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Contributions are invited for the next issue of Network. The theme of the issue will be Psychology, Multiculturalism, and Racism. The issue will present a selection of papers to stimulate debate about the challenges of cultural diversity and showcase the ways community psychology can contribute to the promotion of positive cultural diversity. To achieve this, we are keen to receive a variety of contributions that address issues related to this theme, including theoretical, empirical and reflective pieces. We are also keen to include discussions and book reviews. All papers will be reviewed. Please see instructions for authors for a summary of the review process.

Please send your contribution to the Special Issue Editors, Lynne Cohen and Christopher Sonn.

Attn: Lynne Cohen
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Email contributions are also welcome

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Lynne Cohen
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100 Joondalup Drive
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Hello Everyone,

Having just taken over as the National Chair of the Community College, I am very keen to develop a "sense" of what community psychologists around the country are up to. This can be quite a difficult task, for notwithstanding all the electronic communication options nowadays, living on the west coast, one can still experience the tyranny of distance! It was, therefore, really interesting to pick up the last edition of Network and read Heather Gridley, Lynne Hooker and Maureen Sutton's survey of the early community psychology graduates from VUT and their reflections on how their training had prepared them for employment. It would appear that the "disinherited bastard child of the sixties" has indeed grown into a strong competent "young adult" and clearly has achieved this through the thoughtfulness and foresight of those who were responsible for developing the core competencies that underpin contemporary training in community psychology.

Equally interesting was Colleen Turner and Heather Gridley's article on the membership survey of the College of Community Psychologists. As the incoming national chair, I'm taking some clear messages from this survey about possible directions for the College's leadership and organisation. We will need to continue to negotiate the relationship between the College and the Professional Development requirements for the College thoughtfully and strategically, particularly around the issues of "affiliate" or "interest group" levels of membership. From my perspective, I believe maintaining a critical mass in terms of numbers ought to be our priority and intend pursuing this as a matter of urgency on behalf of the College.

Finally, I was delighted to see such a network of cooperation and collaboration between colleagues that spanned the continent, crossed academic and non-academic domains and involved both men and women in a range of College activities. It's great to see we practice what we preach! Sincere thanks to all those folk who I know will be contributing a considerable amount of time and energy to make College activities such as the production of Network a reality.

Lisbeth T Pike

Chairperson, National Executive
Morning teas and mailouts: practising community psychology in the areas of mental health and people with disabilities.

Meg Smith

Community psychology evolved out of the practice of working with people in communities rather than in institutions or in counselling rooms. In the area of disability, community psychologists, community development workers and social workers have been instrumental in enabling a number of community groups to advocate on behalf of their members, bring about changes in legislation and develop community networks to replace family and friendship networks lost through long episodes of illness (Bond and Daiter, 1979).

The skills required by community psychologists are inextricably linked with a social and political awareness of the context in which practice occurs. Community workers may well find themselves organising social events, demonstrations, political campaigns and doing mailouts as well as offering more traditional counselling and support to members of their community.

Action and practice in community development tends not to be written up and passed on to future generations of workers to the same extent as findings from laboratory studies in institutions. Academics who have a career interest in getting their work published dominate the journals in most social science areas. Community workers who are often poorly paid and involved in action at the grass roots level are seldom as interested in writing up their experience to teach the next generation of workers. Writing up after a project is finished is usually confined to a report to the funding body if one exists or to the management committee. Information about the process that occurs during the project is generally passed on via informal means such as chatting on the way home from the management meeting or debriefing on the phone. Getting directly involved in a community project may be the only way that community psychologists can learn from the experience of community action.

But psychologists can offer a great deal to community groups. Analysis and development of future strategies can be of great value to community groups struggling to gain recognition for the value of their work. Impartial and trained observers with some sympathy for the aims and ideals of the project can help to pick out key factors in the success or failure of the project. In the area of self help groups for people with mental health problems, it was a group of community psychologists who evaluated the early GROW groups in Australia and identified the strengths of the self help movement in mental health (Young, 1990).

Community work is also a growing area of employment for new graduates in psychology (Franklin et al, 1996). However, unless psychologists have some experience in working with community groups, they are likely to be non-competitive for community jobs compared with social work and welfare graduates who undertake placements in community development and group work. Community organizations generally don't have the resources to train new staff: community work demands a high level of initiative, enthusiasm and a repertoire of working skills as well as the ability to relate to a wide range of people on a number of different levels. Jane Mears and Natalie Bolzan in their analysis of self help groups in mental health heard some of the complaints about professional workers made by community groups: these
complaints revolved around the inability of workers to be flexible, and to move beyond an individual perspective; other complaints were that workers imposed a therapy group structure and focused on weakness and pathology rather than setting up structures for the group to become independent and helping members identify their strengths.

The articles in this edition of Network came about through a process of inviting practitioners actively involved in community groups to reflect on their experience. Academic psychology is limited in what it can provide to students interested in community practice. Students majoring in psychology who are interested in community work can broaden their training by combing studies in psychology with studies in sociology, politics or community development. But practical experience is an excellent teacher. Most community practitioners gain their involvement in community work by personal interest in a particular issue or by actively seeking out community groups that welcome enthusiastic and resourceful volunteers. Some practitioners have founded organizations: the Alzheimer's and Related Disorders Association of NSW was founded by a number of health workers who themselves had a relative with dementia and who could see the limitations of current institutional approaches to treatment of people with dementia and their families.

There are probably no right or wrong answers in community development but there are strategies and processes which can be applied in particular situations. Understanding the community in which you work is always the key factor in successful community work. A group of people disabled by mental illness has far different needs and strengths than a community of women in an inner city suburb. Some of the strategies in community development will work for both groups and some will be unique to the social and political context of the community group. Learning is an ongoing process and comes from a variety of different sources. But as the article by Fran Gale and Genevieve Rankin points out, community development around a particular issue may also need to take into account psychological processes which hinder participation and political action.

References


Community Psychology in Residential Rehabilitation

Judy Poll

Introduction

Growing up in a middle class, suburban family, I have lived a sheltered life in the outer eastern suburbs of Melbourne. I went to a regular high school, spending most of my youth (and my fast food job-funded pocket money) at the local shopping centre. Conversations I had at home would centre around issues such as clothes, music, the selling of public utilities, whose turn it was to do the dishes, and the importance of universal health and education systems. My loyal 'lefty'dad, in conjunction with ABC and Triple J, was instrumental in influencing my beliefs and value system – including my passion for social justice. After traditional undergrad and fourth year psychology training at a major University (15 minutes from home), I was accepted into a Masters of Community Psychology at Victoria University in Werribee. Which is in the western suburbs. One and a half hour's drive away.

During the course, I learnt the values underpinning community psychology, and was excited to find that they closely paralleled my own growing beliefs. At the completion of my course, I accepted a position as a psychiatric disability support worker at a new psycho-social residential rehabilitation program run by Richmond Fellowship of Victoria. During my first few months at "Narana", I was pleasantly surprised to find many examples of community psychology principles being applied in my program.

Richmond Fellowship is the largest provider of psychiatric disability support in Victoria. Having successfully tendered for new programs in recent years, Richmond Fellowship now runs 36 programs in Victoria alone. Richmond Fellowship of Victoria (RFV) is committed to providing a high level of support for staff and to working genuinely towards client empowerment. Community psychology principles are evident in both RFV's philosophy, and my manager's own value system. These values create an atmosphere that influences staff attitudes, and thus clients' experience of the service. I'm now going to outline how eight community psychology principles are applied at Narana.

Sense of Community

Coming from a privileged position in our society as a white, middle class, educated, heterosexual person, I was unaware of how important a sense of community can be. I quickly learnt at Narana that a feeling of belonging plays a crucial part in the success of the program and impacts on residents' self image, ability to cope, social skills, and sense of safety. Residents often speak about this feeling of safety, and of not being alone any more, of 'having roots'. Nurturing these feelings has been a strong focus of the program.

A sense of community has been achieved by various aspects of the program, and begins with the respectful and inclusive attitude of staff with residents and with each other. The physical structure of the buildings in cluster style housing (three units with three residents in each) built around three communal areas adds to this sense. The activities and groups in the semi-structured program are either gender groups, or whole program recreation and sport, thus residents are constantly in contact with each other. Residents are encouraged to look to each other for support, particularly after office hours. Camps provide another way to increase group bonding and togetherness, particularly when new residents enter the program.

Community Development

From 21 years experience in establishing residential programs, RFV had produced a well formulated three phase strategy to work with local residents, councillors and shopkeepers in the area before a program is established. However, in January 1999, Victorian Premier Kennett made public a pre-emptive press release concerning the proposed Wantirna service without informing RFV. This incident made it necessary for Narana staff to fast track many steps in the standard strategy.

There was a negative reaction from surrounding neighbours, who were vehemently opposed to a psychosocial service in their quiet neighbourhood. A strong lobby group had previously attempted (unsuccessfully) to block both a local GP clinic and a drug and alcohol outreach service from opening in the area.

The neighbours' resistance campaign began with a flyer entitled "Mental asylum moving into 'Smith' Ave", and a plea to attend a neighbourhood meeting. About sixty neighbours attended that initial meeting. A neighbourhood committee was formed and became influential by making emotive presentations to local council members, parliament members and the media, as well as holding several neighbourhood meetings and using further leaflet drops. The neighbours' concerns were ones often cited when community residential programs are established:

- Residents would be loud, violent, drug using, and sex offending and therefore make the neighbourhood unsafe and cause property damage.
- The service was not 24-hour staff supported, therefore
neighbours were concerned that residents would not be adequately contained
• Property values would decrease
• The street would become congested with staff cars, and
• There would be no consultation with neighbours
So influential was this group that they managed to obtain extra funding in order to have 24-hour staff support within the first three months of the service opening.

Narana's community development response to this situation was both thorough and on-going. It began with a leaflet drop to all the surrounding neighbours, with relevant information about the service, mental health, safety issues, contact details and criteria for residents. This was swiftly followed up by a door knock and face to face visits with concerned neighbours. Norena staff began a program of on-going forums with neighbours and other community service providers, offering a space to hear concerns, relay information and consult with neighbours about the physical structure of the service and contact processes. The manager offered support groups for the neighbours. Whenever letters or calls from neighbours came to Narana, they were followed up with calls, visits, and on-going offers of meetings and visits to the service to discuss concerns. Nearby shopkeepers, emergency services and the local G.P. were given information and visited by staff. Staff met local councillors, government staff and local members of parliament and one local councillor visited another RFV program and spoke to staff and residents there. Opportunities for neighbours to visit another RFV program and speak to neighbours there were also offered.

Gradually, through a lot of time, empathy and diplomacy, a majority of the neighbours and all of the nearby service providers began to accept the Narana program as being a part of their community. Today there are still three-monthly neighbours meetings at Narana, and a newsletter informing neighbours of the goings-on of the service. Nowadays some neighbours come to Narana BBQs and meet with residents and staff. One neighbour even dressed up as Santa at Christmas. Residents enjoy a tentatively friendly relationship with neighbours, a smile and a quick word on the footpath.

Participation
Narana is very committed to providing opportunities for residents to participate in all aspects of the program. Narana residents contribute to the planning and evaluation of a variety of activities, including house meetings, gender groups and 'Creating Options', a weekly social and recreational program for young people with mental health difficulties (the only one of its kind in the area).

Staff Interviews
Right from the beginning, I found resident participation at Narana. My initial interview involved two residents, who had written and asked their own questions of me. Residents are also involved in the discussion of interviewees and their opinion is given genuine consideration when appointment of new staff occurs.

Service Identity
Narana is a new service, funded by money from the Youth Suicide Task Force. It began taking residents in March, 1999. Residents were involved in forming the identity of the service. The naming of the program was a major process, and staff held workshops where residents discussed what the service meant to them, made sculptures, produced some writing and spent hours discussing the issue. Residents and neighbours finally voted on a list of suggested names. Narana was chosen, meaning "a place where people from different cultures meet and share stories, a place of hearing, listening and understanding". Residents also designed the program logo for a pamphlet and letterhead.

Policy and planning days
An ongoing example of resident participation in the program is the three-monthly Policy and planning day, when residents meet with staff to discuss and draft program policies. Since the program began, several policies have been drafted and signed off including; social drinking, drug use, and safety/violence policies.

The workshop
Narana has been particularly adept at both promoting the program and educating the wider community about residential rehabilitation. In September, 2000, Narana facilitated a workshop at a large local hospital on 'setting up a psychosocial rehab program' and included a resident panel. In the community psychology tradition of seeing the participants as the 'experts', the residents wrote and presented their thoughts and answered questions as well as giving timely advice to the health professionals in the audience. I was privileged to be a part of a resident-directed presentation at the international Richmond Fellowship Conference in Canberra in November 2000. The session included both residents' own stories, Powerpoint information about Narana and a consumer
panel who answered challenging questions from professionals and consumers in the audience. The workshop was a resounding success and resulted in numerous requests for a CD-ROM version of the presentation.

Consumer Representation to RFV Statewide
As part of an RFV service-wide initiative, one of Narana's outreach clients (and ex-resident) holds the position of 'consumer representative' for the eastern region. She has been instrumental in conducting an evaluation of the programs in the area, and presenting a report to the board of RFV.

Partnership and Collaboration
For many reasons, it is necessary for Narana to work collaboratively with external agencies. Being a new service, Narana needed to establish connections and networks within the community. External services are important components of a holistic plan for residents to achieve their goals. The target group of the service is one with complex needs; youth (16-24), with mental illness, often accompanied by drug and alcohol issues and at risk of homelessness and suicide. Thus a strong support network is crucial.

Community Mental Health Clinics
Almost all of Narana residents are linked in with the local community mental health clinic, and see psychiatrists, case managers and other professionals there. Narana staff spend a lot of time working on relationships with clinical services. It is very important for key workers (support workers who 'key work' or individually work with a particular resident) to develop a positive relationship with a resident's case manager as the link person for issues involving medication and psychiatrists. Case managers are involved in the initial six weekly review and three monthly independent program plan (IPP) reviews of residents. New case managers are invited to Narana for a visit and info sharing about the aims of the program and the role of a key worker. In addition, secondary consultation occurs every month with a clinician to be used as a clinical resource and link with clinic. Clinicians also are invited to attend program social days.

It is important for Narana staff to also have a collaborative relationship with various other external agencies. Currently two drug and alcohol agencies are working together with Narana program to establish protocols for new Narana residents with substance use issues to use their services.

Other agencies Narana works with include: local day programs, employment agencies, education (disability officers of Tafe and uni), recreational agencies, mediation services, Centrelink, community health centres, and Office of Housing. We also work closely with residents' families. Our role can include support, education, referral, advocacy with other agencies, and sometimes even mediation.

Evaluation
Narana has a variety of methods to evaluate whether the program, residents and staff are achieving their intended goals. We have policy and planning days every three months when residents and staff meet and look at policies and issues at Narana. Residents have an initial 6 weekly IPP review when first entering the program, and then ongoing three monthly IPP reviews with their keyworker, program manager and case manager to explore how they are working on the rehabilitation goals. Program groups are regularly planned and evaluated.

Staff have staff planning days periodically through the year. Supervision is also emphasised not just at Narana, but in all RFV programs. Staff have individual supervision with their manager fortnightly, peer supervision groups monthly, team reflection (at 4pm on Fridays, to reflect on staff's feelings about their week), staff meeting weekly (which includes secondary consultation with a clinician and a clinical psychologist fortnightly), and team supervision.

In addition to this atypical level of support for staff, there is wide scope for training. In my first year at Narana, I participated in 5 workshops covering topics such as drug and alcohol, suicide intervention, self harm with borderline personality disorder, being a keyworker and working with same sex attracted young people. This was in addition to the half organisational days, and organisational AGMs.

Social Justice/Advocate
A big part of my role is advocacy, and strong sense of social justice is necessary to continue the almost daily fight against ignorance, stigma, and fear of mental illness. As support workers, we hold an educational role with other health professionals and families. We are often our resident's advocate when working with other agencies (education, clinic, drug and alcohol, G.P's, Centrelink, financial institutions including state trustees). With residents themselves, much of our work is to assist residents to know and exercise their rights in regard to money, education, and social responsibility – and to
support the belief that they deserve the same opportunities as others who have no diagnosed mental health problems.

We staged two political workshops at Narana, one at the electoral education centre in the city, and one on-site, preceding the federal election. Staff chose a major party each, researched the resident-elected policies of mental health, drug and alcohol and the GST, then were interviewed by residents in each ‘party room’ of the Narana office, in order for residents to gather information to win prizes. The workshop ended with a rowdy discussion focused on the refugee issue. Residents and staff were delighted (and enlightened) by the experience.

Empowerment

As the ‘bottom line’ for community psychologists, empowerment is also a major aim in support work positions. This role is very different to my previous experiences in placements, when I held a counselling/duty worker role. Support work in residential rehabilitation can basically be described as wading around in the middle of residents’ lives. It is not just seeing a client one hour a week, but seeing them eight hours a day, five days a week. So it’s exhausting, and emotionally inescapable sometimes, BUT it is also a unique opportunity to witness incredible change in someone’s life.

Trying to create an empowering environment in support work is a complex process, as residents need lots of support but also direction to achieve independence. Negative symptoms (i.e., depression, amotivation, lethargy, loss of hope), often make it difficult for residents to even get up in the morning, much less achieve their goals. I often view it as dancing between encouragement, being quite directive and allowing space for independence to blossom. Empowerment in this context is a long process that needs time, effort, consistent support and follow through. Cultivating hope is crucial.

The program’s first goal is to start people living in the shared units at the program. They then move through the program, and into their own outreach unit in the community, maintaining connections with Narana through their outreach worker and some groups. The next step is to access mainstream support agencies. In the three years since Narana began, we’ve already had seven young people move through the program and successfully maintain their outreach unit. Unfortunately some people leave Narana less happily, and there have been two overdose deaths. It is in those times where I’ve had to work hard to accept the fear this job sometimes entails.

Competencies Enhancement

This is the special part of the job. There are so many negative and difficult issues for a young person recently diagnosed with a mental illness - suicidal ideation, self harm, medication and its (often disturbing) side effects, depression, aloneness and despair are all the hard parts. However, our job is very much about focusing on enhancing competencies. We work hard to encourage residents with mental health difficulties not to see themselves as diagnoses, but as whole people with many positive facets. We emphasise skills, talents and interests when looking at goals for rehabilitation, and we give lots support and encouragement to pursue creativity. By doing this, we hope residents can find a reason for getting up in the morning, and then can experience successes, have fun, have things to talk about and find ways to meet like minded people.

A developing part of our gender groups is to bring back successful outreach clients who talk to residents about how to manage in outreach. When ex-residents teach residents, they also experience a sense of pride in their own success.

Conclusion

As a beginning community psychologist, I thoroughly enjoy many aspects of my work as a support worker at Narana service, as my role allows me to practise many of the skills and values I learnt whilst studying. I think it’s imperative for community psychology graduates to realise that the values and philosophies they learn in their courses can be applied not only to purely ‘psychological’ positions, but also in a variety of settings, including community mental health.
Setting up self-help support groups: an essential service for people living with a mental illness

Bernette Redwood
Project Officer, Support Group Training Project, NSW Association for Mental Health

Support Groups for people who have had a mental illness

Everyone who has ever had a mental illness has a unique but familiar role to relate. Support groups are about people with a mental illness who meet in order to look at how they can deal with their mental illness so that they can be an intrinsic part of society. Support groups are not about (as some people believe) people with a mental illness coming together to talk endlessly about their problems. Discussion about the struggle to get on with their lives and what they are now doing about it however does occur in most support groups.

There have been a number of types of support groups established for people recovering from mental ill health. GROW was started in 1957 in Sydney at a time when effective treatment for mental illness was not available (Young, 1990; Locke, 1979). People often spent many months in hospital waiting for the illness to go into remission, submitted to psychosurgery or learned whatever techniques they could to cope with the symptoms of their illness. Self-help groups began to be formed as a response to the growing use of psychotropic drugs used to treat mental illness. PALA was formed in Sydney in the early 1970s to protest the over prescribing of phenothiazine tranquilizer drugs and to promote alternatives to drug treatment for all mental illness. Other groups such as the MAD group formed in 1981 in response to growing dissatisfaction with existing services and abuse within mental health care. The MAD group was supported and encouraged by workers at Leichhardt Women’s Community Health Centre and later become the Depression and Mood Disorders Association of NSW (Smith, 2000). McColl and Hough (1979), in recounting the stories of people who had survived a breakdown in mental health, commented on the lack of alternatives to public mental health services for many people and the isolation felt by people who could not share their experiences with their family or previous friends.

Support groups can vary somewhat in that some are just for self-help support, but some include a social component or guest speakers - all the time, or occasionally. The most significant aspect of support groups is the sharing of information that facilitates the coping strategies of the people involved. While support groups are not about therapy or medical intervention, information about available relevant services or new drugs that have been successful for that person is extremely significant in people’s coping strategies.

The Effectiveness of Support Groups

It is fairly common for people who experience a mental illness to lose any self-esteem they previously had before the illness and to believe that everyone else is totally well and coping - so no one would be interested in talking to them, much less making friends with them. Many people are very afraid that it will be discovered that they are not living up to what they perceive as other people’s vision of them. But many people with a mental illness have also held down various kinds of professional positions or significant jobs before they became unwell, and somehow they nearly all believe that this was a person who existed before they became ill but has little relevance to who they are now.

There are many people who have recovered from an episode of mental ill health who are employed in high level or professional jobs. But maintaining a professional profile can be very difficult. People with a mental illness often dare not say that they feel down or depressed as anyone else might do, for if they say it at their workplace (no matter how understanding the organisation might be) other staff might well become anxious that they are about to have an ‘attack’. If the workplace doesn’t know that they have a mental illness, then the pressure is even greater to lead a ‘double life’. Often only when people attend support groups can there be any degree of honesty about the difficulty of coping with their daily lives. The support group provides a safe environment to explore issues of coping in everyday life and to gain genuine support and reassurance from other people.

