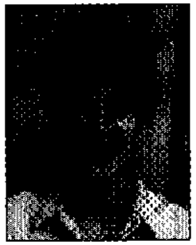
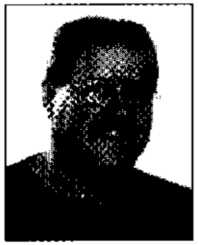

Mr John Walker


Mrs Wendy Malcolm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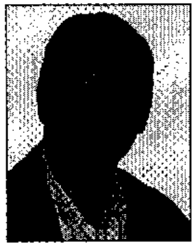
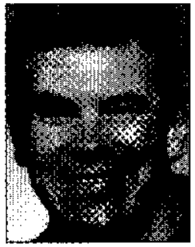

Dr Mike Kyrios


Dr Kate Moore


Dr Penny Egan-Vine


Dr Ian Brighthope

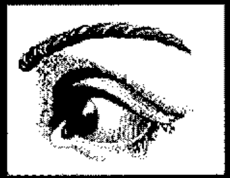

Mr Neil Cole


Mr Paul Best


Painting by Ken Raff, 2001 for Wendy Malcolm – a symbolic portrait of her recovery from anxiety, depression and OCD.

MENTAL HEALTH NEEDS IN ALBURY-WODONGA AND DISTRICT

A Report from the 'On the Edge' Working Party 2002



Anxiety & Depression Support Group
Albury Wodonga

In conjunction with:

Anxiety Recovery Centre Victoria

LA TROBE UNIVERSITY
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Anxiety & Depression Support Group
Albury Wodonga

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A Report from the 'On the Edge' Working Party
2002

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Anxiety
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Contents

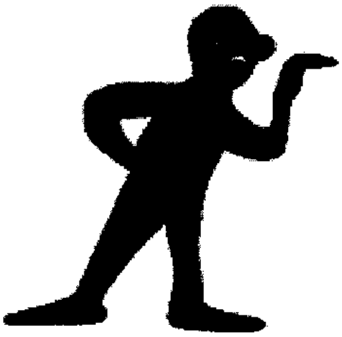
Overview and Acknowledgements

In May 2001 our working party implemented the "On the Edge" forum. Along with being a resounding success, the forum provided the opportunity to collect information from community members about mental health issues in Albury Wodonga and districts. We then set out to make the information available to policy makers, service providers, consumer representatives and individuals with the aim of improving mental health services in our region. This report is the result of those efforts.

The information in the report was purposely collected in two different ways; as words (qualitative) and numbers (quantitative). The qualitative information was collected during a final session of "On the Edge". Participants responded to three questions about mental health issues in Albury Wodonga and the region; What is going well? What could happen differently? Where to from here? The second quantitative approach defined need categories and then collected survey information that was used to examine relative need. These two different approaches resulted in consistent and complimentary findings. Initially the report includes an executive summary and recommendations from both the qualitative and quantitative information. The body of the report then details these findings.

The authors of the qualitative information were: Margaret Dalmau (Greater Murray Area Health Service), Patience Harrington (Wodonga City Council), Tony Lane (Department of Human Services), Wendy and Richard Malcolm (Anxiety & Depression Support Group), Darryl Maybery (La Trobe University) and Dr Penny Egan-Vine. The quantitative dimension was contributed by a group of third year research students from La Trobe University Psychology Section (Wodonga Campus). They were Laura Hoare, Melinda Massey and Brett Sprunt and were supervised by Darryl Maybery. We also thank Reinhard Beissbarth, Andrea Reupert, John Walker and Chris Gullifer for their assistance in relation to reading and editing of this document.

There were also many others who contributed to the compilation of this report – we thank them for their tireless assistance and their feedback along the way.



We return this information to our community
in the hope that it improves all our mental health.

Introduction – "On the Edge" Forum

The "On the Edge" Forum for anxiety and depressive disorders was held at Wodonga campus of La Trobe University on the 25th, 26th and 27th of May 2001, co-hosted by the Anxiety & Depression Support Group (Albury Wodonga) and the Psychology Section of La Trobe University.

More than 400 people attended the Forum. Over 70 people attended the introductory event (a movie night) held on Friday evening, 220 attended the first day of the conference and 130 attended on the Sunday. The Saturday program included a professionals' workshop/seminar attended by close to 70 psychologists, social workers and mental health workers.

Professor Ian Hickie, the CEO of the Jeff Kennett inspired depression initiative, Beyond Blue, was the keynote speaker. The forum:

- Brought a number of other prominent speakers to Albury Wodonga regarding depression, obsessive compulsive disorder, social phobia, panic and other disorders.
- Raised community awareness regarding anxiety disorders and depression.
- Helped reduce the stigma of mental illness.
- Provided information and resources about anxiety disorders and depression.

In terms of the future, a key component of the forum was the collection of information, data and ideas about the needs of the community (e.g. consumers, carers, practitioners) in relation to anxiety and depression. It also sought to be positive and active regarding future activities.

Finally a forum provides a platform for people to be heard and "On the Edge" provided the opportunity to collect different kinds of information, from a variety of key stakeholders.

Executive Summary and Recommendations

The executive summary provides an overview of both the qualitatitive and quantatitive information that was derived from the forum. It first summarises the central issues derived from this research and then provides recommendations for futurc Albury-Wodonga and district community mental health activities. The summary is then followed by recommendations for future activities to improve the mental health of Albury-Wodonga and district community.

Qualitative

The qualitative data focused on six separate issues. These were:- treatment services, support for consumers and families, public communication and education, equity and access to services, across service communication and planning, and future forums and conferences. Within this information there were many occasions where verbatim comments from participants fell across categories. Generally they were assigned to one category but where it was appropriate were included in other sections.

Existing treatment services were generally perceived as being too remote (geographically and conceptually), under staffed and poorly funded. There was a general belief that increased staffing in mental health services was necessary to improve service delivery.

A specialist clinic for anxiety disorders and depression would shorten treatment delays and reduce misunderstandings by practitioners, negative labelling and poor referral systems. This would offer an alternative service to acute psychiatric services and an opportunity for early intervention. The service focus should also consider wellness with less emphasis on purely medical treatment. A multidisciplinary approach (i.e. social workers, psychologists, occupational therapists, dieticians, and general practitioners) was believed to be important.

It was also thought that the current level of referrals to existing support services by General Practitioners was poor and that education was necessary to improve knowledge and respect for the role that others can play in treatment. Education in this area would move some forms of mental illness from being perceived as 'trivial afflictions' to being seen as issues of real concern.

The need for improved co-ordination of services including across state borders was frequently mentioned. Requests for deliberate and planned co-ordination were made rather than relying on serendipity (also see *Across-service Communication and Planning).* Current problems of duplicated services were highlighted, as well as the need for the coordination and planned direction of funds. Improving consumer participation was also seen to be important.

