

# CA

## **Defining counselling: a practitioner's approach**

Doctor-turned-counsellor  
Vicky Dawes on the  
importance of counsellors

## **Mental wellness in a time of crisis recovery**

Black Dog Institute executive  
director Professor Sam Harvey  
shares his insights

# *defining* COUNSELLING

*Part 2*



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## What some of our graduates are saying...



AIPC's course material is excellent; it is structured and is user friendly with information being specific. AIPC tends to meet the needs of people. I believe that study will not end here for me as I am already looking at post graduate work. My difficulty is finding an institution as well structured as AIPC. And yes, guess what, nobody compares! I am in the process of negotiating my next course with AIPC. On a final note, AIPC have made it possible for me to achieve my dream. Thank you."

**Angela, AIPC Higher Education Graduate**

"When I first found out about the course I was excited at the prospect of doing a degree that was solely focused on Counselling and run by an Institute who specialise in providing counselling training. All in all I have enjoyed my study in the course and would recommend it to others who are looking for a flexible degree that they can do at home."

**Claudia, AIPC Higher Education Graduate**

"The Institute has been an exceptional institution to study through. I have studied with a few institutions over the years but the Institute has by far been the best. What I particularly like is the fact that the lecturers manage to afford students a great degree of flexibility in terms of fitting their studies into their day to day lives whilst maintaining an extremely high standard of education."

**Will, AIPC Higher Education Graduate**



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Submission guidelines

### Editor

Dr Philip Armstrong FACA

### Co-editor

Dr Matthew Bambling  
PhD

### Technology adviser

Dr Angela Lewis  
MACA PhD

Cover: Fiona James

### Editorial advisory group

Dr Nadine Pelling PhD  
Dr Ann Moir-Bussy PhD  
Dr Philip Armstrong  
FACA

### Production design coretext.com.au

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**The Editor**  
**Australian Counselling Association**  
PO Box 88  
GRANGE QLD 4051  
[aca@theaca.net.au](mailto:aca@theaca.net.au)

See page 55 for peer-reviewed article submission guidelines.



## Editorial



Rural and regional health  
**Philip Armstrong**  
Editor

It's a simple fact that Australians who live in rural and remote areas have poorer health outcomes than those who live in cities, not to mention higher rates of suicide and self-harm.

Right now, our system is failing these people. And with the pandemic driving unprecedented demand for our services, Australia's already-drowning mental health system is at breaking point.

With uncertainty about the future, the continuing development of COVID-19 strains and the increasing incidence of natural disasters, we are experiencing a perfect storm of circumstances – the true, long-term health impacts of which are impossible to predict.

With that being said, if the government doesn't enact major policy change within the next five to 10 years, we can expect to see a widening of the socioeconomic divide, coupled with a significant rise in suicide, youth violence, drug and alcohol issues and family breakdowns.

I refuse to accept a future in which the only people able to afford timely mental health services are the affluent. ACA launched a national rural and regional health report to complement the *Counsellors Care* campaign ([counsellorscare.com.au](http://counsellorscare.com.au)), which we cover on page 12 to shed light on this important topic.

Also in this edition, part two of our focus on defining and driving the counselling profession,

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I refuse to accept a future in which the only people able to afford timely mental health services are the affluent.

---

we meet many other researchers and health professionals who are committed to trailblazing work to ensure reform happens.

We meet executive director of Black Dog Institute Professor Sam Harvey, who leads research and on-the-ground programs to understand, treat and prevent mental illness.

We also talk to keynote speakers Dr Nicole Hill, Joe Ball and Dr Laura Shannonhouse from the recent International Association for Suicide Prevention summit ([iasp.info](http://iasp.info)), who are similarly pushing for better healthcare models to support other priority populations in need – young people, the LGBTIQ+ community and older, isolated people.

I am overwhelmed with the passion and pride in our counselling and psychotherapy community to boost understanding of their own profession – we are a legitimate part of allied health services.

Enjoy the issue. ■



### Be published

Share your research and articles to the editor of *Counselling Australia* via email to [editor@theaca.net.au](mailto:editor@theaca.net.au). See the inside back cover of *CA* for the submission guidelines.



## UPCOMING EVENTS 2022

### NAIDOC Week

3–10 July

NAIDOC Week seeks to bring more recognition to the history, culture and achievements of Aboriginal and Torres Strait Islander peoples. NAIDOC Week is an opportunity for all Australians to learn about First Nations cultures and histories and participate in celebrations of the oldest, continuous living cultures on Earth.

### Jeans for Genes Day

6 August

There are daily challenges faced by those living with a genetic disorder. Jeans for Genes Day raises money to fund projects to make a tangible difference to the lives of those affected. Visit [cmrijeansforgenes.org.au](http://cmrijeansforgenes.org.au) for more information.

### Wear it Purple Day

26 August

Wear It Purple is a youth-led volunteer organisation that strives to foster supportive, safe, empowering and inclusive environments for rainbow young people. Celebrate Wear It Purple Day on 26 August, so that “everybody has the right to be proud of who they are”. Visit [wearitpurple.org](http://wearitpurple.org) for more information.

### Daffodil Day

28 August

50 per cent of all Australians will be diagnosed with some form of cancer in their lifetime. Daffodil Day is a fundraising event run by Cancer Council Australia, and it is the biggest fundraising event on the Cancer Council’s calendar. For more information, please visit [daffodilday.com.au](http://daffodilday.com.au).

### R U OK? Day

8 September

R U OK? Day is the national day of action dedicated to reminding everyone that every day is the day to ask, “Are you OK?” and support those struggling with life’s ups and downs. For more information about R U OK? Day please visit [www.ruok.org.au](http://www.ruok.org.au). For educational resources go to [ruok.org.au/education](http://ruok.org.au/education).

### World Suicide Prevention Day

10 September

World Suicide Prevention Day is observed on 10 September each year to promote worldwide action to prevent suicides. The International Association for Suicide Prevention (IASP) and World Health Organization (WHO) play a key role in promoting this event. For more information, please visit [iasp.info/wspd](http://iasp.info/wspd).

### World First Aid Day

10 September

Since 2000, World First Aid Day has been organised by the Red Cross and Red Crescent societies. Together, the societies raise public awareness of how first aid can save lives. For more information, please visit [twinkl.com.au/event/world-first-aid-day-2022](http://twinkl.com.au/event/world-first-aid-day-2022).

### World Heart Day

29 September

Help raise awareness for cardiovascular disease on 29 September. Visit [world-heart-federation.org](http://world-heart-federation.org) for more.

# Technology Update: Telehealth



Photo: Pexels

## Focus on CoviU, trusted by over 90,000 practitioners in Australia

Telehealth has been thrust into the mainstream since the COVID-19 pandemic limited physical access for many essential healthcare services. This created much-needed change in telehealth services – now with more people, from any location, having timely access to a broader number of healthcare services.

We asked CoviU, the platform that has conducted over seven million consultations, to share tips for choosing a telehealth video platform.

### Bespoke telehealth software

CoviU is one of the most widely used telehealth solutions in Australia, with over 90,000 practitioners using the software – but there are many other options for health providers. General video platforms like Teams and Zoom offer reliable and easy-to-use video solutions, and bespoke telehealth

solutions such as Cliniko are tailored to suit health professionals. We asked CoviU to compare its product to these (see page 7).

### Information for health providers about telehealth

- ▶ Telehealth guidance for allied health professionals – Allied Health Professions Australia ([ahpa.com.au/wp-content/uploads/2020/06/AHPA-Telehealth-Guide\\_Allied-Health-Professionals-May-2020.pdf](http://ahpa.com.au/wp-content/uploads/2020/06/AHPA-Telehealth-Guide_Allied-Health-Professionals-May-2020.pdf))
- ▶ Checklist for telehealth services – Australian Government ([mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/F47F4FC1848FAEC2CA25855D008395C9/\\$File/Factsheet-privacy-checklist-for-telehealth-services-20200804.pdf](http://mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/F47F4FC1848FAEC2CA25855D008395C9/$File/Factsheet-privacy-checklist-for-telehealth-services-20200804.pdf))
- ▶ Telehealth – Australian Digital Health Agency ([digitalhealth.gov.au/initiatives-and-programs/telehealth](http://digitalhealth.gov.au/initiatives-and-programs/telehealth))

*This is not a paid review.*

### Questions to ask when choosing a telehealth video platform:

1. What function do I need this for now and in the future? Thinking about your goals in each subsequent step is important.
2. Can I afford it now and into the future? What pricing options are provided?
3. Can I try before I commit? Does the platform offer free trials?
4. Does it meet Australian relevant laws and legislations? Check privacy and information security requirements at the Office of the Australian Information Commissioner.
5. Where is the data stored?
6. Does it have the features and tools you need to conduct consultations?
7. Does it work on the devices you use?
8. Is the system regularly enhanced?
9. Is there adequate support? Are users kept well informed about changes or issues?
10. What is the uptime and availability like of the system? How fast is the system to use?
11. What is the usability like? Is it easy to use without training?

### The story of CoviU

The CSIRO (Commonwealth Scientific and Industrial Research Organisation) and technologist Dr Silvia Pfeiffer's research into telehealth delivery platforms led to the creation of CoviU – a platform designed around healthcare professionals' needs and to meet Australian security and privacy requirements. The platform integrates video with everyday tasks, clinical tools and functions like making appointments, obtaining patient consent, performing assessments and making payments. Learn more about CoviU at [coviU.com](http://coviU.com).

**Table 1: Comparing the Coviu platform**

|                 |                                                  | Coviu     | Google Meet                     | Zoom                             | Microsoft Teams                  |
|-----------------|--------------------------------------------------|-----------|---------------------------------|----------------------------------|----------------------------------|
| <b>Security</b> | HIPAA compliance                                 | ✓         | ✓                               | ✓                                | ✓                                |
|                 | Security/privacy end-to-end Encryption (E2EE)    | ✓         | ✗                               | Yes, but limits certain features | Yes, but limits certain features |
|                 | Purpose-built for clinical use                   | ✓         | ✗                               | ✗                                | ✗                                |
| <b>Features</b> | Browser based – no download required             | ✓         | ✓                               | Limited features                 | ✓                                |
|                 | Consultation minutes                             | Unlimited | Capped at 60 mins* on free plan | Capped at 40 mins* on free plan  | Capped at 60 mins* on free plan  |
|                 | Clinical in-call tools                           | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Interactive whiteboard                           | ✓         | ✓                               | ✓                                | ✗                                |
|                 | Patient waiting area                             | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Online appointment bookings                      | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Custom forms and post-session surveys            | ✓         | ✗                               | Some                             | ✗                                |
|                 | PMS integrations                                 | Some      | ✗                               | Some                             | ✗                                |
|                 | Pre-call and in-call payments                    | ✓         | ✗                               | ✗                                | ✗                                |
| <b>Support</b>  | On demand phone and online support               | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Live training sessions and guided implementation | ✓         | ✗                               | By request                       | ✗                                |
| <b>Platform</b> | Advanced reporting                               | ✓         | ✗                               | ✓                                | ✓                                |
|                 | Manage multiple clinics/locations                | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Fully white labeled                              | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Host on your own domain                          | ✓         | ✗                               | ✗                                | ✗                                |
|                 | Single Sign On (SSO)                             | ✓         | ✓                               | ✓                                | ✓                                |

Source: Coviu @ 2021

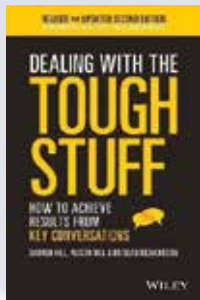
**Table 2: Competitors to Coviu**

| Company             | Origin | Website                    | Competitive Features                                                                                                                                              |
|---------------------|--------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| HiDoq               | AU     | hidoq.com.au               | ■ Pay-as-you-go pricing (per consult) ■ 100 per cent money-back guarantee                                                                                         |
| Zoom for Healthcare | US     | zoom.us/pricing/healthcare | ■ 100+ end points ■ Virtual backgrounds                                                                                                                           |
| Doxy.me             | US     | doxy.me/en                 | ■ Currency exchange with payment ■ 12 end points ■ Dedicated landing page, analytics for your organisation                                                        |
| Pexip Health        | US     | pexip.com                  | ■ 100+ end points ■ Dial out to third parties for second opinion support ■ 30-day trial                                                                           |
| Welio               | AU     | welio.com                  | ■ 10 per cent of profits are dedicated to advocating for GPs ■ Text message consultations ■ No fees to some clinicians 'your time, your patients, your fee'       |
| Neo Rehab           | AU     | neorehab.com               | ■ Pay per hour and monthly subscriptions options ■ Distance and angle measuring                                                                                   |
| GP Consults         | AU     | gpconsults.com.au          | ■ Pricing per individual clinician, and bundle/monthly options ■ Soon: 'Cub Care' – online healthcare for children (after hours, specialist doctors for children) |
| Doximity            | US     | doximity.com               | ■ Free service offering to some health professionals ■ Text messaging and customisable caller ID                                                                  |
| Cliniko             | AU     | cliniko.com                | ■ Customisable health records and treatment notes ■ Split-bill payment, bundle and monthly options ■ Track product stock levels ■ Cliniko community forum         |

Source: Coviu @ 2021

Photo: Unsplash

## Book review



**Dealing with the tough stuff: how to achieve results from key conversations? (2nd edition)**

By Darren Hill, Alison Hill and Sean Richardson

Reviewed by Catherine Dodemont

As you read this, you may be in the middle of a 'tough stuff' conversation or just come out of a series of urgent meetings that have left your head spinning, causing you stress, anxiety and anger and left you wondering, 'what just happened? Where do I start to address problems that are fast becoming migraines?' If you have answered with a resounding YES, then this book is a valuable resource for you.

