Southern PHO Brief Intervention Service	Dunedin Office: Phone: 0800 477 115 Fax: 0800 477 116 Address: 1 Bond Street Dunedin 9054 Mailing Address: PO Box 218 Dunedin 9054	The brief intervention service supports individuals who think they need help to become emotionally well. It may include education about emotional wellness, medication and illness prevention; stress management; problem solving skills; learning coping strategies or getting specialist help if required.	Support service referral required. No cost to consumers. Clients requiring more than 6 sessions will be linked with other appropriate services.
Books on Prescription	Phone: 03 418 1677 www.southernpho.health.nz/wellbeingbooks.php Address: Balclutha Library 23 John Street Balclutha 9230	The 'Books on Prescription' scheme is a joint initiative between the Southern PHO and the Balclutha Library. Self-help books are offered to patients with mild-moderate mental health issues.	No referral required, though other services can refer.

Public Health South	<p>Phone: 03 419 0465</p> <p>Address: 24 Clyde Street Balclutha 9230</p>	Registered nurses who provide free and confidential well child and youth health services to South and West Otago. They provide health information and advice, parenting support and advice, nursing health assessments and discussion of health service options and choices.	<p>No referral required, though other services can refer.</p> <p>Free service.</p>
Catholic Social Services Pathway Counselling	<p>Phone: 03 418 4089</p> <p>Address: 18 James Street PO Box 172 Balclutha 9230</p>	Counselling with a focus on lifestyle and holistic health and wellbeing. Work with consumers, responding in a caring and compassionate way to their need for support.	<p>No referral required, though other services can refer.</p> <p>There is a cost to consumers, the level of which depends on your ability to pay.</p>
Bill Rout Counselling	<p>Phone: 021 513 995</p> <p>Email: billrout55@gmail.com www.billrout.com</p>	Talking does help. Bill Rout provides a professional, private and confidential counselling service for the Clutha and Catlins District. Issues supported include relationships, anger and violence, stress, depression, trauma, grief and addictions, or finding more meaning and self-direction.	<p>No referral required, though other services can refer.</p> <p>There is a cost to consumers.</p>
Salvation Army Community Missions Centre	<p>Phone: 03 418 3871</p> <p>Address: 14 Clyde Street Balclutha Next door to Clutha Health First entrance.</p>	A community mission centre that offers general support, as well as specific programmes including the Bridge programme for Alcohol and Drugs and groups such as spiritual development. Also runs a foodbank and one-on-one support work.	<p>No referral required.</p> <p>Free service.</p>
Anglican Family Care	<p>Phone: 03 418 2530</p> <p>Email: south@familycare.co.nz Fax: 03 418 2531 www.familycare.co.nz</p> <p>Address: 4 Clyde Street PO Box 264 Balclutha 9230</p>	Offers a range of services to the families. Child and Family Support Service offer "Home Based Family Support", providing advice and support around child behaviour and parenting skills; Family Outreach is an intensive, long term support for families with children less than one year of age; Family Centred Service is a family violence prevention service.	<p>No referral required, though other services can refer.</p> <p>Free service.</p>
SF Otago Supporting Families	<p>Phone: 03 455 5973</p> <p>Email: fieldworker@sotago.org.nz www.supportingfamilies.org.nz</p> <p>Address: 34 Prince Albert Road St Kilda Dunedin 9012</p> <p>Mailing Address: PO Box 4003 Dunedin 9046</p>	Works with families that have someone in their life that has a mental illness. They offer support, advocacy, education and groups. They also have children programmes for children with a person in their life with mental illness.	<p>No referral required.</p> <p>Free service.</p>

