***THE INFLUENCE OF BUSH IDENTITY ON
ATTITUDES TO MENTAL HEALTH IN
A QUEENSLAND COMMUNITY***

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STATEMENT OF ORIGINALITY

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Lisa Maree McColl

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ABSTRACT

The main objectives of this research were to determine the influence of bush identity on attitudes to mental health in rural Australia, what influence these attitudes have on service provision and utilisation, and what measures can be taken to improve attitudes to mental health and services in the bush. The research has included an extensive literature review of Australian historical and contemporary bush culture, the political economy of rural restructuring, rural mental health, as well as State and Federal policies and programmes for mental health care delivery. An ethnographic study of "Ruraltown", a rural centre in Queensland, was undertaken over a three-year period which involved semi-structured interviews, questionnaires, observations and community interaction.

The results from the questionnaires and interviews in the Ruraltown study indicate that attitudes to mental health in rural areas *are* influenced by bush identity, defined by reference to historical and current characteristics which include self-reliance, resilience, independence and stoicism. Social identity theories have been applied in this study to determine how the socialisation processes have incorporated these characteristics among the rural population, and rural males especially. In turn, these incorporated attributes and values have a direct impact on their attitudes to mental health and the willingness to seek help for problems of a psychological nature. Other aspects of rural life such as perceived lack of confidentiality and anonymity, fear of gossip, and isolation also impact on attitudes and the utilisation of mental health resources. Stigma is a significant barrier to recognition and acceptance of mental health issues. Hence, seeking help for mental health problems does not form part of the coping strategies for many in the bush.

Mental health services, therefore, are not as readily accepted or utilised in rural Australia. Although some rural people do access mental health services, many more go on suffering with mental health problems rather than addressing them. Recommendations have been made to promote awareness and enhance education and attitudes to mental health, improve services and increase service utilisation. The study has also identified the problems facing mental health consumers in Ruraltown and some suggestions have been made to overcome these and assist in consumer empowerment.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
AGPS	Australian Government Printing Service
BBBS	Big Brother Big Sister Program
CAG	Consumer Advisory Group
CCP	Community Connections Project
GST	Goods and Services Tax
ICPA	Isolated Children's Parent's Association
MHCDO	Mental Health Community Development Officer
MHIG	Mental Health Interest Group
MHU	Mental Health Unit
NMHP	National Mental Health Plan
NMHS	National Mental Health Strategy
NRHA	National Rural Health Alliance
NU	Neighbourhood Unit
PHCU	Primary Health Care Unit
QGYSPS	Queensland Government Youth Suicide Prevention Strategy
QMHS	Queensland Mental Health Strategy
QRAA	Queensland Rural Adjustment Authority
RDA	Rural Doctors of Australia
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
SIT	Social Identity Theory
TAFE	Tertiary and Further Education

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CHAPTER 1

INTRODUCTION

*Schizophrenia and depression do not sit well
with the generic beer-ad image of the bush.*

It jars with the romance of endless blue skies and sun-drenched plains.

No Banjo Paterson hero ever had bipolar disorder (Winter 2003, p. 12).

Mental health in the bush has become an issue of pressing concern in recent years.¹ With an increase in stress, emotional problems, and suicide, often resulting from increasing economic recession and restructuring, the challenges faced in providing mental health support to rural areas have reached a critical juncture. Through a study of "Ruraltown", a rural centre in Queensland, this research seeks to contribute to, and extend knowledge about, attitudes to mental health in the bush. In the course of this study, problems with mental health service provision and utilisation in the bush have also been revealed.

The contention here is that the historical Australian bush identity that was popularised in the nineteenth century persists today. While it is recognised that many of the characteristics described in this identity are common to rural people in other lands, the circumstances in which this identity was created and internalised are what make the Australian bush identity distinctive. The fact that Australia is historically, socially, geographically and culturally different is what makes bush identity unique. It is not only a rural identity, it is a *bush* identity, and it refers to those people who live and work in the areas and industries with

¹ "Mental health" will be used as a general term, defined as "the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being and optimal development" (*Second National Mental Health Plan* 1998, p.26). It must be emphasised that there will be no attempt to imply diagnostic ability or medical interpretation of situations; attitudes to mental health will be examined purely from a social science perspective.

which the Australian bush identity was first associated in the nineteenth century, that is, the pastoral industries of the Outback. It is a constructed rural identity of a settler society with penal origins. As will be discussed in Chapter 2, Australia's original penal status was fundamental to the genesis of this identity. In addition, the vast distances between inhabited areas and the search for a unique national identity, distinct from Britain, contributed to the cultural construction, assignment and recognition of this identity.

The theme of identity is central to this research and of great significance in Australia, conceptually, empirically and politically. It will be argued here that the popularised qualities of the historical bush identity and legend, "conceived" in the nineteenth century and so important to Australian culture, helped create a national ethos and identity, aspects of which continue to be exhibited in people of the bush today. This will be demonstrated through an analysis of attitudes to mental health.

"Rurality" is the contextual term that has been used to describe symbolic, historical, cultural, social, political, geographical and economic aspects of rural places (Lockie & Bourke 2001, p.9). The context of "rurality" that will be discussed here is a sociocultural one. According to Lockie and Bourke (2001, p.8) "rurality" from this perspective "assumes that rural residents have their own subculture and differ culturally from urban residents". Share et al (2000, p 409) also argue that this approach "focuses on the experience of rurality as a 'way of life' — the sum of behavioural and attitudinal norms and values expressed and experienced by rural dwellers". Bush identity and its influence on attitudes to mental health will be explored through this sociocultural perspective.

Attitudes to mental health will be examined from a poststructuralist viewpoint. Lockie and Bourke (2001, p.27) explain that "the poststructuralist perspective challenges us to do more than simply examine what it is that people believe — it challenges us to investigate

how these beliefs are produced and maintained over time". Through such a perspective, this study has sought to analyse the role that one causative element — "bush culture and identity" — has had on attitudes towards mental health in rural areas, and how this relates to the predisposition of rural people to access mental health services. The weight of evidence suggests that there is a very strong connection between bush identity and attitudes to mental health, and that mental health status and treatment is directly influenced by bush culture and identity, with all its associated characteristics, traditions and mores.

A "social view" of mental health has also been adopted here. As Luck et al (2000, p 173) explain, "a social view of health recognises that social, economic, cultural and political factors, which lie outside the health system, make a major contribution to patterns of health and illness among population groups". The changing social, economic and political circumstances in rural Australia over the last few decades are important in terms of their influence on mental health status and service delivery in rural areas. These changes will be discussed from a political economy perspective to contextualise the current mental health situation.

There is also a gender dimension to this research. It was found here that bush identity, both historically and currently, was recognised as a predominantly male one, by both men and women. Women do have a place in this identity but it perceived as secondary or less important. In addition, bush men and women experience and respond to mental health issues differently. The quote at the beginning of this chapter represents the general attitude of men to mental health in the bush, a view that is evident in this research. From the evidence available, it appears that rural women, on the other hand, confront mental health issues more openly and willingly, for themselves and their families. As Luck et al (2000, p 232) point out, "we believe that women and men will benefit most if the majority of health research recognises gender as a

major influence on health attitudes and behaviour, and incorporates gender into the research design". Lockie and Bourke (2001, p.12) also recognise the importance of putting "the lens of feminist analysis" on all aspects of rural society. Gender identity in the bush has a direct impact on how mental health is perceived and addressed, and affects the strategies that men and women use to cope with bush life.

The socialisation process of bush people in historical Australia since European settlement, and its reinforcement through institutional and governmental agency, has been so effective that many of the traditional qualities and personality characteristics persist today. The application of Social Identity Theory (Tajfel 1982) in this research will assist in explaining how and why bush identity has been so resistant to change. It will be argued that the popularised image of previous generations of rural Australians, demonstrating attributes such as stoic independence, resourcefulness and strength, are embedded in "bush" society and influence the population today. Therefore, mental health is a term that is not readily identified with or accepted. The stigma attached to mental or emotional issues is very powerful and admissions to such vulnerabilities are not common (Fuller 2000, p.150). According to health professionals, this leads many bush people to go on suffering unaided or even to suicide. The statistics, indicating a growing incidence of suicide, are unequivocal, and show, for example, that the suicide rate in rural Queensland is much higher than in urban areas (see ABS 2000, De Leo & Evans 2002).

Bush identity — an overview

The literature reviewed later in this research indicates that there was a basic identity and code of behaviour in the bush, especially strong in men, which suggested that one must be stoic, independent, strong, determined, resourceful and rarely admit defeat or ask for help. This identity has historical roots, as Ker Conway (1989, p.8) argues: "The

bush ethos which grew up from making a virtue out of loneliness and hardship was built on the stoic values of convict Australia. A 'real man' despised comfort and scorned the expression of emotion. The important things in life were hard work, self-sufficiency, physical endurance, and loyalty to one's male friends, one's 'mates' ".² This quote highlights the influence of our convict beginnings on bush identity and expresses very effectively the norms and values which bush people, and males in particular, were expected to live by; however, in recent years, they have become a difficult regime to follow. It will be argued here that there is an identity unique to the bush that encompasses many of the qualities and traits that were publicised and popularised through the historical creation of the bush legend. But, in recent years, rural communities have been subjected to major social, economic, political and environmental changes which have put pressure on rural areas and exposed the limitations of "bush culture" as a coping mechanism. The implications for mental health have been dramatic. As O'Hehir (1995, p.554) explains, "in many instances, these 'stoic' belief systems may cost lives through domestic murder, stress-related disorders, suicide or premature death".

The idea of the bush has assumed a prominent position in the culture of Australia since European settlement. Bush *life* is now not idealised as it once was, but the historical images of the bush and its people remain an essential component of Australian identity, one that is recognised and celebrated from Perth to the Gold Coast. This is particularly evident at times of significant national expression such as the Bicentennial year in 1988, the Sydney 2000 Olympics, the Centenary of Federation in 2001, and especially in the "Year of the Outback" in 2002. The overwhelming popularity of, and public response to, official reminiscing demonstrates that the bush retains its pre-eminent position in

² Because quotations have formed such an integral part of this work, long quotations have been integrated into the text to complement the reading and presentation of the thesis. To distinguish them from other citations, all quotations from the participants in the Ruraltown study have been italicised.

Australian folklore and history. On a smaller scale, for example, when the “bush” comes to Australian capital cities at the annual agricultural shows, the fascination with the bush is everywhere — the bush myth is played out with many urban dwellers donning the rural dress code — Akubras, moleskins, Drizabones and R.M. Williams boots. Audiences revel in “Man from Snowy River” displays that have always captured the essence of this legend.

Despite this annual urban “trip down memory lane”, the reality is vastly different. As Rees and Fischer (2002, p.3) argue, “despite the bush’s place in the nation’s folklore, for many city people these days, what lies outside urban boundaries is often an unknown landscape, destined not to be a part of their life experience, beyond cinema screens or romantic bush ballads”. According to Mackay (1999, p.44), the reason we cling to the rural myth is that “we find it difficult to face the bleak truth about rural Australia and its problems. We prefer the myth of the bush pioneer: the flinty, resourceful, sardonic, laconic stockman who can cope with anything. The more we embrace the romance of the outback, the more we are blinded to the harsh realities of life in the bush, and to the special needs of rural communities”. This may explain the challenge in dealing with the very real problem of mental health in the bush. Nonetheless, it seems that no matter what the situation may be in the bush today or how strained relations may be between rural people and the remainder of Australia, the legend lives on.

Those in the bush do not often get caught up in this mythologising; they live and work there and experience the harsh realities that have been, and always will be, part of bush life. At times, portrayal of the bush image and identity does not sit well with bush people. As one member of the Queensland Rural Women’s Network (2004) stated in the course of fieldwork, “one of my most hated images is one the Queensland tourism mob have frequently used over the years — a set-up shot of ‘drovers’,

with perfectly coiffured blond hair in white moleskins! They've used it dozens of times — you all would have seen it somewhere — and it's one of the most dreadfully ridiculous images you ever saw!" These "tried and true" images are not necessarily representative of bush life. As Bowden (1995, p.9) argues, "country people are beginning to be regarded as almost another culture, a different kind of Australian, stuck in Akubra hats and the ways of the sixties". Rees and Fischer (2002, p.3) also point out that "in recent years a divide has arisen between the cities and the bush, with a perception that somehow there's a different country out there, Outback".

The current situation in the bush

From a political economy perspective, there have been many external factors that have contributed to the critical situation in the bush (see Lawrence 1987, 1995, 1998, 1999, 2000, Gray and Lawrence 2001a, Lockie & Bourke 2001). The economic downturn of the wool, cotton and beef industries, combined with structural changes and international competition in a wide range of commodities, climatic factors, technological change and economic transformation, have led to high levels of unemployment, increasing numbers of farmers selling up or experiencing foreclosures, high levels of debt, an increase in rural poverty, and a loss of identity and self-esteem in bush people. Due to hardship on the land, people frequently look to the towns for off-farm work. However, in the face of falling local incomes and loss of public and private services (banks, hospitals and schools) these towns too are suffering with many businesses unable to survive. There has been a demographic shift with many young rural people moving to urban centres to find employment or education. Hence, the profile of the rural population is changing and aging, and a process of rural decline appears to be emerging and consolidating.

Global economic restructuring, the growth of agribusiness, government deregulation of protection policies, environmentalism, increasing communication technology, and the mass media have all impacted dramatically on the functioning of rural communities (see Lawrence 1987, 1995, 2000, Burch et al. 1992, 1998). Feminist ideology has also introduced ideas and practices that were once alien or unarticulated in rural areas, where patriarchal tradition has been dominant (see Alston 1994b, 1995c, 1998b). With the impacts of globalisation, deregulation and competition from agribusinesses, many small farms are being forced to sell, amalgamate or compete with big businesses with larger resource bases (see Gray 1995, 2001a, 2001b).

Rural towns have also suffered as a result of agricultural restructuring (Lavelle 2003, Sidoti 1998). Banks are withdrawing services from rural areas and, once the bank and often the post-office go, other businesses follow. It is then not feasible for many businesses to operate in a community that has no financial or postal service. People are then forced to travel to larger centres to conduct business affairs and, while there, they use other services provided by shops and medical centres (see Hallebone et al 2000 & 2003, Rees & Fisher 2002). Thus, the demand in smaller bush towns decrease and further decline occurs. This is the cycle of despair and hopelessness many rural areas face in the new century (Stehlik et al 1999, Rolley 2000).

It is not surprising that, when faced with such multifaceted crises, the incidence of depression and suicide in the bush has increased so dramatically (Sweet 1998). Such problems have an even greater impact because they appear to be externally generated, inevitable, and thus beyond the capacity of rural communities to influence. Consequently, the most fundamental concern regarding mental health in the bush is the prevailing perception that still exists at a grassroots level. As Yellowlees (2000) argues, "we need to understand more about the qualities that make up a rural culture and use these to better inform

our health planning". The unique culture and identity that exist in bush communities render conventional service methods inappropriate and problematic, as evidenced in this research. Cumes (1998, p.42) also argues that "the poor state of rural health is exacerbated by a paucity of research into rural mental health issues which creates a vicious cycle — lack of research leads to a lack of information which inevitably leads to lack of funding and lack of services. The overall result is that rural health services and research are a neglected issue". This research is designed to contribute to a resolution of this problem by opening the dialogue about mental health issues in the bush.

Thesis outline

In the following chapters, this thesis will explore the above issues in more detail, and investigate the relationship between these recent pressures and mental health in the bush. An extensive literature review, carried out in Chapters 2, 3, 4 and 5 will cover four main themes:

- Chapter 2 gives an historical overview of the formation of the bush identity and ways in which it became entrenched into the Australian psyche;
- Chapter 3 provides a comprehensive discussion of Social Identity Theory (SIT) and other theoretical perspectives to lay a theoretical and conceptual foundation from which to explain the origins and persistence of bush identity, and to demonstrate how it became entrenched in the hearts and minds of rural Australians. From there, it will be possible to demonstrate how bush identity may influence attitudes to mental health.
- Chapter 4 will include an analysis of recent changes in rural Australia which will contextualise the issue of mental health in the bush; and

- Chapter 5 will present an overview of rural health and mental health studies to demonstrate the relationship that exists between bush culture and mental health.

Chapter 6 will discuss the research methodology and serves to review the major sources used for the ethnographic study that formed the major part of this research project. It explains in detail all stages of research in the community, how the stages were carried out, what data collection methods were used, and any additional information regarding the community. The chapter also details the ethnographic principles used in the research.

Also included in Chapter 6 will be a discussion of the research activity undertaken and an introduction to the key informants. To obtain an in-depth view of bush culture at work, through the eyes and voices of community, and to determine attitudes to mental health at the local level, an ethnographic study of "Ruraltown" (pseudonym) was undertaken. The reason the study was guided by ethnographic principles is that it was based on people's actual experiences and attitudes in a bush community, and it is argued that the major influence here is a cultural one. The study was a process of methods used to understand how these bush people perceive mental health issues and what influences or motivates them to feel this way. Newspapers, public records, government policies and publications, and rural magazines were also examined. These sources have been utilised to ascertain the official or publicised position on mental health in the current context, or as supporting evidence.

Chapter 7 will explain in detail the results from the Ruraltown study. This explanation will include results from the questionnaires, interviews and other observations made in the Ruraltown study. Common patterns or themes about attitudes to mental health have been identified through the analysis of these results.

Chapter 8 provides a summary and interpretation of the data. Themes that relate to attitudes to mental health in the bush have been extrapolated from the findings of the research. These results were put into a contextual framework through a comparative analysis with previous studies and similar findings relating to attitudes to mental health were revealed. Additional issues uncovered in the community will be outlined which have added to the knowledge about attitudes to mental health in the bush.

Finally, in the Conclusion (Chapter 9), a summary of the findings from the research is presented. These findings provide answers to the research questions that were posed before the study commenced. In the conclusion, recommendations have also been made that could assist in enhancing attitudes to mental health in Ruraltown, and improve service provision and delivery.

In summary, this thesis will examine the influence of bush identity on attitudes to mental health, and discuss the major barriers to the recognition and acceptance of mental health issues in the bush. A more comprehensive understanding of bush culture and identity will inform policy makers, services and communities on the best way to tackle mental health in the bush. Community education and cooperation is needed to dilute the powerful stigma attached to mental health issues. The participation of families, schools, hospitals, community organisations, law enforcement agencies and governments is required to enhance education and acceptance of mental health as a positive affirmation for the whole community. As Moodie and Verins (2002, p.3) argue, "private structures such as families and friends, and the more public institutions such as schools, sports clubs, local government, religious organisations, service groups, youth organisations and arts and cultural groups have a role to play in maintaining and enhancing our sense of connectedness and inclusion". In the following chapters, this thesis will contribute by filling some of the existing gaps in

knowledge about bush identity and culture, attitudes to mental health and the relationship between the two, and propose some recommendations to improve attitudes and jettison the pejorative images associated with mental health issues in the bush.

Personal account of research interest

Following is a short disclosure of my interest in attitudes to mental health in the bush. As Denscombe (1998, p.74) argues, “researchers need to *supply their readers* with some insights into the possible influence of the researcher’s self on the interpretation of events or cultures. *There needs to be a public account of the self which explores the role of the researcher’s self*”. Holliday (2002, p.137) also argues that the researcher’s own life experience may be used as evidence and states that “adding a statement of experience brings personal presence and ownership to the discussion, which may indeed strike a chord with readers who have had similar experiences, also reminding them that this is a ‘real world’ issue”.

I first became interested in mental health when working in an administrative position for a psychiatrist from 1996 to 2001. In January 2000, there was an article in the newspaper about depression and the need for more research into prevention and treatment. It also mentioned the increasing rate of suicide in rural areas, especially affecting young men. Bouma and Atkinson (1995, p.27) argue that “the research process begins when our curiosity is aroused... An observation, something we read, a claim someone made, a hunch about something, each may serve as a stimulus to begin the research process”. My curiosity was aroused and I decided to pursue the topic of mental health in an academic sense and started thinking about how bush people address mental health problems. I wanted to combine my interest in the mental health arena with my academic training in Australian Studies. In addition, I have a personal understanding of

bush culture and identity through family background, and aspects of this experience stimulated my interest further and contributed to the analysis of attitudes to mental health in the bush. I have also witnessed the poor gender relations and limited opportunity for women on the land thus affecting their mental health status and personal situation.

Research Parameters

For the purposes of this dissertation, the terms “bush” and “rural” have been used interchangeably unless specified to refer to people of the bush, or to communities that, through involvement in the pastoral industry, geographical distance, population size, service provision, and lifestyle attitudes and values, can be differentiated from other regional or urban centres. The study employed both a historical and a contemporary approach. As there have been many changes in bush circumstances and identity, an ongoing assessment is needed from approximately the late nineteenth century to the present day to obtain a more complete picture of the bush context.

The term “help-seeking” has been used in this thesis to refer to “the extent to which individuals utilise different sources of support for overcoming personal difficulties” (Nicholas et al 2004, p.2).

In accordance with current policy and medical practice terminology, mental health patients or clients are referred to as “mental health consumers”.

Due to the constraints on length and time in the preparation of this study, and the additional cultural implications involved, Aborigines in the bush and those of a non-English speaking background were not separately identified and analysed in this study. However, with the recent attention that mental health has attracted, a new vista of research has been opened up and government has also formulated

policy specifically addressing the issues confronting these two groups (see Queensland Health (1996) *Aboriginal and Torres Strait Islander People — Queensland Mental Health Policy Statement* and Queensland Health (1996) *People from a Non-English Speaking Background — Queensland Mental Health Policy Statement*). Separate studies are needed in order to address the unique circumstances faced by these groups in rural Australia.

Gender issues will be included here as they are intertwined with the everyday socialisation of Australians in the bush. It will become evident that any analysis of the bush, be it historical or contemporary, would be incomplete without including gender as it has been essential to the formulation of the bush identity and is also relevant to an assessment of mental health. Class issues have also been touched on, though not to the same extent as gender.

CHAPTER 2

AN HISTORICAL PERSPECTIVE OF BUSH IDENTITY

If this is Australia, and not a mere outlying suburb of England: if we really are the nucleus of a nation and not a mere handful of expatriated people dependent on an English Colonial Secretary for guidance and tuition, it behoves us to educate our children to a knowledge of the country they call their own.

*(From "A Neglected History", Henry Lawson, 1888,
quoted in Cronin 2000a, p 52)*

The purpose of the following history of Australian bush identity is to show how it was conceived and constructed in the late nineteenth century, what the inclusions and exclusions were, and why it remains an important part of Australian culture today. Phillips (1998, p.282)

argues that "views about Australian identity serve as a barometer of socio-political change and renewal in Australian society". The longevity of bush identity, expressed through the bush legend, demonstrates its ongoing importance to Australian history and culture. The personal characteristics that were popularised in this legend such as stoic self-reliance, resilience, independence and strength are evident in the bush identity today. As will be shown later, it is arguable that these qualities have a direct impact on attitudes to mental health in the bush.

Australian cultural identity has undergone numerous changes since European settlement. The bush identity of the late nineteenth century was the first significant representation of a uniquely Australian character. The bush legend was then popularised through arts and literature, which disseminated the qualities and characteristics that became synonymous with the "typical" Australian. However, close examination of the bush legend reveals discrepancies and inadequacies and it was argued to be an exclusive and largely fabricated identity

(White 1981, Walter 1989). Despite this belief, the bush legend and identity remain an essential component of Australian nationalism. This chapter will chart the course of the bush identity and legend, examining how Australian cultural forces consciously created and popularised this image in the late nineteenth century and again in the 1950s, and how this identity has changed to encompass the new ideals and challenges of the twentieth and twenty-first centuries. It is important to articulate the history and dimensions of this identity in order to make sense of its relationship to attitudes to mental health. In this regard, a discussion on nationalism and cultural identity is a necessary first step in establishing the context for the formation of Australian cultural identity.

The emergence of Australian nationalism

The settlement of Australia coincided with the growth of European nationalism which gained momentum in the late eighteenth century following the French Revolution. It was an era of great change through industrialisation, urbanisation and modernisation, which resulted in the formation of nations and independent political entities. Gellner (1983, p.169) argues that “it is nationalism which engenders nations and not the other way around”, and further that “nationalism is not the awakening of nations to self-consciousness: it invents nations where they do not exist”. Different forms of nationalism — cultural, political and economic — were manifested in the process of creating independent nations and national distinctiveness.

The main function of nationalism was to generate and advance the modernisation process. Nairn (1981, p.127) argues that “nationalism since the early nineteenth century was, in essence, the forced reaction of one area after another to the spread of capitalism, and it was the dominant cultural form of modernisation”. One of its fundamental objectives was to encourage a national or collective identity out of previous local and regional consciousness, to make the nation the main

focus of social and political organisation and action. To achieve this feeling of community and social cohesion in the new societies, it was necessary to emphasise a common culture, history, identity and tradition. As White (2003, p.55) argues, "it is no coincidence that the rise of national history in the nineteenth century paralleled the rise of nationalism itself: history and the nation state needed each other".

The new agenda of nationalism relied, first and foremost, on the communal acceptance of the goals of unification by 'the people'. For nationalism to be successful, people needed to be aroused into identifying as a collective entity. To do this, they looked to their history and traditions to engender a common cultural bond. According to White (2003, p.55), "the past is a core constituent in any notion of national identity and the production of a shared national past is a prime function of history". Smith (1997, p.36) also argues that "the concept of a nation cannot be sustained without a suitable past and a believable future". From this past, myths, symbols and chronicles tend to reinforce national identity and distinction and have the power to create unity. With regards to a nation's past, Overing (1997, p.1) maintains that "myths are narratives that express the fantasy origins of a people. They contrast with history which details truthfully the real events of a people's past". By this, he is implying that there is no real foundation to national myths, that they are fabrications designed to serve the superficial function of belonging. However, Schopflin (1997, p.26) is more flexible and convincing in his argument, stating that "myths cannot be constructed purely out of false material; it has to have some relationship with the memory of the collectivity that has fashioned it. Members of a community may be aware that the myth they accept is not strictly accurate but, because myth is not history, this does not matter".

It is frequently the case that the account of a nation's past is altered, modified, appropriated, even invented, in order to emphasise national

distinction. Nairn (1981, p.168) illustrates this by arguing that “all over Europe, new nationalist movements invented or purloined histories and symbols, with small regard for historical logic or decency”. Claims such as these prompt the academic question of which came first, the myth or the social reality in which the myth was born? Or, as Smith (1986, p.177) puts it, “is the ‘past’ we yearn for a mere invention designed to meet our present needs?”. This is not to suggest that nations can be invented at random or haphazardly, without any substantiation or qualification. As Featherstone (2003, p.346) argues, “the nation becomes presented through a set of more or less coherent images and memories which deal with the crucial questions of the origins, differences and distinctiveness of a people”. However, through an investigation of some nations’ pasts, discrepancies may be revealed. The aim of the myths and traditions that are chosen is to present a desired image of the past. Hobsbawm (1984, p.13) argues that “the history of a nation is sometimes not what has actually been preserved in popular memory, but what has been selected, written, pictured, popularised and institutionalised by those whose function it is to do so”. It may be a partial reflection of the history-writer’s own culture, personal history and value system.

Finding an Australian identity

*We'll honour the man who can't afford
To wait for a job that suits,
But sticks a swag on his shoulders broad
And his feet in bulcher boots,
And tramps away o'er the ridges far
And over the burning sand
To look for work where the stations are
In the lonely Western land.*

(From “The Australian Advertisement”, Henry Lawson, 1890,
quoted in Cronin 2000, p.107)

An important distinguishing factor when studying Australian nationalism since European settlement is that it was based on a British Dominion and was originally settled as a penal colony. According to Colling (1992, p.8), "what made the Australian male experience the frontier in a different way from American or South African pioneers can be summed up in one word — convict". Australia was not originally perceived as a land of opportunity; it was an extensive jail that housed criminals, a place to be feared. Eddy (1991, p.24) maintains that "the first phase of British settlement, the convict era, was sufficiently distinct and historically so bizarre as to distinguish the 'Antipodean' colonies from every other earthly habitat". Convicts, ex-convicts and native-born Australians greatly outnumbered free settlers until the mid-nineteenth century (Hodges 1992). White (1981, p. 23) explains that "...the result was that to be Australian, whether convict, native-born or free settler, was to be tainted with the brutality and depravity of the convict system".

Fundamental to Australia's penal status was that it connected nationalism intrinsically to imperialism, and it created a new nation with its white history beginning from settlement in the eighteenth century, coinciding with the rise of nationalism. As Alomes (1991, p 2) argues, "Australia was a new country where the identity of the nation had to be defined for the new inhabitants in some ways from the start". There were no suitable (ie non-Aboriginal) established national characteristics, traditions or legends to be aspired to.

In order to rid Australia of the convict stain, a new image was procured. This image or identity was sought in the bush through the ever-expanding wool industry. As White (1981, p.29) argues, "the establishment of the wool industry turned the gaol into a vast sheep-run which, by 1850, was providing half of Britain's wool. Newcomers were lured by a new image of Australia as a land of opportunity for all comers and, above all, the working man". The shearers, drovers and

bushworkers were being idealised as the national type. These workers were real but they were not necessarily representative. However, White (1981, p. 103) highlights the imperial significance of the bushworker and states that “the bush worker, rather than the urban or agricultural worker, gave Australia its identity in the empire”. This is an important observation as it illustrates the boundaries and exclusiveness of the historical bush identity. Ker Conway (1989, p. 12) argues that the bush workers were “...seen to be living life on a heroic scale, while the settled life of the wheat farmer returned less profit and seemed domestic and lacking in adventure”.

In Australia, the period of the 1890s is most often associated with the establishment of a national culture or identity, and it was believed that this was expressed most effectively through the Australian bush legend. A legend, as Horne (1989, p.55) defines it, is “a simple story (fact or fiction) that illustrates a myth, and a myth is not a ‘story’ but a belief held in common by a large group of people that gives events and actions a particular meaning”. In Australia at this time, the myth was that the ‘true Australian identity’ was to be found in the bush. The legend was that this identity was defined by the harsh conditions endured in the outback, and by the qualities and virtues attributed to those who lived and worked there. Hodges (1992, p.6) argues that “unlike the American West which promoted small farm settlement and therefore the ethic of individualism, the nature of the Australian interior and the economic conditions of the nineteenth century created large single properties employing many casual hands”. Ker Conway (1989, p. 7) also explains that “a man could buy the government leasehold for hundreds of thousands of acres of grassland at a modest price if he settled the land and undertook to develop it”. It was these men who were deemed to possess the uniquely Australian bush identity.

The 1890s is renowned as a period of intense political, social and artistic activity and the literature of this era expressed many of the

anxieties, ideological conflicts and contradictions related to social conditions and hardships experienced by much of the population. The bush figured prominently in the arts of this period, and writers of the 1890s were consciously seeking a distinctly Australian character. White (1981, p.89) notes that “a large new community of professional writers and artists had emerged in Australia in the 1890s, and the fact that this younger generation was more likely to be Australian born helps explain their direction towards a distinctly national culture”. The *Bulletin* circle, under the direction of the editor J.F. Archibald, refers to a group of writers who engaged collectively to produce a uniquely Australian literature through that newspaper in the 1880s and 1890s. These writers mainly had a journalistic background and, in addition to their own works, the creative input of individual writers was also invited to publish. The *Bulletin* circle helped create a “professionalism” of the literary arena and, in turn, this new professionalism complemented the status of the circle (White 1981).

The *Bulletin* circle was also attempting to establish an inter-relationship between the outback and the city, to promote national unity. Though essentially a Sydney-based paper, from the outset the *Bulletin* announced itself as a national Australian newspaper. This encouraged a mass market, with readership extending Australia-wide. It was often referred to as “the bushman’s Bible” (Carter & Whitlock 1989, p.117). Lawson’s (1983, p.194) explanation for this was that “the *Bulletin* brought the city and the globe to the doorsteps of the people in the outback and made them neighbours in print”. The “bushman’s Bible” was a cherished reference as it reinforced the supposed “Australianess” of the magazine. Through this cultural medium, the *Bulletin*, the bush legend was introduced to city people. According to Featherstone (2003, p.348) “a nation is an abstract collectivity which is far too big to be directly experienced by people”. Therefore, the bush was delivered to the nation “in print”.

The *Bulletin* was anti-imperialistic in its views and rejected the old cultural values of Britain. Essentially, it was appealing to readers to create a “uniquely Australian” identity, as part of an attempt to jettison the colonial (and convict) status. Walter (1989, p.35) argues that “in the late nineteenth century, the intelligentsia expressed their revolt against the old British-orientated cultural establishments by projecting their values onto the bush”. In the Australian bush, a unique identity that possessed qualities derived solely from the new experiences in Australia, and cultural independence from Britain, could be fostered. Francis Adams, writing in the period and cited by Alomes (1991, p.62), suggested that “it is in the ranks of the shearers, boundary riders and general station hands that the perfected sample (of Australians) must be sought”. The bush provided the site for the ideal national character. Inglis Moore (1971, p.77) also points out that “contrary to popular opinion, the writing of the 1890s does not glorify the bush. Rather it is a glorification of the bushmen versus the bush environment. The bush is the black shadow which throws up, in a simple, stark chiaroscuro, the light of the bush hero”.

Another contributing cultural formation in the creation and popularisation of the “real” Australia in the 1890s was the Heidelberg School of painters. These painters claimed to be seeing Australia for the first time through Australian eyes. Serle (1973, p.71) remarks that the major figures of this school believed that “they gave a more faithful depiction of the colours of the Australian landscape than any before them”. These artists were greatly influenced by the French Impressionists, yet they adapted the techniques, or invented new styles, to accommodate to the Australian environment. The painters of the Heidelberg School were determined to produce an “Australian” art and, as Serle (1973, p.70) argues, “these painters’ inspiration was a reflection and product of the ferment of the nationalist idealism of the day”.

The bush figured prominently in the literature of the 1890s. However, the way the bush and bushfolk were depicted during this time revealed two conflicting images or legends. These were the bush legend and the pioneer legend. With reference to the bush legend, Hodges (1982, p.12) argues that "the myth-making process accelerated in the 1890s by the discovery of the bush by literary men". This legend, discussed later in Ward's (1958) argument, idealised the Australian bush and bushworkers employed in the pastoral industry as fostering a uniquely Australian identity. This identity was defined by the harsh conditions endured in the outback, and by the qualities and virtues attributed to those who lived there. "Mateship" was the moral essence of the bush legend and women were rarely acknowledged. As Ker Conway (1989, p.7) argues, "if he shared his life with a wife and children, they lived marginally on the edge of his world of male activity".

Hirst (1992) recognised an alternative to the bush legend in the literature of this period and he subsequently formulated the concept of the pioneer legend. Hirst (1992, p.14) argues that this legend portrayed a different and more holistic image of the bush: "it celebrates courage, enterprise, hard work, and perseverance; it usually applies to the people who first settled the land, whether as pastoralists or farmers, and not to those they employed, although these were never specifically excluded". This was an important diversion from the bush legend, which tended to focus exclusively on the workers in the pastoral industry; this legend recognised the people that the bush legend overlooked. The female contribution was recognised and depicted more favourably in the pioneer legend and not just as an adjunct to male endeavours, and an Aboriginal presence was also noted. Both of these legends were present in the literature of the 1890s.

The idealised bush

*To escape these endless vaults of bricks and pitch a tent outback,
If I get a chance I'll graft until my very sinews crack,
Meanwhile may all the angels up in Paradise look down
On a man of sin who died not, but was damned and sent to town.*

*(From "In Town", Edward Dyson, 1896,
quoted in Cantrell 1977, p. 150)*

The literature of the 1890s both influenced and reflected popular social attitudes of the period. Recurrent themes in 1890s literature were pejorative depictions of the urban centres, the harshness or, conversely, the idealisation of bush life. The depressing conditions of city life encouraged many writers to mythologise the bush. As Cantrell (1977, p.138) points out, "the literature revealed underlying tensions in Australian society, and a tension frequently reflected in literature of the period was that of the city vs. the bush". For example, the above excerpt from Dyson's "In Town" (1896) tells of the poverty of city life and idealises the bush as having qualities far superior to the city. Through the use of rhetorical devices, thematic oppositions and conventions, Dyson gives a powerfully morbid portrayal of the hardship of urban life, thus depicting the bush as a utopian refuge. However, Lawson opposed this idealisation of the bush, as demonstrated in the following excerpt:

*Ah! We read about the drovers and the shearers and the like
Till we wonder why such happy and romantic fellows strike.
Don't you fancy that the poets ought to give the bush a rest
Ere they raise a just rebellion in the over-written West?*

*(From "The City Bushman", Henry Lawson, 1892,
quoted in Cronin 2000, p.234)*

Lawson chronicled the pioneer's experience and the harshness of bush life. As Hirst (1992, p.20) points out, "he [Lawson] never abandons the view that the life of small settlers could be wretched and narrow, but he becomes more willing to celebrate their powers of endurance and the cooperation between them" Lawson maintained that romanticising the bush was not giving an accurate picture of the hardship and loneliness experienced by many rural people. His depictions impress on the reader negative aspects of bush life and illuminate the alienating qualities of the outback. "The City Bushman" (1892) was written in response to Banjo Paterson's and others' bush idealisation. Davison (1992, p. 123) argues that "in his flight from the horrors of the city, Paterson retreated in land; his solution to urban ills was to open up 'the rolling fertile plains' to closer settlement". For Lawson however, sentiments such as "the drover's life has pleasures that the townsfolk never know" from Paterson's "Clancy of the Overflow" in 1889 (Campbell & Harvie 2000, p.105) gave a false representation of the actual hardship that was experienced in the bush.

Women's representation in early literature

*I love a sunburnt country,
A land of sweeping plains,
Of rugged mountain ranges,
Of droughts and flooding rains,
I love her far horizons,
I love her jewell-sea,
Her beauty and her terror-
The wide brown land for me!*

*(From "My Country", Dorothea MacKellar, 1908,
quoted in Luck 1988, p.339)*

Summers (1975) and Lake (1986) discuss the exclusion of women in historical narratives. According to Summers (1975, p.42), women were

only represented to serve some symbolic or ideological purpose in the nineteenth century and she argues that, for men, “this was a means of evading having to cope with women as unique and diverse individuals, reducing them to a sexist conglomerate”. Lake (1986, p.118) discussed the misogynist views expressed by the *Bulletin* in the nineteenth century regarding the exclusiveness of men in the bush and states that “the *Bulletin* was the most influential exponent of the separatist model of masculinity which lay at the heart of the eulogies to the bushman”. The early establishment and maintenance of these myths in Australian culture has had long-term repercussions for contemporary bush women.

Schaffer (1988) also examines how the cultural construction of masculinity and femininity influenced the developing Australian national image and she adopts a Lacanian approach to understand the production of cultural identity and meaning. In short, this approach maintained that the imaginary construction that is taken to be real is given social meaning through the symbolic order of language (Schaffer 1988, p.9). The impact of language and literature tends to confirm or reflect proposed dominant ideologies. Schaffer (1988, p.xii) applies this theory to the symbolic representation of women in the nineteenth century and argues that “women have been considered absent in the bush and the nationalist bush tradition”.

Many representations of women in early literature about the bush were of a metaphorical nature. As the above excerpt from “My Country” (1908) shows, MacKellar represented the landscape in the feminine as encompassing both beautiful and harsh conditions, and treacherous surroundings. Also, the original version of “Advance Australia Fair”, written in 1878, only addresses “Australia’s Sons” which is indisputable evidence of the unacknowledged place of women in the nineteenth century. Schaffer (1988) argues that this displacement of the feminine operates to construct the Australian myth of women’s lack of

importance or participation in historical Australia. However, a re-evaluation and restructuring of women's place in Australian and rural history has now been effected. This will be discussed further in later chapters.

Another observation made about MacKellar's (1908) poem "My Country" was that she was a wealthy young woman from an exclusive suburb in Sydney and not, in fact, from the bush (Luck 1988, p.337). She too was projecting an image that was not necessarily real or widely believed. As Blainey (2001, p.53) argues, "in 1900 many Australian farmers and pastoralists did not like a sunburnt country. Financially they could not survive a long drought; it might lead to a nervous visit to the local bank manager. So the affectionate verses written by Dorothea Mackellar were — for that time — rather outspoken". This is another example of how urban writers romanticised the bush without necessarily experiencing the hardship and struggle that was endured in that environment.

An alternative perspective on women's contribution in early Australia is delivered through the pioneer legend, as discussed above, and was evident in the stories of Barbara Baynton (1902). She was more concerned with the actuality of women's experiences and contributions to outback life, and admits to their courage and strength in the face of great difficulties. As Summers (1975, p.312) argues, "a savage corrective to the romantic myths of bush life come from the pen of Barbara Baynton who, in story after story, depicts the hardships and miseries experienced by bush women". Baynton writes a conflicting history to that popularised in the bush legend and disputes the myth of male exclusiveness in the outback. She also challenges the stereotypical ideas of the period about "women's place". There were also other women of the period who voiced the reality of their lives through literature (see Spender 1988). However, Spender (1988, p.1) concludes that "the dominant images have been of men and their mateship as they battled together to survive the harsh life of the outback. When women's writing

did not reflect nor promote this image of Australia and its new national heroes, their work was largely ignored”.

Occasionally, Henry Lawson gave an account of the female bush experience. For example, in “The Drover’s Wife” (1892, quoted in Cronin 2000, p.238-243), he describes the plight of bush women and the hardship experienced in the outback. The alienation and turmoil faced by the woman depicted in his story is palpable. Hirst (1992, p.22) argues that “there is a sense in which all his (Lawson’s) bush women are heroines because, as he insists time and time again, the bush is no place for a woman”. However, according to Hodge and Mishra (1990, p.170), “Lawson’s story casts the woman in a more positive and effective role, but her effectiveness is ultimately there to save the masculine ideal of the legend, rather than to explore the situation of women in Australia”. It is not an entirely egalitarian view of the bush. Writers and intellectuals from the 1890s presented and popularised certain themes and images that strongly influenced, and continue to influence, public perceptions.

The bush legend revived

The radical nationalists of the 1950s, commonly referred to as the “Old Left”, continued the idealisation of the bush and argued that it was in the 1890s that the bush legend received its “apotheosis”. Ward (1958) wrote the most influential account of this argument in *The Australian Legend*. In this work, he discusses the importance of the bush in Australian culture and consciousness and examines where the Australian legend — the “noble bushman” — came from, how it was instilled and accepted as “typical”, and if it had any social reality. Ward (1958, p.1) agrees that “most writers seem to have felt that the ‘Australian spirit’ is somehow intimately connected with the bush”. His explanation for this “spirit” is firmly within the bush legend, where he argues that there was a national identity that began in the outback and

this identity, and the values attached to it, were transferred to the city through literary means.

In *The Australian Legend*, Ward (1958, p.86) maintains that “there was a national identity which began with the convicts and was refined among station hands and shearers in the outback”. The “nomad tribesmen”, who are central to Ward’s argument, refers to the bulk of the labour in the pastoral industry in early Australia whose work was widespread and of a temporary nature. Working in the pastoral industry was an important distinction to farming the land. As Ker Conway (1989, p. 12) argues, “the large acreage’s of graziers carried more status than the struggling family farms of wheat farmers. The work of the grazier might be lonely and arduous, but he was seen as living life on a heroic scale, while the settled life of the wheat farmer returned less profit and seemed domestic and lacking in adventure”. The lives of the shearers, drovers, and other pastoral workers were also romanticised as being hazardous and exciting.

Convicts surface again in Ward’s argument where he (1958, p.88) states that “a nomadic habit of life was another prominent convict trait that was evident in the bush ethos”. However, this argument is oversimplified as it puts all bushworkers in a single group. As Inglis Moore (1971, p.57) points out, “it might be mentioned that most bushmen did not belong to ‘the nomad tribe’ but were settled as station hands and sometimes worked on the one station for most of their lives”. There was also a big distinction between the landowners (or “squatters”) and the bush workers. Gray and Lawrence (2000, p.34) argue that “the so-called ‘squatters’ occupied lands that the early settlers chose to consider as empty”. As a result, according to Hornadge (1985, p.30), there was contempt for the squatter’s wealth and privilege and “there were two sorts of squatters: bloody bastards and just plain bastards”. Therefore, the “bush workers” were not all part of one group, but many groups of differing status and prestige. Ward attracted a great deal of criticism

about the validity and uniformity of his argument, as will be illustrated in due course.

Basic to Ward's legend is the suggestion that the quintessential Australian character was developed in the outback, through the independent bush workers in the pastoral industry. He (Ward 1958, p.13) argues that "from the beginning, outback manners and mores, working upward from the lowest of society and outwards from the interior, subtly influenced the whole population". Ward proposes that the values of the outback workers, once transferred to the city, came to dominate the Australian ethos. However, long before Ward even published his ideas on the Australian bush, the bush legend was being contested. Alomes (1991) demonstrates, through the writings of Fred Bloomfield (1860-1941), the shallowness, omissions and stereotypes of the Australian bush legend. For example, Bloomfield (cited in Alomes 1991, p. 73) argued that "the characteristics of the bushman, such as his pessimism, his callousness, his atheism and his stoic endurance are common to *all* isolated people, not only Australians". However, it can be argued that the history of settlement, the harshness of the Australian outback, the vast distances, and the social and economic conditions in which these qualities were fostered were uniquely Australian.

Ward (1958, p.180) also examined the importance of "mateship" to the bush legend and states that "the bushman exhibited that 'manly independence' whose obverse side was a leveling, egalitarian collectivism, and whose sum was compromised in the concept of mateship". He even goes so far as to suggest that this mateship became, for some, a consciously held substitute for religion. Ward (1958, p.214) also credits the success of the bush unions to this male camaraderie and argues that "the bush unions had in them that feeling of mateship which was understood already, and which always characterised the actions of one white man to another". The characteristics of "white and male" resonate from this statement and from the whole of Ward's

theorising. Alomes (1991, p.86) also recognises the importance of the unions to the mateship ethos and states that “the unionising of shearers and other pastoral workers put the new religion of bush mateship and solidarity on a practical basis”. Goodall (1995, p.90) also explains that “the pastoral workers, through the strength of the Amalgamated Shearers Union, became in the 1880s and 1890s the backbone of the trade union movement. Their culture thereby became influential on a whole area of Australian life which had little real contact with the bush itself”.

Bushrangers were also seen as possessing uniquely Australian qualities, the most famous being Ned Kelly and his gang. Hodges (1992, p.10) argues that “the bushranger exemplified the outback ethos in its most extreme form, being more completely independent, anti-authoritarian, tough, resourceful, and loyal to his mates, than the most thoroughly acclimatized bush worker”. Ned Kelly wreaked havoc in the bush, stealing and murdering, and was in and out of jail during the period from 1870 until his execution in 1880 (Cave 1968). However, he was elevated to folk hero through his defiant rejection of authority. Seal (2002, p.11) states that Kelly was “the last of the bushrangers” and points out that “one of the most enduring aspects of Ned Kelly’s image has been his role as a friend of the underdog, a living symbol of the vengeance of the inarticulate against the forces of law and power they believed to be oppressing them”. As discussed later, Kelly is still granted a form of “hero” status in Australia.

Ward’s study centred on a particular ethos or tradition that he argued was fostered in the bush through the “noble bushman” and then permeated Australian society. He believed that this legend culminated in the late nineteenth century and was most emphatically expressed in the literature of the 1890s. His judgements were very influential in, and immediately following, the 1950s. Other “Old Left” writers such as Vance Palmer echo Ward’s argument. In his book *The Legend of the*

Nineties (1954), Palmer examined the 1890s in more detail and reviewed, amongst other aspects, the influence of the *Bulletin* and the Heidelberg school on bush identity. He too believed that it was in the outback that a distinctly Australian national character was found. Palmer (1954, p.172) concluded that “the 1890s turned the eyes of Australians inwards and impelled them to discover themselves and their country. Without that period of intense self-absorption, it could not so quickly have found a voice and an individual vision, acquired a character and sense of community”. However, many omissions and inconsistencies have been exposed in Palmer’s argument and he too has been subjected to New Left criticism.

A re-examination of the bush legend

The emphasis that the 1950s radical nationalists placed on the 1890s, and their confirmation of the popular bush legend of this period was, more or less, uncritically accepted until about the 1970s. Intellectuals at this time, referred to as the New Left, began to challenge the validity of radical nationalist reasoning. It was proposed that, when examining the past, historians were reacting to, and affected by, current issues. As Turner (1979, p.11) argues, “we cannot choose our past; that is given. But we can choose our history, for history is part of the present”. Walter (1989, p.38) too argues that, when discussing the period of the 1890s, it is often more relevant to examine the context of the debate; that is, the ideological climate in the 1950s, the time of Ward’s writing. Docker (1991, p.xxi) sums up this idea by stating “in the 1950s, in the dark hour of suburbia, with the World War II social unity and common striving more and more disintegrating, the radical nationalists felt it was a matter of great urgency to keep alive the *Nineties*, that time, so they argued, when the values of a true Australian nation and national culture and democracy was formed”. This will become clearer through an analysis of White’s argument, which is supported by many others.

In his analysis of the Australian image, as it supposedly developed in the 1890s, White (1981) argues that the bush image or legend was a fabrication by the urban intelligentsia. He supports his claim by explaining that ideas and materials were collected in the outback yet developed in the city, thus creating the erroneous impression that the outback was the “real” Australia. Davison (1992, p.129) agrees, arguing that “... it was not the transmission to the city of values nurtured in the bush frontier, so much as the projection onto the outback of values revered by an alienated urban intelligentsia”. White (1981, p.85) argues that “Australians were urged to respond to this image emotionally, as a test of their patriotism”. This was, and is, paradoxical as one of the most pervasive features of the history of Australian settlement is the high level of urbanisation (see Glynn 1970, Rowse 1978). As Reekie (1981, p.86) points out, “this preoccupation with rural life as the source of a distinctive Australian identity sat curiously beside its high level of urbanization”. White (1981, p.99) considers this “a good illustration of just how self-conscious and artificial the process of defining the Australian identity could be”.

The writers of the 1890s were obsessed with finding something “unique” in Australia to document, and to jettison the “stain” of convictism. Thus, they turned to the bush for a distinct character or identity. Hirst (1992, p.23) maintains that “the writers (Lawson and Paterson) were making a tradition as well as reflecting one — how much they created and how much they reported has been one of the matters debated in the argument over *The Australian Legend*”. And what are we to do about those Australians who were not included in the *Legend*? As Hodge and Mishra (1990, p.xv) argue, “one of the paradoxes of this character that has been noticed yet strangely discounted is the fact that neither this character nor his setting is or has been ‘typical’ in any useful sense. Most Australians are left with the paradox that they are not ‘typical Australians’ at all”.

Another explanation given for the strength and acceptance of this bush myth in the 1890s was the hardship and poverty of urban life. White (1981) comments on the negative images associated with the city in the 1890s, resulting in writers' reactive input of values in the bush. As mentioned earlier, this was a consistent theme reflected in 1890s literature that pointed to an underlying tension in Australian society. Glynn (1970, p.78) reflected that the crisis of the 1890s depression gave rise to a changed Australian attitude towards urban life, one of insecurity and distrust, and this promoted the mythologising of the bush. The urban centres were seen as sites of poverty and unemployment. White (1981, p.102) argues that "they [writers] also projected on to their image of the bush their alienation from their urban environment: they sought an escape from what the city represented...and most chose the bush as an imaginative refuge".

As discussed earlier, artists of the 1890s in Australia also made a conscious effort to use already existing myths about the nation and the bush to portray and confirm the desired image, and label it "Australian" art. Hughes (1970) discussed the self-consciousness of Australian art and its obsession with what its identity ought to be. His (Hughes 1970, p.27) explanation was that "a nation based on an idea rather than on blood needs some transcending image to reveal itself and, therefore, it was necessary to transform this bush image into a reality and give it some credence as being unique to the nation". The artists were almost obliged to paint the Australian outback as they were merely conforming to the already popularised images of the Australian nation. White (1981, p.99) concludes that "the bush simply provided a frame on which to hang a set of preconceptions". The priority, once again, was that the national expression be distinct.

As discussed earlier, "mateship" figured prominently in the bush legend. The nineteenth century accounts of bush life and experience conjured images of masculine strength, independence and mutual

struggle. As White (1981, p.83) explains, "the emphasis was on masculinity, and on masculine friendships, and teamwork or 'mateship' in Australia". The historical construction of mateship was paramount to the development of the male image. Altmann (1987, p.107) expands on this and argues that "what is unique about Australian mateship is precisely its mythological character, with all its linkages to nationalist and working class values".

The male exclusiveness of mateship and the bush ethos, White (1981) also believes, contributed strongly to the anonymity of women in the nineteenth century. This negation to include women has operated to construct the Australian myth of women's lack of importance or participation in historical Australia. Dixon (1976, p.57) states that "those versions of our history share a crippling central characteristic: almost without exception, they are written by males about males yet claim to tell us about national characteristics". The repercussion of this female displacement, Lake (1986, p.116) argues, is that masculinist values and identity have been elevated to the status of nationalist traditions. It can be argued that women's subjugation and second class status in rural Australia remains a reality. Although mateship was believed to demonstrate a belief in equality, Horne (1989, p.184) points out that "it was and is a fraternalism to which no boongs, Abos or sheilas need apply". Walter (1992, p.16) also recognises that "one problem in the method of the radical nationalists was their failure to account for groups and values that were at odds with the bush ethos".

As a group, the Aborigines had also been left out of historical penmanship and mateship was not the only area in which they were considered absent. In the historical nationalist tradition and identity, their presence has also been silenced. With Federation in 1901, the Aborigines were not even included as part of the population of Australia. As White (1981, p.112) argues, "the Aborigines were a small enough minority now to be ignored quite pointedly in the Constitution

itself; most of the estimated 67 000 Aborigines were not counted at all". As far as Australian history was concerned, it began in 1788, with white settlement. Lawrence and Gray (2000, p.35) argue that "it is both ironic and sad that those Aboriginal people who, following the destruction of their tribal societies, were to create wealth for the graziers, remained at the opposite end of the social scale from the new land owners". The Aboriginal experience since settlement, with their different cultural background and as the victims of total dispossession, testifies to a vastly different history and identity. Aborigines construct and represent their own version that admits to the overt prejudice and discrimination they endured. In contemporary times, Aboriginal place in Australian history has also been rewritten (see Reynolds 1981, 1991, Attwood 1989, Hodge & Mishra 1990).

White's (1981) major objective was not exclusively concerned with discovering a distinct and unique history of Australia, but rather with validating, querying and exploring the origins of the one we already know. White (1981, p.106) poses the question — "...where, then, comes the legend that it was only in the 1890s that writers and artists gave the expression to the 'real' Australia ...?" And he arrives at the conclusion that "they simply created their own". The excerpt from Lawson (1893) below, written almost a century earlier than White's critique, was of a similar tenet:

In conclusion, we wish to Heaven that Australian writers would leave off trying to make a paradise out of the Out Back Hell; if only out of consideration for the poor, hopeless, half-starved wretches who carry swags through it and look in vain for work — and ask in vain for tucker very often. What's the good of making heaven out of a hell when describing it as it really is might do some good for the lost souls there?

*(From "Some popular Australian Mistakes", Henry Lawson, 1893,
quoted in Cronin 2000, p.275).*

In summary, critical examination of the bush legend revealed discrepancies and inadequacies in the tale and it was found to be an exclusive and partly fabricated identity (White 1981; Docker 1991; Schaffer 1988). The bush legend represents only a partial version of Australian history. It does not include Aboriginal or feminist interpretations of Australian history, or resistance or accommodation histories — these accounts present a vastly different picture of Australia's past (see Reynolds 1981, 1991; Attwood 1989). With regards to the power of the bush legend, Dibble (1995, p.30) concludes that "hegemonic fictions work more to the advantage of some (dominant) groups while simultaneously managing to be sufficiently attractive to other (subordinate) groups to elicit affirmation and participation from them". Despite this fact, the bush legend and identity remain an essential component of Australian nationalism. Some of the original qualities that were espoused in the bush legend and lifestyle, such as egalitarianism, mateship, freedom and the spirit of democracy are very much a part of our national identity today. Many Australians value these ideals as "typical" to Australia and political rhetoric often reaffirms this attachment.

The effect of war on bush identity

*From shearing shed and cattle run,
From Broome to Hobson's Bay,
Each native-born Australian son,
Stands straighter up today.
The man who used to "hump his drum",
On far-out Queensland runs,
Is fighting side by side with some
Tasmanian farmer's sons.*

*The mettle that a race can show,
Is proved with shot and steel,
And now we know what nations know*

And feel what nations feel.

*And with Australia's flag shall fly
A spray of wattle bough,
To symbolise out unity,
We're all Australians now.*

*(From "We're All Australians Now", Banjo Patterson, 1915,
quoted in Campbel & Harvie 2000, p.371).*

World War I was an extremely significant event in the formation of Australian cultural identity and the reaffirmation of the bushman qualities. It has been argued that the outbreak of war in 1914 provided Australia with a testing ground of international proportions for the national character. As Alomes (1989, p.163) maintains, "perhaps no event more influenced the character and development of Australian nationalism than the Great War, and it has been seen as a crucible in which Australian nationhood was forged". The founding moment of "nationhood" was the 25th April, 1915, and the site was Gallipoli. From that day on, an annual ritual of commemoration has been established and Anzac Day has become the unofficial national day (see White 2003).

Before the Great War, Australian intellectuals were clinging to the bush, and to the bushman, as the nation's claim to distinction. As Waterhouse (2000, p.221) argues, "increasingly, the conception of itinerant bush workers as tough and resilient, committed to mateship, resourceful, and defiant of authority was privileged by journalists and historians, playwrights and scriptwriters, in ways that were not evident in the nineteenth century". They were popularised and sanctified as expressing the true character and identity of Australia. A verification and elaboration of this identity was achieved and embodied, both figuratively and in actual terms, through the "digger" at Gallipoli in 1915. The digger (or Australian soldier) became the national type – *He* was a hero, resourceful, brave, highspirited, cunning, humourous,

industrious etc. etc. — the superlatives that have been used to describe the digger are endless.

The qualities that were once assigned to the bushman were largely transferred to the digger. Alomes (1989, p.67), amongst others, argues that “the soldier was the latest and finest possessor of the values ascribed to the bushman”. These traits were already documented in literature about the bush. White (1981, p.127-28) points out that, as a result of this self-conscious construction, “well before the outbreak of the Great War, the image of the Australian soldier was being sketched in and, at Gallipoli, the ready made myth was given a name, a time and a place”.

The “mateship” that was pronounced in the bush legend was also mythologised as the uniquely Australian creed of the diggers. As Smith (1986, p.178) argues, “the recombination of a myth or identity must be ‘in character’ and intuitively ‘belong to’, or cohere with, a traditional past and its peculiar flavour”. Therefore, “the digger” was attributed with having the same resourceful die hard qualities that the Australian bushman had possessed, and “looking after your mates” became their ultimate calling. Mateship in war was especially potent. As Altmann (1987, p.169) argues, “the mateship myths were given a new conservative edge by their link to Gallipoli: mateship now was a part of the national pantheon, and to question it was to cast doubts on the bravery of the Australian fighting man”. However, according to Carroll (1992, p.147-148), “the mateship ethic is not essentially Australian: it can be seen in many other societies, probably in all societies at one level or another”. Nonetheless, due to the importance of “mateship” to both the bush and Anzac legends, the view persists that the ethic may be more widespread in Australia.

The most prominent figure in the creation of the Anzac tradition and digger myth was C.E.W. Bean. He was not a trained historian but a

journalist. However, this was merely a technical difference as he functioned in a similar capacity to the historian in the development of Australian nationalism. Bean (1924) wrote the most significant and well-renowned series of Australian war history. Acting as official war correspondent from October 1914, Bean gave a comprehensive and first-hand account of Australia's experience in the Great War, and he was largely responsible for the instillation of the digger into the Australian national character. At the end of the collection of *The Official History of Australia in the War of 1914 – 1918*, Bean (1924, p.910) proclaimed that “in no unreal sense, it was on the 25th April 1915 that the consciousness of Australian nationhood was born. Anzac Day — a national celebration on the anniversary of the Landing — is devoted to the memory of those who fell in war”.