Improvements to current systems for managing those with a mental illness were suggested. These included: focusing greater emphasis on follow-up after discharge from hospital; creating "safe houses" away from acute psychiatric units; implementing other therapies (with specialist counsellors, other types of therapies) as well as medical services; providing direct access to services rather than via general practitioners; improving options for young people (e.g. day placements, specialist youth inpatient service); and recognising and improving services to those with a mental illness and a substance abuse disorder.

There were four issues of concern in relation to support needs. People commented on issues associated with the current Wodonga support group; ideas about establishing new support groups particularly in regional areas, better linking of consumers to established supports and support for those caring for those with mental illnesses.

Comments regarding the existing Wodonga support group centred on the need for more instrumental support (e.g. funding, facilities) and referral processes to it. Other comments focused on the importance of improving members' understanding and skills in areas such as Cognitive Behaviour Therapy techniques, managing suicidal group members and the co-morbidity (interelationship) of disorders and substance abuse. As mentioned, there was a general view that additional support groups were necessary. These comments mostly focused on developing groups in rural areas (e.g. Corryong) but a few comments suggested the need for specific types of groups (i.e. those with a mental illness and substance abuse).

A final important area was focused on improving support for carers of those with a mental illness. This centred on issues such as developing carer support groups and programs with a specific mention of children with parents who have a mental illness. Other comments focused on providing more information, education, support and advice to carers generally.

The three issues associated with communication and education were– the provision of information, the necessity for community education, and the style of communication in the media. The first involved the provision of information to all groups involved with mental illness. Resource material (directory of local services, resources and options) employing varied delivery formats should be developed.

The second issue centred on generally educating the public but also mentioned education in schools, workplaces and with General Practitioners.

The final issue centred on improving the use of the media to educate and 'normalise' mental illness in the community and to educate the media about appropriate reporting of mental health issues; aiming to reduce the over sensationalising of such issues.

There were a great number of comments that indicated the individual's experience of a service delivery system that at times was not accessible and was perceived as not meeting the needs of many people with a mental illness and their carers. These issues fell into three specific categories.

Firstly, the broader community requires more access to education and information about mental health issues. This would reduce stigma and improve general community understanding about mental illness (also see above). Second, there appears to be a lack of access to specialist mental health services in rural areas. This has the following impact:

- Restricts access to skilled people;
- Impedes early intervention /diagnosis;
- Illnesses getting "out of control".

Finally, it was thought that some service providers did not know about treatment options that specialist services could provide.

A key suggestion was an access point such as a cross border anxiety-depression disorder clinic that could "house" specialist services, be a key entry point into the service system and provide support for both consumers, carers and providers of services.

Most comments in this category appeared to have been made by individuals and carers who have been directly affected by mental illness rather than people employed in the mental health area. Overall the prevailing view was that significant work still needs to be done to develop a comprehensive sector of services. This would include a variety of treatment approaches and clear pathways and referral points.

Individual comments revealed significant variation in the perceived quality of services provided for people with a mental illness. Identified problems were attributed to a lack of overall coordination between service providers and the absence of some treatment approaches locally. The organisations attracting the most comment were public mental health services, general practitioners and private psychiatric service providers. Although there would no doubt have been some level of communication and planning by these key services providers (and others) in the past, more attention is needed in the future.

These comments applied to within and across state borders. Other services and groups that were mentioned who also have a stake in the issue include: community health services, schools and consumer support groups.

There was overwhelming support for future forums. Participants thought that "On the Edge" provided a blueprint for future forums and should become an annual event. In addition to the generous support for the forum, there were many suggestions regarding future events, activities and improvements to the format. Some of the latter were to have fewer speakers for longer sessions, more on carers and others suggested additional content (e.g. postnatal depression) as being necessary.

Quantitative

The quantitative data identified ten areas of need that were generally overlapping with the qualitative information. In addition this data provided important information regarding the comparison of each of the need areas - helping to determine those areas most unmet in the community. The category with the highest level of need was awareness/education, which received a score of poorly met need on the rating scale. This was perceived as the most important and unmet need in the community. This was supported by written comments from the questionnaire.

Almost as important was the need for more 'carer resources'. Participants said that the information available for carers regarding anxiety and depression and the level of emotional and financial support for carers was poor. This was also reinforced by verbatim comments from the quantitative questionnaire.

There were five need categories that scored in the 'below satisfactory' range. These were quality and amount of information available, support/resources, immediate access to services, financial costs, and quality of care. These categories again represent unmet needs in the local community. These findings were also supported by verbatim comments from the questionnaire.

Recommendations

Educate General Practitioners regarding mental health issues and other services that are available for people with a mental illness.

Increase the levels of education in the community regarding mental illness.

Develop a mental health resource directory for consumers/carers/professionals in multiple formats.

Increase education in schools regarding mental illness.

Increased utilisation of the media to educate and destigmatise mental illness available in the community.

Educate and monitor the local media regarding appropriate reporting of mental health issues.

Improve the support, information, and education available for carers.

Increase the information available to and educate the general public on referral and pathways procedures for services.

Lobby for increased staffing in mental health services.

Establish a specialist anxiety and depression clinic.

Greater emphasis (and lobbying) to improve the co-ordination and communication between services across the border.

Improve consumer participation in the planning and development of mental health services.

In conjunction with current mental health services, facilitate the improvement of follow up of clients following discharge from hospital.

Lobby for increased Medicare coverage of psychiatrists and psychologists within the public health system.

Recognise and develop services to meet the access needs of those in rural communities.

Increase and improve access to a range of services and alternative therapies for those with a mental illness.

Greater involvement of multidisciplinary teams (Social Workers, Occupational Therapists, Dieticians, Psychologists) in the management of mental illness.

Improve the skills of the members of the AlburyWodonga Anxiety & Depression Support group to better enable them to support others in the community.

Investigate options for improving the financial support of the Albury Wodonga Anxiety & Depression Support Group.

Current support services for carers and consumers be expanded (particularly in remote locations).

To follow up (within two years) the success of the 2001 'On The Edge' forum with regular events.

To review the format and content of future events.

Future events should involve the general public and service providers with more information in greater depth.

Report

Introduction

In Australia, it is estimated that one in five people experience serious disruption to their mental well being in their lifetime *(Commonwealth of Australia, 1997)*. Up to 4.7 million Australians are thought effected by at least one mental disorder in a 12-month period *(Department of Health and Aged Care, 1999)*, with 12.6% of the population suffering an anxiety disorder, 9.5% an affective disorder, 9.5% substance abuse and .5% schizophrenia *(Clarke, Drake, Mellsop, Stedman & Yellowlees, 1997)*. People with a mental illness are among the most vulnerable and disadvantaged in our community and evidence also suggests that these disorders are a major health issue in rural areas due to a lack of services *(Mathews-Cowey, 2000)*.