Royal New Zealand Plunket Society	<p>Otago Area Office Phone: 03 474 0490 Email: otago@plunket.org.nz Fax: 03 466 9535 www.plunket.org.nz</p> <p>Mailing Address: PO Box 1275 Dunedin 9054</p>	New Zealand's largest provider of support services for the development, health and wellbeing of children under 5. Plunket works together with families and communities, to ensure the best start for every child. Whanauawhina – caring for families.	<p>A support agency or health professional must refer people.</p> <p>Free service.</p>
Child Youth and Family Service	<p>Phone: 0508 326 459</p> <p>Address: Corner George and Charlotte Streets</p> <p>Mailing Address: PO Box 152 Balclutha 9240</p>	Child, Youth and Family helps families help themselves. They believe all children belong in families that will love and nurture them. They team up with many different groups so that families have the support they need to help their children thrive.	<p>No referral required, though other services can refer.</p> <p>Free service.</p>
South Otago High School Guidance and Counselling Service	<p>Phone: 03 418 0517 Email: cbloxham@sohs.school.nz Fax: 03 418 0516 www.sohs.school.nz</p> <p>Address: South Otago High School Frances Street Balclutha 9230</p>	South Otago High School is a co-educational Year 9-13 High School. Its core role is teaching and learning for academic success. It has a strong pastoral care network of Form teachers, Deans, Senior Staff, Guidance Counsellor and other support staff who work with students.	<p>No referral required.</p> <p>Free service.</p>
Adventure Development	<p>Phone: 03 470 1691 Mobile: 021 281 1130 ben@adventuredevelopment.co.nz www.adventuredevelopment.co.nz</p>	A multidisciplinary drug and alcohol counselling service for people aged 13 to 19 years old. Work closely with youth struggling with substance use issues whether mild or severe.	<p>No referral required.</p> <p>Free service.</p>
Relationships Aotearoa	<p>Phone: 0800 735 283 Dunedin@relationshipsotearoa.org.nz www.relationshipsotearoa.org.nz</p>	Relationships Aotearoa have a Counsellor in Balclutha 2 days per week. Please phone to make a booking.	<p>No referral required.</p> <p>There is a cost to consumers, though some funding is available. Please phone to enquire.</p>
Southern Support Eating Disorder Service	<p>Phone: 0800 328 744 Fax: 03 476 4255 Email: southernsupport@ashburn.co.nz</p> <p>Address: 496 Taieri Road Private Bag 1916 Dunedin 9054</p>	A community based eating disorders service in primary and community health that covers the Southern region. Has two key pathways: A clinical assessment, treatment and referral pathway for people concerned about an eating disorder, and an educative, advisory pathway for professionals.	<p>No referral required, though all clients must be enrolled with a GP.</p> <p>Free Service.</p>
Sport Clutha	<p>Phone: 03 418 3046 Email: sportclutha@sportotago.co.nz www.sportotago.co.nz</p> <p>Address: 20 Glasgow Street Balclutha 9230</p>	A community service providing a range of events, sporting opportunities and recreational activities.	Is not a counselling or advice service
Shine Massage Therapy	<p>Phone: 027 424 7808</p> <p>Address: 2 John Street Balclutha 9230</p>	Therapeutic, sports, relaxation, and pregnancy massage. Massage can be a great way to manage stress, anxiety and depression and can aid a person's road to recovery and healing.	<p>No referral required.</p> <p>There is a cost to consumers.</p>

Osteopathy Works	<p>Phone: 03 418 2226 www.osteopathyworks.co.nz</p> <p>Address: 7 John Street Balclutha 9230</p>	A hands-on, holistic approach to treating the whole body. Osteopathy uses movement of the human body to help restore and maintain more normal bodily function so the body is more able to 'help heal itself' from any stress, trauma or disease.	<p>No referral required, though other services can refer.</p> <p>There is a cost to consumers.</p>
Miramare Ltd	<p>Phone: 03 474 5555 Email: dunedin@miramare.co.nz www.miramare.co.nz</p> <p>Mailing Address: PO Box 989 Dunedin</p>	Provides information and options about the different ways their support needs can be met, and then implements those services on their behalf. The access point for Southern District Health Board funded support services for people who have a disability resulting from psychiatric illness. They implement and regularly review services following a needs assessment report.	<p>Anybody can refer, but information must be provided that demonstrates significant illness resulting from psychiatric illness.</p> <p>Free service.</p>
Gore & Districts Community Counselling Centre Inc	<p>Phone: 03 208 5366 Email: office@gorecounsellingcentre.com www.gorecounsellingcentre.com</p> <p>Address: 17 Traford Street Gore 9710</p>	Provides counselling, psychotherapy, and education to children, young people, adults, couples and families in Gore and surrounding districts. We also provide a free alcohol, drug and addiction service.	<p>No referral required, though other services can refer.</p> <p>Cost to consumer depends on service used.</p>
Gore Women's Refuge Inc	<p>Crisis Line: 03 208 9333 Phone: 0800 00 4343 Email: refuge@ispnz.co.nz http://www.womensrefuge.org.nz/</p> <p>Address: 77a Main Street Gore 9710</p>	Supports women and their families who are victims of domestic violence. Offer a confidential, non-judgemental service that is a place of safety for all women and their children.	<p>No referral required.</p> <p>Free service.</p>
Tokomairiro Waiora Incorporated	<p>Phone: 0800 769 648 Fax: 03 417 7431 Email: tokowaiora@xtra.co.nz</p> <p>Address: 80 Union Street Milton 9220</p> <p>Mailing Address: PO Box 117 Milton 9241</p>	A kaupapa Māori Health Service providing Whānau Ora services in South Otago. Ensure existing health professionals and providers are co-ordinates, and that Māori are assisted to better utilise the services that are available. Services are available to the whole community.	<p>No referral required, though other services can refer.</p> <p>Free service.</p>
Te Oranga Tonu Tanga	<p>Phone: 03 476 9510 Fax: 03 476 6001</p> <p>Address: Te Taiahoaho Wakari Hospital 369 Taieri Road Dunedin 9010</p>	A kaupapa driven Māori service for adults and children providing awahi, manaaki and tautoko to those individuals and whānau who are experiencing a significant mental health issue. Providers have expert knowledge of tikanga Māori, life experience, clinical expertise within mental health and most importantly a passion about supporting Māori on their journey to recovery and in sustaining a healthy lifestyle.	<p>No referral required, though other services can refer. Clients should be currently receiving support from a registered mental health professional.</p> <p>Free service.</p>