And so, Anzac Day became institutionalised into the Australian character as the ultimate expression of national unity and pride. Gallipoli provided the setting for the conscious, deliberate manufacture of a national myth. While Bean was a very influential figure in this mythologising, it must be remembered that he was not acting alone. Later historians followed his lead to the letter (see Gammage 1975, Mandle 1978, Laffin 1965 & 1986). If war can be considered as the genesis of national identity, then Bean's collection about World War I can be interpreted as a statement to the world about Australia and Australians. Paterson's excerpt below demonstrates this idea:

*Brotherhood never was like it;
Friendship was not the word;
But deep in that body of marching men
The soul of a nation stirred.*

*They fixed their grip on the gaunt hillside
With a pluck that has won them fame;
And the home-folks know that the dead men died
For the pride of Australia's name.*

*(From "Australia Today 1916", Banjo Patterson, 1916,
quoted in Campbell & Harvie 2000, p.373).*

Bean was aware, from the outset, of the enormous impact that this initial experience of war would have on Australia as a nation. As Kapferer (1988, p.122) argues, "Bean's prodigious energy was generated within an overt awareness, present from the very moment he left Australia with the troops, that he was witnessing the stuff of myth at the moment of its creation". Bean (1946, p.19) also considered the "test of a great war" as being the well-spring of national definition and set out directly to give his history and its actors a distinctly Australian personality. To do this, the bush figured prominently in his writings and diggers' traits echoed those of the bushman. For example, Bean (1946, p.41) argues that "to enlist for the war, there crowded into recruiting offices all the adventurous spirits, rather numerous in Australia, that must be in anything that was moving!". He was bestowing on the diggers a degree of recklessness and spontaneity that supposedly existed in the bushmen. At other times, he refers to their determination and stoicism, their gallantry and bravery — all bushman qualities. Ironically though, as Inglis (1965, p.33) points out, "the unromantic fact is that most Australian soldiers had gone to school in the suburbs". However, the persuasiveness and patriotism of Bean's recollections was so strong that this did not seem to matter. Bean (1946, p.143) argues that "as the diggers had set their hand to this contest of war, they could see no hope for the future happiness, or perhaps existence, of their nation if they failed". A touch melodramatic perhaps, but such is the nature of Bean's recollections. Throughout his chronicles, Bean does not single out any one individual soldier; it is the common soldier who is the hero. This is why his history and style is often referred to as "democratic" and, thus, representative.

The legacy of Anzac

*And I watch the track on the Red Soil Plain
To the east when the day is late,
For one who shall surely come back again,
In summer's heat or in winter's rain,
Limping under his swag in pain —
For a wounded Anzac mate.*

*("The Return", Henry Lawson, 1916,
quoted in Cronin 2000, p. 695)*

The glorifying of the digger persisted after World War I and the sacrifice of all the Australians who had perished in battle was immortalised in the Australian War Memorial. As many diggers were buried where they had died, the Memorial would be a sacred reminder of the men who had "created the nation" and would teach Australians about war. Kapferer (1988) maintains that the symbol of Australian nationalism is the Australian War Memorial. Through this monument and museum, Kapferer (1988, p. 122) argues that "the world of Anzac, made to live in its recorded detail, would enable later generations of Australians to enter its mythic reality, to reembody the Anzac ideals, and thereby regenerate the nation established by the Anzacs". Bean (cited in McKernan & Browne 1988, p. x) selected a statement that would explain what this institution signified and it reads: "...they gave their lives. For that public gift, they received a praise which never ages and a tomb most glorious — not so much the tomb in which they live, but that in which their fame survives, to be remembered forever when occasion comes for word and deed....". In addition to the bush legend, embodied in the Memorial is another legend of the Australian national identity, conceived at Gallipoli. Like the legend, its original purpose was to commemorate the sacrifice of Australians who died in the First World War. However, it has since been expanded to include and represent all

wars in which Australia has taken place and all those who have fought, (including the rather belated addition of female and Aboriginal servicepeople).

Bean provided the framework and set the boundaries for Australian military historiography, which had been uncritically accepted for several generations. He had established a powerful myth and model for the uniquely Australian identity which is invoked in the media and in practical ceremony at least twice a year — on the 25th April, Anzac Day and again on Remembrance Day, 11th November. Each year, as Anzac Day approaches, the public is reminded by the media, and especially in the newspapers, of its significance to our peculiar national identity. The story is retold about the adversity, courage, sacrifice and mateship that was exhibited at Gallipoli on the day that “made the nation”, and reiterates the qualities as ones to which we should all aspire. War, especially World War I, still assumes a prominent and thought-provoking place in the minds of most Australians. The contemporary status of the digger and the Anzac tradition is still paramount to the Australian national identity. This tradition is intricately connected to the bush legend and, like the bush legend, women and Aborigines had once again been largely absent from the early stories.

The politicising of Anzac Day tends to occur each year and, because of the media attention and public involvement that Anzac Day attracts, it has become, for some, a day of protest. The marginalisation of women on Anzac Day has provoked heated feminist opposition. As the Australian national identity was supposedly consolidated at Gallipoli and in World War I, this has restricted nation-making to males once again. Aborigines and Torres Strait Islanders are another group that challenges the contumacy of the digger myth. They have been represented in every twentieth century war that Australia has fought in, yet their participation had been ignored and the publicity surrounding their participation all but non-existent until the late 1980s (see Hall

1989 & 1991, Ball 1991). As Pratt (1990, p.18) argues, “the absence of historical acknowledgement of their [Aborigines] efforts makes a sad mockery of the words ‘Lest We Forget’”.

Manifestations of bush identity in 20th Century film

The bush legend and identity continued to be represented through cultural mediums in the twentieth century, including film. Moran (1989, p.157-58) traces twentieth century Australian film history as follows: “...production dropped sharply in the 1920s, steadied somewhat in the 1930s, revived briefly in the 1940s but faded into nothing by the early 1960s, revived with government assistance in the 1970s, dropped sharply in the early 1980s, only to boom again for about six years”. One of the earliest films in Australia was *The Kelly Gang* (1906), which told the story of Ned Kelly, the late nineteenth century bushranger. The fact that Kelly and his Gang stole from the rich and were defiant of authority seemed to appeal to bush people. Hodges (1992, p.6) maintains that “convicts, emancipists, native-born, and immigrant workers alike shared the conviction that, morally, Australia was ‘their’ country, and resented that so much of it should be given by the government to rich new-comers. This resentment was to find its clearest expression in the elevation of the bushranger to the role of folk hero”.

Kelly was alive and carrying out his escapades in the bush in the late nineteenth century, at the very time the bush was being espoused as the “true” Australia. Blainey (2001, p.71) states that “Ned Kelly first won national respect partly because his life was so exciting; his battle against the odds so effective at first”. Seal (2002, p.2) adds that “of all the popular attitudes towards Ned Kelly, an especially persistent one is that the bushranger represents that most pervasive of Australian myths — the belief that the ‘real’ Australia, the Australia of independence and freedom, is ‘out there’, in ‘the bush’, or ‘the north’, anywhere but in the

cities". Therefore, it can be argued that Kelly does "represent" an aspect of the search for an Australian identity. However, as Seal (2002, p.1) asks, "why are we still singing, writing, making films about him, still trying to excuse, celebrate, or debunk a figure that has become the only approximation of a defining image this diverse continent can manage after more than two hundred years?". One explanation may be found in Carroll's (1992, p.150) argument, that "Australia lacks the pantheon of national heroes normal in other countries".

The arts and media throughout the twentieth century continued to portray aspects of the bush legend. The bush myth was strongly represented in early Australian feature films. As Molloy (1988) argues, "naturally, the infant Australian film industry, itself a product of the 1890s, derived its stories from themes and characters of the bush, and thus became a significant contributor to the bush myth". Early films, such as *The Sentimental Bloke* (1919), *On Our Selection* (1932) and *Dad and Dave Come to Town* (1938), were concerned with the superiority of the bush over the city. Other themes from the bush included the romance, adventure and opportunity that came with pioneering of the land in *The Squatter's Daughter* (1933), and the action and hazards of the bush was the theme of *The Overlanders* (1946), with Chips Rafferty as the bush hero (Molloy 1988). In the feature documentary *The Back of Beyond* (1954) an alternative view of the bush was given, as Cunningham (1989, p.63) demonstrates: "how does white Australian society survive in this most inhospitable of ecologies? ".

Several Australian films were produced in the 1970s and 1980s with the bush as their backdrop. Wright (1995, p.2) notes that "the 'revival' of the Australian film industry in the 1970s was due predominantly to the provision of government funding for film production". Films such as *Sunday Too Far Away* (1975) and *Picnic at Hanging Rock* (1976) both included representations of the bush but with differing themes. The former focused on the code of mateship in the bush and the pressure to

conform to the masculine bush image. Dermody and Jacka (1988, p.100) argue that “*Sunday Too Far Away* created in film a truly confident likeable icon of male Australianness”. However, as Turner (1989, p.107) also points out, “...the most important aspect of *Sunday Too Far Away* was that even as it mobilised popular mythologies of mateship and the bush, it also (at least) hinted at contemporary critiques of such constructions of Australianness”. *Picnic at Hanging Rock*, on the other hand, focused on femininity and illustrated the mystical quality of the bush and, as Molloy (1988) argues, “the incongruity of British customs in this environment”. Once again, as Wright (1995, p.3) argues, “within the context of Australia’s struggle to establish a national identity, these films point to the Australian landscape as one of the primary determining features of ‘Australianness’ in cultural products of the 1970s”.

The bush imagery in film carried over into the 1980s, with productions such as *Breaker Morant* (1980), *My Brilliant Career* (1981), *The Man from Snowy River* (1982) and *Gallipoli* (1981). The bush featured prominently in these films and all contain elements of the historical bush identity and legend. The film version of Banjo Patterson’s 1890 poem *The Man from Snowy River* (1981) was a box office success in the 1980s. However, as O’Regan (1985, p.245) argues “*The Man* is not a reassertion of the pioneer legend A. B. Paterson attempted to create. *The Man* is self-consciously a spectacle film with a flagrant disregard of the values and perceptions of the times”. The film is a romanticised view of mountain men and horses, and not of the outback pastoral workers in the bush legend nor the outback men and women in the pioneer legend. Nonetheless, the film functions as a close analogy and manages to capture elements of both legends. O’Regan (1985, p.245) argues that “the terrain *The Man* inhabits is that of the cigarette commercial, clothes fashions, real estate, tourism, soap opera (melodrama), bush dancing, John Ford and John Wayne. In other words, the film is firmly situated within Australian popular culture”. However, Wright (1995,

p.4) argues that "...it falls squarely into the genre of the melodramatic American Western...". Whatever the case, the affiliation that many Australians feel with the film and its images testify to its popularity and longevity.

Moran (2000, p.170) points out that, after the release of the film, "the marketing campaign produced an extensive range of merchandise that was promoted in and around the film". Icons from the film such as bush clothing and riding paraphernalia were merchandised and appropriated through marketing and advertising; as O'Regan (1985, p.247) argues, this was designed "... to sell, construct and package *The Man From Snowy River*". *Snowy River* themes were also included in the "Sydney Olympics Opening Ceremony" in 2000, followed up by "The Man From Snowy River Arena Spectacular" performed in all capital cities during August and September 2002. Australians have embraced all three versions of *The Man from Snowy River* as it has such a significant place in Australian culture. As the producer of the Arena Spectacular concluded in a *QCL* article (*QCL Friday Magazine*, August 2002, p.14), "at the end of the day the horse is why Banjo Patterson's poem is such an integral part of Australia's history. This show will work — because even before they come into the stadium, people have an affinity with the poetry, with the music and with the horses". All of these representations of *The Man From Snowy River* have kept this "affinity" alive.

The current popular series on Channel 9, *McCleod's Daughters*, which started in 2001, has traces of *Snowy River* elements with one prominent difference: it is the women running the show, riding the horses, wearing the Drizabones, and shearing the sheep. The show is set on a property aptly named "Drover's Run" and, in spite of the gender re-presentation, it contains several themes of the bush legend. It was noted in the *Woman's Day* (30th July 2001) that "*McCleod's Daughters* is a rarity in the television world — a series where women occupy the lead roles and men, normally the central characters in rural TV dramas, never get to

save the day". It is a modern-day version of the bush legend, which may help explain its appeal. *McLeod's Daughters* is the one of the most popular locally produced drama series in Australia. Kennedy (2003, p.184) argues that "the popularity of the televisions series (*McLeod's Daughters*) confirms an inherent belief in the strength of rural women that forms part of the Australian cultural tradition". The series has recently premiered on a United States cable television channel, delivering aspects of the bush legend to an overseas market and attracting huge accolades in the process (*Sunday Mail* 10th October 2004, p. 45).

Peter Weir's *Gallipoli* (1981) chronicled the wartime service of two ordinary Australian men, both incidentally from the bush. The film highlights images, myths and characteristics that are popular in both the bush and the Anzac legends. According to Sohdie (1985, p.194), *Gallipoli* was "...a national celebration of a central Australian myth of military courage, imperial sacrifice, and a nationalist conscience...". The "larrikinism" of the two main characters and their adventurousness, defiance and mateship were all important qualities assigned to the Australian bushman and the digger. As Ross (1985, p.13) notes "other nations make films about their generals, we have films about our privates".

In contemporary times, the image of Anzac, which has its roots in the bush legend, is also well represented in Australian culture with many publications, screening of series, films, even advertisements, that have capitalised on Anzac symbols and imagery. These representations are not solely motivated by profit but they function, in the present, to continually remind Australians of Gallipoli and, in essence, their identity. The power of the story of Gallipoli and Anzac Day to instill pride and patriotism is evidenced by the ever-increasing number of young Australians who make the trip to Gallipoli each year to pay their respect to the fallen heroes of Anzac. As Inglis (cited in Wilcox 1999,

p.80) points out, “there is a new scholarly interest both in Anzac memories and in the pilgrimage as a cultural form”.

Historical mini-series such as *Against the Wind* (1978) and *1915* (1982), set in the bush in historical Australia and at Gallipoli respectively, also have historical significance for, as Moran (1992, p.208) argues, “their aim was to portray the development of national consciousness ...”. Films in the late 1980s included representations of the bush from a different perspective. For example, as McManus and Pritchard (2000, p.9) argue, films such as *Crocodile Dundee* (1986), included “...masculine mythologies and the sense of rural Australia as a strange and hostile place...”, and they maintain that “the (basically urban) film makers engaged in these projects highlight a set of conflicting images about the place of rural and regional Australia within national landscapes”. More recently, *The Farm* (2000), a docu-drama on the ABC, and Channel 7’s weekly *Blue Heelers* series (1992), depict the difficulties of living in the bush and bush communities. Advertising too disseminates popular rural images. As Finkelstein and Bourke (2001, p.47) point out, “the rural is signified through such images as cattle dogs, sheep, milk, dry land and dust, the stockman, Akubra hats, R.M. Williams boots and Drizabones”. All of these cultural mediums reinforce the bush identity and legend.

Other contemporary manifestations of bush identity

The media also plays a role in disseminating stereotypical images of bush men and women. Luck et al (2000, p.221) argue that “there is a persistence of collusion, in many instances supported by the media, in upholding the common masculinity stereotype even if most men don’t see themselves fitting it”. Media images of the bush are responsible for perpetuating many of the myths about rural men and their stoic characteristics. In an article by Brodziak (2002, p.48), he asks us to picture an image of “The Man From Snowy River” as neat, manicured and well-groomed. “Heavens above!”, he states, and argues that

"Australian men have struggled with the concept of masculinity and its connection with stories of the "Outback", of hard work and rugged beauty". It is through such cultural mediums that the image of men in the outback has been popularised as tough, self-reliant, stoic and rugged image. Luck et al (2000, p.221) ask: "how are men able to value themselves and others in a world which seems to be giving such strong messages about men having to demonstrate their adverse masculine behaviour? ". With regards to mental health, it can be argued that this "adverse masculine behaviour" may be costing lives through suicide.

In some recent campaigns directed at men and their health, famous sportsmen such as Denis Lillee (Healthy Mind & Body 2002) and Dick Johnson (Pfizer 2001) have been enlisted to deliver the health message to men. Denis Lillee was part of a drive to promote the benefits of natural medicine to men in 2002 and Dick Johnson was the front man for a "Men's Health Tune-Up" campaign in 2001. It was hoped that, through the association with sport, this information could be made more appealing to men. The weight of evidence suggests that men in the bush may be more resistant to seeking help for health needs due to cultural impediments such as self-reliance and stoicism. There is no simple way to jettison the negative qualities of the bush legend and to only promote the positive characteristics. As Cornwall concludes (1997, p.12), "we need to move beyond old fixed ideas and find ways of thinking about and analysing gender that make sense of the complexities of people's lived realities".

The mateship ethos that has guided both Anzac and bush tradition has remained a powerful ingredient in Australian nationalism throughout the twentieth century. As the former vice-president of the national RSL, Bruce Ruxton, once stated with reference to Australia's economic problems, "we have to 'look after our mates'. That's the faith that has got us through war and it will prevail again. It is still very much a part of the Australian national identity" (*Channel Nine News*, 10th August

1993). The political rhetoric of Prime Minister, John Howard, often includes the concept of mateship to make his message more appealing and inclusive. In a speech entitled *Politics and Patriotism* (Howard 1995), when Mr. Howard was Leader of the Opposition, he used the phrase “practical mateship” and concluded that “to me, like many, the Australian identity has always meant practical mateship. It has meant a great egalitarian tradition and a shunning of pretension and pomposity. We have that independent ‘can do’ quality”. By introducing mateship into political discourses, there is an implication of unity and cohesion. As Smith (1986, p.201) argues, “the mythology of the past enables leaders to set the goals for the community by referring to the great era of heroism as a model of action and achievement”. Thompson (1994, p.252) concludes that “stories of Australia’s past have emphasised sentimental stereotypes to fit an egalitarian view: mates, gentlemanly bushrangers, hard-done-by bushrangers, laconic farmers, proud diggers, stout-hearted drovers’ wives and decent blokes”. These images are still used to emphasise the historical bush identity.

In addition to Anzac Day, our national identity is also promoted on the occasion of Australia Day (though some would argue, not as effectively). Despite the rhetoric in the media about, for example, “our great nation, the Lucky Country or Land of Opportunity” and so on, many Australians fail to become caught up in the celebration, perhaps because many do not know what they are meant to be celebrating. As Inglis argues (cited in Wilcox 1999, p.90), “it may be that our uncertainty or ignorance of what the day commemorates helps us celebrate it; for if we think specifically and vividly of that day in 1788, we may find it easier to feel outraged, or uncomfortable, than to rejoice our nationality”.³ Mackay (1999, p.7) points out that “festivals need two

³ In the *Courier Mail* on Australia Day, 2001, accompanying the usual rhetoric about the “richness of our lives as Australians”, there was a cartoon which offered rather fitting comic scene of Australia Day in 1788. It depicted a British officer declaring that they need a truly symbolic gesture of Australia Day, something symbolic of the great new land. A second British officer answers: “I know, I’ll declare a long weekend” (*Courier Mail* 26th January 2001, p.16).

things to work: a symbolic hero — or a symbolic group of heroic figures — and a powerful sense of relevance to the lives of ordinary people”. It can be argued that Australia Day has neither.

The Centenary of Federation on the 1st January, 2001, did not seem to inspire any swelling of pride despite the political rhetoric about what a symbolic day it was for the democracy of Australia. There were a number of splinter issues that may have been occupying a more prominent place in the minds of Australians such as the Republican debate, the adequacy of the Constitution and reconciliation with indigenous Australians. On the 1st January 2001, *The Australian* published a cartoon that addressed the question of national identity, entitled “The Unjolly Swagman” (see p.v). It depicts a rather solemn, depressed looking swagman who states “I don’t feel like doing anything”. An exasperated sheep replies: “pull yourself together man — there’s a lot of national identity riding on this” (*The Australian*, 2nd January 2001). The swagman who, at the time of Federation, was the embodiment of the “typical Australian” appears to be confused and lost as to his place in our national identity. It can be argued that this cartoon illustrates three points of particular significance to this study:

1. That bush identity and bush people need to be understood and represented realistically, in the current context, and no longer in the romanticised version;
2. That bush people are experiencing enormous difficulties and may not be coping well with their current circumstances; and
3. It also may be highlighting that the search for, and preoccupation with, national identity in Australia continues.

The cartoon holds a poignant message about the superficiality of the search for a national identity and those who are left out or discarded. As Schaffer (1988, p.3) argued, “we are confronted with paradox: to find, rather than celebrate, a national identity”⁴

Finally, perhaps the most significant display of Australian cultural identity was in the *Opening Ceremony* of the Sydney 2000 Olympic Games. Many representations of Australia were on display: from the stockmen and women in their Drizabone coats, moleskins, Akubras and riding boots, rural traditions and icons, Aborigines, urbanisation, climate, flora and fauna improvisations, bush fires, Australian cultural acts, and multiculturalism (*Channel 7*, 15th September 2000). Smith (1986, p.208) states that “our myths, memories and symbols must be constantly renewed and continually retold, to ensure our survival. The nation becomes the constant renewal and re-telling of our tale by each generation of our descendants”. The *Opening Ceremony* almost depicted the entire evolution of Australian national identity with only one apparent omission. There was no reference to the Anzac tradition or the digger legend. But perhaps that was an appropriate “oversight” as war and soldiers have no place in such a positive and unified international event.

Another poignant message that Australia expressed in the *Opening Ceremony* was its pride in Aboriginal culture and heritage, and its

⁴ Part of the 2001 Centenary of Federation celebrations in Queensland included a play called *Way out West (Legends & Larrikins: A Travelling Federation Show)*. The *Show* was well received by both bush and city people alike in Southwest Queensland because of its “true to life” representation of the bush. It was a tent show that revolved around authentic stories of the people of western Queensland. As one of the writers (*Way Out West* programme 2001) explained: “we wanted this show to be different. It wasn’t going to be theatre that was created for a city audience and then taken out into the country. The genesis of this show would be in the country. The stories would come from the people of the outback and be about their own diverse experience”. The show included themes such as drought, floods, loneliness, stress, droving, gender inequality, suicide, discrimination against Aborigines, alienation from government and urban areas, and youth leaving the country. It was considered a “true” display of bush life with realistic images and experiences and included many of the issues discussed in this thesis.

commitment to reconciliation. Multicultural Australia was also favourably depicted with the resounding themes of pride and acceptance of ethnic diversity. Kane (1997, p.118) argues that “in multiculturalism, the official break with a racist past appears complete”. The celebrated inclusion of both Aboriginal and multicultural themes made a clear statement to the world of official policies of cultural tolerance and invitation. Whether this statement was, or remains, as “clear” to Aboriginal Australians is debatable.

Perhaps the embodiment of bush culture and identity in contemporary times is in the outback heritage centre, the Australian Stockman’s Hall of Fame in Longreach, Queensland. The founders of the Hall were the artist, Hugh Sawrey, and R.M. Williams, of bush clothing fame, and it was officially opened in 1998. Trotter (1998, p.18) argues that Sawrey and Williams wanted to establish a memorial to the early pioneers and a repository of outback culture. As a tourist destination, the Hall showcases Australia’s pioneering history. It displays art works, outback relics, a library of outback literature and, as Trotter (1998, p.19) states, “it aims to commemorate and honour not only Australia’s pioneers, but also the poets, writers and artists who have helped record the history and living conditions of Australia away from the major metropolitan areas”. The Hall is a re-affirmation of the symbolic importance of bush identity and culture to Australian people.

In 2002, Australia celebrated the “Year of the Outback”. Rural Australia was honoured through celebrations and festivals throughout the country, commemorating the outback’s contribution to Australian history, culture and economy. As Bruce Campbell, founder and chairman of the “Year of the Outback” explained to a *Queensland Country Life (QCL)* reporter, “the purpose of Outback 2002 is to unite Australians, to focus undivided attention on the inland, its immense diversity, its extraordinary past and its vital role in our future” (*QCL* 6th September 2001). It was hoped that this concentration on the outback

would generate urban interest and participation, broaden the understanding of current problems being experienced and assist in restoring pride and motivation in many rural communities. There were more than 2000 shows and events organised Australia-wide to honour the “Year of the Outback” (QCL 1st August 2002). Significantly, Bruce Campbell concluded, at the end of this Year in which Australians were invited to ‘go bush’, “they came to feel a part of it and came to understand that we are not two nations — city and country — but one people entrusted with the care of the world’s greatest island continent and the only Outback on earth” (*Sunshine Coast Daily* 21st December 2002). The aim of unification was realised throughout the Year and gave those urban Australians who participated a view of bush life and possibly empathy for rural problems.

Conclusion

Tracing the course of the bush legend and identity has demonstrated how it was formed, engendered and popularised in Australian society. Although many aspects of the historical bush legend were found to be restrictive, inaccurate or outright fabrication, some of the original qualities that were popularised in the bush legend and tradition, such as egalitarianism, mateship, support for ideas of freedom and democracy, are very much a part of our national identity in contemporary times. As Finkelstein and Bourke (2001, p.46) argue, “the depiction of an egalitarian, monocultural, masculine and Anglophile Australia, which prevailed for most of the twentieth century, was an idealised view, again with little reference to reality”. Despite the fact that only a minority still inhabits rural areas, most Australians are proud of this bush heritage and identity. Smith (1986, p.178) examined the “multiple nature of the past” and argued that “the past that is handed down is multi-layered and susceptible to different interpretations. It is based upon conscious selection and moulding”. There are different versions of the past that are presented to us. In considering Australian

history, Bulbeck (1998, p.157) also advises that “rather than thinking of any one history as true history, we should think of them as partial, all written from a particular standpoint”. This is certainly true of the history of the Australian bush identity. The next chapter will outline theoretical perspectives of bush identity which assist in explaining how this identity became embedded in rural society, why it persists in contemporary times, and why this identity may influence attitudes to mental health.

CHAPTER 3

A THEORETICAL PERSPECTIVE OF BUSH IDENTITY & CULTURE

It is of the greatest importance to every man amongst us that he should have some clear idea of what position he occupies in relation to other people, and that he should understand what it is that fixes his prospects and circumstances in life. We must always keep in view that our object is the greatest good for the greatest number.

(From "Australia for the Australians", Banjo Paterson, 1889, quoted in Campbell & Harvie 2000a, p.65)

This chapter will discuss some theoretical perspectives of bush identity: what are its features, why it has been so resistant to change and what effect it has on attitudes to mental health. There are several explanations for the differences that exist between rural and urban identity in Australia such as geographical distance, demographics, politics, occupation, attitudes and lifestyle. Robbins (1973, p.1200) argues that "the identity concept is useful in generating hypotheses about social and/or cultural events". The "social identity" of people is influenced by cultural factors and these differ between rural and urban communities. Gray and Phillips (2001, p.52) explain that "culture consists of the ways in which people live their lives and the values and beliefs which lie behind what they do in everyday activities". Therefore, bush culture provides guidelines for the identity of rural people.

The collective identity of rural Australians will be explained through the application of Social Identity Theory (SIT) and other identity theories. From a poststructuralist perspective (Lockie 2001, p.27), it will also include feminist and political economic ideologies to determine their

impact on rural identity. In so doing, this research offers explanations for how rural identity and culture influence attitudes to mental health.

An important foundation from which to build an explanation of collective rural identity in Australia involves an examination of Social Identity Theory (SIT) (Tajfel 1982). While SIT may incorporate some or all of the aforementioned aspects as a means to explain difference, it argues that the fundamental determinant of identity is group affiliation or membership. It holds that the feeling of belonging to a particular social group overrides individual differences thus compelling group solidarity. SIT and other identity theories will be outlined in more detail and later applied to a rural setting in order to explore their practical application. Consideration will then be given to rural identity and responses to mental health issues. The application of social identity theories to the bush setting effectively demonstrates the power of group identity to exist within the individual. However, the limitations of this theoretical approach will also be outlined.

In most research, theory is used to guide the process of analysis and provide a foundation for the explanation and understanding of social phenomena. As B. Turner (1996, p.11) argues, "theory may be regarded as a broad framework for organising and ordering research, or as a collection of general concepts which are useful in directing research attention, or as a specific orientation which leads the researcher to well-known problems and issues". Theories are valuable in research as they can be practically applied to provide guidelines, explanations or predictions of certain behaviours (Glaser 1967, p.3). Fetterman (1998, p.5) argues that "... the researcher's theoretical approach helps define the problem and how to tackle it". SIT and other identity theories have been used here to explain bush identity and the impact it may have on attitudes to mental health. Feminist theory, in the broad sense, has also been utilised in this research. Warren (1988, p.47) explains that "feminist theory seeks to direct social science analysis towards issues

and interpretations focused on gender". When examining Australian bush identity or culture, and attitudes to mental health, the category of gender cannot be ignored.

Social Identity Theory will be applied here to demonstrate the foundation and continuation of the bush identity. Distinctiveness theory, social dominance theory, social labelling and social learning theories will be briefly discussed to explore and evaluate what part they play in explaining and understanding identity formation and outcomes. These theories, including social cognition theories, provide comprehensive explanations of the social group's involvement in both personal and collective psychological identities. They will be referred to collectively as social identity theories. Identity will be viewed as being a product of the social environment in which it was fostered. Additional aspects have also been considered to help explain how and why bush identity remains so strong in contemporary Australia and how it has changed. Feminist theory has been incorporated into the study, as previously noted. As Hughes (1997, p.123) argues, "feminist research has highlighted how inadequate conceptualisation of terms such as 'work' and 'the family' in conventional rural research has led to the neglect of rural women's voices in academic research". Rural identity, through the "female voice" and experience, may articulate an alternative perspective. As Naples (2000, p.199) argues, "by incorporating women's perspectives into ethnographic accounts, feminist researchers have developed more complex analyses of gender dynamics in communities, families and other social institutions".

Social Identity Theory (SIT)

SIT, originally conceived by Henri Tajfel in the 1970s, and subsequently developed by others (I. Turner 1996, Worchel et al 1998, 1999), was considered very innovative in social psychology circles as it broadened the study of the individual to incorporate group membership and the

influence that group membership has on behaviour. Tajfel (1982, p.2) argues that "social identity will be understood as that part of the individual's self-concept which derives from their knowledge of their membership of a social group (or groups) together with the value and emotional significance attached to that membership". It is through group membership that individuals are able to obtain self-worth, belonging and social guidance through favourable comparison to other groups. SIT does not focus on individual identity gained through introspection but on the identity and self-concept that people obtain through social interaction and group formation. The emphasis is on the group, not the individual. Operario (1999, p.29) points out that "the social identity approach emerged as a compromise between individual-level and group-level explanations". Ashforth (1989, p.21) also explains that SIT encompasses both personal and social identity and states that "social identification, therefore, is the perception of oneness with or belonging to some human aggregate".

SIT was previously distinguished from social cognition theory by the fact that the latter focused on psychological beliefs and influences as guiding social behaviour rather than behaviour being the result of external group forces. However, in recent years, it has been recognised that one has much to offer the other. They both focus on the inter-relationship between the practical application of group theory and the cultural context. Abrams (1999, p.6) explains this 'marriage' as the "socialising of social cognition, particularly through a shared focus with SIT on stereotyping and prejudice", or alternatively, as a perception that "social identity theory is a true social cognitive theory, which specifies cognitive and social processes and structures and their interrelationship". Operario (1999, p.48) opts for a combination of the two, arguing that "social cognition researchers must continue to remember the significance of society and its implications for internal processes; social identity must continue to remember the significance of the self, and the internal states that moderate reactions to one's

context". Aspects of both theories can be united to obtain a more comprehensive explanation of group behaviour.

There have been several extensions or adaptations of SIT to explain group dynamics. Turner (1982, p.17) used SIT as a basis for the development of social categorisation theory and argued that "social identification can refer to the process of locating oneself, or another person, within a system of social categorisations or to any social categorisation used by a person to define themselves and others". He was, however, refocusing on individual identity rather than the group. As Oakes (1994, p.93) suggests, this was a significant theoretical shift, "from Tajfel's conception of social identity as *reflecting* group affiliations, to Turner's suggestion that social identity comprised of self-categorisations of the self which *caused* group phenomena". Although both theories involve the group and the individual, the emphases are different.

It has been so far established that SIT is dealing with groups, not individuals. From a social psychological perspective, Tajfel (1982, p.36) states that "a social group can be usefully conceptualised as a number of individuals who have internalised the same social category membership as a component of their self-conception". However, once a group is established, other features are necessary to ensure its continuation. To perceive a group as worthy of membership, it needs to foster a favourable social identity. Bar-Tal (1998, p.93) points out that "this view is achieved not necessarily through positive perception but rather through comparison on appropriate dimensions. The comparison allows one to perceive the ingroup as 'better' than relevant outgroups". Differentiation from other groups is the means by which membership is judged as preferable.

To distinguish one group from another, it must have common characteristics that are deemed positive and desirable by group

members. As Finkelstein and Bourke (2001, p.46) argue, “a sense of identity is not only produced from conflict and difference but also from a sense of belonging, a sense of sameness and harmony”. I. Turner (1996, p.21) points out that “Tajfel’s general point is that human social conduct is fundamentally rule-governed. People seek to act appropriately (and evaluate themselves positively) in terms of the social norms and values of their social groups and wider society”. The adherence to the group’s ideology and codes of behaviour consolidates and attracts membership. Bar-Tal (1998) also discusses group norms, values, goals and ideologies, which he collectively terms “group beliefs”. He (Bar-Tal 1998, p.111) echoes Tajfel when he states that “the selection of group beliefs depends very much on a group’s goals, common experiences, ideas, norms and values and they play a determinative role in the formation and maintenance of social identity”. New members to the group must adopt and support the group ethos. As Worchel (1998, p.60) points out, these new members generally have a lower status and must prove themselves worthy of membership to the group.

Beliefs and values that the group holds need constant re-affirming. As Bar-Tal (1998, p.111) explains, “central group beliefs may become part of the group’s culture and tradition, and then they are especially enduring, passing from generation to generation”. Smith (1986, p.208) had previously discussed this phenomenon in *Ethnic Origins of Nations* where he argued that “our myths, memories and symbols must be constantly renewed and continually retold by each generation of our descendants to ensure their survival”. Worchel et al (1999, p.7) maintain that “groups become known by their ‘character’ which is relatively enduring and outlives the individual members”. The sharing of positive beliefs and traditions reaffirms belonging and provides a common basis for the group. Prior to these theorists, Robbins (1973, p.1208) also had discussed this argument, stating that “if any society is to survive, it must have some institutionalised means of inculcating in

its members' knowledge of behaviours and symbols appropriate to given identities and must periodically ensure that those identities are confirmed or reinforced". These "behaviours and symbols" can also provide a source of identity and self-esteem for the individual even when there appears to be little else to define their existence.

The employment of norms, values and goals also serve to control the behaviour of the group. Individuals need to conform to these simple and predictable forms of behaviour to ensure group acceptance and stability. Lloyd et al (2004, p.4) discuss the importance of role models in learning socially accepted behaviours. Hogg and Abrams (1988, p.159) argue that conformity to these socially accepted behaviours "is transmitted through socialisation enforced by agents of social control (parents, teachers, police etc.) who have the power to ensure normative (socialised) behaviour". Those who do not conform satisfactorily risk rejection from the group and, therefore, it is an effective means of reducing anti-social or deviant behaviour. In some cases, certain members may have trouble adopting or accepting the group's code of behaviour or ideals. According to Worchel (1998, p.61), "marginal members who are not central to the group's identity are the first to leave". They may leave by choice or be forced out through pressure or discrimination from the ingroup.

Another way of looking at differentiation between groups is that of discrimination and prejudice, either subtle or overt. To activate the belief that a group is superior to another, prejudice or bias must be involved. Ashmore (2001, p.35) argues that once group membership is established, it becomes necessary for the self to "achieve positive valuation, maintain secure inclusion, and protect ingroup boundaries" through comparison to outgroups. Hence, the use of the terms "ingroups" and "outgroups" as a distinction between groups is commonplace in discussions of SIT. To further emphasise this difference, Worchel (1998, p.59) argues that "in some cases, demands

are made on outgroups which cannot be met, precisely to 'prove' that the outgroups are evil and unfair". This serves to empower and galvanise the ingroup.

It is also by this process that stereotypes are formed. Put simply, Oakes (1994, p.161) states that "stereotyping is the process of ascribing characteristics to people on the basis of their group memberships, perceived from a particular vantage point and within a particular context". To be considered a stereotype, the image needs to be a widely held and homogenous belief about a group. Tajfel (1982) also pointed out that stereotyping enhances ingroup similarity that, in turn, promotes social cohesion in the group. Stereotypes can be positive or negative, mostly the latter in SIT discussions. As group value is based on comparison, stereotypical representation of other groups is usually inferior. Stereotypes generally refer to groups, not individuals and, therefore, if there is only a minority who defies the stereotype, it is not likely to rescind the popular image. For Tajfel, (cited by Oakes 1996, p.115), "the group, and the cultural traditions, group interests, social upheavals and social differentiations that go with it, was the *primary* causal factor in stereotyping, and other factors had to be understood in light of the fact that stereotypes reflect and make possible *group life*".

Hogg and Abrams (1988, p.77) agree with the stereotypical dimension of SIT and believe that stereotypes have three social functions: social causality, social justification and social differentiation. Stereotypical social causality refers to the assigning of blame to another group for negative events; social justification "permits" a group to act against another; and social differentiation is activated when insecurity threatens to erode a group's solidarity. These are termed the "macro-social aspects" of stereotyping and, according to Hogg and Abrams (1988), they serve to add historical validity to social behaviour and allow for the prediction of future conduct. However, stereotypes can also be used for political purposes and may not be wholly accurate. As Oakes

(1994, p.187) argues, “they may gloss over real differences and sacrifice strict truth for fast, tolerable approximation or worse”. Nonetheless, stereotypes are an essential ingredient for group formation and social identity.

There is a more turbulent aspect to SIT, and Hogg (1988 p.15) suggests that SIT is closely linked to Marx’s “conflict” view of society. This view focuses on the competition and conflict between groups in society, as opposed to consensus and cooperation. To highlight this point, Hogg (1988, p.66) discusses the ethnocentrism of the majority of social groups, with the most extreme form of this group nepotism being genocide. He focuses on the negative aspects of intergroup interaction. Brewer (1996, p.26) agrees and states that “in its more dramatic manifestations, the activation of social identities may lead individuals to behave in ways that are contrary to personal self-interest, even at the cost of personal survival”. Ashmore et al (2001, p.8) also argue that SIT incorporates elements of this tenet and state that “regardless of whether intergroup conflicts are played out peacefully in cultural or political arenas, or become violent or murderous, social identity is usually involved”.

Another perspective on SIT is Brewer’s (1991) optimal distinctiveness theory. Brewer (2001, p.21) explains that “distinctiveness theory postulates that human beings have two powerful social motives: a need for *inclusion* that motivates assimilation of the self into large, impersonal social collectives, and an opposing need for *differentiation* that is satisfied by distinguishing the self from others”. This theory focuses upon the unique characteristics a group may possess to differentiate it from other groups and to encourage membership, very similar to SIT. With respect to distinctiveness theory, Ashmore (2001, p.214) explains that “much discrimination is driven by ingroup positivity and it is thus *favoritism for one’s own group*, rather than *discrimination against an outgroup*”.

Social dominance theory gives another view of identity. This theory puts forward a hierarchical explanation for intergroup relations. Sidanius (cited by Operario 1999, p.44) argues that acceptable levels of status differentiation exist in society to account for “large scale examples of group dominance that occur in the absence of overt conflict, such as ethnic or gender oppression”. There can be pronounced status differentiation or social dominance, for example, in class differences in the bush; that is, between those who own properties, those who live on farms and town dwellers (see below). However, the status quo is generally maintained through common rural goals and characteristics. This aspect of identity can be seen as encompassing a combination of both distinctiveness and social dominance theories.

Two additional theories that offer perspectives on identity are social learning theory and social labelling theory. It is argued that social learning plays an important role in the formation of one’s identity, especially group identity. Bandura (1977, p.17) states that “by observing the different outcomes of their actions, they [people] develop hypotheses about which responses are most appropriate to which settings and this information becomes a guide for further action”. Socialisation in children occurs through learning appropriate behaviours and responses from parents and other authority figures. It is through such learning that personality traits and identity are formed.

Social labelling theory, on the other hand, relates to how others react and categorise deviance; that is, in failing to act appropriately, a person may be labelled as deviant (Pilgrim & Rogers 1999, p.13). Worchel (1998, p.60) also points out that new members to a group often need to “prove themselves” worthy of group membership before being accepted. The *learning* of appropriate group behaviours reduces the likelihood of not being accepted or *labelled* negatively. These are both powerful determinants in guiding behaviour in the bush.

Some criticisms of Social Identity Theory

As the following discussion outlines, some criticisms of SIT reveal areas that need more consideration. Although SIT provides a viable explanation of the process of social identity, it does have some shortcomings. The identity of women as a group provides new challenges for SIT. Griffin (1989, p.176) argues that "SIT has tended to treat the key social group 'women' as a relatively static and unitary category. There are female sub-groups or contradictory groups". When studying women, it must be remembered that women, like men, are not a homogenous group. For example, one cannot assume that gender and feminism are always intertwined or equivalent; each is a separate identity. Feminism has a negative public image in certain environments, and in the media, which serves to inhibit the involvement of many women, thus making it a distinct identity from gender. Class identity can be viewed in the same way. SIT does not account for the multiple social identities that most people possess.

SIT also often fails to take into account the social and historical context of the situation when defining identity. As Condor (1989, p.30) argues, "despite paying lip service to the need to consider 'historical context', social identity approaches are largely ahistorical". They also fail to encompass the changing status of different identities, such as gender and class, in the group over time. This negation can give an inaccurate contemporary portrayal of the group's current identity. For example, the application of SIT to the changing identity of bush women is problematic. While it helps to explain the origins of the rural female identity, SIT fails to acknowledge that this identity is multi-faceted and has been altered by contemporary forces.

The social context also plays a crucial role in the interpretation and acceptance of an identity. There may be more than one identity present that could shroud or exaggerate the presence of another. By taking into

account the social situation at the time of review, other influences can be considered or minimised. Hogg (1996, p.71) also subscribes to this argument and states that "SIT tends to focus on intergroup differentiation and intragroup homogenisation, and has not fully explored intragroup differentiation (eg class, gender, age) that is not necessarily antagonistic" (also see Worchel et al 1999). Intragroup differences such as the ones mentioned above are present in all bush communities and may have a significant impact on the social, economic and mental health status of members of the rural group.

Identity can be multi-dimensional and, therefore, attention needs to be given to other identities that may coexist and to the social variables that could influence a situation or response. Skevington (1989, p.195) concludes that "the major criticisms of SIT have revolved around the exclusion of the social context, the over-reliance on positivistic methodologies and the treatment of social groups as relatively uniform". To give an accurate impression of any group situation or identity, the historical and social contexts are vital considerations. SIT fails to include these contexts.

Hogg (1988, p.217) also argues that the recognition of intra-group (class, age, gender, occupation) differences may open up and pose new theoretical challenges for SIT and advocates a study of the association between interpersonal and intergroup relations. Worchel et al (1999:3) term personal identity "the neglected twin in the identity family" and argue that personal characteristics may also directly affect intergroup behaviour and intragroup identity. However, it is also possible for some identities to operate simultaneously without imposing restrictions on the expression of other identities. In conclusion, Hogg and Abrams (1988, p.218) commend the scope of SIT and argue that, "by avoiding the reduction of groups to individuals, it (SIT) allows us to conceptualise the *relationship* between the individual and society, and to place theoretically the group within the individual". This dissertation will be

concerned with doing precisely that; acknowledging that culture and identity in the bush are a by-product of genuine and publicly “assigned” group characteristics and traits to bush people in early Australia. These characteristics have defined them as “a group”, and have been adopted, built on, popularised and accepted since then. Alternative frameworks, such as postmodern theorising, may fill some of the gaps exposed or not considered by SIT. However, for the purposes of explaining the origins and continuation of bush identity, the simple application of social identity theories has been adequate.

Application of social identity theories to Australian bush identity

Following is a discussion of how social identity theories can be applied to the formation and analysis of Australian bush identity. There are predominant characteristics that can be explained as resulting from being a member of the rural social group. Castle (2002, p.342) argues that “rural people traditionally have accorded importance to group and community action when addressing common problems. Apparently they believe that individuals’ aspirations can be achieved most successfully if individual effort is supplemented with cooperative endeavours”. This is essentially what SIT argues; group identity and goals reign supreme over individual needs and actions. SIT has been employed to examine the historical origins and why aspects of this bush identity continue to be exhibited. Robbins (1973, p.1217) argues that the examination of expressive areas of culture such as religion or myth may also help to explain the identity structure of a society. Establishing the historical roots of bush identity will help contextualise current attitudes to mental health.

As discussed extensively in Chapter 2, the bush figured prominently in historical Australia. It was argued that a distinct Australian identity was to be found in the bush, defined by the harsh conditions endured in the outback and by the attributes of those who lived there. The

Australian economy was viewed as dependent on the bush in the early days and this served to consolidate its status. This assumption was oversimplified, as there were other industries of economic importance to Australia in the nineteenth century such as mining and manufacturing. However, they did not achieve the legendary status that the pastoral industry of the “real bush” achieved. The perceived pride and wealth of Australia remained in the outback well into the twentieth century, and “riding on the sheep’s back” was the arrogant economic expression to validate its importance. The itinerant stockman/bush worker was the first positive national identity of Australia (which, in reality, was born from penal stock). In response to this, a rural social group was forged and validated; so too were the characteristics that were bestowed upon them. This is the first step necessary in situating or locating a group or collective identity in SIT.

The iconisation of the Australian bush was achieved through oral histories and literature of the period, and cultural formations such as the *Bulletin* and the Heidelberg school of painters. Buchbinder (1994, p.74) argues that “cultural texts are more than simple narratives or images. They reflect models and ideologies abroad in the culture, and (by giving these form through narrative, example and illustration) reinforce them and refract them back into the culture”. The images of the bush were given life through cultural expression and, therefore, became part of a unique Australian tradition. A break from British identity was deemed necessary for young Australia and the bush became the site of differentiation and for an alternate identity.

The idealisation of bush life was also exemplified by pejorative images of the city, as sites of poverty, unemployment and pollution. The aspect of SIT that comes into play here is the negative portrayal of other social groups, that is, the rejection of British ideals and urban lifestyle. This served to distinguish the rural group as being unique and superior. The foundation of a lifestyle and political distinction between rural and

urban centres was laid. Negative stereotypical images emerged from both domains and the division between the city and bush was fixed, another feature of SIT.

The characteristics of the bushman were also being sketched in at this time. *He* was portrayed as stoic, independent, resourceful, hardworking, chauvinistic, anti-authoritarian and egalitarian, one who lived by the creed of mateship. The absence of women in the bush myth was a blatant oversight in early chronicles of the outback. Of course, women were present in the bush but, as they were a minority, it seemed to suit some of the storytellers to wipe their existence and thus elevate the solitary life of the bushman to legendary status. These common characteristics assigned to the men of the bush consolidated them as a group. Mateship was the essence of bush tradition and culture, and their other traits, all perceived as positive, were essential elements of male socialisation. As discussed previously, women and Aborigines were excluded from this identity, however, these general bush characteristics were broadly accepted and circulated, and they served to validate the identity and the group. Common group values beliefs and attributes are essential elements of SIT.

The bush identity of the nineteenth century was transformed at Gallipoli in World War I. The Anzacs were credited with having the same characteristics as the bushmen and, therefore, the legend lived on. The venue had changed but the same basic attributes applied: white, male, independent, anti-authority etc., all under the auspices of mateship. In some ways, the Anzac legend replaced, or at least assumed prominence over, the bush myth and "the digger" became the embodiment of Australian identity. The theme of the Anzac legend continued throughout the twentieth century and shows little sign of fading, evidenced by its rejuvenation and celebration every year on Anzac Day and Remembrance Day. However, the bush no longer assumes prominence in the hearts and minds of most Australians, except on

public occasions where it is appropriate to rekindle the image and put it on display. Nonetheless, aspects of the historical identity remain real to those who live and work in the bush.

In order to reaffirm the rural group's identity, historical features and characteristics are celebrated and retold. As Worchel (1998, p.59) argues, "in many cases, efforts are made to 'reach back' in history to establish the legitimacy of the group, recognize patrons and previous founders, and locate the marks that will distinguish the group and identify its 'rightful' members". As discussed previously, in Australia, the bush heritage and legend are thematically displayed and celebrated on symbolic occasions in urban centres to illustrate the roots of our national identity. The bush legend is also celebrated in contemporary times through cultural mediums such as literature, television and film (see Chapter 2). These modern portrayals have the effect of reaffirming the historical bush legend in contemporary times. However, in the bush, this history is their legacy and is continuously on display. People in the bush "reach back" regularly as many aspects of this identity and its popularised characteristics persist today. In several bush communities, characters from the past are glorified, stories re-told in verse and song, and significant events remembered and celebrated (Reeves & Fischer 2002). This theme is also discussed in the Ruraltown study (Chapter 6) as this community also actively celebrates its bush history.

As discussed above, there is usually status differentiation *within* a group. In bush areas, this can be quite pronounced with respect to gender and class. Class differences are most evident between those who live on the land and those who live in town (see Gray 1991, Poiner 1990, Dempsey 1994). The former group wields more political power and attracts a certain historical prestige through land ownership. Also, *within* agriculture there are further hierarchical differences — between pastoral property owners, and farmers and rural workers, with the first

group being considered socially and economically superior. Lawrence and Gray (2000, p.47) argue that "...there has always been an historic and important distinction between the 'farmer' and the 'grazier'. The former was identified with hard work, austerity and adversity; the latter with privilege and success" (also see Chapter 2 & 4). However, as Dempsey (1992, p.137) explains, "the strong belief in egalitarianism in a country town fosters the mingling of men of different classes or status groups, and cross-class mixing is also facilitated by structural factors such as the geographical isolation of these towns, their small populations, and their limited financial resources". Common rural interests and membership in the broader group usually obscure class differences.

Rural cohesion amongst different classes can also be secured by adopting grand narratives or over-arching themes such as the superiority of rural life, or by working towards common rural goals against a common enemy, for example, drought, politicians or the city. For example, Rolley and Humphreys (1993, p.260) argue that "the bonding which transcends many class boundaries has its origins in the subjugation of all people by the elements, affecting each regardless of social status". The experience of drought or flooding, which affects both town and country people, can have a unifying effect.

Bush attitudes to metropolitan Australia also tend to consolidate them as a unique group. According to Linn (1999, p.viii), "rural social culture today, while strongly localised, has elements that are all-encompassing — a sense of difference from urban people being one factor and a frustration with politicians another". Further to this, Share et al (2000, p. 417) argue that "an egalitarian ideology and belief in a shared fate in the face of the common external 'enemy' (the city and the government) may militate against the development of a class consciousness". In contemporary times, the political and ideological gulf remains between rural and urban Australia. As discovered in this research, many in the

bush regard their urban counterparts as dissimilar in character and lifestyle. With regards to identity, Bulbeck (1998, p.408) argues that “despite the dramatic and comparative decline in the rural population and primary industries’ contribution to the economy, people living in the bush continue to construct themselves as different from the mass of the population who live in the cities”. It is unlikely that the rural-urban chasm will be bridged until more attention and support is given to rural problems.

In Chapter 2, it was argued that the female presence in historical Australia was muted which created the myth of women’s lack of importance to Australian bush history and identity, and elevated the bushman to iconic status. As Saugeres (2002, p.378) argues, “cultural symbols and ideas of gender do not only sustain and reinforce gender inequalities, they also concretise, justify and validate them”. The historical construction of gender identities in the bush has contributed to the unequal gender relations. Patriarchy continues to dominate in much of rural Australia and women remain a relatively dependent and disadvantaged group (see Schaffer 1988, Dixon 1999, Alston 1994, 1995a, 1995c, 1998). However, in the vast majority of cases, gender discrimination is tolerated in the rural group. From her study in Southern France, Saugeres (2002, p.386) concludes that “whereas men construct their masculine identities through the appropriation of the farming landscape, an appropriation they reproduce through discourse and practice, women construct their identities as marginalised others whose relationships to farming is defined in relation to their husbands”. This same argument can be applied to the Australian bush. Grace (2003, p.106) concludes that “the experience of rural women includes being constructed as the ‘other’ on two counts: their rurality and their gender”. With respect to SIT, these are examples of status differentiation, which are generally accepted to reduce conflict and preserve the interests of the rural group.

Social Identity Theory and attitudes to mental health in the bush

When considering bush identity, it is important to examine the unique cultural construction of Australian gender identities. As discussed earlier, Australia was settled as penal colony and this had a major influence on the early identity of men and women in Australia (Colling 1992). It was not adventure or exploration that brought them to Australia but punishment in a cruel, unfamiliar environment. The working class background of most workers in outback Australia also had an impact on the formation of a collective identity through shared goals and values (see Hodges 1992). The difficult conditions experienced in early Australia fostered the development of qualities such as reliability, steadfastness, loyalty, ingenuity, courage, toughness and humour, and emotional expression was discouraged as a sign of weakness (Colling 1992:9). As discussed earlier, these enduring qualities became part of Australian bush culture, identity and folklore.

It can be argued that the cult of mateship forged in these times lay the foundation for a national masculinist tradition. As Colling (1992, p.158) sums up: "mateship has served men well in the past. It is a relationship that, by its very nature, allows men to endure and survive in times of hardship and join together in celebration. Its major flaw lies in its inability to easily adapt to the changing needs of men". So entrenched are the "rules" of mateship in male socialisation, especially in the bush, that adapting or relaxing the creed seems unlikely. Dempsey (1992) discovered in his study that mateship might also inhibit men from seeking emotional support from their "mates". He (Dempsey 1992, p.136) argues that "...in my experience, in the company of a *group* of mates, they keep their problems to themselves. Fears about the future, problems at work, sexual, family, or money worries are not discussed except in terms that shift the responsibility onto others: their boss, their wives, their girlfriends, or 'the system'". These are the qualities that have been accepted as part of the rural male collective identity. Women

do not fit into the mateship code of the bush.

Social learning, as discussed above, is particularly valid when applied to mental health issues in rural areas. From an early age, emotional or vulnerable, expressive behaviours, particularly in males, were sanctioned, ostracised, stigmatised and therefore are not encouraged (Connel 1986, Colling 1992, Cornwall 1997, Levant & Habben 2003). This too has historical roots. As Ker Conway (1989, p.9) argues, in the bush "everyone knew the most important gift to a child was an upbringing which would toughen him (or her) up so as to be stoic and uncomplaining about life's pains and ready for its reverses". The learning of acceptable social roles and behaviour restricted both men and women from acting "inappropriately" in the rural environment. As Horton et al (1997, p.272) argue, "one of the most striking characteristics of rural culture is its ability to suppress deviation within the group. Constant pressure is brought to bear upon individuals to conform to the expectations of the group". The fear of being labelled abnormal or different inhibits expression of vulnerable behavior. However, these learned social roles and so-called "appropriate responses" can impact negatively on the mental health of people in rural areas. Bourke (2001c, p.122) argues that "rural people are aware of the consequences of engaging in conflict: residents disagreeing with 'popular' opinion may be stigmatised or marginalised and, as a result, many of their social networks may become disrupted". Those who experience mental health problems may feel reluctant to acknowledge or seek treatment for their condition due to pressures to conform and "be normal". Complying with rural group values and beliefs often prohibits people from seeking help for mental health problems.

With respect to behaviour, there are definite patterns of social identity in the rural world that sanction and determine acceptable conduct for women. In her discussion of the social learning approach to gender, Bussey (1986, p.94) argues that "gender-related behaviours are believed

to be acquired through the reinforcement of responses that socializing agents deem appropriate and the discouragement of behaviours judged inappropriate through parents and observational learning". Female behaviour in the bush is also determined by certain social identity expectations. According to Ker Conway (1989, p.9), "she could care for the sick, help fight a bushfire, aid a horse or cow in difficult labor, laugh and joke at life's absurdities and reverses, and like a man, mock any signs of weakness or lack of stoicism in her children". Bush women were encouraged to adopt similar resilient characteristics to males. With respect to mental health, Fullagar and Gattuso (2002, p.7) argue that "they [women] interpret depression in relation to the socio-cultural context of a rural community where the stigma attached to mental illness is pervasive and where women are governed by entrenched norms about feminine identity that provides them with little support".

Rural male identity is even more restrictive when it comes to dealing with mental health problems. Cochrane (1983, p.149) concludes that "being labelled, in other words, being regarded as different by important other people, has serious consequences for the self-identity of the person so labelled". The socially learned fear of rejection or being stigmatised often over-rides admission and acceptance of mental health issues in rural areas. This argument is supported through the results of the Ruraltown study.

With regards to men's health, Luck et al (2000, p.4) argue that "it is necessary to examine the socialization of boys and men, and how this affects the way in which they maintain their health, how they respond to illness and how they do or do not seek help". Emotional expression or repression is a part of gender development. This is particularly so when investigating rural men's attitudes and responses to mental health issues. The male socialisation practices in the bush have been very resistant to change as the cultural perpetuation of qualities such as stoicism, resilience, toughness and emotional immunity are still strong.

Although rural men's health issues have been receiving attention in recent years, especially in South Australia (Luck et al 2000, p.174), entrenched attitudes and practices have been slow to change. According to Little (2000, p.621), "the notion of conquering or taming the hostile rural environment for agricultural or other productive use has been equated with "masculine" qualities of physical strength and aggressiveness". When examining the construction of the rural gender identities, it is important to include the historical and cultural forces at play.

In discussing mental illness and gender, Pilgrim (1999) highlights the over-representation of women in mental health statistics. She (Pilgrim 199, p.49) explains that "women may be more likely to recognize and label mental illness or, put another way, men may be less likely to view their problems as psychiatric ones". As will be demonstrated through this research, rural women are more willing to address problems experienced by either themselves or their families and are not as apprehensive about the social repercussions. It appears to be more socially acceptable for women to show emotions, possess nurturing qualities and seek medical, emotional or financial advice for their families. For rural men, however, it is not so easy. According to Cochrane (1983, p.57), "sex differences in rates of mental illness presents perhaps one of the clearest examples of the social creation of mental illness". The evidence may suggest more psychological problems in rural women due to their propensity to address mental health problems, however, this may not be an entirely accurate representation. Lack of presentation for help by rural men does not necessarily mean that they are not experiencing mental health problems; they may be doing so in private.

There is a demonstrated reluctance by rural men to admit to emotional or psychiatric problems (see Colling 1992, Ruraltown study). Help-seeking behaviour would also be affected by these perceptions, and

removing this reluctance is difficult. As Luck et al (2000, p.224) point out, "not only do boys and men experience health differently to girls and women, but they also interact with health services differently". The process to change these ideals is a difficult one. As Cornwall (1997, p.11) points out, "if certain ways of being a man are culturally valued, then asking men to abandon these identities altogether without anything of value to hold on to is clearly unreasonable". Many rural men may feel this traditional identity deconstruction is what women and feminism are asking, hence their defensiveness and opposition. However, Cornwall (1997, p.12) concludes that "by recognising that men can also feel powerless, scope can be offered for men to reflect on their own behaviour towards those they feel they have power over. As behaviour is learnt, it can also be unlearned and relearned". Whether this is possible in rural Australia, where so much emphasis is placed on conforming to traditional roles and qualities which are part of bush identity, remains to be seen.