There is now a growing awareness of the benefits of support groups (both long and short term) for people with a mental illness. Originally doctors, psychiatrists, and health professionals generally were reluctant to refer clients to support groups, as they believed that the groups were only about people coming together and talking about their ‘war stories’.
The concept of support groups is certainly not new. Long (1983) noted that there had been a significant increase in the number of support groups in the past ten years in the United States and that they were becoming an important source of health care. At least six million people in the United States participate in support groups each year, and perhaps 12 to 15 million people during their lifetimes - about the same number who seek psychotherapy. Members of these groups are people with a symptom, disorder, situation, or experience in common who unite to fulfill a need, overcome a handicap, or cope with a crisis (Long, 1993).

The Support Group Training Project
The Support Group Training Project at the NSW Association for Mental Health is intended to address some of these issues. The planned outcomes for the project will benefit not only those support groups already existing but also any people who have experienced a mental illness and who want to set up new support groups and talk to other people about their experiences of living through mental illness.

The Support Group Training Project commissioned researchers at the University of Western Sydney to do a needs assessment in regard to support groups and this has provided significant data about the needs for support groups across New South Wales. This is important research as there has been almost no academic investigation in Australia regarding the benefits (or otherwise) of support groups for people with a mental illness.

The report, Support Groups for people who have mental health problems: A needs assessment in New South Wales states, "With deinstitutionalisation and the changes in policies concerning psychiatric hospital care, people who have episodes of mental illness spend much less time in hospital and are often discharged into the community while still recovering from an episode of illness."

The support groups can offer support, social interaction, information, or any combination of these. However, the priorities are to consult with consumers and carers as extensively as possible in regard to what they perceive their needs are in regard to support groups.

One of the major benefits of the Support Group Training Project is that it will address the issue that many group leaders do not have the resources and support needed to ensure their long-term commitment to providing this service on a voluntary basis.

The project fits particularly with the focus of the Second National Mental Health Plan on the prevention of depression and related disorders (Commonwealth Department of Health and Aged Care, 2000). Support groups can reduce the isolation of living with a mental illness: experience with the support groups run by the NSW Association for Mental Health is that many participants who are in crisis are more likely to contact other members of the group to seek support before they contact mental health professionals. This is because they are usually assured that they will get instantaneous acceptance and understanding from the group member they contact.

The objectives of the Project are to discover exactly what support groups can offer people with a mental illness; to provide people with a mental illness with well managed, well-resourced support groups; to train a network of support group leaders in the practical skills needed to establish and run effective support groups; and to facilitate the development of partnerships between other agencies and support groups to ensure mutual aid. Partnerships with psychiatrists, local mental health services and general practitioners are crucial in setting up and maintaining support groups. An important resource is the development of resources which can be used on an ongoing basis by current and future support groups, community mental health centres, non-government organisations and training bodies, including universities and TAFEs.

Resources will include a self-help group leaders manual; a train the trainer manual; an educational video; media materials; and information about access to electronic information.
Support groups need to not only operate effectively but also to have a professional profile. The Project will offer training in the principles of running self-help groups; group dynamics; leadership and leadership sharing; issues about fundraising, legal and financial accountability; confidentiality; and addressing the needs of a volunteer worker. Specific issues affecting people with particular illnesses; such as medication, mental health and guardianship legislation and access to other health and welfare services need to be addressed for some groups. It is hoped that trained group leaders will be then able to pass on their skills and resources to new people to ensure the continuity and effectiveness of the groups.

The anticipated outcomes of the Project are that there will be more effective groups operating; that group leaders will have improved skills and confidence in running groups; that there will be effective resources in place to facilitate the existence of new groups as well as sustaining existing groups. It is anticipated that there will also be improved referral systems and partnerships with mental health services, general practitioners and psychiatrists and that there will also be a general increase in consumer wellbeing, and therefore a decreased need by consumers for mental health services, such as crisis care and hospitalisation.

4. Outcomes of Support Group Training Project to date
To date twelve new self-help support groups have been established across New South Wales. The target population for these groups has been diverse. Current groups are:

- four support groups for consumers that are open groups,
- one group for carers generally,
- one group for Greek women who are carers,
- group for people experiencing anxiety and panic disorders,
- one group that is specifically for women with drug and alcohol and depression issues, one group for Aboriginal men with depression and associated disorders.

The training for support group leaders to facilitate running support groups has been held on six occasions in both metropolitan and country areas. Five of these training sessions were held for any consumers who wished to attend. The sixth session was held in conjunction with the Transcultural Mental Health Service.

The training is run over a two-day period and the participants are required to attend both days in order to be accredited with the training. The response to the training has been excellent. There has been an attendance of approximately ten people to each training session. Fourteen people attended the training programme with the Transcultural Mental Health Centre.

Feedback from general training:
Has the training been useful to you?
Yes - 58; No - 2.

Do you now have more confidence to run support groups?
Yes - 54; No - 6

Have you enjoyed the training?
Yes - 60; No - 0

Was the training:
Very Good - 42; Good - 18; Fair - 0; Poor - 0.

Comments received in regard to the training programme:
- Thank you as it is a great relief to have this training. I've been doing it blind for so long.
- Great opportunity to network with other group leaders.
- Role-plays particularly were a great help but I enjoyed all the training.
- I found the course great. The most dynamic training I have been involved in.
- The training sessions greatly improved my confidence and self-esteem.

Feedback in regard to the training programme for NESB people:
Did you find the day useful?
Yes - 14 No - 0

Do you have a better idea about mental illness?
Yes - 12 No - 2

Do you have a better idea about support groups?
Yes - 12 No - 2

Did the day meet your cultural needs?
Yes - 11 No - 3

5. The need for community acceptance of the benefits of support groups
The acceptance that support groups are an essential component of health care for people with a mental illness is becoming more widespread. However the Council of
Once people with a mental illness feel supported and therefore stronger and more able to cope, they look towards attempting to change community attitudes to mental illness - and the rights of people with a mental illness. At this time, stigma is a very significant factor affecting the rehabilitation of people with a mental illness. Speaking out about one's experience in the mental health system is risky for many people. Unless Area Health Services and mental health services generally change their focus from acute care and shift the focus towards client centred services that will empower consumers and assist in prevention of possible future episodes, current policy underpinning will not alter. In managing the Support Group Training Project, experiential evidence in regard to consumer satisfaction with increased availability of support groups is extensive and consumers frequently state that they strongly believe that support groups contribute greatly towards reducing medical intervention.

6. Geographical issues regarding Support Groups

Support groups in rural areas are of major significance. People in many rural areas in New South Wales have only limited access to general practitioners and at times almost no access to psychiatrists. In some rural areas, psychiatrists fly in about once a month. In other areas, such as Lightning Ridge, the psychiatrist flies in approximately every three months or people are forced to travel long distances for psychiatric care. People with a mental illness in rural areas want effective, non-stigmatising support, their main option is often support groups. An important aspect of small rural areas is that people with a mental illness are often very conspicuous, or at least identified by the community. Therefore the ability to meet together in a confidential manner (often in someone’s home) ensures that support in coping with his or her mental illness in such an environment is feasible. The location of a support group in remote and rural locations is a real issue for people with a mental illness in the bush: the distance between towns and villages within the same region may mean that one location is inaccessible to people from other communities. The issue can be partially addressed by the use of telephone networks and email contact (Ansiewicz, Mears and Bolzan, 2000)

Public education is an intrinsic component in facilitating positive changes in government allocation of moneys.
7. Conclusion

The evidence clearly identifies that support groups can be important in both the recovery and continuing well being of people with a mental illness. Support groups can link people together in a way that facilitates an increase in their self-esteem, confidence, communication and coping skills. Having someone who has gone through the same experience being able to reassure them that all their difficulties can be managed and effectively dealt with is obviously powerful for people just out of hospital or having just been diagnosed.

In line with these successes is also the likelihood that people with a mental illness will be better able to successfully work with their relevant medical practitioners and thus facilitate compliance with the proposed medical regime. "Lack of recognition of the importance of support groups is an extremely important issue for those involved in mental health support groups. It would appear that the lack of acknowledgment from professionals of the role of support groups is acutely felt. This lack of recognition creates obstacles to the establishment and ongoing functioning of support groups, particularly in regard to referral of appropriate people to the groups." (Ansiewicz, Mears and Bolzan, 2000)

As Australia still lacks widely available community and outpatient services (particularly in areas outside the metropolitan area) support groups can be meaningful networks that provide ongoing support and information about access to available services.

Ultimately Phillip Long in the Harvard Mental Health Letter (1993) sums up the significance of support groups in our society at the present time. "In an environment in which families, churches, and other traditional institutions may have come to seem inadequate, these groups are a new way of establishing a common life - a type of affiliation that is especially useful in crises. Other causes of the self-help revolution are loss of confidence in the health care system, limited availability of mental health services, and scientific advances that have led to a rise in the number of people with chronic medical conditions. As the cost of health care rises, insurance companies, corporations, and mangers of health maintenance organisations may increasingly favour self-help groups".

Therefore it is hoped that the Support Group Training Project will be able to address some of the needs of people with a mental illness who want to set up support groups but are unsure how to go about it. However a project of this size cannot respond to all the requests received across New South Wales from people with a mental illness wanting training and advocacy. It is hoped that the Project operates on a "train the trainer" model that people with a mental illness be able to resource their peers and give them the necessary information and training in regard to establishing support groups.

The fact that there is starting to be wider community and professional recognition of the fact that support groups give people with a mental illness the ability to cope on a day to day basis will have a powerful impact on the lives of people with a mental illness. This recognition ensures that the stigma of mental illness will be reduced. Then people with a mental illness will have the support to be better able to maintain their independence, establish relationships, and feel that they are not alone in believing that they should be valued for their strength in dealing with their illness and look towards recognition that they can successfully get on with their lives.

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Australia's Young People: A Resource Rather Than A Problem

Ann Dadich

INTRODUCTION

The mental health of Australia's young people has received increasing political attention in recent years. The inquiry into the human rights of people with mental illness by Brian Burdekin in the early 1990s clearly documented the emotional, social and economic difficulties experienced by people with mental illness and their carers and recommended government funding for a wide range of community resources including support groups (Human Rights and Equal Opportunity Commission, 1993). A report on homeless young people highlighted the devastating effects of poverty and family disintegration and the role that stress and mental ill health played in youth homelessness (Human Rights and Equal Opportunity Commission, 1989). In 1992, international eyes were on Australia following a visit by Professor Vitit Muntarbhorn – a special rapporteur appointed by the United Nations Economic and Social Council. Vitit Muntarbhorn had some hard things to say about the situation of children, particularly in the context of family poverty, and of course the disproportionately poor progress of Aboriginal and Torres Strait Islander children compared to mainstream Australians (Boss et al, 1995).

Since such investigations, political figures have given the area the attention it deserves (albeit tokenistically) promising increased funds to improve the mental and emotional health of young people. To further affirm the significance of the area, the New South Wales Carr Labor Government established the Office of Children and Young People in 1995 (1999).

Recent Australian studies suggest:

- A quarter of all young people experience depression before the age of 18, with those between 15 and 17 years being most at risk (NH & MRC, 1996);
- One in twenty 15 to 16 year olds engage in regular self-harm (Hibbert et al, 1996);
- 61 percent of tertiary students report suicidal ideation (Schweiter et al 1995);
- Up to 11 per cent of high school students attempt suicide (Pearce & Martin, 1993);
- When compared with other nations, Australian adolescents have the highest usage rate of amphetamines by injection (Pennington, 1996); and
- Young women have a harmful preoccupation with dieting, with 60 per cent engaging in unhealthy weight loss practices at any one time (Wertheim et al, 1997).

These findings represent the new morbidity – problems for children and young people that are not physical defects or infectious diseases but that are developmental, behavioural and psychosocial problems (Oberklaid, 1988). More devastating though, is the much-publicised Australian suicide rate for those aged between 15 and 24 years. The 1998 figure stood at 446, representing 25% of all deaths for this age bracket. Admittedly this was an improvement on the 1997 peak rate of 510, which represented 26% of all deaths for this age bracket (ABS, 1999).

While good mental health is important for everyone, attention to youth mental health has the added dimension of being an investment in good adult mental health (AHMAC, 1994). Government and professional services alone cannot address the problem with incurring huge costs. "We need an approach for dealing with these mammoth problems – one that will expand our resources without significantly increasing our costs" (Riessman & Carroll, 1995, pix).

One such method might be the use of self-help groups, as their effectiveness and economic efficiency has been demonstrated repeatedly in the adult world (Lewis, 1988). This approach allows for a dramatic shift in perspective. Problems become assets. Individuals requiring help become the providers of help – "we can view these people as potential help givers – a resource rather than a problem" (Riessman & Carroll, 1995, pix).

SELF-HELP GROUPS

"Self-help" has become a single label, but it masks a wide variety of diverse developments (Richardson, 1983, p41).

The popularity of self-help groups is evident when one attempts to locate support for almost any health or mental health problem. The most recent edition of a Self-Help and Social Action Group Directory published by the Collective Of Self-Help Groups in Victoria, has located over 700 within Australia alone (Apr. 2000). In the United States, the prevalence is even greater. A recent search of the database produced by the National Clearinghouse located a self-help group for every illness identified by the World Health Organisation (Riessman & Carroll, 1995).

*Although numerous self-help groups form around a disease or handicap, this disease or handicap never stands alone: with self-help groups it is always connected with psycho-social factors like loneliness, fear, lack of...
understanding and stigmatisation" (Lafaille, 1983, p169). These groups primarily address coping with and prevention of particular conditions or experiences – problems that medication cannot cure (Hatch & Kickbush, 1983). They serve to influence how members define their issues, for the situation is typically personal in nature and not limited to the domains of a particular medical or social profession.

There is much heterogeneity among existing groups, even among those that share the same title. Differences can be found when inspecting group aims, the principles adopted to achieve these aims, the nature of members' involvement, the involvement of professionals, and so forth. Despite this though, there are common elements shared by the groups, thus allowing self-help groups to be collectively labelled as such. "They are composed of people with a single common problem who have joined together to provide a common solution to it. Everyone is fully involved and committed. They work by members giving help to one another on a mutual, reciprocal basis. They share, in short, a common framework" (Richardson, 1983, p32).

The propensity to give help may be greater among seasoned veterans due to experience, accumulated knowledge and a sense of commitment to others in a similar situation. However the egalitarian nature of self-help groups allows the roles of helper and helpee to be interchangeably labelled as such. "They are composed of people with a single common problem who have joined together to provide a common solution to it. Everyone is fully involved and committed. They work by members giving help to one another on a mutual, reciprocal basis. They share, in short, a common framework" (Richardson, 1983, p32).

The millions of drug addicts, compulsive eaters, gamblers, and debtors are all on the same continuum as the normal person... what Erich Fromm (1947) dubbed the "pathology of normalcy", pointing out that the pathology highlights the basic tendencies of the society. We are not suggesting a lack of qualitative difference between the drug addict and the rest of us. Addiction requires new methods of intervention" (Riessman & Carroll, 1995, p11).

RESIST CONFUSION

There exists a number of what might be termed quasi-self-help groups (ibid) which are directed by or have the greater involvement of professionals – herein defined as medical-technical experts in various health and mental health problems (Branckaerts & Denke, 1983). These should not be confused with the self-help groups referred to in this document – that is, those that exist outside the clutches of professional domination. Although both approaches may provide members with support, information and skill development opportunities, it is the latter that exists without the constraints of theory, funding agreements or managers.

"Bureaucratic organization is characterized by hierarchy, impersonal rules, and a division of labor that emphasizes technical competence. Self-help, by contrast, is highly personal; competence is based on experience, it does not have a highly differentiated division of labor, and it is typically non-hierarchical" (ibid, p6).

It is also argued that self-help groups adopt a more holistic approach to health, distinguishing between healing and curing. "The term healing [is used] to refer to what is done by the patient (or the patient's body) in order to resolve a problem of the body, mind, or spirit, whereas the term curing usually refers to what is done to the patient by a physician or therapist" (Upledger, 1989, p67).

Another more obvious difference is that the help provided by self-help groups is not a commodity that can be bought or sold. It is cost free, thus increasing access opportunities. On the other hand, professional help is usually a commodity – and a very costly one at that.

Although the term mutual aid is often used interchangeably with the term self-help (Wilson, 1983), Riessman identifies self-help as "the crucial, overarching notion and mutual aid as one of its forms" (Riessman & Carroll, 1995, p5). Riessman also distinguishes between macro and micro self-help, the former of which includes:

- The relationship of self-help to social change;
- The professional-self-help dynamic;
- The role of the state; and
- The relevance of self-help to policy issues.

The latter however concerns the mechanisms and characteristics of self-help that contribute to its effectiveness. In agreeing with these arguments, the terminology herein will be similar to that adopted by Reissman (ibid).

BENEFITS

In the attempt to keep members returning, the help provided by self-help groups manifests in many ways. After all, it is important that groups retain their experienced members for the benefit of new comers. Although not an exhaustive list, some of the benefits include:

- Emotional support which can be: Provided communally or on an individual basis;
  Aimed at helping the individual to adjust to the situation or change it; and
  Available primarily at the time of crisis or over a longer term;
- Information and advice to ease the coping process;
• Direct services which can be provided casually or through a structured format;
• Social activities;
• Lobbying activities to initiate change (Richardson, 1983); and
• Development of social and organisational skills.
Self-help groups may offer all or some of these at one time or another, primarily because “many problems have in fact more than one solution and groups naturally try to meet members’ needs in as many ways as they can...” More fundamentally, however, many conditions entail a series of different problems” (ibid, p34). Furthermore, as a consequence of members’ varying attitudes and the fact that they are at different stages of a common cycle, they come to group meetings with different needs and wants. “Organisations formed around certain demanding and long-standing conditions will find... commitment readily available. Others will have to place particular emphasis on creating it” (ibid, p41).

The emphasis on the help received from others – external self-help – is complemented with an emphasis on internal self-help. Self-help groups promote the use of “latent inner strengths and the special understanding that comes from proximity to the problem or need” (Riessman & Carroll, 1995, p3). It is here that one may find an emphasis on self-determination, self-reliance, self-production and self-empowerment.

WHEN TO JOIN
It is interesting to note that members seldom join a self-help group at the time of crisis. A study by Richardson (1983) found that before joining, over half the members of three self-help groups (one for parents of mentally handicapped children, one for lone parents and another for carers) had experienced their particular problem for over two years. Adjustment to their new situation may account for this.

SUCCESS
The success experienced by self-help groups might be attributed to its use of occidental learning. Members are provided with incidental opportunities to learn through their interaction with others – van der Avort and van Horberden (1983) label this identification resonance. They explain that “an aspect of a problem gains meaning during the resonance process (through the associations in the group) and greater understanding of the problem is gained” (p149). It is argued that the therapeutic application is very extensive. Members are provided with insight into:
• The possible external manifestations of their problem, or certain aspects of;
• The causes and backgrounds of the problem; and
• Possible solutions to the problem, or certain aspects of.

But without cooperative members, self-help groups simply do not exist. Although it could be argued that altruism is the underlying premise of such groups, it is still very possible that members have ulterior motives for their ongoing involvement. In addition to the opportunities to learn and to receive support, “Helping, in general, feels good” (Riessman & Carroll, 1995, p25).

The success of self-help groups may also be attributed to their anti-bureaucratic philosophy, which encourages members to take “one day at a time”. This user-friendly approach prevents members from becoming overwhelmed by their problem, enabling them to view it instead as manageable. However, this philosophy is accompanied with a strong emphasis on active problem solving (ibid, 1995).

Choice of technique may also explain success and can include:
• Discussion of the problems;
• Exchange of information and experience;
• Personal awareness;
• Mutual support; and
• Encouragement (Lofofille, 1983).

“Becoming a member is a change in itself, but there is also change as far as others are concerned, such as relatives and friends. The degree of approval and understanding of these others exerts an influence on the participation of the individual. The individual deciding to participate not only has to cope with a change in relationships with friends and relatives but with a change in the definition of these relationships as well.

Many self-help groups... promote the involvement of relatives... relatives form the primary environment to which attention should be given, and from which opportunities may arise” (Bakker & Karel, 1983, p177).

BUT WHAT IS SUCCESS?
Is it improvement of a condition? Improvement in psychological well being? Because self-help groups focus on subjective feelings and states of mind, success may be self-defined. Attempts to measure success will consequently pose great difficulty. Hatch and Kicnkbusch (1983) suggest that “conventional medical criteria that relate to improvements in physical functioning are insufficient for judging achievement” (p). They suggest that subjective change is susceptible to empirical
assessment and an examination of group processes. On a broader level, success may also be measured by social change. For instance, success may be the extent of improvement to the attitudes and behaviours of professionals or to the quality and structure of institutional services (ibid).

PROBLEMS

But there are problems for community self-help groups. Self-help groups, akin to the self-help movement, generally suffer from a lack of professional credit — "an underestimation of the importance of controlled observation and systematic accountability, key elements in the armor of the professions, which labor under the burdens of detachment and impersonality" (Riessman & Carroll, 1985, p1x).

Most self-help groups lack standards and formalised policies; and most fail to advise community members of their existence or even evaluate the group's adopted techniques. "Their members are often people without much experience of running organisations; they often lack confidence in their own ability to contribute to groups; and the major health and social problems which face most of them make huge demands on their life, often making the time they have available for groups unpredictable as well as limited" (Wilson, 1983, p 161). The effective operation of a self-help group can be expensive of participants' time. Other prerequisites for successful group operators can include a degree of self-confidence and organisational skill, as well as material resources like an accessible venue and transport.