Youthline	Phone: 0800 376 633 Text: 234 Email: talk@youthline.co.nz http://www.youthline.co.nz	A national telephone counselling helpline run by youth, for youth. Provides counselling, information and referral.	No referral required. Free service.
LifeLine	Phone: 0800 543 354 http://www.lifeline.co.nz/	A national telephone counselling service run by trained volunteers. Provides counselling, information and referral.	No referral required. Free service.
Age Concern	Phone: 04 801 9338 Fax: 04 801 9336 Email: national.office@ageconcern.org.nz http://www.ageconcern.org.nz/	Promotes the rights, wellbeing and quality of life of older people. Promotes healthy, active ageing to people of all ages.	Is not a counselling or advice service
Otago Rural Support Trust	Phone: 0800 787 254 http://otago.rural-support.org.nz/	Part of a nationwide network of Rural Support Trusts. Members are local rural people with a wide range of experience and knowledge in dealing with challenging rural situations.	No referral required. Free service.
Rural Women New Zealand	Phone: 0800 256 467 http://www.ruralwomen.org/	A charitable, membership-based organisation which supports people in rural communities through learning opportunities, advocacy & connections.	No referral required. Free service.
Mental Health Foundation	Phone: 09 300 7010 http://www.mentalhealth.org.nz/	Provides information and training, and advocate for policies and services that support people with experience of mental illness, and also their families/whanau and friends.	Is not a counselling or advice service
The Lowdown	http://www.thelowdown.co.nz	An interactive website that aims to help young people recognise and understand depression. This site encourages and enables them to seek appropriate help, or puts them in touch with trained professionals.	Free Online Support Service
Depression.org.nz	http://www.depression.org.nz	Information and an online self-help programme "The Journal". John Kirwan leads individuals through self-tests, various treatment options and advice.	Free Online Support Service
MoodGYM	http://moodgym.anu.edu.au	An evidence-based interactive web program designed to prevent depression. It teaches the principles of Cognitive Behavioural Therapy is associated with decreased symptoms of anxiety and depression.	Free Online Support Service
BluePages	http://bluepages.anu.edu.au/	Provides information on treatments for depression based on recent scientific evidence. The site also offers screening tests for depression and anxiety and has links to other helpful resources.	Free Online Support Service
CALM (Computer Assisted Learning for the Mind)	http://www.calm.auckland.ac.nz/	A motivational tool for students struggling with depression, anxiety, stress, and other factors that contribute to poor study s. Includes information, advice and tips on mindfulness	Free Online Support Service

Appendix C – Service Description Information Sheet

Organisation Name:

We as an organisation **DO/DO NOT** (*delete as appropriate*) agree to have our details, as outlined below, made available in an information package available to support services and the community.