There are rigid gender "rules" in rural areas. Connel (1986, p.345) argues that "neither gender role is fixed, however, many choose to conform to traditional patterns. In the case of rural Australia, men adhere to their hegemonic role and women to their subordination as that has been the norm". Rural males are reluctant to show any emotional vulnerability. Levant and Habben (2003, p.177), in their discussion of American rural men, point out that "adherence to a more traditional code of masculinity (in rural areas) with rules such as "Real men don't cry", should not be seen as abnormal. Emotional expression may in fact be prohibited for rural men". This same argument applies to Australian bush men, where conforming to conventional models of masculinity is paramount.

As discussed later in the Ruraltown study (Chapter 8), the fear of labelling through sexuality issues is particularly pronounced in rural areas. Homosexual rural men do not represent the image of what a

rural man is supposed to be. In Roberts' study (1995, p.151) of rural gay men, he found that "there is strong pressure to conform to local norms and the price of non-conformity is ostracism and sometimes physical abuse. This increases feelings of isolation and the need to remain in the closet". As a result, they may remain in the group as marginalised members, leave of their own accord or be forced out through pressure or discrimination from the ingroup. Mental health consumers can also be regarded as not "complying" with the bush image and, as evidenced in this research, are marginalised members in the Ruraltown community.

Little and Jones (2000, p.638) propose that "there is a need to understand how particular forms of identity are reinforced through the values and practices of rural society and through the marginalisation of others". Rural male and female identity are constantly being reinforced through industry arenas. As discussed by Liepins (2000, p.605), contemporary industry arenas such as agricultural organisations and the media present a gendered organisation of farming, that is, male oriented. Moreover, rural women are rarely accorded active involvement in the business and are mostly represented in the domestic sphere (see Bell & Pandey 1989, Alston 1998b). Through such representation, traditional images of rural gender identities continue to be supported. Despite the fact that contemporary views are more egalitarian and have become mainstreamed in recent years through some sections of the media and progressive organisations, disproportionate gender identities continue in the bush.

In some circles, recognition is finally being given to the historical and contemporary contribution of rural women and, in turn, empowering some women to challenge traditional roles. However, there are others who remain acquiescent to patriarchy and some aspects of traditional bush identity remain. Worchel et al (1999, p.5) point out that "in some cases, intragroup identity [eg women] may be relatively divorced from

actual group membership". As discussed in Chapter 4, gender identity is often relegated in preference of maintaining the status quo. With respect to mental health issues, rural men are still reluctant to acknowledge emotional or psychological vulnerability and rural women appear to "manage" the mental health of the family (see Noonan 1995, Fullagar & Gattuso 2002, Alston & Kent 2004). In turn, it can be argued that both gender and bush identity influence attitudes to mental health.

From a political economy perspective, substantial changes have occurred in the late twentieth century that have altered the face of rural Australia (see Chapter 4). These changes impact on the identity of rural people. As Worchel et al (1999, p.14) argue, "social identity may suffer if one's ingroup is threatened or demeaned. The threat to the group may develop from events internal to the group, such as failure to reach a goal, economic or structural collapse, or events of fate (natural disaster)". Globalisation, deregulation, economic restructuring, service withdrawal and unemployment can all be considered as threats to the rural group.

Drought too has been widespread, causing considerable economic and personal difficulties. According to Mules et al (1995, p.239), "the drought highlights notions of a rural identity *in extremis*, especially given the campaign by farmers to have the drought recognised by government as a natural disaster, and the need for farmers to articulate their position in a struggle for survival in various media forums". External forces have been altering the face of the bush and challenging the boundaries of this historical identity.

The repercussions of these changes have, at times, been tragic for many with a dramatic increase in suicide rates, alcoholism, domestic violence and emotional or stress-related problems. Gender identities have also been altered as a result of these external pressures, leading to

uncertainty about expected roles and behaviours. As Lloyd et al (2004, p.2) discovered in their study, “as a result of this role ambiguity and the persistent expectations of the traditional male roles, many young males are experiencing stress and this is particularly true among people with mental illness”. In light of these pressures being experienced in rural areas, Gray and Phillips (2001, p.59) ask: “will rural cultures continue to offer people a means of understanding their world and prescriptions for the conduct of their lives?” In the context of these current dilemmas, it is surprising that more help for mental health issues is not sought in rural areas, yet bush culture and identity still appear to mitigate against this.

Chapter conclusion

The collective identity of rural people in historical Australia has been so embedded that many of the historical qualities and codes of behaviour persist today. Through the application of social identity theories, this chapter has demonstrated that the popularised attributes of their forebears such as stoic independence, resourcefulness, resilience and strength are common characteristics of bush people today, especially men. Dempsey (1990, p.298) maintains that “... it is men rather than men and women who exemplify the virtues associated with the Australian Legend, a man’s legend subscribed to by both sexes”. This will be demonstrated further in the results from the Ruraltown study (Chapter 8), where women recognise bush identity as being a male identity and one that influences the help-seeking behaviour of bushmen. Rural men have been socially conditioned to conceal emotions or vulnerability. Therefore, mental health is not a concept that is readily identified with or accepted.

The stigma attached to mental or emotional issues is very powerful and admission to such problems is perceived as weak, shameful and demeaning. The socialisation and the resultant social identity of bush

people are so enduring and rigid that changing their attitudes to mental health presents quite a challenge. In their discussion of rural men, Luck et al (2000, p.70) argue that "because a man's identity is so dependent on his job and status in the world outside the family, if this goes the blow may be so severe that he will commit suicide". By the same token, Fullagar and Gattuso (2002, p.5) recommend that the socio-cultural determinants that affect rural women's experiences of mental health problems also need to be recognised. It is through the socialisation process in the bush that common values, norms and behaviours are learned. This collective identity has historical substance and, therefore, is very resistant to change.

This thesis demonstrates that social identity theories can be applied to the formation of a group identity in the bush, expressed through a unique culture. The restrictions and specifications of this identity have problematised the approach that is used regarding the concept of mental health in the bush. The study of the Ruraltown community will illustrate how this collective identity in the bush reflects specific attitudes and values and, in turn, determines behaviour, with respect to mental health. This study will be directed towards discovering whether individual responses to mental health issues in the bush are a direct result of membership of bush society and identification with the traits of bush culture and identity. In addition, the research analyses the extent to which embracing this identity results in the suppression of mental health problems. In conclusion, Abrams (1999, p.19) advises against "losing sight of the macro-social dimension of social identity theory that addresses the societal context of social identity and intergroup relations". The social identity and context that was examined in this thesis is the Australian historical and contemporary bush identity and the aspect of this identity that has been analysed in more detail is attitudes to mental health. The following chapter outlines the changes that have been experienced in the Australian bush in the last few decades, which have influenced both the identity and mental health

of bush people. It will also include a section on gender in the bush as women remain a marginalised group in contemporary rural Australia, in perception and practice, and this affects attitudes to, and experiences of, mental health issues.

CHAPTER 4

RECENT ECONOMIC, POLITICAL AND SOCIAL CHANGES IN THE BUSH

*Thunderstorms were forecast again today but did not come
— the only moisture I felt was my tears of frustration.
No feed and the ground water almost gone
and we are not yet “drought declared”.
The government could give farmers subsidies —
the picture is too big, the elements too powerful and unpredictable
and we are too powerless and too human.*

*(Excerpt from a letter to “The Country Web”,
— Rural Women’s Network, 2003, p. 28)*

From a political economy perspective, the structures and social forces that impact on the experience of rural Australia through macro circumstances are largely beyond the control of rural communities. This chapter will summarise the changes that have occurred in rural Australia over the last few decades that have impacted on the mental health of rural Australians. As Sainsbury (2003) argues, “mental health needs to be viewed as something that is heavily influenced by what goes on outside the individual’s psyche and area of personal control; to see the social and political factors that shape an individual’s and a community’s mental health”. Despite the major changes which Australia and its rural heartland have experienced in the late twentieth and early twenty-first centuries, the bush has retained its place in the national folklore. According to Hegney (2000, p.204), “during the last 200 years, the reality of rural life has seldom overcome the myths (of ‘mateship, battlers and stoicism’) that have been incorporated into the discourse of Australians”.

This chapter, framed within a political economy perspective, discusses recent economic, political and social changes that have impacted on rural Australia, which are critical to an investigation of the relationship between bush identity, attitudes to mental health and the provision of services. It is divided into two sections. The first section will outline the ramifications of long-term decline for rural areas — natural, economic, political and social. As Lawrence (1987, p.53) argues, “as paradoxical as it may seem, the development of capitalist agriculture appears to lead to the under-development of rural regions”. This argument will be explained more fully through an analysis of the recent changes. The second section will concentrate on gender issues in the bush. The identity and actions of rural people are intricately tied up in gender demarcations and, therefore, gender issues cannot be overlooked.

RECENT CHANGES IN THE BUSH

The loss of banking and telecommunications services and government agencies have left country people stressed and their communities debilitated. The consequence overall has been declining social cohesion with increased suicide and mental health problems in rural areas and a lack of trust in government.

(Rees & Fischer 2002, p. 203)

Rural Australia has experienced major problems in recent years, some natural, others social and political. As well as locally generated problems, there have been external socio-economic factors that have contributed to the critical situation in the bush. Hallebone (2000, p.214) argues that “the recent process of global economic restructuring, agricultural readjustment, farm amalgamation, rapid technological evolution, and political change have contributed to the declining socioeconomic viability of many rural areas”, resulting in depopulation, unemployment, poverty, loss of services, incomes and opportunities (see Lawrence 1987; Gray 1991; Gray & Lawrence 2001; Pritchard 2000;

Lockie 2001; Alston 1994a, 1995, 1998, 2003). It is only by taking into account the recent social, political and economic changes in the Australian bush that mental health can be understood in its proper context (see NRHA Position Paper 2003). As Naples (2000, p.210) concludes, “we can no longer explore rural life in any part of the world without taking into account the larger social, political, cultural, and economic pressures that are woven into and through rural residents’ everyday lives”. Following is an assessment of the influential economic, political and social changes in rural Australia.

The nature of rural communities

There are some characteristics that are common to bush communities. Gray and Phillips (2001) discuss these characteristics and note that they are usually referred to as the ideology of “countrymindedness”. They (Gray & Phillips 2001, p.54) explain that “countrymindedness is used to refer to a set of ideas shared by rural dwellers, based on the differentiation of rural from urban Australia in terms of both the cultural and structural”. This countrymindedness enables rural people to distinguish themselves as a cultural group, giving them a collective identity that contrasts them from others, usually urban Australia (see Chapter 2 – Social Identity Theory). Aitken (cited in Lockie & Bourke 2001, p.9) argues that countrymindedness also has a political function: “it presents the interests of farmers and graziers as the interests of all rural people..., giving farmers and graziers considerable political influence considering their relatively small numbers”. Poiner (1990, p.65) also argues that “there is no question that in the rural ideology, ownership of land underscores the social worth of men as well as affording them economic and hence political advantage”.

As discussed in Chapter 2, the divide between city and country has historical roots. The city was portrayed as a site of crime and poverty, juxtaposed against the idealistic life of freedom and adventure in the

bush. However, countrymindedness was and is more than the work of historical and cultural forces. Lockie and Bourke (2001, p.9) argue that this ideology symbolically opposes city life and the interference of government (also see Linn 1999). The changing circumstances in rural Australia in the last few decades have reduced the economic significance of the bush. However, as Blainey (2001, p.32) states: "the rift between country and city is wider than at any time in the last 150 years. The rift is so wide that the return of rural and outback prosperity — if by chance it does return — will not quickly narrow the gap. For the country grievances are not simply economic: the grievances are also social and cultural" (also see Share et al 2000). Rees and Fisher (2002, p.204) argue that "too often the protests of the bush have been dismissed as a mantra of doom and gloom. Not surprisingly, the result has been a general feeling among people outside capital cities that they have been ignored". It can be argued that this would reinforce their countrymindedness.

Due to the notion of "countrymindedness", rural people in Australia have generally been perceived as a relatively homogenous group. The diversity of non-metropolitan Australia is rarely acknowledged, with differences in population structure, employment patterns, cultural orientations, social status and income distribution (Fraser et al 2002, p.289). Dale (1994, p.329) argues that "using the generic term 'rural', while useful in the design and delivery of community services, does not reflect other practical or value-related factors, for example, between Aboriginal, mining and farming areas, which may differentiate communities". Philo et al (2003, p.268) also argue that "if few texts proceed to tackle difficulties involved in defining the rural, simply operating with accepted classifications based on statistical indicators, even fewer address broader questions implicated in the deeper conceptualising of the rural". A discussion on the Queensland Rural Women's Network email site (qrwn-l@mailman.usq.edu.au 6/1/04) addressed this very issue. One woman stated that "a chief problem is

that dwellers in Australia's largest cities tend to view rural people as being one big homogenous mob (no doubt similar to the mob on *McLeod's Daughters*!). They don't realise that there are unique cultural differences inherent in particular regions or industries". There are differences within and between rural communities. Bush culture cannot be perceived as a uniform, single entity, and not all rural areas have the same level of need. As Wainer and Chesters (2000, p.143) point out, "rural people and places are not homogeneous and there are some groups of people living in some rural places that experience more of the negative aspects of life than the rest of the population".

There are differences also apparent between those who live on the land and those who do not. As Gray and Phillips (2001b, p.53) point out, "when applying the concept of culture to rural Australia, two important issues arise: consistency over time and space. The most obvious spatial differentiation occurs between town and country — townspeople live different lives to those of farmers". Whittenbury (2003, p.150) also argues that, "the interests of rural town dwellers are not simply synonymous with the interests of people in the agricultural sector, as has been assumed in mainstream rural social research". Gray (1991, p.140) reported in his study that "a town-dwelling employed person told me that the farmers thought themselves to be 'lords of the manor', and that they had a general contempt for people in the town". Also, according to Poiner (1990, p.86), "farmers and their families at all times have an extra prestige loading by virtue of the fact that they are 'on the land' ". There is a definite barrier between farmers and town dwellers, however, as was discussed in Chapter 3, these differences are usually exhibited covertly.

Differences can be further broken down between what *type* of farm people work on — pastoral or farming — with the graziers carrying higher prestige. Lawrence and Gray (2000, p.34) argue that "graziers have tended to own large tracts of land, have inherited family wealth

from the heady days of high wool prices, often reside in stately homes, possess a good education, and have taken leadership roles in industry...and, as a consequence, their image is connected with privilege and status" (also see Gray 1991, Ker Conway 1989). On the other hand, vegetable growers operating small tracts of land are seen to be lower in the social hierarchy. Stehlik (2001, p.31) discusses the importance of considering the social construction of "space". In this case, the rural "spaces" of farm or grazing property have been socially constructed as having different levels of prestige. As discussed in Chapters 2 and 3, this difference has historical roots. The polarisation between types of farming also appears in other current research about rural areas (see Lawrence 1987; Gray 1991; Lawrence & Gray 2000; Poiner 1990; Dempsey 1990).

Dale (1994) discusses the service delivery implications of the differences between rural spaces. Dale (1994, p.332) argues that, while it is recognised that there are differences in service delivery between urban and rural communities, there should also be recognition of differences in delivery between "off-farm" and "on-farm" rural culture. This is an important differentiation when examining mental health service delivery in rural areas, as will be discussed in the Ruraltown study (see Chapters 7 and 8). The cultural differences within particular rural areas (town, farm and property) can be remarkable. Fraser et al (2002, p.292) argue that "the heterogeneity that characterises rural Australia emphasises the need for a finer level of investigation in future studies and policies related to mental health". However, as discussed below, there are also common bonds between townspeople and those on the land which, at times of crisis, tend to override these differences. The current research acknowledges that there are differences between rural communities and spaces, however, to maintain coherence, the term "rural" or "bush" have been used interchangeably to discuss both town and farm, unless otherwise specified.

Climatic influences

Australia has always been under “extremes” of climatic influences. Drought, floods or fire can dictate financial prosperity or otherwise in rural Australia. As Daly (1994) so eloquently puts it, rural areas are either “wet as a shag or dry as a bone”. Daly (1994, p.xv) defines drought as “a protracted period when the water supply is inadequate for the needs of its users. The vulnerability of an enterprise to a drought is influenced by a number of factors: the duration of the drought, its intensity, its geographic extent, and the long-term sustainability of the enterprise to the area”. Stehlik et al (1999, p.56) point out that there is often confusion about the definition of drought (also see Botterill & Fisher 2003). However, at present, it is believed by many that some rural areas are enduring one of the worst droughts ever experienced.

During the current drought, farmers have suffered extensively due to economic and personal hardship. Mules et al (1995, p.243) argue that “the drought is more than a natural phenomenon with social consequences; it is a symbolic event that involves strategic positioning of meanings about what it is to be a farmer”. Botterill and Fisher (2003, p.3) also point out that “drought cuts into our national income, puts enormous stress on our farming families and communities and, when combined with some farming practices, can degrade our environment” (see Lawrence et al 1998). And the effects of drought are usually long-term. As Jensen (1998a, p.12) argues, “the devastating effect of drought on farm incomes and subsequently on regional and local economies is clear. The effects of drought are, however, often recognised only for the duration of the drought, ignoring the fact that the after-effects of the drought can have long term implications for the region”. Dixon, from the Department of Primary Industries farm financial counselling service in Queensland, agrees and states in a *Sunday Mail* article (14th October 2001, p.10) that “they [farmers] normally don’t get into trouble overnight and don’t get out of it overnight. Things don’t turn around in

the blinking of an eye". Droughts cause widespread, long-term problems for affected areas. Although many have contingency plans to cover such times, due to the unpredictable and protracted nature of droughts, these can become ineffective.

Two recent studies (Stehlik et al 1999, Alston & Kent 2004) have concentrated on the social impact of drought. These studies emphasise the devastating emotional effects that drought can have on individuals, families and communities. The financial and emotional traumas of losing livestock and watching land deteriorate can also compound feelings of hopelessness and despair. Barnes (2000, p.7) explains that "killing sheep makes perfect sense when no fodder is available but it remains only a partial solution unless the farmer receives assistance in dealing with his sense of loss at the need to kill the sheep. As farmers who've spent years building a sound breeding stock watch all that hard labour disappear before their eyes, how do they deal with such emotions as fear of the future, anxiety, anger and the frustration that help always seems to be 'too little too late?'" ⁵

For some rural communities, drought can also have a unifying effect; both town and country are fighting a "common enemy", prompting feelings of belonging and communion (Stehlik et al 1999, p.74, Rolley & Humphreys 1993). However, it can also be socially divisive. As Cheers (1998, p.117) points out, "although national sympathy has increased for rural people due to drought, this sympathy has focused more or less exclusively on farmers, partly because of the strength of the farm lobby

⁵ Anecdotally and from personal experience, floods too can have similar distressing impacts. It may be necessary to drag stock from boggy drains, to constantly move livestock to higher ground or, if you are unable to reach the animals, live with the knowledge that they are going to drown or starve. Due to flooding and inaccessibility to surrounding towns, it may be necessary to have food dropped by helicopter. This can create additional problems. From one personal experience, for example, the noise of the helicopter scared the sheep back into the water, the methylated spirits broke in the drop, all over the sugar, flour and other porous food items, rendering the contents useless, and all we could do was watch from the veranda in the pouring rain. The hardship, frustration and anger experienced over such incidents are clear; the mental health implications of this may be even more harrowing.

and partly because of Australian mythology which equates 'rural' with 'farming'". In their study, Stehlik et al (1999, p.75) also point out that "structural differentiation, within farm communities but more especially between farm and town communities, raised questions about the commonality of interests".

The effects of drought are not isolated to rural properties. Alston and Kent (2004, p.70) found that "the prolonged drought, the problems associated with determining eligibility for benefits and increasing regulations have created significant levels of alienation and mistrust within the community". Drought can severely affect rural towns too. Rural businesses in towns may suffer as a result of decreased demand or capital, and there may be resultant unemployment in the towns that negatively impacts on communities and individuals alike. King (1994, p.3) argues that "the economic plight of farmers and the drought have caused the shutting down of essential community services in smaller country towns, especially in finance, communications, health and welfare, and the loss of homes and employment for many families. At a time when rural communities are in most need of help, community-based resources have been cut back". As a result, Stehlik et al (1999, p.60) argue, "communities are not economically or socially enriched by the in-migration of 'new people'. Instead, people have either left the district or are surviving with the support of social security income payments or on overdrafts". The effects of drought can be far reaching, even to urban centres (Botterill & Fisher 2003). For example, there may be price rises on some food items, however, what happens at "drought-level" hits much more than the hip pocket.

An issue worth noting is the re-definition of drought and recent changes in drought policy (see Daly 1994, Botterill & Fisher 2003, Stehlik et al 1999). It is recognised that these may also have adverse repercussions for farm and town populations. Not being able to "manage drought" effectively, as advocated in new policies, may invite or intensify feelings

of failure for some farmers. As Stehlik et al (1999, p.78) argue, “if drought ceases to be seen as an enemy to be fought and comes to be seen as something more manageable and expected, through which good farmers apply their skills and cope well while other farmers fail, the universal identity which farmers can claim as battlers against a meteorological foe will be lost”. The battering that a farmer’s identity could incur because of this perceived “failure” is bound to have an impact on their mental health. Another repercussion of drought redefinition, according to Stehlik et al (1999, p.78), would be that “cultural differentiation between town and country would change, not in terms of the basis of the status order, but rather in the weakening of claims to status by formerly highly-ranked individuals”. The identity and mental health implications for both town and country are apparent.

Drought and mental health

The effects of drought may have serious consequences for the mental health of rural people. As reported on *ABC Online* (2002) by the Australian Psychological society, “many farmers will be suffering depression as a result of the drought, and it is heightened because there is no end in sight”. Alston and Kent (2004) discuss the gendered differences in the impact of the drought. They (Alston & Kent 2004, p.48) found in their study that “men noted the link to land and stock and the emotional trauma of watching the land and stock suffer. Women were more inclined to note the emotional impacts of having no income, the struggle to support their families and keep their children in school, and the sheer energy sapping efforts associated with their multiple roles”. These particular concerns create a stressful environment for the entire family and may also negatively impact on marital relationships. Belyea and Lobao (1990, p.62), in their study in the United States, point out that “economic distress also carried over to the marital relationships, as couples with greater distress tended to

blame each other more for farm losses (e.g. losses due to finances, climate, disease, vandalism)".

Drought can also damage the social structure of farming communities. King (1994, p.3) argues that "farmers become depressed, develop low self-esteem and feelings of failure. They may feel that they have lost the family heritage in the land and may experience loss of social status and reduced income. This accumulation of loss and their part in it, in having to destroy their own livelihood through the slaughter of their animals, is devastating". Loss of control over their environment through drought can precipitate mental health problems for rural men. As Price (1999, p.143) argues, "there is an increased risk of mental health problems as a result of situations where they (men) lose control, as in unemployment". This same argument can be applied to the loss of control experienced in drought. Stehlik et al (1999, p.66) conclude that "there is evidence the drought is one of those factors which can cause significant stress and consequent deterioration in health and family relations among farm families".

It is abundantly clear that mental health issues in the bush are intricately connected with the adverse effects of climatic influences such as drought or flooding. In response to this, the Bush Connection, a non-government rural community organisation, has established a confidential service helping rural people who have been adversely affected by drought. This service will liaise with small businesses and farmers and explain what is available to them. As the drought coordinator explained, "a lot of people don't know what's outside their fence line — the drought has kept them pre-occupied" (*Rural Weekly* 4th June 2004, p.3).

Economic changes

Rural economic and social changes at the local level can be very effectively understood by examining the global context. As McMichael and Lawrence (2001, p.153) argue, “a truly ‘global’ agriculture is now emerging, one defined by market liberalisation and the identification of a new regulatory regime”. Globalisation has been characterised as the opening up of opportunities for communities and countries alike to the world market (Jensen 1998a, p.13). However, it seems the benefits have been swallowed up by the “big guns” in globalisation. Sidoti (1998) explains that “in the last few decades, the globalisation of agriculture and the decline in the terms of trade have resulted in a loss of income for many farming families and many farms are now only marginally viable, if they are viable at all”. Jensen (1998a, p.23) also argues that globalisation is a double-edged sword and states that “while it (globalisation) is offering every region or community the possibility of access to the wider world markets, it also ensures that the markets of each region (both domestic and export) will be vulnerable to the exploitation by external firms”. Hallebone et al (2003, p.224) agree, stating that “there are two kinds of disadvantage of patterns of globalization to local communities: the global dictation of markets (in this instance, for agricultural products) and the loss of local infrastructure needed to sustain the community”.

However, globalisation can be seen to have a positive aspect for some rural groups. Not all rural people or places are in decline or despair. There are some communities that have been able to meet the challenge and have even prospered in spite of, or because of, these changes. A shift in business focus has created many profitable ventures such as farm tourism and diversification of product base (see Lawrence & Gray 2000). Therefore, the condition of “rural crisis” is not an all-encompassing reality (Wainer & Chesters 2000).

Globalisation has also become a localised source for advancement. Initiatives to learn about, and capitalise on, the benefits of the global market at the local level may actually improve the economic prospects for many rural communities. Stehlik et al (1999, p.30) argue that “the ideology of self-help and the associated realisation that the state is unwilling/unable to act to assist rural towns might provide the impetus for regional/global connections”. Communities may be able to turn the disadvantage around. Herbert-Cheshire (2003, p.14) concludes that “too often, rural Australia is depicted as a place of crisis, comprised of rural dwellers who have become ‘victims’ of global and national change”. Although the issues associated with globalisation seem to compound a drastic situation of financial and social deprivation, with some rural towns languishing under the pressure, not all are suffering and, in fact, some are flourishing (Rees & Fischer 2002). As Cocklin (2003, p.5) concludes, development can both create and destroy some forms of human and material capital.

It can be argued that significant economic pressures on rural communities have also stemmed from deregulation and a withdrawal in government support. While these changes have benefited some rural areas, others have suffered. For example, Lavelle (2003, p.2) argues that “world prices for basic commodities like wool and wheat have fallen and those regions highly dependent on them face hard times. Small and medium-sized farms have found they are becoming less and less viable. Incomes have fallen and bank foreclosures and bankruptcies are common”. On the other hand, McKenzie (2000, p.74) argues that “deregulation, the removal of protection and the rapid integration of the country into a global economy, have been seen as the only mechanisms that could maintain prosperity and quality of life”. In many areas though, this has not resulted. As Lawrence (2000, p.422) explains, “since the early 1980s, budgetary pressures and anti-intervention policies have led to a withdrawal of most of the substantial state support once enjoyed by rural producers”. According to Robinson (1990,

p.137), this has resulted in “the polarisation of farm businesses by various forms of agrarian change, involving the size of holding, capitalisation, the labour force and the type of farming (also see McMichael & Lawrence 2001).

These changes can be considered under the umbrella heading of “restructuring”. Policy is now guided by economic rationalism or, the term preferred by Higgins (1998), neo-liberalism, advocating limited government interference in the rural economy (also see Hallebone et al 2000). Stehlik et al (1999, p.24) argue that “for neo-liberalists, social arrangements are seen to flow logically and advantageously from the market. It is inefficient to prop up producers who are not economically viable, nor is it desirable to seek to ‘save’ country town whose economies are in decline”. There is a domino-effect of diminishing sustainability.

However, the perceived “market freedom” that has been introduced through economic rationalism has, in many cases, had the opposite effect. It has facilitated the expansion of corporate agribusinesses (Rolley & Humphreys 2000, p.244). Lawrence, (cited in Lockie 2001, p.24), argues that “control over the agricultural production process was shifting away from farmers and toward agribusiness — the collection of firms who supplied farm inputs and bought, processed, distributed and retailed farm outputs”. These big businesses often have greater access to funding and new technology and farmers have been forced to become more self-reliant and resourceful to remain viable (Gray et al 1995, p.54). Lawrence and Gray (2000, p.44) point out that “this gives agribusiness great influence over the practice of farming and renders the concept of ‘self-reliance’ as meaningless in every way except mythology”. Napier (2002, p.6) points out that “globalisation and the rise of transnational companies combined with communication and transport revolutions have increased competition. Transnational companies can ‘shop’ anywhere in the world on any given day so

inefficient businesses have nowhere to hide". Accordingly, Morse (2002, p.5) maintains that "the profitability gap between small farms and large is ballooning as bigger farms reap the benefits of economies of scale. It is farmers with higher profitability that are expanding their business, while those who are treading water are selling up" (also see Lawrence 1987, Connell et al 1996).

Rural debt has increased substantially over the last few decades.⁶ Connell et al (1996, p.404) reported that the average national farm debt in the period between 1978 and 1995 increased by 48%. In response to the financial difficulties being experienced by Queensland farmers, a statutory body, the Queensland Rural Adjustment Authority (QRAA), was established in 1994. The prime function of the QRAA (2000, p.2) is to "administer a range of Commonwealth and State Government schemes of assistance, skills enhancement, industry restructuring and other specific purpose programs. The QRAA aims to encourage the development of a more resilient and self-reliant rural sector in the face of international competition, structural change and seasonal variation". The Authority also reports on rural debt in Queensland. The figures released by the QRAA in 2000 (2000, p.8) showed that "primary producers in Queensland had increased their level of debt by \$586.6 million over the previous 12 months (1999-2000), representing an increase of 11.1%". Moreover, in a Rural Debt Survey in 2003 (QRAA 2003), it was reported that rural debt in Queensland had increased by \$1.043 billion, or a 16% increase from the same survey in 2001. In this climate, many farm debtors are having difficulty meeting repayments of loans, which can add to the financial and personal pressure experienced. There is a documented link between financial stresses and mental health problems for rural people (see Armstrong & Schulman 1990, Belyea & Labao 1990, Ortega et al 1994,

⁶ Rural debt can be defined as "the total indebtedness of all farmers/rural enterprises throughout Queensland, where the servicing of the rural debt relies primarily on farm-generated income" (QRAA 2003).

Stehlik et al 1999, Alston & Kent 2004). Farm poverty is also an outcome of these financial difficulties (Lawrence 1987, p.46).

Moreover, when faced with mounting financial and personal problems, many are forced to leave the industry (Higgins 2001, p.178). This may lead to a feeling of abandonment in the bush and an estrangement from the government (Rees & Fischer 2002, p.202-204). Reithmuller (1998, p.2) points out that “the reduced importance of agriculture to the economy means that its representatives are finding it increasingly difficult to influence government on policy issues or to argue for special treatment from the government”. Hence, rural areas may feel even more alienated. As Rolley and Humphreys (1993, p.256) argue, “at present, policies based on economic rationalism not only ignore the need for appropriate social programs to accompany economic changes but in fact threaten the very existence of rural communities and are detrimental to the long-term maintenance of rural environments”. According to Hallebone et al (2000, p.215), in the process of heavy funding cuts for health organisations and health-related services, “there was no discussion of issues of long-term sustainability for rural communities in policy frameworks”.

Small or family farms have been hard pressed to survive when faced with the competition from corporate agriculture. According to Burch et al (1992, p.274), “the farmer and the family farm are increasingly subordinate and dependent members of complex agribusiness corporations — organisations which have a national and international focus” (also see Lawrence 1987, Macgarvey 2003, p.187). Napier (2002, p.6) also argues that “small businesses such as family farms are under pressure in a competitive world dominated by big business. Family farms need to develop and use every advantage to achieve success”.

The restructuring of agriculture has led to what is best described as “detraditionalization” (Gray & Lawrence 2001). Traditions of social interaction based on cooperation and mutual support have been

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replaced by more competition. Stehlik et al (1999, p.27) argue that “detraditionalisation can be best understood as the dis-embedding of patterns of communal authority and customary practices by the intensification of, in particular, consumer culture — itself a product of globalising tendencies”. Lawrence (1999, p.193) explains that “approaches to farming, the significance of family, community obligations, and commitment to a ‘rural’ lifestyle have been called into question as structural changes have undermined the traditional values and lifestyle choices of farming in Australia”.

However, many farmers have been sustained by their belief in tradition. According to Gray (2001b, p.54), “as small farms have suffered the exigencies of climates and markets, so farm families have been sustained by a belief in their own nobility and the necessity of their work”. Rather than fold and resign their farm, many hang on to their lifestyles and have an emotional attachment to the land and culture of agriculture, as this is all they know; it is their identity (Lawrence 2000, p.40, Rowe 1997, Bryant 1992). However, as Gray (1995, p.68) concluded, “the concepts of rural ideology and ‘the farmers’ creed’ are no longer adequate for explaining the social conditions of farming”. Farmers are being forced to acknowledge and accommodate to the social and cultural changes that have occurred due to rural restructuring.

In spite of these difficulties, some farmers have responded well to the changes and adaptations have been made, such as obtaining off-farm work to subsidise the farm (see Gray 2001a, p.42, Rees & Fischer 2002, Stehlik 2003, Alston & Kent 2004). Some farmers have managed to extend their product base and diversified into more exotic crops such as olives, tropical fruits or kangaroo farming (Reithmuller 1998, p.18, Gray 2001a, p.55). Farm tourism is another example of versatility. In many cases, off-farm employment has been obtained to keep the farm viable. However, the downside of this, as Stehlik et al (1999, p.27) argue, is

that “off-farm work has also altered the capacity of people to engage in voluntary associations, increased stress in marital relations, and altered the social status of producers”.

The demographics of farming too are changing. Many young people are leaving the land and, as was found in the *Land & Water Australia Report* (2004) “people are farming longer into their later years as younger ones become less interested in taking over”. As a last resort, some farmers and farm families have been forced to sell their properties or amalgamate with others. Stehlik et al (1999, p.25) also point out that “in the ten years from 1985-86 to 1994-95, one in every twelve rural properties had disappeared (most were amalgamated with another or other properties in an effort to increase viability)”. Where this resulted in farmers moving to the city or becoming a hired labourer on a farm, there would be major problems of adjustment. Few farmers have lived experience of anything other than the farm. Stewart (2000, p.137) discusses the sacrifice involved and argues that “there is a cultural difference that city people and legislators need to understand: *a farm is more than just a business venture*; there is an emotional side to it”.

Many farmers abhor the idea of leaving the land to find work in another occupation. When discussing small, family based enterprises, Lawrence (1995, p.8) points out that “many are unable or unwilling to be retrained and will struggle to have their definition of farming accepted as legitimate”. Farmer (1986, p.59) argues that “the overwhelming identity as a farmer, in fact, no doubt accounts to why these people persist in agriculture despite deepening debt: they cannot contemplate not being farmers”. The stress is compounded by the enormity of this decision (Stehlik 1999, p.64). Grief issues attached to losing the farm, as outlined on the *Better Health Channel* (2003), may include “loss of identity, loss of home, professional isolation, and feelings of guilt, failure and inadequacy”. In addition, Gray et al (1993, p. 16) argue that “leaving farming is not merely a career change. For those who have

inherited the farm, it involves loss of birthright, loss of social status and community contact, and loss of access to a satisfying career and quality of life". These "losses" can be overwhelming and impact directly on the mental health of affected rural people.

Loss of livelihood, lifestyle or tradition as a farmer or property owner also has identity implications. As Luck et al (2000, p.70) argue, "because a man's identity is so dependent on his job and status in the world outside the family, if the farm goes, the blow may be so severe that he will commit suicide". This is a critical aspect of rural social identity and impacts directly on the mental health of farmers. Governments of all persuasions have attempted to address some of these problems, for example, through rural restructuring grants and adjustment schemes. However, they are unable to counter the emotional impact on farmers. According to Cheers (1998, p.54), "while we do have financial readjustment programs and financial counselling, we do not respond to the personal anguish and loss of identity which many feel when they lose their land".

Of significant importance in this time of financial crisis is the work of the Rural Financial Counselling Service. This service provides advice on budgeting, contracts and loan applications, information on government assistance schemes and Centrelink benefits, and also refers to other professional counselling services (Department of AFFA, 2001). The Rural Financial Counsellor travels to properties or provides assistance from an office in a rural centre. However, during the provision of their financial advice, Alston and Kent (2004, p.xiv) argue that "these workers also find themselves called on for social and emotional counselling, tasks for which they are inadequately trained". Although they may not be specifically trained, they have an intimate understanding of the pressures facing farmers and agricultural businesses and, therefore, may be in an opportune position to act as a referral mechanism for mental health services. This will be taken up further in the Ruraltown

study (Chapter 8). The problems facing farmers are complicated and multi-faceted. As Gray and Lawrence (1996, p.186) conclude, “social and welfare workers and rural counsellors should be made aware that the taking of off-farm work as well as the increased self-exploitation of family members in farm work, will bring greater stress and, potentially through family tensions, the destruction of personal relationships and the breakup of farms which families are striving to nurture and preserve”.

Decline in social capital

The recent political, economic and social changes in the bush have negatively affected community and voluntary organisations. Many people in rural communities are too busy or disinclined to partake in traditional social networks such as rural groups, clubs and sporting organisations due to increasing personal obligations. These agencies are a sample of what can be referred to as “social capital”. Social capital, as defined in an ABS discussion paper (2000), “related to the resources available within communities as a consequence of networks of mutual support, reciprocity, trust and obligation”. The participation of community members in social networks such as local activities, events and voluntary organisations is often the “glue” that holds some rural communities together. Castle (2002, p.335) argues that “in the absence of social capital, producers and consumers at the micro level need consider only independent preference functions”. However, this is usually not out of selfishness or lack of community interest but rather necessity for survival. As Stehlik (2003, p.103) points out, “many (people) identified the drought as the major reason why they no longer participated as much in such activities that could not be directly associated with farm production”. Recent factors which have limited community capability to develop social capital, as argued in the “Valuing Rural Communities” Discussion Paper (1998, p.24), included “loss of population, particularly among professional people, and the

need for off-farm income has meant farming families are unable to contribute to local activities and organisations". The ingredients for building social capital and sustainable communities are being lost.

Social bonds have also eroded due to the current pressures being experienced. Portes (as cited in Morrow 2001, p.4) argues that "the concept of social capital stands for the ability of actors (individuals, groups) to secure benefits by virtue of membership in social networks and other social structures" (also see Cullen 2001, p.6). It is a positive concept and is paramount to the maintenance of healthy communities. However, when faced with all the challenges outlined above, rural communities struggle to maintain their social ties and traditions. As Stehlik et al (1999, p.26) argue, "social capital is believed to have deteriorated, severely limiting the ability of communities to do the very things expected of them by neo-liberalism — that is, to be resourceful, 'self-reliant', and to provide the intellectual wherewithal to catalyse their own future growth" (also see Alston & Kent 2004, p.101). Social capital is a useful concept but has not been systematically analysed here.

Unemployment

The economic downturn of rural industries, combined with climatic factors, has led to unemployment, an increase in rural poverty, and a loss of identity and self-esteem in bush people (Wolfenden 1996). Many have been forced off the land into the towns to seek alternate employment, yet there are few jobs to be found. Rural towns are feeling the pressure too. As Lawrence (1987, p.49) argues, "the combination of the narrow economic base of most country towns and the population movement out of agriculture has served to reduce work opportunities for the entire rural population". Unemployment is high in most rural centres. The Human Rights Commissioner, Chris Sidoti, commented in an interview (Wise 1998) that there are two broad categories of concern in rural areas: "firstly, the rate of change is so fast it has become a

cliché — and yet no one is looking at the consequences of change. Secondly, related to that, services are being withdrawn without any account of the human consequences”.

Due to decreased demand and lower incomes, rural businesses have also been experiencing considerable hardship as a result of the drought. However, Cheers (1998, p.114) argues that the procedures in granting the Exceptional Circumstances Relief Payment are discriminatory and points out that “it is not available to rural private enterprises other than farmers. These can be equally affected by natural hazards”. Lavelle (2003, p.2) also explains that “it’s not just farmers who are affected when demand for rural goods drops. Before long, banks, accountants, retail stores, and health professionals shut up shop. This has a further flow-on effect, causing other members of the community to leave in a downward-spiralling cycle sometimes called the ‘sick town syndrome’”. Considering the social structure of “the rural”, it is not only farmers and farm families who are affected by unemployment. There are numerous other groups who need to be considered: labourers, railway workers, machinery suppliers, mechanics, shops, and bureaucrats in “the rural”. It has been argued that lack of control over the socio-economic environment (through unemployment and other factors) can have a direct affect on a person’s emotional health and well-being (see Malko 1993, p.78, Lawrence 1987, p.53, Alston & Kent 2004). This is particularly relevant to rural areas.

In some cases, however, people on the land may find they are not entitled to social security payments such as unemployment benefits because of their ownership of farm assets. Bryant (1992, p.162) states that “the formula for assets testing is based on an urban notion of a reasonable asset limit and debt structure and thereby can exclude members of farm families in financial need”. Further to this, a report by Healthsharing Women (1994, p.92) argues that “because they are often ‘assets-rich’, poverty for farmers is different from poverty for many

urban dwellers. Crucially, their assets make them ineligible for unemployment benefits, but off-farm work is difficult or impossible to find in depressed rural areas". These financial difficulties can exacerbate an already depressing situation.

Unemployment and financial problems also have social and emotional consequences. As the manager of Anglicare in the Ruraltown study (Chapter 7 & 8) stated, "there are a lot of angry and resentful people in Ruraltown. I think some of it is to do with unemployment and financial issues, and general coping issues with family and life generally". The increase in unemployment in some rural areas has been accompanied by an increase in crime. Law enforcement agencies in rural areas also need to be given adequate resources and education when dealing with the unique circumstances of rural areas. Cumes (2000, p.45) maintains that this is already taking place and argues that "perhaps the most outstanding feature of mental health as it is practiced in rural and remote regions is that policy, practice and law have recognised the need to adapt, and be appropriate to, the actual conditions of life in these regions". However, as evidenced in the Ruraltown study, law enforcement agencies, especially the police, still encounter difficulties due to the lack of knowledge, resources and support.

Demographic changes

Due to the reduced employment opportunities in rural areas, there has been a significant demographic shift. Many young rural people move to larger towns to find employment or further their education. Hence, the profile of the rural population is changing and aging (Argent & Rolley 2000, p.145-146, Thomas 1994, p.101). According to Stehlik et al (1999, p.25), the rationalisation of private services has resulted in government withdrawing or closing services and people are leaving country towns. Hallebone et al (2003) discuss how a declining population in one rural community led to the downgrading of the

secondary school which, in turn, led to further population loss. They (Hallebone et al 2003, p.231) argue that “loss of families has meant a shift in demographic profile of the community and fewer young people staying in the community for their secondary education”.

This also reduces the attraction of newcomers to the community. Hallebone et al (2000, p.227) stated that, in their study, “the towns became unattractive to potential new families, since there was a perception (and reality) of declining services. According to Lavelle (2003, p.1), “State and federal governments are less ready to put health services into areas where the population is declining. And the people in these areas have less money to pay for the services than they once did”. There may be a domino effect of a loss of professional expertise as a result. And then, as Stehlik et al (1999, p.26) point out, “rural regions, unable to provide the necessary leadership or economic enterprise might then be labelled as ‘backward’, not because of any intrinsic backwardness, but because the state has seen fit to remove some of the very people whose social capital might have contributed to regional economic growth”. The loss and pressure continues to grow.

Government withdrawal of services

In recent years, many services, including banks, post offices and government services have been transferred to larger regional centres (Argent & Rolley 2000, Stehlik et al 1999, Alston & Kent 2004). Bank closures have a significant impact on rural communities. Generally, if a bank is lost, other businesses follow and there is further service withdrawal (Tonts 2000). This can have a psychological impact through a sense of deprivation. As Hallebone et al (2000, p.223) discovered, “the withdrawal of the major bank, after residents had been assured that it was not pulling out but simply cutting hours, was seen as a breach of trust, and had resulted in distrust within the community”. The presence of a bank in a country town can be a symbol of security, identity and

prosperity to people, and the withdrawal of this service may compound the feeling of abandonment. According to Argent and Rolley (2000, p.142), “bank closures not only lead to local employment loss and increased local costs in accessing face to face financial services, but also represent to local people the perceived non-viability of their town” (also see Share et al 2000, Gray & Lawrence 2001a).

Rural bank losses have also attracted political debate. The announcement (April 2002) of the impending closure of fifty-six branches of the National Australia Bank (NAB), including seven from rural Queensland, invoked anger and resentment in many rural areas. The Federal Minister for Agriculture, Warren Truss, in an article in the *Queensland Country Life* (11th April 2002, p. 4), adopted the social obligation stance regarding the NAB situation and rather passionately stated that “the National Australia Bank was built on the sheep’s back, and rural Australia has been very good to it over the years. It is time they repaid some of that loyalty”. In the same publication (*QCL* 11th April 2002, p. 4), Liberal senator Ian MacDonald pointed out that “it can’t call itself a National bank if it only provides services to metropolitan areas. It should be called Capital City Bank”.

This theme was also expressed at the local level, in the Ruraltown community (Chapter 8). The heavy-handedness of some banks was raised by a local councilor. In addition to the lack of urban understanding of rural problems, she stated that “banks often foreclose on properties in rural areas without any verbal discussion or alternatives offered”. In a Queensland “needs analysis” (Seabrook 1994, p.410) survey of graziers, conducted in 1993 to identify current issues of concern and perceived prospects for the future, the negative portrayal of banks and agents was a common theme. Park (1994) discusses the communication problems between financial institutions and farmers. He (Park 1994, p.406) believes that “many farmers are reluctant to talk to their financiers about their difficulties and, at the same time,

financial institutions are slow to explain to customers policies such as the application of penalty rates or the high cost of restructuring loans. The responsibility for this poor communication must be shared by both the bankers and the farmers". In the study by Gray et al (1993, p.49), it was discovered that "those in particularly difficult financial situations tended to offer 'bank warning' (of overdue payment, bank overdraft etc), rather than 'low prices' as their most difficult event". According to Stewart (1998, p.139), "the thug tactics implemented by banks are abhorrent; they are professionally trained to intimidate honest, hardworking people using what can only be described as psychological warfare tactics to put a "guilt trip" on farmers that they are a failure so as to induce them to go quietly and not fight". As stated above, it is well documented that the financial pressure that many farmers and rural businesses are under has a direct impact on their mental health.⁷

The Queensland Primary Industries and Rural Communities Minister, Henry Palaszczuk addressed the need for banks to be more understanding of rural needs in a *Queensland Government Media Statement* (12th June 2002) after a Reserve Bank Board Meeting, held in Melbourne in May 2002. Palaszczuk invited the Board of the Reserve Bank of Australia (RBA) to hold one of its eleven monthly meetings in a rural community. It has never met in a rural or regional community and it last met in Brisbane in 1993. Palaszczuk stated that "in the past, the Reserve Bank has been accused of using an economic barometer more attuned to the conditions of Sydney or Melbourne, but it also has to

⁷ Reithmuller (1998) also discusses the tactics used by banks and suggests that there may sometimes be deception or misinformation involved. She uses the example of Swiss francs loans made to some farmers in the mid-1980s. Banks made these loans to farmers as they had lower rates of interest. However, there was a rapid depreciation of the Australian dollar in 1985. As a result, many farmers who had taken out Swiss franc loans were unable to repay their loans. Reithmuller (1998, p.19) argues that the farmers did not fully understand the risks associated with such a loan and that "it is unlikely that such a situation could have arisen in a large regional branch". The ABC televised a docu-drama of this apparent breach of conduct by rural banks in the production of "The Farm" (2000). This series outlined the trauma caused by the financial losses, the resulting bankruptcies and, in one known case, suicide. Clearly, bank tactics, closures and foreclosures have rejuvenated and given new emphasis to the old argument of urban hegemony and over rural stability.

take into account the developments in rural and regional Australia". He then suggested that the meeting be held in a Queensland community, considering the drought conditions in many parts of the State"

(*Queensland Media Statement* 12th June 2002). Palaszczyk also recommended that the bank needed to become more attuned to the economic conditions of rural Australia. The Governor of the RBA, Ian Macfarlane, responded by offering to consider the invitation. This first request was in May 2002. Eighteen months later, in a Media Statement issued on 12th November 2003, Palaszczyk again repeated his call for the RBA to meet in rural Queensland. Palaszczyk concluded that "the Reserve Bank is right to consider the farm sector before making any decisions on interest rates, but I urge it – before its 2nd December meeting - to appreciate that the drought has not yet broken" (*Queensland media statement* 12th November 2003). At the time of writing (June 2004), the Reserve Bank has still not met in rural Queensland.

Improved communications

Improved communications and the Internet also have had an impact on rural areas. There has been a reduced need for many small local businesses as orders can be placed and paid for via the Internet and then delivered, bypassing the need to even go into town (Reithmuller 1998, p.18). Sorensen was cited in an article published in the *Rural Australia: Towards 2000 Conference Proceedings* (Doyle 1998, p.98) as stating that "the Internet has the potential to devastate businesses in many small rural communities as those in major regional centres could use it to steal trade away from rural retailers". The Internet allows access to goods and services, anywhere, anytime. The decreased demand for local goods, combined with the reduction in population, could then lead to a further withdrawal of services. According to Sorensen (1998, p.100), the social downside to the Internet in rural areas may be expressed through less reliance on the local community

for ideas, information, education and entertainment. Bourke (2001c, p.126) maintains that "...information technology and increased/faster transportation has changed social networks, markets and local businesses".

Despite the negative consequences of Internet technology for some rural people, it also has some beneficial social aspects. The use of email and the Internet has improved access to social networks and information that may have previously been unavailable to rural areas. According to Stehlik et al (1999, p.30), "the introduction of new satellite, computer and other technologies has the potential to bring rural society closer to metropolitan Australia in terms of tastes, values, and social and economic expectations". Isolation for many women, for example, can be reduced considerably through email contact with others in discussion groups such as the Queensland Rural Women's Network (QRWN). 'Welink' is another mailing list that aims at linking urban and rural women. As stated on the Women's Infolink Infosheet (No.14, 1999), "women in rural and remote parts of Queensland who participate in 'Welink' say that it has been useful in breaking down their sense of isolation". Moreover, according to Haslam-McKenzie (2003b, p.138), "not only did it (emailing) provide social support and 'virtual friendship' and made networking for rural women's groups more effective, it also facilitated improvements in family and community businesses". During the drought of the 1990s, as outlined by Stehlik et al (2003, p.96), "for many families, turning to sophisticated farm management approaches using information technology enabled them to better manage their resources, and this in turn enabled more strategic planning for farm production".

There are social and educative advantages of information technology. However, it is still not a widely used resource. As Nissen (2004, p.201) reports, "a 2001 ABS study revealed that small country town use of home computers (32% compared to 42% nationally) and the Internet

(25% compared with 37% nationally) was well below the national average". Telemedicine is also an innovative technology that is being trialled in many rural areas but, as will be demonstrated in the Ruraltown study, its use has also been problematic.

Environmental changes

In the last couple of decades, Australian government has begun addressing environmental degradation in rural areas (Share et al 2000, Lockie 2001). Lawrence (1995) notes that environmental problems such as soil degradation, salinisation, waterlogging, pollution of river systems, threats to wildlife are among the environmental problems associated with farming. He (Lawrence 1995, p.3) argues that "these problems result directly from the practices which farmers have adopted in an effort to remain competitive in the international trade arena". Share et al (2000, p.421) argue that "farmers overcrop, overgraze, and overuse chemicals, not out of greed but for economic preservation in times of stagnant or falling commodity prices". It has been recognised that this cannot continue and extensive land and water degradation has led to the development of a number of environmental initiatives.

The Landcare Program has attempted to address these issues. Lockie (1999, p.219) points out that "the term 'landcare' is used in Australia to describe everything from a specific government program — the National Landcare Program — to a land ethic, a set of land management practices, an extension program, or just simply 'caring for the land' ". The major aim of the National Landcare Program is to promote agricultural sustainability by linking conservation to production, in a cooperative and coordinated manner (see Cooney 1998, p.14). According to Lockie, (2001, p.243), "Landcare is credited with not only doing something positive about rural land and water degradation, but also with doing much to revitalise rural communities and economies along the way". Landcare meetings also have a social function. As Stehlik et

al (1999, p.89) found in their study, "Landcare meetings emerged as one of the principle ways in which people were still able to 'get together' socially".

The necessity to comply with sustainable measures may have presented many farmers with an ethical dilemma as well as an economic problem: preservation of self or environment? Vanclay (1992, p.94) points out that "no matter how environmentally aware these farmers may be, if they don't have the capital to outlay, or are prevented from borrowing further, they can't undertake any adoption of soil conservation strategies that involve additional spending". Lawrence (2001, p.146) concurs, stating that "the 'struggling' farmers are often aware of how they can alter production to reduce environmental degradation, but sometimes this requires substantial investment which may not be possible". However, to achieve environmental sustainability, changes need to be made on a global level and Australian farmers are no exception. As Lockie (2001, p.229) concludes, "environmental sustainability includes the ability of current generations to meet their needs and aspirations without compromising the ability of future generations to do the same thing". Stern and McClintock (1999, p.21) recognise the pressure on farmers and maintain that, in addition to environmental concerns, they have to contend with economic pressures and changing social relationships. In these changing environmental circumstances, farmers may feel a sense of guilt, self-doubt and pressure to change practices, which in turn could compound their stress to comply with sustainable measures.

This section has provided an overview of some of the more significant changes in rural communities in recent years. Obviously, the social changes have been significant. The impact they have had on identity, lifestyle and relationships in the bush is evidenced in the current climate of decline. Rural towns are under considerable pressure to "prop up" their community, both economically and socially. With rural

restructuring, many vital services have been withdrawn from rural communities such as banks, schools, hospitals and post-offices. This has led to further closure of businesses, increased unemployment, limited career or educational opportunities, poverty, welfare dependence and isolation. Pritchard (2000, p.49) concludes that “in an era of burgeoning agricultural surpluses, continuing low prices, environmental degradation, farmer stress and rural protest, new approaches to resource management, new ways of thinking about production, and new options for a sustainable future remain in very short supply”. These circumstances have led to a growing resentment in rural areas for, as Darlington (1997, p.78) argues, “rural Australia produces a disproportionately large share of the nation’s wealth and assets, yet receives a disproportionately low share of the benefits”.

In conclusion, the weight of these changes has precipitated the need to review current practices. As Herbert-Cheshire and Lawrence (2003, p.12) suggest, “arguments about the need to sustain rural community life should not be based upon an unrealistic or romantic vision about the “good old days” of rural living, or even a desire to preserve an existing way of life. Instead, a range of processes are needed that seek to enhance the economic, social and environmental well-being of present and future generations of rural Australians”. The dilemma now to be confronted, in light of these pressures, is how to encourage rural people to recognise and treat mental health issues before they become overwhelming? If this is not addressed they will, at best, be struggling, and at worst, suicidal.

GENDER ISSUES IN THE BUSH

*Through Australia’s heart, you’ll find her.
 She’ll be fit and very tanned.
 Every wrinkle tells its story,
 on the daughters of the land.
 Through the bushfires and the windstorms,*

*and the droughts and flooding rains
She'll be there when hearts are broken,
picking up the pieces again.*

*(Excerpt from "Daughters of the Land",
Marie Dennis, cited in "The Country Web", 2001, p. 25)*

Gender issues in the bush have gained attention in recent years. In the past, the use of the category of gender as an analytical category was not widely circulated or accepted in the bush and any action to challenge male hegemony was met with great resistance. As Alston (1994b, p.26) points out, "hostility towards men is unacceptable in a system that depends on a high degree of cooperation". This is a major impediment to the circulation of feminist ideas in the bush. Many men and women fail to recognise feminism as a legitimate cause and do not want to relinquish any control over their social environment. According to Colling (1992, p.36), "the issues raised by the feminist movement demanded self-criticism, examination of feelings, and a lot of other non-logic-based things that men had, traditionally, little stomach for. They weren't used to examining their feelings and motives, particularly in front of women: it made them too vulnerable".

Some bush women also prefer to adhere to customary sex roles to maintain harmony in the home and town. According to Alston (1995a, p.150), "to challenge cultural norms and historical processes is to invite conflict within their family and censure within the community". Acceptance and maintenance of the status quo is often more desirable, especially for older women. That is not to say that women are the "victims" of patriarchy as they have an integral role in the effective operation of the farm and the domestic sphere. However, their power may be limited due to patriarchal relations. The experience of rural women will be addressed in this chapter to highlight their contribution to rural Australia and also to draw attention to their persisting

subordinate status in bush communities, and limited representation in the rural political arena (see Alston 1995a, Alston 2003, Rowe 1997).

To understand how these gender roles have been constructed and institutionalised, a brief account will be given of the position of bush men and women in contemporary Australia. In the past, men have been represented as holding the positions of power and dominance in rural areas. Campbell and Bell (2000, p 544) argue that “one characteristic of power is the way in which it becomes natural, normal, unquestioned and unacknowledged — in other words, invisible — and men and women are differentially empowered in rural society”. Male hegemony has been more or less taken for granted in rural areas in the past. Following is a brief summary of the construction of female roles in rural areas

Historical and contemporary accounts of rural women

Historically, Australian bush women mostly have been depicted in a trivial or powerless way, if considered at all (see Chapter 2). As discussed earlier, there were many women who were forced into dependence and the acceptance of their secondary position was due to their powerlessness to challenge the status quo. However, there were also women who spent long periods alone and coped with situations of extreme hardship. History is replete with the stories of women who were successful and independent in their own right. Corrective histories about such women (Summers 1975, Schaffer 1988, Lake 1986, Dixon 1999, Alston 1995a, 1995b & 1995c) testify to these examples, thus challenging the diminutive identity of bush women. However, they are not widely circulated or mainstream depictions. Women’s actual experience of bush life presents a vastly different picture to popular knowledge. This is both a historical and contemporary reality and is evidenced in the literature of the past and their representation in the present (Schaffer 1988, Alston 1995a, Matthews 1984, Dixon 1999,

Hunter & Riney-Kehrberg 2002). As Alston (1995a, p.2) argues, “the devaluing of women and their contributions to agriculture has been a constant feature of our history”. Female subordination, in perception and practice, persists in the bush today, despite the continued self-reliance of many women. Campbell and Bell (2000, p.40) point out that “the farmer is commonly constructed as a ‘he’, although women’s labour is central in most agricultural production. Here masculinity is a marked category within rurality that promotes the invisibility of women”.

In addition, the historical experience of rural women has been different from their urban counterparts. As Ching (1997, p.3) argues, “some fail to acknowledge that a rural woman’s experience of gender inequality may be quite different from that of an urban woman” (Also see Haslam-McKenzie 1997, p.27). Gender expectations and responsibilities for rural women are different to their urban sisters. It can be argued that rural women’s work is also undervalued in urban society, and this is reflected in the fact that there had been no statistics collected regarding women’s work in agriculture until the mid-1990s (Broad 1998, p.61, Gooday 1995, p.33, Alston 1998b & 2003).

Rural women’s roles

The lifestyle choices for rural women have been relatively limited in the past. It can be argued that their circumstances have mostly been of financial dependence, limited career options, household duties, childcare and educative responsibilities, maintenance of the family unit, isolation, and the provision of emotional support for children and husbands. These are unpaid responsibilities, therefore, forcing women into a relatively powerless situation. This point is argued in the National Plan for Women in Agriculture and Resource Management, “A Vision for Change” (1998, p.4): “women’s contributions are often undervalued, if valued at all, because so much of their work is ‘invisible’ — unpaid and simply expected as part of their roles as mothers, wives and partners”

(Also see Whittenbury 2003, Alston 1995a, 1995b & 1995c, 1998a & b). However, women's contributions have significantly increased with the economic recession in rural areas. Many women have taken on farmhand and livestock responsibilities to reduce financial burden. It was reported in Fuller et al's study (2000, p.151) that "for many women, they are required to be the teacher, the cook and the bottle washer, the orderer of stuff, the bookkeeper, the community supporter, the wife and usually the boss's offside as well".

The responsibilities of rural women can be very demanding. According to Alston (1995a, p.6), "for many farm women, they may find themselves performing a triple shift as they balance domestic tasks, farm work and off-farm work". A woman in this study also raised the notion of a 'triple shift' in a questionnaire from the QRWN Conference in October 2002. The respondent stated that "there is constant uncertainty for women in rural areas; they have to be there for everyone – the 'triple shift'".