Most of us engage daily in conversations in our workplaces with colleagues, higher management, supervisors and teams. At various times our conversations challenge us to deal with salient issues the authors call 'the tough stuff.'

Strong personalities, conflicts of opinions, values, beliefs, attitudes, behaviours and emotions all come to the table when key conversations are beckoning. This book will help to critically reflect upon our own tough stuff before tackling the workplace woes – specifically, our own language styles, body language, our values, belief systems, behaviours and triggers to others that we share space with every day.

The key themes are well defined and designed to aid in educating and clarifying how to respond to others constructively. Some of these themes include:

- the tough stuff, which provides the foundational skills aimed at assisting in identifying the difficult moments;
- the fluff stuff, which addresses clarity in language;
- the unsaid stuff, which ensures maximum leverage from non-verbals;
- the gruff stuff, which addresses anger and high emotions;

- the huff stuff, which assists with resistance, stubbornness and defensiveness;
- the rough stuff, when restructures, redundancies and dismissals are looming; and
- the enough stuff, which addresses prioritising the important issues towards promoting resilience in self and others.

Empathy, compassion and self-care are topics that are addressed to build confidence and resilience. The authors have included recent research references and case studies that help unpack tough thoughts, feelings, emotions and behaviours in many different workplace settings. The case studies are ones I am sure we can relate to assisting the critical reflect process of why we may become stuck,

defensive or avoid what needs to be addressed.

I believe *Dealing with the tough stuff* is a valuable resource not only for counsellors employed in allied health settings and private practice, but also for providing empowering skills for the tough conversations that may need to be addressed in our families and social circles.

**Publishing details**

Hill, D., Hill, A., Richardson, S. (2016). *Dealing with the tough stuff: how to achieve results from key conversations (2nd edition)*. John Wiley & Sons Australia, Australia

**About the reviewer**

Catherine Dodemont  
M.Couns, B.Soc.Sci.  
Past. Couns. (ACU) ACA  
Hon. Level 4 Member  
Clinical Counsellor ACA  
Accredited Supervisor



# TRAITS OF COUNSELLORS AND PSYCHOTHERAPISTS

Lifelong learner

**Person-centred**

**SKILLED IN MODELS OF COUNSELLING**

**COMPASSIONATE**

**Helper**

**Patient DEDICATED TO HELPING**



**Active listener**

Builds rapport first

Encouraging

Observant



**OPEN-MINDED**

**EMPATHETIC**

Curious

Understands confidentiality and professional boundaries

**Can develop a non-judgemental approach**

Cares about the warmth of environment

**CRITICAL THINKER**

**Best interests of counsellee in mind**

Humility

**Resilient. Respectful. Relaxed**

**ADAPTIVE COMMUNICATION STYLE**



Counsellors help you describe what's going on for you, helping you to figure out some options to deal with your issues. So what are the qualities of a counsellor?

The registered counsellor supports consumers with behavioural change through psychological interventions (*ACA Scope of Practice, 2nd edition 2021*)

# THE CUP THEORY: A VISUAL TOOL FOR TEENS

By **Liz Muganda**

The busy nature of human life means that we, as individuals – whether old or young – face challenges every day. The important thing is not how quickly we get past the challenges, but how we manage them.

In this article, I will discuss the cup analogy, which is a visual way of understanding pain or trauma in human bodies and minds when they are under stress. It also looks at how healing is beneficial, and the process involved. This can be called the ‘emotional cup’.

The article will focus on teenagers presenting with a ‘full cup’ of negativity, frustrations or stressors and how to encourage them to identify what is in the ‘cup’, to what level, and when to empty the cup.

It is evident that gen Z and gen Alpha have more negativity, frustrations or stressors in their cups than expected. I see this every day in my role as a school wellbeing officer working with teenagers in one-on-one and group sessions. In families and communities, there are assumptions that the early generations – baby boomers, gen Jones, gen X, gen Xennials and the millennials – have high levels of resilience, a topic that has been often debated.



Gen Z and Alpha have some similarities between them, the most common and understandable being that both generations are advanced in technology – as most parents would say, ‘the digital generation’. Accordingly, their social-emotional level of tolerance is low and they will need more support from parents, teachers and community at large.

Lately, teenagers have been presenting to me with their emotional cup nearly full with at least one of the following: anxiety, anger, the death of a loved one, fear of the unknown, lack of sleep and proper eating habits, the negativity of social media, and general frustrations. It could also be filling up with stress, depression, shame, rejection, lack of sense of belonging and self-identity, resentment and guilt. As the cup is reaching its capacity, there could also be some

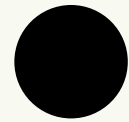
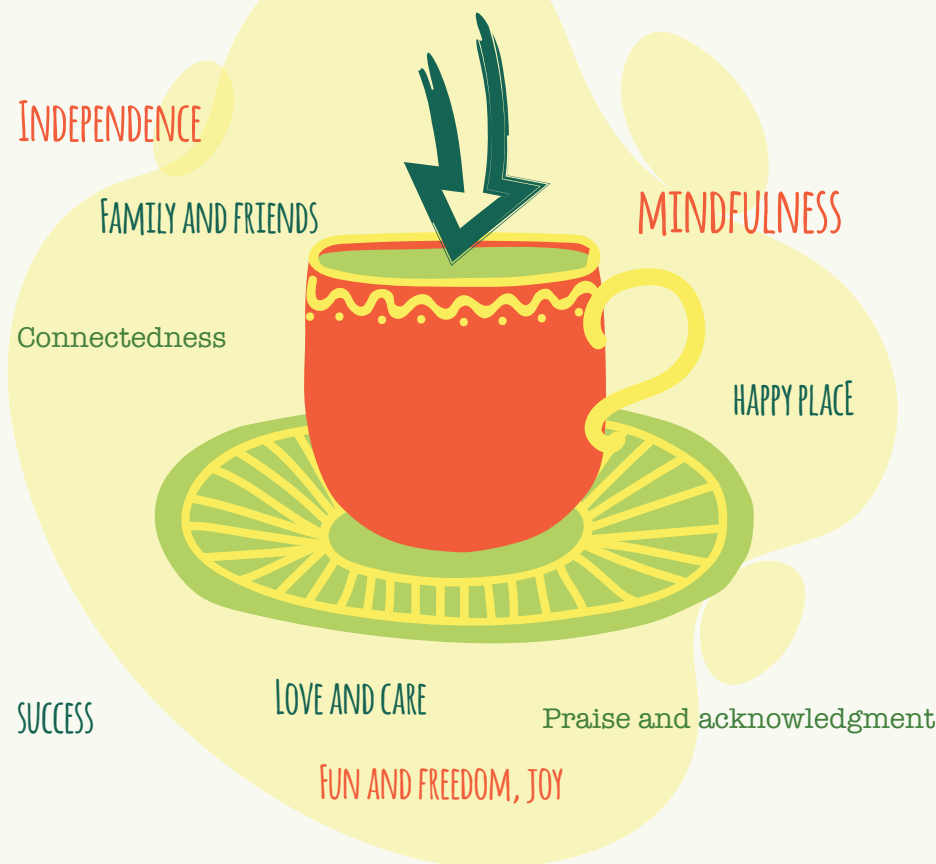
trauma, chronic illness or pain, an ill family member or loss and grief, and it starts to overflow.

These negative emotions will affect young people’s wellbeing and health, which further affects their academic life, their family relationships and their ability to maintain positive friendships, and incurs feelings of isolation.

As a result, the cup analogy gives me the opportunity to discuss with young people other ways of refilling their cups with positive and healthy emotions before they hit a rough patch. They will then be able to do some self-reflection in a time and space that is safe for them and to list what makes them feel worthy.

Amy Morin’s book, *13 things strong kids do: think big, feel good, act brave*, encourages teenagers to be stronger and minimise feeling sorry for themselves – especially

## FILLING YOUR CUP



About the author

Liz Muganda  
Liz Muganda previously worked with the Victorian Department of Justice and Community Safety (young offenders) for 14 years, and she is currently working with the Department of Education. She is an ACA member Level 4. Liz holds a postgraduate degree in counselling, child and maternal health, and a master's degree in social change and development. She has also attained a bachelor's degree in youth studies.

in a world that is unpredictable and, at times, scary. Teenagers are approaching adulthood and still in the process of developing maturity, which affects their ability to navigate their world and everything around them. This pressure has only increased during the COVID-19 pandemic, where computer screens became blackboards, kitchen benches became classrooms, backyards became playgrounds and, on rainy days, lounge rooms became indoor play centres.

Another part of using the cup theory is to encourage teenagers to be in tune with their emotions and how they feel in a single moment. Being able to identify and address those feelings will help young people to learn to empty their cups of negativity and practice filling them with positive,

healthy emotions. These emotions include experiencing care and love, connectedness to friends and family, success, praise and acknowledgment. It also helps them to find happiness and have fun, feel freedom and independence, and enjoy mindfulness.

Technology's advancement has changed the world rapidly and significantly, and young people need to unplug and prioritise self-care. Using the cup theory has assisted me to encourage young people to identify their happy place and how to get there by implementing wellbeing plans. ■

**More information**

▶ *13 things strong kids do: think big, feel good, act brave* by Amy Morin, [www.amazon.com.au/13-Things-Strong-Kids-Do/dp/0063008483](http://www.amazon.com.au/13-Things-Strong-Kids-Do/dp/0063008483)

**Generations**

- Baby Boomers**  
born 1946 to 1964
- Gen Jones**  
born 1954 to 1964
- Gen X**  
born 1965 to 1980
- Gen Xennials**  
born 1977 to 1985
- Millennials**  
born 1981 to 1996
- Gen Z**  
born 1997 to 2010
- Gen Alpha**  
born 2011 to undefined

*\*Date ranges are approximate and vary depending on the source*

# Australia's hidden health crisis

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*The National Regional Check In*  
**A report by the Australian Counselling Association**

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## A message from our CEO

Every Australian deserves access to mental health care - but sadly, that's not the reality for everyone. It's a simple fact that Australians who live in rural and remote areas have poorer health outcomes than those who live in cities, not to mention higher rates of suicide and self-harm.

Right now our system is failing these people. And with the pandemic driving unprecedented demand for our services, Australia's already drowning mental health system is at breaking point.

With uncertainty about the future, the continuing development of COVID-19 strains, and the increasing incidence of natural disasters, we are experiencing a perfect storm of circumstances, the true, long-term health impacts of which are impossible to predict.

With that being said, if the government doesn't enact major policy change within the next five to 10 years, we can expect to see a widening of the socio-economic divide, coupled with a significant rise in suicide, youth violence, drug and alcohol issues and family breakdowns.

At the ACA, we refuse to accept a future in which the only people able to afford timely mental health services are the affluent. The time for reform is now.

Australia is in the midst of a mental health crisis. Over the past decade, Medicare-funded mental health services have nearly doubled. Even prior to the pandemic, 65 per cent of GP visits were connected to psychological issues. Now, as evidence of the longer-term mental health effects of COVID-19 starts to emerge, this figure is expected to grow.<sup>1</sup>

The challenge for mental health providers is how to cope with this surge in demand and ensure that support is provided when and where it is most urgently needed. While this is very much a nationwide issue, in rural and regional areas - where mental health services are most lacking - the system is almost at breaking point.

So what does this mean in real terms for everyday Australians? And what options are available to help alleviate the pressure? This report seeks to understand the context and environmental factors contributing to Australia's mental health crisis, examine the broader implications and put forward potential solutions.