There has been considerable mental health research focusing on the prevalence and level of disability *(National Survey of Mental Health and Wellbeing of Adults, 1997)*, factors associated with the use of mental health services *(National Survey of Mental Health and Wellbeing of Adults, 1997, Parslow & Jorm, 2000)*, symptoms and behaviour problems *(Brewin, Vetro, Wing, McCarth & Brugha, 1990)*, the burden of disease *(Andrews, Sanderson & Beard, 1998)*, attitudes towards *(Jorm, Medway, Christensen, Korten, Jacomb & Rogers, 1999)* and the social costs *(Leon, Portera & Weissman, 1995)* for those with a psychiatric disability. But little research has investigated the needs of those with a mental illness generally and specifically in rural areas *(Mathews-Cowey, 2000)*.

Need has been defined as a want for a resource or service, a lack of a required or desired resource *(Martin, 1982)* and any identifiable condition which limits an individual, group or community from meeting their full potential *(Kettner, Moroney, & Martin, 1990)*. From a treatment perspective, mental health needs have been examined from the different perceptions of practitioners and consumers (Jorm et al., 1999), the types of needs for care of individuals with a mental illness *(Bebbington et al., 1997)*, the unmet needs of individuals with specific disorders in the community *(Bebbington, et al., 1999)* and regarding those with a severe mental illness (e.g. accommodation, level of self care, *Phelan, Link, Stueve, & Moore, 1995)*.

However, little research has examined the needs of those in the community with more moderate and infrequent conditions (the bulk of mental health service consumers) or the needs of their families. This lack of information led to the two studies reported here. The Albury Wodonga Mental Health Working Party undertook the qualitative component and third year psychology students of La Trobe University (Wodonga campus) focused on the quantitative part of this report. The latter was part of a group research project that forms part of the students' final year in the Bachelor of Behavioural Science (details of contributors can be found on the acknowledgements page). The two studies were undertaken independently of each other in an effort to triangulate the findings within each set of data.

It has been suggested that to determine community need a comprehensive assessment of different areas of concern should be conducted *(Jorm, Korten, Jacomb, Rodgers, Pollitt, Christensen, & Henderson, 1999)*. This may include assessing gaps in services, examining perceptions of resource allocation, evaluating how effective the services in question are, and allowing for the recommendations regarding service delivery *(Alston & Bowles, 1998)*. Need is a subjective term and community or group needs can vary depending on who is conducting the analysis.

Previous researchers *(Jorm et al., 1999)* compared the beliefs of health professionals to the general public on how helpful mental illness interventions are to individuals with schizophrenia and depression. The results showed that General Practitioners, psychologists, and psychiatrists had different beliefs to the general public about treatment interventions for mental illness. For example, health professionals rated the use of medication as helpful in the treatment of depression whereas the general public saw this intervention as harmful. Jorm et al. (1999) concluded that the opinions of health professionals and the general public differ greatly in the treatment of mental illness. This suggests that an individual or community need will vary depending on the perspective from which it is perceived. Gaps in services and their delivery can occur as a result of which perspective influenced the policy maker's decision. These gaps may include the sufferer not wanting to see a professional, the sufferer not knowing of any services in the area where he/she lives, or alternative treatments not being available.

In contrast to the studies listed earlier, sufferers' needs are not the only needs associated with mental illness. The Anxiety Disorders Association of America (2001) indicate that carers of those with a mental illness (such as family members, friends, and significant others) may also have needs as a result of the illness. These carers are thought to meet some of the needs of sufferers by becoming involved in therapy sessions, helping the sufferer through depressive and anxiety producing situations, and offering support and encouragement *(Anxiety Disorders Association of America, 2001)*. While carers offer individuals support, there is little literature on what the carers believe the sufferer needs in terms of treatment or with regard to their own needs.

Research Aims and Approach

The general overarching aim of the two studies was to examine the key areas of need for those with mental health concerns (including carers of those with a mental illness) in Albury Wodonga and district. Two secondary aims were to examine the relative needs within our community and to examine these needs from different perspectives (i.e. health professionals, consumers of mental health services and carers) making sure that these different groups were included as participants in the research. A final aim was to develop, pilot and validate a questionnaire that could be used in future research to identify community mental health needs.

"Numbers and words are both needed if we are to understand the world" *(Miles & Huberman, 1994, p.40)*. Consequently this study used both qualitative and quantitative methods of data collection and analysis. There are a variety of reasons for using both qualitative and quantitative data:

- To enable confirmation or collaboration of each other via triangulation;
- To produce or develop analysis, providing elaborate detail;
- To initiate new lines of thinking; * Can expand the depth and scope of the study as a whole *(Miles & Huberman, 1994)*.

Several authors have highlighted concerns with the focus group approach *(Straw & Smith, 1995; Seal, Bogart & Ehrhardt, 1998)* and in particular how more sensitive topics or information may not emerge within a group process. Consequently, a number of individual interviews and small focus groups were employed to develop the quantitative questionnaire.

The qualitative approach was used to clearly define, from a large number of participants, the central issues associated with the delivery of mental health services in this community. The quantitative approach sought to both triangulate this data and to provide a mechanism for the examination of relative need. Both sets of data were collected at the 'On the Edge' forum held on the 26th and 27th May at La Trobe University (Albury Wodonga campus).

The qualitative and quantitative approaches are shown below. Each section details specific information about the methodology used, the results obtained and discussion of the findings.

Qualitative Data

During the forum participants provided their thoughts regarding the following three questions about Anxiety and Depression in Albury Wodonga and the region.

- What is going well?
- What could happen differently?
- Where to from here?

Participants

Forty-two individuals and 12 groups (made up of approximately 100 individuals) responded to these questions. At the commencement of the forum, (at registration) participants were given sheets containing these questions and were asked to add to or complete the sheets throughout the two days of the forum. A locked box in a prominent position at the forum was provided for completed forms.

Collation of Responses

There were 25 A4 pages of verbatim responses, which were then collated by four local individuals knowledgeable in the mental health field and the local district. Initially these individuals independently defined themes (categories) from the data and then came together and agreed on the clear and consistent themes within the verbatim responses. Generally there was agreement from these members regarding common themes. The six themes were:– public communication/education, support for consumers/families, treatment services, equity and access, communication/planning by services and future forums/conferences. Many of these themes (e.g. communication/education) consisted of a number of smaller themes. These categories are outlined in detail in the results and discussion section that follows.

After the identification of these themes, individuals took responsibility for elaborating on and developing the concepts associated with each topic. The linking of a topic to an individual attempted to join the topic area with the relevant community expertise of the individual/s involved. Individuals with responsibility for specific areas were Margaret Dalmau (Greater Murray Area Health Service), Tony Lane (Department of Human Services), Wendy Malcolm (Anxiety & Depression Support Group), Darryl Maybery (La Trobe University), Dr Penny Egan-Vine (Grief & Loss Counsellor) and Patience Harrington (Wodonga Council). These individuals also sought assistance from others in developing the area of interest and undertook considerable collaboration with each other to develop this report.