Another repercussion of their "domestic" status is that a great deal of women's work remains concealed or not public. Macgarvey and O'Toole (2003, p.186) note that "in local townships, women's experience of 'invisibility' has resulted in two overriding axes of power, namely men's material power and the economic dependence of women; and the ideology of gender which defines men's activities as superior to women's". Financial dependence on husbands and partners often limits women's ability to elevate their status. As Dempsey (1994, p.49) argues, "unless women can substantially increase their economic power, men will, as the providers, continue to retain the power to delegate to their wives as much of the domestic labour and childcare as they choose".

In the present economic environment of rural areas, it has been necessary for some rural women to obtain off-farm employment. Kennedy (2003, p.184) states that "off-farm work by women now contributes about \$1.1 billion a year to the overall viability of farming

enterprises". However, though they may receive a pay packet for the work they do, it does not necessarily give these women economic freedom. The money earned usually goes toward supplementing the farm income and household expenses. Haslam McKenzie (2003a, p.57) argues that "women are committed to the survival of the farm, and to the maintenance of their husband's mental well-being. Their off-farm work, far from representing a distancing from the farm business, represents a strategy to ensure its survival" (also see Alston 1995a, p.95, Stehlik et al 1999, p.56). Through this employment, Alston (1998b, p.30) maintains that "women are simply adding to their already extensive workload in order to subsidise the farm without any commensurate change in the power balance and with little realignment of patriarchal gender relations".

In spite of this, off-farm work is often a willing and empowering financial contribution for these women. In turn though, there may be negative repercussions for marital relationships. As Noonan (1995, p.4) discovered in her study, "some farmers, especially the older men, have trouble coping with, and feel ashamed, that their wives are going out to work to keep the family and the farm going". Kennedy (2003, p.182) also maintains that "the trend towards off-farm work has strained many traditional husband-and-wife partnerships...". As discussed in the next chapter, pride is a crucial factor of bush male identity and women may bear the brunt of their frustration. Jennings and Stehlik (2000, p.75) argue that "... in moving into off-farm paid work, farm women experience increased workloads, as well as relationship and family conflicts, as they challenge the dominant patriarchal hegemony which had previously kept them primarily relegated to the domestic sphere and under-recognised in the 'public' sphere of off-farm work". Despite increasing workloads, bush women's lives are still often viewed as an adjunct to male endeavours. According to Whittenbury (2003, p.150), "women are perceived in their family location, are deemed responsible

for family and household tasks, and where they undertake paid work, their income is perceived as secondary to the male's 'primary' income".

Women are generally responsible for providing a number of volunteer services in rural areas that would otherwise be filled by paid employees or simply not done. Rowe (1997, p.41) argues that "rural women's voluntary work supplements the social infrastructure. It is the very glue of rural communities, particularly in these times of contracting government and private services". However, as Rickson and Daniels (1999, p.243) argue, "one area of commitments or activities that may be reduced as the need for on-farm labor of farm family members increases is membership in voluntary organizations, be they private, social, community, or industry based" (Also see Alston & Kent 2004). Additionally, Alston (1998b, p.27) points out that volunteer work is generally not recorded as work and argues that "there is no record of these voluntary contributions that may compensate for lack of service provision and make an indirect economic contribution to farming communities". This is another example of the invisibility of women's work.

Gender and feminism

The use of the category of "gender" as an analytical basis has been perceived as a threat in the bush and any action to challenge male hegemony has been met with great resistance. Women who vocalise their discontent or threaten traditional values and norms could risk community estrangement or rejection. This is one reason that feminism is not a readily endorsed concept in many contemporary bush communities, by both women and men. According to Alston (1995a, p.26), "feminism is seen as very threatening because it seeks to limit farm women's traditional sources of power and provides no obvious gains in exchange". The tradition of conservatism is an essential component of their social identity and also a common rural stereotype.

Some bush women prefer to adhere to conservative sex roles to maintain harmony in the family and community, and retain authority in the private sphere. As Dempsey (1992a, p.258) found in his study: "it appeared that surrendering control in the domestic sphere was tantamount to surrendering a portion of a woman's identity as a wife and mother". Another barrier for feminism in rural areas is that it is urbo-centric. Haslam-McKenzie (1997, p.25) argues that "the parameters that describe urban feminism are not realistic benchmarks by which to delineate rural feminism". This urban bias of feminism has served to further alienate many farm women (Alston 1994b, p.26).

That is not to say that rural women have no control over their lives. Their domain tends to be the home and how it is run, and some prefer their domestic control to more public power. Gender identity is sidelined in preference of family responsibilities (Alston 1995a, p.27). There are many women who want change but, as Hogan (1994, p.34) points out, they do not want to associate with the contexts of gender and feminism. Acceptance and maintenance of the status quo is often an easier option. As Alston (1995a, p.150) argues, "to challenge cultural norms and historical processes is to invite conflict within their family and censure within the community". Poiner (1990, p.131) also argues that "many women have for years assented to this (dependent) position and even been active agents in reproducing the circumstances for future dependence".

However, there are small groups of mostly younger women who are contesting traditional roles and are willing to risk public disapproval to support feminism and equal rights. As Warner-Smith and Brown (2002, p.47) argue, "younger women are more likely to see themselves as businesswomen whereas their mothers took it for granted that they would be the 'gofer' of 'offsider' on the farm". In effect, there is possibly the beginning of a new social identity for women in the bush, which may redefine gender relations and alter conventional male hegemony.

For this to continue, however, Alston (1994b, p.29) points out that rural women need to be aware that feminism does not threaten their private power but argues for increased representation in the public arena and more control over resources. Public visibility and recognition is what is long overdue.

Challenging gender roles in the bush is a difficult task. As Briskman (1999, p.8) argues, “despite the changing nature of women’s participation in rural areas and exposure of rural women to feminist aspirations, overt and covert pressures to ensure that sexism and discrimination on the grounds of sex are more difficult barriers for rural women to confront than they are for their urban counterparts”. Dempsey (1992b, p.273) argued a similar point: “men have not only maintained their dominance of the structures and institutions of Australian society but also their cultural hegemony”. Saugeres (2002) had similar findings in her rural study of Southern France. She (Saugeres 2002, p.384) argues that “there were several single women, the majority of which were widowed, who were in charge of their farms, and in spite of an increasing number of farmers’ wives working off-farm, many still worked on the farm. But because farming is defined as a masculine sphere of activity, male farmers see the work that women do as being secondary to theirs”.

A recurring theme on the QRWN Website over the last few years of this research is that of rural women being shown little or no respect by agricultural agents, bank managers or salesmen. Usually such principals ask to speak to the “boss” if a woman answers the phone, or infer that the woman would not understand the nature of the business. One respondent on the Website discusses the tired assumption that a woman is “just a farmer’s wife” (qrwn-l@usq.edu.au, 2003). She recounted the story that she and her husband were equal partners on a sugarcane farm in Queensland and, as he was recovering from an operation, running the farm became her sole responsibility for a period.

Due to their change in circumstances, the female farmer decided to seek income protection cover for herself in the case of an emergency. She was appalled to hear the reply from the insurance company, via the bank: "because this lady is a farmer's wife, income protection is not necessary and does not warrant covering. The wife is in business as a tax purpose only and the wife does not exert enough for the farm". This particular woman received overwhelming support from other women on the Website who have experienced similar sexist treatment from male-orientated businesses. It is these belittling and insulting conjectures that are increasingly frustrating for farmwomen who are every bit as worthy, and sometimes more knowledgeable, than their male counterparts in business. Alston (1994b) also discusses the frustration of some farmwomen who are treated disparagingly by agricultural principals. She (Alston 1994, p.27) argues that "even if she is a partner, or if she works full-time on the farm, a farm woman will usually be treated as irrelevant by significant people off-farm eg. bank managers, salesmen or agents" (also see Alston 1998b, p.29).⁸

Farm inheritance and family farming

Women's place in the family-farming scenario can also be confining. According to Alston (1995a, p.7), "one of the most striking elements of

⁸ Interestingly, this experience of Australian rural women is repeated overseas. A Wisconsin farm woman (Kavazanjian 2000: 1), reported on the web in her paper entitled "Women aren't equal ... in how we are treated by agribusiness", these same concerns on Agriculture Online in the United States. She states that "during the past 15 years as the female farm partner, I've been ignored, insulted, humiliated, even propositioned by agricultural salesmen. It's easy to get mad, frustrated or depressed at the indignity but that won't change anything". Instead, she shares what she calls her short list of truths (or strategies) to deal with these situations: "she who answers the phone controls the message; she who writes the checks controls the cash outflow; she who mails the registration deserves top billing; and finally, she who has a loving supportive husband overcomes the gender inequities inherent in farming, uses them to her advantage, and even learns to laugh at them occasionally" (Kavazanjian 2000: 3). Another rural female farmer on the QRWN email list recounted the frustration at always being asked to speak to "the boss" on the phone, not only by men but women too. As she stated, "they don't believe that women would be able to run a farm on their own, or maybe they think women would have more brains than to do all the hard work herself." However, for some, it has become a bitter pill to swallow passively.

family farming is the practice of passing the farm from father to son (patrilineal inheritance), a practice which ensures that farms are owned and controlled by men and that women's most common point of entry into farming is through marriage" (Also see Poiner 1990). An informant in this research, currently in her fifties, discussed the economic "favouritism" her brothers received when she was growing up on a farm in Queensland. She stated that her brothers were sent to boarding school as that was considered a "better investment" than she and her sister going away to school. She also stated that, when her father died, the farm was left to her brothers to carry on the lineage. The sisters missed out on the assets and finance so that the family farm could continue under the management and ownership of the sons. Jennings and Stehlik (2000, p 73) maintain that "farm women are often marginalised due to their lack of financial stake in the property". Dempsey (1992b, p.136) also discusses the kinship system of "father to son" and argues that "the impact of gender discrimination by families organizing (or failing to organize) jobs for their children is most noticeable in farming". However, even if a woman does have ownership of land, it does not necessarily give her forgone power or respect either, as discussed above. It should be noted that this may be a near universal practice and not only confined to Australia.

Asset division in the case of divorce can also raise problems for many rural women, and some leave relationships empty-handed (Alston 1994, p. 27, 1995a, p.19). Anecdotally, there is evidence of this happening on more than a few occasions. Poiner (1990) also recognizes that women's lack of financial independence can be problematic when it comes to separation, divorce or domestic violence. Family-farm intergenerational situations can make these issues even more complicated. In a discussion on the QRWN email list (qrwn-l@usq.edu.au, 2004) about "In-laws in family business", it was argued that "if one of the men in the family decide to end a marriage, his wife, who is suddenly considered the daughter outlaw because she has become a threat to the wealth of

these men, can have a very difficult time trying to get any type of settlement from her former husband and the men in his family. Yet surely she deserves something for the years she supported her husband and the family business". According to Barnes (2000, p.8), "the persistence of the 'dreaded daughter-in-law' syndrome in rural areas remains a seat of family hostility because two generations are daily locked together in the family business" (also see Kennedy 2003).

The Queensland Women's Infolink has published an Infosheet (1999, No.16) discussing positive communication in extended family farming and other businesses. The Infosheet discusses strategies for women to "preserve the harmony of family relationships" and states that "positive communication is a real key to improved family and business relationships, so it is worthwhile investing some time and energy in learning more about communicating in different ways". Although it is not condoning the fact that women are often excluded from the decision-making process in family farming, it appears to be advocating their submissiveness in the process of family communication. Kilpatrick and Bell (2000, p.5) argue that "family-based expectations about gender and intergenerational roles and relationships do not always transfer into effective business roles and relationships". Women need to be respected and included as active members of the family farming team.

Succession planning and financial strategies in family farming have been the topics of many articles in the rural media (*QCL, Ruraltown Paper* and *Rural Weekly*) over the last few years. The Queensland Department of Primary Industries (1997) has also published an article entitled "Keeping Peace on the Farm: two generation farm families" with suggestions for reducing conflict and stress for farm families. Hopefully this attention will ameliorate the problems that rural women, and men, may encounter when dealing with such sensitive family issues.

Media representations of rural women

As was previously discussed, the historical representation of farm work has operated to reduce or hide a female presence and this persists in contemporary Australia. Alston (1995a, p.140) argues that “the structural arrangements that surround the business of farming have acted to confine women to a secondary position, to obscure the significance of their contributions and to silence their concerns”. Male-dominated arenas such as rural government agencies and the media have tended to mute their contribution. Media representation depicts rural women as relatively inconsequential and undervalued (Sheridan 1994, p.22). Bell and Pandey (1989) previously discovered this in their analysis of advertisements in *The Land*. Franklin (1994, p.6) argues that “there is a concerted need by country women to combat the inaccurate, stereotyped and demeaning portrayal of rural women in television advertisements and in the rural press”. Sheridan (1994, p.23) concurs: “a perusal of the ads contained in the rural press would lead one to believe that women play no part in farming activities at all — that farming is still a ‘man’s game’”. The images of the “rural man and woman”, to which not all conform, have been upheld and incorporated into gender identities in rural areas (Little 1997, p.155). Liepins (2000, p.615) concludes that “the potential for deconstructing these ‘truths’ and creating alternative knowledges rests predominantly with new women farmer’s groups and government structures that have moved slowly to support them”. As discussed in the last chapter, the television programme *McLeod’s Daughters* has presented a more contemporary image of bush women.

Women’s organisations

Women’s community organisations such as the Country Women’s Association (CWA), the Red Cross and church groups have been well established in rural areas since the early twentieth century,

campaigning for community resources or fundraising for local causes. They have been successful in obtaining a number of key services for rural areas such as infant welfare services and hospitals (Lynn 1999, p.16). These groups have also provided a social outlet for numerous isolated women. They are essentially conservative groups and this is evidenced through the CWA's original motto, published in each issue of their monthly magazine "The Queensland Countrywoman": "Honour to God, Loyalty to the throne, Service to the country, Through Country Women, For Country Women, By Country Women" (CWA magazine, 2001, p. 2). As Teather argues (1994, p.136), "as rural people regard themselves as the guardians of conservative values, so does the CWA".

On the CWA's agenda in Queensland in recent times has been to attract younger members to their ranks due to the ageing membership of the organisation (CWA magazine 2001). However, many women object to the conventional stance taken by the CWA: of accepting, and even promoting, the inferior social position of rural women, and of supporting male hegemony (Teather 1994, p.139). The activities that members of the CWA partake in such as craft, sewing and cooking, or what Teather (1994) calls the "tea and scones image", may seem outdated and no longer relevant in a progressive and supposedly egalitarian modern world. This image may be even less relevant in the current economic and social milieu for rural women.

In response to these outdated practices, in the late twentieth century, most States have formed Rural Women's Networks that have younger membership and are more progressive and political in their criteria. As Clark (1989, p.52) points out, "whereas traditional groups tend to support the sexist belief that a woman should be in the home and have a man support her, contemporary groups recognise that men and women have equal right to participate in employment, family life and community activity". Proactive contemporary rural women's groups are now challenging these traditional roles and reporting the "real work" of

rural women. For example, the Queensland Rural Women's Network states that "our network seeks to help rural women realise their own power as agents of change by encouraging them to take an active part at both a domestic and professional level, so that our rural communities survive well into the twenty-first century" (Cruickshank 1994, p.385).

Younger women have chosen to modernise the more conservative organisations such as the CWA which appear to promote, or at least support, the patriarchal nature of rural society. Rural women deserve to be recognised for the contributions they make to the family, community and country. The survival of traditional groups depends on their ability to "move with the times" and recognise the changing role of women in rural communities. As Teather (1995, p.7) argues, "such women seek a voice and an image that is very different from those traditionally presented by the CWA's: it is urgent, informed, relatively youthful, professional, forward-looking, and combines social concerns with those of rural businesses". Many younger rural women are no longer prepared to accept the confines of domesticity and, through economic necessity, many cannot afford to even if they wanted to due to off-farm work and increased responsibilities.

Rural policy and politics

Government policy addressing rural women's concerns often fails to address the entirety of the situation. Although State and Commonwealth governments have devised policies and strategies (see Reference List) to assist women in rural communities to overcome financial and personal hardship, how these translate for rural women at a "grassroots" level needs evaluation. However, it has been documented there has been a failure of official recording agencies to realise the "pluriactivity" of rural females. As a result, Alston (1998b, p.27) argues that their labour is "unrecognised, invisible and vulnerable, with no

basis to demand recognition of their efforts or to challenge existing gender relations in agriculture”.

In addition, women’s issues can often fall under the “family umbrella”, rendering their individual concerns as secondary. Summers (1975: 19) argued that “the uncritical use of the term ‘the family’ has added to the propensity to reduce the discussion of women’s activities to simple schema whose content is assumed rather than actually described and analysed” The Women’s Infolink Infosheet (1999, No.16) that was discussed above, published by the Office of Women’s Policy in 1999, over 25 years after Summers wrote the above, still appears to support female nurturing and subservience in the family. It appears to suggest that women be acquiescent and adopt an accommodating position in family discussions to reduce potential conflict between other members. This is advice from the Office of Women’s Policy in 1999 - how is this to advance female freedom of expression or choice?

With respect to female representation in the political arena, change is slow. Alston (2003, p.23) argues that “following the significant downturn in commodity prices and long periods of drought that resulted not only in many families leaving agriculture but a also a rise in the numbers of women in farm families working off farm to support their families, women demanded attention to their situation”. This led to the formation of new community groups such as Australian Women in Agriculture (AWIA) and the Foundation for Australian Agricultural Women (FAAW). Other units or alliances were subsequently formed as part of the Office of the Status of Women. However, advancement is problematic. As MacCulloch (1995, p.74) argues, “in recent years, governments have, to a degree, attempted to by-pass gender altogether, via the adoption of a social justice strategy”. Alston (2003, p.24) concurs that there has been dwindling support for rural women specifically, stating that there has been shifting support to other hot topics such as youth issues. Muir (2003, p.198) states that “despite the recognition of

the need to include diversity and, by inference, women in decision-making in the corporate, government and many industry spheres, most positions of power are still dominated by men". Liepins (2000) also discusses the gendered organization of farming where she examines how men are represented in industry arenas such as agricultural organizations and the media. According to Alston (2003, p.30), these agencies appear to be operating in a "cultural milieu that devalues women". Haslam-McKenzie (2003a, p.44) rather cynically concludes that "perhaps in some public arenas, issues of importance to women from rural, regional and remote Australia have been written off or sidelined, reminiscent of feminist backlash — 'the girls have had their chance' - and a wily way of keeping women 'in hand' "

Alston (1995c) discussed the neglect of ABARE and the ABS to record the work of Australian farmwomen. The definition of farm work has caused some controversy. For example, domestic or "helping tasks" on the farm are not assessed as work and are not counted in farm statistics. However, these tasks do make an economic contribution to the farm enterprise because they reduce costs. This same argument can be applied to the women who act as business managers and bookkeepers. Rickson (1997, p. 94) points out that "the women who are nationally about one-third of the agricultural workforce are still often invisible in the statistics of labour force participation and other measures of 'economic production' ". Alston (1998b) also argues that the phallogentric view of women's work and knowledge as having little value has been assisted by official under-reporting of their efforts (also see Alston 1995c, Williams 2003).

In 1999, the Federal government established the Regional Women's Advisory Council. As Deputy Prime Minister John Anderson explained at the Regional Women's Advisory Council Appointments in September 2002, "I established the Regional Women's Advisory Council because the Government understands the importance of having a direct link

with women in rural and regional Australia. The previous members of the council brought a unique perspective to key regional issues such as identifying the key factors that help successful regional communities manage change". The appointment of a new council was on 27th September 2002 and was appointed for a two-year term. At the Regional Women's Advisory Council meeting in Queensland in September 2003, the issue of representation of women on boards, in Local Government and committees was raised again (*Regional Women's Advisory Council 10th December 2003*). It was stated that "the Council remains concerned about the low representation of women on boards, in Local Government, and on decision-making committees. It is seeking assurances from the Australian Government that they still see increasing women's representation as a priority". According to Haslam-McKenzie (2003b: 138) "rural women are demanding that their work and presence on family farms and in their communities and industries be recognised by all levels of government, farmers, agri-business and agricultural organisations". Although the rhetoric of government continues to support the presence of women on rural bodies, they remain under-represented in positions of authority. In conclusion, Alston (2003, p 30) argues that "the women's agenda should be dealt with through mainstreaming; that is, introducing a gender dimension into all policy making. Under a policy of mainstreaming, we would be moving to ensure that departments of agriculture treated women and men engaged in agriculture as equally valid clients of their entire organisation, and whose needs and issues are to be core departmental business" (also see Pini 2003).

The purpose of this lengthy analysis of rural women's situation in Australia is to contextualise gender and mental health in the bush by outlining the female position in the rural social and economic world. It is arguable that bush women continue to be a disadvantaged social group with limited choices and opportunities, and current policy and strategy falls short in addressing many of the fundamental issues facing

rural women. As Rickson (1997, p.92) argues, “understanding women in agriculture is basic to understanding global changes in agricultural production and practices, visions of future possibilities of ecological sustainability, and to developing socially just and viable policies for the next century”.

The weight of evidence suggests that the Australian bush continues to be “a man’s world”, despite the increasing contribution of women. These conditions are directly related to the way mental health issues are perceived and dealt with by both men and women in rural Australia. An analysis of Dempsey’s community study *Small Town* (1990), and the subsequent publication of *A Man’s Town* (1992), provides illuminating evidence of the gendered nature of rural society. Recent government policy has attempted to balance this scale of inequality. However, as Lawrence (2001, p.72) rather pessimistically concludes, “perhaps the gendered structure of policy making will be reflected upon by male and female farmers along with their gendered relationships on the farm”.

Conclusion

The recent transformations in the bush have been accompanied by an increase in poverty, unemployment and health problems, demographic changes and a loss of services. As Cheers (1998, p.6) argues, “unfortunately for rural Australia, ‘rationalisation’ has come to mean the relocation of infrastructure and services from small communities to larger regional centres, and from government to the non-government sector”. Ideas about rural identity have also changed. According to Fitchen (1991, p.1), “in the flux and schisms of adaptation to new situations, the definition and identity of ‘rural’ becomes blurred and the supportiveness of a cohesive community may diminish”. General attitudes to mental health in the bush and the implications of these on service utilisation will be discussed in the next chapter to determine how rural people are adjusting to the changing circumstances.

CHAPTER 5

MENTAL HEALTH IN THE BUSH

*He picks at the calluses on his broad, worn hands
like worry beads
He can feel the pricking at his eyes, but he'll not escape
to the refuge of tears again, dammit.
With the same practised ease that he throws a fleece
or swings into a saddle, he'll find a way to silence
the jangling disquiet that has ruptured the rhythm of his days.
But he won't talk about it, least of all to his mates.
And he's determined not to see the doc —
none of that "pouring your heart out" stuff for him.
He doesn't believe in mental illness any more than he believes
the bright predictions from the boys at the weather bureau.
He'll not seek the blessing of a name for the way he feels—
instead, he'll live with the terror, with the fear he's going crazy.
It's his secret, his shame".*

(From Queensland Country Life, Friday Magazine, Aug 2003, p.12).

Rural studies conducted over the last three decades in Australia have revealed a number of features that are distinctive to the bush. These conditions have a direct impact on the recognition and treatment of mental health issues. To establish a frame of reference for the present study, the impact of bush identity on attitudes to mental health, a literature review of Australian rural health, and some international, studies follows. This will also include a service delivery and provision component, outlining the general problems faced for services in rural areas. Although the research intentions of the respective projects may have been multifaceted, certain common characteristics of rural areas

have been revealed. According to Jopson (1999), "the fallout of massive change (in rural industries) had produced a rise in the incidence of marriage difficulties, drug and alcohol abuse, behavioural problems in children, depression and suicide" (also see Cheers 1998, p.48). These problems can all be categorised as, or can have an effect on, mental health issues.

Of particular significance, as stated in the Royal Flying Doctor Service (RFDS) Annual Report (2000, p.1) is that "people that live and work in rural, regional and remote communities experience stress related health problems, in particular psychiatric disorders, 28% more than their urban counterparts" (also see Lawrence 1987). One interpretation of this statement is that the very nature of rural communities could foster mental health problems that are different or unique to the bush. Therefore, the treatment of such problems needs to incorporate knowledge of bush culture and tradition. As Loustau (1997, p.17) points out, "in attempting to understand and analyse health and illness in any society, individual behaviours, interactions and social structures must be placed within a cultural context. Culture affects perceptions and experiences of health and illness". This is evidently so in the Australian bush. Equally, there are significant differences in the gender experience of mental health, as will be discussed here and in the Ruraltown study. While this chapter is not solely about bush men, more time has been dedicated to a discussion of their concerns because they appear to be the ones who are most influenced by bush identity and are reluctant to address mental health issues.

Factors that impinge on mental health in the bush

The circumstances of living in the bush include isolation from services, cultural differences, conservatism, and smaller populations, to name a few. All of these have a bearing on the treatment and acceptance of mental health (Griffiths 1996, p.17). As stated in a National Rural

Health Alliance (NRHA) Position Paper (2003, p.8), "people living in rural and remote areas face a number of social factors (such as isolation, higher rates of unemployment, stigma as a result of less anonymity, exposure to environmental hazards, lack of services or providers, effects of economic restructuring) which may lessen their sense of control over their lives, thus exacerbating the problems of mental illness" (also see Armstrong & Schulman 1990). Deans (1993, p.77) also argues that "the socio-economic environment has a pervasive influence on ill-health. When the individual experiences a lack of control over their environment, they become depressed, passive and unresponsive". These conditions affect both mental health status and treatment of problems. As a result, Bushy (2000, p.34) believes that "characteristically, people who live in remote areas often develop independent and innovative coping strategies to compensate for the long distances to formal health care agencies".

There may also be a reluctance to seek medical help unless it is urgent. In Jopson's (1999) article, she reports that "families were usually 'in a desperate state' before seeking assistance" (also see Lavelle 2003, p.2). Buckley and Lower (2002, p.11) also argue that "rural men tend to deny symptoms of a chronic nature and only utilise health services when symptoms are regarded as life-threatening". Geographical and economic factors of rural living have a direct bearing on the ability to confront health issues in a conventional way. Bushy (2000, p.36) points out that "rural people seemed to worry less about physical health and to be more likely to reject the sick role than urban dwellers". With specific reference to mental health, Fuller (2000, p.152) believes that "the circumstances of rural and remote communities do have an effect on the manifestation of, and response to, mental health distress. These circumstances are the culture of self-reliance and the economic hardship, trauma and isolation that these communities endure".

Although distance from services is generally an accepted part of living in the bush, other factors can also compound this distance. Work obligations, financial barriers, weather and road conditions are some of the extenuating circumstances in rural areas. Veitch (1994, p.85-86) points out that "isolation from services can lead to a delay in treatment-seeking, and a "wait and see" attitude about medical problems might not be an option so much as a necessity to these people". The further away a service, the less likely rural people are to access medical attention in a timely manner. Puckett (1993, p.56) also notes that "in rural areas, there is greater dependence on the weather, and geographical isolation may incline towards loneliness and depression". These factors all effect service utilisation due to lack of financial resources for travel or the inability to be absent from the farm for prolonged periods (Wright 1995).

Due to the isolation and hardship experienced in rural areas, there tends to be a culture of self-reliance. Bushy (2000, p.35) notes that "when it comes to healthcare, self-reliance and independence have been demonstrated to be strong characteristics of rural dwellers, who often manage on their own or turn to family and friends for assistance rather than formal agencies" (also see Rolley & Humphreys 1993). Fuller et al (2000) explain that this self-reliance has two important side-effects, that one is not allowed to show emotional 'weakness', and there is a mistrust of outsiders. They (Fuller et al 2000, p.177) argue that "there is therefore a cultural context in which rural people will be reluctant to seek help from professional mental health and counselling services". In their study, Stehlik et al (1999, p.82) found that, even when people recognised apparent problems (causing stress) and a need for support, very few accessed help. The findings of the Ruraltown study (Chapters 7 & 8) concur with these observations. Self-reliance and independence are part of the coping strategies common in the bush but, when dealing with mental health, these qualities may be hindering the path to wellness and recovery. As O'Hehir (1995, p.554) argues, "rural males

are conditioned to be stoic and get on with the job no matter what, but one often wonders at what cost to themselves and their families". The culture of self-reliance affects attitudes to mental health.

Another unique aspect of rural life is that the farm or business is intertwined with family issues due to the close proximity of work and homelife. Armstrong and Schulman (1990, p.477) argue that "farming also differs from other occupations in terms of the nature of the interrelationship between the enterprise and the household". This has emotional repercussions, as raised by Barnes (2000, p.7): "it is a simple fact that for rural families, love and business and blood and money are inseparable. But it's a fact that's frequently overlooked when dealing with the stresses faced by farming families". (Also see Stehlik et al 1999, Gray & Lawrence 1996, Napier 2002, Fuller et al 2000). Certain mental health issues may not be dealt with for fear of disrupting family harmony. Hegney (2000, p.205) argues that "there are high levels of stress-related illnesses such as hypertension and psychiatric disorders among farming families due to the close connection of business and personal life" (also see Lawrence 1987). When such a fine line exists between work and home life, relationships are more stressful and vulnerable to pressures; people are usually "stuck" in the centre of the problem (also see Sarantakos 2000, Humphreys 2000, Verrinder et al 1998)

Economic hardship through changes in farming structures, deregulation and climate also impact on the mental health of people in the bush. With respect to the financial crisis caused by drought, Stehlik et al (1999, p.62) argue that "the structural conditions over which farm people have negligible control have created a complex situation confronting farm families as they contend with the vagaries of climatic variability, the international agricultural economy, and with their own beliefs and values". Armstrong and Schulman (1990, p.479) found in their study of financial strain and depression among farm operators in

North Carolina that “financial strain at the level of the farm business could give rise to depression because it lowers a farmer’s sense of control. Perhaps it is the feeling of powerlessness in and of itself that leads to depression among farmers”. Circumstances beyond their control, such as the weather, international restructuring and deregulation of agriculture have direct impacts on the coping abilities of rural people and these undoubtedly have mental health ramifications. According to Belyea and Lobao (1990, p.62), “increased stress and related social-psychological and behavioural problems have been linked with the restructuring of agriculture by a small but increasing number of studies”. This has also been supported by studies completed in Australia (Gray & Lawrence 1993 & 1996, Stehlik et al 1999, Stehlik 2002, Alston & Kent 2004).

As stated in the Introduction, in this research “mental health” is defined as “the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being and optimal development” (Second National Mental Health Plan 1998, p.26). In rural areas in general, there has been less exposure to the concept of mental health and mental health education and, therefore it is often a misunderstood condition (see Ruraltown study results, Chapter 7). Many perceive the term “mental health” negatively, as being associated with only serious conditions and, in particular, with the rather pejorative term of “insanity” (Fuller 2000, p.151). Therefore, if people present for treatment at all, it is often when a condition has become critical.

The concern about the stigma attached to mental health is also quite pronounced in the bush. SANE Australia (2001) defines stigma as “an attempt to label a group of people as less worthy of respect than others”. The stigma associated with mental health is closely related to a failure to recognise mental health problems in an appropriate manner. As Fuller et al (2002, p.179) point out, “stigma means that, even if there

are specialist mental health or counselling services available locally, their visibility in a small community makes them hard to use anonymously" (also see Sweeney and Kisely 2002). Mental health is not viewed as a positive concept; its meaning can be jaundiced through fear of being labelled. According to Winter (2003, p.12), "mental illness is the last taboo. Through stigma, poor community awareness and patients' fear of 'discovery', particularly in small communities, psychiatric patients are an invisible army". Urban communities, to a degree, share such concerns but the evidence suggests that the stigma is more intense in rural areas.

There are serious repercussions of this stigma. King (1994, p.3) argues that "the closeness of farming communities, long seen as a strength, may act as a deterrent when the demands of strict confidentiality prevent people from dealing with their own or a close family member's suicidal behaviour". Size (1998) concurs: "there is a collective fear/stigma of mental illness in rural communities and often there is a conspiracy of silence about its very existence. The classic dynamic in rural communities of 'neighbours helping neighbours', so effective in addressing other common challenges, is immobilised" (also see Stehlik et al 1999). Farmers typically pride themselves on their self-reliance and independence, so asking for help can be difficult. Stigma mitigates against seeking help for mental health problems and was also found to be a prominent theme in the Ruraltown study (Chapter 7 & 8).

The pride of rural people is also closely related to their self-reliance. When it comes to mental illness, pride makes it difficult for some to admit to the need for help. According to Philo et al (2003, p 264), "this attitude colours responses to mental ill-health, particularly because these rural dwellers end up supposing that they *should* be able to cope with their own emotional problems without resort to mental health services". Rural people tend to balk at the suggestion that they are not coping. In his study, Dale (1994, p.332) discovered that "what the

families found most valuable was not the dollars, or the information about the different schemes, subsidies and rebates, but the simple fact that somebody cared enough about their family to drive 100 kilometres off the main road to visit. Many families did not want counselling or money, unemployment benefits or job retraining. Nor did they want help to quit their land with dignity". Park (1994, p.403) also found this in his study of "A Rural support service in Southern Queensland". The support service was provided by Lifeline for six months in 1992 to study the effect of the drought and to provide information on services, financial assistance and counselling support. Most respondents expressed appreciation of the fact that they were being visited and listened to. He (Park 1994, p.405) also found that "seeking help was often an embarrassment to the farmer, especially if it involved social security benefits" and, as a result, many said they were coping even if they were not (also see Seabrook 1994). The other side of the 'pride' coin, the *shame* of having a mental illness, was obviously a powerful deterrent to help-seeking. The recognition of the common characteristics in bush people, particularly "on-farm", such as self-reliance, pride and stoicism, is of paramount importance to mental health service provision.

Concerns about privacy and confidentiality also inhibit psychological help-seeking. Griffiths (1996, p.18) states that "the need for personal privacy in high visibility settings may prevent potential clients from seeking help. The possibility of being seen accessing the local psychological service is a risk of personal invasion many are not prepared to take". Humphreys (2000, p.180) also reports these concerns and argues that "because of the nature of mental health problems, the reluctance of many people to use them because of perceived stigma, and concerns about privacy and confidentiality, it is important that these services should be made available in a form that respects the needs and preferences of users" (also see Atkinson et al 2003). The provision of

services in rural areas must be appropriate to the culture at hand (Dale 1994, p.333). This will be taken up further in the Ruraltown study.

Closely linked to the issues of privacy and confidentiality was the fear of gossip and rumour which also has a sanctioning effect on help-seeking for mental health problems. Cheers (1998, p.78) argues that "gossip keeps information circulating and provides a way of commenting publicly on questionable, unacceptable and also exemplary behaviour without the source becoming known". Macklin (1995, p.77), in her 1992 study, stated that "several workers indicated that a number of clients refused to walk into the community health centre to a specialist worker or counsellor because they were concerned that they would be seen entering the building by others in the community". This is a recurring theme in the bush. Day and Dunt (1994, p.42) also found in their evaluation that, based on fear of rejection by the community, gossip was seen as a major problem by some sufferers (also see Noonan 1995). Philo et al (2003, p.272) concur and argue that "what is largely absent is the anonymity of more densely populated places, with rural dwellers being caught in a field of visibility where everybody seemingly knows everybody else's business, and where keeping secrets, maintaining confidentiality and avoiding being the subject of 'gossip' is so much harder than for people living in towns and cities".⁹

Due to the smaller populations, there is also a perceived lack of anonymity in rural areas that can be a major inhibitor to treatment. Buckley and Lower (2002, p.13) argue that barriers to accessing health services for rural men include "...discomfort in the waiting room environment and privacy issues centring on others not knowing they have visited a service ...". Philo et al (2003, p. 272) conclude that "what is clear from numerous studies is that the 'glare' of rural familiarity can

⁹ It is not unusual for rural people to travel to another town or city to avoid being identified accessing mental health treatment. Anecdotally, I am aware of rural mental health consumers travelling over four hours to Brisbane to see a psychiatrist for a one hour appointment and then travelling home again.

feed into the often quite acute under-utilisation of local mental health services". This issue was also raised in the Ruraltown community.

In the bush, mental health issues are often considered distinct or separate from the effective operation of a farm or business, if they are considered at all. Personal problems are just that and, for many, obtaining professional help would not be an option. According to Dunn (1996, p.9), in his discussion of psychology services in rural Australia, "mental health services may have to confront years of mythology and misunderstanding among populations that have traditionally had little or no tolerance, or experience, with such services". For example, he (Dunn 1996, p.9) argues that "the young male residing in a remote township in Western Australia suffering from severe personal problems and depression is unlikely to seek the assistance of a psychologist, as relevant as it may be — it is not a service that will readily form part of his solution or response". Men especially do not see counselling as an acceptable means for addressing problems. It is very difficult to jettison the social "rules" of the bush. Bourke (2001b, p.94) agrees and argues that "young men (in rural areas) are expected to take problems in their stride, and it is acceptable for them to use violence to address their problems". It can be argued that seeking help through counselling would not even be considered in most cases.

The increase in rural unemployment, as discussed in the previous chapter, has certainly had social and emotional ramifications. Unemployment can lead to the additional social problems of alcohol and substance abuse, especially in young people, which then could accelerate the cycle of despair (Sidoti 1998, p.5, Lavelle 2003, p.3). In a media release by the NRHA (1999) it was stated that "recent evidence has shown that hard drug problems are common in rural areas. Nevertheless, drug users and persons with serious alcohol problems remain largely hidden in the Australian bush". Abuse patterns generally

require specialist services and, as these are not readily available, the problem can remain hidden or untreated. Domestic violence or suicide may even result (Thomas 1994, p.100). However, even if specialist intervention was available and accessible, there is the possibility in the bush that emotional problems would remain concealed due to embarrassment or shame (see Fuller 2000, Ruraltown study).

There also may be a lack of knowledge or familiarity with mental health disorders or treatment in the bush, or it just may not be a priority. Fuller et al (2000, p. 151) argue that “symptoms of mental distress may not be recognised as a problem or the help of mental health specialists sought”. Therefore, services need to consider this when dealing with rural people. Health providers especially must tread carefully and adopt a subtle approach when treating rural people or they may risk alienation in an already skeptical environment. As community education is a key theme in the *National Mental Health Plan* for rural and remote areas, acknowledgement of these rural characteristics needs to be incorporated in the delivery of education programs. Education is the key to acceptance.

Rural people also need to be aware of the nature of mental health services and what support they provide. According to Cheers (1998, p.172), “physical access problems are compounded in rural areas by poor publicity about where, when and how services can be obtained”. Lichte (1996, p. 39) discusses the educative role of the psychologist in the bush and maintains that community education is important to reduce stigma and misinformation associated with mental illness. Ignorance about the value and role of mental health services may lead to under-representation or lack of consultancy (also see Hill 1996). The more mainstream mental health information and terminology become in the bush as part of general health dialogue, the more acceptable the concept will become.

Older people in rural communities have been identified as a group needing additional mental health support. As Gattuso (2004, p.36) argues, "rural Australia is ageing rapidly and the health status of older people living in rural and remote areas is worse than that of people in metropolitan areas. At the same time, services are being reduced, augmenting the need for innovation". Older people are often more socially isolated in rural communities due to distance and the fact that their mobility may be reduced. Alston and Kent (2004, p.66) also remark in their study that older rural people are the least likely to ask for assistance because of pride and stoicism. Addressing the mental health needs of this group requires overcoming the barriers of isolation, self-reliance and pride.

There are several non-government organisations that have created programmes for rural areas to help communities cope with stress. Lifeline launched a "Tool kit for getting through the drought" (2000) aimed at farmers and rural communities. It discusses the physical, psychological and behavioural symptoms of stress and offers suggestions on how to deal with or reduce these symptoms and improve coping mechanisms. Another informative brochure, prepared by Women in Agriculture — Victorian Mallee Group, was called "Coping with stress in our rural communities" (2000). It too discusses how to recognise and cope with stress or rural crisis, how to deal with depression, and when and where to seek professional help. The information in these brochures was delivered in a straightforward, easy to understand manner by rural groups that may be more stigma-neutral than mental health agencies for people in the bush. Lifeline also has a nationwide rural mental health information service called "Just Ask", reached by a toll free number, which can provide information and referral needs for people with mental health problems. However, due to the anonymity of this service, it is difficult to measure utilisation rates by bush people. Despite attempts by these non-government organisations to address the mental health needs of rural people, they do not appear to have been as

successful as hoped for, as the following discussion of rural mental health issues demonstrates.

The increase in rural suicide

The extreme manifestation of mental health problems is that of suicide and the increase of suicide in the bush is an area of great concern. There has been a documented link between farming and depression due to uncontrollable and unpredictable life stressors (see Armstrong & Schulman 1990, Belyea & Lobao 1990). Belyea and Lobao (1990, p.71), through the results of their Ohio study, argue that "the restructuring of agriculture thus seems to be associated with increased stress and related social-psychological problems, such as depression". In the face of Australian deregulation and drought, Highfield (2000 & 2002) also reports the life-threatening depression that many are experiencing on Australian farms. Although the total Australian suicide rate has fallen over the last seven years, rural suicide rates remain high, especially in Queensland where the rate is 14% higher than the national average (Queensland Health Resources 2003).

At the 6th National Rural Health Conference, Bartik (2001) discussed the fact that depression and anxiety in young people are under-diagnosed in rural areas. He (Bartik 2001) points out that "the suicide rate for young rural males has increased four fold over the last thirty years and up to three quarters of the kids who die also suffer from depression". Further to this, De Leo and Evans (2002, p.1) found that "young people (15-24 years) in rural areas are 35% more likely to complete suicide than young people in urban areas; older people (55 years and over) in rural areas are 30-50% more likely to complete suicide than older people in urban areas; and the highest rate of suicide was in the Western region of Queensland" (also see King 1994 & The Queensland Government Suicide Prevention Strategy 2003-2008). Carr-Gregg (1997) discusses the rural-urban difference in youth suicide

rates, with a significant increase in rural areas. Cheers (1998, p.31) believes that “in recent times, it (youth suicide) appears to have been largely the result of rising unemployment, declining populations, disintegration of many rural communities, a pervasive sense of hopelessness and despair and, for many, the demise of farming as a way of life”.

The fact that the suicide rate is highest in Western Queensland is pertinent to this research. It is the region where the Ruraltown study was performed. As will be discussed later, there have been several reported cases of suicide in the Ruraltown area in recent years. There has also been a proposed link between rural youth suicide and sexuality issues. As Bourke (2001b: 94) points out, “traditional masculinity pervades rural society, making it difficult for young men who deviate from this in any way — by writing poetry, disliking sports or enjoying dance, not to mention being gay”. It was reported in a Lifeline article (1999) that “one third of all suicides in rural Australia involved youth struggling to come to terms with their sexuality”. While this may be hard to substantiate, the issue of male sexuality in a tough rural environment was always going to be contentious. The Ruraltown Community Connections Project, discussed in Chapters 7 and 8, deals specifically with sexuality issues and suicide.

Suicide in the bush has raised a number of questions about precipitating factors. Mungall (1999, p.7) argues that “farmers are at greater risk of suicide than average. It is not clear whether there is an increase in depression in the farming population or whether farming is an unduly stressful occupation. It could be related to farmers spending considerable lengths of time alone”. Luck et al (2000, p.70), in their discussion about the recent increase in suicides among farmers in Britain also believe that social isolation, ease of access to firearms and the economic threats to their livelihood may also be factors. This same argument has been applied to Australian farmers (see Strong et al 1998,

Dudley et al 1998 and *National Action Plan for Depression* 2001). These factors need to be taken into consideration when addressing prevention mechanisms.

Anecdotally, single vehicle car accidents in rural areas may also be suicidal acts. Carr-Gregg (1997) points out that “official figures of suicide have to be taken with a grain of salt as it is not known how many single road traffic deaths can be put down to an act of suicide”. A rural businessman in the Ruraltown study (2003) also stated: “You’d find a lot of car accidents out here would be suicide. Blokes who can’t hack it and have a head on with some other poor bastard and that’s it. You also hear about blokes hitting a tree on the property. Not likely, but the family still gets the life insurance because it’s an ‘accident’”. Not long after this conversation, it was reported in Ruraltown’s newspaper (*Ruraltown Paper* 8th April 2003, p.9) that “police stations in country areas have outlined that single vehicle accidents in high-speed zones are prevalent”. In the current climate, it is not entirely implausible to suspect that some of these accidents may be suicide attempts.

Due to the “secrecy” surrounding suicide as a whole, Stewart (1998) argues that it is difficult to gather reliable statistics for rural suicide. However, he (Stewart 1998, p.136) does point out that “it can be clearly seen that the number of officially-recognised suicides has been going up sharply and this surely must be a major indicator of societal stress”. Like mental health issues in the bush, addressing suicide attracts a stigma. When Fry (2002) asked a Queensland farmer about the problem of suicide in the bush, he responded: “well of course the subject that you’re touching on is generally a very secret sort of subject. Communities don’t like to talk publicly about that we don’t really like to talk about that. It’s a very difficult subject”. The reluctance of this farmer to even discuss the issue of suicide indicates the extent of the stigma attached. Price (1999, p.149) argues that “one of the key

causal factors in suicide is mental illness". Clearly, we *need* to be able to talk publicly about mental health, mental illness and suicide.

The circumstances of rural life have been extremely difficult over the last couple of decades. As outlined on the *Better Health Channel* (2003b), "in recent years farming families are under increasing pressure. Financial hardship and other difficulties can lead to stress, depression, relationship breakdown, substance abuse, increased risk of farm accidents and, in some cases, suicide". These circumstances have an obvious effect on mental health status and attitudes. In an interview with Stewart (2001), the National president of the Rural Doctors Association, Dr. David Mildenhall, stated that "I think in rural areas, we can speculate and it's possible that the economy, the general downturn in rural communities, the possible wider closing of services, the increased unemployment all contribute (to mental health problems)".

Another interesting point that needs considering was also raised in this interview. Dr. Mildenhall (Stewart 2001) stated: "I think the big thing is that people are being treated now. It is being picked up. And it is just possible that ten years ago there was this amount of depression but it wasn't being treated". Two providers in Ruraltown (Chapter 8) also made this suggestion. One commented that "in years gone by there were no services and when there are no services what else can you do but cope or don't cope. A lot probably did have a mental illness and suicided as a result of that as there were no services to help them". The other queried: "is it because people are more stressed or is it because people are now starting to see that there is help available?". One interpretation of these comments is that, in the past when there were fewer or no mental health support services in rural areas, bush identity and its associated characteristics of stoicism, resilience and self-reliance *were* the only existing coping mechanism. However, as will be shown in the Ruraltown study, although there are services available now, many people continue to suffer mental health problems as a result of the

stigma in rural areas. It was commented in an article in the RWN magazine (*Country Web* 2003, p.26) that: “She’ll be right mate!”; almost legendary words in Australian male culture but, unfortunately, this thin veneer of coping can sometimes cover up an intense struggle to survive, perhaps even stay alive”.

Gender in the bush and its impact on mental health

Males and females in rural areas may comprehend and experience mental health issues in different ways. O’Hehir (1995, p.556) argues that “male socialisation has conditioned us to turn a blind eye to stresses, anger and to our inability to communicate. Men, both within isolated areas and cities, are time bombs waiting to explode”. These perceptions can be attributed in part to the historical and cultural forces that have shaped gender roles in rural Australia. These cultural forces include the media, arts and literature, education and government. According to Roberts (1994, p.125), “in rural society, the roles of both genders have largely been governed by a set of traditional conservative values which make up the unwritten code of behaviour of farmer and grazier communities”. In reference to the male code, Colling (1992, p.85) states that “when toughness is the norm, sensitivity is doubly hard”. These conservative values impact not only on gender roles and identities, but also attitudes to mental health.

An important consideration in terms of rural men’s mental health is that of isolation and loneliness. Anecdotally, it has been reported that women are leaving rural areas to find employment or further their education in larger regional or urban centres, thus leaving a dearth of potential partners for rural men. Also, due to the isolated working conditions of some rural males on properties, it may be difficult to maintain social contact or attend functions where they may meet females. As discussed in Chapters 7 and 8, the Community Connections Project (CCP), under the auspices of Anglicare in

Ruraltown, was started in 2002 to address the mental health needs of rural isolated males and encourage them to seek support if they are experiencing problems. In the CCP Report (2004, p.4), it was noted that “isolation for rural men can be reflective of an absence of supports (family, wives, girlfriends or friends)”. However, it was also stated that “contacting members of this target group was also likely to take some time as distances are great and the ethos of not talking about feelings and/or seeking help are of a multiple generational background”. One male informant in the Ruraltown study believed that the shortage of women in the bush was a contributing factor to rural men’s isolation and increased the likelihood of loneliness and mental health problems. This can be considered a good example of how the changing demographics of rural areas may have an influence on mental health problems.¹⁰

As discussed in Chapter 3, attention needs to be given to the socialisation of men in relation to mental health issues. Price (1999, p.150) argues that “while all of us experience risks to our mental health, for men the risk is compounded by the fact that they are not expected to become mentally ill and, if they do, their socialization militates against them seeking the appropriate help”. In the bush, due to cultural preconceptions, it can be argued that this is even more pronounced. Levant and Habben (2003, p.177) recognise that rural men would be less likely to seek psychological help and argue that “some of the basic elements of psychotherapy (i.e. expressing vulnerability, ‘talking through’ problems, gaining access to emotions) conflict with traditional masculinity ideology”. According to Wainer and Chesters (2000, p.144), “rural men may also be vulnerable to mental health problems due to

¹⁰ In 2002, a number of media campaigns were started to assist in finding wives for rural males, especially farmers. The Women’s Weekly invited single women to write to 50 eligible farmers; 3000 replies were received from women. It was also reported in the *Sunday Mail* (7th July 2002, p.3) that “earlier this year (2002), the National Farmers’ Federation and a national women’s magazine recognised how difficult it was for farmers to meet women and initiated a campaign to find them wives”. Although these campaigns were of a light hearted nature, however, they may be an indication of a more serious problem.

changing understandings of masculinity and femininity. Traditional rural masculinity is associated with hardness and a taboo against seeking help with problems, leading to a reliance on women's skills in emotional work". Dempsey (1992a, p.139) discovered through the women in his study that "the men always return home to pour out their worries for fear of being ridiculed if they discuss them with their mates".

Families take on many healthcare roles in an isolated rural setting. Malcolm (2000, p.169) argues that, in rural areas, mental health problems are usually attended to within the confines of the family. According to Humphreys (2000, p.181), "in this way families will remain the cornerstone of healthy rural communities". It can also be argued that, as mental health problems are often addressed within the rural family, this usually becomes a female responsibility. Women may become the emotional mediator between family members, at the expense of their own mental health. According to Summers (1975, p.177), "the woman alleviates stress between family members and thus enables them to keep going at whatever work they are engaged in outside the home" (also see Alston & Kent 2004).

The woman is not only responsible for managing the household and all that it entails, but also for the emotional and mental health of partners and children. There is the expectation that women will care and nurture (Poiner 1994, p.56, Alston 1995c, p. 92). The off-shoot of this, according to Summers (1975, p.178), is that "other family members can avoid the responsibility of managing their own emotional lives, of acquiring emotional maturity; but who comforts the comforter?". Alston and Kent (2004, p.67) agree, stating that "of some concern is that many (women) place their own health and well-being as a very low priority within the context of the family, farm and drought". According to Fullagar and Gattuso (2002, p.5), "rarely is there any reference to the social, cultural and political dimension of women's lives that may indeed contribute to their feeling of being overwhelmed, undervalued, pressured and unable

to manage autonomously". It appears to be "taken for granted" that women will cope and take care of the family. However, isolation also affects the mental health of women in the bush.

The responsibility for the mental health of the family usually falls on rural women. Fahey (1994) reports an example of this in her study in South Australia. When a rural man was handed a brochure on stress management he responded: "give that to the wife, it's her business" (Fahey 1994, p.18). Rural men are reluctant to acknowledge mental health needs. Grace (1994, p.355) argues that "male farmers typically respond to stress by immersing themselves in physical labour and distance themselves emotionally, and women respond by trying for closer communication and repeating suggestions which is often perceived as nagging". Noonan (1995, p.2) also discovered that "farming women are coming forward and acknowledging their stresses and the reasons for them, and are expressing their concern about their male relatives, who in many cases do not admit to stress or the resultant physical and mental health problems". It can be a tentative and difficult situation for women who are trying to alleviate their spouses' or family's stress. Alston and Kent (2004, p.67) discuss the emotional impact of the current drought on rural women where they argue that "women report a weariness of spirit yet at the same time report needing to monitor the health of those around them and a need to hide their own feelings from their partners. They perceive an important part of their role is to be an emotional sheet anchor for the family". It can be argued that a repercussion of this is that women's emotional and mental health may suffer.

In addition, as the rural female is generally responsible for keeping the books and accounts up to date, they often deal with the financial pressures at home. Stehlik et al (1999, p.85) point out that "one of the lesser known 'inside' tasks that some women identified was the handling of the in-coming phone calls from stock agents to the bank

managers" (also see Gray & Lawrence 1996, Alston & Kent 2004). The financial counsellor in the Ruraltown study (Chapter 7) also raised this issue, stating that *"on a lot of farms the wife does the books. If the pressure is building, he goes out to the paddock and she's the one who gets the call from the bank manager to say the account is overdrawn. Some of them just don't want to answer the phone during the day"*. An article called "De-stressing strategies for rural life" appeared on the QRWN website (qrwnl@mailman.usq.edu.au, 2003). It noted that "financial stress can often be the catalyst in bringing relationship problems to the surface and can also result in illnesses such as depression, adding a further burden on a family or relationship". It can be argued that, as women are usually the bookkeepers, they may feel the financial burden more acutely and be subject to considerable stress as a result.

Domestic violence and mental health

Another indication of troubled times in the bush is the reported increase in domestic violence. As stated in the National Rural Women's Forum Recommendations (1995, p.26), "the increase in domestic violence is a symptom of the rural economic breakdown". In her discussion of "The Ugly Side of the Bush", Crisp (2000, p.18) also reports that "domestic abuse is nothing new but in 2000 it remains the secret shame that's reached epidemic proportions in these difficult economic times". Cox et al (2001, p.280) argue that it is difficult to get a true picture of the extent of abuse "because the problem remains predominantly gendered, silenced, private and hidden throughout all spectrums of Australian communities". The emotional and personal trauma caused by such violence needs to be tackled before women and men are able to feel in control of their lives. Domestic violence can seriously impact on the mental health and well being of all family members.

The problem of domestic violence has also been a response to the strong patriarchal gender relations in rural areas (Franklin & Teather 1994, p.7). It is a social problem, Bourke (2001b, p.97) argues, “because of the structures, cultures and contexts of rural communities — for example, police being ‘mates’ with the perpetrator, the victims not being anonymous, those in power ignoring the problem because ‘that kind of thing doesn’t happen around here’” (also see Wainer & Chesters 2000). Anecdotally and from personal experience, these problems are very much a reality in contemporary rural areas. There is a real reluctance by some victims of domestic abuse to go to the police or to visit medical services in their local area for fear of identification or gossip. As Macklin (1995, p.71) found in her study, “local gossip networks had a powerful sanctioning effect on people and, as a result, certain social problems remained hidden or, at least, were denied. This denial helped to maintain social relations that contributed to many social problems, including domestic violence and sexual abuse” (also see Briskman et al 1999).

Anecdotally, I have knowledge that some women have travelled considerable distances to another town, to hide their abuse and receive treatment anonymously, if at all possible. However, in many cases, treatment or assistance is never sought and some continue to suffer their abuse in silence. They may be ashamed, depressed, have no where to go, or stay on to ensure financial support for their children. As Strong et al (1998, p.102) argue, “females in rural communities list concern for economic survival as one of the top reasons for not leaving a violent domestic situation”. One informant in Crisp’s (2000, p.19) article states: “domestic violence is not a black/white, rich/poor issue, it’s everywhere in the bush. Family and friends know it’s happening but no one talks about it. It’s through the generations and it’s still very hidden. Victims stay because the options are so limited”.

Isolation is a key factor in a rural woman's experience of domestic violence that may require extra safety measures. A study done in rural Victoria (Cox 2001, p.281) found that "violence is made worse by the fact that many of the victims live in isolated areas and have no means of transport to either escape or to get help" (also see Wainer & Chesters 2000). Crisp (2000, p.18) also asks "how do you call for help when your nearest neighbour is thirty kilometres away and your partner has taken the phone and the only car?". Isolation is also recognised in a Women's Infolink Domestic violence Infosheet (1999, No.5) where it is stated that "rural women may need special strategies to deal with physical isolation". It suggests that organisations such as Domestic Violence Services can help rural women prepare a safety plan on who to call and where to go for help. However, it also recommends that the police are notified as "they have a duty to investigate and protect you". While this may be true in an ideal rural world, it does not always happen, as Bourke (2001b) points out above.

There have also been recent attempts in some rural communities to reduce the incidence of domestic violence. In Ruraltown (see Chapter 7), for example, in Domestic and Family Violence Prevention Week in May 2004, "Expect Respect: there is no excuse for abuse" was the theme. The aim was to educate the community about their rights and to recognise the warning signs of potentially abusive relationships. Domestic violence was defined as "the misuse of power and control by one partner over the other in an intimate relationship" (*Ruraltown Paper* 6th May 2004, p. 2). Contact details were given for those who needed advice or support. Funding was also approved during that week to provide support for a "men's worker" who would focus on counselling and assisting the perpetrators of family violence to break the cycle of abuse. According to Roberts (1998, p.800), "education and intervention programs aimed at decreasing the level of family violence are likely to benefit the mental, as well as the physical, health of women victims and children". The current Federal government in Australia also has a

campaign called “Violence Against Women: Australia Says No” (Commonwealth of Australia, 2004), aimed at reducing domestic abuse and it was being canvassed extensively in newspaper and television advertisements prior to the Federal election in October 2004.

Alcohol and substance abuse may also be contributing factors to domestic violence (Gould 1989, p.26). Luck et al (2000, p.221) argue that “abuse of alcohol and drugs associated with violence are often the coping strategy which damages the individual man’s health and also that of the women and children he knows”. It has been well documented that alcohol abuse in rural areas is an ongoing problem (see Healey 1999). Yellowlees (cited in Kerby 1997) argues that “rural communities are drinking three times the national average”. It is essential that community education programmes about domestic violence continue for the benefit of abused families in the bush.

Issues in mental health service provision in rural areas

Rural Australians have less access to general health services than in urban Australia (see Humphreys 1999). There has also generally been a shortage of mental health workers and services in rural areas. As Cheers (1998, p.58) argues, “of all health services, rural people have poorest access to counselling and mental health facilities. Those who need these, perhaps most noticeably isolated youth, are literally ‘all alone’”. In addition, it was argued in the NRHA Position Paper (2003, p.8) that “lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of mental health personnel in rural and remote areas”. The issue of recruitment and retention of doctors and an appropriately trained medical workforce has been a major focus of activity for government over the past ten years.

Access to female GPs is a significant problem for some rural communities and it can be difficult to attract female GPs to rural areas. In Wainer's (2004, p.52) study, she found that the major change needed to recruit and retain female doctors in rural practice was "in the understanding that most (female) doctors come with families and there must be a place for everyone in the family. This means a job for her partner and child care and schooling for their children" (also see Carson & Stringer 1998). These are big considerations for female doctors moving to rural areas and, therefore, it becomes a community responsibility. Lippert (2003, p.184) concludes that "to ignore the issues of female GPs (such as childcare, and locum doctors for maternity leave) is to render invisible fifty per cent of the potential solution to rural GP shortages".

Knowledge about the pressures of rural life is needed to address mental health in the bush. Johnston (1992, p.56) discovered that it was often a "culture shock" for urban health professionals who practice in rural areas, and that they need to understand small town politics and characteristics to treat people effectively. This issue will be taken up further in the Ruraltown study (Chapter 8). According to Humphreys (2002, p.9), "the absence of adequate rural health-care services to many small isolated communities is exacerbated by the significant and worsening gap in the level of economic well-being between metropolitan and rural regions". To counteract the shortages of GPs in rural practice, Topps et al (2003, p.97) argue that "cultural immersion through training programs based in rural communities, providing additional skills training that is relevant to rural needs and greater teamwork among rural healthcare providers, will address the shortfall".