## Key issues fuelling our mental health emergency

### Excessive wait times for those most at risk

Since the advent of COVID-19, demand for mental health services has spiked – most noticeably in states that experienced long periods of lockdowns. Consequently, waiting lists to see mental health providers are now in excess of six weeks in many parts of Australia, with demand so high that many psychologists are unable to take on any new patients.

For the one in three Australians who live in rural and remote areas, however, the situation is even

more pronounced. Despite the fact that suicide and self-harm rates increase the farther from cities you go, the overwhelming majority of psychiatrists and psychologists are employed in urban areas.<sup>2</sup> As a result, access to these mental health professionals outside of cities is significantly reduced – therefore exacerbating the demand for their services.

This lack of Medicare-funded mental health providers in rural and regional areas is having a direct impact on patients’ ability to get the support they need, when they need it. According to the *National Regional Check In*, a report commissioned by ACA,

68 per cent of those living in rural and regional Australia experienced depression and anxiety over the past two years. The same study also found that 26 per cent of patients living in non-metro areas had to wait four to six weeks to see a psychologist or psychiatrist, while 14 per cent waited seven weeks or more to access mental health support.

Not surprisingly then, many regional Australians said they felt unsupported during their mental health challenges, identifying ‘feeling completely alone and isolated’ as a key trigger for their mental health challenges.

“Twenty-six per cent of patients living in non-metro areas had to wait four to six weeks to see a psychologist or psychiatrist, while 14 per cent waited seven weeks or more to access mental health support.”

### Seven factors fuelling mental health decline in regional Australia



Financial stress



Lack of support



Pandemic burnout



Regional isolation



Fear of COVID-19

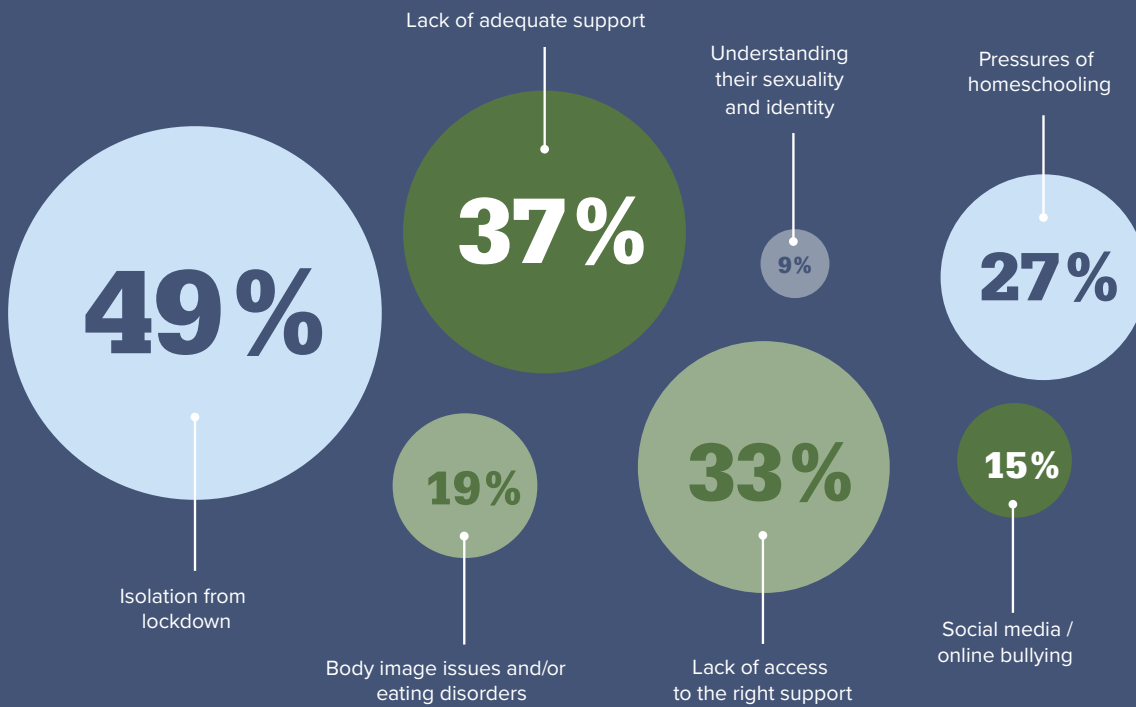


Losing loved ones



Stress of lockdowns

Factors contributing to children’s mental health challenges\*



\*percentage responses from questionnaire participants, several factors per respondent

**The pandemic ripple effect on children and families**

Of course, it’s not just adults who are experiencing mental health issues as a result of the pandemic. One in six Australians living in regional, rural or remote areas said their children have also suffered, citing the isolation enforced by lockdowns and the pressures of homeschooling as some the biggest contributors to their children’s deteriorating mental health.

Even children suffering from perennial concerns like body image issues, online bullying and understanding their sexuality have been indirectly affected by the pandemic; a third of parents found it difficult to access adequate or appropriate mental health support for their children due to the increased demand on already limited regional services.

For many parents, supporting their children through these challenges with little to no professional assistance has taken its toll on their own mental wellbeing. More than half of parents went through a period of depression or anxiety themselves; for one in five this was a new experience. Of those surveyed, close to half admitted to feeling lost and hopeless as a result, while 13 per cent attributed the subsequent breakdown of their family unit or relationship to the pressures of trying to cope.

**COVID-fuelled pressures in the workplace**

For working Australians – and those with young families in particular – learning how to juggle work and home responsibilities has been one of the greatest challenges of the pandemic.

Homeschooling, remote working and a lack of job security created a perfect storm in which mental health issues could take hold.

According to the *National Regional Check In*, workplace-related anxiety and stress affected over a third of Australians nationwide. The same percentage of those working in regional Australia had similar experiences, with one in five seeking professional support to help them manage their rising stress levels.

Despite Australia’s economy having grown considerably over the last few decades, few rural and regional Australians have benefited from this increased prosperity. Even pre-pandemic, Australia’s two-speed economy has seen regional Australians already experience much higher levels of job insecurity in comparison to metropolitan workers.<sup>3</sup>

“Now, being able to find and keep a job is even more difficult for regional Australians, 24 per cent of whom cited declining job security as one of the key concerns impacting their mental health.”

Now, being able to find and keep a job is even more difficult for regional Australians, 24 per cent of whom cited declining job security as one of the key concerns impacting their mental health. And for more than one in ten regional Australians, the fear of losing their job during the pandemic became a reality.

Meanwhile, many Australians struggled to adjust to new ways of working enforced by the pandemic. From working remotely to conducting their working lives behind masks and screens, close to a third of regional Australians said these necessary changes to how they did their job or delivered services triggered a decline in their mental health. Those working on the frontlines of the pandemic were particularly at risk for mental

health issues, with 20 per cent of essential workers from regional or rural areas acknowledging the negative psychological impacts of being exposed daily to the risks of contracting COVID-19.

### **The mental toll of natural disasters**

From record-breaking floods in Queensland and New South Wales to devastating bushfires in Victoria and Western Australia, the pressure natural disasters place on our mental health services should not be underestimated.

In the wake of environmental catastrophes like these, it's common to see increases in people suffering from depression, anxiety and post-traumatic stress disorder. And it's not just those

directly affected by disasters who are dealing with their fallout. Many emergency and recovery workers, as well as the families of those affected and the communities around them, seek the support of mental health professionals to help them process what can be a highly traumatising experience.

In 2022, many communities only just beginning to recover from the financial and emotional impacts of COVID-19 were hit by yet another emotionally harrowing event, placing an already stretched system under even greater pressure. And with extreme weather events expected to become increasingly common, it is crucial that Australia's mental health services are equipped to deal with inevitable spikes in demand.

Photo: Pexels/Andrew Neel





## A GP's perspective

Growing up in rural and regional Australia, I experienced firsthand the lack of access to healthcare services – and the adverse health outcomes that occur as a direct result. It's one of the reasons I'm such a passionate advocate for equitable access to quality healthcare for every Australian, irrespective of their postcode.

I see the GP as having a fundamental role in helping address the current mental health crisis. GPs are the first point of call when it comes to all areas of health, particularly mental health. They usually have an existing relationship with patients and they will often recognise the signs of mental illness before the patient does. It is up to the GP to ask the right questions, facilitate the discussion around mental health and, above all, provide a safe space where a patient feels comfortable enough to be vulnerable and discuss their mental health.

Importantly, the GP is also the facilitator in linking patients with mental health services. As such, they are well aware of the lack of access to appropriate support. One of the key findings from the National Regional Check In that stood out to me was the percentage of GP presentations focusing on mental health – these findings are certainly inline with, or perhaps even less than what I see on a day-to-day basis.



Dr Michela Sorensen

Photo: Supplied

Since COVID-19 hit, I have seen an exponential increase in the number of people presenting with mental health concerns. This trend spans all age groups, from children right through to the elderly. The triggers vary, but most frequently they have been health, anxiety, social isolation, financial stress and also relationship stress.

The current mental health crisis is a very complex issue and there is no one, simple solution. This is however, one cog in the wheel that has the potential to be hugely beneficial. As the research shows, there are over 4000 registered counsellors currently available to provide mental health care. Making their services available under the Medicare Benefits Schedule (MBS) is one way to increase access to mental health care, particularly in rural and regional Australia.

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One of the key findings from the *National Regional Check In* that stood out to me was the percentage of GP presentations focusing on mental health – these findings are certainly inline with, or perhaps even less than what I see on a day-to-day basis.

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## A simple solution to a complex problem

The recent 2022 budget pledged more than A\$600 million in new funding for mental health over the next five years – but while a step in the right direction, it does not go nearly far enough. None of the measures put forward address the most urgent issues facing the mental health sector today: the shortage in the number of workers available to provide immediate support; and excessive wait times for those seeking help.

### Unlocking a qualified workforce

One potential and swift solution to the staffing issue involves making better use of the thousands of registered counsellors and psychotherapists employed right across Australia – including regional and rural areas. Registered counsellors and psychotherapists are a qualified, highly trained sector of the mental health workforce, but are currently under-utilised as their services are not funded under the Medicare Benefits Schedule (MBS). This makes them financially unviable for many of those seeking mental health support.

The outcomes of redressing this oversight are likely to be considerable. Reports show that allied health professionals such as psychologists providing MBS

items for Focused Psychological Strategies spend approximately 60 per cent of their time delivering counselling services, compared to just 30 per cent delivering mental health interventions.<sup>4</sup>

As counselling specialists, registered counsellors and psychotherapists could significantly reduce this burden, freeing up psychologists to focus on more advanced cases and lowering wait times across the board. What's more, this is a workforce that can be accessed immediately: right now, there are at least 4000 registered counsellors who meet the current criteria for the MBS, while a further 1000 could be eligible to register within six months.

### Economic benefits of Medicare-funded counsellors

From a financial perspective, including registered counsellors and psychotherapists within the MBS has the potential to benefit both patients and the wider economy.

Despite the fact that the MBS was created to facilitate bulk billing, figures show that less than 30 per cent of service providers bulk bill. By contrast, an overwhelming majority of ACA members have said they would welcome the ability to bulk bill their services. As such, funding registered counsellors in this way would not only significantly improve access for those in lower

socioeconomic areas but also make it financially within reach.

There's also a broader economic argument for these services to be Medicare listed. Mental health and suicide has been estimated to cost the Australian economy A\$220 billion annually – an amount that could be substantially reduced with improved access to support and earlier intervention from mental health professionals. Compare that to the A\$224 million it would cost to annually fund 3000 Registered Counsellors operating at full capacity and the financial benefit is clear.<sup>5</sup>

Added to this is the positive impact such a move would have on the per capita service cost for government and on out-of-pocket costs for consumers accessing services under the Better Access Initiative (BAI).

## Safeguarding Australian's Mental Health

While there are multiple external factors contributing to Australia's current mental health crisis, many of which are outside of our control, right now there is an opportunity to alleviate and potentially even reverse the declining mental health of our nation.

It is the strong recommendation of the ACA that registered

counsellors and psychotherapists are added to the list of allied health professions in the Health Insurance (Allied Health Services) Determination 2014, which provide Focused Psychological Strategies under the MBS BAI.

Including registered counsellors into the BAI will significantly increase access to bulk billing services, especially for our nation's most vulnerable. In the absence of a viable solution from the government, it presents an appropriate, cost-effective and immediate solution that would ultimately help save lives. ■

**References**

Research for the *National Regional Check In* was conducted by Pure Profile on behalf of the Australian Counselling Association between February 22, and March 2, 2022. The research surveyed 2009 Australians aged 18+ with an equal representation of those living in metro and non-metro (rural, regional and remote) areas.