But when resources are lacking, the expectations of new comers can remain unrealised and they may terminate their involvement prematurely. Seasoned members may also experience frustration when, in the attempt to develop joint interests, individual passions revealed great disparity (Brackoert & Deneke, 1983). It has been proposed that "Excessive preoccupation with one's own disease may retard recovery" (LaFalille, 1983, p 171).

Consequently government recognition for many self-help groups has not been forthcoming (Bakker & Karel, 1983). GROW for instance, is one of the most well-established self-help groups in Australia and caters for those with mental health issues. Yet financial support was not received until 1985 for evaluation purposes (Young, Dec. 1990). Further funding for self-help groups concerned with mental health issues has come only recently, with an announcement by the New South Wales State Government in February 1999 (NSW Health, 1999). Such support is often preceded by an attempt to develop policies for self-help groups particularly in health and welfare systems, to legitimise the expense. However there is a possibility that in this context, the concept of self-help will be deformed. Bakker and Karel (1983) argue:

"A different sort of policy is required for self-help. The essence of it should be an educative attitude on the part of the authorities, following developments at grass roots and consulting with those concerned...self-help groups should not be classified under existing structures. Separate provision should be made with separate policy-making...In fact, what we are talking about is a policy for stimulation and development which would have the trust of the groups and would maintain regular contact with them. Its agenda would be developed from...the different kinds of support needed by groups" (p184).

Such support may give the impression that the government is attempting to obfuscate responsibility. "The emphasis laid on the role of the individual can imply that the citizen is going to be deprived of something without getting anything back in exchange" (p183). But without government support, self-help groups continue to have difficulty attracting professional credibility, which in turn contributes to the difficulty in attracting government support.

FLOURISHING STILL

"Books by themselves can only give you ideas; if you really want to learn about mental health you have to be around people who are living mentally healthy lives themselves" (Fuller, 1998, p3).

To the surprise of many professionals, self-help groups have flourished. Two studies using large household samples found that an estimated 7.5 million American adults participated in a self-help group in 1992 (Lieberman & Snowden, 1983). Without funding, without administrative support, without professional credit, many groups have overcome numerous obstacles. Furthermore such groups have had an enormous impact on the ratio of those needing help to those providing the help.

1. "The number of individuals involved exclusively in help-giving roles is vastly reduced, and the number of helpers is increased dramatically.
2. Even when receiving help the receiver knows that tomorrow or even later at the same meeting he or she will provide help to someone else, which removes the loss of status experienced by one who is only a helpee.
3. The help-giving power of the entire unit is expanded because of the power that emanates from so many individuals playing the helping role" (Riessman & Carroll, 1985, p4-5).

Such quantitative change has been accompanied by
qualitative change. This is because the help provided is
derived from a new source – the experience of fellow help
seekers. Although once passive, their latent potential has
now been activated.

Given their lobbying power, self-help groups are also an
important vehicle to meaningful social change. Although
self-help groups generally retreat from society to address
their demands for empowerment at a local level, some
groups have proven their ability to successfully challenge
the current narcissistic compulsive consumerism, by
utilising the strength, experience and competence gained
(ibid).

It is not suggested that self-help groups are the panacea
for all the damaging side-effects of the welfare state. They
are however another piece to the jigsaw of holistic care.

Yet the approach adopted by self-help groups is hardly
new. Villages and tribes in many rural communities have
utilised the group approach to problem solving for
hundreds of years (ibid). But it appears that the wave of
new age psychology – with its themes of openness and
the acceptance of difference – has returned this traditional
approach to western society. For it is only now that we are
remembering its age-old benefits.

HISTORY

Like elsewhere in the world, Australia witnessed a surge in
the number of self-help groups in the 1970s. However
some of the more well-known self-help groups, like
Alcoholics Anonymous and GROW, came to exist in
Australia much earlier (Smith et al, 2000).

But how did this approach begin? It has been argued that
the mounting dissatisfaction with professional services
gave birth to self-help groups – the failure to provide equal
distribution of resources; the delivery of services in
punitive ways. “It would be easy to answer that it emerged
from pain, and at a certain level this is valid. But that
response is incomplete” (Riessman & Carroll, 1995,
p12).

The zeitgeist was very much responsible for what we have
witnessed. “Revolutions typically do not occur at the
lowest point but rather when expectations are rising in
light of changing conditions and new possibilities” (ibid, p18).

American history speaks of the friendly societies, consumer cooperatives and ethnic-based power groups of
the early twentieth century. In recognising the perils of
industrialisation (the decline in neighbourhoods, increased mobility and the familial breakdown), these
groups met the needs of those struggling to cope and also
politised these needs (Katz & Bender, 1976). However
the formation of Alcoholics Anonymous in the United
States in 1935, began the modern era of self-help for it
offered a new alternative – a new type of neighbourhood
(Riessen & Carroll, 1995).

Following World War II, Australia, akin to the other western
societies, enjoyed much economic growth. Rations were
lifted, employment opportunities flourished and
consumerism was on the rise. Consumerism brought with
it many things. It replaced many traditional communal
supports with "the cold comforts of competition, rampant
individualism, bureaucracy, the TV set, and the prying eye
of the technostate" (ibid, p17). On a positive note
however, it also brought with it the power of choice.

Although in a somewhat limited way, consumers were
given opportunities to develop an ability to appraise,
critique and evaluate. Consumerism also provided
individuals with opportunities to control their daily
behaviours (e.g. Shopping, banking, etc.), thus fostering a
sense of self-empowerment.

Self-empowerment was also aided by:

- The expansion of formal education;
- The expansion of the media, particularly television,
  which served to educate its viewers and impart the
  findings of investigative journalism;
- The demise of trust in large institutions – government,
  the professions, business – particularly as a
  consequence of major political events in the past two
decades; and
- The social movements of the 1960s, namely civil
  rights, Vietnam, free speech and the counterculture
  (ibid).

The 1960s gave great momentum to the self-help
movement of the 1970s. It was this decade that saw the
emergence of many conscious-raising groups, which
were initially concerned with identity issues. In using their
ability to appraise, critique and evaluate, brave individuals
recognised gaps in existing support services (particularly
in health and welfare) and circumvented credited
professionals to develop small supportive communities.
Consequently many group members experienced
enhanced self-empowerment. This is primarily because of
their reliance on local resources (that is, others in a
similar situation who meet regularly at a local venue to
solve specific problems) as opposed to a reliance on
entrenched establishment authorities. “In this sense, self-
help represents not a rebellion against the imperial
grandiosity of the modern world but rather a return to the
more governable limits of neighbourhood, friends, family,
and self” (ibid, p21).

THE AUSTRALIAN WAY

Given the commonalities shared by the Australian culture
and self-help groups, one can understand why the
community quickly accepted the latter. It has been argued
that Australian culture has a number of salient features,
namely:
NETWORK

Secularism;
Anti-intellectualism; and
Populism (Patience, 1992).

These concepts are also central to the approach adopted by self-help groups. Such groups emphasise:

- Demystification through the preference for simple and direct principles, as opposed to jargon and circuitous explanations;
- Anti-elitism and anti-expertism; and
- Equality — not only among members but also at a personal level and in the private domain (Riessman & Carroll, 1995).

Despite Australia's egalitarian ideology, "not everyone has the same capacity to initiate and sustain groups or an equal opportunity to take part in them" (Hatch & Kickbush, 1983, p.195). Economic, social, psychological and geographical reasons have been cited.

But what of age? Would the capacity of a young person be further limited simply because of chronology? Patience (1992) argues that young people are quite susceptible to cultural influences. He asserts that elements of Australia's hard culture — secularism, populism, racism and xenophobia and its masculinist sexism — are potentially psychopathogenic to young people, especially adolescent males. These elements stunt psychosocial maturation as they negatively influence the consciousness, identity, understanding and behaviour. Although his arguments may hold some truth, it appears that the benefits reaped by many adult self-helpers have been readily recognised and harnessed by some Australian young people. Consequently they have established groups for young people experiencing a mental illness or emotional problem — namely, the Australian Society of Students with Mental Illness; Young GROW; and the Youth Sexuality Network.

AUSTRALIA'S YOUNG PEOPLE

While the Commonwealth and the States/Territories share responsibility for the welfare of young people, it is latter (both in the government and non-government sectors) that provide most of the practical services (Boss et al, 1995). Yet in deciding which services are responsible for the various problems experienced by young people, there has been little consistency between the States/Territories (Sawyer et al., 1992).

A prime reason may be the difficulty in precisely defining the age of young people and the various problems they experience. Such ambiguity may allow for unfettered freedom in the development of policies that are appropriate to regional conditions. But it has also produced "a bewildering array of jurisdictions and legislation, which means that children and young people can be advantageously or disadvantageously affected, depending on where they live" (Boss et al, 1995, pxxiv).

There also exists variety in the terminology used. In reviewing relevant literature, often the terms adolescent, teenager, and young person are used interchangeably. Since its appearance in a 1905 text by G. Stanley Hall, the term adolescent has traditionally been linked to delinquency and can thus possess negative connotation (Fuller, 1998). The term teenager can also be limiting as it is often applied exclusively to those aged 13 to 19 years. It is for these reasons that the term young person will be adopted herein.

But how old is a young person? There currently exists no widely accepted age bracket to confine young people. Akin to the United Nations, the NSW Health Department suggests the broad scope of 12 to 24 years (Dec. 1998), whereas the National Youth Affairs Research Scheme has proposed 15 to 20 years (1992).

Placing primary importance on school level, Fuller (1998) asserts that young people can be categorised as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Year at School</th>
<th>Common Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early adolescence</td>
<td>5 to 8</td>
<td>Body growth and shape, sexuality, teasing about appearance</td>
</tr>
<tr>
<td>Middle adolescence</td>
<td>9 and 10</td>
<td>Individuation, family bottles, social success — being cool, finding a niche</td>
</tr>
<tr>
<td>Late adolescence</td>
<td>11 and 12</td>
<td>Sex, drugs, gangs, falling, freedom, finances, sexuality, depression</td>
</tr>
</tbody>
</table>

"Sixteen years of age is not an absolute cut-off point for adolescents to be able to provide informed consent. Research on the ability of young people of normal intelligence to give informed consent for treatment shows that children as young as 8 years may show some consent capacity" (Waters, et al, p153).

Given the author's interest in youth mental health services, it is noteworthy that those between 15 and 24 years are likely to experience a significant shift in responsibility for personal care from the family to the individual (AHMAC, 1994). This is most likely due to current New South Wales law which allows those over 14 years to legally consent to their own general medical or dental treatment (Minors (Property and Contracts) Act s.49) (McAllister, Oct. 1999). Not all would agree with such preciseness. While some research suggests that children as young as eight years old can demonstrate a capacity to consent...
to treatment (Waters et al., 1992), guardians remain responsible for guiding their child’s development. However it is widely held that young people have rights over their own bodies, as well as the right to confidentiality and privacy (Waters et al., 1992). Thus, for the purposes of this document, young people will include those aged 15 to 24 years.

MENTAL ILLNESS AND EMOTIONAL PROBLEMS

Akin to other age brackets mental illness and emotional problems are of a great variety among young people. However, in addition to this heterogeneity, there are added difficulties. Defining such problems in young people is a rather complex and contentious issue. Consideration must be given to the inter-relationship with emotional disturbance and behavioural disorder; the influence of developmental stage on the presentation of symptoms; the difference between adult and juvenile forms of the same disorder; and the role of contributing factors in diagnosis (Boss et al., 1995). One such contributing factor is the experience of the service provider. In their attempt to identify the mental health problems experienced by young people, most service providers in one study based their response on their personal experience of working with young people rather than epidemiological studies (Sawyer et al., 1992). These participants represented various agencies including health, mental health, welfare, education, youth, and self-help groups. "It is possible that problems which are commonly present in young people in the community but not among young people attending health, youth, welfare or education services will receive less attention" (ibid, p18). It is for the above reasons that there is little consensus in defining the mental illness and emotional problems of young people.

However pubertal development is often accompanied by unhealthy psychological development. It is often at this time that psychological disorders have their onset with around 50% first being manifest between the ages of 16 and 18 years (Sawyer et al., 1990). Depression, substance abuse, conduct disorder and psychosis have all been cited, with suicide, psychosis and the effects of abuse perceived as having the worst prognosis (Sawyer et al., 1992). A sample of youth service providers in one study believed that:

- The effects of abuse, depression and suicide cause the greatest distress to young people;
- Psychotic disorders and suicide cause the most distress to families; and
- Substance abuse and conduct problems pose the greatest financial burden for the community (ibid).

Despite difficulties in diagnosis, it is estimated that up to 15% of those aged under 18 years suffer from psychiatric disorders which warrant recognition and up to 5% that suffer from disorders which warrant intervention (RANZCP, 1984). In New South Wales alone, there are approximately 1.25 million people aged between 12 and 24 years – 20% of the population (NSW Health, Dec. 1998). This fact should mean an abundance of appropriate treatment options. But often difficulties in diagnosis are accompanied by difficulties in treatment. Narrow clinical definitions, admission criteria and legislative charters of the relevant departments or institutions often deny young people the attention they require (Human Rights and Equal Opportunity Commission, 1993). So too does the foreign terminology adopted by professionals. In their interviews with young people, Sawyer and associates (1992) discovered that most did not understand the meaning of the terms mental health problems and psychiatric illness/disorder – even if the participant was using an adolescent mental health service at the time of interview. The researchers note, "most services which provide help for young people with mental health problems or psychiatric disorders describe themselves as, for example, a "Mental Health Service" or a "Department of Psychiatry". In light of the findings in this study, it seems reasonable to suggest that some young people with mental health problems may not obtain help because they are unaware of both the nature of their problems, and the services from which they may obtain help" (ibid, p39-40).

Should the above barriers be overcome, there are still inherent problems with the services that may see the premature termination of treatment by the young person. Through interviewing samples of service providers, young people living in the community, and young people using an adolescent mental health service, Sawyer and associates (1992) provided great insight into views toward existing services. For instance, 90% of the former reported gaps in the mental health services offered to 15 to 20 year olds. Given their experience in educational settings, the sample of community young people made reference to:

- The under staffing among School Counsellors and to provide help;
- young people with problems initially present for help of a wide range of different services (Sawyer et al., 1992); and
- young people often have limited resources to manage personal care (AHMAC, 1994).

LEARNING FROM OUR PAST

Australia has witnessed great change in the treatment of mental illness and emotional problems. Akin to adult treatments, the 1950s encouraged the use of behaviour therapy and medication for young people with such problems – particularly because of the invention of neuroleptic medications. In the 1960s, more experimental
practices were adopted – LSD therapy as well as experiential and humanistic therapies. It was a time when “the pursuit of individual knowledge, experience and awareness was combined with collective action” (Fuller, 1998, p20).

Swept up in a wave of community health, mental health in the 1970s looked beyond the internal world of patients to therapies. Family therapy became more commonly used. From Aboriginal or Torres Strait Islander homes, this can while for others there is multi-generational unemployment to seek out similarly minded people. The families of young people have also changed, increasing in diversity. For those from Aboriginal or Torres Strait Islander homes, this can often mean living in a multi-family household. The prevalence of single parent families and blended families are also increasing. “We have shifted from a situation of asking parents how many children they have to asking children how many parents they have” (Fuller, 1988, p29).

Can today’s young person be typecast? Great heterogeneity makes this very difficult, hence the wide acceptance of the term Generation X – a label coined by Coupland (1991). McKay (1997) however does see a shimmer of homogeneity and refers to the current generation of young people as the Options Generation. He suggests that these are individuals who “hold off on making definitive moves because something better might always show up” (Fuller, 1998, p30). For the many young people who experience mental illness or emotional problems, perhaps that something better might be in the form of a self-help group.

Support for this model can be derived from multiple sources. The young participants interviewed by Sawyer and associates (1992) highlighted that young people generally appreciate opportunities to discuss their problems with others who have similar problems and are of a similar age. “This view was often expressed by the young people in the clinic group who appeared to derive support from their peers and who, at times, described adult staff members as “threatening” (ibid, p43).

Effective treatment and rehabilitation for young people with mental illness aims to:

- Prevent relapse, re-hospitalisation and avoidable complications of the illness;
- Enhance independent functioning; and

Experienced clinicians are of the opinion that the best treatment and rehabilitation for young people with mental illness involves a multi-dimensional approach, where support is offered on differing levels, including that of the community (ibid). Community settings are particularly useful in influencing the environmental and social determinants of ill mental health and unhealthy lifestyles (National Health Strategy, 1993).

There is good reason to include self-help groups within this multi-dimensional approach (Haliburn, 1987). They may be particularly beneficial given the considerable influence of peer groups among young people, and mentally ill young people often require social skills training (Waters, et al, 1992). And discussions that require inter-personal problem solving and conflict resolution skills are also of value to young people (Van Slyck, Stern & Zak-Place, 1996). “Rehearsal of coping skills leads to better performance when they are needed” (Fuller, 1998, p10).

The ideal model of treatment for young people with mental illness and emotional problems would be a comprehensive mental health service network that includes a range of different components (RANZCP, 1982; Wells, 1982). The network would balance the relatively expensive provision of individual treatment with the less costly community-based, preventive initiatives. Such a model may assist young people assume more responsibility for their own health care (AHMAC, 1994).

But even without the diagnosis of a mental illness, young people remain at risk of self-harm and suicide (Boss et al, 1995). Low self-esteem, family breakdown, poor education, leaving school early, homelessness, and, particularly for young males, the pressure of societal role expectations, increase this risk (Human-Rights and Equal Opportunity Commission, 1993). This has been affirmed by both public consultations (AHMAC, 1994) and young people in another study who generically cited stress and family issues (Sawyer et al, 1992).

In reducing this risk, there is much support for the benefits of connectedness (Resnick, Harris & Blum, 1993) particularly to family and schools. Connectedness
enhances personal resilience to emotional difficulties and may circumvent further escalation (Fuller, McGraw & Goodyear, 1998). In fact it has been suggested that connectedness is negatively correlated with emotional problems (Fuller, 1998). Australian young people who have experienced emotional problems praise the support offered by committed individuals — people who provided guidance, a sense of identity and a sense of belonging (ibid). More importantly, they were available, even if incidentally, over a long period of time.

Whether or not there exist family and school supports, self-help groups may provide a community in which such resilience is nurtured. For the connectedness young people feel toward specific people or places does not appear to generalise to other settings (ibid). But Fuller (1992) asserts that the only prerequisite in promoting resilience, attachment and a sense of belonging in young people, is a conscious decision to embark on such a project.

“Belonging somewhere doesn’t mean being owned or dominated, it means feeling a part of a place, somewhere you feel recognised for who you are; somewhere an eye will be kept on you and you will look out for others; a place where you are visible and relied upon; a place where you are in an ongoing relationship, both its highs and lows, with others; a place where, when you call out or knock on the door, they just have to answer” (p9).

Self-help groups could offer young people opportunities to reframe their predicaments and thus consider new possibilities for change and improvement. This could occur while ensuring the new perspective is in tune with existing values, for the support is derived from like-minded peers.

It is thus the aim of this research project to test the viability of this option for young people experiencing mental illness and emotional problems. It may be argued that the mere presence of an external researcher within a self-help group environment may disturb the very essence of the group — for traditionally there has been little commonality between self-help groups and professionals. But it appears that many self-help groups and professionals are forming new relationships.

THE WAY FORWARD

It is a long-standing belief that self-help groups arose because of disdain with professionals. Their inability to provide comprehensive information, adequate care, or simply understand the predicament of their patients. However in recognising their limitations, an increasing number of self-help groups have utilised the knowledge and skill of professionals in various ways, often to the benefit of both parties.

A professional can play many roles within a self-help group:

- A seminar presenter;
- A provider of informal medical counsel;
- A role model of effective group facilitation and organisational skills;
- A link to a network of campaign-targets;
- An independent assessor or consultant;
- A source of referrals;
- Even as a resource to refer individual group members needing more personal attention (Caplan, 1974; Silverman, 1976, 1980).

In their study of Californian self-help groups, Goodman and Jacobs (1984) identified thirteen different professional roles. They also discovered that 83 per cent of these groups had the involvement of a professional to some degree.

The professional can also intercede between self-help groups and professional organisations, thereby attracting the financial support necessary for the group’s operation (Bakker & Karel, 1983). Funds are often required for administrative tasks and the use of an accessible venue and other facilities. Collaboration between these traditional rivals has been sighted internationally. Hollstein and Perths (1980) cited examples in Germany, Austria and Switzerland; Young and Rigge (1980) in England; and Lieberman and Borman (1978) and Gartner and Riessman (1980) located examples in the United States. Such examples create a better working climate for like-minded others.

Bakker and Karel (1983) suggest that collaboration could also occur in less conspicuous ways:

- explicitly devoting time to self-help groups within the training of health professionals;
- Through the financial support of statutory authorities for the purpose of applied or action research, which may be further aided by professionals with particular research skills; or
- Through government support toward the establishment of clearing-houses or support centres.

As long as professional involvement is limited in time and intensity, an effective working partnership between self-help groups and professionals will ultimately benefit both parties. With a sense of guile, self-help groups are in a better position to access resources, which will enhance their operation, and professionals are given an opportunity to increase their clientele. But more importantly, a synergy is created which greatly expands the resources available to those with mental illness and emotional problems.

Despite this, many members of self-help groups continue to fear the genuine possibility of losing group autonomy and creativity to professionals. Many have witnessed the distortion of development in self-help groups by the crude...
efficiency concepts used by professionals. They have also observed the negative correlation between external control and group members' self-confidence in their ability to help others or themselves. "One of the main dangers may be the restriction of self-help group development due to excessively narrow definitions of health or of self-help groups that might be imposed by conventional bureaucracies" (Bronckaerts & Deneke, 1983, p.186). The concern of these group members is further validated by:

• Ostensibly supportive professional organisations which dictate the types of support offered and aims the group should strive to achieve (with often the former being dependent on the latter);

• The overpowering involvement of individual professionals who inhibit the movement of the group; and

• Researchers who approach self-help groups with preconceived definitions and ideas of the tasks executed by such groups (ibid).