Contact details:

Where possible, these should be generic contact details for the service, rather than worker specific. Please leave sections blank if your organisation does not have, or is not comfortable publicizing, that means of contact.

Phone:

Email:

Website:

Address:

Other:

(Eg: Fax)

Service information:

Please briefly (*20-40 words*) outline the core role of your service

For example *“Works to help families who are linked with mental health issues. Provides information and support for these families and helps improve service access by promoting local knowledge and service collaboration.”*

Access Information (please delete as appropriate):

Referral method:
required

Health professional must refer

Any support agency can refer

Not

Cost:

Yes, there is a cost to the client

No, the service is free

Any additional notes:

Thank you for your support. If you have any questions, please do not hesitate to be in touch with Nick Erskine on 021 296 1607 or ersni405@student.otago.ac.nz

Appendix D – Guided Self-Help Support Model Framework

OVERVIEW OF MOODGYM

MoodGYM is an open-access online therapeutic program for depression, anxiety and emotional wellbeing primarily based on Cognitive Behavioural Therapy with elements of Interpersonal Therapy. It can be accessed at

<https://moodgym.anu.edu.au>

The Australian-based program was originally designed for young adults, which is reflected in parts of its writing style and examples, but has good evidence for older age groups as well.

It is broken into 5 modules which must be completed in order

1) Feelings

Introduces the program's characters and demonstrates that mood is influenced by thoughts

2) Thoughts

Describes the types of dysfunctional thinking, some methods to overcome them and a self-assessment tool

3) Unwarping Dysfunctional Thoughts

Provides behavioural tools to overcome dysfunctional thinking. Includes assertiveness and self-esteem training.

4) De-Stressing

Assesses life stress, pleasant events and provides downloadable relaxation tapes.

5) Simple Problem Solving and Relationship Breakdown

Provides a simple framework for problem solving and works through the example of typical responses to breakup

It explores these modules through the use of six characters who model different types of dysfunctional thinking common in mental illness.

The program provides information around common aspects of depression and anxiety, often by answering questions such as “What is the correct or appropriate way to think?” or using the six characters to personalise concepts.

The site is not meant as a purely informational program, however, and there are a number of standardised quizzes and exercises throughout. The results of these quizzes and exercises are stored in each user's personal workbook on the site and responses are often used in later exercises to tailor questions to the user.

Whilst the site is designed to be user-friendly and to encourage participants through the program itself, there is a documented benefit of having a support person within the community to motivate and to provide technical support if needed.

The following pages provide a suggested framework for how that support could occur within the existing Clutha service network. It should be noted that we are not affiliated with MoodGYM in anyway, and do not claim that this is the only framework that could be used.

We are merely looking to offer one possible way of utilising the effective tool that is online therapy.

OVERVIEW OF THE SUPPORT FRAMEWORK

In creating this framework we had several key goals in mind.

We wanted to create a framework that...

- 1) ...was based on previous studies and evidence sources
- 2) ...involved minimal extra time commitment for community providers, given the already high demand for, and workload of, services
- 3) ...would allow patients who otherwise would not have been seen to receive evidence-based treatment without requiring services to indefinitely accept them as clients
- 4) ...was appropriate for delivery in Balclutha (and, more broadly, rural New Zealand)
- 5) ...acknowledged the limitations and risks associated with minimal contact psychotherapy

To that end, we created a model that involved referral to the website in an initial consultation and then four phone calls of approximately 10 minutes duration delivered across four weeks.

The key aim of this time period is to get the client comfortable with the website and have them complete the first three modules (Feelings, Thoughts, Unwarping) of the program.

Whilst the aim is to create a good rapport and trust in the supporting professional, the online program should be the primary source of therapeutic intervention.

KEY SUGGESTIONS REGARDING SUPPORT

1. Familiarise yourself with MoodGYM program – try first module (Feelings) which can easily be completed in under 30 minutes if casually going through it.
2. The other modules follow a very similar pattern and understanding the site layout will be helpful if anybody gets confused.
3. Be very clear in the initial session as to what your role is. There is some evidence that suggests attempting to provide brief talking therapy as a support person decreases effectiveness compared to purely educating and encouraging progress. You should be clear from the start that your engagement is time limited and is in order to support people undertake the self-help program.
4. Support ideally should be delivered by phone, which in these situations has been shown to be more effective than face to face or written communication. Particular care should be taken if relying only on written communication.
5. Ideally both the client and you should have access to MoodGYM during calls.
6. As a professional, you have the important jobs of selecting clients and giving credibility to the program. Another important job is documenting the recommendation of the self-help program and ideally all further contact with the client throughout this process

SUPPORT FRAMEWORK

Below is a brief overview of the suggested support framework. Details of each session is expanded on separate pages in order to be easy to refer to during the session itself.