There has always been a shortage of medical and allied health personnel who practice in rural areas. In recent times, this shortage has become critical with doctors and nurses in short-supply (NRHA 2003). Hanna (2001, p.10) points out that "overwhelming evidence exists to

demonstrate that the doctor : population ratio is far lower in remote areas than in metropolitan regions". Thomas (1994, p.104) also argues that "many bush nurses have the responsibility for looking after whole communities on their own or without little outside assistance because there are no doctors or other health professionals in these areas". When doctors leave rural communities to practice elsewhere, the "loss" can be significant. As Lavelle (2003, p.2) points out, "losing any health professional is a blow for a country town but it's especially difficult losing a doctor. Apart from treating illness, the doctor has quasi-legal functions like issuing medical certificates for school, work and social security benefits, workers' compensation claims and so on". In addition, the limited numbers of general practitioners may struggle to meet the demand and cope with medical conditions to which they cannot dedicate adequate time or expertise. As Leech and Walters (1995, p. 498) explain, "GPs are also under stress — most of the care is curative rather than preventative because of staff shortages and time constraints" (also see Welch 1994). Doctors in the bush are placed under considerable pressure due to these problems.

As will be indicated later in the Ruraltown study, doctors and mental health services are inundated with clients with mental health problems in rural communities and many general practitioners treat mental health patients due to the limited specialist services. Day and Dunt (1994, p.57) also discuss the key role of GP in the treatment of mental health in rural areas. However, as argued in the *National Action Plan for Depression* (2001, p.x)), "few doctors are likely to be able to recognise depression, let alone the circumstances and factors influencing its occurrence in a consultation last ten to twelve minutes". The shortage of mental health practitioners may lead to under-qualified personnel treating people with mental health problems (NRHA 2003, p.9). Sherwood (2000, p.79) also points out that "... there is a need for counselling training by rural health providers". The repercussions of the shortage of mental health workers in rural areas, as Leech and Walters

(1995, p.502) explain, is that “there is an epidemic of need related to such things as violence, abuse, addiction, family breakdown, anxiety, depression, grief and loss. These things may be hidden, but they are devastating in their effects”. It is difficult to treat this compote of conditions, which may be present simultaneously, with limited services and personnel.

Mental health changes at a structural level have also impacted acutely on rural communities. Matthews-Cowey (2000, p.267) notes that “over the last three decades the delivery of mental health care has moved from primarily being provided by large institutions to being provided in the community”. However, many communities are ill equipped to deal with demand. As a consequence, MacCulloch (1995, p.79) believes that “the process of deinstitutionalisation has led to a vacuum of care with services being removed and institutions being shut down. There has been a shift to community care which essentially equals family care which is unresourced and unnoticed” (also see NRHA 2003). It can be argued that the pressures experienced by rural families would be even more acute due to the lack of already existing services. Hegney (2000, p.207) describes the repercussions of government restructuring of health services in the 1990s as “a trend towards a ‘user-pays’ system and the delivery of health care by private practitioners, leading to services being downgraded or closed, fewer services in rural areas, and a decrease in new settlers”. All of these changes have impacted at the local level with people in rural communities missing out on services and resources to accommodate to this downgrading.

Geographic isolation and lack of funding have also restricted adequate delivery of mental health services. In most areas, they are not constant or accessible and, in some cases, not present. Depression and stress-related illnesses often go undiagnosed and untreated. This has resulted in severe consequences, evidenced in the increase in rural suicide rates. Bartik (2001) argues that “because of limited specialists services and

large distances it's often difficult for health professionals to identify young people with anxiety and depression and implement early intervention strategies". Specialists, such as psychiatrists, are very limited and treatment is often unattainable (Yellowlees 1992, Fraser 2002). Fuller et al (2002, p.182) note that "a lack of time to treat conditions satisfactorily" was raised by several mental health workers in their study. The Ruraltown study (Chapter 7) supports this finding. Counselling, which is more time-consuming, cannot take precedence over the more severe clinical crises.

Due to lack of appropriate mental health facilities, especially after hours, consumers may need to be transferred to larger regional centres to get appropriate treatment. As Fuller et al (2002, p.176-7) point out, "this can add further to an already distressing situation for the affected individual and family members, and also the health and other human service professionals involved (such as police and ambulance)". It also puts pressure on the hospital in such areas, which is usually the first point of call for urgent cases. As noted by the National Rural Health Alliance (2003, p.9) "few local hospitals have the resources to deal with people in the acute phases of mental illness, who often require hospitalisation and intensive therapy". Telepsychiatry is utilised in some rural communities to increase access to mental health treatment, however, its acceptance is problematic. These and other issues will be further addressed in the results from the Ruraltown study (Chapter 8).

However, service delivery is more than a question of resources. It is important that rural lifestyle and values be taken into consideration when delivering health services. Dunn (1994, p.333) argues that "the service delivered must be appropriate to the culture at hand". Judd et al (2002, p.297) also found that "improving the mental health of rural Australians does not rest entirely on improving the availability of services. Seeking professional help requires that services are not only available, but also accessible and acceptable (ie. offered in a manner

congruent with local values using a model of delivery appropriate to the setting)". Fuller et al (2002, p.177) too argue that "beyond physical access to mental health care, cultural barriers will determine the acceptability of a service; that is, whether people will actually use it". The ethic of self-reliance works against help-seeking in rural areas and, therefore, a more subtle approach may be required. The manner in which a service is both portrayed and delivered to the rural community is important. This will be further taken up in the Ruraltown study (Chapter 7 & 8).

Recent primary healthcare initiatives in rural areas

As discussed in the *Queensland Mental Health Plan (QMHP)* below, health care at the primary level is specifically important in rural areas. Primary Health Care, according to Livingstone (1994, p.44), "is designed to establish a balance between health promotion, prevention, treatment and rehabilitation, as well as encourage individuals and communities to take responsibility for their own health status". The utilisation of primary health care is necessary in rural areas where specialist services are not as readily available. The *National Primary Mental Health Care Initiative* (1999) was designed to "improve the quality of care delivered to consumers by building partnerships between GPs and mental health services and by supporting GP education programs". The need for cooperation and partnerships in the bush was emphasised in the *Second NMHP*. As mentioned above, the *QMHP* also recognises the value of primary health care. When resources and medical services are limited, teamwork and communication are essential. It is for these reasons that primary health care centres have been established in several rural towns throughout Australia (see Wells 2003).

Malcolm (2000) demonstrated the benefits of primary health care model for rural areas in a Tasmanian study. In this study, a mental health worker was sharing rooms with a GP in rural Tasmania. The main aims

of the three-year project were to upskill GPs and other health workers, educate the community about mental health, liaise between services, and provide one-to-one counselling (Malcolm 2000, p.163). The findings from the study indicated that GP confidence levels increased, feelings of isolation lessened and peer support was experienced. On the community level, knowledge was also enhanced. Malcolm (2000, p.171) notes that a major indication that the community saw the project as effective was the attendance of a large number of people at a mental health meeting held to address funding issues.

In a further appraisal of the rural Tasmania study, Malcolm (2002) also comments on the major benefit of addressing mental health at the primary level. She (Malcolm 2002, p.24) argues that “one of the hallmarks of primary care is prevention and if this type of service can alleviate the suffering of those affected by mental illness, and the associated deterioration in social, family and economic functioning, and prevent these problems progressing, then it fulfils the aims of those involved in primary health care”. Ratnaike and Parham (2002, p.3) also raised this point in their discussion of early intervention strategies by community agencies, arguing that community agencies often deal with mental health issues at a primary level. Therefore, by adopting an early intervention approach through the up-skilling of staff, influencing policy within the agency, and strengthening links with other agencies, the benefit to clients will be heightened. However, according to Fuller et al (2002, p.183), “the difficulty with primary level mental health care is that these generalist workers may not have the skills required to recognise that mental health problems exist or respond best to the window of intervention opportunity that a mental health crisis and a call for help provide”. Problems with primary level mental health services will be outlined in the Ruraltown study (Chapters 7 & 8) where clinical/crisis intervention usually takes priority over an early intervention approach. Lack of training was also an issue.

Thomson (1995) discussed the value of a primary health care approach for the Royal Flying Doctor Service (RFDS) and notes that the RFDS definition of primary health care is both an approach to care delivery, and the level and type of service provided. Further to this, Thomson (1995, p.577) argues that "our approach to primary health care is concerned with collaborative networking; encouraging consumer and community involvement; effectively balancing health care priorities of individual and immediate needs against group and longer term needs; encouraging partnerships with secondary and tertiary sectors; and promoting equity in health outcomes and health access of individuals and groups". It is necessary for doctors who are part of the RFDS to consider all the fundamental elements of a situation in order to respond to the unique physical, psychological and social effects of rural life. Hence the need for a primary health care approach.

The RFDS has also expanded its service to include allied health professionals such as psychologists. Responsibilities by such professionals include counselling, networking, referral and information about support services, and this has been well received by remote clinic staff (RFDS Magazine 2001, p.4). Education and support is an essential part of the Service. The Queensland RFDS launched an educational CD-ROM to help train health practitioners with additional skills when dealing with mental health problems. Its stated aim was to "improve the mental health of those people who live in rural and remote locations, because their health service providers will be better able to detect, manage, refer and follow-up mental health problems" (Bush Telegraph, 1999). A more holistic approach is advocated through primary health care and helps the RFDS to carry out its mission: "to bring peace of mind to rural Australians by providing the world's best aerial service" (Thomson 1995, p.577).

In his discussion of rural health in Queensland, Livingstone (1994) emphasises the importance of community involvement in the delivery of

health care arrangements for rural areas. The regionalisation of Queensland's health care system was part of a statewide plan to improve access and delivery of services. To this end, service planning and delivery was devolved to a local level, specifically through a primary health care model (Livingstone 1994, p.44). The optimum approach focuses on the prevention, rather than treatment, of illness, placing a more educative and positive spin on health care. However, Livingstone (1994, p.45) acknowledges that "actual practice may not reflect the rhetoric. It can be difficult for rural and remote communities to coordinate and plan for all the necessary services whilst still maintaining a cost-effective and representative approach. The formation of partnerships between policy makers, academics and practitioners is vital to the fruition of the primary health care approach". Harvey (2001, p.296) too is cautious about primary health care and concludes that "rural communities, in spite of new initiatives in primary health care and prevention, emerge from these programs with community based models of care that increasingly shift the cost of acute services to individuals; the very individuals who, relatively speaking, are becoming less able to meet such costs". At a practical level, problems with the primary health care approach will be illuminated further in the Ruraltown study (Chapters 7 & 8).

National Mental Health Policy

The issue of mental health in the bush has become a pressing political concern in recent years. The Federal Government recognised the extent of mental health problems in the general community and coordinated a program called the *National Mental Health Strategy* (NMHS 1992). Cumes (1998, p.37) outlines that this strategy was a cooperative program between the Commonwealth, State and Territory governments that aimed to improve the mental health of individuals and the community over a five-year period from 1993 to 1998. In broad terms,

the strategy advocated structural reform of mental health services with an emphasis on community-based care and integration of services.

An evaluation of this Strategy was published in December 1997 (*Evaluation of NMHS 1997*) and is briefly summarised now. Five main observations were made in this *Evaluation*:

- substantial change has occurred in the structure and mix of public mental health services in Australia over the period of the *NMHS*;
- the range and quality of mental health services available have improved substantially;
- the *NMHS* has been instrumental in producing, or at least, accelerating the change process;
- there has been notable change in human service systems operating outside the traditional mental health boundary, which have been previously reluctant to accept responsibility for mental health clients; and
- despite these positive developments, there remains some dissatisfaction with many aspects of mental health services such as access to, and quality of, services.

(*Evaluation of NMHS 1997*, p. 1)

Community mental health services had improved and increased dramatically as a result of this Strategy. However, stigma and discrimination surrounding mental illness remained strong. It was against this backdrop that the *Second National Mental Health Plan: 1998-2003* (1998) was formulated and endorsed by all Australian Health Ministers in 1998, continuing the agenda for mental health policy reform.

The *Second NMHP* (1998) embraced the objectives of the first and introduces three further priority areas for reform: promotion and prevention, development of partnerships in service reform, and quality

and effectiveness of service delivery (*Second NMHP* 1998, p.6). The importance of fostering partnerships between health and service providers, carers and consumers in the community was emphasised in the Plan. To this end, it (*Second NMHP* 1998, p.16) states that “consumers should have a key role in planning and evaluating the services they use and must be able to influence the way their service needs are met...at both the system and service levels through policies, procedures, protocols and funding”. The Plan also discusses the fact that, as specialised mental health services are insufficient in rural and remote areas, networking between general practitioners and other community health services was essential. Inter- and intra-service co-operation and communication was emphasised to ensure there was no duplication or gaps in service provision in the bush.

Rural and remote communities were identified as a priority target group under the *Second National Mental Health Plan*. It was noted in the Plan that “people living in rural and remote communities (RRCs) in Australia have particular mental health needs due to isolation, the impact of economic restructuring, and exposure to environmental hazards such as drought, flood and fire (*Mental Health Promotion & Prevention National Action Plan* 1999, p.26). Transport difficulties, distance from, and/or lack of, services and service providers all tend to compound these problems. The national strategies for rural Australia, as outlined in the Action Plan were to:

- identify opportunities for mental health promotion and illness prevention;
- establish pilot programs in response to local needs and in partnership with local communities;
- establish pilot community development approaches and evaluate mental health outcomes;
- develop education and training programs for the health workforce;

- support and promote systems for integrating issues relating to people from RRCs into the planning, monitoring, and evaluation of initiatives in the *Action Plan* (MH P&P NAP 1999, p.27).

Once again, the themes of community participation, education and liaison were highlighted. As part of the *National Youth Suicide Prevention Strategy* (1995-1999), the *Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia* (2000), evolved. This framework also encompassed the themes of prevention, participation, education and understanding. The *LIFE* framework consisted of three companion documents: *LIFE: Areas for action*, *LIFE: Learnings about suicide*, and *LIFE: Building partnerships*, which covered all aspects of suicide prevention, community partnerships and general information about understanding suicide. It was aimed at all community services with an interest in suicide prevention and mental health promotion.

A mid-term review of the *Second NMHP* was conducted in July-August 2001. Two independent mental health reviewers, Professor Graham Thornicroft and Professor Virginia Trotter Betts, from the United Kingdom and the USA respectively, undertook Australia-wide consultations over a two-month period to provide an international perspective and ascertain the progress of the *Second Plan*. Their inquiries were based on the soundness of content of the *Second Plan*; the progress being made towards, and obstacles to, its implementation; the expectations for achievements by 2003; and the overall strengths and weaknesses in achieving the *Second Plan* (Betts & Thornicroft 2002, p.10). In an international context, they found that Australia was at the forefront in its approach to issues of mental health. According to Betts & Thornicroft (2002, p.15), "Australia's *National Mental Health Strategy* is thus a standard for other nations in what can and should be done as a national policy initiative and demonstrates how federal and state governments can agree through policy documents to address difficult social and health concerns".

In spite of this encouraging finding, short-comings in the *Strategy* were also identified. For example, the limited access to qualified specialist staff for rural and remote areas and a consequent reliance upon primary health care were identified as unsatisfactory. There were also concerns expressed about the inequitable number of psychiatrists that service rural areas and the funding implications stemming from this (Betts & Thornicroft 2002, p.13). Perhaps the most significant finding of the Review was the overwhelming support for a *Third National Mental Health Plan*. Betts & Thornicroft (2002, p.22) concluded that “a *Third National Mental Health Plan* is essential for Australia in order to bridge, consolidate, and push forward the significant gains of the First and Second Plans and to assure Australia’s position at the forefront of international mental health policy”.

The *Third National Mental Health Plan 2003-2008* was released in July 2003. The goals of this plan were to: emphasise mental health promotion and prevention of mental health problems, increase responsiveness to consumers and carers across all mental health and related services, strengthen quality, and foster research and innovation across the sector for sustainable programs and services (*Third NMHP* 2003, p.3). Rickwood (2004) also notes that “recovery” was a major theme of the Third Plan that aims to “maximise well-being, empowerment, opportunities and meaning in the lives of people with a mental illness”.¹¹ Establishing partnerships with community services to assist people to overcome mental health problems was also a major component of this Plan. As such, Wells (2003, p.34) points out that “the Plan recognises the importance of continuing to develop strategies that enhance the role of GPs and other primary care providers in delivering mental health care”. In addition, the core concepts of promotion and prevention were noted as paramount in addressing mental health requirements. It was noted in the *Third Plan* (2003, p.30) that

¹¹ ‘Recovery’ is defined as “living well in the presence or absence of one’s mental illness. The breaking down of stigma and discrimination is central to recovery” (O’Hagan 2004)

evaluation will be carried out in various stages over the next five years, “to determine what works, what does not work, and what should be replicated or further developed”.

Queensland Mental Health Policy

A *Ten Year Mental Health Strategy for Queensland (QMHS)* was initiated in 1996, covering the period to 2006, which incorporates elements of the Australian *NMHS*. The focus of the *Queensland Strategy* was also on enhancing community-based care through the use of primary health care services, as discussed above. The *Strategy* (QMHS 1996, p.4) states that “the central principle for planning and delivering mental health services is that they must target the needs of consumers and demonstrate the effective use of resources in meeting these needs”.

People from rural and remote communities of Queensland were identified as having special mental health needs. Some key initiatives for these communities included:

- the employment of locally-based mental health professionals, to provide support between visits by specialist services;
- the establishment of collaborative networks between health and service providers to cover all the ongoing care and management requirements of consumers;
- the development of strategies to improve recruitment, retention and training of rural health workers;
- and the support of the primary health care sector in addressing mental health issues in rural communities.

(QMHS 1996, p.14-15).

It was argued in the *QMHS* that people from rural and remote communities were a priority group and needed special attention. This was observed through the provision of “outreach services” or visiting

specialist mental health services, in conjunction with local primary health or mental health providers. It was argued that access to these services was essential for rural and remote areas to be able to obtain ongoing mental health treatment (QMHS 1996, p.20). However, services are *not* always obtainable or present in rural communities. Therefore, it can be argued that, at a practical level, this goal has not been reached. This theme will be demonstrated further in the Ruraltown study (Chapter 7 & 8).

In 1997, Cabinet also endorsed the *Queensland Government Youth Suicide Prevention Strategy* (QGYSPS). This Strategy includes prevention, early intervention, and treatment strategies in its framework. Young people in rural/remote areas were identified as being an “at risk” group (QGYSPS 1997, p.5). Through the implementation of both the QMHS and the QCYSPS, it was hoped that people in rural and remote communities would be adequately resourced. However, as will be demonstrated through the Ruraltown study, services in areas of rural Queensland are still found to be lacking in resources and treatment options.

A *Mid-Term Review for the Queensland Mental Health Plan* was completed in June 2003, however, the Queensland Director General of Mental Health did not sign off the Review until June 2004. When Queensland Health was contacted for a copy of this Review in July 2004, I was informed that the Mid-Term Review was for internal use only and a copy could not be obtained. Therefore, at the time of writing, it was not possible to provide any official feedback as to the status of the QMHP. This will be an objective for future research.

Rural and regional mental health development

The Mental Health Branch of Queensland Health developed the *Queensland Mental Health Community Development Strategy* in 1993.

This Strategy aimed “to foster the development of community responses to Australia’s mental health policy” (Whiteside 2002, p.28). Thirteen community development officers (CDOs) were employed throughout the State. The main objectives of the Strategy were to raise community awareness about mental health, improve mental health consumers’ access to community resources and increase the capacity of people with a mental illness to take part in the community. Mental health promotion and prevention was the increasing focus of the CDO’s and, in 1999, the new position of mental health promotion and prevention resource officer was developed to support the CDO’s work (see Whiteside 2002, p. 28). As discussed in Chapter 6, a Mental Health Promotion and Prevention Resource Officer was employed in Ruraltown in late 1999 and this position focused on community mental health promotion, education and support for mental health consumers in Ruraltown. However, funding for this position and other similar positions throughout the State ceased in mid-2002, leaving the task of mental health promotion and consumer support wanting. This will be discussed further Chapters 7 and 8.

Due to the emphasis on consumer and carer participation in the QMHS, the Queensland Mental Health Consumer Advisory Group (QCAG) was established in 1993. This was a Ministerial Advisory Group that “provides strategic advice to the Queensland Minister for Health about mental health consumer and carer views on the provision of mental health services in the state” (*QCAG Information Sheet*). The Group also sought to promote the meaningful involvement of consumers, carers and families in the planning, delivery and evaluation of mental health services. The aim was to support and encourage the establishment and development of consumer and carer advisory groups (CAGs) at local levels for all mental health services in Queensland (*QCAG Information Sheet 2001*).

CAGs were also encouraged to advise mental health services at the local level. There are in excess of thirty-two local CAGs in the Queensland and one of these was set up in Ruraltown in December 2002. As stated by the head of the Mental Health Unit at Queensland Health in Brisbane, assistance to the local CAGs is usually determined at the Health District level. Assistance may come in the form of fund allocation or 'in kind' assistance such as providing a room for members and administration support. However, there have been significant problems reported with funding and support for the CAGs. This will be taken up further in the Ruraltown study in Chapters 7 and 8.

Problems with mental health policy

It has been argued that rural mental health policy requires a unique approach, one that is not based on urban models. As James (1989, p.13) points out, "city professionals and advisers to government assistance schemes often fail to understand rural problems; nor do they find it easy to deal with independent country people who keep their troubles behind the farm gate". Cheers (1998, p.93) also argues that rural policies are often urbo-centric; that is, largely "an urban response by urban people to urban problems". Without having an appreciation of the problems encountered in the bush, it is difficult to propose solutions that adequately address these at the local level. In his report about the difficulties facing rural America, Beeson (1998) also expresses these concerns: "farmers rightly perceive that government policies and corporate practices have contributed to the situations they find themselves in, and many farmers and rural residents blame urban-based and urban-biased policy makers for their plight".

Knowledge about bush culture and rural problems must be taken into consideration when formulating mental health policy for the bush. According to Humphreys et al (2002, p.9), "many decision-makers lack sufficient grassroots understanding of the rural context, where a strong

rural community culture and issues of access are paramount, of how rural communities operate, and of what is needed and what will work in rural environments". When structuring rural policy, an acute understanding of rural life and culture is needed to deliver more holistic programmes that will effectively tackle rural issues at a grassroots level. Failure to consider these cultural elements could lead to inappropriate and ineffective strategies. In light of this, Lavelle (2003, p.6) concludes that, "the future health of Australia's country towns might depend more on what the towns do for themselves, than on what bureaucrats and policy makers decide in the big cities".

It has been proposed that government funding for mental health problems is inadequate. In a SANE Australia media release (2003) it was argued that "the human and financial costs of mental illness to the Australian community are significant and yet mental health problems, which constitute 20 per cent of health service need, receive only 6.8 per cent of the Australian health budget". It has also been argued that government funding has been misdirected. As Hanna (2001, p.14) argues, "Australia has spend millions of dollars to increase the number of doctors in the bush, but their numbers continue to fall, and the health gap widens". It may be more appropriate to use some available funding to enhance already existing services, improve educational opportunities and broaden health promotional activities.

In addition, the repercussions of government deregulation and restructuring have been considerable in terms of mental health decline. Rees and Fischer (2002, p.204) argue that "the political challenge for governments is to manage and minimise the inevitable pain of change — something that has not always been achieved". Cheers (1998, p.56) also believes this to be the case and argues that "the fact that a large number of marginal farmers would be forced to leave their farms as a result of primary industry restructuring could have been foreseen because restructuring was government policy. Services could have been

put in place, including counselling for social and emotional problems” (also see Hallebone et al 2000 & 2003). However, as will be evidenced in this research, even when services have been put in place, there has still been reluctance by people in the bush to utilise them.

Conclusion

This literature review of mental health issues in the bush has highlighted many of the problems faced in the recognition, acceptance and treatment of these conditions. The major barriers to help-seeking have been explored. As discussed in Chapter 2, the bush legend dictates that men be tough, resilient, self-reliant and unemotional, among others. This also has implications for the way rural women address mental health issues. Through the research in Ruraltown, and an analysis of supporting evidence, it will be argued that some of the barriers to mental health stem directly from the Australian bush identity, with its entrenched ideological beliefs of independence, self-reliance and stoicism that dissuade acknowledgement of problems. As Barnes (2000, p 8) concludes, “it’s time to unmask the myth that strong men cope, no matter what this harsh land throws — particularly when what we call coping actually boils down to a non-expression of emotions. Masculine toughness does not alter the fact that feelings of futility and despair are natural reactions when watching the work of a lifetime die with each bullet”.

A more comprehensive understanding of Australian bush identity and lifestyle would ensure that policy, services and communities are better informed on the best way to tackle mental health problems in the bush. As stated in a “Letter to the Editor” (*QCL Friday Magazine* September 2003), “increasingly, the burden of weight must lie with our politicians and policy makers. In regional and rural Australia, where difficulties such as unemployment and poverty are causing breakdowns in families and communities, we are robbing people of their ability to live with

hope, dignity and self-esteem. Too often, these are the exacerbators of problems such as depression and they must be addressed as a matter of urgency". The next chapter outlines the methods used in a study of attitudes to mental health in a Queensland rural community, and also delivers an overview of data collection and introduces the key informants who were consulted in the community.

CHAPTER 6

METHODOLOGY OF THE STUDY: MENTAL HEALTH IN RURALTOWN

*Gathering stories and information and impressions and emotions —
all the good gooey stuff that makes up everyone's daily lives —
is the heart of qualitative research.*

(Fitzpatrick et al 1998, p.56)

The qualitative research undertaken in this thesis employed identity concepts and deals primarily with the influence of bush culture and identity on attitudes to mental health. It is divided into two sections, the first being a methodology literature review to explain the research process, and the second section provides details of the community under review which, for the purposes of this research, will be called "Ruraltown"¹², and the data collection procedure undertaken in the community. Extensive primary and secondary sources have been examined in this essentially qualitative study of Ruraltown which uses ethnographic precepts to examine attitudes to mental health in the bush and explore the underlying sources of these attitudes.

RESEARCH METHODOLOGY

The research methodology used in this study was predominantly qualitative. Rather than evaluating the prevalence of mental health problems in Ruraltown, the study sought to understand the social influences, structures and processes operating in the community which may affect attitudes to mental health (see Gillespie 2000, Lupton et al

¹² In the interests of anonymity, sources used for the description of Ruraltown will be contained in a confidential annex to the thesis.

1992). This was the rationale for using a qualitative approach in this research: while it may touch on reports of the extent of mental health problems in rural areas, it is more concerned with rural society: its structures, processes, culture, identity, beliefs and traditions, which in turn influence *attitudes* to mental health. For Denzin and Lincoln (2000, p.4), the essence of qualitative research is to “seek answers to questions that stress how social experience is created and given meaning”. This formula has been applied to determine the “where, when, what and how” of attitudes to mental health in the bush.

Due to the nature of the subject being examined, that is, the relationship between bush identity and attitudes to mental health, multiple approaches of qualitative research have been employed. Denzin and Lincoln (2000, p.2) state that “the multiple methodologies of qualitative research may be viewed as a *bricolage*, that is, a pieced together, close-knit set of practices that provide solutions to a problem in a concrete situation”. Another term frequently used for in studies with multiple methods is “triangulation”. Tashakkori and Teddlie (1998, p.41) explain that “the concept of the “triangulation of methods” was the intellectual wedge that eventually broke the methodological hegemony of the monomethod purists”. As Creswell (1998, p.211) argues, “triangulation enriches the evidence and guards against potential errors” (also see Minichiello et al 1995). The more methods used, the less chance for invalid biased results.

This study provides a “thick description”: it gives the context of an experience, states the intentions and meanings that organized the experience, and reveals the experience as a process (Denzin 1994, p.505). To delve deeper into the values, opinions, attitudes and behaviours of people, which was the intention of this research, a qualitative approach was essential. Spradley (1972, p.136) argues in a classic statement that “too much research is done in the name of

science without regard to its effect on the people studied and for their well-being". People and their attitudes were the focus here.

The qualitative research methods undertaken to examine attitudes to mental health in the community included anonymous questionnaires, informal discussions, formal semi-structured interviews, participant observation, field notes, and personal experiences in the field. Fieldwork is essential to any ethnographic study — it is necessary to experience and observe the culture or group first hand in order to cross-check, compare and triangulate information on which to build the foundation of a knowledge base (Fetterman 1998, p.9). Questionnaires were used to gather data on attitudes to mental health. According to Bessant (1999, p.78), "the advantage of the survey questionnaire is that it can collect large amounts of information — or at least sample the views, beliefs and activities of large sections of the population". Interviews with key informants were also appropriate for the goals of this research as they allowed for elaboration and elicitation of important information.

Analysis of the questionnaires and interviews was conducted by grouping common themes, ideas and subjects together, and measuring the frequency of responses. As the groups were small and the responses received were not extensive, it was decided that the use of computer analysis was not warranted. An effective thematic analysis was possible by manual categorising. Hall and Hall (1996, p.134) maintain that "where the same words appear in different people's responses, you can be fairly confident in grouping the replies together". This also applies to the same themes or meanings of statements. Minichiello (1995, p.247) argues that "data analysis is the process of systematically arranging and presenting information in order to search for ideas". The data needed to be grouped into common themes or patterns, and then explanations or propositions were put forward and patterns were elucidated from this data.

The recurrent mention of certain words, concepts or themes in both the questionnaires and interviews alerted the researcher to their importance and, therefore, data analysis was an ongoing procedure. Analysis of the completed interview transcripts revealed predominant ideas or opinions about mental health issues in Ruraltown. It became apparent which were the key issues and what factors influenced these outcomes. The data obtained was very rich in its content, meaning and inference. To use this data effectively, it needed to be coded. As Minichiello (1995, p.258) argues, "codes need to be conceptually based and clearly defined. The codes you devise should be related to the research questions asked and fit into a conceptual scheme". Reconstructing the codes or themes that appeared in the questionnaires and interviews was the crux of the data analysis.

The ethnographic study of Ruraltown

In order to gain a representation of rural society, a study of "Ruraltown" was conducted to obtain first hand knowledge of a small-scale social world and attempt to explain it with reference to the operations of wider society (Wild 1981). The Ruraltown study was based on ethnographic (or in-depth cultural) principles. As Neuman (1991, p.346) explains, "*ethno* means people or folk, and *graphy* refers to describing something. Thus *ethnography* means describing a culture and understanding another way of life from the native viewpoint". In support of the use of ethnographic data in qualitative research methodology, Roberts (1995, p.152) argues that "the collecting and reporting of iterative accounts provides access to the subjective and interpretive world views of people, thus highlighting the impact of social phenomena on their lives". The main reason for adopting an ethnographic approach to the study of Ruraltown was that the central issue to be examined was a cultural one: bush culture. According to Fetterman (1998, p.1), "ethnography is the art and science of describing a group or culture". It is argued here that bush culture reflects certain mores, beliefs and behaviours that

impinge upon the identity and everyday lives and attitudes of the people who are part of that group. This is the essence of Tajfel's (1982) theoretical perspective on social identity. He argues that an overriding factor of individual identity is the knowledge that one belongs to a group and hence adopts the group's identity, traits and characteristics (see Chapter 3).

Fitzgerald discusses the methods used in ethnographic research. She (Fitzgerald 1997, p.52) states that "ethnography involves the use of any technique or method which will allow the researcher to address the issue at hand and rarely involves the use of any one technique or method". It can involve any or all of the following: observation, participation, interviewing, analysis and interpretation of secondary sources, experiments, questionnaires, critical self-reflection and introspection. The topic of interest is the focus of the ethnography, not the methods used. Comparability of the procedure and findings of this study to other similar projects has also been undertaken to support the findings. According to Fitzgerald (1997, p.59), "ethnography is about understanding human phenomena: the meaning, purposes and motivations that underlie them. It is about understanding how people adapt and adapt to the world around them — and why they do so in a particular way". This research project attempts to understand how bush people feel about mental health issues, why they feel this way and where these attitudes come from.

Through an ethnographic study, the researcher is able to explore, understand and interpret cultures, societies and lifestyles. From this perspective, one can postulate theories about how and why a culture operates to produce certain ideas or behaviour. Atkinson (1994, p.248) argues that "ethnography usually refers to forms of social research which has a strong emphasis on exploring the *nature* of particular social phenomena, rather than setting out to test hypotheses about them". Marshall (1999, p.57) takes this one step further and states that

“one could argue that human actions are significantly influenced by the setting in which they occur; thus, one should study that behaviour in real-life situations. The social and physical setting including the norms, traditions, roles and values are crucial aspects of the environment”. This study examined how and why mental health issues are perceived the way they are in the bush, and how they are often “silenced” in the rural context. This study has then related these factors to the existing cultural and social bush identity.

Marcus (1994, p.566) argues that ethnography is a “cultural translation”, and bush culture, in this instance, was the subject for interpretation. Creswell (1998, p.60) argues that “the final effort of an ethnography is a holistic cultural portrait of the social group that incorporates both the views of the actors in the group, and the researcher’s interpretations of the views about human social life in a social science perspective” (also see Denscombe 1998, Fitzgerald 1997). It can be argued that a cultural examination of any community will reveal aspects of that community that may be otherwise hidden.

Being an ‘outsider’ to the community, extensive prior research was conducted to gain familiarity with the history, industry, people and services in the town. Acceptance into the community did not, on the surface, appear to be a problem. There were four separate visits to the Ruraltown community over a period of three years, with each stay being approximately one week. Interviews, questionnaires, group meetings, participant observation, casual interactions, and presentations were carried out during these visits. In addition to results from the interviews and questionnaires, extensive fieldnotes were taken of observations about people, organisations, attitudes, and occurrences in the community, and the Ruraltown newspaper and other local documents were also analysed. It is often what is *observed*, rather than what is *said*, that can provide the most important evidence. The ethnographic study involved four visits to the site, to observe, assess and interact

with the community. The intention was to form a more complete picture of the community, to include the personal views of the participants, the meanings they attached to every day life and what their attitudes to mental health were in the social context.

The initial key informant was discovered through an article in the Ruraltown newspaper. The “snowballing” or referral method was then used to find other informants who might be interested in participating in the study. As Johnson (1990, p.81) argues, “the snowball procedure provides the ethnographer with the explicit means for moving through the community in some methodologically and theoretically meaningful way” (also see Hall 1996). The initial key informant suggested other mental health and service providers to consult. They, in turn, referred me to other providers or consumers, and so on. It was a very effective way to canvas the community.

The interviews

Semi-structured interviews were carried out with most of the key informants. The value of using the semi-structured interview, according to Wilkinson (2003, p.45), is that “the interviewer directs the interview more closely. More questions are pre-determined though there is sufficient flexibility to allow the interviewee an opportunity to shape the flow of information”. It was also important that the interviewees understood the nature and purpose of the research in order to obtain the appropriate context of information. A detailed Project Information Sheet (see Appendix 1) was given to each interviewee to inform them of the research intention and parameters, and reduce misunderstanding of the project objectives.

Therefore, the questions asked needed to be specific and understood by the interviewees. From a symbolic interactionist perspective of question-answer behaviour, Foddy (1993, p.21) explains that “respondents will

constantly try to reach a mutually shared definition of the situation with the researcher". To ensure there was no confusion, some principal points were made explicit before the interviews. These points were: that the topic was clearly defined so the respondent was fully aware of what was required from them, that they had the knowledge and understanding that was needed to answer the question, and that the research situation did not influence the nature of the answers given by respondents (Foddy 1993, p.13).

The initial interviews used the "funnelling" strategy (see Appendix 6 & 7 for interview transcripts). Minichiello (1995, p.84) describes this as "a process of questioning in which the interviewer controls the flow and type of information being asked by starting the interview with questions of a general and broad nature, and it is only later that he or she is required to be more specific in responses". For the early interviews, general information about Ruraltown and its services, and other rural issues, were discussed to establish rapport and trust with people who may be part of the ongoing study. To inform the research process further, probing questions about mental health were asked to obtain a fuller understanding of the issue. For example, it was not assumed that the interviewee had the same understanding of bush culture as the researcher. In this case, probing questions were asked to elicit greater detail and clarification (Minichiello 1995, p.90).

Another benefit of using interviews of key informants, in addition to the questionnaires for the general sample, is that it provided the opportunity for clarification and elaboration so there was no misunderstanding of meaning or question (Tashakkori & Teddlie 1998, p.102). Not all the participants suggested were suitable or knowledgeable informants with regards to the aims of the study, however, all information gleaned was useful in some way. The in-depth interviews with providers and community members expanded on the patterns and attitudes that were apparent in the questionnaires. The

interviews were loosely constructed around certain themes and, by categorising the responses in relation to these themes, common patterns were revealed. As Hall (1996, p.199) explains, “categorisation is required to allow comparisons between informants and to show how widespread certain feelings and attitudes may be”. Direct quotations from these interviews have also been included. According to Hall (1996, p.211), the use of direct quotations adds to the richness of data and allows the informants to speak for themselves.

Naples (2000) raises an interesting point with regards to choosing the boundaries of the study and the informants. She (Naples 2000, p.195) states that “dynamics of power influence how problems are defined, which knowers are identified and are given credibility, how interactions are interpreted, and how ethnographic narratives are constructed”. It is important to be alert to the fact that some experiences or beliefs may be “hidden” due to external pressures or fear of recrimination in the community. This is especially valid in the case of group interviews. The researcher needs to be aware that intragroup hierarchy or conflict may affect some responses. Fontana (1994, p.365) discusses the problems associated with group interviews and states that “they may interfere with individual expression, the group may be dominated by one person, the group format may make it difficult to research sensitive topics, and “group think” may be a possible outcome”. I was acutely aware of these potential problems in the group and joint interviews that were carried out in Ruraltown. However, they did not appear to influence respondents’ answers in any way.

As stated above, an Information Sheet about the research project was given to each interviewee. Participants were also asked to sign a Consent Form (see Appendix 3) regarding the use of the data they gave. These signed Consent Forms allowed for the use of information imparted by the informants as evidence in an academic context for the research. Permission was also obtained from all of the informants to

tape record the interviews. This allowed for a more relaxed style of interview in which elaboration of relevant details could be made.

The questionnaires

The canvassing of rural groups by questionnaire — at the QRWN Conference, Ruraltown Rotary Club, Ruraltown Isolated Children's Parents Association, Ruraltown health and service providers, Ruraltown Consumer Advisory Group, Ruraltown Financial Counselling Service, Ruraltown Police, and Ruraltown Agforce — illustrated some of the belief patterns and attitudes to mental health in the bush. The questionnaire for health and service providers was slightly shorter than that given to the other groups. However, the same themes were covered (see Appendix 4 & 5). Non-random "convenience" sampling was employed as the above groups were easy to gain access to and were essentially representative of rural people (Mangione 1995, p.38). Denzin (1994, p.202) also explains that it is easier to seek out groups, settings, and individuals where the processes being studied are most likely to occur (also see Silverman 2001). When choosing a sample, Hall (1996, p.107) argues that "it has to be representative and must be chosen carefully to mirror the characteristics of the target population and needs to be large enough to inspire confidence in the results". It was important to gather information from a significant number of men and women in structured rural groups, and not to rely solely on the information from health and service providers.

Perspectives were also obtained from a number of Ruraltown mental health consumers. Hughes (1997, p.156) argues that "as part of the postmodern 'turn' in rural social scientific research, attention has started to be directed to the lives and experiences of 'marginalised' groups in rural society". By gathering the opinions of women and mental health consumers in the Ruraltown study, a more holistic and representative picture of general attitudes to mental health could be

obtained. Naples (2000, p.199) concurs: “although community leaders (in this case, health and service providers) provide particular insights as key informants, we might develop deeper understandings of problems as well as solutions for rural community issues by listening to women and other marginalised groups”.

An Information Sheet was attached to each questionnaire to inform the respondent about the nature of the research (see Appendix 2). The questionnaires were anonymous, with the inclusion of contact details being optional. The questionnaires distributed to the above groups included open-ended and closed-ended items, and also included questions to be answered using a numbered scale to measure the extent of agreement or disagreement with certain statements. The purpose of these questions was to determine the frequency of particular answers, and to organise the responses into categories relating to bush identity. It did not involve the formal development of a scale and averages, as in the use of the Likert scale (see Wilkinson 2003, Mangione 1995, Tashakkori & Teddlie 1998). In this case, respondents were asked to express their response — ranging from strongly agree to strongly disagree — to statements regarding mental health. The value of using the questionnaire was the protection of respondent anonymity, and the same format could be used for different groups, increasing the reliability of answers and making the number of responses easier to measure (Wilkinson 2003, p.39).

However, gaining a representative sample was difficult due to the non-response rate. Hall (1996, p.130) argues that “the difficulty with non-response is that if the number of informants not replying to a questionnaire is large, then the information from those who do reply may be biased because they differ in some significant way from those who did not reply”. This would be difficult to measure when using anonymous questionnaires. Mangione (1995, p.60) also argues that, if the response rate is low, the study may be less useful as the majority of

the sample is not represented in the results. Along the same lines, Williams (2003, p.99) suggests that “often, frustratingly, the people who refuse (to answer) are the very ones the researcher wants to include in the analyses”. In this study, due to the nature of the subject, obtaining responses from rural men was problematic. However, as will be considered in the *Results and Analysis chapter*, there are other influencing factors to be considered, and additional supporting evidence has been used in this study to allow for assumptions to be made. Although it may not be possible to claim authoritatively that the same mental health situation exists in every Australian rural community, it is plausible to accept that conditions would be very similar.

There were no strict methodological guidelines or techniques used in this study. It was an empirical investigation and the researcher was directly involved in deciding what and who are included in the data collection. The aim was to get to the core of the issue being examined in the least disruptive manner, hence the need for relaxed integration into the community. The Ruraltown study has also assessed the impact of macro-economic and political changes at a local level.

Due to the nature of the research, there were ethical and axiological considerations in method, decision-making and reporting. As mentioned above, all interviewees signed consent forms and anonymity was assured at all times. The ethical guidelines in conducting such a study were adhered to, to reduce the likelihood of biases and values clouding issues where possible. Ethical submissions were made to the University at regular intervals and approval was granted to carry out the research in Ruraltown.

However, as is often part of ethnological analysis, personal experience was included and connected with at times in the interpretation of the research and, where this has occurred, personal involvement has been identified. As Denscombe (1998, p.73) points out, “we can only make

sense of the world in a way that we have learnt to do using conceptual tools which are based on our own culture and our own experiences". However, a keen awareness of potential impartiality may reduce this tendency. Naples (2000, p.195) terms this process as "reflexivity"; that is, careful monitoring of ones own subjectivity. Gillespie (2000, p.185) also agrees that "objectivity may not be possible but self-conscious detachment can be achieved". With reflexivity in mind, the first person has been used to distinguish myself in the research. As Holliday (2002, p.143) argues, "the use of the first person is a major device for separating the researcher's agenda from the other voices in the text, thus increasing transparency and accountability".

In this qualitative study, generalisation from the particular region of Ruraltown to other parts of the country was undertaken with care. As Roberts (1995, p.152) found in his ethnographic study of gay men in rural areas, "the research focused on the qualitative dimensions of the experiences of those interviewed. It is not possible to report on the prevalence of these experiences beyond the sample, although this is anecdotally supported". This same argument applies to the current study, with respect to attitudes to mental health. Other studies that have focussed on the theme of bush culture and/or mental health have revealed similar findings. Stehlik et al (1999, p.15) also argue that comparison to other studies and the use of triangulation may also be a way of supporting the findings of a research study and mitigate against potential bias.

In the early stages of the research, I was mindful of the sensitive nature of the subject of mental health. Precautions were taken not to overtly publicise my interest for fear it might alienate people or hinder participant involvement in the study. Warren (1988, p.23) discusses the importance of not provoking suspicious or unwelcome attention in the field. Only the key informants were aware of my initial research interest in the community and they were reassured from the outset that my

intention was to provide a constructive, positive and useful application of the data collected.¹³

The aims of the Ruraltown study

As noted earlier, a town in South-West Queensland, which will be called “Ruraltown” in this research, was chosen for the study of attitudes to mental health in a rural community. The aims were:

- to ascertain if the historical bush identity is recognised currently in Ruraltown;
- to determine if bush identity has any influence on attitudes to mental health in Ruraltown;
- to discover if these attitudes affect service provision and utilisation in Ruraltown;
- to collect data through the use of interviews, questionnaires and observations, and contextualise that material within a broader framework;
- and, finally, to propose any solutions or suggestions that can be of assistance in improving the reception to, and use of, mental health services in rural areas.

All four visits to Ruraltown involved meeting new providers, consumers, and community members, and catching up with previous interviewees. The additional information obtained each time served to confirm and extend my earlier impressions about attitudes to mental health and the services in Ruraltown. These impressions and the information obtained

¹³ Although Information Sheets about my project were attached to all questionnaires and given to all interviewees, at times there appeared to be a misunderstanding about the intention of the research, particularly in the questionnaire responses and interviews with consumers. I sometimes felt I was being incorrectly credited with being able to “fix the situation”. However, I had a keen awareness of this vulnerability, and that the frustration or distress with personal situations may have intensified some respondent feelings or responses. At all times, I was empathetic to their situation but careful not to take on a “counsellor” role. I do not believe I allowed any of these situations to colour my judgement or divert the purpose of my research.

will be discussed at length through a “thick description” of the data and findings in the Results and Analysis chapter (Chapter 7). Through such a description, other less obvious evidence has also been revealed. As Holliday (2002, p.81) concludes, “ ‘sorting’ winks from twitches and illuminating the deeper meaning beneath them requires that the researcher has to *do* something with the data and *make* a case for how winks are different to twitches”. When all the data from the Ruraltown study have been combined through a thick description, supportive evidence has been found in many forms.

Between visits to Ruraltown, I was able to remain abreast of rural concerns, issues and interests as a member of the QRWN and through subscription to their email list. Some of the issues raised through the QRWN have been discussed in other chapters. Members from all over rural Queensland post to this list and it is a rich source of information. I attended several meetings held by the QRWN and the National Council of Women (NCW) in regional Queensland, at Gympie, Murgon and Toowoomba. These local meetings, and the 2002 QRWN Conference, were held to discuss rural issues that were pertinent, though not confined, to rural women. Diverse issues were raised at the meetings such as drought declaration procedures and restrictions, domestic violence, assets testing for welfare, water and freight problems, rural health problems, insurance and public liability issues, and wild dog control.¹⁴

¹⁴ Issues of particular significance to this research were addressed at the QRWN-NCW AGM at Gympie in July 2002: the issues of rural suicides, and the problems with recruitment of health workers to rural areas. At this meeting, I presented an overview of the mental health situation in Ruraltown and expressed concern about the lack of continuity of funding for positions and programmes, and service provision in Ruraltown. The example I gave was the termination of the Mental Health Promotions Project after only 3 years, just as it was becoming effective. As a result of this discussion, a Resolution was passed at the meeting and presented to the Queensland Minister for Health. The Resolution read: “This meeting commends the Government on recognising the need for increasing the funding for rural mental health, and requests that the Government provide recurrent funding for such programs and for support structures, for more than 3 years, to provide continuity of care and trusting working relationships”. Although a comprehensive reply was received from the Minister, outlining all the initiatives and policies that the Queensland Government has

Participation in these QRWN and NCW meetings was a valuable way to obtain a broad perspective on problems facing rural communities in general, as well as the particular issues relating to mental health. Rural newspapers such as the *Queensland Country Life*, the *Ruraltown Paper* and the *Rural Weekly* were also analysed regularly to provide data on rural issues, community events or changes at the local level that may have an impact on the area of mental health. The local newspaper is a valuable source of information about a community. As Kirkpatrick (1995, p.222) argues, "the [local] paper is to an important extent written *with* people and not *by* them; and, in the sense that it is written *for* them, in terms of an interest larger than the paper itself: that of the local community". The research activities conducted between the Ruraltown visits were useful for making ongoing connections to, and critical to the process of, the study in Ruraltown.

In summary, the ethnographic study of Ruraltown was a qualitative analysis that utilised methods such as semi-structured interviews, questionnaires, participant observation, the taking of fieldnotes and community interaction. Through the use of these methods, attitudes to mental health have been gathered from community members, service providers and consumers. In the following section, a detailed description of Ruraltown and the mental health services consulted is given, followed by an account of data collection in the community.

THE RURALTOWN STUDY

Once a traveller leaves metropolitan Australia behind, not only the geography changes but also the social and political environment, the demographics, and the infrastructure.

(Wilkinson & Blue 2002, p. 1))

The setting for the analysis of attitudes to mental health was a rural community in South-West Queensland called "Ruraltown". The reason this community was chosen is that it is sufficiently isolated to illustrate the service problems experienced in the bush. It is mostly sheep and cattle country. This is an important distinction for this research as, historically, Australia's wealth was largely founded and sustained on the pastoral industry well into the twentieth century. As Lawrence (1987, p.14) argues, "the wool industry is considered, along with that of wheat and beef, to be part of the holy trinity of Australian agriculture". In addition, it was through the well-spring of lifestyle characteristics and personal traits possessed by the drovers, shearers, bushworkers and squatters of the nineteenth century that the bush identity was forged (see Chapter 2). It can be argued that the people of Ruraltown and its surrounds, as in many other Australian bush communities, remain influenced by the historical bush identity, culture and legend. Gray (1991, p.6) argues that "to understand the events observed in fieldwork, it is necessary to establish their historical context". The Ruraltown study sought to determine if characteristics of the historical bush identity were still exhibited today, and what effect, if any, this identity has on attitudes to mental health.

However, it must be recognised that the findings of this study will not necessarily be conclusive and may not provide complete "answers" to the research questions. The outcomes are interpretive and provisional, and are especially so given the dynamic nature of the change process in

rural areas. Moreover, the sensitive nature of the subject may have inhibited the involvement of participants and affected response rates to the various structured and unstructured questions.¹⁵

I went into the field with four overarching questions:

1. What, if any, is the influence of bush identity on attitudes to mental health?
2. How 'real' is this identity in the bush today?
3. What are the implications of this identity for mental health service provision and utilisation in rural Australia?
4. How can attitudes to mental health be improved in the bush?

To answer these questions, it was necessary to have an initial understanding of bush culture and identity — what it represents and includes, where it came from, how it was developed, and to establish if it has any 'real' significance in contemporary times. According to Denscombe (1998, p.73), "making sense of what is observed during fieldwork observation is a process that relies on what the researcher already knows and believes, and it is not a voyage of discovery which starts with a clean sheet". Prior knowledge was gained through extensive research of primary and secondary materials (See chapters 2, 3, 4 & 5). As noted in the Introduction, I was also able to draw significantly on personal experience to extend the dimensions of the

¹⁵ A recent study similar to the one performed in this research also encountered the problem of obtaining adequate involvement and responses. Rogers-Clark informed me at interview in 2001 about a study that she was commencing, examining the relationship between depression and suicide among men in rural Queensland. She later explained to Krosch (2002) that "the research team was looking to learn from the wisdom of men who had overcome depression, and apply their knowledge to other men who might be struggling with the pressures of rural life". It was hoped that about a hundred men would take part, however, only ten men volunteered. Rogers-Clark (Krosch 2000) explains that "the research team surmised that this shortfall may indicate an unwillingness on the part of rural men to share their problems, and just continue to go about their work stoically". The low response rate in the current research study may also reflect this reasoning. However, as Oxley (cited in Wild 1981, p.125) argues, "if you cannot study what you wanted to study, study the reasons why you cannot". Accordingly, I considered the reasons why some people in the bush, especially men, are reluctant to address and discuss mental health issues, as an important contribution to the discussion of mental health perceptions and identity.

research inquiry. Grace (2003) notes that it was her country childhood that was a powerful sub-conscious motivating factor for researching rural issues. She (Grace 2003, p 105) states that "it is a way of integrating and making meaning of a part of one's life". It is also my experience of bush culture and issues relating to mental health that prompted this study. In order to further explore, test, validate and extend the knowledge and experience of bush identity, and to determine its impact on attitudes to mental health, the study in Ruraltown was carried out.

DESCRIPTION OF RURALTOWN

Ruraltown is a community in Southwest Queensland. It is situated about five hundred kilometres from the coast. Ruraltown was first settled in the mid-nineteenth century and recently celebrated its 140-year anniversary (*Ruraltown Paper* 3rd September 2002, p. 3). It developed as a service centre for the rapidly developing pastoral industries. It continues to service these industries, as well as the oil and gas industries, and has become a major State public sector centre and a tourist destination. Ruraltown supports a broad range of economic sectors and its main function is to support the commercial, community, administration and infrastructure needs of the Southwest region of the State. However, like most communities in the region, the existing and future viability of Ruraltown is linked directly with the stability and prosperity of the pastoral and agricultural sectors of the economy.

In its history, Ruraltown has suffered through many natural disasters such as drought and flooding. Many bush fires over the last century have also caused widespread damage to the area (*Ruraltown Paper* 3rd September 2002, p. 3). The recent long-term drought and rural restructuring (see Chapter 3) have acutely affected Ruraltown. Some farmers in the Ruraltown district maintain that the area has been in drought for the last ten years (*Ruraltown Paper* 31st August 2004, p. 1).

Despite this, Ruraltown was only added to the “drought declared” list on the 20th February 2002 (*Ruraltown Paper* 21st February 2002, p. 1). The declaration was a long time coming for many farmers and businesspeople in Ruraltown who have been struggling with the repercussions of drought for a significant period. It was reported by the QRAA (2003) that 21.5% of total rural debt in Queensland in 2003 was in the Southwest region, which includes the Ruraltown district.

The population of Ruraltown at the 2001 Census was 6346 people, a decrease of 1.4% since the 1996 Census. If people in the surrounding districts and on properties who are also serviced by the town were included, the population then reaches 15 000. The local authority area of the Ruraltown Council covers 78 square kilometres. Because of its central location in the west, it has a high visitation rate by the travelling public. Ruraltown has a post office, five Banks, a Legal Aid and an Aboriginal Legal service, government and administration offices, petrol stations and grocery stores. There are three schools in Ruraltown — Primary and Middle Schools, a Catholic Secondary School, and a College which caters for years eleven and twelve and TAFE students. In recent years, a Woolworth’s Supermarket, Target Country store, Fosseys, McDonalds, and KFC outlet have been established in Ruraltown. The town has a Youth and Recreation Centre, a Cultural Centre, a cinema, and a Turf Club for horseracing. Ruraltown supports many sport and recreation activities such as tennis, golf, bowls, athletics, ponyclub, rugby union and league, soccer, cricket and netball. There are also cattle sale yards. The town has several motels to accommodate passing tourists and itinerant workers in the area. The Visitor information Centre provides information on accommodation and tourist outlets. The local newspaper in Ruraltown is published twice a week and I subscribed to it for three years to gather information about local issues, community events and to keep abreast of any significant changes in Ruraltown.

The primary industries represented in the area include beef, wool, wheat, hard grains, timber, goats and wine. There are other industries in the town that provide substantial employment for locals such as a sawmill, farming sector outlets such as Agforce, Landcare and Landmark, and museum devoted to local natural resources. The sawmill, which has experienced recent job losses due to fire and downsizing, is under continuous threat of closure. Ruraltown has a number of Queensland government agencies that service the District and provide employment at managerial and administrative levels.¹⁶

Ruraltown is proud of its history and bush heritage and celebrates many events that are part of the bush tradition. For example, in the “Year of the Outback” in 2002, Ruraltown held celebrations in August, beginning with a four-month cattle drive along local stock routes, arriving in Ruraltown on the 14th August 2002. The culmination of the celebrations was the re-enactment of a famous nineteenth century court trial in Ruraltown involving a cattle thief. The local paper retold the story that “this cattle thief was one of the colourful characters that found notoriety in the late nineteenth century when he stole 1000 head of cattle from an outback station, ‘droving’ the cattle to South Australia before he and his accomplices were captured. A trial was held and, when the jury returned a not guilty verdict, the Ruraltown court was banned from handling criminal cases for two years” (*Ruraltown Paper* 3rd September 2002, p. 3). Like in the case of bushranger Ned Kelly (see Chapter 2), this is another example of bush people celebrating the life of a criminal underdog. There were also displays, novelty events, country markets, and arts and crafts exhibitions, to name a few. The aim of the four-day long celebration in Ruraltown was to showcase its historical and contemporary characters and celebrate “the bush”. As a local State

¹⁶ It was argued that this has both beneficial and negative effects. The former manager of the local newspaper explained that “if there weren’t so many government agencies, there would be significant unemployment. However, government agencies can also mean a transient population, with people being transferred in and out of Ruraltown on a fairly regular basis, which does not establish community continuity”.

government member stated, "it is time for a greater understanding by city people of the true spirit of rural Australia and its ability to triumph over adversity, which goes to the very heart of Australia's identity" (*Ruraltown Paper* 15th March 2002, p. 4).

There are other smaller scale events held in Ruraltown which bring the city and the country together such as a popular annual racing carnival. Also, in September 2004, a shearing and woolhandling competition was held in Ruraltown. The Ruraltown Mayor stated that "there's nothing more iconic of the Australian country way of life than the traditional skills of shearing and wool handling. Those skills have done so much to develop our economy and even our folklore" (*Ruraltown Paper* 20th August 2004, p. 14). Events such as these are very significant to the community of Ruraltown as they are re-affirming the importance of the bush both to themselves and the nation; in essence, they are authenticating and reifying the bush legend and their place in it. Bush culture and identity are alive and well in Ruraltown, as will be evidenced through this study.

HEALTH AND COMMUNITY SERVICES IN RURALTOWN

Of particular relevance to this study are the health and community services in Ruraltown. There is a Base Hospital and a nursing home for the elderly. A number of general practitioners practice in Ruraltown from private surgeries. Centacare is a psychology service that provides counselling and educational services to the community. It is a fee-paying service, funded by Queensland Health and Catholic Education Office, and has a psychologist and counsellor on staff. There are other community-based services such as Red Cross, the Salvation Army and St. Vincent de Paul which provide crisis and emergency support to the community. The Royal Flying Doctor Service (RFDS) also operates out of Ruraltown, providing outpatient and operating services to the district.

There is a Primary Health Care Unit (PHCU) which provides services for mental health and allied health.

The three main agencies concerned with mental health support in Ruraltown that were consulted for this study are the Mental Health Service (MHS), (which is part of the Primary Health Care Unit - PHCU), the Anglicare Western Region office, and the District Community Support Centre (Neighbourhood Centre). These three services provide assistance free of charge to the public. Ruraltown's Base Hospital, private GPs and Centacare have also been consulted, though not as extensively as the aforementioned services. The three main mental health services, which are the main providers to the community, will now be discussed in more detail.

THE THREE MAJOR MENTAL HEALTH SERVICES

The Mental Health Service (MHS), operating within the PHCU, is under the auspices of Queensland Health and has an Adult Mental Health Service and a Child and Youth Mental Health Service. At the time of writing, there were two Adult Mental Health Workers, both from nursing backgrounds, and one Child and Youth Mental Health worker who is a social worker. There is also a visiting Mental Health Care Service that visits approximately every five weeks from a large regional Base Hospital. The aims of the MHS are to:

- provide services in the community to people with long-term mental health problems such as depression;
- assist in identifying needs in the community for mental health services;
- provide accessible services close to where people live and work; and
- to minimise hospitalisation by provision of early intervention.

The MHS also attempts to play an educative role in the community, provides crisis intervention where possible, and now facilitates and supports the Consumer Advisory Group (CAG). A brief outline of these Advisory groups was given in Chapter 5. The aim of the CAG was “to assist and empower consumers and carers so that they are able to contribute and respond effectively to the National Mental Health Plan in the town area” (CAG brochure 2002). This Group will be discussed later in more detail. The MHS has been described by a worker as “an extremely busy, under-resourced service which, out of necessity, has more of a clinical/crisis intervention than an early intervention/preventative focus”. For this reason, its role is different from that of Anglicare which adopts a more preventative, consumer-oriented approach. Although both agencies are addressing mental health issues, they do this from different perspectives, which creates the potential for conflict in treatment goals and outcomes. Problems within the service will be highlighted further in the next chapter.