But there exist professionals who want to challenge the existing definitions and responses to medical and social problems. Recognising the limitations of existing structures, they see in self-help groups a lever for change – a way of taking health care out of the consulting room and into the community. Admittedly it is not always clear whether this partnership is an expression of "colonialism or of subversion, of professionals seeking to exert a more pervasive if more subtle influence on the behaviour of the lay population, or of lay people challenging the assumptions and prerogatives of the medical professionals. Movement in both directions seems to be in progress" (Hatch & Kickbush, 1983, p193). However these individuals have made possible the increasing number of examples of bona fide collaboration between self-help groups and professionals – alas, the climate is changing. And greater public visibility of such examples will only help transform the political and cultural climate in their favour (Bronckaerts & Deneke, 1983).

Politically speaking there is a place for self-help groups. Advocates for the self-help movement can be found on both the left and right poles of the political sphere, thus cutting across many boundaries. The United States and Britain have demonstrated the viable existence of self-help groups within both a free enterprise health system and under a centralised national health service and European countries with systems that lie somewhere in between (Hatch & Kickbush, 1983).

In light of the support given to both self-help groups and youth mental health by the New South Wales' State Government (Carr Labor Government, 1999), there may be great political viability for self-help groups for young people with mental illness or emotional problems. It is for the aforementioned reasons that the research here proposed will be endeavoured.

UN youth definition
ABS Census 15-20 yr olds
Youth suicide (1999), ABS Canberra
ABS Australian Social Trends 2000 (4102.0)

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Introduction

When Families in Partnership (FIP) was used on national television to illustrate a community group that has been successful in the Australian context (ABC Lateline, February 15, 2001), its selection as the example was a public acknowledgement of the success this group has achieved.

In his analysis of the small-group movement in the United States, Banks (1997) posits that such a movement is thriving in that country (four of every ten Americans now belong to such a group), because of their ability to create “flexible and changeable bonds” across different boundaries. The means through which such groups come together to find solutions to common problems are at times complex, and have formed the bases for discussion by a number of disciplines. A brief review of the literature provides evidence of multiple explanations of how people become ‘social actors’, a process through which individuals and groups of people become actively engaged with their community so as to bring about a degree of social transformation from which they will collectively benefit (e.g. Putnam 1993; Freedman 1994; Gill & Simeoni 1995; Cox 1995; Rothman 1973; 1995; Baum 1998; Leeder & Dominello 1998; Damen, Mortelenaars & Van Hove 2000; Hawe & Shell 2000).

The influential work on education by Paulo Friere amongst the poor and disposed in South America demonstrated how people with similar need come together so as “to name (italics in the original) the world in order to transform it” (Friere 1972:135).

Notions of advocacy, common interest, shared values, reciprocal trust, capacity building, cooperation, networking and social capital, are all common in explanations and analyses of this process.

This article reports on Families in Partnership as an exemplary case study of how a small group of women, mothers of children with disabilities, living in the Macarthur Area in South Western Sydney forged alliances with institutions and the wider community. The paper describes the evolutionary process of the group, their concerns and achievements to date, and comments on possible limitations and future cautions.

A coming together

The catalyst for Families in Partnership began in 1997 when a small group of women (the instigators) with similar experiences, all mothers of children with disabilities, approached the University of Western Sydney (UWS) Campbelltown Campus, with the intent of forming a partnership with the university. A partnership with key institutions and agencies was seen as a way to find amenable solutions to many of the problems they were experiencing. What set these women apart from other women and held them together in a common bond, were their shared experiences and concerns about their disabled children. They were concerned about what would happen to their children as adults - when their children reached the chronological and ‘magical’ age of 18 when some services will no longer be available to them. They had also recognised gaps in a system that provided neither holistic, nor continuity in care for their children. All reported having experienced unsatisfactory communication and feelings of powerlessness in their interactions with teachers, health professionals and other service providers. Similarly they had first hand experience of the ineffective way that different sectors across different institutions communicate with each other, such as information not being transmitted between health and community services, or between health and education sectors.

As a result of their acute feelings of ‘disadvantage’ in dealing with professionals, one of the first activities pursued by the group was the development of a advocacy skills program (See Table 1) which all instigating mothers undertook. The implementation of this program provided the opportunity to record the stories of other families that validated and reinforced the commonality of experiences reported by the instigators.

'Them and us' and other issues

In a focus group conducted by two of the authors, some of these issues came into light more fully. The focus group consisted of 10 women of different age and occupational background and with children of varied age and levels of disability. The focus group was undertaken before the first advocacy skill program so as to glean the women’s specific needs and experiences.

Fragmentation in services was identified as the key issue of concern. Discontinuity in care and educational services was likely to be experienced when a child moved from one kind of educational institution to another, as highlighted here by the comments of three women with children of...
different age and different level of disabilities:

It’s bloody hard. It’s hard when you leave an environment where you’ve been secure and you’ve had services, then you go into the Department of Education then all of a sudden it depends on where you are. So if you (the child) goes to a SSP [School for Special Purposes] her services stop at the hospital straight away and then you’ve got to rely on DOCS [Department of Community Services] to give you speech, physio and OT. But if there is no one in those positions you don’t get any. So then you have to go back to private and it’s the cost of going private and fitting time into school hours. So you are learning a whole new system each time a child transfers to a new environment. There is no network set up in services that can say this would suit your child and if it doesn’t we can offer support.

It took us a good couple of months to find an actual preschool that would take all my children so that I wasn’t running from one end of Campbelltown to the other just because he had a disability.

Now my son is 18 so I’ve been dealing with a little bit of early intervention, primary school, high school, my son finishes this year and now I’m trying to learn how to cope with TAFE.

Discontentment with the existing school system, based on the perception that it failed to recognise their child’s special needs, coupled with poor communication with teachers and a perception the system “had no tolerance for our children”, coloured many of the women’s stories. This is how one woman spoke of her situation:

You go to school and it’s just about academic success or failure. There’s no consideration of what the dynamics are that make up the child. My son goes on detention. They don’t feel that that’s something I need to know, but if I can address those issues at home it might help him at school with my little talk at home. So like if they just made it more a team and it’s not. It’s them and it’s us and there’s that big division. They don’t realize that we are experts on our children. We know how to get the best out of them.

Embedded in these voices were also reports of positive experiences. In such instances it was an individual teacher or school principal that had made the difference. It’s taken me four years to get positive about school and only because last year we really got a good teacher who was very family focused...for the first time I felt I was totally in control and could be listen to ... on how I wanted my daughter educated.

A second woman spoke in glowing terms about the school where her daughter had recently being transferred. A transfer had been initiated after she had “felt I was hitting a brick wall” with the (previous) school principal.

They’ve (school staff) walked over mountains to help her. She goes to this school and they’ve done so much for her.

Juxtaposing the here and now, women questioned what would happen to their children as they and their children grew older and they, as parents, were no longer around to advocate on their behalf. This, as noted in the following comment, produced a kind of anxiety as well as desire to do something about it ‘right now’.

Our children are expected to fit in to these categories and they just don’t fit and no one is tolerant even though they’re aware, but no one is tolerant enough to accept it. That’s okay while I’m here, I can do this for him, but what I get concerned about is when I’m not here who’s going to fight for him? So... I want to fix things now so when I’m not here he can carry on.

Continuity between and within services, was high on the women’s agenda of what needed to change. Further it was self-evident that, as with most parents, these women want the best for their children. While they are aware that the children’s disability places limitations on what they can achieve, collectively they express a desire for their child to achieve his/her fullest learning (and life) potential. While most had had negative and unproductive experiences, several women spoke of how things could be made better by forming links with service providers. The women were also able to envisage what might happen to their children in the future and wanted institutional changes that would assist their children when they are adults.

FIP and its achievements

As with similar ‘grass roots’ groups (e.g. Banks 1997; Finn, Chewckoway 1998; Darnen, Mortelmans, Van Hove 2000) FIP set out to find solutions to a shared problem - a lack of co-ordination of services around the care of disabled children and their families, as well as a perceived inability to truly participate in the planning and implementation of that care. Such feelings are important according to Hyde (2000), who asserts that participation and control are important dimensions of effective health care and other social services. The genesis for improving the situation is based on a philosophy that seeks active engagement and co-operation between the children, their families, community sectors and service providers in order “to create the best possible ‘whole-of-life’ care and services for people with developmental disabilities in the Macarthur area” (Families in Partnership Co-operative Ltd, 2000, p.44). This philosophy is expressed in the key goal to:

empower families to work in partnership with professionals and service providers in order to enhance the life chances of families with members who have developmental disabilities in the Macarthur region and to empower the community to recognise ability diversity throughout all age groups. (p.45).

FIP identifies itself as a grass roots group wanting to
maintain its community links as well as increasing links with institutions. The group is also working to develop partnerships and to influence policy development and the provision of services and facilities at all levels of government and by Non Government Organisations (NGOs). The group's capacity to build and make horizontal and vertical links has proved highly successful. Table 1 summarises some of the group's achievements:

As shown by the summary of activities, the ability of this small group of women for capacity building over four years has been remarkable. When analysing what has been achieved it should be noted that these women have many other commitments and responsibilities. Most are in part time or full time work, some are single parents, all have at least one child with a disability that, by definition, requires special care, and most have other young children to parent and care for. While this paper cannot provide a definitive reason for their success it is self-evident that the group is made up of highly motivated women, who have made a personal commitment to make a difference to the quality of their children's and other children's lives.

In analysing what has been achieved we were guided by Rothman's classic exposition (1973; 1995). Rothman proposes three different approaches to community intervention:

1. Locality development - where the goal is capacity building, integration and self help;
2. Social planning/policy approach - where the goal is rational problem solving through change in policies and planning;
3. Social action - a more radical and critical approach whose goal is in the shifting of power relations and resources and in achieving basic institutional

Table 1. Summary of achievements since establishment of Families in Partnership in 1997.

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Establishment of FIP Board &amp; Advisory Committee institutions e.g. Macarthur</td>
<td>Mothers have 50% representation on the Board, which is chaired by a mother. The Board also has representatives from Temporary Care, DOCS, UWS, Department of Education. The Advisory Committee includes academics, a sitting member of Federal parliament, the General Manager of Campbelltown Hospital, representative from government and community sectors. The Board has executive power, while the Committee acts in an advisory and at times advocacy capacity on a range of matters including how to address funding issues.</td>
</tr>
<tr>
<td>Set up of the Advocacy Skills Program</td>
<td>A 6 week program now in its 3rd year. Its aim is to teach mothers skills in assertiveness, advocacy, conflict resolution and effective communication, so they can be confident when dealing with professionals. Originally funded by the Cabramatta Leagues Club, more recently the program received a grant to continue the program from NSW Department of Women.</td>
</tr>
<tr>
<td>'Building Bridges' Conference</td>
<td>A state wide conference held in 1999 at UWS. Over 400 people attended, participants included families with disabilities, service providers, academics and government representatives.</td>
</tr>
<tr>
<td>Funding of Play Program</td>
<td>A special school program that uses a 'buddy system' to enhance the school experience of disabled children.</td>
</tr>
<tr>
<td>Developing &amp; receiving funds for the position of a Development Officer</td>
<td>This state (NSW) funded position has recently been filled. The role includes responding to special needs of new (and old) families with disabilities by helping their navigation of systems.</td>
</tr>
<tr>
<td>Special School Project</td>
<td>A proposal for a school to serve the special needs of children with disabilities in the Macarthur area is currently being negotiated. This pilot project involves collaboration and support from stakeholders such as NSW state government and UWS.</td>
</tr>
<tr>
<td>Becoming part of the Social Entrepreneurial Network</td>
<td>A newly established national association that links 'grass roots' groups like FIP together.</td>
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changes. FIP's desire to build reciprocal and interconnecting relationships with those sectors in the community who share in the responsibility, the care, education, health, and the shaping of the social and personal behaviour and sense of worth of their children is clearly reflective of Rothman's concept of locality development. However juxtaposed to this is also the salient and persistent desire of the group to shift the power base by taking back control of what is to happen to their children and their families.

Limitations and cautions
At a glance it is obvious that FIP has achieved much. Alongside these achievements there are inherent limitations within the project. To date we have no evidence of how effective FIP has been in making a difference at the personal experiential level. We have not evaluated if and how women's behaviour has been positively affected as a result of their exposure to FIP, or in the certainty of their capacity to deal more effectively with health and other professionals, or how much better they are in advocating for their children on issues that concern them. We do not know if gaps in services and/or poor communication have been minimized and/or improved. The small number of women involved makes any such evaluation conditional on context and personal differences between individuals.

At another level it is difficult and perhaps too early to know if FIP will ultimately impact on government policies. More generally we have concerns that governments, of whatever political persuasion, may be tempted to pull back on precious resources and adopt a 'let them help themselves' attitude, as grass roots groups such as FIP become more assertive and more able to find alternative ways to assist and resource themselves. But perhaps the greatest threat to the group's survival is that it may 'run out of steam'. Inherent in this is the potential for members to become fatigued, move to other areas, assume other responsibilities, and/or be overtaken by new models, new ideas, new 'buzz' words and new ways of doing things before achieving what they have set out to do.

Discussion
Meeting the needs of young people with a disability and their families in ways that are both generic and specific requires a shift in focus. As C. Wright Mills (1959) so aptly stated, personal troubles become public issues when there is groundswell of concern. Having a child with disability is more than 'personal troubles'. These are public issues that need to be addressed in a comprehensive, sensible and sensitive manner. The mothers in the current project are actively engaged in building strong bridges where none existed. They are agitating for change.

In many ways FIP embodies the high level of energy, passion and creativity, and the personal cost and sacrifice that women in particular are willing to make to ensure that the quality of their children's future will be maximised. Importantly it is also about a small group of women finding a collective voice to bring about a shift in the power balance, by attempting to reclaim control over determinations of what is best for their children, and demanding to be responded to in ways that are meaningful to them and their families. The model they have adopted clearly shows a desire to collaborate, connect and work with and alongside those who in the past had most of the control over what should, or should not, happen to their disabled children and indirectly to them and their families.

The (post)modern phenomenon of small group movement can be sustained, according to Banks (1997) in societies such as the United States where there are fewer traditional connective ties, because:
1. Members are more interested in the collective benefits produced by the group than in any community they can enjoy alone;
2. The collective benefits are not divisible into individual "units", it can only be enjoyed in common, and nobody can abscond with the benefits. (1997:31)

FIP serves as a microcosm of how 'community action' becomes a transformative process for the 'actors' themselves.

Acknowledgments
We would like to express our thanks all the women in FIP for their inspiration and the genesis of this paper.

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To Know or Not to Know: Psychic Numbing and Australia's New Nuclear Reactor

Fran Gale, Genevieve Rankin

It is argued that 'psychic numbing' is an important constraint on activism and mobilisation in the campaign against the Australian Government's decision to build a new nuclear reactor in suburban Sydney. Psychic numbing can be challenged and recede but in this case the political context, in particular, the pro-nuclear position of the Government acts to maintain and enhance numbing.

'To be or not to be, that is the question' Hamlet (Act 111, Scene 1).

The Australian Government is proposing to spend $527 million on building a new nuclear reactor in suburban Sydney. Surveys of public opinion have consistently shown between 75% - 89% of Australians do not agree with the decision to build a new reactor (Insight Research 2000, BBC Consulting Planners 1997, Keys Young 1997).

Our study aimed to shed light on the question of why overwhelming popular opinion is against the new reactor, yet mass mobilisation has not been achieved.

One hundred and sixty residents participated in the study. Both male and female residents were interviewed and a semi-structured interview schedule was used. Households were telephoned from a random list of residents living in two suburbs, in the local government area of Sutherland, which are in close proximity to the reactor. Residents were drawn in equal proportion from these two suburbs. Sutherland is predominantly white Anglo-Saxon and middle class (Australian Bureau of Statistics 1996).

A qualitative methodology was chosen primarily because this approach enabled activism to be examined from a perspective which placed residents' voices at the centre of analysis.

Three main factors emerged in data analysis: 'psychic numbing', the framing and management of information by pro-nuclear authorities and residents' sense of lack of agency in the face of government and institutional power. Psychic numbing is the primary focus of this paper. The two other factors are discussed in relation to their role in maintaining it.

Psychic Numbing

Residents' comments such as:

'Too much information would cause panic'.

The 'need not to know' can be a form of resistance to mounting evidence. Citizens' psychic numbing,
according to Lifton and Markusen, can become an active process on behalf of certain forms of moral and psychological passivity. Drawing parallels between nuclear threat and the Nazi Holocaust, they point out that, two factors contribute to psychic numbing. First, the truth is disturbing and therefore resisted and second, in the absence of such mass destruction in one's own life, it is difficult to imagine. These factors can contribute to a 'need not to know' which takes on elements of self deception. 'Indeed the numbing, disavowal and doubling, along with the self deception and corruption enabled one to know and not feel or both to know and not know' (1990:241,198).

Describing the pervasiveness of numbing, Lifton and Markusen observe that it is a 'vicious circle' with extreme dissociation at the centre among those most closely involved with the nuclear industry (e.g. nuclear strategists) and less but still active dissociation at the periphery (including the numbing of citizens). Significant in this circle are the reassurances made by 'experts concerning the safety and wisdom of their policies and scenarios' (1990:217).

Maintaining and Enhancing Numbing Images and the imagination as a site of struggle

The battle for the collective imagination is an important site of struggle between pro-nuclear and anti-nuclear forces in shaping the way nuclear issues are perceived by the public. The new reactor has been presented to the community by the Government and its agency the Australian Nuclear Science and Technology Organisation (ANSTO) as essential for the production of isotopes for cancer treatment.

In the 'ideology of nuclearism' there is an 'exaggerated' embrace, Lifton and Markusen argue, of technology and dependency on it for 'security, peace and something close to salvation'. This creates a narrative which focuses on heightened collective life rather than on mass destruction. 'It becomes the master narrative for those in power and for many others, to the extent that alternative voices can find little expression'. Nuclear narratives are sustained by certain psychological mechanisms, such as psychic numbing, which protect people from registering their potential or immediate harmful effects (Lifton and Markusen 1990:12,13).

The Australian Government's public emphasis in the 'nuclear narrative' is that the new nuclear reactor will produce life saving medicine. In order to 'sell' the new nuclear reactor to the public, the Australian government has a strategy to 'overstate' the benefits of a reactor for isotope production for nuclear medicine (Background Briefing ABC Radio 29.3.1998). Many residents reported feeling confused, believing that if the reactor isn't built Australia will be at risk of having no isotopes for cancer treatment.

'he reactor is needed for isotopes for hospitals'.

'my cancer was treated by isotopes from that reactor'.

A number of nuclear medicine specialists in Sydney distribute ANSTO public relations material, to their patients, potentially giving a misleading impression that their treatment was produced at the reactor.

Here the reactor is presented as 'life saving'. The threat (of the reactor) is dressed as 'progress'. One resident explains that she is concerned about the proposed new reactor but knows:

'he (existing) reactor does lots of good work'.

The pro-nuclear authorities have seized the high moral ground using symbolic, emotionally charged moral messages. Imagination is changed, writes Fischer, when addressed in its own language i.e. in the language of image, symbol and metaphor (1992:10). The image of the reactor as making people well and saving lives is pitted against its more negative, sinister associations of, potentially, making people ill and bringing about death.

Nuclear numbing is a mild form of dissociation (people can remain functional and quite reactive in other areas) but, Lifton and Markusen emphasise, it is of enormous collective and historical significance. Its consequence is a widespread inability to imagine nuclear genocide. Our failure to imagine, is at least due, in part, to a psychological resistance to taking in 'the most dreadful of images and the absence in past experience of anything approaching the scope of such annihilation. That event, because of the dimensions of its ahuman technology, is difficult to imagine. For all of us it remains remote' (1990:248, 249).

In some European countries presentation of alternative images have broken through numbing and seen it recede. In Australia, while politicians and ANSTO representatives have presented a 'life saving' image of the proposed nuclear reactor to the public, in Germany the ecology movement has successfully captured public imagination by presenting realistic horror images and scenarios based on scientific assessment. In the wake of this, German citizens have become even more concerned about the ecological issue, according to Beck, than about unemployment (1991:5). This local Menai resident refers to her German experience:

'I've come from Germany, we are fighting hard against reactors there. I've got information from there and I know what can happen'.

These comparisons draw attention to the importance of political power relations to the processes which give meaning to 'facts'. In Australia, Sutherland residents have
not been given the information that isotopes are already imported by companies in competition with ANSTO, although this puzzled resident’s comments were echoed by others: ‘there have been periods where ANSTO has closed down, they must get the isotopes from somewhere else when that happens’.

Neither have residents been informed about possible alternative technologies for isotope production. Cyclotrons, for example, have been shown to be a cost effective way of producing medical isotopes (Bennett 1999). When pressed on the implications for Australia of not having a nuclear reactor for nuclear medicine, Dr Geoff Bower, President of the Association of Physicians in Nuclear Medicine, said it was ‘probably not life threatening, I think that is over drawing it and that’s what people have done to win an argument. I resist that’ (Green 2000). Clearly, the government and ANSTO’s campaign on nuclear medicine has provided a very different message to the community as residents’ accounts indicate.

Prevailing definitions and interpretations of similar events can differ widely. This raises the question ‘who principally defines the issue?’. Anti-nuclear groups are sometimes victorious in their efforts to frame situations as problematic, but as Koopmans and Duyvendak point out, only when they operate in a political context that offers them opportunities to do so (1995:12).