The total amount of contact with the client is **40-55minutes** spread across 4 weeks.

Session 1 (10-15min):

Within a regular consultation or appointment, advise client of MoodGYM website. Give clear information regarding the evidence, the role of the program, the role of provider as a general support and motivator, and the level of engagement they should expect.

Call 1 (10 min):

Check to see if the client has begun the program. Review progress through Introduction and “Feelings” Module. Give positive feedback on **any** progress made. Ask if there are any barriers preventing using the program, navigating the website or completing the interactive examples including the “Bad Hair Day” exercise. Set time and date for Call 2.

Call 2 (5-10 min):

Review progress through “Thoughts” module. Give positive feedback on **any** progress made. Ask if any difficulties completing the exercises involving identifying and contesting warped thoughts. Encourage completion of “being nice to yourself” exercise. Set time and date for Call 3.

Call 3 (5-10 min):

Review progress through “Unwarping” module. Give positive feedback on any progress made. Ask if any difficulties completing the reporter’s notebook or self-talk exercise. Encourage completion of pleasant activities quiz. Set time and date for final call (Call 4).

Call 4 (10 min):

Give positive feedback on **any** progress made, highlighting that it has been a month since their first appointment.

If client has completed the three sections, encourage them to continue the program on their own and to practice the lessons around unwarping thoughts and trying to objectively assess situations if they feel a “warpy” thought.

If client has not yet completed three sections, encourage them to carry on with the section they are on (refer to appropriate section in this document). If they do not wish to, or have made little progress refer them to www.depression.org.nz or a local service (including their GP) depending on how much support you believe they require.

If in doubt:

If ever in doubt regarding the safety of the client or others, either ask them to see the service again or else refer them to a different service. Whilst there is good evidence that MoodGYM and other self- help modalities, they are not to be used in acutely suicidal clients.

They should be used for subclinical, or low to moderate clients only.

SESSION ONE (10-15 MINUTES)

Session one is designed to take place in routine consultation with a client. This session is vitally important as it sets the 'ground rules' for the overarching support program.

Selecting clients:

Online self-help therapies are a tool to be used, and like all other treatment modalities they won't suit everybody.

Key points that potential clients should have

- 1) A familiarity with computers/the internet
- 2) The ability to use a computer **in private** for 30+ minutes per week
- 3) Confidence with text-based communication
- 4) A willingness to provide contact phone number and schedule weekly meetings

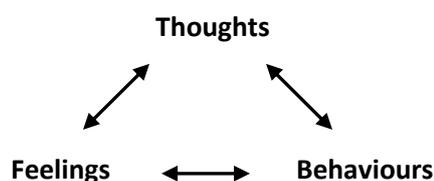
Clients should not

- 1) Be imminently suicidal or pose serious risk of self-harm
- 2) Have severe depression, or other mental illnesses such as psychosis which you feel may prevent them being appropriate for the treatment

Educating clients:

MoodGYM is free program developed in Australia that has been repeatedly shown to reduce depression and anxiety symptoms. It is important to convey that it is not "a website on depression" but an evidence-based program that works on the principles of cognitive behavioural therapy.

Cognitive behavioural therapy works by examining the links between thoughts, emotions and behaviours and then trying to address how we think to change our emotions and behaviours (which are often inappropriate when depressed). It may pay to draw a diagram explaining how thoughts flow into emotions and behaviours as below.



Empowering clients:

Clients should be encouraged to engage with the program, aiming to complete 1 module each week. The program works based on homework and exercises, and is very much a self-help therapy.

Clients need to be aware that you, as a provider, will not be providing a therapy and that phone calls are purely 5-10 minute calls to check how they are getting through the program. They should be aware of the 4 week time limit for support.

CALL ONE (10MINUTES)

The suggested mechanism behind calls being the most effective means of support is that they allow a more personable approach than email/txt message, whilst being harder to lose focus during than a face to face consultation. Calls should aim to be focussed and direct, whilst still being supportive. This call should set the tone for future calls, so it is important that this is conveyed.