1. Department of Health
2. AIHW (2022). Mental health services in Australia, COVID-19 impact on mental health -Australian Institute of Health and Welfare (aihw.gov.au)

3. *Regional inequality in Australia and the Future of Work* aph.gov.au/DocumentStore.ashx?id=91f653a3-992e-4e82-a8cf-e910b091b7c1&subId=564100

4. National Health Workforce Dataset, 2016

5. *National Productivity Commission 2020 Report*

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# Suicide prevention insights for those most at risk

The 2022 International Association for Suicide Prevention 10th Asia Pacific conference, held recently in Queensland, brought together eminent health professionals to share insights and expertise and advance work in this critical field. **By Melissa Marino**

The positive impact of meaningful connection established through targeted intervention, conversation and cultural awareness was highlighted at the 2022 International Association for Suicide Prevention 10th Asia Pacific (IASP) conference, which was held from 3 to 5 May.

In the conference keynote address, it was stated that young people, older citizens experiencing isolation, LGBTIQ+ people and Indigenous Australians were identified as 'priority populations' and among those most at risk of suicide.

But if meaningful connection and targeted strategies could be established by health professionals and through the broader community, outcomes could be improved.

## YOUNG PEOPLE

Suicide is the leading cause of death in Australians under the age of 24 years. Yet despite significant public health investment, the number of suicides in young Australians has not significantly declined.

Keynote speaker Dr Nicole Hill, a youth suicide prevention researcher at Telethon Kids Institute, University of Western Australia, said suicide prevention approaches should be targeted to the needs of young people who are particularly vulnerable to a range of suicide-related phenomena, such as self-harm and suicide clusters.

To help identify those needs she examined more than 3500 suicidal deaths based on 10 years of National Coronial Information System records that take in police, autopsy, coroner and toxicology reports.

This has provided new data-rich insight into who is at risk, and opportunities for prevention – especially for those exposed to the suicide of another.

### Strengthening the health system

Dr Hill found that nearly 40 per cent of young people who died by suicide had communicated their intent to die to someone in their life.

This highlighted the need to equip people in the community to respond effectively, take disclosures seriously, avoid stigmatisation and encourage health-seeking behaviour.

“We also have to make sure services are in place so when people respond, young people actually have a place to go,” she said.

Dr Hill found one-third of young people who died by suicide in Australia had a known history of suicide attempt. More than 40 per cent had a formal diagnosis of mental illness – the majority depression, followed by anxiety and psychotic disorder.

Importantly, she said, 81 per cent of those who had a diagnosis had sought treatment. About one-third had received medication and therapy, 12 per cent therapy alone, but more than half had received medication only.

This suggests the system was failing young people who were being prescribed medication in the first instance as a bridging measure while on waiting lists for psychological services.

“It raises the question of whether we need to be putting peer-support programs or others in place so young people have access to psychological and psychosocial support in addition to medication,” she said.

Specific training in suicide prevention for GPs and other primary points of contact is also an “important next step”, she said.

### Broader society

Along with improvements in the health response and training, the data also pointed to other avenues for suicide prevention. That 70 per cent of young people who died by suicide were not enrolled in education at the time of their death pointed to the need to run mental health and suicide prevention training programs in schools sooner.

“We need to be thinking about suicide prevention at an earlier age, so if young people are leaving school, they have a toolkit they can

draw on for their own mental health and wellbeing,” Dr Hill said.

Findings that one in five young people had a relationship breakdown in the year they died and one-quarter a history of family conflict indicate such suicide prevention strategies should focus on problem solving and developing interpersonal skills.

In workplaces and the community, programs such as Gatekeeper training – where citizens are taught to recognise and respond to those at risk of suicide – would also help those not at school.

“From a research perspective and for stakeholder community organisations, we need to really think ‘how we can broaden our reach to these vulnerable young people outside of education’,” she said.

Strategies to address substance abuse were also an important factor in suicide prevention. Dr Hill’s analysis revealed one-third of young people who died by suicide had illicit substances in their systems, and many died with high alcohol concentrations, indicating significant cognitive impairment.

The data also revealed that one-third of young people who died by suicide came from disadvantaged backgrounds, indicating that suicide was not just a medical or mental health issue, but also a social problem influenced by a lack of services.

“We need to be holding our governments to more accountability when it comes to helping individuals living in socioeconomically disadvantaged regions to have greater access to healthcare and mental health, education and other services,” she said.



Photo: Pexels/Jennifer Polanco

### Clusters a significant risk

Dr Hill's research homed in on suicide clusters involving social links among young people to help visualise, for the first time, how suicide contagion operates. This will help identify those at risk of subsequent suicide or suicide attempt, and opportunities for prevention.

She found there was three times greater odds of suicide in those who had lost a loved one, friend or acquaintance to suicide. Importantly, she found a similar effect regarding suicide attempt among young people who had witnessed a friend self-harm.

This provided solid evidence that exposure to suicide was a significant risk factor for later suicidal behaviours. And it pointed to the need for postvention strategies to be enacted not only after suicide, but also after suicide attempt. This is because suicide attempt is a significant risk factor for later death by suicide, she said.

"So, if we are thinking of upstream strategies where we can intervene amongst young people who may be at

heightened risk further down the track, then this is a key opportunity."

By analysing social links among suicide clusters using an epidemiological technique, Dr Hill found young people aged 10 to 18 who had lost a friend were most vulnerable to suicide contagion and dying by suicide.

She also found a higher rate of concordance with subsequent suicide between young Aboriginal and Torres Strait Islander people and among those living remotely.

### Clues for postvention

Also critical in the findings was what was not found, she said. And that was that no significant association was found between those who died after a suicide exposure with a prior mental illness.

This should inform screening practices in schools that, after a suicide, through a mental health model of risk vulnerability, tended to focus on those with prior mental health conditions.

"It means we need to be broadening our conceptualisation of who might be at risk,

particularly when young people have been exposed to suicide,” she said. “In suicide prevention we need to be thinking not only about mental health but also the relationships individuals have.”

Dr Hill found there was a critical three month “window of opportunity” for schools to enact postvention strategies after a suicide. Of the young people who died in suicide clusters, 50 per cent died within 90 days of the first exposure.

Undertaking Circles of Vulnerability assessments with young people and their families to identify social connections and those at risk is important, she said. And in a social media era where those connections could traverse thousands of kilometres, postvention strategies need to adapt.

Social media itself is now fertile postvention ground, she said. In a study drawing on experience from those who had responded to suicide clusters, Dr Hill found at-risk groups could be targeted after a suicide

through online advertising features and soft help-seeking messages.

She also highlighted the need for surge funding to support the extra services required in the community should a cluster emerge.

Ultimately, a dynamic, nationally coordinated, regularly updated self-harm and suicide monitoring system needs to be built so data can drive evidence-informed decisions around suicide prevention. “It’s not a matter of doing more, it’s a matter of doing things differently and using data to inform these critical targets,” she said.

### LGBTIQA+ COMMUNITY

One critical target in suicide prevention is the LGBTIQA+ community. In his keynote address, Joe Ball, CEO of LGBTIQA+ peer-driven support organisation Switchboard Victoria, shared some startling data.

Nearly half (41.9 per cent) of all LGBTIQA+ people had made a suicide attempt or thought about a suicide attempt in the last 12 months, according to the latest La

Trobe University Private Lives study. And one in two transgender people make a suicide attempt throughout their lifetime.

But rates of suicide among young LGBTIQA+ people have not been accurately formally measured because it is not captured in official material, such as the coronial data analysed by Dr Hill. Also, accurate figures around the transgender population are not available because sexuality and gender identity were not recorded in the census.

And such non-representation at a bureaucratic level, Joe said, reflect a major part of the problem contributing to increased suicide risk.

It is well understood that high rates of suicide and suicide attempt are due to discrimination, inequity and stigma, he said. For too long LGBTIQA+ people have been officially invisible, a status that fed into a wider message from society to feel shame about who they are.

This was reflected in his own experience, when he framed the discovery of his own transgender identity as a teenager as a “gender identity crisis”.

Today, he said, he stood proudly against the shame others put on the global LGBTIQA+ community. “And we’re fighting back daily against those who wish to erase us – including through suicide,” he said.

### Cause for celebration

The LGBTIQA+ community has a rich, unique culture and long, multigenerational history. It is culture that includes chosen families, a culture of collective

## Statistics on suicide in Australia

- More than 3000 lives are lost to suicide every year
- Males make up three-quarters of suicide deaths
- An estimated 10 million Australian adults know someone who has died by suicide
- One in two young people is impacted by suicide by age 25

Every life lost to suicide is heartbreaking. It is important to remember that every statistic represents a life lost and has a cascading impact across the community.

*\*Statistics provided by Suicide Prevention Australia*





Photo: Pexels/Brett Sayles

persistence in the face of persecution, and a culture of strength represented by community-controlled organisations through events, advocacy and archiving history. “And these cultures can be part of preventing suicide,” he said.

Connection to community and seeing positive representation are known protective factors against suicide. “We know that social isolation from queer communities is a driver of LGBTIQ+ suicide,” he said. “And positive representation matters. It is the hope that people can live a life if they can see positive representation of themselves.”

Through government, a national LGBTIQ+ suicide prevention framework should be built and linked to the national framework for the prevention of family violence, he said. This is because one of the main suicide drivers for

LGBTIQ+ people is family violence and rejection. “Tragically, our community escapes family violence through suicide.”

More investment was also needed in LGBTIQ+ controlled organisations, including the expertise of people with lived experience of suicide.

In the meantime, individuals, businesses and mental health service providers can equip themselves to make a difference, he said.

While displaying rainbow flags and asking people their pronouns is appreciated by the LGBTIQ+ community, he urged delegates to go beyond this “rainbow wrapping” and make meaningful connections, for example by co-designing suicide prevention programs with community-controlled LGBTIQ+ organisations.

“The crisis is momentous. The challenge is staggering. But I

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It is well understood that high rates of suicide and suicide attempt are due to discrimination, inequity and stigma. For too long LGBTIQ+ people have been officially invisible, a status that fed into a wider message from society to feel shame about who they are.

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Photo: Pexels/Brett Sayles



have faith that we are more than what divides us and that we all have something to benefit from a world where LGBTIQ+ people are included, free from discrimination, and where our cultures can thrive.”

## OLDER PEOPLE

The importance of meaningful connection in suicide prevention, particularly for older people experiencing isolation, was highlighted in the keynote by Laura Shannonhouse, associate professor at Georgia State University.

Data collected in the US prior to the COVID-19 pandemic found about 20 per cent of older people receiving home and community-based services met a clinical risk for suicide.

But she reported that the mental health of older adults improved

during the pandemic through a ‘warm calling’ intervention – part of a study funded by the US Government’s Department of Health and Human Services.

The trial involved phone calls to participants over an eight-week period. Some callers employed a belongingness and empathy (BE) model and others also used BE WITH training. This stands for ‘belonging and empathy, with intentional targeted helping’, and is based on the international evidence-based Applied Suicide Intervention Skills Training (ASIST) program. A third control group received no treatment, rather just a clinical call each fortnight to complete survey questions.

“The overarching research question was ‘can a small dose of sincere connection improve

mental health outcomes;” said Dr Shannonhouse, who is a certified counsellor. And the answer appeared to be ‘yes’.

“We have preliminary evidence that older adults receiving dosages from volunteers trained in LivingWorks ASIST manifest significantly higher positive psychological outcomes when compared to those not receiving treatment,” she said. Specifically, they found significantly reduced depression and significantly reduced thwarted belongingness (or sense of isolation), and improved quality of life.

“Older adults talking to ASIST-trained caregivers were having their social needs met,” she said.

“And I think this goes to show that ASIST is more than a Gatekeeper training. It’s a way of interacting and

“Choosing to live or die is a tough choice, but being offered a third option at a critical moment – ‘would you agree to stay safe for now’ – is something that’s really respectful, she said. “We can’t take the choice away from people, but we can offer a third option. And it’s this little miracle that saves lives.”

fostering that human connection and getting to that deeper understanding.”

### Sincere connection

Dr Shannonhouse said even those trained in basic two-hour BE training sessions had an impact. Providing a small dose of sincere connection, BE training draws on befriending literature. It involves concepts such as reciprocity, intimacy, reliability and respect. Further BE WITH training equips callers to identify signs that somebody might be distressed or thinking about suicide.

Callers learnt how to ask directly about suicide and understand how suicide came into the older person’s life. Through that connection and understanding a third option could be introduced, Dr Shannonhouse said.

“Choosing to live or die is a tough choice, but being offered a third option at a critical moment – ‘would you agree to stay safe for now’ – is something that’s really respectful, she said. “We can’t take the choice away from people, but we can offer a third option. And it’s this little miracle that saves lives.”

Dr Shannonhouse said the research would continue to grow, building on the “hundreds of suicide interventions that have taken place”.