The Neighbourhood Centre (NC) is a philanthropic organisation that was established in 1980, and is sponsored by the town council and four other Shire councils. Under the auspices of the town council, funding comes from the State and Federal governments. The overall purpose of the NC is to “provide a range of support services that will enhance individual, family and community development towards optimum independence and cohesiveness”. It provides the community with support services such as family support, emergency relief, and home and community care. There are also sections that provide housing and tenancy information, supported accommodation, and community housing projects. The Supported Employment Service specialises in placing, training and supporting people with disabilities. The Domestic Violence Service assists victims through crisis intervention, education programs and court support. There is also a Men’s Worker who attends court with the perpetrators of domestic violence, in an attempt to help them break the cycle of abuse. For most of the Ruraltown study, the

NC also employed a Rural¹⁷ Family Support worker which was a service (formerly mobile) supporting rural families through counselling, appraising of information on rural and drought issues, and parenting assistance. The financial counsellor from the local Rural Financial Counselling Service used to accompany the Rural Family Support worker on property visits to offer any further assistance. However, the Rural Family Support counsellor left the position in early 2004, and has been replaced with a Family Worker who sees families at the NC but no longer travels out of town to properties. The Neighbourhood Centre also provides a comprehensive database of all services available in Ruraltown.

Anglicare Western Region is part of the wider Queensland Anglicare Organisation that was established in 1870 to respond to the many needs of communities and offer hope to those who are facing challenges in their lives. There are now more than seventeen agencies in Queensland, committed to assisting people, regardless of age, gender, race or creed by:

- advocating social justice
 - enabling people to reach their full potential
 - providing community care and education
 - working in partnership with government and other welfare groups
- (Anglicare brochure 2002).

The Ruraltown Anglicare Centre has three main focus areas. The first is the Mental Health Family Support Service which assists and resources families who are affected by mental illness. This service facilitates community participation through the implementation of a non-clinical support service to mental health consumers and carers, and the broader community. The second service that Anglicare provides is a Young Family Support Service, in the form of volunteer assistance for

¹⁷ In this case, 'rural' refers to families from out of town, on the land.

young families and new mothers, and support and training for foster carers. This service provides a twenty-four hour on-call service to foster carers in the region and is responsible for recruiting, training and supporting foster carers, and finding suitable placements for children and young people. The third focus area is the Community Connections Project which is discussed in detail below. Anglicare is committed to working within an enabling framework that is informed by social justice principles of equity, access and inclusion, is respectful of human rights, and dedicated to working with, not for, people (Anglicare brochure 2002).

Anglicare is active in overturning the negative images attached to mental health problems and promoting early intervention and prevention. Of particular relevance to this research was a project that commenced in Ruraltown in 1999 called the Community Participation Project, under the auspices of Anglicare Western Region. It was an initiative of Queensland Health, in response to the National Mental Health Strategy for mental health services reform. The project included twelve community development projects across the State, including one in Ruraltown, and all were managed under the auspices of incorporated, non-government organisations. The position of Mental Health Community Development Officer (MHCDO) at Anglicare was funded by this project for a period of three years. The main focus of the Project was to promote and improve consumer and carer participation in service planning, delivery and evaluation. Promotion (of mental health) and prevention (of mental health problems) were major themes. It was very much a consumer-focussed project, advocating participation and partnerships in the community, to develop strategies that facilitate mental health promotion, prevention and early intervention (Anglicare Project Information Sheet 2002).

As part of this broader project, a Mental Health Promotions Project commenced in Ruraltown in September 2001, under the supervision of

the Mental Health Community Development Officer (MHCDO) at Anglicare. This project was based on community development principles and emphasised consumer participation that aimed to give consumers a voice in their treatment, rather than adopting a provider-centred approach. As Sheil (2000, p.28) argues, “the broad principles of community development practice have to do with the inclusion in decision-making of those who will be affected by the decisions. Participation and ownership are key aspects of this work”. Promotion of mental health was effected through radio segments, information brochures, and the “Promoting Mental Health Awareness Forum” held in April 2002 (discussed further below). The MHCDO also formed a Mental Health Interest Group (MHIG) for consumers, carers and other interested people. The Group met regularly for support and to address any concerns that members had, and membership rose to approximately eighteen by April 2002. The MHCDO was encouraging and supporting this Group through the transition of formalising into a Consumer Advisory Group (CAG).

According to providers at Anglicare, the procedure to register and operate as a CAG requires administrative and organisational experience that some consumers may not have. The MHCDO with Anglicare was assisting with the transition to registration as a CAG, however, this process lapsed when the funding for her position was terminated in June 2002. Despite the considerable progress that had been made in spreading the mental “health” message through various mediums, especially the “Promoting Mental Health Awareness Forum”, and supporting mental health consumers and carers, the loss of funding meant that there was no longer a worker whose role was to promote mental health and consumer involvement in Ruraltown. This represented a major loss to mental health promotion and consumer advocacy in Ruraltown. Responsibility for the CAG was taken over by the PHCU to assist in their management. However, as will be revealed in

later discussion, there have been considerable problems with this partnership.

The Community Connections Project (CCP), under the auspices of Anglicare, is also relevant to this research. The CCP was approved by the Commonwealth Department of Health and Ageing, under the National Suicide Prevention Strategy in August 2002, and was funded for a three-year term, until July 2005. A community worker at Anglicare implements the project in Ruraltown and surrounding districts. The Project works with three target groups, identified as being at risk of suicide and/or self-harm: rural isolated men, people who experience mental illness, and gay, lesbian, bisexual and transgender young people. It also works with the broader community to build supportive networks for those at risk of suicide or self-harming behaviours. The three areas of job specification for the community worker are case management, community capacity building including increasing tolerance of diversity, and education, consultation, and as a resource for the community (CCP report 2004). The former manager of Anglicare explained that "it was called the Community Connections Project as its main aim was to link individuals with resources, whether they are locally based or elsewhere, using different technology. There will be scope to meet anywhere, or linking to chat via the Internet and email". A male community worker first filled the position in early October 2002. This worker made considerable progress contacting members of the target groups. In the first ten-week period, he had engaged with 118 individuals, mostly those with sexuality issues. However, the worker left his position in December 2002. The position was then readvertised in January 2003 and a second male community worker started in the position in February 2003.

Over the following year, this worker was successful in engaging clients representing all three target groups and individual counselling and groupwork was conducted throughout the Southwest region. Risk

factors identified for these target groups included poor community attitudes and stereotyping of members, lack of personal resources, geographical isolation, lack of social supports, unemployment, and financial difficulties due to drought conditions (CCP Report 2004). The major aims of the CCP are to remove the negative stereotypical images of these groups and eliminate the barriers to acceptance and coexistence in the community. Links were established with other interested community groups, organisations and government agencies. Information flyers have been intermittently distributed in the community. Media coverage, in the local newspaper and regional newsletters, has publicised the project's foci. Despite the progress made, the worker had to leave the position in January 2004 due to ill health. Again, it was advertised and filled by a female community worker from Ruraltown in March 2004. This worker was interviewed during the final visit to Ruraltown in May 2004 and outlined the problems facing the CCP (see Chapters 7 & 8).

DATA COLLECTION IN RURALTOWN

In order to obtain information about mental health at the local level, four visits were made to Ruraltown over a period of three years. These visits, each of about a week, included several interviews and re-interviews, questionnaire distribution, meeting attendances, presentations, informal meetings and observations. Key informants were contacted prior to each visit to set up interviews. Several interviews with representatives from the three mental health agencies — MHS, Neighbourhood Centre and Anglicare — and the CAG were carried out over the three-year period to obtain consumer, community and service providers' views on attitudes to mental health. In addition to these interviews, emails were exchanged with providers and consumers on a regular basis to keep up with changes at the local level. The questionnaires also gave a general cross-section of opinions from the various agencies. A table summarising those interviewed during the

four visits to Ruraltown is presented on page 220, and at table outlining the groups that were canvassed by questionnaire appears on page 224.

FIRST VISIT TO RURALTOWN – APRIL 2002

After the decision was made to focus the study in Ruraltown, contacts and key informants in the area of mental health were found. The first visit took place in April 2002 because, through an edition of Ruraltown's newspaper, I discovered that a Forum was being held to promote mental health awareness in the community. The Forum was being organised by the Mental Health Community Development Officer (MHCDO) with Anglicare Western Region, in conjunction with the Ruraltown Rotary Club. The Anglicare MHCDO became an ongoing key informant regarding mental health in Ruraltown and, through telephone conversations and correspondence, provided me with much of the initial background information regarding mental health services in Ruraltown. The significance of Anglicare's involvement in promoting mental health and their role in the Mental Health Awareness Forum are explained below.

Background to the "Promoting Mental Health Awareness" Forum

As part of Queensland Health's response to the *National Mental Health Strategy*, twelve community development projects across the State were established in 1997, all under the auspices of incorporated, non-government organisations. The major focus of the community developments projects were to promote and improve consumer and carer participation in service planning, delivery and evaluation, with particular focus on promoting mental health and understanding in the chosen communities (Anglicare 1999a). The community development project in Ruraltown commenced in November 1999 with the following major objectives:

- to identify the needs of consumers, carers and their support networks in the Health Service District;
- to improve the participation of consumers and carers in service planning, development, delivery, management and evaluation;
- to develop partnerships between consumers, families and carers, private government and non-government sectors and the broader community;
- to facilitate access to, and the development of, a range of community based support services in the non-government sector; and
- to develop strategies which facilitate mental health promotion, prevention and early intervention.

(Anglicare 1999b).

The fundamental notions underpinning the Project were that it was better to work with, rather than for, community members, and that they, rather than external stakeholders, should define the community problems. It was with these principles in mind that the Anglicare MHCDO, in conjunction with the Ruraltown Rotary Club, organised the “Promoting Mental Health Awareness Forum” that was held on 24th April, 2002.

The Australian Rotary Health Research Fund (ARHRF) had also been active in the promotion of mental health and Ruraltown’s Rotary Club was keen to be involved in this latest field of research. Over the five years between 2001 and 2006, ARHRF pledged to find \$5,000,000 to improve recognition and treatment of mental illness. Arising out of this pledge was a series of community forums dealing with mental health issues, which were held throughout Australia over 2001 to 2003 (ARHRF 2001). The aims of the forums were to:

- help de-stigmatise mental illness;
- bring the community into contact with mental health services and support groups;

- stress the importance of early recognition and treatment;
 - clear the myths and misunderstanding of mental illness;
 - offer future hope for consumers and carers; and
 - form ongoing partnerships between Rotary Clubs and mental health services and support groups
- (ARHRF Community Forums Brochure, 2002).

The “Promoting Mental Health Awareness Forum” was advertised in Ruraltown from early 2002 by letterbox drop, radio segments, and in the local newspaper. No letterbox drop was made to surrounding properties or towns. In the lead-up to the Forum, the Anglicare MHCDO also had regular (weekly) thirty-second slots on the local radio station to deliver the “mental health message” to the community. For example, she would present statistics to illustrate how common mental health problems were, how to recognise a mental health problem, what services were available, and how to prevent mental health issues. The purpose of these radio spots was to get the concept of mental health out into the community, to expose the myths surrounding mental health, to get people thinking about mental health issues, and to deliver information to those in need without prejudice or exposure.

There was significant pre-Forum media coverage in the local paper for two months prior to the event. However, most of this coverage focused on negative aspects of mental health and statistics. In response to this, the MHCDO from Anglicare stated that *“I was actually not happy with the pre-Forum media coverage and disassociated myself from it. Most of the statements were made by a representative from Rotary and were very ‘crisis mentality’, focusing on the stigma and giving incorrect facts about the suicide rates in Ruraltown. Anglicare is more focused on promoting positive mental health rather than tragic circumstances”*. Thus, in the eyes of some participants, the promotional aspects of the Forum were being misrepresented before the event and this may have had a bearing on final attendance figures.

The “Promoting Mental Health Awareness Forum” was originally scheduled to be held on 23rd March 2002, however, it was postponed until 24th April 2002 due to the conflict of interest between Rotary and Anglicare in the organisation and promotion of the event. Also, there was some difficulty in finding appropriate speakers for the evening and over who should be Master of Ceremonies (MC). Rotary suggested a retired gynaecologist who was also a Club member to MC the evening, whereas the Anglicare MHCDO felt it was more appropriate to find someone more representative of the discipline of mental health. Rotary “won” — the retired gynaecologist was invited to be MC. With these differences overcome, the Forum went ahead.

Attendance at the Forum was not significant (50-60 people), despite the fact it was widely advertised locally, and it did not appear to be a “comfortable” gathering. There were three guest speakers at the Forum; a service provider, a mental health consumer and a consumer advocate. After each speaker, the audience was invited to ask questions or make comments, however, only two or three service providers did so during the one and a half-hour Forum. From my observation, there appeared to be a general reluctance to freely engage in discussion.

The main objectives of the first visit to Ruraltown were to attend the “Promoting Mental Health Awareness Forum”, familiarise myself with the community, observe the people and the surroundings, talk to the key informants, and gather data about the concerns and issues that people in the district may have. Semi-structured interviews were conducted with five key informants from the community to gather data about the social, economic and health status of the community. The five key informants were:

- the Mental Health Community Development Officer (MHCDO) with Anglicare;
- the Rural Family Support worker with the Neighbourhood Centre;

- the Adult Mental Health Worker at the MHU;
- the Child and Youth Mental Health Worker at the MHU; and
- the Manager of the Ruraltown newspaper.

Results from these interviews will be discussed in the following chapter. This first visit established the boundaries of the study and familiarity about the issues involved in mental health attitudes and delivery in a bush setting was achieved.

SECOND VISIT TO RURALTOWN – OCTOBER 2002

The second visit to Ruraltown took place in October 2002. The plan for this visit was to follow up on the previous interviews and also to make additional contacts with community members. I had also prepared questionnaires to distribute to some Ruraltown community groups to gather more representative opinions on rural mental health attitudes and concerns. (A copy of this questionnaire can be found in Appendix 4).

Before the visit, the Rotary Health Officer was contacted to obtain permission to deliver some anonymous questionnaires for members of the Ruraltown Rotary Club. He informed me that there would be a Rotary meeting during my visit Ruraltown and invited me to give a short presentation. There were eighteen men at the Meeting, ranging in age from about forty to sixty years. The presentation covered aspects of bush culture that the group would be familiar with, a summary of the current hardships facing rural areas, and the link between these and mental health issues in the community. Questionnaires were distributed to the group and Reply-paid envelopes were provided for the return of questionnaires. Discussion of these responses will be given in the Results and Analysis Chapter.

Prior to my arrival in Ruraltown, informal interviews were set up with the informants whom I had met on my first visit. Additional contacts were also made. I met with the Ruraltown QRWN president and a local council member for an informal discussion about what they considered to be important issues in the area. Whilst not specifically addressing mental health concerns, the discussion provided some insight into rural problems that may impact on mental health. The local QRWN president also put me in touch with the Administration Officer for QRWN who lives on a property outside of Ruraltown. At a morning tea appointment, she spoke at length about confidentiality concerns in Ruraltown regarding mental health. This informant also highlighted the lack of understanding that exists in the community about depression, and the lack of choice in treatment options or doctors.

As mentioned earlier, the “snow-balling method” (Johnson 1990:62) works particularly well in rural communities due to the smaller social networks and enhanced local knowledge. I was also introduced to a representative from the Isolated Children’s Parent’s Association (ICPA). This person, who is also a local therapist, raised the issue of the stigma surrounding mental health problems in the bush and she offered to distribute some questionnaires at the next ICPA meeting in early November 2002. I subsequently received several detailed responses from the ICPA meeting (see Chapter 7).

Interviews during this second visit were conducted with the following informants:

- the Rural Family Counsellor, Neighbourhood Centre (2nd interview);
- the MHCDO with Anglicare (2nd interview);
- the Adult Mental Health Worker at Primary Health Care and the Hospital Social Worker (2nd interview and 1st interview respectively);
- the Manager at Anglicare (1st interview);

- appointment with the Ruraltown QRWN president and a local Council member (1st interview);
- appointment with the Administration Officer of the QRWN (1st interview);
- interview with a local therapist, also a member of the ICPA (1st interview).

During the second visit to Ruraltown, additional contacts were made and questionnaires were distributed to two rural groups. The responses from the questionnaires distributed both to Rotary and ICPA during this visit provided a localised general perspective of attitudes to mental health and the services provided. These responses will be further discussed in the Results chapter. Questionnaires were also distributed at the QRWN conference not long after this visit, which was held in Brisbane in October 2002. Although responses were not specific to Ruraltown, they represented opinions from rural women that tend to support the findings from the questionnaires of Ruraltown.

THIRD VISIT TO RURALTOWN - SEPTEMBER 03

Prior to my third stay in Ruraltown in September 2003, contact was made with Anglicare to set up interviews and engagements for the visit. Previous interviewees from Anglicare were no longer in their positions, so appointments were set up with their replacements; two mental health workers and the Manager. Contact was also made with the Neighbourhood Centre and the Mental Health Unit at PHC. A member from the CAG was also interviewed during this visit.

One of the new mental health workers at Anglicare became the key informant for my third visit, providing me with additional information and contacts. This informant also invited me to attend the regular Interagency meeting which is open to any consumer, health service employee, or interested members of the community, to exchange

information and ideas on relevant health or consumer issues. The meetings are held monthly in the Businessman's Club in town, and there were fifteen participants at this meeting from Anglicare, the Neighbourhood centre, Education Queensland, Aboriginal Affairs Youth Workers, Enable, Disability Services Queensland and Working Against Abuse. Questionnaires (very similar to the other questionnaires) were also distributed at this meeting (see Appendix 5).

Before my visit, I had also contacted the informant who had distributed questionnaires at the annual ICPA meeting in 2002. At a lunch meeting, we had an informal discussion about mental health services in Ruraltown. A meeting was also scheduled with a registered nurse that worked at the local hospital and was also an ICPA questionnaire respondent. She was keen to participate further in the study.

A meeting was held at Anglicare with two mental health workers, the new Anglicare Manager and a local psychologist. It was an informative group interview which, with permission, was recorded. I also attended the local Agforce and Landcare offices to deliver questionnaires to be administered at their next group meetings.

Another appointment was scheduled with the mental health nurse at the MHU whom I had interviewed on the two previous visits to Ruraltown. At her suggestion, I telephoned the PHC team leader to discuss funding arrangements for PHC but it appeared that this respondent did not want to get involved. I finally met with the team leader during my fourth visit to Ruraltown.

A lunch appointment was held with a member of the Ruraltown Consumer Advisory Group (CAG) to obtain a consumer perspective of the mental health services in Ruraltown. As the President of CAG was away, she suggested I meet with another CAG member. (The President of CAG was interviewed at a later date). This interview gave an alternative view of mental health services in Ruraltown. Permission was

also obtained from the President of the CAG to post questionnaires to her for the CAG members to complete.

A meeting was held with two representatives from the Neighbourhood Centre, the Rural Family support worker and the Community Housing representative. The latter informed me that the Neighbourhood Centre had received an invitation that day from the hospital to a consumer forum about the formation of a Health Advisory Group (HAG) in Ruraltown. The invitation stated that “the goal of the HAG is to open a partnership between the community and the local Queensland Health Service in Ruraltown. It will make recommendations on health service development and delivery, that will better reflect the needs of consumers”. Information from this meeting will be discussed further later. The Rural Family Support worker, who had been interviewed on the two previous visits, was also present at this meeting. As explained earlier, her position was funded to support rural families and those who are drought affected.

Summary of interviews from the third visit include:

- group interview with the Manager and two mental health workers from Anglicare, and a psychologist from Centacare (1st interview);
- mental health nurse at the MHU (3rd interview);
- a member of the CAG (1st interview);
- a Community Housing Representative and the Rural Family Support worker, both from the Neighbourhood Centre (1st and 3rd interview respectively);
- interview with a local therapist who is also an ICPA representative (2nd interview);
- meeting with a Ruraltown RN who is also an ICPA representative (1st interview);
- brief interview with the Men’s Health worker at the Neighbourhood Centre (1st interview).

During the third visit to Ruraltown, new providers and previous interviewees were consulted. The additional information obtained confirmed my earlier impressions about mental health services in Ruraltown and will be discussed at length in Chapter 8. During this visit, different providers mentioned the hospital as being a site that requires improvement in the delivery of mental health services. This was followed up during my fourth visit to Ruraltown.

FOURTH VISIT TO RURALTOWN – MAY 2004

The purpose of this final visit to Ruraltown was to fill in any gaps in the research and collect extra information that may relate to attitudes to mental health. In preparation for the final visit to Ruraltown in May 2004, providers and informants were once again contacted by email and telephone to set up appointments for re-interviews or discussions pertinent to the research. Providers made recommendations for additional contacts for this final visit. Twelve interviews and informal discussions were carried out and again, all interviewees signed consent forms. Themes from these interviews are discussed in the following chapter.

On the first day of the visit, three interviews were undertaken with new informants. The first of these was with a CAG member whose details were passed on from the President of the CAG who has been an ongoing informant in this research. With the new informant's permission, a meeting was held at his home and we had a lengthy discussion about the Ruraltown CAG. He informed me that he had been a member of the CAG since its inception in 2002. Although there was initial assistance in the form of administration support, he said this quickly dropped off after a change in position at PHC. He stated that the CAG had received no further assistance, monetary or otherwise, for the administration of the group. The information gleaned further emphasised the problems that the Group is facing.

Prior to this visit, there had been an article in the Ruraltown newspaper about a telemedicine trial that was being piloted at one of the doctors' surgeries. This technology allows people to access treatment via videoconferencing. As stated by the Practice Manager in the article, "the private service is available to anybody with a referral from a general practitioner and allows patients to communicate with a psychiatrist or psychologist without leaving Ruraltown, and with no excessive waiting times" (*Ruraltown Paper* 24th April 2004, p. 6). An appointment was made with the Practice manager and mental health nurse.

At this appointment, the Practice Manager explained that a group of doctors who recognised the problems faced when trying to access specialists in rural areas established Healthshare, the company responsible for setting up the videoconferencing system. It allows for doctors in rural and regional areas of Australia to provide patients with specialist care via videoconferencing in the comfort of their own surgery (Healthshare brochure). The service has been operating in Ruraltown since January 2004. It works on the same fee structure as seeing a specialist in person: Medicare covers a portion and there is a gap for the patient to pay. In addition, there is a facility fee charged to the patient for online time. This service has been discussed further in the following chapter.

A meeting was held with Ruraltown's Rural Financial counsellor, as was recommended previously by the NC's Rural Family Support worker. The Rural Financial Counselling Service is part of the Rural Management Centre and helps primary producers and small rural businesses in rural areas who are experiencing financial hardship and have no other source of financial advice. Other services include assistance with loan applications, welfare information, business management issues, book-keeping, and reviews of contracts with lending institutions. Another role is to provide referral details to other services as deemed appropriate. It is a confidential, free service that is funded by the Commonwealth (50%)

and State (25%) governments, and by community contributions (25%) (Rural Management Centre Brochure). The Ruraltown financial counsellor was consulted to find out more about the mental health implications of his work. The counsellor was given a questionnaire to complete and another four to distribute to members of his workplace. As the police in Ruraltown also have a role in mental health crises at times, questionnaires were distributed at the police station.

An informal meeting was held with a former worker from Anglicare who was in the process of setting up a counselling clinic in Ruraltown. She had been interviewed on a previous occasion and provided additional information on the problems being faced by mental health consumers in Ruraltown. Interviews were also held at Anglicare. A joint interview was conducted with the two mental health workers, and one with the female community worker from the aforementioned Community Connections Project. A discussion was held with the Coordinator of "Big Brother Big Sister" (BBBS) Mentoring Program, which is also under the auspices of Anglicare. This was a new initiative for Anglicare and, while not specifically targeting mental health, it aims to reduce potential problems for children such as loneliness, isolation, self-esteem issues and substance abuse. A lunch appointment was conducted with the Manager of Anglicare and the Housing representative from the Neighbourhood Centre to follow-up on issues discussed previously.

An interview was held with the Team Leader at the PHCU to discuss funding issues and the administration of the CAG. Although she appeared reluctant to discuss the research project in the previous visit, the Team Leader was very helpful at interview. The mental health nurse from the MHU was also interviewed during this visit. The Team Leader from PHC suggested I contact a researcher from the Office of Rural Health in Ruraltown who had previously completed a Masters thesis examining the attitudes of generalist nurses in Ruraltown and surrounding areas to patients with mental illness. It was a useful

discussion and confirmed previous concerns expressed by informants about the attitudes of nursing staff at Ruraltown hospital.

The Rural Family Support worker from the NC was also contacted by email before coming to Ruraltown to inquire about the workshops for rural men that she had hoped to organise for early 2004. She informed me that she was no longer in the position with the NC and was now working in another regional centre. The worker stated that she was unable to organise the workshops due to personal obligations but hoped that this would be taken up by her replacement. At interview with her replacement, the Family Support worker at the Neighbourhood Centre explained that the word “rural” had been taken out of her title as her position no longer focused on servicing rural areas. When asked why, she said that there was no specific rural position anymore and her main role was child protection.

During this visit, interviews and re-interviews were conducted with the following:

- a different member of the CAG (1st interview);
- the Practice manager and mental health nurse at a private GP’s office regarding the Telemedicine facility (1st interview);
- the Rural Financial Counsellor (1st interview)
- the Community Connections Project worker at Anglicare (1st interview);
- the Coordinator of the ‘Big Brother Big Sister’ mentoring programme at Anglicare (1st interview);
- joint interview with two mental health workers at Anglicare (a 1st and 2nd interview);
- the Manager of Anglicare and the Housing representative from the Neighbourhood Centre (2nd interviews);
- interview with a former Anglicare mental health worker (2nd interview);
- the Team Leader at the PHCU (1st interview);

- the mental health nurse at the MHU (4th interview);
- the Family Support worker at the Neighbourhood Centre (1st interview);
- a researcher at the Ruraltown Office of Rural Health (1st interview).

During the final visit to Ruraltown, re-interviews with past informants and interviews with new contacts were undertaken, to add to the study about attitudes to mental health. Questionnaires were also distributed to the Rural Financial Counselling Service and the police station. The purpose of this visit was to reinstate contact with the informants, fill any gaps in evidence and remain abreast of any recent changes in service provision. A follow-up visit will be considered at the completion of this research. Between the third and fourth visit to Ruraltown, a lengthy interview was held with the President of the Ruraltown CAG in Brisbane. Several telephone interviews were also been conducted with this mental health consumer. Over the span of the three-year study, regular email contact was maintained with several informants. A table summarising the interviews held in the Ruraltown study appears on page 244.

In conclusion, the study in Ruraltown was an ethnographic study based on the premise or theory that bush culture and identity influence attitudes to mental health in Ruraltown. As mentioned previously, as an outsider to the community, it was necessary to have an understanding of bush culture and mental health before going into the field and this was achieved through considerable personal experience and extensive primary and secondary research. However, care was taken not to let this prior knowledge influence the interpretation of the findings. In the study, several methods such as interviews, observations, interactions, questionnaires and informal discussions were carried out to determine attitudes to mental health in Ruraltown. The results and analysis from this study about attitudes to mental health have been outlined in detail in the following chapter.

CHAPTER 7

RESULTS AND ANALYSIS

We need to identify, validate and find ways of measuring the various dimensions of community well-being and identify the factors contributing to it

(Cheers & Luloff 2001, p.142)

Gathering data about attitudes to mental health in the Ruraltown community was the main aim of the fieldwork and this was accomplished through the methods of questionnaires and interviews. In this chapter, a summary of results from these will be presented. Through an analysis of these results, common patterns or themes about attitudes to mental health have been identified. The employment of methods such as interviews, questionnaires, informal discussions and observations has informed this study of attitudes to mental health in Ruraltown. Information resulting from direct questions, and other data about attitudes to mental health, is outlined in the following summary of results. Through the analysis of these results, certain themes are pre-eminent. These include the negative perception of mental health as a concept, the stigma attached to mental health problems, rural conditions that may affect mental health, and problems with mental health service provision in Ruraltown. These results support the hypothesis that bush identity does have an impact on beliefs about mental health in rural areas.

RESULTS FROM THE QUESTIONNAIRES

The purpose of this section is to discuss the results and data that were obtained from these questionnaires. A total of 262 questionnaires were distributed over a period of three years to different informants, groups

and stakeholders, and 47 replies were received. Speculation about reasons for the somewhat low response rate of 18% included a lack of time or inclination to complete the questionnaire, discomfort with the subject being discussed, or suspicions about the true intentions of the study. Whatever the reason, the questionnaire results do contribute meaningfully to, and support, the findings from interviews, interactions, observations, and the primary and secondary literature. An aggregated summary of the returned questionnaire responses appears on page 238, followed by a short discussion of the findings.

Information Sheets (see Appendix 2) were given with the questionnaires (Appendix 4) to explain the research project to respondents. Responses were received from the Ruraltown Rotary Club, the Isolated Children's Parents Association, Agforce, Ruraltown Police, the Rural Financial Counselling Service and the Consumer Advisory Group. Slightly shorter questionnaires including questions about service provision (see Appendix 5) were also returned from representatives of health and service agencies in Ruraltown. Representatives from Anglicare, the Neighbourhood Centre, Education Queensland, Aboriginal Affairs' youth workers, Enable, Disability Queensland and Working Against Abuse were given questionnaires. Questionnaires were also distributed to other agencies in Ruraltown — the Department of Education, Landcare and the Department of Natural Resources — however, no responses were returned. Included in the above totals were the 150 questionnaires that were distributed at the Queensland Rural Women's Conference in Brisbane in October 2002. Network (QRWN) Conference in Brisbane in October 2002. In the following analysis of results, there has been a quantification of the qualitative data, demonstrating the number of similar responses. With the exception of the Consumer Advisory Group (CAG), the results of the questionnaires from these groups will be given by *theme* rather than by *group*, and include italicised verbatim quotes from the questionnaire respondents. The responses from the CAG will

be discussed separately, to provide a more personalised view of attitudes to mental health and the repercussions of these in Ruraltown.

Table: Summary of questionnaires distributed and returned

Name of Group	Q'aires distributed	Q'aires returned
Ruraltown Rotary Club	20	6
Ruraltown ICPA	17	7
Ruraltown Agforce	15	2
Ruraltown Police Force	5	5
Financial Counselling Service	5	2
Health & service providers	20	9
Consumer Advisory Group	8	8
QRWN Conference	150	8
TOTAL	262	47

The themes by which the questionnaire responses were organised are:

- mental health as a concept;
- barriers to help-seeking;
- stigma and its origins in the bush;
- bush conditions that affect mental health;
- adequacy of mental health services and information;
- and suggestions to improve attitudes to mental health.

Mental health as a concept

With respect to the term “mental health”, 44 respondents believed it was a negative concept. It was raised that people were unfamiliar with the concept and it was often misunderstood. The responses tended to

confirm the almost universal status of the word “mental” as a pejorative concept.

The reasons given for this negative perception included:

- *The term “mental health” usually conjures up images of madness or craziness.*
- *The community fails to accept a mental health problem in the same manner as a physical illness because of the negative connotations.*
- *In past years, mental health was seldom acknowledged as a separate health issue*
- *Often people condemn what they don’t understand or can’t control.*
- *Older people may see it as negative, younger people may see it as more positive as it is discussed or talked about more often. It also depends on a person’s exposure to people with a mental health issue.*
- *It is difficult to visibly identify mental health problems thus making them misunderstood*
- *As soon as the word “mental” is used, it seems the recipient has severe problems. However, I’m not sure if this is due to a lack of education.*
- *People associate “mental” as being crazy/ stupid, however, I don’t know what else you’d call it.*
- *Throughout my work (police officer), I often deal with people suffering mental health issues and, in a lot of cases, I feel that they are a danger to the community and themselves.*
- *Mental health denotes a person with issues that require help.*
- *I believe that regardless of what term is used to portray ‘mental health’ issues, until the community changes its attitude, a stigma will continue to be attached for these consumers (health provider).*
- *The stigma attached; it is too closely associated with mental illness — do people understand the difference?*
- *People interpret mental health as “mad”.*
- *It doesn’t sound right; it implies there is a mental problem*
- *It has negative-sounding connotations*

- *It brings up images of deeply disturbed people.*

Barriers to help-seeking

Forty-one respondents believed that people in the bush would not seek help for mental health problems, and an overwhelming majority agreed that the major barrier to help-seeking was the shame and embarrassment of admitting to a mental health problem. The second most popular deterrents were the perceived lack of confidentiality in the community and fear of gossip. Lack of time, knowledge and services were also noted as barriers to help-seeking. Fear of illness and financial reasons were attributed by a minority of respondents as having a bearing on seeking assistance for a mental health problem. In their questionnaires, health and service providers were asked to elaborate on reasons for people not seeking help. These responses included:

- *Transport/travel reasons, pride, perceptions of 'counselling', small community gossip.*
- *In small rural communities, merely being seen entering a mental health service can lead people to stating "Oh, such and such must be seeing the psychiatrist".*
- *Worries about confidentiality – who will find out what I'm saying? Also worries about what the family might think. This all comes from a lack of knowledge about the concept of mental health.*
- *Lack of confidentiality – (the hospital is renowned for leaks). Also, we just learn to cope in the bush.*
- *Men in rural areas would rarely come forward to ask for help. I guess they feel it would make them "less masculine, a wimp and incapable of looking after themselves".*
- *The culture of rurality – stoic, hardworking and healthy. The problems of anonymity and appropriate services.*
- *The barriers have been "mindsets" where the rural person must be seen as tough and coping with anything.*

- *Services are not tailored to meet rural clients' needs. The appointments are only for one hour and clients may need to drive one to two hours each way for the appointment. If someone is very ill, a driver may have to take him or her, which could mean that two people are away from the farm for three to four hours for a one-hour treatment! Also, as appointments are usually in a public place, the car may be seen and the patient identified.*

Stigma and mental health in the bush

When asked if there was a stigma attached to the concept of mental health in the bush, 41 respondents believed that there was. Beliefs about where this stigma comes from included:

- *The perceived tough image of "western people", and the related belief that to have a mental illness is seen as a weakness.*
- *Because of the "tough bushie syndrome".*
- *Lack of understanding and bush culture – "you've got to be tough in the bush".*
- *Lack of community education and fear, possibly as a result of movies and the media giving it (mental health) negative promotion.*
- *The essence of bush life is independence in spite of adversity eg. drought, prices etc. If the "whole" person unravels, the snowball effect unravels the family and the business. It is highly dependent on an individual's capacity to cope and keep going.*
- *The old concept of isolation/ sun/ etc., someone being different must be affected and a bit mad.*
- *Lack of education/ knowledge on what "mental health" is. It still holds a certain level of shame and embarrassment due to the way the bush is.*
- *The "old bush ideology" – we can cope with anything eg. weather, commodities etc. The Aussie battler psyche. This is still encouraged by the media in many ways. There is a failure to realise that rural people*

are often in the midst of a grieving process eg. dying stock, family issues etc.

- Country/rural attitude – tough, macho image. Fear of friends knowing of illness.
- Small communities are apt to gossip and the problem could easily get out of proportion and lead to embarrassment.
- The subject tends to be avoided, especially with the older generation. In the bush, you can't be seen to have a mental problem.
- In the bush, if people are diagnosed with a mental health problem, they feel like they have failed and let the family down. They do not know the signs.
- Emotional aspects of life are indicators of weakness that are not conducive to survival in the 'tough' rural environment.
- It's all about the rural culture. "Tough men don't cry" or don't need help, and rural people are perceived as "tough people" who do without.
- To be economically viable, you need to be strong and healthy — both physically and mentally. This belief stems from the bush culture.
- Most bush people believe they can cope and should be able to "work it out". This is, I believe, part of their culture of having to make do with what they have. They can't access services as easily because of isolation.
- History of mental health, incorrect perceptions, rumours, small town gossip.
- People in western areas generally take longer to move ahead with their attitude. I feel that many of them associate mental health with institutions for mentally ill, thus if they admit they have a mental health issue, they could be put away!
- People are embarrassed and don't want to be seen as mad. Many people in rural areas believe that earning an income and supporting their family take precedence over their own health/mental health.
- I believe that especially among uneducated persons they tend to label people with mental illness and this is due to a lack of education.

- *People do not want to have the “mental illness” title attached to them as it could mean a lack of business or respect within a small community.*
- *Country people are proud people and because news can never be kept on a personal level (the whole community knows) then people don’t want to be known to have mental health issues.*
- *“Stoicness” [sic]: “I should be able to handle this” attitude*
- *People think you are inferior and don’t want anything to do with you.*
- *Because farmers are meant to be tough.*
- *I think attitudes are changing, especially with women but I think many men, especially the older males, would find it hard to accept the need for mental health services because of the culture of the bush.*
- *Rural people are supposed to be strong.*
- *I’m not sure it is any worse or better in the city. Mental illness is still related to weakness or inability to cope and that can’t happen in the bush.*
- *You usually only hear about the criminal or bad cases and not the everyday people who need help.*
- *Lack of knowledge, isolation and lack of confidential services.*

These responses appear to support the argument that bush identity and culture do contribute to the stigma surrounding mental health issues and have an impact on attitudes to mental health.

Rural conditions that affect mental health

All survey participants believed that there were unique conditions in rural life that affect people’s mental health. Isolation, distance, unemployment, financial hardship, poor service provision, lack of specialists, substance abuse, children moving away, seasonal problems, long hours, high debt, drought, government policies, financial stresses,

and education for children were all recognised as factors of rural life that may affect mental health. Other responses included:

- *Rural people are at the bottom of the food chain! They are price takers, not makers, and have a gross lack of control over their income due to an increasing amount of bureaucratic interference.*
- *Rural businesses are forced to make financial decisions with little or no relevant knowledge eg. financial decisions are made regularly on whether to sell stock (ie. income) without having any concrete weather predictions — there is constant uncertainty.*
- *Rural business is “all or nothing” — no half/part-time/coasting “taking a break” type scenarios.*
- *As men find it hard to network and are isolated, the effects of this are felt by rural women who experience loneliness as a consequence.*
- *It is often not possible to be “invisible” while receiving treatment.*
- *Isolation, loneliness and lack of support.*
- *Drought, huge workloads, isolation, personality-type dominances, conservative values, and stressful workplace.*
- *The people who are providing the assistance need to be aware of the conditions that clients live in and need to know the rural way of life.*
- *There is constant uncertainty for women in the bush — they have to be there for everyone – the “triple shift”.*
- *The rural family business means that esteem and tradition may be tied up in generations of business, especially in terms of self-esteem and depression. People live and work in the same environment so if work is not good (drought) you see it at home (no grass, cattle dying etc.). The business is tied with family. Everything that happens on a farm affects a wide number of people and is across at least two generations.*¹⁸

¹⁸ Although this may not be the case for all those surveyed, family farming is still an important tradition for many rural people, as previously discussed.

The general consensus was that there are unique conditions of rural life that impact directly on mental health.

Adequacy of services and information

The mental health services available in the bush were, on the whole, perceived as inadequate; likewise for the availability and quality of mental health information. Comments about these issues included:

- *There is a lack of understanding about what the services offered and they appear to be poorly coordinated.*
- *People can “fall through holes in the net”.*
- *There is a lack of funding and qualified staff.*
- *Support is irregular, if it is available at all — people that need support on a regular basis do not have access to appropriate services, often for months at a time. There are a minimal number of psychologists and no psychiatrists.*
- *GPs have referral mechanisms but everyday people may want to access their support privately and not know where to go. Having to go to a GP for referral to specialists is time-consuming and an additional financial burden to people who often can't afford it.*
- *Services are not well advertised, are expensive without a doctor's referral and self-help is not easy to access. they are not well advertised, are expensive without a doctor's referral and self-help is not easy to access.*
- *There needs to be positive images associated with mental health and seeking assistance needs to be ‘normalised’.*
- *Most mental health services are under-staffed, poorly managed, overcrowded and seldom treat conditions at an acceptable level*
- *The hospital does not have designated rooms for violent mental health patients (the closest is 350 km away). Also, those who work with mental health patients only do so Monday to Friday, 8am to 4pm.*

- *In the South-west (of Queensland), distance, isolation and cost are huge issues. Services are expected to cover such a huge area, which makes it difficult to provide a high level of service to all consumers/target groups. Although the population is smaller, the distance you need to travel to see clients is huge so it takes more time and this means less clients are seen.*
- *There are very few mental health specialists who travel to visit people who live outside the town.*
- *Lack of coordination of services, lack of knowledge as to what's available, and more services on a more regular basis are needed.*
- *There is no indigenous mental health worker, clients can't go to appointments in work cars because of gossip, lack of flexible service delivery- it mostly occurs in a clinical setting and the worry of labeling with diagnoses.*
- *Getting help to people when there is a need, that is, it is hard to get an appointment with mental health workers.*
- *Because of limited services/workers, access is extremely difficult (eg. if a worker is sick, there is no one to replace them). There needs to be consideration for the fact that, due to small populations, many workers will already have some contact/relationship with consumers. Also there is no allowance for consumer's choice or potential personality conflict with service providers as there are so few.*
- *There is insufficient collaboration between services, leading to overlapping and gaps in delivery.*

Comments were also made by some providers about the inability of the hospital to deal with mental health patients due to a lack of appropriately qualified staff. As the hospital is the only after-hours health facility in Ruraltown, it was believed that this problem warranted urgent attention. It was also raised that, due to the lack of integration and communication between the different services, there was duplication in some of the services provided by facilities. In turn, the lack of integration between the services led to needs being missed or

some areas being over-serviced. This will be further discussed in the Chapter 8.

Suggestions to increase awareness about mental health in rural areas

A majority of respondents made suggestions to improve mental health awareness in rural areas. They were:

- *Have more psychiatric units so mental health patients would not have to be transported out of their community.*
- *Funding regular dinner-type seminars with guest speakers.*
- *Closer liaison between GPs and mental health professionals to identify problems in their infancy.*
- *Need to know more about what is being done and keep trying to help us understand.*
- *Information leaflet distribution, "late night" TV and radio information sessions and talkback.*
- *Need mental health services to work in liaison with GPs, as rural people would be likely to call on the doctor first.*
- *More targeting of rural males and the environments they frequent eg. sale yards etc.*
- *More flexibility in the hours and days which mental health services operated in rural areas, and also a need for more diverse and trained service providers.*
- *Decrease caseloads and increase prevention and promotion, workers, and professional development opportunities. Provide more accurate and appropriate information on mental health.*
- *Change the term "mental health" to something positive like self-care.*
- *Increase awareness for rural men.*
- *Teaching people, through articles and advertisements in media, about what mental health is, giving ideas about how to improve their mental*

health, practical steps that they can take, normalising the 'unknown' or 'scary' aspect of mental health.

- *Funding for a mental health promotion worker whose specific responsibilities are to educate, promote and raise awareness.*
- *If there was a need, I feel services would be readily available within our community — perhaps we are on of the luckier rural areas. I feel by embarking on a public campaign would not be an answer because of the stigma/embarrassment still perceived by people. Local GPs are overburdened with mental health problems — a major portion of their consultations are mental health orientated.*
- *Whilst many doctors freely promote antidepressants these days, the cycle is very hard to break. Community awareness programmes have to be a plus but often target the wrong people.*
- *"Promote" is a difficult term for the west to handle. We just want to live the way we choose – "promoting" something smacks of falseness even though mental health issues are very real. Most rural people just get a job done, and help neighbours from their own experience rather than seek expert advice.*
- *Put articles in newspapers that rural people read, have high profile people publicly acknowledging their own problems eg. depression, have community workshops.*
- *Have public displays/information stands, advertising, incentives to professional staff to encourage them to live in remote areas.*
- *Improve employment opportunities as it raises self-esteem and outlook on life. Provide more specialist services — there is no point in promoting awareness if the services are not readily available and affordable.*
- *Publicise more widely in the local paper where to access one on one help, not just in doctor's surgeries or hospitals.*
- *Phone support is available but in my experience, people are nervous about accessing it. Continue media promotions eg. radio, television, newspapers — but only where people can access it easily.*
- *More high profile people who are respected in the community and have experienced mental health problems need to come forward to help*

awareness that it can happen to anyone, help is available and recovery is possible

- *Better education.*
- *TV commercials about mental health. Also have more facilities for admission to psychiatric units rather than having to transport sufferers out to the city units. It's like "out of sight, out of mind".¹⁹*
- *Health extension via primary industry organisations such as Agforce.*
- *De-stigmatise it, publicise success stories of drugs/therapy/natural remedies, acknowledge post-natal depression and its impact, acknowledge high rates of depression and publicise the symptoms.*
- *Promoting some form of name change for general mental health and also a promotion of the fact that people don't choose to be ill. Families also worry about the stigma if they talk openly about their problems – again confidentiality is a concern.*
- *Work with local doctors and improve their knowledge*
- *'Normalise' all aspects of health — physical, mental, social — tailor city advertising to rural. "Coping with the stress of drought" sounds better than mental health.*

These suggestions indicate that mental health education and promotion is both needed and wanted in the bush.

Responses from the Consumer Advisory Group (CAG)

The CAG consists of mental health consumers, those that utilise the mental health services available through the MHU in Ruraltown. Eight questionnaires were given to this group in October 2003 and all were returned over the following month. These questionnaires were answered briefly, with limited additional information regarding mental health in

¹⁹ The premise behind the government policy of "deinstitutionalisation" included the reduction in the number of psychiatric units so people could be integrated back into the community. However, it can be argued that this has caused problems in the care of rural and isolated people with mental health needs.

Ruraltown. However, the data included was, nonetheless, enlightening from a consumer perspective and, at times, decidedly pessimistic and hopeless.

All eight CAG respondents believed the term “mental health” to be a negative one and four gave a reason for this. These reasons were to the point:

- *Because people don't want to know about it.*
- *It doesn't sound nice.*
- *No one cares*
- *When people hear “mental” they shut you out, it is their fear and they think we should be locked up. This is a great tragedy and why there are so many suicides. No one wants to listen*

All respondents believed that rural people were not inclined to seek help for mental health problems, with shame and embarrassment being the predominant reason, followed by fears about confidentiality and gossip, lack of knowledge, services and providers. Once again, all CAG members surveyed believed there was a stigma attached to mental health in the bush. Responses included:

- *People don't care.*
- *Mental is a dirty word.*
- *Doctors, nurses and general people don't give a damn.*
- *Because people in the bush need to think they have to keep a stiff upper lip. They are worse at admitting there is a crisis level problem than city people.*

Unique conditions in rural life that affect people's mental health were also identified. These conditions again revolved around the stigma attached to mental health problems and the limited treatment options. The stated conditions were:

- *No one wants to know you, they treat us as if we have a death illness, we lose our friends, no one cares, the hospital is the worst. They just do not want us there.*
- *Just the way people are.*
- *Financial, distance, no real help.*
- *There is not enough [services].*
- *We live too far from the help we need. Phone calls never get returned, appointments are not kept, this makes us feel more unwell.*

With respect to the mental health services in Ruraltown, it was unanimously agreed that they were inadequate. The reasons given resonate with personal despair and feelings of neglect:

- *They don't care.*
- *No one wants to know you.*
- *Because no one wants to take the time to care. Phone calls are not returned. We sit by the phone waiting for mental health to call back all day and you are let down. It is very difficult when you live on your own on a property 1 hour and 20 minutes away.*
- *Because people don't tend to talk about their problems in public therefore less people talk about where to go for help.*
- *Lack of money for people to get help. Anyone with depression does not read the papers or watch TV, they are on their own.*

Five respondents made suggestions to encourage awareness and promote mental health in rural areas. These included:

- *Get people to come and talk to us and get our stories to the top health officials.*
- *Get more services, remove the stigma, have more psychiatrists and psychologists in the bush.*
- *The people with all sorts of mental illnesses should come together and talk to the people that make the decisions for us. It is only us that go*

through it who can tell people what it is like, and then they might change the way they treat us.

- *Change the name from "mental". People think you will give them a disease. More education has to be done for us, more money spent to help us in the bush, more support given as we feel we are on our own. Christmas is the worst time for us and everything is closed down.*
- *HELP HELP HELP HELP!* (was the final suggestion).

These responses, especially the last one, suggest that, for those who suffer from mental health problems in Ruraltown and who are most affected by negative attitudes to mental health, the situation is desperate. The feeling of abandonment and isolation is palpable from all responses. It could be argued that, due to their negative experiences of mental health issues, their feelings of frustration and desperation with the situation might have been intensified. However, the lack of empathy or understanding that these people feel signifies that there are very real problems in the way mental health issues are dealt with in the bush. The characteristics of bush culture such as self-reliance, stoicism, impassivity, and toughness, combined with the isolation from mainstream mental health services, compounds their alienation and isolation even further. The current research hopes to address this very situation.

Summary of results from questionnaires

A total of 262 questionnaires were distributed to the various rural groups and 47, or 18%, were returned. Although the total response rate from these questionnaires was relatively low, at 18%, common themes could still be identified. An aggregation of these themes follows:

- 93% of questionnaire respondents agreed that there was a stigma attached to mental health issues in rural areas. 53% of participants self-identified the source of this stigma as being the bush ethic,

culture or tradition or, as one put it, "*the bushie syndrome*".

- 87% agreed that most people in rural areas would not seek help for mental health problems.
- 85% of respondents believed that the major barrier to help-seeking in the bush was the shame and embarrassment of admitting to a mental health problem. Other popular responses were a perceived lack of confidentiality and gossip in rural areas, lack of services, lack of knowledge and lack of time.
- 77% of questionnaire respondents agreed that the term "mental health" was a negative one. Reasons given all point to the fact that, historically, the word "mental" seems to indicate a severe psychological problem, one that is shameful or unacceptable in a rural community.
- 70% of questionnaire respondents made suggestions to improve attitudes to mental health in Ruraltown: 48% made suggestions to increase community education and the promotion of mental health through information seminars, media coverage, advertising and public displays; 33% of the suggestions were about ways to improve the mental health services in Ruraltown; and 15% advocated a name change, from "mental health" to a more positive term.

In a world where the concept of mental health is not fully understood, it was not surprising that bush people would consider the concept to be negative. From anecdotal evidence and most of the above questionnaire responses, the word "mental" conjures up negative images of insane, crazy, violent people. It is this pejorative image of mental "health" that prevents it from being seen in a positive light.

There was almost unanimous agreement that there is a stigma attached to mental health in the bush. Of particular significance to this study was that many believe that this stigma stems from the expectation in bush tradition that one must be tough, stoic, independent, resilient, impassive, and persevere through adversity without seeking help. It can be argued from these results that bush people acknowledge the existence of a bush tradition or legend which has popularised certain characteristics, facilitating an "identity" which rejects the seeking of help with mental health issues and affects attitudes to mental health.

The stigma of mental health problems often prevents people from seeking help, especially in rural areas, where pride, hard work and strength are valued attributes. To display emotional weakness in the tough rural environment is not acceptable for many sufferers. Therefore, accessing mental health services does not form part of their response to personal difficulties. This stigma appears to be a crucial impediment to mental health service utilisation in rural areas. However, it is a difficult task to measure service adequacy in Ruraltown and the bush due to the possible existence of "hidden" cases that may never present for help.

As mentioned earlier, and evidenced in the above responses from both women and men, bush identity is generally perceived as a male one. As such, males tend to hold more traditional views about emotional or psychological issues and are much less willing to seek help. As one provider stated, *the traditional methods of coping for men have always been more acceptable than admitting to a need for help*. The "traditional methods" this provider refers to are explained by Bushy (2000, p 35): "when it comes to health care, self-reliance and independence have been demonstrated to be strong characteristics of rural dwellers, who often manage on their own or turn to family and friends for assistance rather than formal agencies". It has been proposed that rural men need to be educated that there is assistance available to help them cope with

stress or to conquer problems by less personally debilitating means. The conspiracy of silence and shame of having a mental health problem needs to be jettisoned but the means in which to do this remains problematic.

Suggestions to improve attitudes to mental health in the bush revolved around ideas of promoting mental health as a positive concept (emphasising health, not illness) and the prevention of mental health problems through education on how to recognise and deal with any potential problems. It was recognised by some that "mental health" needed to be presented to the bush in a unique fashion. It is unsatisfactory to attempt the promotion of a concept that has always been perceived or understood in a negative way. While this may be a universal problem with regards to the term "mental health", it can be argued that bush ideology, tradition and values compound this negativity. A name change may improve attitudes to mental health in the bush, however, a conceptual overhaul needs to emphasise the positive aspects of possessing mental "health". Targeting rural males with mental health needs was also recognised as a priority for it is very difficult to overturn the powerful bush ideology of independence and self-reliance. It is obvious that, because of this ideology, delivering a mental health message to the bush needs to be contextualised within this framework.

It is, of course, difficult to draw any firm conclusions from such a small sample of questionnaires but, when combined with the interview results, anecdotal evidence and other studies, these responses add to a broader understanding of bush perceptions of mental health. It can be argued that it is not necessary to jettison the bush legend and identity as it serves a practical and historical function. However, the detrimental characteristics that the legend promotes should be recognised and reduced where (and if) possible to enhance attitudes and enable appropriate treatment of mental health issues. The following collection

of interview results overwhelmingly supports the findings from the questionnaires.

RESULTS FROM THE INTERVIEWS

As noted previously, interviews were also conducted with a range of groups and individuals to add to the study. Additional information and different perspectives have been gleaned from interviewing a number of key informants. The selection of interviewees was based on the "snowball sampling" method (Minichiello et al 1995, p.61). As outlined in the Methodology chapter, after contact was made with the initial key informant, referrals were made to other potential research participants and so on. Over the 3 years and 4 visits to Ruraltown, 33 interviews and re-interviews were held with health and service providers and consumers (see Table on p 220). These interviews were semi-structured, with a series of open questions, guided by interview schedules (see Appendix 6 & 7) which cover the main research themes. Additional themes and issues were also discussed as they arose. There was no strict format to the interviews as some issues were tangential to others.

To ensure that the interviewees understood the nature and purpose of the research, an Information Sheet (see Appendix 1) was given to all interviewees prior to the interview. This sheet stated the purpose of the project, that is, to determine attitudes to mental health in the bush and where these attitudes stem from. The informal approach to interviewing was also conducive to discussion of any points or questions that were unclear.²⁰ Respondents could, and were encouraged to, provide

²⁰ This worked well in most cases, however, there was an interview with a consumer where the purpose was not clearly understood and he misinterpreted the research intentions. He was a willing informant but it was clear that he needed to ventilate personal issues that may not have been appropriate in the circumstances. There was another instance when a potential interviewee did not have a clear understanding of the research. As Foddy (1993, p 74) points out, "whether or not respondents will be motivated to help the researcher ultimately depends upon how they define the research situation". For example, an informant at PHC was contacted by the

additional information or ask questions about any issue if they felt so inclined.

All of the key informants were residents of Ruraltown at the time of interview. Most were from Anglicare, the Mental Health Unit, and the Neighbourhood Centre (descriptions of these services were provided in Chapter 6). However, there were also community informants and members of the CAG interviewed, who were either contacted by me or referred by providers. All interviewees signed consent forms, allowing for the academic use of the information gleaned. However, due to the sensitive nature of the subject, the names of informants have been omitted. The five main areas that were covered in the Ruraltown interviews included:

- the concept of mental health and what it means to respondents;
- who presents for help with mental health problems;
- what influences help-seeking behaviour;
- what are the main problems with service delivery; and
- what can be done to improve service utilisation.

Other issues were also revealed through subsidiary discussions. As with the questionnaires, findings from interviews with the key informants in Ruraltown will be discussed by *theme*, rather than by *interviewee*. The aim in both the questionnaires and the interviews was to identify common patterns and themes, as these represent a form of ethnographic reliability and a main tool of analysis (Fetterman 1998, p 96). These themes illustrate how attitudes to mental health in the bush are formed, where they come from and what impact they may

researcher to request an interview about funding details for the mental health service in Ruraltown. That person stated that the relevance of funding was not apparent when my project was only exploring attitudes to mental health. An interview was not pursued as this respondent had defined the research in her own terms and would not be a willing participant. However, she was interviewed at a later date and this gave me the opportunity to explain the project further. In the end, she provided very helpful information regarding mental health attitudes and services in Ruraltown.

have on service utilisation. Categorisation of the interviews into themes has been carried out to determine the frequency of responses.

Table: Summary of interviews carried out in Ruraltown

Interviewee	Where from	No. of interviews
Rural Family Counsellor	Neighbourhood Centre	3
MHCDO	Anglicare	2
Adult MH nurse	MHU	3
Ruraltown hospital social worker & Adult MH nurse – joint interview	MHU	1
Ruraltown QRWN president & a local councillor – joint interview	Lunch appt	1
QRWN Administration Officer	Morning tea appt	1
Local therapist	Lunch appts	2
Child & Youth MH worker	MHU	1
Manager, Ruraltown newspaper	At newspaper office	1
Former Manager, Anglicare	Anglicare	1
Anglicare Manager & 2 MH workers	Anglicare	2
CAG member x 2	Lunch appts	2
Housing representative	Neighbourhood Centre	2
ICPA member	Lunch appointment	1
Men's Health worker	Neighbourhood Centre	1
Practice manager & MH nurse	Telemedicine Unit	1
CCP worker	Anglicare	1
Coordinator, BBBS programme	Anglicare	1
PHC Team Leader	PHCU	1
Rural health research worker	Office of Rural Health	1
President of the Ruraltown CAG	Lunch appt & phone interviews	4
TOTAL NO. OF INTERVIEWS		33

Interview themes

The five main themes that were revealed in the interview data, as listed below, are closely linked to the research questions and have been discussed in detail:

- mental health as a concept;
- stigma and rural culture;
- rural circumstances affecting mental health;
- problems with service provision, recruitment and delivery; and
- subsidiary issues affecting rural mental health.

As with the questionnaires, the responses from interviewees have been transcribed verbatim and are also italicised

MENTAL HEALTH AS A CONCEPT

When asked about the concept of mental health, all interviewees agreed that it was a misunderstood and negative concept. The negative perceptions attached to the concept of mental health are not unique to the bush. However, it appears that these negative perceptions are more exaggerated in the bush due to less exposure to the concept and unique lifestyle characteristics. It has been supported throughout this research, both empirically and anecdotally, that the juxtaposition of the terms “mental” and “health” is problematic in perception and practice. Reasons stated for the negative connotation of the concept include:

- *There is a stigma attached to the word “mental”— when I say to a client that I could refer them to the mental health team, they think “oh my god, what’s wrong with me!”*
- *I think there is also confusion about what mental health is, what mental illness is and all that type of thing. Perhaps in the city you*

might be more exposed to all that type of information

- *People think mental health equals mental illness. You're brought up in the family to just cope and you cope within the family. People don't access the service (Anglicare) because they think we deal with the mentally ill.*
- *It's the word "mental" that turns everyone off. Especially people on properties, they think mental health is bad and don't understand that having good mental health is positive. People immediately look at the bad side of it.*
- *The word "mental" is our biggest obstacle. People think of someone who is deformed, or mental or maybe a bit crazy. We need to educate that mental health is like physical health, it's all part of the same overall health.*
- *It's the media too. You don't hear about the person with bipolar who is doing wonderful things for the community, you hear about the Claude Gabriels (convicted murderer with schizophrenia) and the Port Arthur killings!*

It would appear from these responses that the concept of mental health has negative connotations for a significant number of people in the Ruraltown region. Even attempts to promote mental health have been met with controversy. For example, the "Promoting Mental Health Awareness" Forum that was discussed earlier would have been an ideal opportunity to put a positive spin on the image of mental health in Ruraltown. However, as one of the organisers of the Forum explained, *I disassociated myself from the pre-Forum media coverage as most of the statements being made by other organisers were very 'crisis mentality', focussing on the stigma and tragic circumstances rather than promotion of mental health.* When I attended this Forum, I also noticed that the

focus did appear to be on illness and negativity rather than health and promotion.