Below are the tasks that should have been completed in the introduction and the first module. This should not be considered a checklist to be covered with clients, but a guide to what they should have covered in the week since their first session.

Introduction:

- 1) Created an account
- 2) Read the information regarding the program
- 3) Been introduced to the six characters of MoodGYM
- 4) Completed the Goldberg Depression and Anxiety scales and been given feedback as to the range they fall in
- 5) Completed the “Warpy Thoughts” quiz giving an indication of the level of thought priorities they have across 7 categories

Module One:

- 1) Identified negative thoughts in two of the characters
- 2) Read through examples of how different thoughts can be applied to the same situation
- 3) Be introduced to the “What you think is what you feel” model
- 4) Completed the “Auto talk” quiz examining what warped thoughts they have
- 5) Attempted the “Bad Hair Day” exercise noting events that made them very upset and what they were thinking at the time

If the person has made any progress throughout this, give encouragement and congratulations. If not, try to discern why and then encourage them in a positive manner to give the program a go – again emphasising that it is an evidence based therapy if needed.

If appropriate, briefly introduce the next module.

Set a time and date for the next call.

Example messages:

Great job getting through this far. The important thing to do is keep that engagement up, the program eases you into things initially so you can get used to how things are laid out and now that you’re used to it you’ll start looking doing a lot more therapeutic. The next module is a really crucial one that starts looking more at the types of thinking that can occur when you’re depressed and how to overcome them.

It’s pretty common for people to take a bit to get into any program, including MoodGYM. Is there anything I can do to help you get going?

CALL TWO (5-10 MINUTES)

Evidence suggests that many people do not complete this second module, but those who do are benefit substantially as a result. Studies suggest that completing two or more modules significantly decreases symptoms, so helping clients complete this module should be seen as quite important.

This module is substantially larger than the first. It looks at David Burns' Warped Thoughts types, introducing these then working through many examples of identifying warped thoughts. This can be quite difficult as it involves engaging quite closely with the program and many of the types of warped thoughts are quite similar (meaning it's easy to "get it wrong"). I found it helpful to have a list of the thoughts and meanings printed beside me when doing this module.

The program uses information from the "Bad Hair Day" exercise in Module 1 and gets clients to identify their own warped thoughts and contest these based on suggestions from the program. It is less important they pick the "correct" answer, and more important they identify a dysfunctional thought process is occurring and try to counter it.

Module Two:

- 1) Recap "What you think is what you feel" model
- 2) Be introduced to the 10 types of Warped Thoughts identified by David Burns'
- 3) Read through examples of thoughts based around characters
- 4) Identify warped thoughts in general examples
- 5) Identify personal warped thoughts in exercise from Module 1 "Bad Hair Day"
- 6) Identify warped thoughts in "Auto Talk" quiz from Module 1
- 7) Contest personal warped thoughts from "Bad Hair Day" exercise in Module 1
- 8) Contest the warped thoughts in "Auto Talk" quiz from Module 1
- 9) Summarise personal strengths and psychological weaknesses based on this Module
- 10) Be introduced to self-esteem boosting techniques
- 11) Attempt the "being nice to yourself for a change" exercise which encourages participants to spend 10 minutes each day doing something they like and 5 minutes being nice to themselves

If the person has made any progress throughout this, give encouragement and congratulations. If not, encourage them in a positive manner to give Module 2 a go – emphasising the importance of this particular module (evidence basis, practical skills in contesting common dysfunctional thoughts)

If appropriate, briefly introduce the next module. Set a time and date for the next call.

Example messages:

Good work completing that module as its one of the most important ones in the program and the lessons learned are really helpful ways of tackling common thoughts. The next module builds more on this one by giving a huge range of even more practical ways of countering dysfunctional thoughts.

The research on MoodGYM shows a lot of people find it difficult getting through this module. It also shows that this module is really important. Is there anything I could do to help you get through it?

CALL THREE (5-10 MINUTES)

Module three continues from the unwarping thoughts aspects of Module 2. It provides a structured way of trying to objectively assess situations and gives a range of practical means of dealing with warped thoughts as well as extra techniques of how to improve self-esteem.