A number of callers had also asked to maintain contact with the older adult after their official duties had ended. “So not only did they do life assisting suicide

interventions ... they found this reciprocal connection they wanted to continue.”

ASIST training for people in the community, such as those who deliver meals to older isolated people, is one way to ensure opportunities for intervention are not missed, she said.

And the program could be used across the lifespan, including in schools, for the LGBTIQ+ community and other populations vulnerable to suicide.

Joe Ball said he and all switchboard staff were ASIST-trained. “I think it is all about having the conversations and empowering people to have them,” he said. ■

### More information

For more information and further reading about the topics discussed in this article and the IASP conference keynote, the following resources have been provided by Dr Nicole Hill:

- ▶ Nationwide study on youth suicide ([mja.com.au/journal/2021/214/3/suicide-young-australians-2006-2015-cross-sectional-analysis-national-coronial](https://mja.com.au/journal/2021/214/3/suicide-young-australians-2006-2015-cross-sectional-analysis-national-coronial))
- ▶ Risk of suicide following exposure to suicide and suicide attempt ([journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003074](https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003074))
- ▶ Suicide clusters risk factors ([thelancet.com/journals/eclinm/article/PIIS2589-5370\(20\)30375-8/fulltext](https://thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30375-8/fulltext))
- ▶ Community response to suicide clusters ([mdpi.com/1660-4601/19/8/4444/htm](https://mdpi.com/1660-4601/19/8/4444/htm))

There are various tools and training available to help others recognise the signs of someone who might be at risk of suicide.

#### ASIST program

[livingworks.com.au/programs/asist](https://livingworks.com.au/programs/asist)

#### Circles of Vulnerability assessments

[headspace.org.au/assets/School-Support/Suicide-contagion-web.pdf](https://headspace.org.au/assets/School-Support/Suicide-contagion-web.pdf)

#### BE WITH training (US)

[nbcc.org/resources/nccs/newsletter/ncc-spotlight-laura-shannonhouse](https://nbcc.org/resources/nccs/newsletter/ncc-spotlight-laura-shannonhouse)

[education.gsu.edu/2021/07/14/georgia-state-researchers-awarded-1-3-million-to-combat-suicide-among-older-adults-during-covid-19-and-beyond](https://education.gsu.edu/2021/07/14/georgia-state-researchers-awarded-1-3-million-to-combat-suicide-among-older-adults-during-covid-19-and-beyond)



## Lessons for counsellors

Counsellors are critical gatekeepers in the prevention of suicide, says Dr Nicole Hill, a leader in youth suicide prevention research in Australia.

It is, therefore, integral they and other health professionals receive suicide-specific training and operate as part of a healthcare network with families, educators, community organisations and social systems to identify risk and respond in a timely manner.

Dr Hill says her work shows that one in two young people who die by suicide had a suspected or known mental health diagnosis at their time of death. This is important for counsellors to know as it indicates there are opportunities within the health system to make a difference.

The initial response someone receives when reaching out for help can determine how likely they will be to seek future support, she says. With often weeks-long waiting lists for therapy, it is critical that adequate interim support and information is provided to keep people engaged.

“There’s a duty of care to inform young people of strategies or resources they can use to help bridge that waiting period,” she says.

Crisis helplines, such as Lifeline, “can really help during the fleeting suicidal crisis”, she says. And new peer support programs such as one being trialled by SANE Australia could be valuable.

For young people who have disclosed suicide ideation and have a specific plan, best-practice strategies such as means-restriction counselling and safety planning can be very effective. “The research shows that in the general population, safety planning can reduce the risk of suicidal behaviour by up to 50 per cent – so that’s a really important one,” she says.

Culturally informed care is also critical to ensure LGBTIQ+ young people and others who are marginalised have a safe space to go, she says. “It’s as much about addressing the mental health concerns of young people as the social and cultural contexts and stresses that they face.”

Training more counsellors would help address the issue of mental health in young people but, in the long term, changes to the system to ensure young people could access coordinated, ongoing support are required, she said.

As a keynote speaker at the International Association for Suicide Prevention conference, Dr Hill says such events are important for upskilling, exchanging ideas and learning about evidence-based best practice. On a personal level, it is also invaluable to meet others working in the “significantly underfunded” yet critical field, she says.

“The work is hard. We’re dealing with suicide, which is a very difficult topic and has a personal cost. But being able to connect with others who are dealing with the same challenges is really good for our own wellbeing as well.” ■

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# DEFINING COUNSELLING: A PRACTITIONER'S APPROACH

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In this second installment, *CA* talks to doctor-turned-counsellor Vicky Dawes about the importance of counsellors and its distinction from the medical field.

By **Larissa Dubecki**

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**A**fter seven years of working as a doctor in emergency medicine, Vicky Dawes had reached burnout. “It’s a really common phenomenon,” she says. “But it’s only recently been spoken about more openly. It’s related to the work environment – very stressful, high pressure, little room for taking a break. Then you can add to that the fact that medicine does attract these high achievers who throw themselves into their careers. The telling thing is that burnout does happen to a massive number of doctors.”

Now a clinical counsellor, Vicky can look back and see certain augurs had anticipated her shift to counselling: “While I was in medicine, I always loved seeing people who essentially needed counselling. The other doctors would say, ‘Vicky, can you go and see this person because I don’t know how to handle this’ – because they didn’t know how to handle it. It’s undervalued how important it is, often with people who are quite distressed.”

Taking the leap from emergency medicine to counselling – with a short-lived stint of psychiatrist training in between – has proven a fortuitous one for Vicky. A graduate of the University of Queensland with a Master of Counselling, she spent five years as



Vicky Dawes  
Photo: supplied



counsellor and educator for a not-for-profit doctors' health service, supporting doctors and medical students with their own mental health and wellbeing.

Now in private practice, Vicky specialises in bespoke therapy for doctors, professionals and university students. "Going from medicine, which is socially held up on a pedestal, to counselling – which in many ways isn't – has been interesting. But I absolutely love it," she says. "Giving patients the permission to be vulnerable and responding to shame with empathy is enormously powerful. I really do think that counselling proves, in

bucketloads, the importance of the therapeutic relationship."

#### **From doctor to counsellor: a cultural shift**

Vicky observes from her real-life experience that medicine and counselling are seen in vastly divergent ways, even though both are patient based.

"In my former career as a doctor, I had been taught how to efficiently take a history from a patient, examine their body for signs and symptoms, come up with a diagnosis and differentials, and start treatment – based off the best evidence available at the time," she says.

"As a medical practitioner I was often positioned as expert. Moving into counselling was a complete shift in both mindset and approach. While both roles encourage the doctor or counsellor to approach the patient or client from a position of curiosity and not knowing, in counselling I learned the immense value of deep empathic listening, of recognising the client as expert in their own lives, and of the power of walking alongside someone in their time of need rather than telling them what was 'wrong' or jumping in to 'fix it'. While 'bedside manner' is touched upon in medical training, counselling recognises

the profound importance of the therapeutic alliance underpinning whatever therapeutic approach is taken.”

Her own professional shift revealed the cultural weight applied to the hierarchies apportioned to the health industry.

Vicky says she was seen to ‘abandon’ the more culturally valued field of medicine. “It was culturally unacceptable, especially to doctors of a certain age who would say things like ‘oh, that’s a shame’ when they found out I was leaving – or to tell me they thought I was throwing it all away.

“Your identity as a doctor is so entwined in your sense of self. While colleagues were generally incredibly supportive, it did reveal to me that there is shame attached.”

Vicky remains active in a Facebook group for medics looking for an alternative route through the profession. “It has thousands of members. Almost daily there’s an anonymous post from someone reporting their experience and saying ‘I don’t know what to do’, and I’ll jump in and say I’m very happy to talk. Without fail I’ll get four or five messages from other people saying, ‘I saw your post, can I please speak to you.’ The number of people getting in touch is staggering.”

### A shared experience

In 2016, Vicky graduated from UQ with her master’s degree – where her thesis became the basis for the university’s student-based Mental Health Strategy – and she was struck by the “absolute brain shift” in moving from the medical model.

“You take information, you’re refining it, trying to come up with a

differential diagnosis, you’re very much positioned as the expert. It’s a real brain shift to realise it’s not just about the information that you’re getting, it’s not that you’re the expert, because you’re very much not, but it’s just as much the process and the immediacy of what’s happening between you. It’s such a deeply respectful, shared experience. It’s amazing and such a privilege to be able to do that with people.”

Her approach to counselling involves first gauging the individual patient’s needs, and their hopes as to what counselling will provide.

“I often ask people if they have an idea of what they’re looking for. Sometimes they’re looking for strategies, sometimes they just want to talk and other times they want to figure out why they think the way they do,” Vicky says.

“There’s the solution-focused counselling approach, but I think it’s the deep respect for walking alongside someone in the knowledge you’re not there to come up with all the answers. I’m not the expert on their life but I’m facilitating them on their path of exploration.

“When we think about the contrast with medicine, we know that doctors whose patients like them are far less likely to be sued and, if you delve into that, it’s really about people wanting a personal connection. It’s not the person who prescribing antibiotics, it’s the person who makes you feel safe and heard. That’s the power of the interpersonal therapeutic alliance.”

### The pedestal effect

Originally from the UK (she completed her medical degree at

the University of Birmingham) and then moving to Australia, Vicky has seen a notable difference in attitudes towards counselling between the two countries.

“Sadly, counselling is often undervalued in Australia – potentially due to its unregulated nature, potentially due to psychology positioning itself as expert, and potentially as Australia does not have such a rich and respected history of counselling and psychotherapy – unlike places like the UK, Europe or the US.”

One of the fractures in the way counsellors are seen stems from it being an unregulated profession.

That said, any step to raise the profile of counselling should be taken with careful consideration. She says there are both advantages and disadvantages to trying to get counsellors eligible for Medicare rebates – for instance: “I know many of my doctor clients are deeply suspicious of Australian Health Practitioner Regulation Agency–registered practitioners, due to the fear of mandatory reporting by treating practitioners.”

Nor is Vicky an advocate of counsellors moving into the area of other allied health professionals by performing diagnostic tests, for instance. “Absolutely we need to be more formalised as allied health professionals,” she says. “But while the more formalised assessment processes used by psychologists are often positioned as a strength of psychology, counselling’s strength really relies on there being nowhere to hide. We are not reliant on trying to define someone’s experience according to their responses to assessment, but rather on seeing the person as





a whole and helping the individual to explore that themselves, taking into consideration all the complex influences that make each individual who they are. We're less about labelling and reductionist thinking and [more about] seeing the messy, complex whole of a person. I don't believe counsellors do want to be performing diagnostic tests. There is a risk if you go too far down the traditional diagnostic route that it takes away the power of what counselling is all about."

The unregulated nature of counselling in Australia creates something of a grey area that can only be policed by individuals. "Legally, ethically and morally, counsellors should not be practicing beyond their area of expertise," says Vicky. "While some situations will be standardised – for example, legal requirements – others are likely to differ according to the individual counsellor's experience and training."

### A long and winding road

Vicky uses the concept of 'planned happenstance' to describe her unexpected – and entirely rewarding – journey from medicine to counselling. A term used in careers counselling, it counters the traditional narrative of a career as a linear arc, starting at A and winding up at B.

"Particularly when you're younger you think you need to know where you're going and what your goal is. But planned happenstance is the idea that there's real benefit to taking a meandering route, because not only will you gain experience along the way but also you'll wind up at a place you could never have anticipated at the outset," she says. "Me as an 18-year-old at med school in the UK could never have anticipated living in Brisbane in my 40s as a counsellor. All of my experiences have been really helpful, and I feel like I'm in the right place now." ■



**Vicky Dawes**  
Vicky is a registered counsellor with PACFA (Psychotherapy and Counselling Federation of Australia) and is part of PACFA's College of Counselling Leadership Group. Visit her website [vickydawes.com.au](http://vickydawes.com.au).

# Mental wellness in a time of crisis recovery

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Over the past 20 years in Australia, great gains have been made in public health outcomes; however, mental wellbeing is a notable exception. As the COVID-19 pandemic shines a spotlight on mental health, Black Dog Institute executive director Professor Sam Harvey shares his insights on how we can start to rectify this – and the critical role counsellors will play. By **Melissa Marino**

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**A**s the executive director of Black Dog Institute, Professor Sam Harvey leads research and on-the-ground programs to understand, treat and prevent mental illness.

On a personal level, he keeps on top of his own mental health through a few simple activities. “Spending time with my kids, going out for a walk – they are really important to me so I make sure they’re prioritised,” he says.

His advice to others seeking to maintain their own wellbeing is to recognise the specific activities that matter to them – and to take the time out to do them. “As individuals, taking action is how we can help our own mental health,” he says.