STIGMA AND BUSH IDENTITY

All the interviewees, service providers and consumers alike, were asked if they believed there was a stigma attached to mental health issues in the bush. The responses were unanimously affirmative. Asked where this stigma comes from, responses included:

- *I guess the stigma comes from traditional values, generation after generation. And there's also the tradition in the bush that you have to cope, you've got to be tough. You can't be seen to have a mental illness or to need help, all the way from mental to physical health. I'm sure there are some people out there who would just rather go and kill themselves before they'd go and get help. There is definitely that stigma attached to it.*
- *People on the land are worse than in town. They are very much like "no, we don't need that help, we can deal with it ourselves. We need the financial help but we don't need the emotional support". There is definitely that strong stigma. Even in the young men.*
- *Interest in mental health issues was less for those who lived out of town on the properties — they have less time, greater isolation and are not as open to exploring alternative solutions to problems or seeking outside help to overcome personal issues. This conservatism can also be linked to popular notions of the "stoic self-reliance and pride" of people on the land.*
- *It's very rare that people from properties present for help. Reasons include the bush ethic of self-reliance and pride, lack of knowledge*

about mental health and services, transport, time and cost.

- *The whole rural thing too — big strong men — comes into play quite a bit. People in town aren't probably much that way inclined.*
- *In years gone by, people just got on with it or they went out and got really drunk!*
- *It's from that pioneering stuff, that you're just meant to cope because in years gone by there were no services and when there are no services what else can you do?*
- *I think the biggest thing that has come out of the drought is that a lot of people on properties just haven't been asking for help and just keep going and going and going.....*
- *The Child and Youth Mental Health Worker stated that the stigma is usually apparent in the parents, not the children. She mentioned that some parents can get defensive about their children and I have to choose my words carefully sometimes so as not to appear judgmental or critical. Children from the land don't seem to fall through the cracks as often. They usually attend boarding school, finish grade 12 and go on to university or semi-skilled occupations. It is that socioeconomic factor coming into play again.*
- *Due to the conservative nature of rural communities, "mental health" is a difficult concept to confront.*
- *The former Rural Family Counsellor stated that I see first hand how hard it has been for people on the land yet still they do not ask for help. Prior to her leaving the position, she stated that she wanted to do some training workshops for rural males on properties, to educate them on stress management, health issues, and the services available*

to them. The Counsellor said that she did not want to mention the word “mental” in the title of these workshops as she feared no one would attend. She was hoping to hold these in early 2004 with the assistance of the Rural Financial Counsellor, however, she left her position with the Neighbourhood Centre before the workshops could be organised.

- *The stigma is a result of the fear of failure and conservatism. Previously, problems were dealt with in the family but now there is the breakdown, there is a crisis of support. There is the old attitude of “if you haven’t got the guts, you can’t stick it”. When asked what she meant by this, she referred to the bush culture of independence, stoicism and self-reliance.*
- One consumer stated: *There is a stigma attached to mental health in that it is believed “one must keep a stiff upper lip”. The label of being termed “mental health” [sic] is very frightening because people look down on you in Ruraltown and don’t want to know you.*
- In relation to the conservatism in the community, the former Manager of the local paper stated that *there is a general reluctance to stand out from the crowd or voice opinions. For example, the newspaper has a “Your say” social comment page where community members are asked to comment on fairly benign social or community issues each week. It is difficult to get people to comment or voice an opinion on anything; usually twenty to thirty people will need to be asked to get the required six opinions. This conservatism would also influence attitudes to mental*
- One provider stated that issues of class may also be a factor in the stigma, suggesting that *some people on the land consider themselves to be “above” utilising such as service and may perceive that only disadvantaged groups needed that sort of help. There is also the*

cultural factor of self-reliance on the land. They tended to keep their problems in the family and not seek outside help. Most children from properties go away to boarding schools and therefore no potential contact can be made through local schools. Avenues for communication to these areas about available services or benefits are very limited.

- The stigma of mental health problems in the bush is most acutely expressed through the act of suicide, mostly amongst young men. With relation to the increasing rates of rural suicide in Queensland, an Anglicare worker pointed out that *the Western region (a huge area extending from Ruraltown inwards to the border and upwards to the top of Australia) has the highest suicide rate in Queensland. However, in the South-western area of Queensland, the picture is not clear. The worker explained that in 1992 there were six reported suicides in Ruraltown, five in town and one on a property, and all victims were aged under twenty-four years of age. However, it is no longer possible to get accurate statistics for the Ruraltown area as they are not publicly available. The only public figures accessible are for the much larger ABS-identified regions.*
- However, with regards to suicide in Ruraltown, it was noted in the Community Connections Project report (2004) that “the area covered by this project had no known suicides for a lengthy period up to November 2003. Since this time, there have been three suicides (two in Ruraltown and another in a small community fifty kilometres east of Ruraltown). There was considerable concern about this trend. However, there have been no known suicides for some months now. While there was no known close links between the three men involved, the communities and networks are so close/small, that an interrelationship, even as small as knowledge of other/s cannot be

excluded as an influencing factor".²¹

While it can be argued that there is a universal stigma attached to the word "mental", it appears that this is very pronounced in bush communities, and even more so on the land. Dale (1994, p.332) has discussed the notion of an "off-farm" and "on-farm" rural culture and this comes into play in issues of mental health as well. Lack of understanding or exposure to the concept was often a reason given for this. It was believed, in most cases, that the stigma is due to the historical bush culture of "self-reliance, stoicism, pride and personal strength" that bush people supposedly possess. It was also considered that these qualities were more significant to those who live on the land than those in the town. As a result, this reason has been offered as an explanation in the interviews for the poor attendance rate of people on the land suffering stress or emotional problems to the mental health services in Ruraltown.

Gender also factored into some of these responses from providers. Several indicated that the stigma attached to mental health problems was strong in men of the bush. The notion that bush identity was identified as a male one has been raised previously in this research and in many of the questionnaires. Bush women in this study have acknowledged the existence of bush identity, its contribution to the stigma attached to mental health issues, and its affect on the willingness of people to seek help for mental health problems. However, it was not clear or specifically acknowledged whether bush identity has an influence on female attitudes to mental health in the bush or

²¹ Anecdotally, the issue of suicides being reported as "accidents" has also been raised. During the third visit to Ruraltown, a casual discussion was held with a retired businessman who had previously worked in Ruraltown for 27 years and he stated that "You'd find a lot of car accidents would be suicide. Blokes who can't hack it and have a head on with some other poor bastard and that's it. You also hear about blokes hitting a tree on the property. Not likely, but the family still gets the life insurance because it's an "accident"." I asked why he thinks that it happened a lot and he stated that "it is difficult for people in the bush to seek help, no matter how desperate they get" This point has been raised earlier in the research.

whether they were confining their responses to a discussion about rural men.

RURAL CONDITIONS AFFECTING MENTAL HEALTH

Those interviewed believed there are unique conditions in rural life that may have an adverse influence on the seeking of help for mental health problems. Issues such as perceived confidentiality problems and gossip, and distance and isolation were given as reasons for people not addressing mental health concerns. Statements about these problems will now be outlined

Concerns about confidentiality and gossip

The following comments were made regarding confidentiality and gossip concerns in Ruraltown:

- *People are worried about confidentiality in Ruraltown. In the metropolitan areas, people aren't as identifiable and the population just tends to blend in whereas in rural areas those people probably come to notice more of what's going on. People are really scared of others finding out about them asking for help.*
- *The word from the hospital leaks like a sieve There's no confidentiality and everyone knows about it.*
- *Another reason why people don't seek help is because they worry about who's going to find out, how confidential it will be.*
- *There are worries that you think it's not going to be confidential, or you're going to be seen.*

- A member of the CAG pointed out that the room at Primary Health Care where the group's tri-weekly meetings were held was not soundproofed and this was a real concern. She said the group was *worried that everyone would know your business. Confidentiality is important and if you're worried people can hear you, you can't be honest.*
- Another reason given by the mental health nurse at MHU for people not presenting for help was that, as her family had been in the community for a long time, she was well known. She stated that *people do not want to admit to psychological weaknesses or receive support from a person who may be the daughter, wife or sister of a friend or relative. It is all too close for comfort and 'saving face' is more important.* The social cohesion that is experienced in a small community is often counter-productive when it comes to mental health issues.
- A worker also stated that *there is the confidentiality issue of living in a small town and the fact that some of the people who might access our service are people that we might mix with socially. This is quite a consideration and you have to decide whether to refer them to someone else that you think that they might not see on a social basis, or to an out of town service. It's not always easy to deal with.*
- With respect to confidentiality, the researcher observed that the location of MHU nurse's office in the PHCU was very open. The PHCU is situated in the centre of town and is a one level building that has a huge glassed-in reception area at the front of the building with practitioner and administrative offices behind and off to the right. The mental health nurse's office is at the very front of the building with the sign "Mental Health Worker" on the door. It is visible from both the waiting room and the street. Car parking is also only available out the front of the PHCU. Therefore, anyone with an appointment to see

the mental health nurse would be very exposed and have little chance of concealing their attendance. This structural arrangement appears to be counter-productive for privacy and may add to worries about confidential treatment that have been reported here.

- By contrast, a former mental health worker from Anglicare is very aware of the importance of confidentiality in the delivery of mental health services. She has recently qualified as a counsellor and is in the process of setting up her own practice. She stated that *the new counselling service we are setting up will be in a house we have bought which is away from the business centre of town. It is situated near a school so you can park away from the house and not be so visible. We are not widely advertising and will not have a big sign out the front. We are very aware of the importance of anonymity and confidentiality. We'll be away from town in a homely comfortable atmosphere where people can relax and debrief. We want to educate that everyone has a crisis, and to 'normalise' counselling. It is hoped that referrals will come from word of mouth or through already established agencies. It seems that Ruraltown may be very much in need of such a service, one that is reflective and attuned to client needs.*

Distance and isolation

The distance and isolation from adequate services were also factors of difficulty in treating mental health problems in Ruraltown. Following are some of the comments raised concerning these:

- The former manager of the local paper in Ruraltown stated that *the further west you go (in Queensland), the less understanding there is of distance, travel time and isolation from services. For example, I was working in St. George (five hours from Brisbane), I was notified at 11 am of a meeting that I was expected to attend, being held in*

Brisbane at 1 pm. He also said that *there is a much bigger likelihood of meetings or conferences being held in the larger centres rather than Ruraltown or smaller country towns. This can lead to professional isolation and a decrease in intra- and inter-service dialogue.*

With regard to distance from medical services, the Manager also stated that *if there is a need to travel to Brisbane to attend a specialist appointment, it is be a very time consuming and costly exercise. For example, it can take up to three days to attend one appointment. The travel time to Brisbane and back is two days, attendance at the appointment is another one, it is stressful due to the unfamiliar environment, accommodation, travel, food costs, disruption for children missing school etc. Long-term treatment (eg. chemotherapy or psychiatric problems) can become extremely costly.*

- An interview with a mental health consumer in Ruraltown also highlighted this issue. She stated that *I have a wonderful psychiatrist in Brisbane. It might cost me a bit to go there but I'm far better off there than I am in Ruraltown. Others have to see the visiting psychiatrist who only comes once every six weeks and not everyone can get to see him. They only have time to talk about medication but you need the support as well. As a panacea to this problem, a video linkup from the MHU with a regional centre for consultations through telemedicine was been suggested. However, the response from this consumer sums up the general feeling about this suggestion: when you're feeling depressed, the last thing you want to be doing is looking at someone on a TV screen!.*

The mental health nurse at MHS had the same concerns regarding a video linkup. She said: *it would be a very new idea, especially for people on the land. They would have to come to terms with the fact that they need counselling and that is an issue in itself. I don't know whether they would see it as being personal enough. I think*

telemedicine at times can be impersonal and I have had people say to me that they would prefer to actually see someone and having real eye contact. Telemedicine may conquer the distance problem for treatment, but perhaps not in the case of mental health treatment in an already skeptical rural environment.

- Another aspect of distance is the problem of transport. As one provider pointed out, *there's not a lot of public transport in town so people can't just hop on a bus to get to appointments. Those from out of town would find it more difficult.* Due to increasing financial commitments, it was argued that people could not afford the time to travel to non-essential appointments, hence, many do not present for treatment until the situation is chronic. Although there used to be a Rural Support Officer with the Neighbourhood Centre who was prepared to travel to visit families both in and out of town to reduce the distance problem, she stated that *very few sought or invited outside emotional support.*
- Distance from larger service centres also affects education opportunities for children. For example, in Ruraltown there is only one choice for primary and middle schools, and two for secondary schools: a Catholic school and the TAFE college. As a result, significant proportions of rural children attend boarding school. As one worker explained, *this, in turn, may have an affect on mental health attitudes in Ruraltown and help explain the limited interest in mental health in the bush. Kids educated in larger regional towns or cities are exposed to urban problems and solutions, they may not be as concerned with rural issues, particularly mental health problems. With an exodus of youth, changes may not occur and options for mental health information may not be explored. Thus, older people will probably retain the conservative rural mindset and not be influenced or swayed by more progressive ideas or approaches to personal problem-*

solving techniques.

- The former Rural Support Worker agrees with the difficulties in reaching rural families on the land. She stated that *as most children from properties go away to boarding schools, the potential of contacting these children and their families about local mental health services through community schools is reduced.* Although she was available to see rural clients either at the Neighbourhood Centre or in private homes, she maintains that *it is difficult to obtain access or invitation to these families. They are usually very isolated, not interested, unaware of the service, or do not perceive it as relevant.*

PROBLEMS WITH SERVICE PROVISION

Problems with service provision in rural areas have been well documented in this research. With regards to mental health services, there are problems with the recruitment, retention and appropriateness of staff, funding difficulties, and difficulties with consultation and collaboration. Problems treating mental health patients at the Ruraltown hospital were also identified. Service providers and consumers in Ruraltown have discussed these specific concerns.

Recruitment, retention and appropriateness of mental health staff

- The MHS in Ruraltown has funding, through Queensland Health, for a psychologist, two adult mental health workers, and one child and youth mental health worker. However, in the four visits I have had to Ruraltown in over three years, at least one of these positions has not been filled, sometimes for up to twelve months. As previously discussed, it is difficult to recruit and retain medical staff in rural areas. This increases the workload for the existing staff to sometimes-unmanageable proportions. The mental health nurse from the MHS stated that *if you had the full complement of staff, it is manageable I*

would think. But we have been short-staffed and haven't been able to replace anyone in the full-time position for the last twelve months. Locally we manage but our back up from the regional centre is really lacking. Also, in our team, it would be good if different disciplines were represented. The other mental health worker and I are both from nursing backgrounds but to have an allied health professional as well would be ideal to complement the service and have a different skill mix. A mental health worker from Anglicare concurred: if all the positions the government provided for were actually filled, it's hard to know if that would be adequate. There are some that have never been filled. But we do know that only a small percentage of people who have a mental illness go and visit the MHS or us and we're both chockers so that says something! ²²

- Staff seems to shift around within the services regularly. For example, the former social worker at the hospital changed positions to become the Child and Youth Mental health worker at the MHS. It could be argued that a social worker becoming a Child and Youth Mental Health worker, although she has experience in the social services arena, that child and youth mental health requires more specialised knowledge. The former Manager of the Neighbourhood Centre is now the Manager of Anglicare. Recently, the psychologist who worked as the Rural Family Counsellor with the Neighbourhood centre has left and a worker who came from Education Queensland has filled her position. However, she does not have the same experience or qualifications. The psychologist from the MHU and the one from Centacare have moved to other organisations. As staff leave their positions, they are often filled from the already-lean existing mental health workforce, filled by under-qualified people, or not filled at all, and workloads further increase.

²² "Chockers" is an Australian colloquial expression that means full or overflowing.

- Over the three years of this research, the visiting mental health team from the larger regional centre, which previously consisted of a psychiatrist, psychologist, nurse and social worker, has now been reduced to a psychiatrist. They used to consult every month, then every six weeks, and now every five weeks, but only for one day. This has created caseload problems. The mental health nurse explains: *I guess the major difficulty we have is that there's a clinic for only eight hours once every five weeks. At the moment we have about forty-six patients on our books and the most we can get the doctor to see on an average day would be eight or nine, or even less if there are new patients to be seen as they need more time. So it's very difficult to get each person seen by the psychiatrist every six weeks to three months which is supposed to be the maximum time frame between consultations.* Another serious problem, she said, was that the MHU had not had a child psychiatrist visit for about twelve months and, to make it worse, nor is there one in the larger regional centre so, if there is a problem, families would have to travel to Brisbane. During the May visit in 2004, the MHU nurse informed me that there is now a Child and Youth psychiatrist in the larger regional centre who will be visiting Ruraltown sporadically.
- Between visits, the MHS provides ongoing support and counselling, working with GPs to monitor medication and treatment, and is available for crisis intervention. However, due to their workload, it has more of a clinical, as opposed to supportive/preventative, focus. Between visits by the psychiatrist, consultation with the MHS is by teleconferencing. The mental health worker at MHS explains that *we do video conferencing once a week at the moment for half an hour with the psychiatrist in the regional centre and that's where we review our caseloads. That's not adequate time. Imagine how much you could talk about in half an hour. If you've got a complicated assessment to present, it could take at least fifteen to twenty minutes.* When I asked why only half an hour was allocated, she stated that *the regional*

centre is very busy and it too is short of psychiatrists at the moment. That's a huge issue that really impacts on our service here. If a major regional centre experiences shortages, this is generally felt more acutely in the smaller centres.

- With regards to treatment for mental health clients, an Anglicare worker stated that *I think the services that are here do the best they can and try to work in partnership with each other. But in terms of frequency of the psychiatrist's visits, I think that doesn't provide people with many options – who they can see for one, and how often they can see them. There's no continuity, there's no after-hours. They have to go to hospital or just cope.*
- To overcome the problems associated with a lack of psychiatric support, telemedicine is being trialled through the Healthshare video link-up (discussed in the last chapter) that has been set up in one of the doctor's surgeries to enable access to psychiatrists. It has been in operation since January 2004 and widely advertised in Ruraltown. However, the response has been less than encouraging. The mental health nurse at this Practice explained that *the cost involved, though not excessive, has been a major hindrance to the utilisation of this service since the pilot began. It's a real culture out here, that services should be free because they have been in the past through PHC. Some people can afford to pay but don't think they should have to.* As mentioned above, the MHU, Anglicare and the NC provide assistance for free in relation to counselling or mental health issues. The Practice manager also believed that another contributing factor to the poor response to the Telemedicine service is the fact that there have been limited referrals from GPs. She argues that *any GP in Ruraltown can refer to this service but we have not had one referral (May 2004). Despite the fact that they are all supposedly so busy with mental health patients, it appears that GPs are reluctant to refer patients on to another service, especially one that charges a fee.* Here is a facility

that appears to overcome many of the mental health service provision problems in rural areas, such as travel, distance and isolation, yet it does not appear to be supported or utilised by doctors or consumers due to the cost involved.

- A discussion with an informant who is a registered nurse also revolved around a lack of adequate and appropriate personnel. For example, she quipped that *you can only have a psychotic episode between nine and five, Monday to Friday as there are no after-hours services available to patients who may be experiencing problems*. With respect to appropriate personnel, she stated that *you may have a twenty-two year old female mental health worker from the city trying to counsel a sixty year old bush man. Clearly the two can't relate to one another yet there is no choice*.
- The Rural Financial Counsellor also raised this issue. He stated that *the older generation especially are reluctant to seek help because most providers are young and city-bred. They don't relate to them and don't speak the same "language". They don't understand the [bush] culture and even the doctors don't understand. There are overseas doctors who are sent out to rural areas and they would have no concept of the Australian rural culture. We need more people, but we need appropriate people. Rural people who go on to medicine and come back and practice — at least they have a basic understanding*.
- Finally, as mentioned previously, the Community Connections Project that started in August 2002 with Anglicare and is funded for three years, has experienced serious problems with retaining a community worker. This project targets three groups who were recognised as "at risk" of suicide in the community: gay, lesbian, bisexual and transgender young people; isolated men; and people with a mental illness. It was first advertised in August 2002 and filled by a male worker in October 2002. When the Project first started, the former

manager of Anglicare explained that *there is a great need in rural areas to have a worker who can focus on the mental health needs of homosexual people. The stigma attached to homosexuality in the bush is probably more pronounced than the stigma of mental health issues.* However, the first worker left in December 2002. The position was readvertised in January 2003 and a new male worker commenced in February 2003. He made considerable headway with the Project, however, due to poor health, had to leave the position in February 2004. A replacement female worker commenced in March 2004.

The new female CCP worker stated that the lack of position continuity with this Project has been especially problematic. She stated that *there has been a lack of confidence in the Project because of the number of people in the job. It takes time to build trust and rapport. The main hurdle is that the community knows what groups I'm working with so people don't want to be seen to access it.* She also acknowledges that the fact that she is a woman may interfere with trying to work with isolated and homosexual men. The "appropriateness" of having a female in the position may hinder progress, however, as the Anglicare manager stated, *we had to get someone into the funded position and I had to give her a go. She's keen, she's got some good ideas and we all have to start somewhere to get experience*". The Project is funded until June 2005, however, the Manager stated that he is "*not confident*" that the funding will be renewed.

The recruitment, retention and appropriateness of mental health staff are recurring themes in this research.

Problems with the hospital

The hospital was also identified as a site that needs improvement in the treatment of mental health consumers. Both consumers and providers

expressed this concern. Due to the fact that there are no trained psychiatric staff at the hospital, the perception is that there is a lack of understanding or appropriate action taken. Concerns are outlined below.

- At Ruraltown Base hospital, there is no provision for an inpatient mental health bed. However, if there is a mental health emergency, there is no other after-hours facility for people to go to. The only option is to attend the hospital. In addition, as there may not be qualified staff on duty to attend to a mental health crisis, often the police are called in which can aggravate matters even further. One consumer relayed the story of how she was taken by police car, against her wishes, to the psychiatric hospital in the larger regional centre. She stated that *I felt like a criminal*. The Team Leader at PHC also recognised the transportation of mental health clients as a major problem.

This informant had also been a patient in the Ruraltown hospital for depression and anxiety. She maintains that *there are huge problems with the hospital. They don't want any mental health patient there. They think you are wasting their time. They don't care and they don't understand*. On a later occasion, this particular consumer was admitted to hospital for a medical reason. She explained that *the same nurse who was there when I was in for depression stated: "Oh, are you back in for another holiday luv"*. Needless to say, this attitude is unfortunate when treating any patient, not less a mental health patient.

- Service providers have also highlighted problems with the hospital. For example, one provider from the Neighbourhood Centre stated that, under new legislation (November 2003), the hospital is not permitted to keep mental health patients for more than a day as they do not have suitable facilities and will not be getting any in the near

future. She said that the mental health team is supposed to be called in for assessments so that less patients need to be transferred to the larger regional centre. However, this is not always possible as the mental health team only work in business hours.

- This provider also explained that some patients had been turned away or banned from either the hospital or the PHCU due to anti-social or abusive behaviour, yet they have few other places to go. She relayed a story about a domestic violence patient who was referred from the hospital to the NC for help with accommodation. She stated that, *in discussion with this patient, it appeared she had delusional problems. As there was no social worker at the hospital, the patient was referred to the MHU for assessment. One of the mental health team asked the patient if she was "hearing voices" and, when the patient said no, it was decided that there was no mental health issue. The patient was then sent back to the Neighbourhood Centre.* The provider pointed out that *these clients are seeking our help as they are turned away from primary health areas and I don't see how we are equipped to handle them. We will obviously need to call the police or ambulance at times.* It has been suggested that there is a lack of training or appropriate staff to ensure accurate treatment or diagnosis at both the MHU and the hospital.
- This opinion was also expressed by a number of other providers. One stated that *the nurses aren't trained to deal with mental health patients. Even when they do training, they're okay for a week then go back to their core beliefs. We had a recent example of atrocious post-discharge care. A mental health client was in for a physical injury yet there was no post-care in place. I would have classed for a fairly high suicide risk. At least they should have rang us to alert us of the discharge so we could follow-up. The worst part about it was the isolation that this client suffered in a community this size. It shouldn't happen because we're small enough to care for the members of our*

community one would think. Another stated that the staff at the hospital are not trained, either the nurses or the doctors. We've had a couple of admissions since I've been here and it's been a disaster. They have no idea how to approach a mental health patient. Even if the word "depression" is mentioned, the nurses freak out! I think they bandaid, they manage, they medicate, and the patients are sedated. The hospital has absolutely no contact with the mental health population whatsoever until they are at extreme crisis point. Nurses think "I'll put my blinkers on and hope to hell I'm not on the shift when someone loses it".

- These problems have been extensively documented in a Masters thesis by a Ruraltown researcher, examining nurses' attitudes to mental health patients at the Ruraltown hospital (Clark 2003). Clark (2003) highlighted the importance for rural nurses to understand bush culture and be educated about the most appropriate way to deliver services in rural areas. As rural nurses have a key role in providing health services to the mentally ill in rural areas, she believes it is essential that they have positive and empathetic attitudes towards mental health patients. Clark has recommended that urgent funding be provided for education of the Ruraltown nurses, so they can treat, accommodate and respect mental health patients in an appropriate manner.
- The Team Leader at the PHCU raised another serious issue regarding mental health patients presenting at the hospital for treatment. She stated that there was no expertise in triage for mental health patients at the hospital.²³ The Team Leader explained that *when patients go into emergency, a nurse will assess how quickly they need to be treated, on a scale of one to five, with five being life-threatening. If a*

²³ Definition of triage: "the sorting out and classification of casualties of war or other disaster, to determine priority of need and proper place of treatment" (Miller & Keane 1972, p. 978).

mental health patient comes in, regardless of what's wrong with them, they are usually triaged at about zero or one. Hospitals in other States have shown that you can triage for mental health clients and most come in at four or five. So I find that the most distressing for our clients. The fact that mental health patients are automatically classified as non-urgent demonstrates how inadequate the hospital system is for diagnosing and treating mental health problems.

Funding issues

With regards to government funding for mental health services in Ruraltown, providers expressed concern for the lack of continuity, consistency and availability of funds to keep services operating at an optimal level. Although it is acknowledged by most providers that Ruraltown is well-serviced compared to other more remote areas of Queensland, there are still problems with attracting funding to fill the gaps in services and keeping positions in place long enough to be effective. A few examples will now be outlined.

- In September 2001 a Mental Health Promotions Project commenced in Ruraltown, under the auspices of Anglicare, as part of the 10 Year Mental Health Strategy for Queensland. The position of the Mental Health Community Development Officer (discussed earlier) was funded by this project. It was a consumer participation project, advocating consumer empowerment and involvement in their treatment. It had received funding until June 2002 with the possibility of extension. However, despite the fact that considerable progress had been made in spreading the "mental health" message in Ruraltown through various mediums, especially the publicity surrounding the "Promoting Mental Health Awareness Forum", Anglicare was informed by Queensland Health in April 2002 that the project would be terminated in June of that year.

- The former MHCDO explained that, prior to the time that her position ceased in June 2002, she transferred to another position in May as a Mental Health Family Support Worker with Anglicare. The new position was focused on family issues and, as a result, there was no worker in Ruraltown to concentrate on the promotion of mental health. This also seriously affected the formation of a Ruraltown CAG. As she explained to me at the time, *the MHIG needs to formalise to become a CAG but at the moment we're left in a bit of a lurch because there's no worker to help them. I feel they were organising things but a lot of them have too much on their plate and not functioning high enough to know how to run meetings and do all the full administration stuff.* The responsibility of assisting with the transition of the MHIG to a CAG was then transferred to the PHCU in June 2002.
- At interview in October 2002, the former Manager of Anglicare expressed his frustration at the cessation of funding for the MHCDO. He explained that *several other similar positions throughout the State were funded for several years before this one started and so much of their work had been done in terms of setting up CAGs and moving them to a point of being autonomous. But here, we got the interest and people were starting to throw ideas around and suddenly the work was pulled. We were moving forward with the facilitation of the worker and I think the consumers got a lot out of it in terms of their own development. I mean, any community development work is long term and, if we had another year or two it would have worked.* It was a consumer-focussed programme so the brunt of withdrawal was definitely felt by the consumer. As one Ruraltown consumer stated, *it's just another example of the government not really caring about the rural community.* The current manager of Anglicare concurs: *that's the frustrating thing, we will start to make progress and then funding is withdrawn.*

- Recent funding problems in Ruraltown were expressed in an email from a former Anglicare mental health worker in April 2004. Using her direct quote best sums up the frustration: *Not good news on the mental health front in Ruraltown at the moment. The funding that both Anglicare and Centacare went for will not be announced until the end of May [2004]. Funding runs out for these programs in June. Hence, the psychologist from Centacare has resigned and moved to another position. Not an easy decision but she could not afford to wait and see for the government funding. So down one psychologist for Ruraltown. Centacare's counsellor has also resigned so down one counsellor for Ruraltown. So referrals now go to Anglicare Mental Health Support and hey, they might fold at the end of June so as far as continuity for consumers is concerned there is none!* It was discovered in the fourth visit to Ruraltown that the Anglicare Mental Health Family Support have at least been guaranteed funding until September 2004 and it is hoped that this will be ongoing. Funding issues have been a significant problem for Anglicare and one that appears to be worsening.

It was reported in the Ruraltown newspaper on 29th June 2004 that a new psychologist had been appointed at Centacare, however, the funding was still not assured. The new psychologist stated that *the service I provide doesn't have recurrent funding so I would like people to use the service if they have anxiety, depression or other disorders so that it can continue* (Ruraltown Paper 29th June 2004, p. 5). The issue of on-going funding is dependent upon utilisation, however, due to the stigma of mental health, this may not represent an accurate reflection of need in Ruraltown.

- A mental health consumer also raised the problem of lack of continuity with service provider positions. She stated that it is very difficult for mental health consumers to find someone they can communicate with and trust: *There are not that many workers to*

choose from so once you find someone, it is a blessing. I have had two such people, one from the MHS and one from Anglicare, and now they have both left so you have to go through the whole process again.

When you are already not feeling well, it is not easy to do. Mental health problems can be exacerbated by these changes in staff.

- The President of CAG also highlighted funding problems for the CAG. Funding for Queensland CAGs is supposed to be distributed at the District level. As mentioned earlier, the Director of the Mental Health Unit disclosed that funding for the CAGs was either through the allocation of money, or 'in kind' support through the provision of a meeting room, administration support and any other assistance required to keep the CAG functioning. This particular consumer joined the CAG in March 2003 and has become well versed about the way the CAGs should be administered. When the administration of the CAG was taken over by the PHCU in June 2004, she stated that *funding and encouragement seemed to stop. I was going to resign as President and other members were also going to resign from the Group because we weren't getting any help from mental health [PHCU]. The team leader [at PHCU] was horrified cause, if we resigned, that wouldn't look good for mental health in Ruraltown. She asked if we needed more help with administration. But I'd told her all this in the past and nothing happens. They make lots of promises but never follow through ever since I've been there. It's always been a problem.* Although funds or assistance are supposed to be given at the local level, there are serious problems for the CAG in Ruraltown with the delivery and management of this support. (Problems for the CAG will be discussed further in the following chapter).
- A subsidiary funding issue, indirectly related to mental health issues in Ruraltown, is the education system. As one provider stated, *I think the school situation out here is just pathetic and that's probably got a lot to do with it (ie. mental health problems). I mean, if they had a*

decent school system then kids would probably go on and find self-esteem and wouldn't go onto other things like drugs and crime. They've got one junior school, one middle school, and kids in grade eleven and twelve have to go to the college or on to TAFE and there are too many kids in every class. Only one school for quite a big population is ridiculous. That's just one example of where there's not adequate funding!

- An Anglicare worker also discussed the value of mental health education in schools. She explained that *some of the community health nurses have started something in pre-school, teaching them about feelings etc. I think it's just about starting to talk about it when they're young and looking at resiliency skills too, a lot of the stuff that people, for whatever reason, are missing out on. We need more education.* However, further funding for mental health education within an already under-funded school system does not appear likely.
- There were fears that the May 2004 Budget would result in the loss of funding for the Rural Financial Counselling Service. However, the Rural Financial Counsellor informed me in June, with much relief, that funding has been continued for another four years.
- In September 2004, a CAG member revealed that the Federal Government had withdrawn its funding for the "Young Family Assistance Scheme" at Anglicare, from the 30th September 2004. The informant stated that *this will be disastrous for the Ruraltown District as there are so many young families who need and benefit from this service.* Another repercussion of this withdrawal is that it puts the burden on other services to pick up the demand and meet the needs of young families. Mental health consumers in particular may feel the brunt of this withdrawal. As the CAG member stated: *how can they take away from a District that is so badly in need?* There is also the possibility that the hospital in another town in the District is going to

be closed down which will increase the already-stretched capabilities of the Ruraltown hospital.

The ongoing funding uncertainty for Ruraltown workers makes for a very anxious workforce.

Collaboration and cooperation problems between the services

Another theme that was apparent in the interviews with providers and consumers was a perceived lack of cohesion and collaboration between the mental health services in Ruraltown. There is a monthly Inter-agency meeting held for health and community service providers to discuss problems and concerns within the services and the community. Although it is recognised that attempts such as this have been made to join forces in the administration of mental health services in Ruraltown, many providers believe that these attempts have been ineffective. Examples of collaboration problems will be outlined below.

- The aforementioned Health Advisory Group that was being administered through the hospital was supposed to open communications between the hospital and the community. Mental health clients apparently have been overlooked. The informant who briefed me on this Group in October 2003 sent an email in April 2004, stating that *the HAG is basically a PR exercise to enable better communications between the hospital and the community. There have been no outcomes for mental health*. In an article in the local paper (June 2004), the Ruraltown hospital Director of Nursing stated that “in my opinion, the group has been positive and we have addressed some important issues”. While that may be the case, mental health clients appear to have missed out on the benefits. There is still no allocated mental health bed at the hospital.

- According to providers, there is little collaboration or referral mechanisms in place between PHCU and other mental health services. One provider stated that *although there is a push to get everyone (PHC, Anglicare, Centacare and the NC) to work together because everyone is so busy and so there is not overlap of services, it doesn't seem to be happening*. The former Centacare psychologist stated that she did not feel there was cooperation between the different services. She explained that *the GPs refer to me but PHC rarely does. There are two systems that happen (public vs private), sometimes they meet, sometimes they don't. I've given up trying to work together cause it's left up to you as a private, non-government organisation, not only to instigate but follow through and when you're in my position, when you're one worker and stressed, it's too difficult*.
- A mental health worker from Anglicare argued that *there's a long way to go before you can say that Ruraltown offers a comprehensive mental health service that covers all the needs of clients and maybe that will never happen. At the moment, I see that there are several services doing similar things. PHC don't actually refer to us much so that could be why they're so busy. So we need to find out exactly what they want to do and what they want us to do. Certainly the opportunity is here for them to refer a lot more than they do*. All of these responses indicate that there are significant problems between the PHCU and other non-government agencies.

However, the Team Leader at PHC stated that the relationship with Anglicare had improved greatly over the past eighteen months. She indicated that they wanted to start some joint case management in the next year. She said that some other departments were *more challenging* than others. With regards to the Inter-agency meetings, where the agencies are supposed to meet and discuss problems with service provision, the Team Leader stated that she did not find them very useful. While she recognised the importance of the meetings for

interaction and morale for the clinicians and workers, she said that they had limited benefit for management. She hoped that the managers could start meeting to discuss problems at a higher level about service delivery and gaps in Ruraltown. This appears to be much needed as, when I mentioned the Team Leader's name to the Manager of Anglicare, he did not know who she was.

- Inter-service communication between the mental health services and GPs in Ruraltown was also stated as poor. The Team Leader said that *some GPs refer to us but some never refer at all. They choose an alternative referral. We've tried to work with them, and invite them to meetings when the Director comes, to talk about issues or problems and improve the working relationship, but they seem reluctant to attend. However, I think there are some things about GPs we need to take on board. It's a business for them and time out is money for them. They don't understand or aren't aware of the services, they treat so many different conditions and mental health just may not be on their radar.* As mentioned previously, GPs have also been reluctant to refer to the Healthshare Telemedicine facility that offers treatment through video link-up with a psychiatrist. Despite the facility being widely advertised to all the doctors and mental health agencies, it has been poorly utilised.
- The Team Leader at PHC also raised the issue of service duplication. She stated that *I think it is great what Anglicare are doing but I do see a double-up of structure. For example, we have a suicide prevention officer and so do Anglicare. I'm not sure what can be achieved by having both. It cost so much money establishing those positions and sometimes they only go for a period and then they're gone. If we're both competing for the staff that are around, with funding going into two separate organisations for the same thing it just seems a waste of time, money and resources.* The non-government services also seem to have similar positions in place. There is a family support

officer at the Neighbourhood Centre and Anglicare has two family support workers. An Anglicare worker also stated that many services seem to overlap: *Ruraltown is well serviced but we need to stop doing things twice, reinventing the wheel all the time with staff changes.* The Team Leader at PHC had previously raised this issue about the need to reduce duplication and restructure the services to optimise capacity.

- Another example of poor collaboration and communication between services in Ruraltown was the evident at the time of the “Promoting Mental Health Awareness” Forum in April 2002. I had a meeting with the Rural Counsellor from the Neighbourhood Centre the day before the Forum and asked her if she would be attending. She said that, as she had only found out about it less than a week ago, she had already made previous plans. I found this strange that the Counsellor had only found out about it recently as she works in the mental health arena and that it had been advertised in the local paper on occasion over the previous two or three months. The Adult Mental Health worker from PHC also did not attend the Forum as she “had visitors”. These workers did not attend the only mental health forum that has ever been held in town. This is another example of the poor inter-service communication and collaboration evident in Ruraltown.

Prior to termination of the MH Project at Anglicare in June 2002, I was informed that there was some resistance to the Project from the more traditional services. A worker argued that *Primary Health Care, the largest provider of health care to the area, were very busy, and in the main, only had time to tend to those people “with a serious diagnosis” or extreme cases.* Anglicare is a service that recommends the employment of preventative measures and aims to advise, support and forestall the appearance of mental health problems. This worker believed that it was due to the conflicting ideologies and complaints made both by, and against, Primary Health Care (Queensland Health)

that the MHCD Project was terminated in June 2002. As a result, Anglicare was not able to concentrate on mental health promotion.

- The mental health worker from the MHS agreed that promotion was important for the cause of mental health. She stated that *we just need more people out there doing more promotion as well as the treatment/follow-up sort of things. If we had the funds, a full-time mental health promotions officer would be great. That is part of our role here but my experience is that we are busier with the clinical side of mental health and we don't have the time to do that promotion. It's time and money.*

The Team Leader at PHC also agreed that promotion of mental health is greatly needed. However, she stated that PHC has not been able to involve themselves in many promotional activities. She concurs with the mental health nurse: *the clinical side of our work always outweighs promotion.* However, she did specifically mention the need to educate the community about depression and stated that *we know that rural communities and rural men are prone to depression. We need to get out there and educate the community on recognising depression, demystifying it and removing the stigma.* A provider from Anglicare also recognised the importance of education about depression. She argued that *the biggest demand in Ruraltown is for depression and anxiety support.*

While most consumers and providers agree that the *promotion* of mental health is an essential factor in changing attitudes, there have not been any significant promotion activities in Ruraltown since the termination of the Anglicare Mental Health Promotions Project in April 2002. One provider stated that *after the Forum, things went back to the way they were and it all stopped.* Another provider joked that *another Forum would be good but you would only get a packed house if you said they were opening a mental health institution in Ruraltown. Not saying*

institutions are bad but it would be packed cause it would lower the value of properties in Ruraltown. At least you'd get good attendance though! During Mental Health Week each year, mental health is again the focus, however, it is too short-term and small scale to make any real difference in the community. The divergent priorities and agendas of, and lack of funding for, the health and service providers in Ruraltown seem to hinder any true progress in this area. All of the stated problems with service provision affect both the workers and consumers of mental health services and contribute to the negative portrayal of mental health in Ruraltown.

Problems for the Consumer Advisory Group

Since the CAG has been under the auspices of the PHCU, there have been significant problems expressed by mental health providers and some members of the Group. The mission statement of the Ruraltown CAG is "to assist in empowering consumers and carers, so that they are able to contribute and respond effectively to the *National Mental Health Plan* in the Ruraltown area". The CAG is supposed to work in partnership with the Ruraltown MHS and PHCU, to achieve improved quality of life for the community, and provide a voice for consumers and carers in addressing the needs of people with mental illness in Ruraltown and the surrounding district. It appears that this partnership is not as effective as it might be. Provider and consumer concerns about the CAG are outlined below.

- A local psychologist explained that *it is my understanding that it [the CAG] is all public. They didn't take into account that there are non-public services in Ruraltown. It is a system that suggests that all mental health consumers go through the public system. You think it would relate to all consumers, not only those from PHC, and it's not taking into account anyone else who provides mental health services. It's a great idea but it doesn't cover all.* The invitation for consumers

and carers to join the Group does not appear to be all encompassing. Representatives from the Neighbourhood Centre and Anglicare also expressed this frustration. It appears that the PHCU, which is part of Queensland Health, at times, attempts to isolate itself from other non-government mental health services in Ruraltown. I asked the Team Leader at PHC about the limitations on membership for the CAG and she explained that *the CAG is really the "watchdog" of the Qld Health Service. It has nothing to do with private organisations, and private members were upset that they weren't involved. But it's really for the mental health consumers of Queensland Health.* There is no current support group for private mental health consumers so, if the aim is consumer empowerment, it would seem appropriate that *all* consumers be unified into one group. As an Anglicare informant stated, *once you exclude people, there is bitterness.*

- The President of the CAG explained that the Group is not allowed to seek help outside the PHCU, despite the fact that Anglicare is willing to give administrative support and encouragement to the Group. She said that *we were told that we are not allowed to go to anyone else for help, we must come to the PHCU.* However, with regards to this "help", during Mental Health Week in October 2003 she said that the CAG was not aware of, assisted with, or included in any events that were organised by the PHCU.
- This informant has also attempted to organise a fundraising event and auction for the CAG. She was given \$5, 000 worth of merchandise from two high-profile sporting identities to sell at the auction and raise funds for the CAG. She approached both the PHCU and Rotary for assistance with the organisation of a dinner and invitations. However, she explained that Rotary never replied to her correspondence and, as PHC was not interested in helping in the preparations, the event had to be cancelled. The frustration and

bitterness over the lack of support was evident in her story.

- Two members who have educated themselves on the funding procedures for the CAGs stated that *all CAGs were meant to be allocated \$2000.00 from QCAG to assist them with the administration of their groups. However, there has been no financial support and very limited administration support from PHC.* One member added that *the money was supposed to be there but it never happened. Whether it was distributed amongst the health workers or what but the CAG never saw any of it.* I also asked this consumer about the “advisory role” that consumers were supposed to have in the operation of the MHS. He stated that *no one really wants to know what we’ve got to say. No one wants to talk about the CAG but we don’t know what we’re doing. We asked to get the CAG advisor from Brisbane out here in 2003 to speak to us or at least have a video conference with him to tell us what we’re meant to be doing but nothing ever happens. They don’t care, they just need to say the CAG is running so they get their accreditation, that’s all they want.* The frustration of the consumers is obvious.
- In my final visit to Ruraltown, I inquired about funding for the CAG at interview with the PHC Team Leader. She explained that since the CAG began in 2002, *there had been no available funds to give them.* However, she did state that *in the last week we received \$5, 000 for the CAG here.* This appeared to be a remarkable coincidence. I was asked by the Team Leader not to divulge this news to any of the CAG members until she had the opportunity to do so. She also stated that, now they had the funding, *we’ll be able to pay the members to attend their meetings, we’ll be able to train members so they can sit on our interview panel, and move them forward in being more involved in the mental health service, and now they could get the CAG advisor to do some education.* The CAG members have been waiting for over two years for some support and guidance and, with this funding it was

inferred that they would get all that they have asked for.

- An Anglicare mental health worker was a CAG member when it first started and she assisted in the organisation of meetings and social events. However, she had to resign her membership as mental health workers cannot be members of the CAG. This worker explained that *it is for consumers only and they want them to be able to speak freely. But I think they nearly went under because people with mental health issues can't always cope with doing all the additional stuff required to keep the group up and running. They are a very strong group but are finding it very difficult coping with the boundaries. It's auspiced by Queensland Health (PHCU) and there's been a few things that they've wanted to do but have been told they can't. I'm not sure about how much input they've been able to actually have.* The restrictions placed on the Group, in terms of funding, assistance, who they can go to for help, and who can and cannot be members, does not seem to support their goal of “consumer empowerment through partnerships”.

At a later date, a re-interview was held with this informant. She no longer worked for Anglicare. She stated that *I do not believe that the PHCU had fulfilled what CAG was meant to be. They asked over and over for funds but were not given any. I believe the money from Queensland Health got used somewhere else. The biggest problem for the CAG is that you are dealing with people who have their highs and lows of depression. You can't expect them to be functioning without support to administer the group and that's what Queensland Health were meant to do. They are not listening to the consumer's needs.*

- One consumer summed up his feelings about mental health services in Ruraltown: *mental health care in Ruraltown stinks. They think we're a waste of time.*

The CAG has been discussed further in the next chapter and some recommendations have been made in Chapter 9 to improve outcomes for consumers in Ruraltown

SUBSIDIARY ISSUES AFFECTING MENTAL HEALTH IN RURALTOWN

There are other issues that are not confined to Ruraltown or rural communities but do impact heavily on mental health. Issues such as substance abuse, unemployment and limited opportunities for rural youth are ongoing problems in Ruraltown and all can have mental health repercussions.

- The Adult Mental Health Worker at MHU discussed the problem of substance abuse in the community. She explained that *access to substances such as heroin, amphetamines and alcohol by youths is becoming more widespread*. Although there is often delayed transmission of, or access to, social, cultural or economic benefits, drugs are relatively easy to come by in rural communities. This has led to an increase in crime, unemployment and graffiti in the town. One only needs to look at the list of arrests that are published in the local paper on Tuesdays and Fridays to realise the extent of the problem.
- A worker from the Neighbourhood Centre, which has a Drug and Alcohol service attached, also discussed the problem of drugs in Ruraltown. She said that *drugs are definitely here, hard drugs too. We've got exactly the same problems as anywhere else. We're not protected, it's a global village isn't it. Whatever's against the law will travel!*
- Another informant believed that *the young are leaving which causes a loss of workers and a break up of the family unit. Kids no longer look*

to the family for support as they have too many other options and cop-outs. There are too many choices rather than just working on the farm with the family. There is exposure to too many negative influences nowadays such as music, drugs and unemployment benefits. They are lazy and just want handouts. She also said there was a loss of faith and people no longer look to the church as a guiding influence. This informant considers the main problems with mental health in the bush to be a direct result of the breakdown of the family network, a loss of faith, and lack of relevant personnel.

- There was a recent article in the Ruraltown local paper about syringes being discarded in public places, after a child was pricked by a used syringe (*Ruraltown Paper* 2nd July 2004, p. 4). Health and service providers have mentioned that drugs are a big problem in Ruraltown. The author stated in a follow-up article that “many of us think the drug problems are epidemic in cities and would never suspect country towns like Ruraltown to be affected. But the truth is Ruraltown is not immune to drug problems, but unless we admit it and work towards rectifying the problem, it will only get worse” (*Ruraltown Paper* 6th July 2004, p. 3).
- The Family Support Worker from the Neighbourhood Centre raised another serious issue affecting rural young people in Ruraltown: that of abuse. With regards to her role in child protection, she stated that *I am amazed at how many children sit on that lounge and tell me about sexual abuse in their families and in the community.* Addressing this problem also presents a challenge for Ruraltown service providers.
- Unemployment in Ruraltown was recognised by providers as a serious problem impacting on the mental health of residents. One stated that *the financial concerns that families endure can cause serious stress and have negative repercussions on self-esteem and*

coping abilities. This, in turn, may lead to depression.

- Some providers recognised that considerable problems for youth stem from the limited opportunities for work or further education in Ruraltown. There are those who are lucky enough to get a job, traineeship or apprenticeship. Some may start at the Ruraltown TAFE or move on to go to university. However, as this worker pointed out, *there are others who don't want to leave Ruraltown, their families and support groups, but they can't find work. I think they get really frustrated and they stop growing, they might be on the dole, taking drugs, go to their mate's place every second night, there's no break in the cycle or no growth period.* Although Ruraltown is not unique in its limited opportunities for young people, it is clear that this can lead to an increase in crime, substance abuse and mental health problems.
- The coordinator for the "Big Brother Big Sister" Mentoring Program, under the auspices of Anglicare, stated that there were many problems for youth in Ruraltown such as substance abuse, homelessness, poverty, school suspensions, violence, and isolation. She stated *that children on properties are even more isolated. With the drought, there has been little entertainment or interaction for the kids.* She hopes in the future to expand the service to cater to children on the land through trips to the movies or sports events. She explained that the BBBS program is only funded until June 2005 but was hopeful that it would be extended, also arguing that it takes considerable time for projects to be accepted and successful in rural areas.
- Another area this worker identified as a problem was the schooling system in Ruraltown. There is Catholic School (grades one to twelve) for a limited number of students. There is also the Roma Junior school (grade one to three) and the Roma Middle School (grade four to ten) and, after grade ten, students can then go on to the College of

the South-West which offers grades eleven and twelve, or TAFE courses. Therefore, students as young as seven or eight are going to the Middle School. As the informant explained, *the transition from grade three to four can be quite traumatic for the kids as they are in a school with teenagers. The Junior school is a close knit, supportive home environment and, when they go to the middle school, they lose their safety net. They are being exposed at a very young age to drugs, and becoming victims of bullying. I've heard reports of eight or nine year olds running drugs for the older kids. They are exposed to stuff way to early.* She stated that many parents are not happy with it either. This staggered schooling system is only a trial in Ruraltown. However, it appears to be creating additional problems for students. It is for this reason that she is arguing for the starting age for inclusion in the BBBS program to be reduced from twelve to seven years of age. As she states, *they are really vulnerable in the seven to ten year old bracket in Ruraltown and that's when they can go off the rails.* The BBBS program, she explained, is designed to provide positive role models and guidance for kids who may be vulnerable or lack support from family or friends.

- Introducing education about mental health in schools may help to build up resiliency skills and increase awareness in rural areas. However, many rural schools and community organisations do not have the resources to focus on mental health education or provide support services. The former Child and Youth Mental Health Worker from the MHU discussed this issue in an interview in April 2002 when asked about the "Mindmatters Program". This Program is a secondary school resource aimed at promoting trust, help-seeking and positive mental health and well-being for school communities (Auseinetter March 2002, p.20). The worker stated that, when she met with teachers about the Program, she was told that the curriculum was full and there were too many other priorities; it just did not fit in to the system. However, it can be argued that education

is the key to prevention, acceptance and treatment of mental illness in rural areas and to improving attitudes to mental health.

- Lack of government funding for education was also considered a problem. There was an article in the Ruraltown local paper that headlined “Ruraltown school students left to swelter”. It was reported that, despite 40-degree heat being experienced in the town in April (2004), the Queensland Government had excluded the Ruraltown area from the \$17.6 million dollars that will be given to air-condition schools in the State. The schools and citizens of Ruraltown continue to lobby the State government to receive a “fair go” for their children. One citizen, who has three children at a local school, expressed his anger and stated that “people in the bush don’t get anything and obviously we’re not the Smart State. I’ve been lobbying the Government but it’s hard to get on to the Minister and people don’t want to call me back. We should make our own state in the West; we have had a raw deal for years but when it comes to the kids, something should be done about it” (*Ruraltown Paper* 23rd April 2004, p. 2). Clearly, education is another area where rural communities feel short-changed by government.

Another education funding issue was raised in an article on the front page of the Ruraltown local paper. According to the opening statement, “twenty-one preschool students have been refused schooling through the State system although there is an empty (and fully equipped) preschool room available in Ruraltown” (*Ruraltown Paper* 30th April 2004, p. 2). There are also a number of children on the waiting list to attend preschool, however, Education Queensland maintains that there are not enough funds to open the preschool. As the P and C President of Ruraltown Junior School argues: “we encourage people to come to Ruraltown but if their children can’t come to school then they won’t come” (*Ruraltown Paper* 30th April 2004: p.2).

- A worker at the Neighbourhood Centre believes that there needs to be a twenty-four hour hostel in town for homeless youth. She argued that, *because they are under eighteen, kids can't go for crisis housing and they have nowhere else to go but on the streets*. The Community Connections worker at Anglicare also brought up this issue. She stated that *recently, it has been introduced that youth under eighteen cannot rent a house on their own for legal reasons such as late rent payments and damage. Where do they go? Nowhere. We need a youth drop-in centre that provides information, emergency beds and accommodation*. These housing issues must surely have an impact on the wellbeing and mental health of young community members.
- A discussion with a local councillor raised other issues facing Ruraltown. For example, the local member highlighted the frustration stemming from the lack of understanding of rural problems by both politicians and urban people. She pointed out that *it is not only the drought that is having a disastrous impact on rural communities. There are also other problems such as bank foreclosures without personal consideration, the increasing kangaroo population, unemployment and the departure of young people that are not being addressed at a local level*.

Another respondent also discussed what she termed “irrelevant laws” for the bush such as *gun laws, laws on fertilisers, environmentalism, land clearing, property rights, GST, petrol prices, kangaroos — these laws are destroying the bush and it is very frustrating*. The theme of bureaucratic misunderstanding of what bush life incorporates also recurs in this study.

- Another informant raised the issue of income protection for mental health problems. She discussed the case of a man who was going through personal and financial hardship during the drought due to depression and was unable to work his property. However, when he

put in an insurance claim for lost income, he was not recompensed as, “in the fine print of the policy”, it stated that depression was not compensated under Accident and Salary insurance. As this informant stated, *you can’t win with honesty!* The fact that a mental health problem is not considered to be a serious illness further limits people’s ability to acknowledge or treat the condition in the proper manner.

- In an interview with the Administrative officer from the local QRWN, she discussed succession planning for families on properties. The informant stated that *many don’t know how to go about discussing delicate family and financial issues, avoid it and often wait until it’s too late or end with a totally inequitable arrangement for some family members.* With respect to debt and financial problems being experienced due to the drought, she believed that *there needs to be more human contact by banks, perhaps even someone who is qualified in personal counselling and whose responsibility it is to handle the human side of financial issues.* This problem was also raised in Chapter 3.

Conclusion

This collection of interviews from Ruraltown has revealed a plethora of issues regarding attitudes to mental health, and the acceptance and delivery of mental health services to the community. A variety of views have been obtained and all agreed that the situation needs considerable improvement. This information corresponds with, and adds to, the findings from the questionnaires. Issues such as the negative perception of the term “mental health”, the stigma attached to mental health in the community, unique rural conditions that affect mental health, and problems with service provision were all highlighted. As with the questionnaires, the majority of interviewees recognised the characteristics associated with bush identity as influencing attitudes to

mental health and as a major deterrent in seeking help for mental health problems. The implications of these results, combined with supporting evidence from other studies, will be addressed in the following chapter.

CHAPTER 8

SUMMARY AND INTERPRETATION OF FINDINGS

Successful communities are groups of people who can recognise and accept difference and still work together (Rees & Fischer 2002, p. 7).

The results from the Ruraltown study support the hypothesis that bush identity does have an influence on attitudes to mental health in Ruraltown. The responses given in the questionnaires and interviews have highlighted the fact that the popularised qualities assigned to people through the bush legend are present today. A critical analysis of the data that was documented in Chapter 7 has been carried out in this chapter. This involved a thematic analysis of attitudes to mental health in the bush and the results have been contextualised in relation to other studies. The findings from the Ruraltown study have supported and added to this knowledge and also contributed additional information. Areas in need of further attention have been highlighted. Some interview and questionnaire data from the previous chapter has been restated in this Chapter to assist in strengthening, explaining and interpreting the data.

Similar themes to those used in the *Results and Analysis* chapter will be employed in the interpretation of the data:

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- mental health as a concept
 - stigma and rural identity
 - rural circumstances influencing mental health
 - problems with service provision
 - mental health consumer issues in Ruraltown

MENTAL HEALTH AS A CONCEPT

As was abundantly clear in the results of the questionnaires and interviews, the concept of “mental health” is generally misunderstood or perceived in a negative way. Although there is a “health” component to the concept, it is usually defined in pejorative ways. Reasons given for this included:

- the historical connotation of madness attached to the word “mental”;
- the stigma attached to the concept as a consequence of bush identity;
- the close association with mental illness;
- confusion about the nature and meaning of mental health and mental illness;
- the word “mental” is negative.

The responses from mental health consumers in Ruraltown also testified to this view through statements such as *people don't want to know about it, it doesn't sound nice and no one cares*. One response demonstrated the alienation that mental health consumers experience at being labelled: *change the name from “mental”. People think we will give them a disease*. For consumers to feel so isolated from the rest of the community as a consequence of being labelled as a “mental health consumer” indicates the disparaging connotation attached to this term. Many other respondents also suggested a name change from the word “mental”. It appears that the cause of mental “health” is not being helped by the use of this negative term.

The general misunderstanding over the concept of mental health has been well documented. The strong historical association between the terms “mental health” and “mental illness” was raised in the *Third National Mental Health Plan 2003-2008* (2003, p.5), which stated that “this has led some to prefer the term ‘emotional and social wellbeing’”. MacCulloch (1995, p.75) also highlights the vague wording used in

policy about mental health and asks “when we formulate policy in this area, are we talking mental illness or mental health”? Despite this confusion, in policy, procedure and service provision, the term “mental health” is still predominantly used. Pavis et al and Rogers et al, (cited in Stacey & Herron 2002, p.7), concluded that “lay people (mainly service users) find it difficult to think of and discuss mental health beyond the ‘taken for granted’ and reflected understandings typified by the ‘mental illness’ system. Mental health was either a euphemism for mental illness or a bipolar opposite where mental health is merely the ‘end product’ of the absence or reduction (through treatment) of mental illness”. The findings in the present study support this argument. Although the promotion of mental health is on the agenda of Ruraltown mental health agencies, it has not been effective enough to overturn the negative perception that surrounds the concept.

A study by Fuller et al (2000, p.150), similar to that undertaken here, found that “with very few exceptions, informants indicated that most people in their communities had stereotyped views of ‘mental health’ as relating primarily to severe mental illness that required detention”. The current study also supported this finding that mental health is perceived in a negative way. Herrman (2001, p.73) argues that “just as with mental illness, confusion and vagueness about the concept (of mental health) are powerful reasons for the low priority given for mental health programmes, and the difficulty in mobilizing all those concerned with supporting an overall strategy”. Education is required to overturn the negative image of both mental health and illness, and to differentiate between the two. Clearly, the word “mental” is historically and currently pejorative.

Importance of the media

How the concept of “mental health” is represented to the public also has an effect on how it is perceived. The media has an influential role in the

representation and reporting of mental health issues in Australia. It was argued in the *Mental Health Promoting Media Strategy (MHPMS)* (1999, p. vi) that “media coverage and reporting is ... critical to forming and influencing community attitudes to mental health and mental illness and people affected by mental illness”. The manner in which mental health issues are reported has a definite impact on community perception of the concept. This was recognised in the *National Mental Health Strategy* (1992) and this led to the inclusion of a *Resource Kit for Australian Media Professionals* as part of the Strategy. A segment of this resource kit was the *Mental Health Promoting Media Strategy (MHPMS)*. The *Media Strategy* (1999, p. vi) “aims to develop initiatives and partnerships to promote accurate and positive media reporting and portrayal of mental illnesses, and to support the media to educate the community on issues relating to mental health and mental illness”. Including a list of guidelines about responsible reporting of mental illness and related issues, it was hoped that the media would represent mental health issues in a more positive and realistic light (also see Pirkis & Blood 2001). As Stacey and Herron (2002, p. 10) argue, “the way issues are presented has the capacity to influence community members in both negative and positive ways. It can serve to foster and reinforce stereotypes, or challenge them, leading to more accurate and helpful knowledge and understanding”.