In Australia, the pro-nuclear authorities largely define the issue. For example, 362 highly radioactive fuel rods from the reactor in January 2001 were successfully moved by police management despite protesters highlighting the problems of nuclear waste transportation. French authorities have not allowed the shipment to be unloaded and pending a legal appeal in the French courts it may be shipped back to Australia unprocessed (March 2001). Nonetheless pro-nuclear authorities in Australia have been able to maintain their denial that this situation is problematic.

In Netherlands and Denmark the anti-nuclear movements’ viewpoint that nuclear energy is both dangerous and unnecessary has become the dominant one among public, media and a majority of political parties. In France anti- nuclear forces have been marginalised by a discourse which stresses the safety of the nuclear industry and the need for nuclear power as a guarantee of economic independence and a source of national grandeur. In the Chernobyl case, according to Koopmans and Duyvendak, the strong French state even successfully denied the existence of a problem and in the absence of any competing version among the country’s political elites, was able to convince the population that radiation had somehow halted at the country’s borders and that the unsafe nature of Soviet reactors was of no relevance to superior French technology. ‘This interpretation of the problem may have been unreal, but it was perfectly real in its consequences’ (1995:8,9,12).

There is some parallel in Australia. Emergency Services have been convinced that a detailed plan for an emergency at the Lucas Heights reactor is only necessary for the area within ANSTO’s perimeter fence (Sutherland Shire DISPLAN 2001).

Framing and Management of Information

Situations defined as unalterable and inevitable, however lamentable, Cobb and Elder argue, come to be seen not as policy problems about which something can be done, but as hard facts of life (cited by Koopmans and Duyvendak 1983:174,177).

According to communitarian writers, such as Sandel, conventional politics like that of western democracies, takes the marginalisation of citizens for granted. People feel a loss of control over forces governing their lives and Sandel argues that they have a sense of futility of not being able to contribute anything to the prevailing social order or change oppressive distributions of power: this leads to growing apathy about established political mechanisms (1996:3). In this kind of situation numbing has adaptive advantages: ‘the less one feels the better off one is’ (Lifton and Markusen 1990:198).

Sutherland Council’s Citizen Panel Research reports: ‘many (residents) felt the new reactor decision was just pushed onto them, that there was no satisfactory community consultation process’ (2000:30,31).

One way nuclear numbing is accomplished is by narrowing one’s psychological field or vantage point, for example, a strong focus on defense economy (Lifton and Markusen 1990:250). The value system of the individualist world order, communitarian critics claim, measures human progress in narrow terms: it focusses on material production and consumption but neglects important environment and social factors that are the concerns of all communities (Sandel 1996, Avineri and De-Shalit 1992). This is a view which many residents would endorse, as this resident explains:

‘The economic imperative argument is used (for the new reactor) but do they balance that against the social and environmental impacts?’

An Environmental Impact Study (EIS) into the proposal for a new nuclear reactor was conducted after the decision was made by the federal cabinet that it would be located at the Sydney site. This did not allow for input from residents. In justifying their fait accompli, the government claimed to have conducted a study into what would be the best location to site a reactor in Australia but this document was ‘cabinet in confidence.’ Sutherland Shire Council has been attempting to get access to the material.
these submissions were based on, but have been refused access by the Government. At a recent Administrative Appeals tribunal hearing (1.3.01 Sydney) the Head of the Prime Minister's department filed a Certificate of Exemption from the Freedom of Information Act for these documents claiming the national interest and relationship with foreign countries were at stake. The EIS was conducted without any requirement on ANSTO to reveal the design or detailed cost benefit analysis of alternatives for public consideration.

In order to test in the public arena the claims of experts from both sides of the argument there have been repeated community calls for an independent inquiry into the new reactor proposal. The government has consistently refused. This contrasts with the situation in the US where under the Nuclear Regulatory Commission citizens can call for a public hearing with an independent adjudicator (Hirsch 1998).

A common response is reflected in local residents' bewildered comments such as 'I wrote to the Prime Minister and didn't even get a response'.

The government has established a bureaucratic procedure where the public has no opportunity to contribute to the overall process. This public relations strategy creates a sense of hopelessness - whatever response the community makes, the government will press ahead with the new reactor. Each step of the proposal that is reached is presented as the "green light for the new reactor". Reinforcing the belief that nothing the community can do will stop the reactor is the incremental process for approving it. Australia's Nuclear Regulatory body, the Australian Radiation Protection and Nuclear Safety body (ARPANSA), was set up in 1998 to establish a licensing procedure for the new reactor. While the government has signed a contract with the Argentinian Company (INVAP) to build a new reactor ARPANSA has still not published safety criteria by which any design of a new reactor could be tested.

The outcome of these kinds of processes is registered by residents in comments such as: 'We don't have much of a say – no control'

'It's a Federal Government decision – political'.

Lifton and Markusen's research suggests leaders themselves suffer from psychic numbing (1990:216).

'Leaders are expected to provide guidance in a nuclear world for which they have little appropriate preparation. Rather than confront the full danger, they tend to deny the threat and encourage all other prospective victims to do the same' (Lifton and Markusen 1990:249).

There is a history of government secrecy surrounding the reactor. This has been a feature of the organisation since 1950 when the reactor was built under the Defence Act and subject, until 1987, to secrecy provisions of Australian Commonwealth Law. The government claims the culture of secrecy changed in the 1990s. There is evidence, however, that it simply took on a different form. For example, prior to the formal announcement in September 1997 of its intention to build a new nuclear reactor, the federal government embarked on a strategy of refusing to meet the public's demand for information. A senior member of the federal Science Minister's staff revealed that to "starve the public of oxygen, that is refuse to answer their letters so they had nothing to go on" was an explicit government strategy (Background Briefing ABC Radio 29.3.98).

A legacy of government minimisation is associated with the nuclear facilities at Lucas Heights*. The Chief Executive officer of the Australian Nuclear Science and Technology Organisation (ANSTO) recently said of the proposed new 20 million watt reactor that 'in a worst case accident, no public counter measures would be required' (Garnett 1999). This assessment, as previously discussed, has been accepted by state emergency service personnel, who refuse to divulge any specific plans for managing a nuclear accident that extends beyond the ANSTO site. ANSTO in its Environmental Impact Statement for the new nuclear reactor assumes that in a worst case accident only an insignificant amount (1/1,000,000) of the radioactive gases would escape to the atmosphere (Hirsch 1998). This is in marked contrast to an independent assessment, drawing on ANSTO's figures, of the impact of a worst case accident as spreading a cloud of radioactive gas up to 100kms from the site – enough to cause 40,000 long term cancer deaths (Hirsch 1998).

'Psychic numbing' can also be the more easily maintained because nuclear radiation is invisible and difficult to identify in daily life. 'Trust your eyes and the threat disappears' (Beck 1991:X). Moreover to make the threat visible and determine the level of risk usually requires complicated and expensive instruments and methods.

The 1999 NSW Cancer Council maps show an incidence of thyroid disease "significantly above" the state average in the southern suburbs of Sydney (NSW Cancer Council 1999). For over 20 years local activists have been calling for a health study of residents to test whether there is a higher incidence of radiation caused diseases around the reactor.

Internal advice (obtained under Freedom of Information legislation) to senior public servants, appearing before a Senate Inquiry into the new reactor, included the following response to a hypothetical question about risks of the reactor to local populations:

'The replacement is going to be a safe facility wherever it is located, because it is safe by design. Be careful in terms of health impacts – don't really want a detailed study done of the health of Sutherland residents' (Nuclear Regulatory Commission 1999).

There have not been adequate epidemiological studies of the local community or a comprehensive study of reactor workers' health (Taylor 1993).
To Know or Not to Know

As concerns among interviewed residents testify, ‘psychic numbing’ is not complete and Lifton and Markusen believe it is is possible to ‘simultaneously both know and not know’ (1990:199).

ANSTO and the government tell residents that the reactor is safe, while at the same time providing them with information on what to do in case of nuclear accident (ANSTO 1996). A majority of residents (70%) say they need to be better informed about the proposed new reactor because the information they receive is “confusing”. This resident's comment expresses one of the strongest concerns the research revealed:

“We want a royal commission because it’s seen as independent. Everything so far has been controlled by the Federal Government or the proponent (ANSTO)’. 

Even the former head of Operations and Engineering of the current reactor, Tony Wood, has asked the government not to minimise the danger. Mr Wood has made public that, during his period of being in charge, there were several bomb threats to the current reactor, a threat to crash a light aircraft into the reactor and an unsuccessful bomb attack on the electricity switchyard. While his submission indicates he believes the new reactor should be built, he also emphasises his concern that the government not deny the reality of a worst case accident (Wood 1997).

Most residents, including a number of those who in the same interview say they believe the reactor to be safe, state that they are concerned about living near a nuclear reactor and want a public inquiry into its safety. One most widely held concern was the lack of a solution for nuclear waste storage. Bushfire was another major concern of residents, since, as a number explained, both the 1994 and 1997 Sydney fires reached the perimeter fence of the reactor. Residents’ other concerns include accidents, health risks and the possibility of terrorism.

Simultaneously ‘knowing and not knowing’ can come about through one belief system within the self taking on the evidence and knowing the truth and another belief system within the same self rejecting that evidence as unacceptable and unimaginable. A compelling example of ‘knowing and not knowing’ is found in the behaviour of Kurt Gersten, a Nazi officer who served as SS specialist on the Zyklon B gas used for Auschwitz mass murder, yet, at the same time Gersten made efforts at great personal risk to the inform the outside world of the Final Solution, although his own role in the mass murder process has been described as ‘impressive’ (Lifton and Markusen 1990:235, 197).

In the Hands of Experts

‘Numbing can take the form of assuming that process to be somehow ‘under control’ because ‘it is in the hands of experts’, because ‘people up there’ (leaders and decision makers) are taking care of things… Political and military leaders reluctant to permit their people to experience the truth of nuclear vulnerability, reinforce these assumptions. By stressing ‘strength and security’ leaders enhance everyone's numbing including their own. Part of the way that collective dissociation operates is for even (experts) to experience the sense …. that someone, or some group ‘up there’ in the hierarchy is more wise and knowledgeable than they. It becomes a matter of even the experts leaving it to the experts, until that ostensibly wiser someone turns out to be the technology itself. Through dissociation, they turn human authority over to technology, and the technology is invested with the wisdom they themselves lack’ (Lifton and Markusen 1990:249, 216).

A majority of interviewed residents don't feel they are informed enough to appraise conflicting information and competing claims themselves because information stays in the hands of 'experts' and is not made accessible. The federal government, for example, recently completed a study of the earthquake risk at the Lucas Heights site which showed potential severity of an earthquake was twice that previously estimated by ANSTO. The chair of the technical reference committee stated that the report represented the 'best available estimate of earthquake risk' (Institute of Geological and Nuclear Sciences 2000). ANSTO's public response was to say they have 'peer reviewed' the study and found it to be conservative. The peer review is not available in the public domain and consequently cannot be publicly evaluated (March 2001).

Many residents view these kind of closed processes negatively, in the words of one: 'evidence must come into the public arena'.

The need for knowledge to be democratized has been widely discussed. Beck argues that expert groups in the grey zone of politics, science and industry need to be opened to a variety of disciplines, to alternate experts and to lay people. ‘Democracy needs to be protected from perishing in the thicket of risk expertocracy’ (Beck 1991:14). There are also reasons related to numbing which underscore the need for knowledge in this area to be open to wider involvement of 'non-experts'. The scientific language of nuclear technology has dissociative power, it enhances numbing and disavowal. The 'overabstraction, scientism, numerology and technical jargon' of scientific language encourages distancing (Lifton and Markusen 1990:216, 206).

The power to name reality in this area has been held by experts. In this knowledge area the views of non-experts have been devalued and efforts are made to exclude them from any major role. Those expressing views opposing
those of ANSTO and the government are often stereotyped and labelled, for example as being ‘hysterical’ or as ‘greenies’. Nuclearism is equated with proper psychological and moral adjustment. Nuclear normality is constantly questioned – by the anti-nuclear movement – but, Lifton and Markusen conclude, seems only to recede temporarily and then return in a new guise. Moreover, ‘nuclear normality’, they argue, ‘is increasingly identified with service, or even loyalty to the state. And the great majority of citizens raise no objections’ (1990:251,37).

Challenging Psychic Numbing

Psychic numbing is a ubiquitous mechanism for humans and nations dealing with genocidal situations. Australia has failed to confront its own examples of such processes, for example the massacres of aborigines (Tatz, 1990), and the offering of sanctuary to Nazi and other war criminals (Aarons, 2001). It is suggested that this failure of moral-historical imagination (Glover, 1999), contributes to the continuance of numbing, and that this is particularly relevant in relation to nuclear issues (Lifton and Markusen, 1990:250). This is manifested collectively as an ‘unknowing’ of the nuclear threat to our species. Challenging numbing and reclaiming human agency requires access to information, and accountability and transparency in Government processes related to the reactor. This means challenging present political power relations around Government and bureaucratic management of information.

‘To know or not to know’ could ultimately become an issue of ‘to be or not to be’. Footnotes

Footnotes


2. Technetium 99, one frequently used isotope not currently commercially produced this way, is able to be imported until the cyclotron technology is commercially available. The glut of Technetium99 on the world market provides a disincentive for producers to switch to cyclotrons. The rationale for why Australia wants to remain dependent on a fully publically subsidised source of isotopes is unclear.

3. This would not be allowed in the United States which requires that the reactor design and safety features be subject to an adjudicatory process (Nuclear Regulatory Commission 1999).

4. Lifton and Marksuen note that during the Holocaust in World War II, for German citizens, people usually designated as bystanders, psychic numbing had adaptive advantages: the less one felt the better off one was in relation to the regime (990:198).


6. The current reactor was built in 1956, under the Australian Defence Act, in the Sutherland local government area, because it was said to be remote from Sydney’s population. Even so a formal meeting of the Sutherland Shire Council was told by the Chair of the Australian Atomic Energy Commission (AAEC), Professor Baxter that ‘there would be no emissions from the site’ (Sutherland Council Minutes 14.2.1955). Radioactive gases, however, are emitted to the air as part of normal operations and radioactive liquid material is regularly disposed of through the sewage system.

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Support groups come of age: The integral part that support groups play in continuity of care for people with a mental illness.

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The move from institutional care to community care for those with a mental illness has led to an increase in the numbers of people with a mental illness residing in and seeking support in the community. It was clear from a study that we have just completed for the NSW Association for Mental Health, that for many people, much of this support and continuity of care came from support groups. Although an integral part of continuing care for many people, support groups are not formally recognised as providing this care. The role played by support groups is central to recovery from a mental illness and that support groups and networks should be formally recognised as fulfilling an important role in continuing care of people living with a mental illness.

Support groups for people living with mental or emotional illness are well established in NSW and meet a wide range of needs (see for example Sozomenou, Mitchell, Fitzgerald, Malak and Silove, 1999). Indeed, for many people recovering from a mental illness, support groups are an essential part of continuity of care and play a central role in their recovery. (Salem Bogat and Reid 1997; Davidson et al 1999).

With the closure of large psychiatric institutions and the changes in policies concerning psychiatric hospital care, people who have a mental illness spend much less time in hospital and are often discharged into the community while still recovering from an episode of illness. Many issues confront people with a mental illness living in the community such as: understanding prescribed medication; learning about the illness and; coming to terms with living with a mental illness; learning about symptoms and developing ways of coping. (Davidson et al, 1999). Support groups increasingly provide the venue in which people can explore these issues, seek help and support and gain the necessary confidence to deal with the many issues which they might otherwise confront alone. (Walsh and Hewitt, 1996).

The formation and the on-going functioning of support groups is very much driven by consumers of mental health services, those with personal experience of the often devastating effects of mental illness and psychiatric disability. There are many support groups in NSW serving a variety of different functions and meeting the needs of a wide range of people and the benefits of support groups have been acknowledged in the most recent National Mental Health Strategy (1999). Mental health groups have been set up to support people in the aftermath of the onset of psychiatric disability, to assist and support in recovery from a serious mental illness, to provide on-going support to those with specific diagnoses or problems, to support family, carers and friends, and to advocate for the rights of those with psychiatric disabilities.

There have been few Australian studies into the phenomenon of support groups for people with mental health problems. Young (1999) evaluated the GROW groups but there have been no studies which have addressed wider issues such as the need for support groups for people who experience mental health issues nor the practical problems of how support groups might be set up, resourced and maintained.

The data we have utilised in this paper was collected as part of a study we conducted for the NSW Association for Mental Health Inc in 1999 to explore the needs of people who have experienced mental health problems and who have either attended or sought out a support group. The study sought to add to our understanding of the importance of support groups and to contribute information on what is needed to sustain such groups.

We collected the data for the study through 360 responses to a questionnaire which was widely distributed to people involved in mental health support groups in NSW; six focus group discussions with those who had an interest in support groups and twenty in-depth interviews with key informants.

These 'key informants' were mostly consumers of mental health services who identified themselves through the questionnaire as being willing to be interviewed or someone identified as having 'extensive knowledge' of support groups by those working in the field. Although we interviewed some professionals, most of the interviews conducted were with consumers. We deliberately sought the views of those with first hand experience as consumers of mental health services. These interviews were conducted to collect and document the range of experiences which people had, as participants and/or facilitators or convenors of support groups. The objectives of this phase of the study included understanding what types of support groups existed in the community, and indeed, what sorts of groups or activities people were identifying as 'support groups'. Experiences, both positive
and negative, were sought, as was an understanding of
the factors that facilitated or hindered the establishment
and operation of support groups.

The key informants interviewed included mental health
consumers - both those who had a long history of
participation in support groups, and those who had
experience of establishing and running support groups.
This paper is primarily based on the material collected in
the qualitative interviews. The interviews followed a series
of ‘trigger’ questions, were taped, transcribed and
analysed. The interviews lasted from one to three hours,
and proved to be a very rich and valuable source of data,
containing perceptive insights and crucial information. The
people we interviewed gave their time very freely, and were
very generous in sharing their vast knowledge and
experience with us.

The overwhelming theme that emerged from the interviews
was that for those who had been involved in support
groups, the experience was incredibly rewarding and
enriching. It was very clear that support groups play a
crucial part in supporting and aiding in the recovery and
continued well being of those with mental health
problems, their carers, relatives and friends. Indeed, we
found that support groups are an integral part of the
support system for those with or recovering from a mental
illness, their carers, friends and relatives.

In this paper we will look at the benefits identified by
people with a mental illness who had had some
experience of support groups as well as the barriers they
identified in setting up, establishing, maintaining and
attending the groups. We argue that support groups are,
for many people with a mental illness, an essential part of
the overall infrastructure they require for successful
independent living in the community. We believe it is time
for these groups to gain the formal recognition they
deserve as part of the overall package of care available to
people with a mental illness living in the community. Such
recognition must include resource provision and an
acknowledged role in community based care in the form
of partnerships with formal mental health services. It is
time for support groups to be acknowledged for the vital
and indispensable work they do and in so doing, to ‘come
of age’.

The Benefits

Gitterman and Schulman (1994) offer nine fundamental
concepts of ‘mutual aid’: sharing data, dialectical process,
entering taboo areas, the ‘all in the same boat’
phenomenon, mutual support, mutual demand, individual
problem solving, rehearsal and the notion of ‘strength on
numbers’. The support groups we explored were not
solely mutual-aid, although some were. They also
included groups run by professionals, those which had an
open membership and those which were ‘closed’. Groups
which were included in our study were limited only by the
requirement that they be a community based group in
which membership was premised upon an association
with mental illness. Despite the different emphasis on
actual type of group explored, our findings mirrored many
of the dimensions of mutual aid identified by Gitterman
and Schulman (1994).

Sharing of experiences
Sharing of experiences was seen as one of the most
important functions of support groups. At the most
fundamental level, the support groups enabled people with
a mental illness to get together with people who they felt
to be “like me”. The group provided an opportunity to be
with people who shared a common construction, a
common identity, a space in which the participants could
be “normal”. “Becoming ordinary is a useful tactic to
adopt by people who have been labelled as mentally ill as
a result of apparently deviant behaviour” (Lorenz, 1991 in
Barnes, 1999). Being ordinary is a status which people
with a mental illness may not experience anywhere
outside the group. The group provides a space where
people with a mental illness can reconstruct themselves
as ordinary and explore the experience of living with a
mental illness in the context of everyday life rather than
focusing on treatment and symptoms of illness.

For many of the participants the groups provided the
opportunity to form friendships and networks with people
with similar interests and concerns. For some people,
support groups provide a replacement for family and
friendship relationships lost through previous long
episodes of illness.

It certainly made me feel I wasn’t alone, there were probably
25-30 people that could relate to me and I could relate to
them…. I used to go there every month and be amongst people
who understood. You didn’t have to explain everything, they
just knew, and also, we can laugh at what we do, not laugh at
each other, but laugh together. I think actually being with
people you can relate to helps.

Learning from others
Support groups can also provide a means of improving
the quality of life of participants, by providing the
opportunity to practice improve social skills which may
have been affected by their illness. Respondents reported
the benefits of improved social skills to their sense of self
worth, self-esteem, and collegiality. The group also
provided hope for the future for some members through
identification with others who have been through and
survived a range of traumatic experiences.

Support groups boost confidence and provide a better quality
of life. There are some people who will probably never work,
and they deserve the opportunity to participate. Helps people
gain social skills, maintaining better mental health for people
who are very isolated, at least they’ll come for the meal, and
they are monitored—somebody is in contact with them. They become even more confident if they get involved in organising the group.

And the benefit to consumers, that they’ve done well. That they’ve met others who have done well, otherwise they don’t meet people who have recovered.

Monitoring progress

In some cases members of groups take on the responsibility to keep in touch with each other between meetings and monitor each others progress and recovery. In many areas of NSW there is still a lack of outpatient support and easy contact with mental health services. Support groups can bridge the gap between formal appointments with service providers.