Results and Discussion

There were seven key themes stemming from the responses. They related to public communication/ education, support for consumers/families, treatment services, equity and access, communication/planning by services, future forums/conferences, scope of project group and other issues. Some of these themes (e.g. communication/education) were also broken down into smaller themes. In addition, while the responses were categorized into themes that initially seemed independent, many of them overlapped or were somehow related.

Public Communication/Education

There were three sub themes associated with communication and education.

Information/resource kit: The first involved the provision of information to consumers, their families and professionals regarding the availability of all types of information (from "What is wrong with me?" to "what services are available?"). It was suggested that a resource package/booklet be developed (along the lines of Beyond Blue) for people with depression/anxiety that would include a directory of local services, resources and options. One respondent summarized this view as follows:

> *A booklet available from GPs, Mental Health, counsellors, carers centre, churches, schools, anywhere people gather and go to for assistance. The booklet to share info such as: What causes anxiety disorders —> you're not weird!, What avenues to take to seek assistance, such as: local resource list (a specific list of names, phone numbers in Albury Wodonga and area), a route map eg GP —> counsellor —> professional assistance (paid/subsidised), things you/carer can do, eg:–food, exercise, mental, emotional, physical and spiritual approaches.*

Others suggested that this resource could be made available on the web but it was recognized that access to the web is not available to all.

Community Education: In this area participants thought that there should be increased education of the public, including media reporting and education in schools. It was thought that such education would lead to a reduction in the stigma of mental illnesses and would provide valuable information regarding treatment and resource options in the community. It was thought that education should be provided to General Practitioners, in workplaces, and the general community but also to schools. In terms of the latter the following was a typical response:

> *Development and implementation of programs in schools (primary and secondary) focusing on early intervention and protective factors for suicide preventions and skills for self-esteem and self-talk programs.*

Media: There were two central factors involving the media. The first was to use the media to educate and 'normalise' mental illness in the community. These suggestions were aimed at reducing stigma for those suffering a mental illness. The second focus of suggestions was to educate the media about appropriate reporting of mental health issues; aiming to reduce the over sensationalising of such issues.

The issue of information and education was also outlined strongly in the access and equity section below.

Support for Consumers/Families

There were four issues of concern in relation to support needs. People commented on issues associated with the current Wodonga support group; ideas about establishing new support groups particularly in regional areas; better linking consumers to established supports; and support for those who care for others with mental illnesses.

Existing Wodonga support group: The general comments in this area focused on providing more "support to the local support group". This included providing more funds to the group but also touched on having better referral sources (e.g. educating General Practitioners about referral to the group) and information about the group being made more readily available.

Other important issues were to increase the skills of those within the support group. This included suggestions that support group members need greater understanding of therapeutic techniques such as Cognitive Behaviour Therapy and in matters such as dealing with suicidal group members. The focus of these suggestions was on improving skills to better support others in the group.

Other issues of this kind were that group members should be better educated about co-morbidity. This particularly included alcohol but also other substances in association with a range of mental illnesses. It was also thought that there was a need to improve support group resources generally. More general issues included the need for improved facilities (room size) for the group to operate in and improved support services such as a drop in centre.

Establishing additional support groups: There was a general view that additional support groups were necessary. These comments overwhelmingly focused on establishing groups in more rural areas such as Wangaratta, Corryong, Bright, Myrtleford, Corowa/Rutherglen, Shepparton and the Ovens Valley. Suggestions were also made that members of the current group may look to assist setting these groups up. Others stated the need for a group to be set up with a specific depression and substance abuse focus.

Overall, this category could perhaps be best summed up by the following verbatim comment:

> *I live 30 minutes away from Albury/Wodonga and find travelling a major cost . . . and time to get the support and help I need, to help maintain some sort of normality in my life . . . I wish that a group could be set up for people like me . . . I am amazed to find many other people suffering from mental illness and substance abuse.*

Linking consumers to established supports: There were several comments regarding the need for a support network that would link sufferers to the supports already established in the area. This was perhaps best summed up as follows:

> *I would really like to link into a regional network so that as the local community networks develop there is a broader framework to link into . . . some GP's seem to want to just deal with the issues they are approached with without linking to other services or referring to further supports.*

Support for carers: There was also a considerable focus on giving more support to carers of those with a mental illness. This centred on issues such as developing support groups for carers and providing programs to carers. This also focused on children with parents who have a mental illness with one person suggesting that there should be "counselling for children who live with parents with an anxiety disorder". Other comments focused on providing more information, education, support and advice to carers generally.

Treatment Services

It was recognised by many that the region now has some very dedicated health professionals and consumers who provide and are working to improve mental health services. However, it was generally perceived that existing treatment services were too geographically remote, too expensive for those on limited incomes, under staffed, uncoordinated, and poorly funded. Some services were even felt to be inappropriate. Following on from this, the belief was expressed by several people that an increase in funding, resources, and provision of staff for mental health services would be a good start to improving services. A common statement was "... there is a need for more money and service assistance for intervention and prevention rather than just hospitalisation".

While it was identified that some psychiatric and support services did exist in the area it was thought that they were sparsely located. For example, it was noted that Wodonga residents have to travel to Wangaratta for inpatient psychiatric services, and that Nolan House in Albury has insufficient beds for the area. The perceived differences in the availability of treatment services for NSW and Victoria was also highlighted, as were the anomalies between the State systems with the example given that each State's mental health schedules were not recognised across the border. There was also a sense that some services were being duplicated across the border and that funds could be better utilised to provide more appropriate and coordinated services and increase support for staff. Cross border communication, consultation, and referral mechanisms between services was an area identified as requiring further development by several people.

Having an anxiety disorders and depression clinic – or specialist mood disorders clinic was thought by many to be the panacea for the problems they were experiencing in the current mental health system. A clinic was perceived as a solution to the delays experienced by consumers in accessing treatment, for misunderstandings by practitioners, negative labelling, and poor referral systems among services. It was seen as offering in-patient support away from the acute psychiatric services. A common sentiment was ". . . a clinic . . . to help people with mental illness will help to motivate people and for them to live more comfortably with the acceptance of their mental illness and give support, encouragement and hope to many people in this area."

'The Clinic' was envisaged as being able to provide an alternative to the traditional medical model with a focus on wellness rather than an illness approach to care. Incorporating an early intervention approach to treatment within this model was considered important. This feeling was demonstrated by the following quote *"more focus on early intervention as treatment is more effective if a person is becoming ill, not when he/she is in dire straits or attempting suicide"*. It was also felt important that the clinic should incorporate a multidisciplinary team approach (i.e. social workers, psychologists, occupational therapists, dieticians, General Practitioners) to provide care. As such, it was hoped a clinic would also increase the awareness within the community, with service providers, and with consumers about other treatment options available instead of, or in conjunction with medication.