The module begins with many different exercises to try and it may become overwhelming. It also has a lot of information in it, as participants are encouraged to pick two of the warped thoughts they commonly experience and focus specifically on these. Some of these warped thoughts have exercises at the end of the information, so the exact path the client takes will differ depending on which thoughts they personally identify with.

The client may need encouragement or extra time to get through this module. By this stage, the client may, however, be familiar and confident working through MoodGYM on their own. If appropriate, you should be looking to signpost the end of your engagement with them (Call 4).

Module 3:

- 1) Be introduced to “The Reporter’s Notebook” (a means of depersonalising and evaluating situations)
- 2) Attempt “The Reporter’s Notebook” with situations that make you upset
- 3) Attempt “I Do Have Some Positive Features” exercise (reframing negative statements)
- 4) Attempt “Surveying the Scene” exercise (identifying how others think, feel and act in situations associated with anger or distress)
- 5) Learn about the “Let’s Experiment” exercise which encourages trying things instead of overanalysing them
- 6) Learn about mental biofeedback (counting number of negative thoughts in a regular day), possibly attempt it (requires set up and motivation)
- 7) Read through information on at least two areas of vulnerability (personal highest two from previous quizzes identified for you)
Note: There may be exercises associated with these individual areas
- 8) Attempt “Seeing the Alternatives” (suggesting multiple interpretations of the same event, preferably without accepting responsibility)
- 9) Undertake the Pleasant Events Quiz (requires time commitment)
- 10) Schedule pleasant activities

Set a time and date for the final call.

Example messages:

Good work completing that module as it takes a lot of time, energy and commitment to get through it. Hopefully you’ve taken some practical methods of dealing with common issues from it. I encourage you to keep using anything that you found particularly helpful.

This module takes a lot of time and energy. It’s perfectly normal to find it overwhelming. There are some really positive and really practical ways of dealing with common problems during depression so it can be very helpful to get through. Is there anything I can do to help you get through?

CALL FOUR (10 MINUTES)

This call exists for two reasons.

The first is that, in an ideal world, all clients would have completed all three suggested modules by this stage and found it very beneficial. In which case, this is a quick chance to offer final congratulations and encouragement to carry on through the final two modules of the program.

However, the majority of people will not fall into this category. To stick to a weekly schedule is difficult, and many people will not have completed a module in the 'required' time. For example: in a study of people who completed an online Bulimia program, only half managed to do so on the suggested weekly basis. It is natural that there will be delays, so scheduling and expecting this call also allows leeway to still support people despite these.

Regardless of progress, however, this call should still be seen as the final call. The framework is designed so that people can be supported without excess strain on already strained services. If clients have struggled to engage with the program, or have not found benefit to it, within these four weeks then alternative options need to be considered.

If they feel the program is helping somewhat, but they struggle to complete it then an option is to suggest www.depression.org.nz. This New Zealand based site contains both depression literacy materials (similar depression literacy sites have been shown to be effective at reducing symptoms of depression as a standalone therapy) and *The Journal*.

The Journal is an online therapy program based around problem solving therapy. It contains within it an automated support person model using videos of John Kirwan to encourage participants, as well as automated text and email reminders. There is no clear evidence for the impact of *The Journal* specifically, although similar problem solving therapies have been shown to work.

The Journal gradually eases people into the program, and encourages people to progress at their own pace (within limits) through the information and exercises.

If online programs aren't seen as appropriate or effective by the client after a trial of MoodGYM, then other options must be considered. This may involve seeing them again with a view of reassessing and accepting them into the main service if possible, or referring them to another local provider such as their GP or a community support agency.

Some sources suggest scheduling a follow-up call for a month after this call to check in on the person again, though there is not any evidence behind this as part of an overall therapy.

Any decisions made from this final call should be well documented.

Appendix E – University Ethics Approval



13/101

Academic Services
Manager, Academic Committees, Mr Gary Witte

25 March 2013

Dr J Ross
Department of General Practice & Rural Health
Dunedin School of Medicine

Dear Dr Ross,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "**Translating evidence-based mental health interventions into local service networks in rural communities**".

As a result of that consideration, the current status of your proposal is:- **Approved**

For your future reference, the Ethics Committee's reference code for this project is:- **13/101**.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

A handwritten signature in cursive script that reads 'Gary Witte'.

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. C Jaye Head of Department Department of General Practice & Rural Health