Newsletters are really good for keeping people in touch. Keep people on the mailing list, not take someone off because they stopped coming. That’s happened to me. That’s quite confronting when you’re going through a depression and waiting for the newsletters.

They can also provide something of a constant in what might otherwise be a chaotic life. Knowing that on a certain day at a certain time the group will be there for them can be felt as an anchor for people whose other points of reference, such as work or education, have been eroded.

Information sharing

Some groups also took on the function of providing information to the participants, such as sharing of specialist resources about particular mental health problems, information about medication and management of symptoms. This was done in a variety of ways such as, through guest speakers with particular expertise, leaflets, videos and books. Information about other services such as counselling, nutritional advice, community recreation and family support services was also provided via support groups.

Support groups were multi-faceted for me. It gave me the information to handle the illness. It’s not just about medication and I realised that.

Acknowledgement by Professionals

A few of the participants in this study were also professionals and service providers. Their responses provided a slightly different perspective on the role of support groups. They reported that the policies of deinstitutionalisation and reduced length of hospital stay have meant that people with a mental illness who would have previously experienced long hospital admissions are now being discharged and being managed in the community. The hospital based management program that usually included and valued a groupwork component was no longer operating in the way it had. The hospital groupwork program was either truncated or experienced as a ‘one-off’ activity by many patients. The professionals spoke of the value of the groupwork program and lamented its diminished role. It was reported that some mental health workers had expressed interest in the possibility of a groupwork program being replicated in the community.

A second point made by this small group of respondents was the pressure many workers experience because of increased caseload of people with a mental illness now resident in the community. The opportunity to have their clients belong to another network which might serve to support and monitor clients in the community was seen as a real and valuable incentive for support groups. These findings are to some extent mirrored in the international literature which clearly states that self help groups are a major source of support for families (see for example, Girdon et al., 1990).

As argued above, it was very clear to us that many thousands of people in NSW are deriving tangible and measurable benefits from their involvement in support groups. However, there are still some major barriers to be overcome if we are to enable all those who may benefit from support groups to participate.

The Barriers

People involved with mental health support groups expressed constant frustration with the many barriers encountered in trying to set up, establish and maintain these groups. We will look at the barriers identified by our participants and then explore ways these barriers may be overcome.

Lack of recognition from professionals of the beneficial contribution of support groups

Despite the interest expressed by some of the respondents who were also professionals consumers felt strongly that many professionals did not recognise the value of support groups.

One problem is lack of recognition of their (support groups) importance. There is not enough literature out there. There is not enough recognition at government, doctor, psychiatrist or psychologist level that a support group can be a very valuable adjunct to treatment, and that groups are not in competition with professionals, but are doing things they can’t do, don’t have to do and don’t want to do. We can work in together. I think it is very important for support groups to work in together.

Professionals need to be educated to the benefits of support groups. There is still prejudice from professionals towards referring people to a group. In country areas the local GP is the ideal referral person. Work needs to be done in networking in this area.
Lack of recognition of the importance of support groups is an extremely important issue for those involved in mental health support groups (Biegel, 1995; Salzer, Rappaport and Serge, 1999; Shepherd, et al., 1999). The lack of acknowledgment from professionals of the role of support groups is acutely felt in our sample who experienced it as a barrier to establishing a group.

I was told by the professionals when I tried to get a group going for people with mood disorders that it would attract everyone in the area who thought they were depressed, and that incorrect information given out by group members could harm people.

Consumers spoke of the barriers posed when professionals fail to refer clients to support groups. It not only denies access to those who might benefit from membership of a group, it also excludes support groups from an overall mental health management plan and furthermore it can threaten the viability of established groups if new members are not referred.

You really rely on the mental health team to refer (to the group), which they don’t do.

The group is functioning and we are in exciting times where people are recognising the group, 50% of mental health workers think we are great and 50% think we are a waste of time.

Some of the participants in the sample hypothesised that the reasons for the lack of referral by professionals were ignorance of the support groups and what they could offer, fear that the groups would work contrary to the advice of mental health practitioners and concern over the provision of misinformation.

The taboo surrounding mental illness was also used to explain the opposition of professionals to support groups for those with mental illnesses. The notion of contagion was identified as a barrier to mental health support groups.

Some participants felt this fear stemmed from the reluctance of professionals to undertake any new activity, unless it was ‘properly researched and was published in appropriate professional journals’. In the absence of a body of work that explores the role of support groups for people associated with mental illness, it would appear some professionals are unwilling to sanction or aid such groups.

Consumers, on the other hand, are not so constrained and are also very aware of the benefits that accrue from involvement in support groups. It is consumers, therefore, who are inclined to tackle the problems facing the setting up and maintenance of support groups for people with mental illness, often without the benefit of a guidebook into this uncharted terrain.

No one out here will have the answers for us, we want to do it our own way. Service providers are there and giving their energy and resources in caring for other people but their perception of caring is in trying to change us into what they are. There is nothing wrong with us we just experience something different.

Advertising

The issue of how to publicise a group which may be tainted with the general social stigma associated with the label of ‘mental illness’ was raised in many discussions. Various strategies had been adopted to deal with this issue, including the need for consumers to circumvent this constraint by becoming pro-active, for example, by advertising in the media on their own behalf. Very strong satisfaction is expressed with the support of local papers in this endeavour. Local papers are also seen as integral to educating the wider community and reducing the stigma associated with mental illness, through the publication of informed articles about living with mental health problems.

Impediments are from the professionals especially the psychiatrists who know of the support group but will not refer clients to the support group. We have to depend on the local paper to advertise the meetings.

A major constraint on advertising is lack of funding. Some local papers would only write articles about the group if there was a paid advertisement.

Awareness and Accessibility

Awareness of, and accessibility to group meetings was of considerable concern. Making initial contact with people who may be interested in a group, and sensitive advertising were perceived as crucial to setting up a successful group.

The timing can be a barrier. It is hard to find out about support groups. With OCD most people don’t know they have it. If they do know they have it, a lot of people have a lot of trouble finding us.

The Internet is a good resource especially for those in the rural sector and telephone support is essential.

Once a group is known about the next step is to enable access to people who may have been rendered vulnerable by their illness.

It’s hard to take the first step. I always suggest they bring someone with them and then they’re not stepping out there on their own. People are very nervous about talking in public, they’ve probably never done it, so you need to be aware of that and in the city, logistics are a problem.
Involvement of Health Professionals

**Group Leadership.**

Some felt strongly that professionals should not run support groups and that group leadership and facilitation should be left to the consumers.

*Professionals should not run support groups because it disempowers the group and group survival depends on the good will of the professional.*

Others argued that if professionals are to be involved as group leaders, they need, at the very least, to have some personal experience of mental illness. Because of the very personal nature of, for example an episode of mental illness, it was felt that anyone who did not have personal experience lacked credibility as a group leader. This position was slightly at odds with the feeling that very skilled and well-trained people were needed to cope with powerful emotions which could be associated with mental illness.

It was suggested that one way forward was to develop a structured program through which people could progress in dealing with their illness. Others argued that it was only through the use of a trained facilitator who would know how to deal with such emotions, that people could move forward.

*When you do have such an emotional topic you do get very emotional reactions.*

The views on the role of formal input varied substantially. Our participants had strong and contradictory views on this matter. The suggestions regarding the involvement of professional health workers in support groups varied from the position that professionals should have little involvement in groups, to the view that professionals had a responsibility to establish support and maintain groups. For some this is a pivotal function of the group, for others professional involvement was an occasional event and for some a rarity.

The literature is less rigid on this issue and suggests that most groups operate somewhere between the poles of 'consumer-only' and 'professionally-led' groups. In reality most groups have professionals and consumers participating sharing knowledge and experiences in ways that validates the contribution of both (Shepherd et al., 1999).

**Availability and training of group leaders**

Many saw the role of the leader as the keystone to successful group functioning. The qualities necessary of the leader emerged as very important to the group and included:

- Friendliness, and a welcoming manner were seen by nearly all respondents as important attributes,
- Skills between group times: keeping track of people, initiating contact when people did not come to group meetings, being interested in other people’s problems or achievements; ensuring that people felt supported.
- Network to access resources and to keep in touch with developments and happenings in the field.
- Finding someone with the necessary skills who had the time, commitment and consumer experience to act as a group leader was identified as a barrier to establishing support groups.

**Infrastructure/resources required to maintain support groups.**

Lack of resources or access to basic facilities regularly emerged as an impediment to the running of support groups. Respondents repeatedly informed us that individuals were unable to carry the ongoing burden of financing the support group. It was generally agreed that groups need to be adequately resourced and supported.

Funds are needed to hire venues, provide light refreshments, compile and distribute newsletters, organise mailouts, and regularly advertise the existence of the groups. Funding should be ongoing. In some instances, groups that had been established, failed to continue because of lack of available resources. It was also suggested that consumers (especially leaders) should receive some financial subsidy for travel and costs as a reward for dedication and commitment.

The resources and infrastructure needed included:

- Access to telephones, faxes, type writers, computing, postage and photocopiers. Subsidised transport as costs were identified as an impediment for many people, particularly, but not exclusively, in rural areas. Many people with a mental illness are on pensions and find the cost of transport to distant group location prohibitive. It may be possible to access transport facilities to get participants to the groups. Community buses provided by disability services, local councils, or service clubs could be used. Alternatively a cash-back system could be developed, possibly through the local area health service, to subsidise transport to support groups.
- Access to an appropriate meeting room was also an issue that could impede support group functioning. Meeting spaces that were corridors in constant use, no heating or cooling in summer, rooms with no tea or coffee making facilities, venues which were inaccessible by public transport and rooms in inappropriate venues were all identified as impediments to running successful support groups.
- Other specific issues arose around venue: for example one group was given access to a church facility but prospective group members identified this group as being a church based group and therefore inappropriate. Other issues arose around acceptable
together informally and formed a group. Other groups that typifies a support group structure. Some groups were convened for a specific purpose, or around a similar concerns, histories or issues somehow got organic and happened when a group of people with mental illness may have had trouble sustaining church membership and thus eligibility as members of a congregation to that venue.

- Public liability insurance and accountability was also an issue for some groups. At least three groups ceased meeting because the management of the venue required public liability insurance and the group members were unable to meet this requirement and did not know at the time what to do about it. Groups that meet under the umbrella of an incorporated association with public liability insurance can meet this requirement. There is a clear need to educate group members about legal issues in community groups. Networking is a skill that may assist people in accessing venues. It is possible that networking is a clear role for mental health professionals in liaising and advocating for people with a mental illness to gain access to these venues and resources.

- Cost of tea, coffee and light refreshments were also noted as being quite onerous when they fell to one person, often the convenor to provide. If people are on pensions even a small contribution for refreshments may be difficult for people to give.

- Being able to access medical information or experts in a particular field was mentioned as an important resource to support groups. The invitation of people who could act as role models and discuss their strategies for living with a mental illness was also seen as an important resource.

Who attends support groups?
The support groups that we studied were characterised by complexity and diversity. There is no one type of group that typifies a support group structure. Some groups were organic and happened when a group of people with similar concerns, histories or issues somehow got together informally and formed a group. Other groups were convened for a specific purpose, or around a particular program and stayed with that agenda; whilst still others so convened evolved and followed a very different agenda. Some argued that groups needed to be very focused around particular mental illnesses.

I don't believe certain groups would work together. I don't believe in generic groups, we need specialist groups, 'bipolar, schizophrenia, anxiety disorders.

Because I'm working with NESB groups, we need groups that speak the same language, that is in the initial stage. People need to talk about the same issues-need specific groups for specific illnesses eg. dementia, mental health, need schizophrenia, anorexia support groups.

Some groups have a very flexible membership and welcome new members to every meeting, others opted for a closed membership and, whilst not actively discouraging new membership, have created an atmosphere in which new members feel uneasy.

Where a closed membership exists, it may be the best type of group to serve the interests of its members and may have taken many meetings to become a safe and supportive environment for those participants. New members need to be provided with access to a support group that will need to operate alongside an existing closed group. Other groups do not have the same need and are able to accommodate new members. A size or composition may be reached which makes it inappropriate to take on new members for a time. Some groups thrive on structure, others relish the opportunity to remain unstructured and focus on the social aspects of coming together.

Careers and friends and support groups
Another issue that was frequently canvassed was the nature of the involvement of relatives and friends in support groups. Again, our participants expressed contradictory and polarised views on this issue. Some were adamantly opposed to the inclusion of carers, relatives and friends, others argued that the inclusion of friends in support groups could be very beneficial.

Groups need to include both carers and consumers, as they need each other.

This particular issue illustrates one of the themes that emerged from the study, support groups are varied and ever changing entities. No one formula emerged as the right way to run a support group. Flexibility and responsiveness to the membership appeared to be the hallmarks of a successful group, but how to ensure this flexibility remained unclear. However, we need to be clear that this flexibility is absolutely fine, groups functioned very well with a wide range of different structures and membership.

Lack of model for support groups
It was clear that there is no such thing as an 'ideal model' on which to base support groups. We don't have a model for how these support groups should function.

Indeed, many questions remain about group composition: should groups have a mixed composition? Should those recovering from a mental illness have a separate group? Is it important to have separate groups for different family members? Should groups have a closed membership which is tight knit and exclusive enabling close monitoring of all members? or should groups be open to any one who wishes to come along each meeting? Can such groups act as a safety net to those who are vulnerable?
Groups should not be made up of all stakeholders. Each separate group needs to have their own space to meet, share and ventilate.

In some cases, carers and consumers may not be able to work together, but in some cases they can.

It never occurred to me that you couldn't have consumers and carers in the same group. It was a consumer/carer group for a long time, with no one voicing any discomfort, but then we realised we must make sure we ask them (consumers) whether they'd like to have separate time, as well as time together. There was a feeling that maybe consumers could say more if the carer wasn't there and vice-versa, but many times they don't come with their carer anyway. It seemed to me that carers got a lot of comfort from the fact that it is a difficult role for a carer. The consumers got quite a shock - they knew how hard it was for them and the carers knew how hard it was for them, but they didn't realise how hard it was for the carers. They also got quite involved in seeing how different the condition was for other consumers.

These support groups are for the carers and those with mental illness. I think it is absolutely essential that when they are first ill the relative must come. I tell them they are not to speak and they don't. Relatives are reliable and if they come they are caring and I think one should encourage relatives to come.

It is possible that some mechanism can be provided, like the occasional combined meeting to discuss particular issues, as outlined above. Some saw the benefits in having mixed groups as offering the opportunity for participants to listen to the perspective of the others.

Should groups aim to be educative as well and supportive? Does one need to structure in a social dimension? In spite of a lack of clear direction, the one dimension? In spite of a lack of clear direction, the one

How to move forward

Support groups as part of continuity of care in the community

Support groups must be recognised as making a real contribution to the lives of people with a mental illness, their carers, relatives and friends. Support groups should be seen as an integral part of the continuity of care offered to people affected by mental illness. The very first step in this process is the creating a true partnership between support groups and professionals.

A culture must be developed which ensures that support groups are an integral part of any care package. This means a strong relationship needs to be forged between mental health professionals and support groups. When support groups do have a good relationship with professionals everybody appears to benefit.

When professionals and consumers work together much can be achieved.

It is up to both participants of support groups and professionals to break down the barriers which cause a compartmentalisation of care in the community, between that which is formally sanctioned and that which is informally provided. Participants need to invite, inform and remind mental health practitioners of the activities and professionals need to inquire, seek out and meet with support groups which can be accessed from their areas. Partnerships need to be forged and bridges built to facilitate proper and integrated care of people with a mental illness living in the community.

Need for variety and flexibility

There is no 'mental illness' community. Mental illness cuts across many different groups, ethnicity, age, gender and culture. We need to be able to acknowledge the different needs of the various people affected by mental illness by providing a range of support groups.

It must be recognised and acknowledged that there is a difference between therapy groups and support groups. Both have their place, and complement and supplement each other. Professionals run therapy groups and provide one set of services that consumers may need. Support groups are very different from therapy groups. Support groups may have a therapeutic outcome, but not be a therapy group. It is possible that consumers may attend both a therapy group and a support group, each meeting different needs. Neither group should be seen as diminishing the worth of the other, as they offer different things.

When it comes to support groups for people with a mental illness, no one model is "the support group model". Groups which meet the needs of their members come in many shapes and styles and should be judged on their ability to meet the needs of the members.
Training
Whilst there may not be a need for a professional facilitator in support groups there is a need for a leader who has been trained and is competent in running groups. It may be that professionals can offer specific training in certain areas of group leadership to consumers who are interested or involved in support groups.

Training is a two way street. Professionals who have little or no information about what goes on in support groups may have stereotyped views about what goes on in these groups. Better education about the role and contribution of support groups, as an adjunct to ‘professional treatment’, is necessary. Regular updates about group activities to local professionals by group members can go a long way towards eliminating such stereotyping.

Professionals need to be educated to the benefits of support groups. There is still prejudice from professionals towards referring people to a group. In country areas the local GP is the ideal referral person. Work needs to be done in networking in this area.

Resources
As mentioned earlier, resources are necessary to assist support groups. These resources are rarely extensive, many of which can be provided in-kind by formal mental health services. Resources such as access to photocopying, postage, a venue and telephones provide an important role in the viability of support groups for people with a mental illness resident in the community. Where these resources can not appropriately be provided in-kind, a budget should be found to support the invaluable work of support groups.

Conclusion
In the past consumers of mental health services led the call to establish support groups. Consumers knew the value of support groups and were committed to sharing and helping other people with a mental illness. The evidence is that support groups have continued to provide a most valued and invaluable service to people with a mental illness living in the community. There is evidence that the voice of consumers is now being joined by that of some professionals who acknowledge and respect the contribution of support groups to community care. Support groups were not seen as being an alternative to formal mental health services but as an invaluable adjunct to them. The shared responsibility of mental health professionals with support groups suggests that the time has come for the support group contribution to community care to be formalised. There must be more real partnership between professionals and consumers of mental health services in order to enable both groups to benefit from the contribution the other makes. Such partnerships will signal that fact that support groups for people with a mental illness living in the community have truly ‘come of age.”

References


Self Help Groups for Families of People Living with Mental Illness

Judith Player,
Executive Officer, Association of Relatives and Friends of the Emotionally and Mentally Ill, Victoria

“Self help groups are groups controlled by people who are directly affected by a particular issue.”

The growth of self-help groups in the community was an expression of the 70's Zeitgeist. The verities of the post World War II were questioned and found wanting. The political forces that led us into the Vietnam war could not be trusted. In Australia in 1972 there was a change of political power for the first time in 23 years. In Europe there was an oil crisis. The CPI began to increase at a rate that was unknown during the 60s.

People were relocating geographically. The fracturing nuclear family was replacing the extended family. With the introduction of the sole parent benefit in the early 70s and no fault divorce in Australia in the mid-70s, people had to find a new kind of social support. The first neighbourhood houses were commenced, helped by government funding. The percentage of the population completing tertiary study was increasing. In the medical field, there was questioning of the authority we had thrust upon doctors. No longer were they to be seen as the holders of all knowledge. People began to take more responsibility for their own health, looking at diet and fitness instead of relying on medical institutions to take care of them. There was a shift to alternative medicine, acupuncture and vitamin therapy. The home birth movement and birthing centres became popular as women sought to have more control of childbirth. The consumer movement was strengthening.

At the same time institutionalised medicine was altering in the treatment of people who experienced mental illness. The use of psychotropic medications since the 1950s meant that people were gradually spending less time in psychiatric hospitals. If your relative became ill during the ’70s, there was more likelihood that they would be offered some form of rehabilitation. That meant that they would start coming home on weekends.

There was another element in the experience of families of people diagnosed with a mental illness - they were blamed for the illness. The students of the 60s had all learned about the theories of double bind communications in the families of people who developed schizophrenia. They had dutifully learned how to spell “schizophrenogenic” - the adjective applied to the mothers whose behaviour towards their children supposedly caused schizophrenia. The anti-psychiatry gurus such as R.D. Laing (Laing and Esterson, 1964), David Cooper (Cooper, 1967) and Thomas Szasz (Szasz, 1962) influenced a generation of people training in the social sciences and human services.

The account of ARAFEMI Victoria’s first public meeting lists the following as reasons for the establishment of the organisation in 1979:
- There was little feedback from psychiatrists to help families understand the nature and cause of their relative’s illness.
- There was a lack of community awareness about mental illness, rehabilitation and re-socialisation of patients and a need for education about services and facilities.
- Short term casual or part-time employment opportunities needed to be made available.
- The provision of secure affordable accommodation was seen as essential. (ARAFEMI, 1979)

So we had this convergence - the patient who was spending less time in hospital and the family members who had been blamed for causing the illness but were also expected to aid and assist in the rehabilitation process.

Harriet Lefley, a prominent academic in the American family carer movement, stated: “The movement towards deinstitutionalisation has in general imposed on families a caregiving role for which they are unprepared, untrained and from which they have been systematically excluded in the past.” (Lefley, 1997).

What has been the role of the self-help mutual support groups for family carers?

The major needs being met by the mutual support groups are probably in two main areas - provision of information and provision of social support.

Social support

Research studies have looked at coping strategies and level of burden when a family member has experienced illness or disability of any kind. One study which attempted to overcome the bias of sampling members of existing self help organisations looked at the burden, coping strategies and the social network of a sample of
236 relatives of patients with schizophrenia living in five European countries (Maglione, et al, 1998). The centres were in Naples in Italy, Aylesbury in the United Kingdom, Athens in Greece, Bonn in Germany and Lisbon in Portugal.

The results indicated that in all centres relatives experienced higher levels of social burden when they had poor coping resources and reduced social support. Relatives in Mediterranean centres, who reported lower levels of social support, were more resigned and more often used spiritual help as a coping strategy. The authors concluded that family burden and coping strategies can be influenced by cultural factors and suggest that family interventions should have a social focus, aiming to increase the family social network and to reduce stigma.