For Professor Harvey, the COVID-19 pandemic and the lockdowns that came with it provided a better balance between work and home life and more time for the activities he enjoys.

But for many others, the experience was the opposite. Homeschooling was much harder in smaller dwellings with fewer computers. And many people in the lowest-paid, least-secure jobs either lost employment or were unable to work from home.

The effect of changed working conditions under COVID-19 on people’s mental health was so significant, Black Dog Institute produced a white paper on the issue. “COVID disproportionately affected those who were least able to take another hit,” says Professor Harvey. “And it’s something we really need to keep an eye on because we know the mental health consequences of insecure work are very substantial.”

## Shadow pandemic

Increased reports of depression, anxiety and eating disorders are all symptoms of what has been coined a ‘shadow pandemic’ of mental ill-health playing out in the wake of COVID-19.

By amplifying social disadvantage, the pandemic has propelled trends that have been a



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“As individuals,  
taking action  
is how we can  
help our own  
mental health.”

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Professor Sam Harvey  
Photo: Supplied

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‘The two areas in which we’ve failed are obesity and mental health. They’re the two that are getting worse in the next generation and we don’t understand why.’

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long time building, making mental ill-health one of the dominant health problems in society today.

In Australia, mental health symptoms are now the number one cause for people consulting with their GP, Professor Harvey says. And suicide has overtaken motor vehicle accidents as the leading cause of death among young people.

Unlike other major public health issues that have trended down over time, rates of mental health symptoms, particularly among young people, are increasing year on year, he says.

“This is particularly damning because since the industrial revolution, by and large, we have handed over better health outcomes to future generations – for example in cardiovascular disease and lung health,” he says. “The two areas in which we’ve failed are obesity and mental health. They’re the two that are getting worse in the next generation, and we don’t understand why.”

As the relatively new executive director of Black Dog Institute (since November 2021) this is an issue Professor Harvey wants to understand and reverse. “It’s a huge unanswered question,” he says.

### **Golden opportunity**

What is known is that increased rates of mental ill-health have corresponded with increased awareness of the issue – with both peaking in the pandemic.

If there is any silver lining, this heightened awareness opens a

window of opportunity to address mental health meaningfully, says Professor Harvey, who is also the Institute’s chief scientist.

“As a community and at policymaker level, there’s an understanding of just what a big issue mental health is, and my key concern is that we don’t miss that opportunity with small-scale, ineffective interventions,” he says. “We have to use this moment to do things properly.”

For Professor Harvey, the right approach starts with increased funding. “We’ve underinvested in the past. And given that mental health is one of the most pressing health issues for society, an inadequate proportion of the budget at all levels of government goes towards it.”

Secondly, the funding must back evidence-based, coordinated programs and services around prevention, early intervention and treatment, he says. And COVID-19 has provided a blueprint for how science can guide such a response to a widespread, urgent public health issue.

“We mobilised the scientific community to answer the big questions and the people making decisions were guided by that science,” he says. “We need exactly that to happen with mental health. And the solution doesn’t lie just within the health settings. We have to do the right things in schools, in workplaces and in communities.”

### **Support structures**

Schools and workplaces across Australia are full of good intentions to raise awareness around mental

health, he says. But without adequate, science-backed resources to support them, they could be doing more harm than good.

“By just telling people about symptoms [of depression or anxiety] without giving them any practical skills to deal with them, without making sure there are services that can actually help, you risk at best wasting a lot of money and good intentions on something that’s not helpful,” he says. “And at worst, without offering any practical assistance, you may cause people to be more distressed than they would have been otherwise.”

Instead, he says, if programs such as those based around cognitive behavioural therapy, for example, were used in schools, initial distress could be prevented from developing into a more severe mental health problem.

To investigate the impact of adequate support structures, Black Dog Institute is embarking on research with a group of workers identified at increased risk of mental ill-health. It is screening emergency service workers to identify those who are at risk or unwell, and test whether their outcomes can be improved by having a range of health professionals, including counsellors, on hand.

“The reality is we’ve never been able to show the benefit of that support before, so this is a big step for us,” he says.

### **Coordinated workforce**

Professor Harvey says a larger, better-funded and more-coordinated mental health



Photo: Kenny Eliason/Unsplash

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“There’s a lot of promotion encouraging people to get help when they have symptoms – which is fantastic – but let’s make sure when they see a doctor or counsellor or psychiatrist, they’re not left on a 12-month waiting list.”

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workforce is critical to ensure people get assistance when they need it. “There’s a lot of promotion encouraging people to get help when they have symptoms – which is fantastic – but let’s make sure when they see a doctor or counsellor or psychiatrist, they’re not left on a 12-month waiting list,” he says.

Wait times of this length are ludicrous, he says, and ultimately Australia needs to train a bigger workforce to meet demand.

In the interim, in a lesson learnt through the rise in telehealth consultations over lockdowns, the existing workforce could be used more efficiently by blending online and face-to-face care.

Technology could also help address the fragmentation of mental health care that Professor Harvey says has become more pronounced over the past decade. If people could access their information, for example, they could share it between counsellors and other health professionals and “move more seamlessly between services to receive the support they need depending on how their symptoms are progressing”.

Counsellors, he says, will play a critical role in a better-coordinated pool of mental health professionals supporting people’s changing needs.

“We need more counsellors, but we also need them to be

properly integrated into the other parts of the health service, such as general practice,” he says. “There needs to be more of a focus funding collaborative care that brings everybody together rather than individuals operating in isolation.”

Evidence from Europe and the US shows that when you do collaborative care well, clients have improved outcomes and, overall, the costs are less. In Australia, coordination is challenging because of its mix of state and federal government and public and private sector providers. But it’s a challenge that must be tackled, he says. “Given the size of the problem, I just don’t think it’s optional anymore.”

“We now know you can see clear signs of anxiety when children are in primary school. And that’s important because it’s much easier to treat the problems when their minds are more flexible.”

**Holistic support**

Not a week goes by at Black Dog Institute without a parent or individual seeking help to navigate the system, he says. And there has also been a surge in schools and workplaces asking for advice around how to manage the distress and mental health challenges presenting in students and staff.

Leading Australia’s mental health response through schools, workplaces and communities is one of four key priorities in Black Dog Institute’s new five-year strategy. Another is developing new models of blended care to get optimal,

tailored treatment to individuals.

“We want to make sure that mental health and wellbeing is front and centre when we think about what a post-COVID recovery looks like, making sure that as we return to some form of normality, we prioritise mental health in the way we set up our workplaces, schools and clinical settings.”

In workplaces, training for managers to spot when someone may be struggling is showing a way forward. “We’ve done large, controlled studies demonstrating that this type of intervention has a return on investment of A\$10 saved

for every dollar spent on the training because of the reduction in sickness absence among workers,” he says.

The wellbeing of those working in the sector is also a focus, with the Institute researching why health professionals have elevated rates of mental health symptoms and an increased risk of suicide.

The Institute also provides a national clinical service for health professionals, as well as training programs, resources and networks to manage burnout and promote mental health and wellbeing.

Photo: Unsplash



**Prevention frontier**

In schools, Institute research is underway with primary-aged children on how to reliably identify those who may be struggling and help alter their trajectory. “We now know you can see clear signs of anxiety when children are in primary school. And that’s important because it’s much easier to treat the problems when their minds are more flexible,” Professor Harvey says. “If you leave it until they’re older, it becomes harder to shift.”

There are also promising developments in early intervention for adults, he says. Intitute research from 2021 shows that the number of stressed workers who went on to develop depression was reduced through the use of a smartphone app featuring activities to develop mental fitness and resilience.

“There’s a range of exciting opportunities around prevention that we’re now trying to demonstrate can work broadly,” he says.

Prevention is a long-term goal, but – like most public health research – a focus on the cure usually comes first.

“If we look at other areas of health like cardiovascular disease, the first wave of progress was in having effective treatments. The next wave was working out how you can prevent people becoming unwell through changing diets, increasing exercise and stopping smoking,” he says.

“We now have good treatments for mental health, so one of the next frontiers is prevention – and there’s early signs we can do that at scale.”

And while an increased attention on mental health in light of COVID-19 is welcome, there now needs to be action, he says. “I think the next year or so will really determine whether improved mental health and wellbeing is a lasting legacy of what’s happened as a result of COVID or whether it’s just another false dawn.” ■

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# HOSPITAL TO COMMUNITY: INFLUENTIAL FACTORS IN TRANSITIONING CLIENTS WITH A PSYCHOSOCIAL DISABILITY UNDER THE NDIS

By **Aldo Batalla**

## **Abstract**

In Australia, the National Disability Insurance Scheme (NDIS) provides financial support to eligible Australians who have a permanent and significant disability, including psychosocial disabilities such as schizophrenia (National Disability Insurance Scheme, 2021). This insurance scheme has helped Australians living with a psychosocial disability to access funding for supported accommodation such as group homes, as well as for support staff.

The deinstitutionalisation of patients living with a psychosocial disability into the community has increased with the access to the NDIS. However, the communication between health services and the NDIS is not always fluent and clear and needs to be considered. This paper aims to explore some of the risk and protective factors associated with the transition from hospital to the community under the NDIS. It provides a background to understand deinstitutionalisation and the NDIS, as well as the challenges of having access to this insurance scheme. Also included in this paper is a review of the literature exploring international and local research on the impact of supported accommodation for people with a psychosocial disability who are transitioned from hospital.

Furthermore, a discussion regarding the success of these transitions and the risk and protective factors involved are considered. Some of the risk factors discussed include homelessness, risk of suicide post-discharge and lack of communication between the

NDIS and health services. Thus, there are some protective factors that are identified in this paper, such as well-designed discharge planning, the importance of informal carers (for example friends and family), a positive therapeutic relationship with their support, and adequate access to housing. However, gaps in local research show a lack of knowledge about the impact of the transition to a supported accommodation. In addition, local experimental studies that explore and compare the success of different accommodation models after discharge are needed. An effective communication strategy between the NDIS and health services is recommended when a successful transition is considered.

## **BACKGROUND**

### **Deinstitutionalisation and the NDIS**

The National Disability Insurance Scheme (NDIS) was introduced in 2013 and it has been progressively rolled out across Australia from July





2016 to 2020 (Buckmaster & Clark, 2018). And it is argued to be one of the Australia's most significant social reforms (Taylor & McLeod, 2018). Hamilton et al., (2020) state that, in order to have access to the NDIS, people with severe mental illness need to obtain and submit evidence to prove their illness has a long-term impact on their ability to perform everyday activities. In addition, the NDIS uses a personalised model in order to provide funding to individuals experiencing disability including psychosocial disability (Carey et al., 2017).

Currently, the NDIS provides financial support to 4.3 million eligible Australians between the age of seven and 65 who have a permanent and significant disability including psychosocial disability, such as schizophrenia (National Disability Insurance Scheme, 2021).

According to the NDIS, psychosocial disability is defined as a disability arising from a mental health condition that could result in difficulties performing daily activities (National Disability Insurance Scheme, 2021). For instance, the latest statistics from the Australian Institute of Health and Welfare (2019) suggest that 'depressive episode' is the most common diagnosis for hospitalisation, followed by schizophrenia.

Furthermore, data provided by the National Disability Insurance Agency (NDIA) shows that, until June 2019, there was an increase in participants with psychosocial disability who have met the access requirements (National Disability Insurance Agency, 2019). In relation to a diagnosis such as schizophrenia, it has been argued

that it is characterised by long-term hospitalisation, as well as for the need of acute psychiatric care (Goncalves-Pinho et al., 2021; Wiker et al., 2019). Thus, it can be suggested that individuals living with a psychosocial disability such as schizophrenia could spend a prolonged period in hospital before being discharged to the community.

Deinstitutionalisation has taken place in Australia since the 1950s. In New South Wales, for instance, the policy of deinstitutionalisation was intensified in 1990 with a change in the NSW Mental Health Act stating that individuals have the right to receive care in the least restrictive environment (Newtown, 2001). It can be argued that the support provided by the NDIS, such as supported accommodation funding, could assist people with a psychosocial disability who have been institutionalised for a prolonged period to live in the community in a least-restrictive environment.

In relation to this, McPherson et al. (2018) suggest that, as a result of the deinstitutionalisation, there has been a significant increase in supported community-based accommodations for people with psychosocial disability such as schizophrenia. Even though the definition of supported accommodation varies internationally, in Australia, supported accommodation (including group homes) could be funded by the NDIS for eligible participants with the aim of providing support for the daily tasks and activities to help the individual live as independently as possible (National Disability Insurance Scheme, 2021).