A number of points were raised regarding the central role of General Practitioners in supporting clients and with the level of referrals and access to existing support services. It was thought that the current level of referrals to and from General Practitioners was poor. This was highlighted with the following statements. *"GP's are the first point of call, they need to be central, however, they tend not to refer on"*, and *"I think GP's need to be more informed about available help and services that are available and provide patients with this information"*.

While it was recognised that rural areas are currently under resourced with regards to the numbers of General Practitioners required for the population, it was felt that this exacerbates problems with time, travel, monitoring, referrals, costs and communication. However, for existing General Practitioners, increasing the education available to them on mental health was thought beneficial in the following ways:

- increase their knowledge and understanding in area of mental health and illness,
- increase the respect for the role other professionals and support services can play in treatment,
- decrease the stigma attached to mental illness, and
- move some forms of mental illness from being seen as 'trivial afflictions' to be issues of real concern.

Issues in respect to the co-ordination of existing and future mental health services in the area were mentioned frequently, particularly across state borders. Many requests were made for a deliberated, co-ordinated and collaborated approach to across-border mental health services. It was recognised that while there are National Mental Health Standards there are different mental health planning and funding objectives for NSW and Victoria thus resulting in the inequities across borders regarding the availability and duplication of services.

In addition to cross-border issues there was also a need for more day-to-day integration of and communication between, mental health services. Particularly highlighted was the need for greater co-ordination at a planning level. More co-operation was identified between particular services such as drug and alcohol, aged services, services for younger people, and General Practitioners. Further developing the networking and links between services were seen as beneficial to increasing the support, assistance, and continuum of care provided to consumers and carers. In this regard it was also perceived that there was a need for the development of outreach teams and workers who could connect with and provide support to rural and isolated consumers and carers. The integration and flow-on with current services (i.e. inpatient/outpatient/access line) was identified by many as an area with problems that required further development.

Across many of the responses received there was an explicit or implicit desire for more and improved consumer participation in the development of mental health services. The type of participation requested ranged from simply being asked about what rehabilitation program would best suit them, to being a paid consumer representative involved with different committees to develop better mental health services. There was also a desire to establish *". . . a network of Consumer Advisory Groups (CAG's) through the State"*. The following comment summarises the underlying feelings in this regard *"Respect and listen to consumers as experts, through increased consumer participation"*.

Many suggestions were received as to how current systems could be improved for managing those with a mental illness. These ranged from improving the accessibility and quality of current services, identifying barriers that prevent people accessing support, to the development of new treatment services that include access to alternative therapies. The suggestions can be summarised as follows:

Current services:

- improving follow-up after discharge from hospital
- direct access to services rather than via General Practitioners
- have easier access to services both physically and financially
- patients being informed of all the different treatment options currently available
- recognition and addressing of co-morbidity issues

- better and more information for consumers and carers
- more communication between services
- more education and training
- address multicultural and Aboriginal and Torres Strait Islander mental health issues

Barriers:

- financial barriers to services were discussed particularly with regard to the limited bulk billing that is available and the lack of rebates on psychologists fees.

New Services:

- creation of 'safe houses' away from acute psychiatric units
- drop in centre
- increase in the availability of Cognitive Behavioural Therapy
- rehabilitation program developed in consultation with consumers
- increase in grief counselling and other 'talk therapy' with specialist counsellors
- availability of other treatment options such as alternative therapies (ie massage, nutrition, hypnotherapy, life management skills, aromatherapy)
- 'point of entry advocacy' for people with mental health disorders to assist with negotiating and working the way through the system
- increased funding to have more qualified staff in rural areas
- improving options for younger people (i.e. day placements, specialist youth inpatient service).

Equity and Access

Equity and access issues were widely referred to throughout the forum. In terms of equity some focused on issues to do with attending the forum itself, suggesting that it was difficult for those with children and that perhaps child minding should have been available.

But mostly people focused their equity concerns in relation to treatment and support. They suggested that it was more challenging to gain treatment for people with dual issues (substances issues and mental illness), in relation to money to afford services and that people had to be very ill to obtain immediate access to services.

Issues of access were also widely referred to throughout the forum. These included access to treatment including specialist services, sharing information with people with like problems, information about services and supports, the community generally to information and workshops about mental illness, and support for carers. Not surprisingly these access issues reflect many of the need areas identified in this report (i.e. treatment, education/information, support etc). The following points were made about each of these access issues.

Access to treatment services: As services are predominantly in capital cities it is very difficult to access services in rural areas - sufferers experiencing isolation. This leads to a need for rural people to travel that becomes an added financial and psychological burden. There needs to be key access/entry points to the service system instead of having to "surf the system", a reduced waiting time generally for treatment and greater access to rehabilitation services. These services would be supported by more immediate access to follow up services for consumers on leaving hospital.

Feedback also suggested that increased sharing information with people with similar problems through more forums, workshops and support groups, but also for the community generally in terms of school programs (e.g. mind matters) and forums. Suggestions regarding access to information included more effective use of the media and educational material including internet access for the community should be more readily accessable. Access to support for carers suggested the provision of professional development and training, participation in the visual and performing arts for people with mental illness and increased participation options in planning of services particularly in more isolated areas (e.g. Corryong).

Across-service Communication and Planning

Although the forum was attended by a variety of organisations, individuals and interest groups there was a common theme that indicated that the current level of communication and overall planning was inadequate. Most comments came from individuals and family members who were directly affected by mental illness, who pointed out service gaps and problems. There was little evidence offered by forum participants working directly in service provision that adequate communication and planning processes were in place. However on a positive note many people commented on the forum being a potential springboard from which to make a variety of improvements.

The Role of General Practitioners: Many comments indicated that General Practitioners have a vital role in assisting people with mental illness. A common view was that General Practitioners were not sufficiently well connected to other mental health service providers and support groups. As a consequence treatment was prolonged and individuals did not feel encouraged about their chances of a fuller recovery. The following were typical comments about this issue:

> *I think GP's need to be more informed about available help, support groups etc. and provide patients with this information.*
>
> *I have been suffering from depression on and off since 1996 and have seen 3 different GPs in this time. They have been sympathetic and explained different symptoms etc. of the illness and prescribed anti-depressants...Armed with the knowledge I have gained at the forum, I will ask my GP to refer me to a psychiatrist or someone with similar skills.*
>
> *I was in hospital after an attempted suicide before I even knew Mental Health Services were available in Wodonga, yet my GP had been treating me for major depression for over 5 years.*

There were also comments about mental health services generally. Participants felt that mental health services needed to provide feedback to the General Practitioner concerned, that there needs to be short term follow up of people discharged from hospital and that generally there needs to be more communication between professionals. Others thought that private psychiatric inpatient service to offer anonymity for private patients who tend to be professional people and for whom the public system would not be appropriate.