There are many studies of support group participants where the social support derived from the groups is stated to be of benefit for a variety of reasons. People who attend support groups say that they find the sharing of experience amongst understanding non-judgmental peers to be helpful. (Cook, Heller and Pickett-Schenk, 1999; Torrey, 1983) They will acknowledge guilt and grief in a way that allows other group members to talk about their own issues. Group members will discuss the lack of support from expected sources, such as extended family and friends, and learn that others have had similar experiences. They will be able to discuss stigma, blame, and anger and encourage the focus to be on their own issues rather than those of the person who has experienced mental illness (Katz, and Bender, 1976).

Is the support of group members always appropriate?

- Does unquestioning support reinforce a resignation to the situation rather than encouraging group members to challenge their current responses?
- If it is a long established group, with some group members who have been attending for many years and whose family member is equally a veteran of mental illness, will the group be discouraging to newer members who are hoping for an improved outcome for their relative who has been more recently diagnosed?
- If it is a long established group, will members be receptive to the problems of new members or dismiss their questions in an insensitive manner?

**Information provision**

The second benefit is in information provision: In the family mutual support groups, members will be able to give practical information about the mental health service system, about alternative services, about ways of approaching and using the system. Group members can be reassuring that particular behaviours are symptomatic of illness rather than a relative's deliberate behaviour.

Is the information provided by the group accurate and current?

If it is a long established group, where group members come up with stock responses which do not take account of changes in hospitalisation practice, for example, will the information which they give to newer members be inappropriate or inaccurate? Group members may generalise from their own particular situation, rather than accepting that other families are dealing with different problems - perhaps a different diagnosis, different causes of illness and different levels of coping or resources.

What can the community psychologist or mental health professional bring to mutual support groups - and will they diminish the capacity of the group members to advocate for themselves?

If the professional attends as part of their job role, we overcome some of the challenges of operating a support group independently. The professional can provide a daytime contact number for the group, which does not intrude into the home or privacy of group members. Health or welfare workers may have access to computers, photocopying, postage, and be able to facilitate the distribution of news sheets to group members. Their organisation may fund the cost of the meeting venue. They will have access to information updates, particularly about the service system. They may be able and willing to act as advocates for group members.

The downside of professional involvement:

- Who owns the group?
- Who sets the agenda?

Is the group being initiated by a professional or by the potential group members? If group members find a professional whom they trust to work to their agenda, they can make use of the professional to the advantage of the group. But if the group is the initiative of the professional, should it be called a self-help group? It may be more accurate to refer to the group's role as one of mutual support rather than self help.

A professional worker considering involvement in a support group may like to consider the following points:

- A commitment to self help: the professional needs to accept the power of self help and to appreciate the capacity of people who have shared similar experiences to empathise with each other and to offer each other meaningful support.
- A realisation that professionals can learn as much from group members as group members can learn from them: the professional should be able to put aside the "professional helper" role in favour of respect for the knowledge and experience of the group.
© A preparedness to share professional knowledge, skills and resources with the group members and not adopt the role of ‘expert’ within the group. The true experts of the experience are the group members.

© An awareness of the urge to take control of a group, especially when it appears to be floundering; being able to allow the power to remain with the group members. Even if the group eventually withers, it may have met the needs of the people who formed the group.

© A capacity to work towards the group becoming self-sufficient, with the goal of stepping out of the group as soon as possible if that is the aim of the group. When group members retain ownership and responsibility for the group its agenda may be different to the one the professional would have set. The group processes may be less efficient, according to the professional. The group may decide to go in directions that do not meet the professional’s approval. The professional worker then needs to consider his or her respect for the group and their belief in the power of self-help. The professional worker can inform the group members of his or her inability to be associated with the direction of the group and then resign.

A professional worker may be eligible to be a member of the group. A professional who has a family member with a mental illness may facilitate a family self-help group. The group members may then be even more willing to thrust the mantle of expert onto the professional or may express concern that they have not given the professional any time to air their own difficulties.

When the professional convenes the group, there will be continuity beyond the energy and interest of the founding members. Professional involvement can mean time allocated from paid work, recognition by funding bodies and easier access to resources such as meeting places and publicity for the group. A constant convenor can maintain an open group, where people join at varying times for varying lengths of time. But the self-help focus of the group may be eroded over time.

ARAFEMI in Victoria was very much a creation of self-help. Professional involvement was mainly directed towards assisting the establishment of the organisation but by 1982 professionals had begun to assist with some of the support groups.

We have a number of different types of groups. We have on-going open groups convened by both ARAFEMI volunteers and by ARAFEMI staff members. We have closed groups which are facilitated by staff members.

We try to be specific as to potential membership of a group. Unless people have sufficient in common with other group members they will not get either the support or the information that they may be looking for.

An example of a closed group is the Offspring Group. This group is specifically for people who have grown up with a parent who has experienced mental illness. Group members attend an introductory session where they are given an outline of the course structure and content. They are then asked to commit to attend 10 weekly sessions. From the outset they are aware that the group has an end date and that, if they wish, it will be up to them to continue the group. ARAFEMI cannot resource an on-going group. During those weeks, strong bonds form amongst the group members and they may be reluctant to give up the group. At the end of the 10 weeks group members decide if they wish to continue to meet as a mutual support group. They exchange telephone numbers and make their own arrangements to meet, either at someone’s home or at a restaurant. Our experience is that some groups continue to meet on a less frequent basis for a few months after completing the course. Some people continue to have regular contact for a longer period.

An open group where members have gained support and information as well as acting in an advocacy role with service providers is the “Bridging the Gaps Forum”. This group advertises itself as being for families of young people aged between 16-28. There is a strong educational commitment in the group. The committee decides on topics and has guest speakers most months. Once each year they organise a major forum on a particular topic. The aim of these forums is to publicise particular issues that are of concern to the group members. Last year the topic was “Mental Illness, Substance Abuse and Homelessness”. This year they are inviting speakers to look at the consequences of mental illness, substance abuse and offending behaviours. This group acknowledges advocacy as a main aim. The role of the professional for this group has been to suggest and facilitate access to speakers on the topics of the group’s choice. The professional does not attend all meetings of the group and does not take on the role of group facilitator at the group meetings.

Self help mutual support groups can allow people to assume a measure of control over some aspects of their lives. The objective situation may not change but the individual may be able to exercise some choices that they previously thought were unavailable to them.

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Ageing with a longstanding disability: Important issues for community psychology  
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Psychologists who work in the community are increasingly likely to find older people with longstanding disabilities among their clientele. Previously, few such people reached old age, however due to medical, rehabilitation and care advances, they are now living longer. Living long-term with disability brings with it implications for ageing and for well being in old age. This article discusses factors likely to impact on the quality of life and ability of people with longstanding disabilities to remain living independently in the community. It argues that community psychologists have an important role to play in addressing these factors and in informing psychologists in other areas of practice.

Australia is very aware of the ageing of its population and potential effects on health and welfare expenditure. Governments have introduced strategies designed to maximise the effectiveness of management and delivery of services for older people and to reduce the anticipated burden on health and welfare expenditure. (eg. Office for Older Australians, 1999). However, to date, most attention has been focused on older people as a generic group with little consideration given to the needs of particular groups whose particular life experiences and characteristics may impact on ageing and quality of life in old age.

Stoller and Gibson (1994) argue that many minority groups of older people experience obstacles constructed earlier in life that can become handicaps to well being in old age. One such group is people with longstanding disabilities, that is, people whose initial onset of disability was not associated with the ageing process. Research indicates that, although not a homogeneous group, these people enter old age with fewer resources and more health concerns than members of the general population. Gething and Fethney (1999) reported that the greatest differences lie in socio-economic status and health in that people with longstanding disabilities have lower levels of income, are less likely to own their own home, are less likely to be in paid employment, experience more health conditions, see a doctor more often and take more medication. In a similar vein, the Australian Institute of Health and Welfare (AIHW) (2000) argued that people with disabilities are more vulnerable in old age because of lower levels of functional ability, lower levels of education, the tendency not to use or participate in community services, lower marriage rates meaning that they have no spouse or children available to provide support, less adequate social networks, lower levels of home ownership and greater dependence on pensions without any independent retirement income.

Currently, Australia lacks a planning and research strategy that recognises the ageing population of people with disabilities. This situation is not unique, but has been argued to characterise most western countries (Buys & Rushworth, 1997; Crewe, 1990; Kunkel & Appelbaum, 1992). It has arisen because, until recently, relatively few people with longstanding disabilities have lived to old age. Advances in medicine, rehabilitation and community care mean that many are now living longer and that the numbers of older people with disabilities are growing. This reflects the growth in the overall population of people with longstanding or early-onset disabilities and their increase in life expectancy. The AIHW (2000) predicts that the number of people with early-onset disabilities aged between 15 and 64 will increase by 12% between 2000 and 2006. According to the AIHW (2000), currently, 11% of people aged between 45 and 64 (the next generation of older people) with a severe or profound activity restriction have an early onset disability as compared with 4% of people aged 65 and over.

Recently, people with longstanding disabilities have become vocal about their situation. Forums and meetings, such as one held at the University of Sydney in 1998 (Gething, 1999), demonstrate that people are experiencing anxiety and concern about their well being, quality of life and ongoing independence as they age. Lobbying by people with disabilities and their organisations is resulting in increased attention with some governments already having issued reports (eg. Western Australian Disability Services Commission, 2000). In 1998, the Australian Commonwealth and NSW State governments specified ageing with a longstanding disability as a priority area. The growing numbers of older people with longstanding disabilities means that community psychologists increasingly are likely to come into contact with this relatively new client group.

Government philosophy and policy mean that most people with disabilities live outside institutions and within the community, however many people believe that they will be unable to do remain living independently as they age (Cooper, 1996). The remainder of this article discusses some of the reasons and argues that community psychologists have much to contribute to the well being of older people with longstanding disabilities. Community psychologists can act as advocates for their clients, provide supports
which address barriers to achieving a reasonable quality of life and inform other psychologists and professional groupings about issues and appropriate practice with this growing group of older people. However, in order to do so, community psychologists must become better informed about ageing with a longstanding disability and must be willing to question and challenge many long-held assumptions about disability, ageing, the nature of the effective client-professional relationship and the nature of psychological practice.

**People with longstanding disabilities**

People with longstanding disabilities may have lived with their disability all of their lives or for many years before reaching old age. They have the same needs as other people who are ageing, but have additional issues associated with the presence of long-term disability. They experience changes that occur for others in the population, but these changes tend to occur earlier and can be more debilitating (AIHW, 2000; Marge, 1994; Office for Older Australians, 1999; White, Gutierrez, Gardner & Steward, 1994). Furthermore, many people with severe disabilities experience health conditions that reflect longer-term effects of changes in function (Foley, 1995; Marge, 1994). Examples of what has been termed "secondary disability" are osteoporosis and arthritis, both of which are conditions reported by many people aged 40 years and over with spinal cord injury, cerebral palsy and other disabilities which affect mobility and movement. Another example is that of dementia in people with Down Syndrome. According to Koenig (1995, 1999) changes associated with ageing for people with Down Syndrome occur earlier in the lifespan and show a faster progression.

**Independent community living**

Research indicates that people with disabilities, their informal carers and family are experiencing considerable anxiety about the future. They are unsure that they will be able to maintain a reasonable quality of independent life within the community as they age (Gething, 1999). These concerns reflect the impact of lifelong disadvantage and restricted opportunities and how these, when combined with government policy and practice, serve to restrict freedom of choice and well being in old age. The preference of most people with disabilities is to remain living independently in the community with appropriate supports as they age (Gething, 1999). However, many factors mitigate against this. Two will be mentioned here. These are financial disadvantage and the ageing of family carers (caregivers).

Financial disadvantage. As previously mentioned, Stoller and Gibson (1994) argue that minority groups of older people experience disadvantages that reflect life experiences and opportunities. A disadvantage experienced by most people with disabilities is that of saving capacity throughout life. This affects financial security in old age. Although Australia has equal opportunity policies in education and employment, most people with disabilities who have jobs tend to be in irregular and low paid positions. Many have to use a considerable portion of their income on disability-related expenses, such as purchasing equipment, travel, aids and home modifications. The consequence is that they have difficulty in saving for their future. Inability to build wealth limits the potential to maintain a reasonable quality of life in old age, creating considerable worry which is heightened by perceived reductions in services because of resource cut-backs and the increased likelihood of a user-pays approach to service provision.

The ageing of family carers. Most people with severe or profound disabilities living in households are assisted by co-resident informal carers (AIHW, 2000). Carers are ageing along with the person with a disability (Shean, 1998). This raises the questions of how long family carers can continue in their role and what will happen once they are unable to do so. Caring over a long period of time impacts on health. Payne and Erlich (1998) found that the majority of family carers experience high levels of stress and Schofield (1998) reported that over a third of family carers have significant health problems while Gething and Fethney (2000) reported that carers of people with spinal cord injury and brain injury were significantly more likely than comparable members of the general population to have given up work, to have reduced community activities and to have lower emotional well-being. Until recently, the impact of caring and needs of carers were largely unacknowledged by service providers. However, lobbying by organisations such as Carers Australia has highlighted the need for support for carers and for assessment of their needs as individuals, not just in terms of being able to fulfill their caring role. Community psychologists have an important role to play in assisting carers to optimise psychological wellbeing and in finding strategies to overcome the limitations imposed by their demanding role. Many carers feel frustrated because they have had to put their lives on hold and to put their needs and aspirations second to those of the person with a longstanding disability. Being an informal or family carer can mean giving up full time paid work, living on a low income (often in poverty), limited social contacts, difficulty in taking holidays, difficulty in finding time to oneself, feeling weary and lacking energy, having interrupted sleep, feeling worried, depressed and angry (Australian Bureau of Statistics, 1993; Payne & Erlich, 1998). Psychologists can work with the carer to find strategies to manage such experiences and reactions.

Premature entry into a nursing home. Increased frailty of family carers, combined with the expectation that they will be unable to afford to continue living in familiar...
surroundings in the community, has resulted in the expectation among many people with longstanding disabilities that moving to a nursing home may be the only viable option (Gething, 1999, 2001). Cooper (1996) reported that over a quarter (26%) of respondents with severe physical disabilities in her survey (average age 50 years) believed they would need to move into a nursing home within the next 10 years. Currently, few other forms of accommodation are available for people with high support needs.

Australian Commonwealth and State government policy for people with disabilities strongly advocates against nursing home living. The Commonwealth Department of Health and Aged Care, Aged and Community Care Division (1997) stated that “residential care facilities focusing on the needs of aged people rarely (if ever) enhance the quality of life, or offer the least restrictive accommodation option, for younger people with disabilities.” (p.1). Despite this policy, many younger people with disabilities are living in generalised aged care facilities that have a population with an average age of over 75 years and are not designed to cater specifically for their needs. Many are in nursing homes because they, their family and service providers believe there are no other viable alternatives (MacNeill & McNamara, 1996). This problem is increasing because, unlike previous generations, many people with disabilities are now likely to outlive their parents (AIHW, 1999).

Aged care nursing home living is the least preferred living option for people with longstanding disabilities, their organisations and government. However, currently, over 6000 people with disabilities with high support needs and aged less than 60 years live in aged care nursing homes in Australia (AIHW, 1998). They comprise 4% of the nursing home population, with the largest number being in NSW (Moylan et al, 1995). On average these people are considerably younger than the majority of nursing home residents. As many now have a life expectancy similar to that of the general population, the move to a nursing home brings with it the prospect of thirty years or more of institutionalised living in an environment not designed to meet their social, psychological or physical needs.

This situation, as well as being unsatisfactory for people with physical disabilities, also creates difficulties for nursing home managers and staff who find themselves required to deal with clients who have different needs and expectations from the majority of their residents. Social welfare organisations have also raised concerns. The Melbourne City Mission (1999) concluded: “Placement within facilities focused on providing geriatric care is, by and large, inappropriate for a young person who needs to have an ongoing active life” (p.2).

Recently, governments have shown interest in this issue, reflecting in part the inappropriate nature of such placement and the fact that it is not consistent with government policy. Interest also reflects funding issues, stemming from a context in which the aged and disability sectors receive separate funding and where placement of younger people with disabilities in nursing homes requires use of funds designated for the care of older people.

It is to be hoped that policy decisions will be made in the near future that will result in accommodation options that more appropriately address well being issues for people with longstanding disabilities. In the meantime, it is important for community psychologists and those working in nursing homes to be aware of how the needs of people with longstanding disabilities differ from those of the mainstream aged care population. They must also advocate on behalf of people with disabilities to ensure that they live in an environment which recognises their needs and in which they are able to take part in age-appropriate activities.

**Approaches to psychological practice**

Much of psychological practice remains based on a model that focuses on deficits and the attainment of a cure. This model also sees the psychologist as the ‘expert’ whose opinion is accepted without question. However, the situation is changing. Many people with longstanding disabilities believe that they are “experts” in regard to the bodies they have lived with for many years. They believe that they know more about their bodies and life with a disability than anyone else. Therefore, they believe that health professionals should be willing to listen to them and to accept them as an equal partner in a professional relationship. Many psychologists working in the aged care system would have difficulty in accepting such a relationship. As community psychologists feel more comfortable about working in partnerships, an important contribution for them is to provide a role model to other psychologists in this regard.

The aged care sector tends to focus on deficits, illness and obtaining a cure, reflecting the ageism that is said to characterise much gerontological practice (Gridley et al, 2000; Stevens & Herbert, 1997; Tremblay et al 1997). Ageism and an emphasis on deficits can influence the attitudes of professionals in regard to working with people ageing with longstanding disabilities for whom a “cure” from disability is not attainable. Most people with disabilities (like most older people) are basically well and have periods of illness similar to those experienced by people without disabilities and younger people. Others have medical conditions associated with their disability or the ageing process.

In psychological practice, healthy or successful ageing is generally defined in terms of the maintenance of mental, physical and social health. Butler (1991) defined successful ageing in terms of four types of "fitness".
Physical fitness refers to bodily strength, resilience and ability. Intellectual fitness refers to keeping the mind engaged and active. Social fitness involves forming and maintaining significant personal relationships. Purpose fitness refers to having positive feelings of self-esteem and control over one's life. Such definitions may be argued to reinforce prejudice against older people with disabilities (Australian Office on Disability, 1999) who are unable to meet standards set by people without disabilities. Concepts of fitness need to be re-defined in order to acknowledge that it is possible to age successfully with a disability.

Minkler (1990) argued that if services are to meet needs, they must advocate concepts of "wellness and the presence of disability must not be equated with deficits and lack of "wellness". She argued that services must take a holistic approach that focuses on maximisation of remaining abilities as well as minimisation of deficits. Service providers must not assume that certain deficits are a necessary consequence of old age, but must acknowledge that many deficits can be minimised through appropriate health promotion throughout life. This philosophy is central to community psychology. Once again, its practitioners have a great deal to contribute to psychology on a wider scale.

Governments in Australia already are aware of the need to take a more flexible approach to defining "successful" and "healthy" ageing. They acknowledge that it is possible to age successfully with disability or frailty. For example, the NSW Government (1998) emphasises wellbeing irrespective of presence of disability. It states: "Healthy ageing keeps all older people involved in society and enables their ongoing independence, participation and quality of life" (p.7).

Ageing is not only a biological and physiological process, but also a psychological and social process. Psychological ageing involves the reaction of the individual to cognitive, biological, sensory and motor changes, and to environmental factors affecting these changes. Social ageing refers to the patterns of interaction between the ageing individual and the social system in which they live (McPherson, 1990). As said earlier, people with longstanding disabilities often experience life events, adjustments and environmental factors that impact negatively on their ageing and well being in old age. Many of these impacts come within the realm of interest of psychologists who can assist in redressing reactions such as those reported by Bolandin and Morgan (1997). These researchers noted among people ageing with cerebral palsy high levels of depression, frustration, fatigue, and anger in regard to their ageing, with these reactions often resulting in reduced social contact, independence and social interaction. Psychologists must be aware of these reactions and must have strategies for working with clients to reduce the consequences of these reactions and their potential effects on independence and quality of life.

Attitudes and knowledge

The Australian Office on Disability (1999) has argued that people ageing with longstanding disabilities experience a double dose of discrimination -- that based on age and that based on disability. In Australia, educational curricula in psychology devote very little time, if any, time to issues associated with living with a disability or to ageing with a disability. As a result, many psychologists are unaware of how people with disabilities come to terms with their disability and are able to make adjustments that enable them to live fulfilling lives. Often, psychologists (like the community in general) view disability as a tragedy and focus on deficits rather than capabilities and achievements. They also are not aware of how a world devised and built for people without disabilities creates barriers and handicaps for those with special needs. In addition, psychologists often have difficulty in separating the effects of ageing from those of having a disability and do not differentiate between the effects "typical" ageing, conditions that are not part of "typical" ageing and the effects of having a longstanding disability. Lack of awareness and misconceptions have been argued to affect professional decision making and in the failure to attend to symptoms that could be alleviated (Gatz and Pearson, 1988).

Conclusion

What once may have been viewed as a relatively minor client group is now becoming one that psychologists must make concerted efforts to incorporate into their practice. The increasing numbers of people growing older with longstanding disabilities, together with changes in their expectations and in government philosophy, provide fundamental challenges to many long-held assumptions in regard to psychological practice, the role of psychologists and the nature of the client-professional relationship. Psychologists must take a hard look at their attitudes, assumptions and levels of knowledge about ageing, disability and ageing with a disability if they want to make a genuine and important contribution to community-based care for this client group. If they fail to do this, they may get left behind and marginalised as professional providers.