In the case of people living with a psychosocial disability, it is important to mention that the NDIS does not replace mainstream health services and the funding provided by the NDIS focuses on the individual's functional ability (NSW Health, 2018).

In addition to this, it can be argued that the NDIS and NSW Health will need to work together in providing the support needed for a successful transition from a hospital to community setting. This collaborative process seems to have more weaknesses than strengths, which could have negative consequences for those in the health system living with a psychosocial disability. For instance, different studies suggest that there is a lack of clear distinction between what is to be provided by existing services such as NSW Health and what is to be provided by the NDIS (Bonyhady, 2014; Reppermund et al., 2018; Simpson et al., 2016; Trollor, 2014; as cited in Hamilton et al., 2020). It can be suggested that this lack of clear distinction could have an impact on the care provided for people with complex needs, especially after discharge to the community.

However, it is arguable that this is not the only factor to consider for a successful transition from a hospital to a community setting. There are also some protective factors that are important to take into account when talking about a person-centred approach in relation to the recovery of those living with a psychosocial disability.

Nevertheless, it is important to differentiate the term 'recovery use' in mental health from the medical



Photo: Pexels/Ivan Samkov

terminology associated with cure, as sometimes this term could be misunderstood (NSW Health, 2018). For instance, the term recovery use in mental health is about the individual's whole life. It does not refer only to their diagnosis and symptoms, but it focuses on someone getting back control over their life – and this may or may not include symptomatology (NSW Health, 2018). The NDIS, for instance, gives the individuals with disability more choice and control to get the support they need when and where they need it (NDIS, 2021).

However, accessing and understanding the NDIS can be, at times, confusing (Stewart et al., 2020). In addition to this, Smith-Murry et al. (2018) argued that

feedback from NDIS participants suggest that instead of feeling empowered and encouraged, the process of applying, accessing and understanding the funding package left them with a sense of confusion, anxiety and, in some cases, distress. Furthermore, Stewart et al. (2020) suggest that the scheme resources use language and terminology that could be complex for many people living with a psychosocial disability. Thus, it can be argued that people who have been institutionalised for a prolonged period will need to rely on the understanding of their formal and informal support in order to successfully access their NDIS package.

There is a lack of local research exploring the factors that need to

be considered for a successful transition from a hospital to community setting in individuals living with a psychosocial disability such as schizophrenia. Further investigation is warranted to help understand the risk factors as well as the protective factors that people living with a psychosocial disability experience when transitioning from an institutionalised setting such as a mental health ward to a community setting.

### **LITERATURE REVIEW**

A number of international studies have focused on the impact of institutionalisation on individuals living with a psychosocial disability such as schizophrenia and explore the need for an alternative

A recent Australian study conducted by Houston et al. (2020) unpacks critical points within the NDIS pathway that could have an impact in discharge of participants and at the same time explores where collaboration and adaptive strategies could be targeted to improve the processes

accommodation model, such as supported accommodation. A Danish study conducted by Uggerby et al. (2011) shows that patients diagnosed with schizophrenia who have been hospitalised for a prolonged period had a more complex and worsened outcome of the disorder. Even though this study reflects the living condition and mental health system of Denmark, which may differ from the Australian mental health system and lifestyle, it highlights the importance of deinstitutionalisation as it can be inferred from the findings that individuals diagnosed with schizophrenia who have been institutionalised tend to have a poor outcome when compared with those who are non-institutionalised. In addition, more recent Norwegian research conducted by Wiker et al. (2019) aims to investigate the clinical and demographic factors in relation to allocation to supported accommodation for people diagnosed with schizophrenia and concluded that people diagnosed with severe mental illness present the greatest need for supported accommodation.

A local evidence review conducted by Hayes et al. (2018) focuses on identifying the most effective interventions for early intervention in psychosocial disability within the NDIS. Hayes et al. (2018) identified evidence-based and recovery-oriented approaches to early intervention in psychosocial disability. Those approaches not only meet the criteria of early intervention in the NDIS, but also are relevant to the

participants, as well as considering their preferences (Hayes et al., 2018). It can be argued that even though this study does not consider the outcomes of the transition, it suggested that an early intervention will provide potential personal gains for people living with a psychosocial disability, their families and carers.

On the other hand, a study conducted by Rosenberg et al. (2019) involving one of the major NDIS service providers in the Australian Capital Territory aims to report the compatibility of funding and policy setting under the NDIS with the delivery of evidence-based, recovery-oriented psychosocial services. Using a case study, Rosenberg et al. (2019) explored NDIS funding and policy settings and take into account the practices underlying Transition to Recovery (TRec) programs. Despite highlighting the positive evaluation on the TRec program as well as providing the evidence for additional local research in this topic, it has been argued that it is essential for the NDIS to reconsider how best to promote recovery-oriented approaches in mental health (Rosenberg et al., 2019).

International and local research has shown the importance of the supported accommodation as an alternative model for people living with psychosocial disability who have been institutionalised in a mental health ward. For instance, Harvey et al., (2012) argue that supported accommodation provides additional benefits for people living with a psychosocial disability apart

from being an effective intervention for homelessness.

However, it has been argued that although supported housing appears more consistent with a recovery-oriented approach, it seems to increase the likelihood of participants feeling unsafe, lonely and isolated (Harvey et al., 2012). However, it is stated that there are significant therapeutic benefits when the supported housing is adequate, for example, the increase of choice and control as well as the opportunity for people living with psychosocial disability to create meaningful relationships in their house and in the community (Harvey et al., 2012). Those findings are consistent with Sylvestre et al. (2007), who argue the importance of creating meaningful relationships and increasing community participation in order to decrease symptomatology, increase wellbeing and quality of life and, therefore, a decrease in service use. For instance, in relation to the decrease in symptomatology, a study conducted by Chu et al. (2020) involving patients diagnosed with schizophrenia, who have been institutionalised for 15 years in a mental health institution in Shanghai, concluded that those patients tend to exhibit more severe negative symptoms such as amotivation and anhedonia than those patients living with support in the community. Even though this study was conducted internationally within a culture and health system different to the one in Australia, it provides some important facts in relation

to the benefits of an adequate supported accommodation as well as the outcome of the deinstitutionalisation of individuals living with a psychosocial disability such as schizophrenia.

In terms of the adequate housing for people living with a psychosocial disability, it has been argued over the years that ongoing support in safe and secure housing contributes to improved health and quality of life, as well as provides greater autonomy and increases community participation for people with mental illness (Carling, 1993; Reynolds et al., 2002 as cited in Fossey et al., 2006). On the contrary, it has been suggested that inadequate support and inappropriate housing appear to have a significant impact in deteriorating the mental health and functional status of people living with a psychosocial disability as well as increasing the risk of readmission to hospital, homelessness and poorer long-term outcomes (Fakhoury et al., 2002; Herrman et al., 2004, as cited in Fossey et al., 2006). Although these studies were conducted over 10 years ago, homelessness in individuals living with a psychosocial disability seems to be a current issue. In fact, Davies and Wood (2018) argue that despite the increase in homelessness services and programs in the past decade, solutions to homelessness – such as prioritising access to stable housing and continuity of healthcare – remain an issue in the community that needs to be addressed.

In addition to this, it can be suggested that the process related to discharge from hospital to the community, as well as the people involved in the discharge, plays an important role in recovery. For instance, UK research conducted by Petkari et al. (2020) highlights the importance of involving



Photo: Pexels/Laura Stanley

formal and informal support in the discharge planning of individuals living with a psychosocial disability who have been hospitalised. Therefore, getting all the support involved in the discharge planning may have a significant impact in the recovery.

A recent Australian study conducted by Houston et al. (2020) unpacks critical points within the NDIS pathway – which could have an impact on discharge of participants – and, at the same time, explores where collaboration

and adaptive strategies could be targeted to improve the processes. Even though this study does not target participants in hospital living with a psychosocial disability, it illustrates the challenges faced by individuals with any type of disability who are about to be discharged from hospital to the community under the NDIS.

**Hospital to community: factors to be considered for a successful transition**

When exploring the transition from

a hospital to community setting for people living with a psychosocial disability, it is inevitable to think about the risk and protective factors that need to be considered for its success.

Over the years, risk factors have been associated with the person's vulnerability to relapse, whereas protective factors mitigate against relapse by providing people with resilience in the face of adversity and moderate the impact that stress and symptoms could provoke in the individual's social and emotional wellbeing (Department of Health Risk and Protective Factors, 2006). It can be suggested that these definitions of risk and protective factors could be associated with the success of the transition. However, it is important to highlight how success is understood and how it can be measured. For instance, one way of measuring this success could be by exploring the outcome of different discharge initiatives. In relation to this, the Canadian Institute for Health and Information (2013a, as cited in Xiao et al., 2019) argues that readmission to hospital is often seen as an outcome of poor coordination of community-based services and continuity of care after discharge. On the other hand, another way to measure success in the transition could be by monitoring any changes in the individuals' mental health state as well as in their participation in the community.

In addition to this, research conducted by Chu et al. (2020) suggests that patients diagnosed with schizophrenia who have been institutionalised for 15 years

show more severe negative symptoms, such as the inability to feel pleasure and a feeling of amotivation, than those patients who have been discharged to the community. In terms of the participation in the community, Siskind (2012, as cited in Jose et al., 2021) suggests that when the supported accommodation is adequate, and the treatment environment is appropriate to the individual's needs, there are improvements in activities of daily living as well as in social participation. Thus, in order to be able to access the appropriate treatment and supported accommodation necessary for a successful transition, patients need to have access to financial support.

While the NDIS can provide funding for individuals living with a psychosocial disability, the process of getting this funding could be long, tedious and difficult to understand. In relation to this, Stewart et al. (2020) suggest that the information available that is suitable for the needs of mental health patients is a significant barrier in accessing the NDIS. Additionally, the understanding of the NDIS resources available could be a challenge for mental health consumers (Stewart et al., 2020).

In order to have access to the NDIS, the psychosocial disability needs to be permanent and have an impact on the individual's performance of everyday activities (NDIS, 2021). According to Slade and Longden (2015), demonstrating a permanent psychosocial disability is difficult for consumers due to the fluctuating nature of many illnesses.

It can be suggested that the unclear definition of psychosocial disability could leave the consumers without the appropriate funding. In addition to this, Stewart et al., (2020) state the need for clear and concise information in relation to the term 'psychosocial disability' as well as to whom this term relates. On the other hand, the NDIS suggests that the scheme is designed to provide financial support for daily activities and community access instead of replacing community mental health services or services provided through the health system (NDIS, 2021). It could be argued that this confusion in terminology and eligibility criteria could potentially leave the patient without the support needed such as adequate accommodation.

### **Homelessness**

Over the years, homelessness has been related to a variety of issues including mental health, antisocial problems, aggressiveness, family problems and substance abuse (Fischer et al., 2008 as cited in Forchuk et al., 2013). In Australia, the definition of homelessness differs from the one used internationally. While it is suggested that homelessness refers to 'sleeping rough' or using emergency shelter or accommodation (Fitzpatrick, 2012 as cited in Moschion & Van Ours, 2021), in Australia, homeless is considered to be a person who does not have a house, regardless of being able to live temporarily with friends or relatives, as well as living in emergency accommodation, boarding houses

In addition to the effectiveness of well-designed discharge planning, the appropriate funding, and the risk of homelessness for patients living with a psychosocial disability who transition from hospital to the community, another important factor to be considered is the risk of suicide after discharge.

or inadequate housing (Moschion & Van Ours, 2021). For instance, there is an increase in the population rate of clients diagnosed with a mental illness between 2015–16 and 2019–20 (AIHW, 2020).

According to the definition of homelessness and the statistics available, it can be argued that homelessness in those individuals living with a psychosocial disability can be a major risk factor to consider as part of the discharge planning. In addition to this, MacClure et al. (2008 as cited in Forchuk et al., 2013) state that homelessness is not usually examined in the context of discharge from hospital. Thus, it can be suggested that the failure to include accommodation in the discharge planning could be detrimental for the patients' mental health. For instance, Miyawaki et al. (2020) argue that a higher rate of readmission to hospital exists in the homeless population when compared with the housed population. Additionally, Miyawaki et al. (2020) highlight the importance of an optimal discharge planning and care coordination where if the patient is homeless or at risk of homelessness is considered. Therefore, it is important to include in a well-designed discharge a plan where the patient will be living and what kind of support will be available in the community.