Another comment summed up a general feeling of the need and type of mental health clinic in the area:

> *Set up a clinic to focus on wellness, not a medical model, but a holistic bigger picture model that coincides early intervention programs and sufferers and carers and families.*

Future Forums/Conferences

There was overwhelming support for future events of this nature with very few negative comments. Specific comments included: it was well organised, a blueprint for future forums, good environment and venue and use of humour was important. Several thought that it should become an annual event and others thought that forums should also be held in outer districts. It must also be noted that a separate general evaluation of the conference questionnaire was handed out 'on the day' and a summation of that information can be found in Appendix 1. Those findings also suggested that participants to 'On the Edge' were generally very satisfied with; the general organization of the conference, the presenters' performances and with the educational outcomes that they received.

In addition to the generous support for the forum overall, this feedback highlighted many suggestions regarding future events and activities and improvements to the format. Suggestions included the notion that future forums should look at alternative methods for dealing with mental illness; have fewer speakers for longer sessions; that there should be no division between professionals and consumers; that there be a General Practitioner's conference with, locals as presenters; something on postnatal depression and more emphasis on carers. Other suggestions were made about the specific running of the conference including the availability of more handouts, a kids crèche and some professional support for sufferers. Others also suggested that there should be more information on the web before hand and that information technology be used to link people in more remote areas.

Quantitative Data

Two methodological activities were undertaken in the collection of the quantitative data. It is common when designing questionnaires to do interviews first *(Bogdan, 1992)*. This was undertaken with participants concerned with mental health issues, namely consumers, carers, and health practitioners. This process sought to develop the mental health needs questionnaire to be used to collect data at the forum.

Focus Interviews

The interview component involved six participants and included two consumers, two carers of consumers and two mental health professionals. These participants had extensive knowledge of the mental health field from different perspectives of the problem. The consumers and carers were recruited through contact with the "Anxiety & Depression Support Group," Wodonga, and through contact with the steering committee of the "On the Edge" forum.

Prior to the interviews an extensive examination of the literature regarding mental health and needs item development was undertaken, which resulted in the creation of a focus list of questions that guided the semi-structured interviews. This focus list included questions regarding the sub-topics of treatment related issues, availability of information and levels of disability.

The format of the six interviews were semi-structured and generally undertaken as formal discussions but in a relaxed and open manner. Interviews commenced with briefing statements clarifying the aims and scope of the research. Open-ended focus questions followed, for example "What do you think are the key needs of depression and anxiety sufferers in the local region?" As the interview proceeded, questions were generally more spontaneous (i.e. could you be more specific about what you mean?) and/or directed at specific areas of need. More specific questions included "What information about anxiety and depression do you think should be available to sufferers?" On completion of the interview, participants were debriefed. The interviews were generally one hour in duration.

Questionnaire Development

Following the interviews a draft version of the questionnaire was developed that included information from the interviews, with reference to the literature, particularly the "National survey of mental health and well-being of adults" questionnaire from the Australian Bureau of Statistics (A.B.S.) Canberra (McLennan, 1997). This draft was then sent back to each of the six interview participants for their opinions and feedback regarding items and format. This led to several changes to the draft version.

The final questionnaire was constructed based on information from the literature and the focus interviews. It consisted of six major categories of questions including background information, treatment, support/resources, information and education, carers of those with a mental disorder and cost. The background information included age, gender, status (e.g. professional, carer), diagnosis, type of disorder, severity of disorder, postcode and distance from Albury Wodonga. Table 1 shows the sub-sections and summaries of the questions within each category.

Table 1: Categories of need, labels and example questions.

Label	Category	Example question/s
A	Awareness/education	Indicate your opinion regarding the current level of awareness/ education of the general community regarding mental disorder.
B	Carer resources	The availability and quality of resources (information/ support) for family and friends.
C	Amount of information	The amount of information about the availability of support services/ treatment options.
D	Quality of information	The amount of information about specific mental disorders/ community support groups.
E	Support/resources	Availability of crisis care (medical)/ telephone counselling (e.g. lifeline).
F	Immediate access	Rate the emergency availability of access (ie within 48 hours) of a social worker/ mental health nurse.
G	Quality of care	Quality of care provided by psychologist. Quality of crisis care.
H	Financial cost	Rate your opinion of the financial costs (travel/ bulk billing) of obtaining mental health services.
I	Personal cost	Rate your opinion about asking for help/ attending self help groups.
J	Geographic access	How available (in terms of distance from where you live) are psychiatric services/ psychologists.

The questionnaire employed a seven point likert rating scale with 0 representing no opinion, 1 being poor, 4 being satisfactory and 7 excellent. Questions relating to financial and personal cost used the same seven point scale but 1 represented low, 4 moderate and 7 high. The questionnaire had a section under each category for participants to note additional comments.

Questionnaire Distribution

The questionnaires were distributed to those who attended the 'On the Edge' forum. No identifying information was required on the questionnaires. They were handed out with forum registration documents and participants completed them over the two days of the conference, returning them to a post box. Gentle reminders to complete the questionnaires were undertaken by the master of ceremonies throughout the forum, however it was emphasised at all times that participation was purely voluntary. 87 participants returned questionnaires including 38 consumers (44%), 23 carers (26%), and 26 (30%) allied health professionals. There were 25 males (29%) and 62 females (71%). The average age of all participants was 48 years, and the ages ranged between 20 and 75 years.

There were ten areas of need identified within the quantitative data. These are shown in Table 1 along with sample questions that characterise each category. The needs identified covered awareness/education, carer resources, amount and quality of information, support/resources, immediate access to services, quality of care, financial cost, personal cost and geographic access to services.

Results and Discussion

The data acquired from the questionnaire was initially entered into an excel spreadsheet where statistical analyses were later run in both excel and SPSS statistical packages. The data was initially examined for missing variables, outliers, and normality and were adjusted where necessary. The items making up subscales were reliable with Chronbach alpha's ranging between 0.71 and 0.93. Means and error bars (95% confidence intervals) for the different need categories were then calculated and are shown in figure 1.