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Developing the Skills of a Community Psychologist: Recommendations for Postgraduate Programmes in Australia

Tara Blanchard, Lauren Breen, Gerald Burns, Lynne Cohen, Dawn Darlaston-Jones, Sharon Hillman, Kylie Smith & Cathy Tang

Community psychology aims to develop existing strengths in both individuals and groups through guiding principles which include prevention, empowerment, respect for diversity, collaboration, social justice, from an ecological perspective (Duffy & Wong, 2000). In Australia, this branch of psychology is taught both at undergraduate and postgraduate levels. This paper focuses on community psychology courses at the postgraduate level which includes Masters, Doctor of Psychology, and Doctor of Philosophy levels at Edith Cowan University (ECU) and at Victoria University of Technology (VUT). A students undertaking any of these postgraduate qualifications is required to complete coursework units and a research project, both of which are presented at the academic institution. In addition, completion of a practicum component of the course is required for graduation. The aim of the practica is to develop skills and competencies required of psychologists by the Australian Psychological Society (1996) as prescribed by the College of Community Psychologists (1998). This paper presents student recommendations for postgraduate training in community psychology, and is confined to those issues associated with practica and practica issues units.

Community psychologist trainees need to develop the necessary skills in real life settings, ideally with supervision from a well-trained and experienced community psychologist. However, as there are few community psychologists in Australia, practicum supervision of community psychology students by other community psychologists is difficult to organise. This may present difficulties especially for students undertaking their first practicum, as they often need more direction than on subsequent practice. Furthermore finding a placement in an organisation can be difficult when the organisation has limited knowledge of community psychology.

The Role of Practicum Classes

Community psychology students at the Masters and PhD level are required to complete a minimum of 1000 hours of practice and for Doctor of Psychology students 1500 hours. Students may organise their placements in two to four different settings and organisation. At ECU, students attend three practicum issues classes to complement their field placements. These classes provide a forum for raising issues and difficulties associated with practicum placements and provide students with the opportunity for further skill development.

The authors of this paper have participated in all three practicum issues units and all students have completed at least one practicum placement. These practica were completed in diverse fields including health, remand, and community development. The skills acquired by students were diverse and included a needs assessment, group counselling, post-occupancy evaluation, programme development, submission writing, focus groups, community education, and research design and implementation.

In the first practicum issues classes students who had completed a placement as well as those who were embarking on their first placement experience. This unit involved completing a skills audit (Cooper, 1997), devising ways to tailor practicum experiences to acquire skills, and focussing on sharing and solving practicum issues. It was especially valuable for students beginning their first practicum in the role of a community psychologist to benefit from the accounts of more experienced students.

For the second practicum issues class however, students felt they wanted to develop a different class format. It was decided to focus the unit on skill development, as the students were more experienced and comfortable with their roles as community psychologist trainees. To this end, the first half hour of every class was allocated to a discussion of practicum issues and specific skills were explored in the next two and a half hours. Initially, the students agreed on the skill areas they wanted to develop.
The unit facilitator organised guest speakers with expertise in each of these areas. It was decided to focus on developing skills in the areas of counselling, drug use prevention and intervention, grief, suicide prevention, group facilitation, working with Aboriginal people, and women's health. Knowledge gained from this arrangement was reciprocal as it provided students with the opportunity to meet practitioners who embraced the principles of community psychology. In addition, students were provided with an opportunity to develop future placements as well as a network system for future employment. Students were able to put these new skills into practice in their placements, with increased confidence and ability.

At the conclusion of the second unit, it was decided that the third practicum issues unit should now focus on in-depth skill development by completing integrated and practical workshops on a small number of issues chosen by the students. For example, focus was maintained on cultural issues, group work skills (including community counselling, conducting focus groups and workshop facilitation), submission writing, and suicide prevention.

Based on the experiences and reflections as postgraduate students, the following model (Table 1) has been proposed for the practicum issues units, which focuses on skill development and building strengths. The first unit focuses on auditing skills (Cooper, 1997) and discussing practicum issues, with the first and second year postgraduates sharing their experiences in the first three weeks of semester. The second unit focuses on skill development via guest speakers while still providing an opportunity to discuss practicum issues. The third unit focuses on in-depth, hands-on skill acquisition.

### Table 1

**Model for Practicum Issues Units**

<table>
<thead>
<tr>
<th>Semester 1</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No practicum or practicum issues unit scheduled.</td>
<td>Practicum 2 &amp; practicum issues unit 2</td>
<td></td>
</tr>
<tr>
<td>Students study professional and ethical issues, psychological assessment, and are introduced to community psychology.</td>
<td>Skills development with guest speakers and some discussion of practicum issues.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Semester 2</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicum 1 &amp; practicum issues unit 1</td>
<td>Practicum 3 &amp; practicum issues unit 3</td>
<td></td>
</tr>
<tr>
<td>Discussion of practicum issues with first and second year students attend class together for the first three weeks. First year students continue to attend weekly practicum issues classes</td>
<td>Combine with first years for the first three weeks then 3 full day workshops with first year students invited.</td>
<td></td>
</tr>
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</table>

**Integration of the Practicum Issues Unit**

During this unit, a forum was provided for discussing practicum issues. Various concerns and issues were raised by students that were generic and applied to the diverse placements. Recurring themes included logistical issues associated with beginning and completing a practicum. For example, some students were required to gain police clearances, which added considerable time and cost to the placement. To counteract this issue all postgraduate students could obtain clearance upon enrollment at the university. Other students were required to pay for petrol and/or parking related to their role within the organisation. These costs can be considerable over the average 45 day placement. Petrol costs could be...
negotiated if the student used the organisation's vehicles. However, as students are not employees of the organisation in which they are based, they are not covered by the organisations motor vehicle insurance. This could present legal and financial problems if the student was involved in an incident.

The monetary costs associated with placements are often not apparent until the student has started work in the organisation. Information about these issues prior to the practicum will provide students with the opportunity to make an informed decision whether or not to agree to the practicum at the organisation based on a cost/benefit analysis.

Another issue was the discrepancies in the paperwork required to undertake a practicum. Students are required to keep a logbook (ECU, 1999) of the skills they have learned on practicum. A supervisor's handbook (ECU, 1998) requires the practicum supervisor to rate the student's skills. However, the skills in the student logbook, supervisor's handbook, and a list of APS core competencies for community psychologists are very different. Furthermore, the skills in the supervisor handbook are more appropriate for students in the clinical field and many are not appropriate to the placements of community psychology students. To rectify these issues, the authors have made suggestions for changes to the handbook (ECU, 1999) of the skills they have learned on practicum. A supervisor's handbook (ECU, 1998) requires the practicum supervisor to rate the student's skills. However, the skills in the student logbook, supervisor's handbook, and a list of APS core competencies for community psychologists are very different. Furthermore, the skills in the supervisor handbook are more appropriate for students in the clinical field and many are not appropriate to the placements of community psychology students. To rectify these issues, the authors have made suggestions for changes to the paperwork (see Appendix).

Organising meetings with supervisors may be problematic. Students are required to have three meetings; namely at the start of the placement, one mid placement, and one at the end of the placement. It is difficult to organise meetings and some students did not have these meetings which reduced the opportunity to discuss issues. A number of students therefore, began their second or third placement without having 'officially' finished their first placement. However, it is essential that the end of placement meeting take place to provide an opportunity for closure for the students and the supervisor.

Student Placement
Supervisors Handbook

It is important to provide field supervisors with relevant and succinct information. Therefore, prior to the commencement of a placement, information should be sent to the prospective supervisor outlining the format of a placement, its duration and scope, relevant insurance issues, the role of the student, university, and field supervisor, as well as mechanisms for conflict management. Whether this information is in the form of a letter or a handbook is debatable, but the emphasis should be on concise and pertinent information rather than a pre-occupation with presentation style.

A final report from the field supervisor stating the level of satisfaction with the student and whether goals and objectives were achieved, may be an alternative format to the supervisor's handbook as a record of the placement. Contribution by the student in the form of a brief report about his or her experience of the placement, outlining the skills learnt or developed and any other process issues may be an added advantage. Copies of all documents and reports produced by the student while on placement should be presented to the field supervisor and practicum coordinator as evidence of achievement during the placement.

Role of the Field Supervisor

The purpose of the practicum experience as part of postgraduate training is to provide students with practical skills based experience in applying psychological principles and theory. The role of the field supervisor is to facilitate this learning. Therefore, the activities performed by the student should be relevant to the profession to enhance the student's skills. The field supervisor needs to meet regularly with the student to provide constructive feedback, guidance, and advice throughout the practicum. When the field supervisor does not have community psychology training, a university supervisor is also appointed.

Role of University Supervisor

The university supervisor supports the community psychology trainee to achieve the practicum goals. This ensures the community psychology trainee gains skills, direction, and support from a supervisor trained in community psychology as well as a field supervisor who is an expert in a related area.

It is important for the student to feel supported through the process. To this end, university supervisors need to be available and willing to help manage difficult situations that might arise such as differences in ethics and values as these could potentially lead to conflict in the practicum setting. The practicum issues unit provides a forum for students to express and discuss issues that are causing concern, and receive input from peers as well as the unit facilitator. Practical advice may help resolve the issue.

Role of Practicum Coordinator

The practicum coordinator is responsible for arranging and monitoring the progress of the student's practicum. He or she will meet with the student to discuss possible placement settings, the skills the student wishes to develop, and identify the goals and objectives for the practicum. This is especially important for the first placement where the student might not be aware of the scope of available placements. Even students who are
returning to study after many years working as a registered psychologist might find arranging a practicum difficult. Indeed the very fact that they have worked as a professional could present quite specific problems, especially if the student is used to acting autonomously or in a position of seniority. Depending on the field supervisor and the organisation, the student might be expected to act independently or to simply observe. These issues need to be addressed prior to the practicum and it is important for the practicum coordinator to be pro-active in facilitating discussion of these issues.

The field supervisor and student should decide the necessity of the optional mid-practicum meeting. If this is held, it may involve only the field supervisor and student. Contact with the practicum coordinator may be via telephone or e-mail. However, the final practicum meeting with all three parties is essential to ensure the goals and objectives have been met. It provides the opportunity to discuss the outcome of the practicum and assess the process as both the field supervisor and the student are able to express how the practicum related to their individual needs and development.

Conclusion
Students undertake practicum experience as part of their postgraduate skills development. Practicum issues units, in which related issues are discussed, support the experience and provide an opportunity for skill acquisition. Several recommendations for skills training in community psychology emerged. Firstly, students need to be encouraged to conduct skills audits (see Cooper, 1997) in their first practicum unit to enable them to assess their strengths and weaknesses and can choose practice and practicum unit activities to best meet their needs. Secondly, postgraduate students should be allowed a voice in determining what they want to do in the practicum issues units and these units need to be flexible and adaptable enough to suit students' needs. Thirdly, supervisor's handbooks should provide the student and supervisors with succinct and pertinent information relating to the practicum. Suggestions to improve the handbook in the School of Psychology have also been made by the authors. Finally, students need on practicum should be managed by the collaborative relationship between field supervisor and university supervisor, and if required, the practicum coordinator. These recommendations have implications in the skill training of postgraduate community psychology students and have applications in informing the skills training provided by universities for community psychology at a postgraduate level.

References
WA College of Community Psychologists: 
Still Alive and Kicking!

Dawn Darlaston-Jones, Lauren Breen

Our main aim this year was to raise the profile of community psychology in WA, not only within psychology but also across other disciplines. The guiding principles of community psychology - respect for diversity, empowerment, prevention, and an ecological orientation that sees the person in context - can inform and enrich many diverse areas of practice.

By adopting a multidisciplinary and collaborative approach to community needs and issues, practitioners are better placed to ensure the needs of the community, and of the individuals within that community, are met.

With that in mind we organised a number of events to attract others in related fields such as community development officers, clinical and school psychologists, forensic psychologists, local governments, and community groups. We extended an open invitation to anyone interested in discovering more about community psychology to join us.

The inaugural meeting was held on March 26th with a seminar presentation by Professor Kelly Hazel from the University of Alaska, Fairbanks. Kelly spoke on the topic of culturally proficient research, which proved to be an informative and rewarding seminar that was enthusiastically received by those present. Kelly's presentation was followed by the Annual General Meeting, the main purpose of which was the election of a new committee. These are:

Co-Chair: Dr Neil Drew & Dawn Darlaston-Jones
Secretary: Lauren Breen
Co-Treasurer: Dr. Lynne Cohen & Kaye Abel
Committee: Scott Bayley, Kathy Campbell, Kylie Smith, Tara Blanchard, Jayne Walton, Cathy Tang, Sharon Hillman, & Lara Andrews

The State Election provided the impetus for our second event held on June 18th, when we invited the new State Minister for Health, The Honourable Bob Kucera, to address the topic of 'Prevention'. This is an issue that has gained increasing prominence in recent years and is of great importance for both health professions and communities as it is seen as a real alternative to the strategies used in the past. This provided an opportunity to hear the views of the new government on the role of prevention strategies.

 Approximately 60 people, representing a diverse range of backgrounds, attended the seminar. The Minister was eager to hear from the floor and there was plenty of discussion among those present. Following the seminar the Minister and Mrs Kucera joined delegates for refreshments and more discussion!

One of the outcomes of the election was the Community Drug Summit held in August, aimed at identifying community needs, concerns and possible solutions to drug use. As community psychologist we were particularly interested in both the process of the summit and the outcomes. As a result, our next event on 24th September was in the form of a panel discussion on the process and outcomes of the Summit. Panellists were all delegates at the summit and included Professor Bill Saunders, and Dr. Ali Marsh from Curtin University of Technology; Alison Salmon from Edith Cowan University; Rose Carnes from the Youth Council; Malcolm Smith from Teen Challenge; and Tony Lovett from the CFMEU. Approximately 30 people attended on the evening and enjoyed the lively debate.

During the year the College committee conducted a survey to assess the types of events people would like organised for the future. Based on the responses we have a really exciting year planned for 2002 with a mix of seminars and workshops designed to extend our professional development and provide a forum for interdisciplinary discussion and debate. Each year we have decided to have an overarching theme that directs our professional development.

The theme for 2002 is 'Youth in Focus' which is designed to highlight a range of issues of concern to young people in our community. We will showcase programmes that have enabled young people to achieve their desired outcomes, that help young people to feel part of their communities, and that promote young people as valuable members of society.

- March 25th – AGM Dinner
  Keynote speaker plus three talks presenting school based programmes
- June 24th – Seminar/workshop Youth Suicide Prevention
- September 23rd – Seminar/workshop Youth Community Development Programmes
- November 25th – Seminar/workshop Culture and Youth (CANWA)

This has been an exciting and productive year for the WA College and we look forward to your involvement in 2002.
The following four abstracts present a snapshot of research in community mental health undertaken by students from the Graduate Diploma in Applied Psychology (Community Psychology) at Victoria University. The research supervisor was Heather Gridley.

**Title:** An evaluation of a psychogeriatric training program for nurses, nursing assistants and personal care attendants.

**Author:** Killmier, Helen

**Abstract:**
This paper presents a formative and summative evaluation of a series of psychogeriatric education sessions offered to nurses, nursing assistants and personal care attendants working in hostels, nursing homes and on hospital wards. The sessions were conducted by the Aged Psychiatry Assessment and Treatment Team (APATT), and delivered to staff throughout the North-West region of Melbourne. The evaluation utilised a qualitative strategy and five types of data were collected. Questionnaires were administered prior to each session; the participant/evaluator recorded observations of nine sessions; brief interviews were conducted with presenters after each session; six focus group interviews took place two weeks after the sessions; and the APATT's own evaluation data was accessed. The findings suggest that staff caring for residents in long term care facilities valued the education sessions. Such programs can foster their understanding of the nature of dementia and psychiatric illness in older persons and assist staff to develop strategies and techniques to deal with unpredictable behaviours. The education sessions were also reported to be of mutual benefit to the hostels and the APATT by establishing and strengthening links between both organisations to ensure a high level of service provision to aged clients. Recommendations are offered to strengthen the delivery of such programs and maximise their effectiveness. The evaluation highlights the potential for involvement of psychologists in training and program evaluation as well as direct service delivery in the aged care field.

**Title:** The evaluation of a drop-in service as a setting for psychosocial rehabilitation.

**Author:** Pang, Helen

**Abstract:**
This paper reports on an evaluation of a drop-in service for people with psychiatric disability. The drop-in service is part of the Boomerang Club day program located in the City of Moonee Valley. Increasingly, there has been research that questions the value of drop-in services, given their low expectation environment. It is important, therefore, to gain feedback from stakeholders to clarify issues surrounding the value of drop-in services. The project used a qualitative method of data collection to document the effectiveness of the Boomerang Club drop-in service as a setting for psychosocial rehabilitation. The stakeholders interviewed included thirteen program participants, three staff members, and two referrers. Another eleven program participants also gave feedback by completing a questionnaire. The findings of this study provide strong support for an ongoing need for the existence of drop-in services. Even allowing for limitations in the study, indications are that for some people, drop-in services may be the only social outlets where they can experience peer acceptance, support, and socialisation in a safe and accepting environment whilst they develop or regain their self-esteem, personal and social roles in the community.
**Title:** Self help group perspectives in mental health: What professionals should learn about self-help groups.

**Author:** D'Arcy, Catherine

**Abstract:**

This research formed one part of a two part action research project aimed at planning, producing and evaluating a video about self-help groups, commissioned by the Victorian Office of Psychiatric Services (O.P.S.) staff training team for in-service use. The perspectives of self-help groups were gathered via a process of consultation in the course of producing a video which self-help groups would consider empowering to themselves.

Consultation was carried out with representatives of peak bodies in the Victorian self-help movement: the Victorian Mental Illness Awareness Council (VMIAC) and the Collective Of Self Help Groups (COSHG), as well as with two specific groups: GROW and Collective against Sexual Assault Melton Inc. (CASAM). Results of these consultations stressed the need to communicate values crucial to the self-help movement such as empowerment, mutuality, and experiential knowledge. Concerns about professional infringement of group autonomy and client self determination in groups were also raised. Diversity between groups and the future of self-help group partnerships with professionals were also seen as requiring focus in the video.

Issues, concerns and information raised in the consultation phase provided the basis for planning, producing, editing and evaluating the video. Consultees from three self-help groups were invited for taped discussions based on the issues raised earlier. Material from these discussions was incorporated in the final product.

Evaluation of the video involved questionnaires and discussion following a presentation to nine mental health consumer group representatives. There was enthusiasm towards a video promoting self-help groups within professional education, despite technical difficulties with the video quality. Non-directive collaboration between professionals and member-governed self-help groups was advocated. Professional service assumptions and misconceptions leading to infringement of group self-determination were also challenged. Evaluation results raised concerns about the lack of fuller political treatment of self-help concerns within the video’s educational aims. Suggestions were made for future videos, highlighting the potential benefits of video in community action focused research of this type.

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**Title:** Long-term housing and support for people with a psychiatric disability.

**Author:** López, Graciela

**Abstract:**

This study focused on ten properties of the housing and support program of the Western Region Outreach Service. The aim of the study was to assess the impact that provision of long-term supported housing has had on consumers’ own perceptions of their mental health. Semi-structured interviews with open-ended questions were used in order to capture the consumers’ views and perceptions of the program. Four of the program’s ten residents took part in the study. The results indicated that these consumers were more satisfied in their present accommodation compared to their previous one. Independent, long-term supported housing was identified by consumers as having positively impacted on their mental health. These findings are similar to other studies that have found supported independent housing to be the preferred housing option for consumers. This study highlights the need for housing and support programs to continue to be funded and for the ongoing evaluation of such programs to ensure effective service delivery.

Tod Sloan is to be congratulated on his role in editing this collection of chapters by contributors from a diverse range of backgrounds and opinions. Each voice presents a persuasive argument in support of critical psychology but they are by no means a consensus of what critical psychology is or how it should proceed.

What I found particularly inspiring in this book was the personal journeys of the contributors – which events in their lives led them to the ideological and philosophical place they now occupied, what fired their passion and motivated them to fight for a new vision of psychology. For some, like Jane Ussher it was the realisation that rather than embracing the role of women, and the feminist theory that urged social change, mainstream psychology actively sought to maintain the status quo. Others arrived at critical psychology via the fight for human rights, witnessing the trauma inflicted on dissenters in the name of politics. There are voices that argue for change from within mainstream psychology departments and others who have been forced out to the peripheral fringes of sociology and anthropology departments in an effort to have their voices heard.

Despite the difficulties experienced by these individuals, the overwhelming theme that permeates the book is one of hope and persistence. The belief that by continuing to articulate their vision for psychology, and for society as a whole, it might just make a difference. Although there is no overarching model of critical psychology spelled out by the authors there is a central theme that explicates the principles and role of critical psychology. In particular, Isaac Prilleltensky presents a three-part model of values, assumptions, and practice that he sees as the building blocks of critical psychology. Arguing that theory without practice is redundant, Prilleltensky (and others) suggest we (as psychologists) need to identify the means to achieve meaningful social change and act accordingly rather than simply talk or theorise about what should or could be. This cannot be achieved via the value-free philosophy of mainstream psychology. I believe this is summed up succinctly by Edmund O’Sullivan when he says:

"critical psychology rests on the assumption that the personal world exists, is influenced by and influences the wider social context and cannot be considered apart from it" (p.139)

It is this understanding, so dialectically opposed to mainstream psychology, that in my opinion sets critical psychology apart.

I would recommend this book to anyone who is concerned with social change, social responsibility, and justice. Students and practitioners from many disciplines would benefit from hearing the views held by the authors, but in particular I recommend it to all psychology students especially those in undergraduate courses. You are unlikely to hear these perspectives taught in your classes unless you are fortunate enough to have one or more of these authors on staff. This book presents an alternative - and I would suggest a more real and valid - view on the role psychology should play in society. My hope is that as a minimum this book will spark a debate that leads psychology as a whole to embark upon a period of intense and critical reflection.

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