### **Suicide**

In addition to the effectiveness of well-designed discharge planning, the appropriate funding and the risk of homelessness for patients

living with a psychosocial disability who transition from hospital to the community, another important factor to be considered is the risk of suicide after discharge. The World Health Organization (WHO) estimates that there are 800,000 suicides a year, making death by suicide the 18th leading cause of death in 2016 (World Health Organization, 2019). In Australia, there were 3318 deaths by suicide in 2019 (AIHW, 2020). According to Cho et al. (2016), individuals who have been hospitalised in a mental health ward have a greater risk of suicide after discharge in comparison with non-hospitalised ill individuals. It can be argued that the lack of adequate support and structured environment that a person might face post-discharge from hospital could have a significant influence. For instance, Madsen et al. (2021) suggest that even though the situation post-discharge of every patient is different (that is, their own resources and social networks may differ between patients), leaving a protective and safe environment to return to a chaotic life where they need to face conflict within the family, unemployment or exposure to alcohol and drugs can be a reality shock. Additionally, according to the Policy Directive by NSW Health (2016), the period where the individual might be at a greater risk of suicide is the period immediately following discharge from an acute psychiatric admission. It is suggested that the discharge planning must include early engagement with adequate support prior to the discharge date,

as well as a regular revision of the suicide risk assessments and management plans (NSW Health, 2016). However, Olfson et al. (2010, as cited in Rege, 2020) suggest that 40 per cent of discharged patients do not receive any outpatient visit within the 30 days of discharge. It can be suggested that an adequate follow-up after discharge is needed as part of a preventative strategy.

### **Communication with hospital, community services and family as a protective factor**

Protective factors are also to be considered in the success of the transition of patients from the hospital to community setting. It has been suggested that the success of the transition to the community of patients after an episode of acute psychosis is based on good communication between the hospital and their GP, as well as clear discharge planning (Carr & Harris, 2020). It can be argued that having effective communication between the parties involved in the patient's care not only plays an important role in the success of the transition but also might prevent readmission. In relation to this, Chung et al. (2017) have defined the 'critical period' as the time immediately after hospital discharge as they considered patients are most at risk for hospital readmission, suicide and disengagement from service providers.

Furthermore, it is recommended that the discharge planning starts with the patient's admission and it should involve not only the patient but also their support. That way, a

The role of the social workers in hospitals has been essential in facilitating patients' discharge from hospital and assessing the support the patient and the family will need post-discharge.

plan that is well done will decrease the risk of readmission and improve treatment concordance (Carr & Harris, 2020; Steffen et al., 2009). Nevertheless, the support provided by the family and carers when they are available appears to be beneficial for the patient. In addition to this, Turner et al. (2014, as cited in Carr & Harris, 2020) suggest that there is good evidence that psychosocial support and rehabilitation play an important role in improving outcomes. For instance, the use of psychoeducation to educate people about the illness and how this can be treated, family therapy to assist the family to understand the illness and what it involves, and the application of cognitive behavioural therapy (CBT) for continued psychosis, depression and anxiety, could be some of the psychosocial treatments that can be used for patients living with a psychosocial disability (Carr & Harris, 2020).

Additionally, it has been suggested that carers' involvement improves clinical outcomes as well as psychosocial outcomes such as treatment compliance, symptom reduction and improvement in quality of life, which consequently reduce the need for readmission (Haselden et al., 2019, as cited in Petkari et al., 2020). It can be argued that the involvement of

informal carers, such as friends and family, in the transition from hospital to a community setting has a positive influence in the patient's recovery. Thus, inviting their supports, when those informal supports are available, to participate actively in the discharge planning could be part of the transition success. In relation to this, Xiao et al. (2019) suggest that even though families are crucial to the discharge planning, as they facilitate continuity of care after the transition, there are some challenges to be faced. For instance, it has been argued that if the family or significant other are not available to participate in the discharge planning or even if they oppose discharge, this can often impede or delay the patient discharge (Christ, 1984, as cited in Xiao et al., 2019). Thus, to be able to facilitate the involvement of the families during the discharge planning process, it is necessary to assess the readiness, capacity and willingness of the family to accept the patient back in the community and provide the appropriate care (Xiao et al., 2019).

Finland has adopted a new initiative called Open Dialogue. This comprehensive approach works with families and social networks, as much as possible in the community, in order to help all those involved in a crisis situation

to be together and engaged in a dialogue (Aaltonen et al., 2011). The role of social workers in hospitals has been essential in facilitating patients' discharge from hospital and assessing the support the patient and the family will need post-discharge (Houston et al., 2020). And in NSW, the Pathways to Community Living Initiative (PCLI) plays an important role in transitioning people with severe and persistent mental illness, who have been in hospital for a prolonged period, into the community. The PCLI works with the individual, family or carer to find the best option for community-based living by adopting a rights-based, recovery-oriented approach (NSW Health, 2022).

### **Supported housing adequately serviced**

Different studies have demonstrated the therapeutic benefits of an adequate supported accommodation for individuals living with a psychosocial disability (Sylverstre et al., 2007, as cited in Harvey et al., 2012). It can be suggested that adequate housing with the appropriate support as a protective factor could have a positive impact on the individual's quality of life. For instance, Parker et al. (2021) state that, in general, people living with a psychosocial disability reported favourably on the experience of



Photo: Pexels



community-based residential mental health rehabilitation, highlighting the relationship with staff and co-residents.

Nevertheless, it can be argued that creating a positive environment is important for success, but also being able to create a therapeutic alliance with the client is essential for a successful transition.

For instance, Brunt and Rask (2018) state that the therapeutic relationship between people with a psychosocial disability living in a supported accommodation and their formal carers can improve social participation and, consequently, increased social responsibility as well as improved social functioning (Dixon et al., 2016, as cited in Jose et al., 2021). In addition to this, research suggests that a positive therapeutic relationship between service users and staff is associated with improved outcomes for people living with a psychosocial disability (McCabe & Priebe, 2004, as cited in Taylor et al., 2009).

Another important factor that needs to be considered for a

successful transition from the hospital to community setting is the communication between agencies involved with the patients. According to Houston et al. (2020), an effective connection needs to exist between the NDIS and health, especially for those adults with disability and complex needs who require financial support for discharge.

### **CONCLUSION AND RECOMMENDATIONS**

The NDIS is considered one of Australia's most important social reforms (Taylor & McLeod, 2018). Additionally, with the rollout of the NDIS in Australia, deinstitutionalisation of people living with a psychosocial disability to a supported accommodation in the community in the least restrictive environment has increased. As a result, there is a significant increase in the number of supported accommodations such as group homes.

Nevertheless, there is a need for a collaborative process between health services and the NDIS,

including a clear distinction of what each service is able to provide. In addition, an individual living with a psychosocial disability could struggle in understanding the eligibility criteria as well as the documentation needed to obtain the funding. Therefore, they will rely on other people such as social workers, counsellors, psychologists and occupational therapists to provide evidence of their disability to the NDIS and include this evidence in the application.

A variety of international research, especially in Scandinavian countries, showing the benefit of supported accommodation after discharge from a mental health unit has been conducted. However, even though some of the local research mentioned the importance of the supported accommodation funded by the NDIS, there is a gap in research showing a lack of knowledge about the impact of the transition from hospital to the community. Though, it is important to highlight that there are different risk and protective factors that

need to be considered when a person living with a psychosocial disability is transitioned from the hospital to a community setting. On one hand, risk factors such as miscommunication between services, homelessness and risk of suicide after discharge need to be considered for a successful transition. On the other hand, the importance of a well-designed discharge plan from the beginning of the admission, having the appropriate support in place when discharged to the community and establishing a positive therapeutic relationship, as well as adequate

housing, are the protective factors that need to be considered for a successful transition. In addition, it would be fruitful to propose further local experimental studies that compare the success of different models of supported accommodation, such as group homes and family homes. Finally, it is recommended that the NDIS and health services start a conversation about the possibility to unify policies and procedures for a successful transition from hospital to community-based accommodations. ■

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# CHALLENGES NO OBSTACLE TO DEE'S CAN-DO ATTITUDE

In this feature, *CA* interviews a counsellor and ACA member about their profession, their journey and what they've learned along the way.

Words **Nicole Baxter**, Photos **Corrina Ridgway**

**W**hen Dee McCulloch's three boys were diagnosed with autism, she was determined to give them the best start in life.

Back in 2001, there was no National Disability Insurance Scheme (NDIS), and support services for autistic children and their parents were thin on the ground.

To learn all she could about autism, Dee amassed an extensive library on the subject that she says was Australia's most comprehensive at that time.

Her boys' toy collection was also extensive, so while she was a chief executive officer with a degree in commercial law and experience as a stockbroker, real estate agent and vocational trainer, she also opened a toy and reference library.

This later became a full early intervention centre for children aged zero to seven years.

Dee estimates she raised about A\$10 million to run the charity Friends of Autism to support the centre from 2005 to 2014.

## Turning point

It was no easy task. Accordingly, as a mum trying to homeschool her three boys and run the charity, as well as two other family businesses in real estate and training, Dee reached out to psychologists and counsellors for support.

"The divorce rate among couples with one autistic child is 87 per cent," she says. "As I'm a mum with special needs children, psychologists and counsellors would tell me to take some time for me, have a massage and meditate, and I thought, 'seriously, is that all you have?'" she says.

It was not great advice for a single mum but it prompted her to secure counselling qualifications.

Dee completed a diploma in professional counselling through the Australian Institute of Professional Counsellors.

Since 2007, as part of the charity she set up, she has offered individual, group and marital counselling for parents of children with autism, which, over the years, won several awards for service excellence.

Not long after Dee's boys were diagnosed with autism, her ex-husband was also diagnosed with autism.

## Work rewards

Dee says the biggest reward of her work as a professional counsellor is connecting with people and making a difference in their lives where they feel understood.

A big part of her work involves group therapy where others feel supported, and the language around what a lousy day means is appreciated. For example, the worst day where everything goes wrong was coined a 'Dee' day.

"A parent of a child with special needs generally tries to overcompensate, which puts the parent under more pressure," she says.

"You are trying to achieve acceptance for your child and yourself – in a school setting, for example.

"Many parents put on a front to show they are coping, but the effort it takes to engage other mums and children so they don't judge you or your child can be exhausting.

"When you're in a group therapy session with other parents who understand, there is instant relief when you can say 'this is hard', and there is peer support so you no longer feel alone."



Dee McCulloch  
Photo: Corrina Ridgeway

### Work challenges

When it comes to the biggest challenges in her work as a counsellor, Dee says she struggles with clients who refuse to drop their victim armour and let people see the real them and be vulnerable to start the work.

“There are ways to move forward if people are willing to give them a go,” she says. “But it’s also the most rewarding part of the job when people decide they can have a happy life despite their challenges.”

Dee joined the Australian Counselling Association (ACA) in 2018 as a Level 2 member. She is also a member of the College of Supervisors.

She loves the credibility ACA membership offers and that members are held accountable.

“It is disappointing when anybody can call themselves a counsellor in Australia without having the methodology and training to go with the title,” she says. “The NDIS recommends 20 hours minimum a year of professional development and supervision.”

Every week, Dee spends about 25 hours counselling clients and supervises, plus running her training courses. She also does about 20 hours of pro-bono work.

Her training courses to hone the knowledge and skills needed to provide services to clients through the NDIS are accessible through ACA.

### Conflict resolution

Also offered through her business are mediation and dispute resolution services for high-conflict divorce cases. Most of these cases involve a child or partner who has issues with mental health or special needs.

She and two of her sons have a rare genetic disease, Ehlers-Danlos syndrome (EDS), which means battling chronic pain. She reminds herself daily with zebras (the symbol of EDS) placed around her home that everything will be okay.

Dee’s three boys live at home, where she juggles her work with structuring their days. Her sons are doing well. Andrew, 21, has a significant intellectual disability and lives a life he enjoys. Jordon, 19, studies criminology and justice. Her youngest Lachlan, 17, also has attention deficit hyperactivity disorder and significant learning disabilities. He is homeschooled. Dee designs a program to suit his needs and interests in pet studies and marine biology.

### Lessons learned

To those starting in counselling, Dee encourages humility. “You can learn as much from your clients as

they can from you,” she says. “You shouldn’t be directing anybody’s life, but just helping them on their journey at their pace.”

She encourages her peers to remain open to learning and to never judge.

As a champion for the NDIS, Dee says her work involves a lot of research.

“People who do my courses think they’re in for an easy ride,” she says. “I usually hear deathly silence once I explain how it is and what they should be doing.”

Nonetheless, she says her students are thankful after completing her NDIS courses by truly understanding the system and obtaining outcomes.

In the future, Dee is keen to expand her clinical supervision, live webinars and self-paced learning modules.

“All I can do is make a difference one life at a time,” she says. ■



Dee McCulloch  
Photo: Corrina Ridgeway

# Want to be published?

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### Deadline

Deadline for articles and reviewed articles is 25 January, April, July and October. The sooner articles and papers are submitted, the more likely they are to be published in the next cycle. ■

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