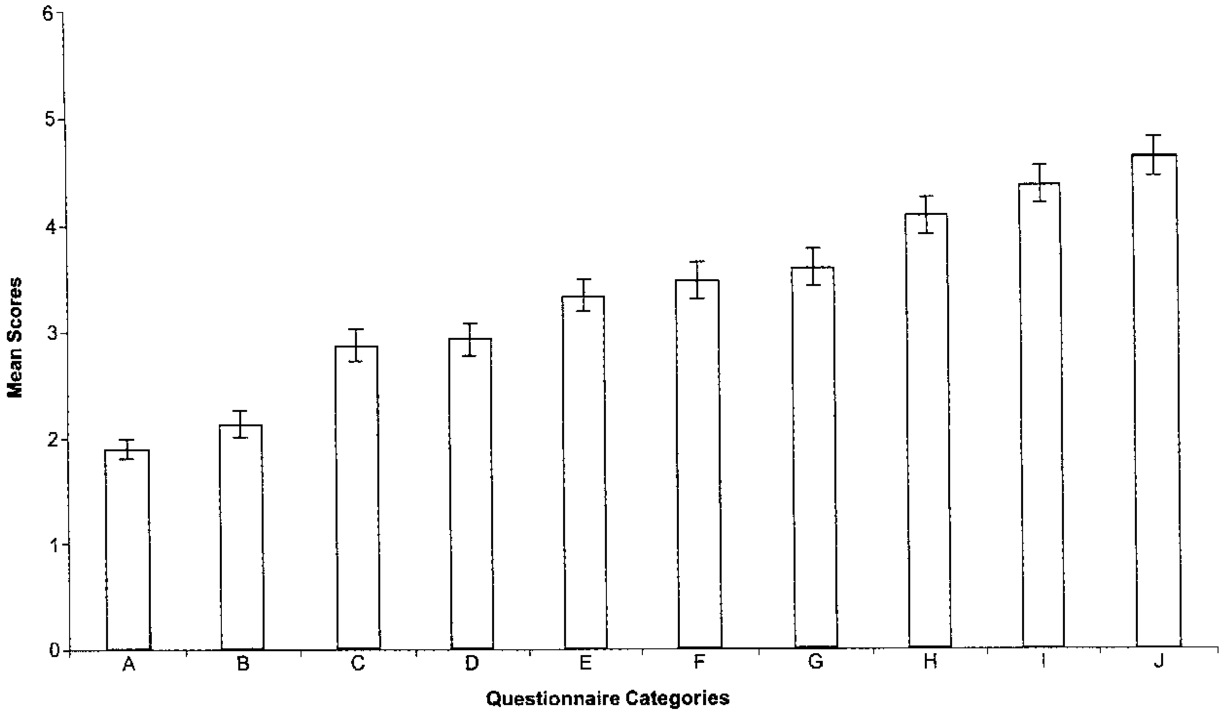


Figure 1. Means and error bars (95%CI) of perceived need for anxiety/depression consumers, carers, and health professionals.

The level of need for anxiety and depression consumers could be grouped into three categories, - low, medium, and high. Figure 1 shows that 'awareness/education' (*Mean* = 1.85) and 'carer resources' (*M* = 2.14) were at a similar level but scored lower than all other categories. Figure 1 also shows that 'amount of information available' (*M* = 2.98), 'quality of information' (*M* = 2.96), 'support resources' (*M* = 3.32), and 'immediate access to services' (*M* = 3.52), 'financial cost' (*M* = 3.65), and 'quality of care' (*M* = 4.07), all scored slightly higher than the categories of 'awareness/education' and 'carer resources' yet lower than 'geographic access to services' and 'personal cost'. The category of 'geographic access to services' (*M* = 4.71) shared some relationship with 'Personal costs' (*M* = 4.34), yet scored higher than all other categories.

The results indicate that there are many areas of unmet mental health needs in the Albury Wodonga region. Access and personal cost were the only need areas meeting a basic (satisfactory) level of need met in the opinion of these participants. The eight other need categories scored below satisfactory, suggesting that efforts should be focused to address these concerns. The category with the lowest score was awareness/education, which received the equivalent score of 'poor' on the rating scale. This indicates that the current level of awareness and education provided in the community and in schools is perceived as the most important need in the community that is currently not being met. This was supported by written comments from questionnaire participants, such as *"Most of the information I have received and the things I have learned, have come from magazines and television" and "If children are educated and mental disorders de-stigmatised throughout the school process, our future generation will have a more empathic and a less negative approach to mental health issues."* It must also be noted that more verbatim responses were obtained from awareness and education than any other category.

The other category that scored low was 'carer resources'. This indicated that there is a lack of information available for carers regarding anxiety and depression, which was supported by verbatim comments such as *"It is not so much a matter of a lack of information, it is more a matter of where and how do I find what I need to know."* There also appears to be a lack of emotional and financial support for these carers, which is reinforced by verbatim comments such as *"A carer has usually sacrificed their career to support the dependent and yet they are paid a pittance"* and *"All carers looking after someone with a mental illness need respite. They do not have enough centres for this type of care."* The category of carer resources also scored the equivalent of poor on the likert rating scale.

The categories scoring in the low to moderately low range were quality and amount of information available, support/resources, immediate access to services, financial costs, and quality of care. These categories were all below satisfactory and once again represent unmet needs in the local community. These findings were also supported by verbatim comments such as: *"accommodation and financial support is needed for people attempting to get well", "a greater community awareness for those that are unwell and do not know where to turn"* and *"the need for more psychiatrists and social workers 24 hours a day for face to face consultations and counselling."*

The two need categories that were rated the highest (least amount of need – rated as satisfactory) were 'personal costs' which referred to the stigma attached with asking for help, and 'geographic access to services' which referred to the distance travelled to seek services. This perhaps indicates that the participants perceive these areas of need to be adequately met (relative to the other areas).

Additional analyses were also undertaken by the student research group to examine if the perception of need across these areas of need were different for consumers, carers and professionals. These findings are shown in Appendix 2. They are not shown in the body of this report as although the overall data is extremely valuable these findings are not without their problems (see problems with this study below).

Limitations of these findings

Firstly, the sample that these studies were drawn from was inadequate (i.e. small, not randomly selected, and perhaps rural/urban-biased). The participants were those in attendance at a forum for such disorders and while knowledgeable about issues and concerns, cannot necessarily be considered representative or random of the specific or general population. In addition the questionnaire, although internally reliable, lacks some items and requires important design improvements (see examples below). Finally, the sample size of the quantitative data did not allow important need comparisons from different perspectives such as: practitioners, carers and consumers; rural versus urban; age; and, gender.

Future changes should include participants being recruited in alternative ways, such as, mail out questionnaires, recruitment of health professionals through their place of work, and recruitment of consumers and their carers confidentially through support programs. Design improvements to the questionnaire including the likert rating scale being altered to limit the number of 'no opinion' responses returned. The questionnaire could also use a vignette format to keep constant the level and type of disorder for the mental health concern. Future researchers could also alter the questionnaire to focus on the areas of need that were perceived as the most unmet, also to focus on differences of perceived need in regards to geographic access, community awareness, gender differences, the different severities of illness, the perceptions of the medical community, and if there are needs for health professionals and carers. Finally future research could also use this study as a basis for comparing the identified need categories in an urban versus rural setting.

Appendices

Appendix 1: "On the Edge" Forum Evaluation

Participants to 'On the Edge' were generally very satisfied with the general organization of the conference, the presenters' performances and with the educational outcomes that they received. The three attached charts highlight that participants were satisfied on all aspects of the event. On average they reported their satisfaction above 3 on a scale of one to 4 (4 being very satisfied) for each of the categories. This was generally supported by all sixty of the attendees who completed the evaluation forms. This was also indicated by the following selected verbatim comments:

1. *It was so focused on rehabilitation and recovery that it addressed refreshingly the needs and support sufferer need - too short - would like more.*
8. *Don't think I can offer any advice you are true professionals.*
14. *Excellent choice of venue, very good facilities and helpers. It has been great to see various community groups work together to achieve such a successful forum and provide the greater community with a vital service.*
18. *I think the programme was too crowded though I do not know what could have been left out. This led to very little time being free for questions and meant that quite a few had to leave before the last lecture ended.*
19. *Would of like to have more questions asked of sufferers and their stories.*
20. *The concept was brilliant – long overdue – it isn't an 'us' and 'them' situation – it is a community awareness that help and remove 'mis' conceptions and maximizes everyone's benefit – through sharing and cooperative integration.*
26. *I felt the room was too stuffy. For people with depression/anxiety, artificial lights and heat was not a good idea. Need a room with windows and natural light.*
28. *Very informative – I learnt a lot more to help me support my daughter with mental illness and carers I work with – Thank you. Thank you for the opportunity to lobby on behalf of carers for more one to one support.*
31. *If there was another forum on this topic I would certainly attend. Thank you to everyone who put this forum on.*
36. *It has been fantastic. All very valuable information. I will now be able to change the direction of my treatment (or lack of) with the information that I have gained here. I think this forum has provided me with a turning point. Things will get better from here on. THANK YOU.*
39. *No information on Post Traumatic Stress Disorder which I suffer from!*
43. *Lets hope the outcome of the forum is increased support for mental illness in the area. Eg clinic for Anxiety Disorders.*
55. *Four years on from my diagnosis and I so wanted an open forum such as this. I have found it immensely valuable and with a full house that I see here, I look forward to another conference next year. Thank you for organizing it.*
56. *Good to see uni students involved with showing people where things were – especially at the front near the carpark.*
58. *I don't mind including my name: (information left out for these purposes) for further communication.*
   As we have learnt so much to assist in helping our 22 year old son. I would like to thank the organization for a very special weekend.
59. *I think there should have been more information about support available, education material etc.*
   The ability to intermingle with the presenters and discuss with the sufferers was excellent.
60. *The organizers of this weekend should be very proud of the success it has turned out. Thank you very much. The humour was wonderful thank you John.*

Appendix 2

Analyses were also undertaken to determine any differences in need perception of health professionals, carers, and consumers, for all categories are shown below in table 1.

Table 1

Mean scores and Standard deviations of perceived need for anxiety/depression consumers, carers, and health professionals.

	Perceived need category	**Professionals**	**Carers**	**Consumers**
		Mean (sd)	Mean (sd)	Mean (sd)
A	Awareness and education	2.16 (1.01)	1.98 (0.88)	1.59 (0.63)
B	Carers resources	2.26 (1.28)	2.21 (1.11)	1.96 (1.13)
C	Quality of information	2.97 (1.21)	3.02 (1.26)	2.93 (1.80)
D	Amount of information available	2.81 (1.16)	2.96 (1.18)	3.07 (1.67)
E	Support/Resources	3.23 (1.27)	3.30 (1.20)	3.38 (1.57)
F	Immediate access to services	3.43 (1.58)	3.60 (1.96)	3.51 (1.89)
G	Financial costs	3.68 (1.70)	3.33 (1.46)	3.79 (1.67)
H	Quality of care	3.98 (1.20)	3.99 (0.87)	4.15 (1.52)
I	Personal costs	4.87 (2.08)	3.76 (1.75)	4.34 (1.81)
J	Geographic access to services	4.54 (1.35)	4.16 (1.95)	5.13 (1.79)

Within the category of awareness/education, a significant difference was found between the perceptions of consumers when compared to health professionals and carers. This category had the lowest overall rating and consumers rated it significantly lower than the other participants.

References

Alston, M., & Bowles, W. (1998). *Search for social workers: an introduction to methods.* New South Wales: Allen & Unwin.

Andrews, G., Sanderson, K., & Beard, J. (1998). Burden of disease: Methods of calculating disability from mental disorder. *British Journal of Psychiatry,* 173, 123-131.

Armstrong, T. (1999). *Taking depression seriously.* Available at: http//www.medicineau.net.au

Bebbington, P., Marsden, L., & Brewin, C. (1999). The treatment of psychiatric disorder in the community: Report from the Camberwell needs for care survey. *Journal of Mental Health,* 8, 7-17.

Commonwealth of Australia. (1999). *Media resource for the reporting and portrayal of mental illnesses.*

Davison, G., & Neale, J. (1998). *Abnormal psychology* (7th ed.). New York: John Wiley & Sons.

Hunt, C. (2000) The unmet need for treatment in panic disorder and social phobia. In G. Andrews, & S. Henderson (Eds.), *Unmet need in psychiatry: Problems, resources, and responses* (pp.277-289). Cambridge UK: Universal press.

Jorm, A., Korten, A., Jacom, P., Rodgers, B., Pollitt, P., Christensen, H., & Henderson, S. (1999). Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public. *British Journal of Psychiatry,* 171, 233-237.

Kettner, P., Moroney, M., & Martin, L. (1990). *Designing and managing programs: An effective-based approach.* Newbury Park: Sage Publications.

Leon, A.C., Portera, L., & Weissman, M.M. (1995). The social costs of anxiety disorders. *British Journal of Psychiatry,* 166 (Sup.27), 19-22.

Martin, E. (1982). A framework for exploring different judgments of social need. *Australian Journal of Social Issues,* 17, 190-201.

Mathews-Cowey, S. (2000). Too much responsibility, too little help: Family carers and the rural mental health care system. *Journal of Family Studies,* 6, 267-271.

Meadows, G., Fossey, E., Harvey, C., & Burgess, P. (2000). The assessment of perceived need. In G. Andrews, & S. Henderson (Eds.), *Unmet need in psychiatry: Problems, Resources, and Responses* (pp.390-398). Cambridge UK: Universal press.

McLennan, W. (1997). *National survey of mental health and well-being of adults user's guide.* Canberra: Australian Bureau of Statistics

Miles, M. M., & Huberman, A. M. (1994). *Qualitative data analysis. An expanded sourcebook.* London: Sage.

Patton, M.Q., (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage Publications: USA.

Parslow, R.A., Jorm, A.F. (2000). Who uses mental health services in Australia? An analysis of data from the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 34* (6), 997-1008.

Phelan, J., Link, B.G., Stueve, A., & Moore, R.E. (1995). Education, social liberalism, and economic conservatism: Attitudes toward homeless people. *American Sociological Review, 60* (1), 126-140.

Seal, D. W., Bogart, L. M., & Ehrhardt, A. A. (1998). Small group dynamics: The utility of focus group discussions as a research method. *Group Dynamics, 2* (4), 253-266.

Straw, B., R., & Smith, M. W. (1995). Potential uses of focus groups in federal policy and program evaluation studies. *Qualitative Health Research,* 5 (4), 412-427.

The anxiety disorders association of America. (2002). Available at: http://www.adaa.org/aboutanxietydisorders