However, mental health and mental illness continue to be “linked” in some media reports. An example of this media misconstruction was in MBF’s *Living Well* magazine (Oct 2002) where it was reported that mental health was one of Australia’s national health priority areas. However, the definition of mental health (2002, p. 15) begins with “mental illness is a very general term that refers to a broad group of illnesses etc.” At no time in the article did it give a definition of mental health, therefore reinforcing the falsehood that mental health and mental illness are the same thing. Deitz (2004) is highly critical about the media portrayal of mental illness. For example, she (Deitz 2004,

p.10) argues that “few newspaper reports detailing the 2003 arrest and weekend detention of Sydney stockbroker Rene Rivkin failed to mention his medication, Prozac, or that he suffers with bipolar disorder. I don’t think Rivkin deserved to have his mental illness used as either punctuation or punchline”. A Ruraltown provider also used a media-reporting example and argued that *you don’t hear about the person with bipolar who is doing wonderful things for the community, you hear about the Claude Gabriel’s and the Port Arthur killings!* As Caras and Cohan-Haerry (2001, p.6) conclude, “it is said that when we change one thing we change everything. Inclusion is a necessary step towards re-evaluating preconceptions and dispelling myths. Mental health specific words now add to separation, shaming and stereotype. We can begin with remembering how very much words matter”.

There have been very few reports in the Ruraltown newspaper regarding mental health, despite the fact that Anglicare and the MHU both suggested that it would be a constructive means of familiarising the community with the concept. Around the time of the “Promoting Mental Health Awareness Forum” (April 2002), there were a few short articles about the Forum and mental health. However, as the former MHCDO from Anglicare stated, the media coverage about the Forum focussed on the stigma and mental illness rather than the value and promotion of mental health. For example, an article in the local paper a week before the Forum was titled “Ruraltown forum aims to clear away the myths about mental illness” and focused on mental illness, not mental health promotion (*Ruraltown Paper* 16th April 2002, p. 3). It was not a very positive headline to encourage community involvement in the Forum.

Decisions about what is considered “newsworthy” in country newspapers also affect whether contentious issues are reported. Kirkpatrick (1995, p.235) argues that “community values inevitably impact more heavily on the content of such [regional or country] newspapers than on the capital-city daily. The big test for the country

papers comes when they are implicitly or explicitly asked to withhold coverage that would allegedly adversely affect the 'advancement' of the town". Cheers (1998, p.87) also argues that "rural newspapers also tend to avoid significant or controversial political and social debate". The former Manager of the Ruraltown newspaper informed me that articles to be published in the local newspaper were reviewed by Head Office in the regional centre and, as such, articles can be "pulled" before publication. The Manager stated that he does not have control over the final product. The MHCDO from Anglicare suggested that this was the reason for the dropping off of post-Mental Health Forum news coverage in Ruraltown. It can be argued that there is still a long way to go before the media and society in general overcome the prejudice that is attached to mental illness or accept mental health as a positive concept. The media has the ability to influence attitudes to mental health.

Caution also needs to be taken in the reporting of suicide in the media as it has been argued that this may have an impact on vulnerable people. It was stated in the *Resource for Media Professionals* (2000) that "higher rates of suicide have been reported during periods when suicide stories are run in newspapers". Though not specifically referring to media reports of suicide, it was argued in the Ruraltown Community Connections Project Report (2004, p.12) that the knowledge of other suicide victims in the area cannot be excluded as an influencing factor for further suicides. Carr-Gregg (1997, p.2) concludes that "while many point to the media reporting of youth suicide, the influence of heavy metal music, the breakdown of the nuclear family or the decline in spiritual values, there is no clear answer to the late twentieth century trends in youth suicide". Nonetheless, as recognised in the *National Mental Health Strategy*, the sensitive reporting of suicide and mental health should be encouraged.

The historical and contemporary influences on attitudes to mental health are widespread. However, in Australian rural communities, due

to cultural and lifestyle differences, they are much more pronounced. The majority of respondents in this study agreed that mental health promotion is important to prevent problems and educate people about such issues and illnesses. However, very little is done due to the magnitude of clinical responsibilities. Herrman (2001, p. 713) discussed the importance of “mainstreaming” mental health promotion and argues that “physical health is an important influence on mental health. Conversely, the importance of mental health in the maintenance of good physical health and in the recovery from physical illness is now well substantiated”. Physical and mental health are inextricably linked to one another, therefore, consideration needs to be given to *holistic* health promotion. It is clear from the information collected in the Ruraltown study that knowledge about mental health issues needs to be greatly enhanced. It can be argued that this would facilitate a substantial improvement in attitudes to mental health in rural areas.

STIGMA AND BUSH IDENTITY

Stigma has influenced the recognition and acceptance of mental health problems. As noted in the *Mental Health Promoting Media Strategy* (1999, p.1), “many people experiencing a mental illness delay seeking help because they are frightened by the illness and fear of stigma and discrimination. If these are reduced, more people will seek help early”. The stigma attached to the concept and experience of mental health problems acutely affects help-seeking behaviour. Dudley (2000, p.451) argues that “goals like societal inclusion, self-determination, and self-sufficiency (for consumers) are hindered significantly by the problem of stigma”. This was clear from the responses from consumers in Ruraltown. Comments like *people don’t care, mental is a dirty word, and doctors, nurses and general people don’t give a damn* indicate the intense feelings of community exclusion that these people feel.

The issue of stigma and mental health is exacerbated even further in rural areas due to cultural impediments (Fuller et al 2000, Sweeney & Kisely 2003, Alston & Kent 2004). As the Ruraltown financial counsellor stated, “emotional aspects of life are indicators of weakness which are not conducive to survival in the ‘tough’ rural environment”. There is a culture of self-reliance which adds to the stigma of seeking help for mental health problems (Sweeney & Kisely 2003: 209). Fuller et al (2002, p.177) also argue that “there is therefore a cultural context in which rural people will be reluctant to seek help from professional mental health and counselling services”. Self-reliance is one of the “identity” characteristics that was popularised through the bush legend. The current existence of the trait of “self-reliance” as an impediment to mental health treatment has definitely been supported in the responses from the questionnaires and interviews in this study. The following examples demonstrate this.

When asked about where the stigma attached to mental health in the bush comes from, some of the responses included mention of *the tough bushie syndrome; the tough image of western people; you’ve got to be tough in the bush; and it’s all about rural culture*. Others stated that *the essence of bush life is independence in spite of adversity; the old bush ideology that we can cope with anything; tough men don’t cry; the tough macho image of country people; and farmers are meant to be tough*.

When asked about the stigma attached to mental health issues, the recurring themes or words used were rural/bush culture, toughness, independence, strength, stoicism, conservatism, coping, hardworking and pride. These words or ideas all express a connection to the historical characteristics that were fostered through the bush legend. The fact that these traits were identified by rural people as being part of their current culture or tradition supports the hypothesis that bush identity impacts on people’s acceptance of mental health issues. As one provider stated, *I guess the stigma comes from traditional values, generation after generation. There’s a tradition in the bush that you have*

to cope, you've got to be tough. You can't be seen to have a mental illness or to need help. I'm sure there are some people out there who would just rather go and kill themselves before they'd go and get help. Obviously, the stigma is extreme if this is the case.

Self-reliance and independence are part of the coping strategies employed in the harsh rural environment. However, when dealing with mental health issues, these qualities may be hindering the course to wellness. With respect to these issues, Dunn (1996, p.333) points out that, to be effective, the service delivered must take into account these cultural elements. Judd et al (2002, p.297) too argue that "improving the mental health of rural Australians does not rest entirely on improving the availability of services. Seeking professional help requires that services are not only available, but also accessible and acceptable (i.e. offered in a manner congruent with local values using a model of delivery appropriate to the setting)". The Ruraltown financial counsellor pointed out that *the people who are providing the assistance need to be aware of the conditions that clients live in and need to know the rural way of life*. It can be argued that these are important considerations when delivering a mental health service to a bush community.

It was also found in this study that stigma was a huge barrier to service utilisation. As stated above, the majority of respondents agreed that a major contributory factor to the reluctance to seek help is the bush culture of stoicism, toughness, independence, resilience and self-reliance. As one respondent put it, *if people are diagnosed with a mental health problem, they feel like they have failed and let the family down*. This sentiment has been supported in previous studies (Stehlik et al 1999, Sweeney & Kisely 2003, Fuller et al 2000, 2002, Alston & Kent 2004). There appears to be an element of shame attached to having a mental illness in rural areas. According to one police participant in the Ruraltown study, *people do not want to have the "mental illness" title attached to them as it could mean a lack of business or loss of respect*

within the community. To deliver a service that is sensitive to these characteristics requires a unique approach.

A serious repercussion of this stigma is that it prevents many people in the bush from obtaining treatment for mental health problems. Sweeney and Kisely (2003, p.210) argue that “the stigma of mental illness is a major deterrent to access to mental health services in rural areas”. Most questionnaire respondents in the Ruraltown study believed that the major barriers to help-seeking were shame and concern over embarrassment. It can be argued that this shame and embarrassment is directly linked to the stoic self-reliance and independence that were cultural “requirements” of bush identity and tradition (see Chapter 5). People on the land in the Ruraltown study were identified as being particularly influenced by this stigma. Several service providers interviewed stated that it was very rare for people from properties to present for help. As one informant stated, *I think the biggest thing that has come out of this drought is that a lot of people on properties just haven't been asking for help and just keep going and going and going ...!* This statement illustrates how bush identity can influence attitudes to mental health. Stehlik et al (1999), and Alston and Kent (2004), in their respective studies of the social impacts of drought, also had this finding.

The reasons given by study participants for this reluctance to seek help can be categorised in terms of factors such as the bush ethic of self-reliance and pride, less time, greater isolation, conservatism, and lack of knowledge about mental health and services. One Ruraltown provider stated that *men in rural areas would rarely come forward to ask for help. I guess they feel it would make them “less masculine, a wimp and seem incapable of looking after themselves”*. Fuller et al (2002, p.183) argue that “the culture of self-reliance and stigma associated with mental health problems make it less acceptable to seek help from a mental

health professional". This was supported in the Ruraltown study, especially for those who live on the land.

The personnel who are responsible for treating mental health consumers may also unwittingly and unknowingly perpetuate the stigma. Rickwood (2004) points out that the attitudes of service providers have been identified as a major impediment for mental health service reform and often sustain the sense of stigma. She (Rickwood 2004, p.3) argues that "many service providers, particularly of clinical services, still hold outdated beliefs that a diagnosis of mental illness is a life sentence to an incurable condition that invariably will have only negative consequences for a person's life course". Clark's (2003) findings about nurses at Ruraltown hospital support this argument. In Clark's (2003, p.76) study, it was noted by one of the RNs at Ruraltown hospital that the stigma of mental illness "is often not helped by having to work with staff who are locals and who have already got the person 'categorised' and 'labelled' as they see them. In small hospitals and small towns some staff easily forget to act professionally and this makes it harder for the person to present for help when they need it". Day and Dunt (1994, p.41) discovered in their research that "the general community expectation, as perceived by consumers, is that they should be able to 'pull themselves out of it' ". Ruraltown consumers also felt this presumption.

Service providers need to be active in overturning the stigma facing mental health consumers and be careful not to sustain it. Dudley (2000, p.452) argues that "some providers may speak to consumers in an age-inappropriate manner, speak 'down' to them or, at times, speak 'for' them. Some consumers in the Ruraltown study reported that they often felt patronised by staff at the MHU and had little or no control over decisions regarding the CAG. As Dudley (2000, p.451) concludes, "social agencies that have been established to promote the well-being of people with disabilities are, at times, inadvertently fostering continued

social isolation and dependency; these agencies also seem reluctant to experiment with new, alternative ways of providing services". It was found in this study that Ruraltown consumers believed that the MHU was not adequately addressing their needs and, at times, fostered their social isolation and dependency.

Innovative ways of overturning the stigma attached to mental health issues need to be employed before the mental health of rural people can be successfully addressed. As suggested above, changing the term "mental health" to a more positive one would assist in reducing the stigma. Recommendations about increasing exposure to, and education about, mental health issues to reduce the stigma were made in the questionnaires and interviews. These included publications in the local media, leaflet distribution, seminars, workshops and public displays. It was also suggested that attitudes might be improved by persuading some high profile people in the community to acknowledge any mental health problems and endorse the promotion of mental health. Regular exposure to mental health issues would assist in "normalising" the concept and reduce the negative impact of bush identity on attitudes to mental health.

RURAL CONDITIONS THAT MAY AFFECT MENTAL HEALTH

The conditions of rural life that may affect mental health have been extensively covered in Chapter 5. In the Ruraltown study, many of these were also identified, such as financial problems and seasonal factors, confidentiality and concerns about gossip, isolation and distance, and service provision problems. These conditions obviously impact on the experience, coping mechanisms and treatment options for rural people affected by mental health problems.

Financial pressures and seasonal factors

Financial pressures are intricately related to the stress and mental health problems that people encounter in rural areas. It has been established through previous studies that there is a connection between financial strain and mental health problems (see Belyea & Lobao 1990, Armstrong & Schulman 1990, Ortega et al 1994, Alston & Kent 2004). Stehlik et al (1999, p.62) also found that “the drought produces for many farmers a financial crisis which, in turn, creates a stressful environment for *all* those living in rural communities”. As many rural communities depend on and support the agricultural industry, there is bound to be a related decline in the towns.

The Ruraltown financial counsellor stated that the Rural Financial Service was extremely busy and highlighted the stressful nature of financial problems for rural families. Although his primary responsibility is helping families with business, administrative or monetary issues, he also witnessed many occasions where stress and emotional issues, for example, domestic violence, substance abuse, withdrawal and depression, were apparent. He stated that *I am predominantly concerned with financial issues. However, marital problems stem from the financial pressure and domestic violence can become a factor. If I pick up on other issues and am given authority by the client, I will put them in touch with another service but then I'll leave it alone.* It was also argued in the “Valuing Rural Communities” report (1998, p.34) that “whilst the role of rural counsellors is to provide financial advice, the nature of their contact with some families highlights the many complex issues these families are facing”. It is for this reason that the Ruraltown financial counsellor often asked the Rural Families Counsellor from the Neighbourhood Centre to accompany him on home visits. He stated that *if there is a lot of tension there, it's handy to have a second person there and, not being sexist, but having a female as well so she can take the wife away if it starts to get*

tense". According to Alston and Kent (2004, p.xiv), "it is evident that they (financial counselling, health and drought services) are experiencing significant increases in their workload, that there is need for enhanced staffing numbers and that financial counsellors need the support of social work services".

Due to the current drought in the Ruraltown area, the financial counsellor's major responsibility was helping with drought assistance and Centrelink applications. As discussed in Chapter 4, there is a tendency to rely heavily on the rural financial counsellor as the assistance sought is of a monetary nature and they understand the nature and culture of rural business. As Rolley and Humphreys (1993, p.254) state, "the role of rural counsellors is to help farm families adjust to the changing economic circumstances, thereby minimising the personal and social problems that often result from an inability to adapt to change". Alston and Kent (2004, p.88) found that "farm family and small business people usually see their need for assistance in financial terms. Yet there is evidence here that while this is the critical issue, it hides the need for social and emotional counselling". The Ruraltown financial counsellor also said that *not many from the land would put up their hand and ask for help. But we're a 'onestop rural shop' — they can walk into this building and there's no stigma — we've got lots of services and no one knows what they're doing here*". The counsellor felt that he was in a good position to recognise other problems and then refer on to the appropriate services.

If there are referral mechanisms in place, the rural financial counsellor can provide a valuable link to services that may not have otherwise been sought. The Ruraltown financial counsellor stated that *if I'm there talking finances and other problems come up, I can pass on information in a subtle way to these people so they can get some help*. The counsellor was asked if it would be valuable to have a mental health worker attached to the Rural Financial Service so people could access

treatment anonymously at the “onestop rural shop”. However, he stated that he was not sure if it would work and, besides, his organisation does not have the additional funding required for such a service. It was also suggested in a Ruraltown questionnaire that primary industry organisations such as Agforce should have a health component. As rural males are more inclined to access such a service, it may be worth investigating the appropriateness of offering mental health support from this venue.

Alston and Kent (2004) discovered in their study that debt levels through loan borrowings or extension of the overdraft had increased for many families (also see DPI Qld 2004a). They (Alston & Kent 2004, p.46) argue that “all were practising belt-tightening including reducing the number of trips to town, reducing to bare minimum off-farm purchases, limiting the time away from the farm, taking no holidays, laying off any hired labour and increasing the farm workloads for all family members”. The constancy of rural business, without being able to have time out or plan around the weather, also impacts on the family. For example, a participant in the Ruraltown study stated that *rural business was all or nothing — no half/part-time/coasting/“taking a break” type scenarios*. In times of drought especially, there is little or no opportunity, time or money to get away from the workplace, thus increasing stress in the home environment. Ortega et al (1994, p.615) conclude that “mental health intervention in the absence of efforts to improve rural economic opportunities and personal economic circumstances may do little to improve the well-being of farmers and rural residents”.

Another added pressure that was covered in Chapter 5 is the close proximity between family and business. It was also stated in the Ruraltown study that *the rural family business means that esteem and tradition may be tied up in generations of business, especially in terms of self-esteem and depression. People live and work in the same environment so if work is not good (e.g. drought), you see it at home (e.g.*

no grass, cattle dying etc.). Alston and Kent (2004: 70) also found that, because of the drought, many people reported social withdrawal with a reduction in community participation, social activities, club participation and voluntary activities. The mental health repercussions of this social withdrawal and isolation have been documented.

Confidentiality and concerns about gossip

Linked to the shame and embarrassment of seeking help for mental health problems, as discussed above, are confidentiality concerns and the fear of gossip in the smaller rural community. All providers in the Ruraltown study mentioned these as major considerations in help-seeking behaviour. For example, one stated that *people are worried about confidentiality in Ruraltown. In metropolitan areas, people aren't as identifiable and the population just tends to blend in whereas in rural areas people probably come to notice more of what's going on. People are really scared of others finding out about them asking for help.* Another respondent expressed the belief that *small communities are apt to gossip and the problem could easily get out of proportion and lead to embarrassment,* and another that *there are worries that you think it's not going to be confidential, or you're going to be seen.* These concerns echo those from previous studies regarding mental health in rural communities (see Chapter 5). "Keeping up appearances" and pride are very important in a small community, hence the exaggerated fear of being "discovered" with a mental health problem. As Cheers (1998, p.233) argues, "in general, rural people will not access social care services or resources if there is any risk that this will become public knowledge" (also see Macklin 1995). Taking strict measures to uphold confidentiality is extremely important yet was perceived to be less than adequate by both consumers and providers in the Ruraltown study (see Chapter 7).

Even if mental health services are available in rural communities, other factors may impede their utilisation. It was documented in Chapter 5 that the stigma and lack of anonymity in rural communities could hinder people from obtaining assistance from mental health services (see Fuller et al 2002, Griffiths 1996). This issue was also raised in the Ruraltown study. As mentioned previously, the MHU nurse's office is highly visible from the street and the reception area of the building. This location may serve as a barrier for those consumers who wish to remain anonymous. In response to this issue, a Ruraltown counsellor, who was also an informant in this study, is in the process of setting up a clinic that will respect people's privacy and reduce attendance visibility.

The issues of lack of privacy in the community and the public visibility of services were significant hindrances to seeking help, as identified in the Ruraltown Community Connections Project report (2004). It stated that a significant barrier is the lack of privacy (as opposed to confidentiality) that exists in rural communities. Members of target groups and associated support agencies reported the difficulties faced by those seeking support. As the CCP report (2004, p. 20) explains: "activities are so visible that walking into an office can identify you: e.g. attending Outpatients on a Wednesday when 'everyone' knows that is the day of the Visiting Mental Health Team, being seen talking to a guy that deals with 'gays and lesbians', walking into a multi-purpose location — but the receptionist is your sister-in-law, or the 16 year old girl at the pharmacy when you place your script for anti-depressants is your neighbour. These people may all be very discreet and never break confidentiality but the visibility can be discouraging of seeking assistance". Confidentiality and privacy issues are very significant in rural areas and this could affect attitudes to mental health and service utilisation.

Lack of anonymity for providers can also be a concern in some rural communities. As consumer choice for treatment is further reduced

through fewer services or workers, the likelihood of knowing the provider is increased. Philo et al (2003, p.272) argue that “mental health clients are quite likely to encounter one another in a diversity of contexts and roles *beyond* the purely professional ones. As a result, recipients of services are often known to practitioners outside of the client relationship, and vice versa, which means that issues about professional and therapeutic boundaries come very much to the fore”. The mental health nurse with the Ruraltown MHU expressed this problem when she stated that *people do not want to admit to psychological weaknesses or receive support from a person who may be the daughter, wife or sister of a friend or relative. It is all too close for comfort and ‘saving face’ is more important.*

A worker from Anglicare also highlighted the problem of potential clients being in the same social circles as the provider. She argued that *this is quite a consideration and you have to decide whether to refer them to someone else who they might not see socially.* Hegney (2000) notes that anonymity for providers may be difficult as they are known and depended on by the community. Fuller et al (2002, p.182) also argue that the boundary between professional practice and social relationships in a small town may be problematic and concluded that “dealing with this social dimension of rural and remote practice and of being ‘constantly on call’ does add to the difficulty and stress that a health professional will face”. The Ruraltown Financial Counsellor also raised this issue and stated that at the Ruraltown show he was *stopped by every second person* and, when he was at the sale yards, *a lot of the blokes talk to me about certain issues.* However, he maintained that, in social situations, he did not mind discussing any problems due to the financial or business nature of his work but recognises that it would be more difficult addressing personal problems in a rural social setting.

Isolation and distance

In the questionnaire responses, most participants agreed that there were unique conditions of rural life that affect people's mental health. Distance and isolation were identified as two such conditions. In the QRWN questionnaires, isolation was the major cause for concern; that is, isolation from services, support networks, specialist assistance, information, and friends. Social isolation can be experienced as a result of distance from social contact but also through a lack of community involvement. It was noted in the CCP Report (2004, p.4), when discussing rural isolated males, that "initially, the definition of *rural isolated* referred to males on properties, geographically removed from easy access to services and the publicity regarding these services". However, it was also identified that "*isolated* can also refer to males living within larger and smaller towns of the southwest; in that isolation can be reflective of absence of supports (family/friends and the like)". Isolation and lack of social contact for rural women was also identified as a problem in the questionnaire responses. Isolation also means that there may be less exposure to the concept of mental health, making it even more difficult to recognise symptoms or access appropriate treatment. Use of the Internet may help to reduce feelings of isolation but not all have access to it or are computer literate (CCP Report 2004).

As services are inadequate, the distances that service providers need to cover for their catchment areas may be vast. One Ruraltown provider stated that *in the Southwest (of Queensland), distance, isolation and cost are huge issues. Services are expected to cover such a huge area, which makes it difficult to provide a high level of service to all consumers. Although the population is smaller, the distance you need to travel to see clients takes more time and this means less clients are seen.* There are very few services, however, that do travel to visit people who live outside of town. Therefore, it is easy for people in need to fall through the service provision cracks. The former Rural Support Officer from the

Neighbourhood Centre in Ruraltown stated that *even though there are a few services that are prepared to travel to visit families both in and out of town to reduce the distance problem, very few sought or invited outside emotional support.*

Isolation also makes it difficult for consumers to make that extra effort to seek help. The CCP report (2004, p. 20) identified as a major barrier “the travelling distances to services and supportive individuals and resources”. CAG respondents also agreed that distance from adequate services was a significant problem. One stated that *we live too far from the help we need. Phone calls never get returned, appointments are not kept, this makes us feel more unwell.* According to Lloyd et al (2004, p.2), “people with mental illness experience social isolation at a disproportionately higher rate than the general population”. Distance and isolation from services and the community can compound service provision and utilisation problems.

Problems with transport may also be a hindrance to seeking treatment. According to Fuller et al (2002, p.177), “many towns in remote areas do not have public transport, making travel difficult for those on a low income. These ancillary costs are an important barrier to access”. One Ruraltown provider echoed this concern and stated that *there’s not a lot of public transport in town so people can’t just hop on a bus to get to appointments. Those from out of town would find it more difficult.* As previously discussed in Chapter 5, seeking medical treatment is generally not high on the list of priorities for those in rural areas, especially those on the land. This is for various reasons — cost, travel, lack of availability, lack of knowledge, or lack of time. Distance from appropriate services is also a problem for those who need to travel to another town or city for treatment. The cost and time away from work may be considerable and could serve to exacerbate stress even further.

As discussed in the last chapter, telemedicine was being trialled in Ruraltown to eliminate the need to travel to receive psychiatric or counselling treatment. However, as mentioned earlier, it was believed that a major barrier to this treatment has been the cost involved. Bourke (2001a, p.5) also found in her study that the cost of health care was a major concern for rural residents and argues that “because rationalisation of services adds to the cost of healthcare, cost is likely to increase. Health care providers need to be aware of this concern”. In the current economic milieu, many doctors have been forced to cease the practice of bulk-billing²⁴. This too applies in rural areas. For example, there is only one doctor out of the five GPs in private practice in Ruraltown who bulk-bills. This doctor was overloaded with patients, as was the bulk-billing clinic at the hospital which only saw patients for one day a week. Therefore, if cost is an issue, there could be lengthy waiting periods before patients are able to receive treatment.

There has also been a reported reluctance by other doctors to refer to the Ruraltown Telemedicine service, possibly due to the cost and the impersonality of telemedicine technology. In an email from the mental health nurse at the clinic (2004), she stated that *costing may well be the reason for this or it may also simply be a thought on how things “should be”, i.e. consults are usually face to face and specialists are usually tangible*. To rectify this problem, the clinic has secured a visiting private psychiatrist to hold the initial consultation face-to-face, with follow-up appointments conducted via the Telemedicine facility. It is hoped that this may alleviate some concerns. However, the mental health nurse at MHU has reservations: *it would be a very new idea, especially for people on the land. They would have to come to terms with the fact that they needed counselling and that is an issue in itself*. According to Judd et al (2001, p.93), “while telepsychiatry has a variety

²⁴ The practice of “bulk-billing” refers to the portion of a doctor’s fee that is covered by the government under Medicare. If a doctor “bulk bills” a patient, only the government portion is charged and, therefore, there is no gap payment or expense to the patient.

of applications, it should be noted that video conferencing will never be as good as, or preferable to, the clinician being present with the patient". With regards to information technology, Sheil (2000, p.138) also points out that "fear of technology, costs involved and problems of access are three common concerns of rural people". Providers and consumers in the Ruraltown study also identified these factors as concerns.

There has also been a reported concern that the Telemedicine facility in Ruraltown does not offer complete privacy. It was stated in the CCP Report (2004, p.20) that "the unit is only used for mental health and is only used on the two days per week the GP doesn't see patients, so administration staff must come in to open up, start the equipment and be around in case of difficulties and security of the surgery". Although it reduces the distance and travel problem for obtaining treatment, acceptance of telemedicine in Ruraltown is cautious. Fuller et al (2002, p.180) argue that "telepsychiatry can provide support to the local human service professional in their provision of first-level mental health care". However, it must first be accepted by those who will benefit from it the most: the mental health consumers.

Social isolation was identified as another problem in Ruraltown. One provider noted that *there seems to be a lot of people in Ruraltown who are extremely lonely. Some rural towns are very community-minded and inclusive. Unfortunately Ruraltown is not one of those.* This isolation is felt more acutely for consumers. Already feeling segregated by the stigma attached to their condition, they are further isolated through a lack of social contact. According to one consumer, *it is very frightening in Ruraltown because people immediately shut you out, they don't want to know you.* It can take considerable time for newcomers to rural communities to overcome social isolation as they are often viewed with suspicion and indifference. An Anglicare worker stated that *Ruraltown is a bit cliquey and it can take up to two years or more before you're*

accepted or belong. If you stay for a few years, it's like you are accepted. As Cheers (1998, p.79) points out, "rural communities will put newcomers to the test and can be quick to label people". Social isolation was also identified in the CCP Report (2004) as an influencing factor in suicide.

SERVICE PROVISION PROBLEMS

Recruitment and retention problems

One of the most significant problems with service provision in rural areas is the recruitment and retention of staff. Fraser et al (2002, p.291) argue that "the maldistribution of the mental health workforce is likely to be a significant contributor to the rural/urban imbalance in utilisation of services". There are fewer GPs, fewer services, fewer mental health workers, fewer psychiatrists and therefore less choice for consumers. Over the three years of the Ruraltown study, recruitment and retention of mental health staff was a continuing problem. The MHU did not have the full complement of staff until May 2004 and there were fears that this would not last. Prior to this, no Child and Youth Psychiatrist had visited the community for over 12 months. It was argued in the NRHA report (2003, p.8) that "family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems. To function effectively, these professionals need to be supported by a greater number of child and adolescent mental health specialists". This professional "support" was seriously lacking in Ruraltown, where there had been no visiting Child and Adolescent psychiatrist for over twelve months and only one Youth mental health worker in the town.

Anglicare and the Neighbourhood Centre also experienced recruitment and retention problems, with staff changing on a fairly regular basis. The lack of access to specialists (psychiatrists or psychologists) was

raised as a concern in several questionnaire responses. The services that are available were reported to be overloaded. Fuller et al (2002, p.180) found that generally, there is a lack of time for workers to counsel people. This was the same with the Ruraltown MHU, hence its focus on clinical needs rather than preventative action. Anglicare tries to fill the “prevention and promotion” void yet is also very busy in its counselling role.

Psychiatric support in Ruraltown is irregular and can be difficult to obtain. There was a mental health team from a large regional centre that visited every month at the beginning of this study (2002) which consisted of a psychiatrist, psychologist, nurse and social worker. This team used to visit by air. However, tragically, members of this original team were killed in a plane crash in 2002. Another team then travelled by car to Ruraltown on a fairly irregular basis. Currently, the team has been reduced to one individual psychiatrist who visits for one day every five weeks. The mental health nurse from the MHU points out that one eight-hour clinic, every five weeks is totally inadequate to see the number of patients who require treatment.

Between visits by the psychiatrist from the regional centre, the MHU works with local GPs to monitor medication, crisis intervention and counselling. However, as stated above, time for counselling is usually very limited due to the number of patients that need to be seen for clinical reasons. There is a weekly teleconferencing session with the regional psychiatrist, however, not much is achieved in these sessions as they are only for half an hour. The larger regional centre is also extremely busy and short-staffed, therefore, is not able to afford Ruraltown any more time.

Due to the visiting psychiatrist's caseload and the time between visits, some people are forced to travel great distances to receive regular psychiatric support. One Ruraltown consumer visits a psychiatrist in

Brisbane on a regular basis. Anecdotally, it is known that several other consumers from country areas also travel to metropolitan areas for availability reasons, but also for confidentiality concerns. It is feared that, if help is sought in their community, anonymity is decreased and fear of gossip is a hindrance to local treatment. Travel, no matter how difficult, is often preferred over the risk of discovery with a mental health problem.

Often, mental health problems are addressed within the confines of the family in rural communities. According to an Anglicare worker *you're brought up in the rural family to just cope and you cope within the family rather than look outside for help*. After the family in rural communities, the GP usually becomes the next point of contact within the health system (Wainer & Chesters 2000, p.145). Walters (1995) labels the GP as "primary health care in action". Alston and Kent (2004, p.85) discovered that "doctors are reporting the need to spend more time counselling because of a lack of allied health professionals including social workers and mental health workers". In the Ruraltown study, the nurse at the Telemedicine unit reported that doctors in Ruraltown were very busy treating mental health problems and this point was also raised in a questionnaire. Another informant stated that *the biggest demand for all services in Ruraltown is for depression and anxiety support*. However, as Herrman (2001, p.710) argues, "there is a continuing failure to recognise and treat mental illness, particularly anxiety and depression, in people attending general practitioners or general hospitals". If primary health care facilities are failing to diagnose and treat mental health disorders effectively due to lack of knowledge or time, how are these problems to be effectively overcome?

The retention of workers in Ruraltown affects the continuity of services. One Ruraltown consumer expressed the difficulty for consumers in finding someone they can trust and communicate with. Choices for support are limited due to the reduced number of staff and services. As

one consumer stated, *there are not that many workers to choose from so once you find someone, it is a blessing. I have had two such people and now they have both left so you have to go through the whole process again. When you are already not feeling well, it is not easy to do.* As Fuller et al (2002, p.180) argue, “a basic tenet of effective mental health intervention is the development of trust, which, we have been told, requires that a health professional work in a rural location for around two years”. However, many providers do not stay long in one location so even if consumers do establish a relationship, it may be short-lived. This concern has made some consumers in Ruraltown reluctant to seek treatment. The current Community Connections Project worker also raised the issue of lack of service position continuity. She maintains that *there has been a lack of confidence in the Project because of the number of people in the job. It takes time to build trust and rapport.*

Lack of funding for positions also has an impact on worker continuity in Ruraltown. With regards to the cessation for funding for the MHCDO at Anglicare, the former manager explained that *we were moving forward with the facilitation of the worker and suddenly the work was pulled. I think the consumers got a lot out of it in terms of their own development, it was a consumer-focussed programme so the brunt of the withdrawal was definitely felt by the consumer.* Another provider from the Neighbourhood Centre also relayed problems with funding continuity. She argued that *we don't have the numbers to compete for funding, we don't have the statistics so funding goes else where. We put in submissions for three years funding then we only get one year and we can't get it off the ground. We might have a program that's working but we can't keep it going. We need more money and time for mental health in Ruraltown.* Cheers (1998, p.170) believes that funding on a per capita basis for rural areas is unfair and suggests that this may be related to the myth of self-reliance. It can be argued that, for mental health issues in rural communities, funding needs to be long-term before any real

progress can be made. It needs to be “kept on the agenda” for people to recognise and adequately address mental health problems.

As discussed in Chapter 7, the particular issues of continuity of funding and positions were raised with the former Queensland Health Minister in July 2002. This was the result of a Resolution being passed at the QRWN/NCWQ meeting in late June 2002. The response, received in September 2002, was quite detailed yet it failed to address these particular concerns. The funding and continuity of positions has become a real problem in Ruraltown from a number of perspectives. It takes more time for people to approach and trust mental health workers due to confidentiality and pride issues. If funding for a position is lost prematurely, as it was with the former MHCDO, people with mental health problems can be left with no resources or support for a considerable period before they renew treatment. This, in turn, may build resentment for the urban-based bureaucracies which initiate such withdrawals, and cause further distress for mental health clients in rural areas. The new Centacare psychologist (June 2004) in Ruraltown urged people to use the service so that funding would continue. As Macklin (1995, p.72) discovered in her study, “where resources were withdrawn the decision related to the deployment of resources according to demand rather than to cost factors. Despite widespread evidence of certain social problems, facilities were under-utilised”. In rural areas, demand is not necessarily reflected in the actual presentation for help because mental health problems often remain “hidden”.

The Team Leader at PHC raised another issue regarding the competition for funding by the different agencies in Ruraltown. She stated that, while other mental health services are doing good work, she did see a double-up of structure and responsibilities. She argued that *to bring a worker on cost a lot of money and if you have two agencies competing for the same staff, it costs quite a bit of money*. This can be counter-

productive for both agencies. As King (1994, p.3) argues “to some extent the relationships among differently funded providers can be competitive rather than enhancing. Problems of coordination of these compartmentalised services frustrate the attempts of any one group to mobilise community efforts”. To give an example, the Team Leader explained that both Anglicare and the PHCU have suicide prevention officers. She stated: *I am not sure what can be achieved by having both, with funding going into two separate organisations for the same thing. Maybe put them in the one organisation and focus on different aspects.* In addition to the apparent duplication of services, this situation does little for service acceptance or relationships in the community. Humphreys et al (2002, p.11) explain that “despite the existence of Commonwealth-State Health Care Agreements and many jointly funded health programs, the rural health scene is littered with problems associated with program duplication, lack of co-ordination and integration of programs, cost-shifting, cross-border issues and lack of mutual recognition”. This situation is not conducive for inter- and intra- service cooperation and communication, and vital opportunities for mental health promotion and prevention of mental illness may be missed.

Problems at the Ruraltown hospital

In 2004, there was a spate of articles in the Ruraltown newspaper about the desperate situation with the shortage of doctors at the Ruraltown hospital and the inability of the hospital to cater to the needs of the community. The Medical Superintendent position was already vacant when the Senior Medical Officer (who had specific training in obstetrics) at Ruraltown hospital resigned in early June 2004. This left only one permanent doctor at the hospital where usually three take care of all clinical needs (*Ruraltown Paper* 4th June 2004, p.1). All local private doctors in Ruraltown have been asked by the hospital’s Director of Nursing to consider be included in an “on-call” roster to relieve the

burden. This request has provoked varied responses from doctors in Ruraltown.

The difficulty with attracting and keeping doctors in rural areas was raised in the article, with one doctor suggesting that conditions need to be made more attractive so that people come to stay and work in the district. The issue that the Government has imposed a limit on the number of patients a doctor who bulk-bills can see was also raised. Perhaps this is one of the reasons why, at the time of this study, only one doctor continued to bulk-bill in Ruraltown. Capping the number of patients for a doctor who is providing economical medical treatment appears to be counterproductive for both the doctor and the patient. As a remedy to increasing demand, a doctor cited in the article urged people to take responsibility for their own health, exercise and eat well to avoid the need to visit a medical practitioner. While this may be excellent advice, it can be argued that it is not an entirely realistic or plausible suggestion for a community of 6000 people, particularly a community experiencing economic stress and preoccupied with day-to-day management of limited financial and other resources.

In a letter to the local newspaper, a community member raised the issue of lack of obstetric services provided at the Ruraltown hospital and the pressure this put on pregnant women and existing doctors. The writer was quite vehement in her comments. She stated: "If I were pregnant, I would not feel confident in the services provided by Ruraltown hospital. The situation at present places too much pressure on existing doctors, both public and private, who do their best to fill the gaping holes in the system. I am also concerned about the pressure that is being placed on the mid-wifery and nursing staff".

The writer also discussed the need to attract and encourage doctors to stay in the community. In conclusion, she stated that "I believe that the community of Ruraltown should expect better service provision than

this, and deserves some answers as to how this situation will be adequately addressed by our local service providers and government representatives" (*Ruraltown Paper* 4th June 2004, p. 4). She also urged other people to put pressure on the "powers that be" to address this problem. Another Ruraltown community member commented in a letter to the newspaper (*Ruraltown Paper* 22nd June 2004, p.4) that "when consumers in Ruraltown comment that they would choose to remain at home and suffer the consequences, rather than be admitted to their local hospital, things are pretty serious don't you think? Time for a change of approach? Maybe".

In a follow-up article a few days later, it was pointed out by a local general practitioner that Ruraltown hospital's staffing levels had always been inadequate and that the doctors at the hospital were forced to work or be "on call" excessively. He stated that "these work practices result in overworked doctors who only stay in Ruraltown for a short time because nobody can work under these conditions" (*Ruraltown Paper* 8th June 2004, p.1). It was also suggested in the article that, in the past, promises of accommodation and other incentives for new doctors at the Ruraltown hospital were not upheld and that this may be the reason there is a retention problem.

The Queensland District Health Manager in Ruraltown went into damage control and responded to these community concerns in a Letter to the Editor (*Ruraltown Paper* 6th July 2004, p.4). She stated that "claims that people would rather stay at home than be admitted to their local hospital are disquieting and hurtful to the staff". The Health Manager explained that two overseas trained doctors from South Africa would join the Ruraltown Hospital in September/October 2004 and that she is committed to working with the community, local and State government representatives to make the health service the best for Ruraltown. She also warned that "we need to be aware that continued criticism of our service discourages existing staff who are doing a great

job, and makes it hard to recruit and retain the additional staff we need" (*Ruraltown Paper* 6th July 2004, p.4). There appears to be dissension between some community members and the Health Service

Cancer treatment was also addressed in an article in the *Ruraltown Paper* (2nd July 2004, p.3) entitled "Appeal for better bush health care". The Rural Doctors of Australia (RDA) president pointed out that people with cancer in rural areas were more likely to die than those in metropolitan areas due to inequitable access to health services. To receive cancer treatment, it is necessary for rural people to travel to urban centres for lengthy periods as there are no local treatment services available. This would incur associated travel and accommodation costs that add further financial pressure. The President of the RDA stated that "we need more of the critical medical technology (in rural areas) used in early diagnosis of cancer such as MRI scanners and more rural chemotherapy and radiotherapy units. We have an aging population and we want all those with cancer to achieve their best outcomes by a process of early diagnosis and treatment" (*Ruraltown Paper* 2nd July 2004, p.3). There have also been reported shortages at the Ruraltown Ambulance Station. The Officer in Charge of the Ruraltown Ambulance stated in an article that "it is as difficult to entice paramedics to country areas as it is to attract doctors. My crew do horrible hours and often they are on call every second night" (*Ruraltown Paper* 11th June 2004, p.1). There is a critical need for medical services and additional staff in many disciplines in Ruraltown.

The shortage of medical services in Ruraltown may be alleviated somewhat by the announcement that a full-time general practitioner had been recruited to start in November 2004 at the Ruraltown Aboriginal Health Service (*Ruraltown Paper* 27th August 2004, p.5). The clinic will be a bulk-billing service and be open to indigenous and non-indigenous people. A Health Worker stated in the article that "other than the hospital, there is only one other bulk-billing service in

Ruraltown so this should decrease the waiting list and help out the other doctors". There will also be a full-time mental health worker at the clinic. Other initiatives to address these problems were being undertaken at the time this study was completed. Welch (1994, p.94) concludes that "the level of satisfaction with GP and hospital services determines whether a community is medically 'happy' or 'unhappy' ". All of the expressed concerns from providers, consumers and community members about the hospital in Ruraltown perhaps indicates that, at present, the community is "medically unhappy".

Appropriateness of staff

In the Ruraltown study, there were concerns about the appropriateness of the staff who treated mental health problems. As mentioned in the last chapter, often staff seemed to shift between different services or agencies. In some cases, it could be argued that the experience or training of some staff was different to the job specifications or requirements. A finding in the NRHA report (2003, p.9) was that, "as a consequence of the shortage of mental health professionals, non-mental health professionals in rural areas are more likely to be treating people with a mental illness". Anecdotally, it was frequently suggested in the Ruraltown interviews that some mental health workers were not specifically trained in psychological counselling, yet this was a part of their role. Fuller et al (2002, p.180) also discovered that, in the context of rural and remote communities, "those human service workers who are immediately available may not have specialist knowledge or experience in providing mental health intervention and the referral options that optimise the window of opportunity". As a remedy to this situation, Aoun and Johnson (2002, p.39) argue that "many rural and remote mental health clients and their support people, families and carers interact with non-mental health qualified professionals at the primary care level eg. hospital nurses, police, community workers. Therefore, a range of rural and remote health service providers require

knowledge, skills and networks in mental health that will enable them to provide quality mental healthcare for rural residents”.

Lack of mental health training, for both nurses and doctors, was identified as a serious issue at the Ruraltown hospital. There were no mental health-trained nurses working at the hospital or specialist doctors. As a result, problems with diagnosis and treatment of mental health patients may occur. As Clark (2003, p.5) found in her study at the Ruraltown hospital, “it can be inferred that those nurses who participated in this study have less than adequate knowledge, skills and support to deliver effective health care interventions to patients with mental illness”. As a consequence, opportunities for early identification and intervention of mental health problems could be impeded, adding to the detriment of symptoms and impacting on long term health outcomes for mentally ill patients. She (Clark 2003, p.112) recommends that “a comprehensive education and training program be developed to increase the capabilities of nurses to provide effective mental health care interventions to people with mental illness”. Aoun and Johnson (2002, p.44) also raised the issue of education of the mental health workforce when they concluded that “the effectiveness of mental health services would be greatly enhanced by general health providers having an improved capacity to understand and support mental health clients and their families”. Appropriate levels of education and training are paramount to effective service delivery in rural areas.

The Team Leader from PHC raised another issue of serious concern. This was the limited ability of the hospital to adequately carry out triage for mental health patients. She stated that *mental health patients are rarely acknowledged as “serious” and if a mental health patient attends the hospital, regardless of what’s wrong with them, they are usually triaged at non-urgent, usually at about zero or one*. Nurses are usually at the front-line of triaging at the Ruraltown hospital and have little or no training or experience in mental health triaging. Sands (2004, p.150)

argues that “mental health triage nursing was found to be a complex, stressful role that involves high levels of responsibility, clinical decision making and multiple role functions”. The inability to triage appropriately creates a stressful situation for both the staff and the patient. The nurses in Sands’ study (2004, p.155) argued that “the psychiatric triage role is highly stressful due to complex decision making under pressure, high levels of responsibility, repeated exposure to trauma and feeling overworked”. Education and training is required before competency in mental health triaging can be reached (also see Brown & Lo 1998, Clark 2003). A worker from the Neighbourhood Centre also raised the lack of ability to carry out triage in Ruraltown. She stated that, in the past, mental health consumers have come to the Neighbourhood Centre as they have not been able to receive adequate treatment elsewhere.

It was found in this study that there is a need for providers to have a cultural understanding of “bush life” to be effective. Cultural and linguistic differences can lead to confusion. As mentioned in the last chapter, an interviewee in the Ruraltown study stated: *you may have a twenty-two year old female mental health worker from the city trying to relate to a sixty year old bush man. Clearly the two can’t relate to one another yet there is no choice.* The Ruraltown Financial Counsellor also discussed the issue of appropriateness of mental health staff. He stated that *the older generation especially are reluctant to seek help because most providers are young and city-bred. They don’t relate to them and don’t speak the same language. There are overseas doctors who are sent out to rural areas and they would have no concept of the Australian rural culture.* Wilsson (1998, p.76) argues that, with regards to social work, different skills are needed to practice in rural areas and a knowledge of structural issues, language aspects and cultural barriers is essential. Levant and Habben (2003) provide some clinical considerations when working with rural men. They (Levant & Habben 2003, p.178) recommend that “providers should consider the context of a rural man’s

environment and how it affects his view of masculinity". Without this understanding, bushmen especially will continue to be reluctant to seek help.²⁵

The belief that the hospital nursing staff was ill equipped to deal with mental health patients was widespread in the Ruraltown study. Clark's (2003, p.iii) results indicate that the nurses in her study at the Ruraltown hospital had reasonably low levels of therapeutic commitment, role competency and role support, and that their knowledge, skills and support to deliver effective health care interventions to patients with mental illness were inadequate. A nurse at a Ruraltown doctor's surgery also stated that *the staff at the hospital is not trained, neither the nurses nor the doctors. We've had a couple of admissions since I've been here and it's been a disaster. They have no idea how to approach a mental health patient.* A mental health consumer in Ruraltown best sums up the alienation felt by patients: *there are huge problems with the hospital. They don't want any mental health patient there. They think you are wasting their time. They don't care and they don't understand.*

Providers also expressed concern about how consumers are treated at the Ruraltown hospital due to lack of appropriately trained staff. Consultation with other services and post-discharge follow-up were identified as being poor. As one provider pointed out, *the hospital has nothing to do with mental health patients in the community unless they*

²⁵ The issue of foreign doctors practising in rural areas and not being able to speak English fluently was discussed in an article in the *Sunday Mail* (23rd May 2004, p 15), entitled "Mind Your Language". A 2003 internal report by Queensland Health's medical advisor for rural health services said that "there were overseas doctors being rushed into Queensland public hospitals and private medical centres to cover serious shortages but their lack of competence was putting patients, employers and the community at risk". In the article, an example of poor language skills by a foreign-born doctor in a rural area was given. After seeing a patient the doctor stated that "the patient is delusional. Crazy. Crazy pain in the head. He kept saying that he was a kangaroo". The patient was, in fact, stating that he was a "jackaroo". This incident was reported in the newspaper but is unsubstantiated. However, it demonstrates that if this kind of misdiagnosis of a medical problem occurs, it could be both dangerous and frustrating for a patient.

present at the hospital at crisis point. There appears to be a general feeling that the hospital operates as a separate entity, reluctant and not equipped to deal with mental health consumers. There needs to be a serious improvement in relations between the hospital and other health services in Ruraltown. As Habibis et al (2003, p.183) found in their study of balancing hospital and community treatment in a rural area, “hospital care remains at the heart of the service. This means that regions such as these need to focus their community services on what is achievable given the level of resources and social ecology”.

Another concern, expressed by a provider, was that there was a lack of confidentiality at the hospital. She stated that *the word from the hospital leaks like a sieve ... there's no confidentiality and everyone knows about it.* Fuller et al (2002, p. 179) discovered in their study that “it is not so much that staff of health services purposively gossip, but that any ‘slip of the tongue’ is more likely to lead to breaking of confidence”. Care needs to be taken not to betray confidentiality in a small rural community where social networks can be intertwined with working relationships.

Lack of after-hours medical services is also a problem for rural areas. According to Fuller et al (2002, p.174), “hospitalisation may occur in remote localities because of a lack of community based treatment options” (also see Rickwood 2004). This is a major concern in Ruraltown since the hospital is the only after-hours medical service available to mental health patients. Numerous respondents and interviewees recognised this as an issue, especially as there is no provision at the hospital for an inpatient mental health bed. An RN from Clark's (2003, p.79) study at Ruraltown hospital stated that “my experience since working in a rural hospital is that those with a major mental illness are left to flounder in small communities. Support from other local agencies was valuable but only offered Monday to Friday, 8.30 till 5.00pm”. An

interviewee in the Ruraltown study joked that *you can only have a psychotic episode between nine and five, Monday to Friday* as there is no real help after-hours. The reason this is such a concern for mental health consumers, according to one provider is that *the hospital has absolutely no contact with the mental health population whatsoever until they are at extreme crisis point*. Understandably, the alienation that mental health consumers already feel may be consolidated by this inexperience at the hospital.

If there are difficulties experienced by hospital staff with the presentation of distressed patients after-hours, the police might be called in to assist. Sweeney and Kisely (2003, p.208) found in their study that, due to the fact that there was no after-hours service, it often led to the involvement of other inappropriate after-hours services such as the police service. One Ruraltown service provider relayed a story about a depressed, emotional person who presented at the hospital late one night. The hospital staff did not know how to handle the situation, called the police who arrived, handcuffed the person and transported them in a police car to the regional centre. This was not an isolated incident in Ruraltown.

A consumer who was transported by police, against her wishes, to the psychiatric hospital over three hours away, stated: *I felt like a criminal*. The police, too, require education on how to respond appropriately and compassionately to a mentally distressed person. Ruraltown police also recognise this need for assistance. One stated that *most mental health services are under-staffed, poorly managed, over crowded and seldom treat conditions at an acceptable level*. Another pointed out that *the hospital doesn't have designated rooms for violent mental health patients (the closest is 350 km away)*. This puts pressure on the police and ambulance personnel who are responsible for transporting mental health patients. As the Team Leader from PHC argued, *if a client is unwell and has to go to the regional centre, the process is very slow*.

There are forms to fill out, you have to negotiate a nurse, the ambulance never wants to go or won't travel at night, the police should not be involved but sometimes have to be. Everyone gets angry, it's time consuming and everyone forgets that it is the client that needs the help. Clearly, this situation is disturbing for all involved

Problems were also identified with post-discharge care from the hospital. According to Lavelle (2003, p.3), "there is a general tendency for hospitals (in rural areas) to discharge people earlier than they used to a decade ago, and that follow-up care may be much less readily available". Matthews-Cowey (2000, p.270) also argues that "problems have occurred because of early discharge of clients and limited follow-up and support from case managers". An Anglicare provider from this study raised this particular concern. She stated that *we had a recent example of atrocious post-discharge care. A mental health client was in for a physical injury yet there was no post-care in place. I would have classed them as a fairly high suicide risk. At least they (the hospital) should have rang us to alert us of the discharge so we could follow-up*. It seems that there is a desperate need to improve mental health education at the hospital before consumers can feel confident and comfortable in the treatment they receive.

Finally, when planning service provision in rural areas, the social and cultural factors of bush life need to be considered. It is only through acknowledgement of the inimitable circumstances of bush life that a holistic mental health model can be formulated. At a primary level, service providers, health workers and community members need to unite, cooperate, integrate and diffuse a positive mental health message. Fuller et al (2002, p.183) conclude that "generalist health and human service workers must be considered as real options for the provision of primary level mental health care". However, they need to be trained to recognise and respond to crisis situations. Aoun and Johnson (2002, p.39) argue that "a range of rural and remote health service

providers require knowledge, skills and networks in mental health that will enable them to provide quality mental healthcare for rural residents". The mental health staff in Ruraltown requires education about the unique cultural aspects of the bush that may impact on mental health and need to work to improve attitudes to mental health issues and services.

Collaboration and cooperation between services

There was an expressed need by Ruraltown service providers to develop a coordinated approach between all the services — the hospital, GPs, the MHU and non-government support services such as Anglicare and the Neighbourhood Centre. Services need to be seen as relevant and useful to the community and their functions need to be clearly defined, for both providers and the community. There were several suggestions in the questionnaires that GPs and the mental health services needed to work more closely in identifying mental health problems. Although referral mechanisms existed between some agencies, others did not, or were reluctant to, refer on clients to another service. This was expressed by the MHU with respect to the GPs. The Team Leader believed that the GPs were reluctant to be involved with the PHCU and some never refer on to the Unit. She stated that *GPs manage most cases of depression out here with minimal interaction from us*. However, as one questionnaire respondent suggested, *there is a need for mental health services to work in liaison with GPs as rural people would be likely to call on the doctor first*. Another suggested that *the mental health knowledge of local doctors needs to be improved*. Efforts are required from all corners to improve knowledge and acceptance of mental health issues in the community.

The former Centacare psychologist and Anglicare workers argued that the MHU at the PHCU rarely refers on to other services. An Anglicare worker stated that *PHC don't actually refer to us much so that could be*

why they are so busy. So we need to find out exactly what they want to do and what they want us to do. Certainly the opportunity is here for them to refer a lot more than they do. Munn (1994, p.363) found in his study that, for services to be effective, they need to work together, be flexible, coordinated, accessible, responsive and “owned” by the community; that is, “the community needs to understand why the service exists and how it can help them”. With regards to the Ruraltown mental health services, one informant stated that they were *adequate but poorly coordinated and disjointed and who looks after what is not clear*. This was a recurring theme regarding Ruraltown mental health services. The services in Ruraltown need to define their parameters to minimise conflict and open referral avenues for the community. It is also necessary to educate community members on where to go and how to seek appropriate help for mental health problems. As one of the Ruraltown doctors argued in a recent newspaper article (*Ruraltown Paper* 10th September 2004, p.1), “the Primary Health Care Unit hadn’t defined its niche in the medical system and their services overlapped with the role of general practitioners”.

Some providers in Ruraltown felt that collaboration between services was lacking, especially with the MHU. One provider stated that *there’s a long way to go before you can say that Ruraltown offers a comprehensive mental health service that covers all the needs of clients*. The MHU was singled out as being particularly reluctant to collaborate with or refer to the other non-government agencies. In their study, Sweeney and Kisely (2003, p.207) found that “mental health workers saw their role as looking after the seriously mentally ill, monitoring them in the community and rehabilitating them to the best of their ability. By contrast, community workers did not accept that mental health workers should only treat severe mental illness, but they felt they should also help those in situational crisis”. One Ruraltown Anglicare provider argued that problems arose due to the conflicting ideologies and practices of different agencies. It was felt that the MHU should also be

involved in promotion and prevention activities rather than solely on clinical aspects. Another Anglicare worker stated that *although we're a service that offers support, I really work from a preventative, early intervention level*. The Team Leader at PHC agreed that promotion was desperately needed and was on their agenda, however, concurred that clinical needs always outweigh promotion and prevention.

The services in Ruraltown had different perceptions about how well the services collaborated. For example, the MH nurse from the MHU felt that there were good inter-agency relationships and referral mechanisms in place. The Team Leader, although stating that it could be improved, also agreed that relationships were satisfactory. However, the other community agencies expressed concern about the lack of interest or support from the MHU. It was clear that the services had different perceptions or expectations from the other. Sweeney and Kisely (2003, p 10) found the same in their study: "the mental health workers believed that they worked well with the other agencies, however, the community workers did not share this view". This lack of consensus about collaboration levels does little for inter-service harmony.

There was a perceived lack of communication and isolation from the MHU by the other services. Sweeney and Kisely (2003, p.209) also discovered that "community workers also felt that as the mental health service had grown, the service had become more distant and detached from the community. Poor communication between the services was aggravated by frequent changes of staff, and community workers were unfamiliar with either MHWs, or their programs". In Ruraltown, it was believed that a better understanding was needed of the roles and functions of the services, who looked after what, and what staff was in place at the MHU. This was the purpose behind the monthly Inter-agency meetings in Ruraltown; in order for services to define their projects and introduce themselves to other agencies for referral purposes. The Sweeney and Kisely (2003) study also highlighted the

importance of monthly inter-agency meetings to exchange information and for peer support. However, the MHU in Ruraltown rarely attended these monthly meetings, thus reducing collegial support for services in the town and increasing the divide between the MHU and other services.

With respect to the lack of collaboration between the MHU and other services in Ruraltown, Munn's (1994, p.364) argument may offer an explanation: "when Health Service organisations assist the same user group as other organisations without consensus, there is a potential for conflict". This may well be the problem in Ruraltown where there appear to be a reluctance to change established functions and tasks. This unwillingness may also be the result of the substantial caseloads of these rural agencies. Sweeney and Kisely (2003, p.210) revealed that the barriers to collaboration between mental health and community-based services were "poor communication, difficulties with referral and cultural differences between services, with the most significant being the lack of communication at individual, case management and organisational levels". The same was found in the Ruraltown study. Munn (1994, p 365) concludes that the positive effects of working together are that "users of service have access to a wider range of services, networking builds consensus and sharing of knowledge which decreases fragmentation and overlapping of services, and leads to a more positive community spirit". These benefits are yet to be realised in Ruraltown.

The promotion of mental health as a positive concept was perceived as necessary for primary healthcare to be effective in Ruraltown. If mental health problems are experienced, early recognition and treatment needs to be encouraged to prevent escalation into a more serious condition. At the conclusion of Malcolm's (2000, p. 172) study, she argued that "decreasing the stigma and bringing mental illness out into the open so we can recognise and treat it and people don't see it as a weakness or

their own fault, is a great step forward". It can be argued that this is what is also needed in Ruraltown, that is, the community needs to recognise, accept and "own" mental health otherwise it will remain "in the closet". All interviewees and most questionnaire respondents identified mental health promotion as being important in rural areas. The mental health nurse at the MHU stated *we just need more people out there doing more promotion. If we had the funds, a full-time mental health promotion officer would be great*. A questionnaire respondent also suggested this: *funding for a mental health promotion worker whose specific responsibilities are to educate, promote and raise awareness*. It was recognised that promotion of, and education about, mental health would assist greatly in reducing stigma and prejudice.

The Team Leader at PHC agreed that promotion of mental health is greatly needed, however, she stated that PHC has not been able to get involved in promotional activities due to clinical obligations. Herrman (2001, p.715) argues that "mental health practitioners will often underestimate the scope of mental health promotion or prevention of mental illness because of the clinical focus that is their business. Those who see the importance of these activities feel daunted by the task". Suggestions in the questionnaires for mental health promotion included: articles in newspapers about mental health, television advertisements, public displays, mental health seminars and information leaflet distribution. One police respondent suggested that *more high profile people who are respected in the community and have experienced mental health problems need to come forward to help others' awareness that it can happen to anyone, help is available and recovery is possible*. This was also suggested in a number of consumer questionnaires. However, in an already skeptical rural environment, I suspect there would be few volunteers. Despite the support for mental health promotion activities, very few are undertaken in Ruraltown.

MENTAL HEALTH CONSUMER ISSUES IN RURALTOWN

Summary of problems facing the CAG

The purpose of this discussion regarding the Ruraltown CAG is to illuminate some of the expressed problems facing consumers in Ruraltown. In addition to the isolation, stigma, service provision problems and community estrangement that these people already endure as a result of their mental health problems, they must also contend with the following difficulties. Closely related to service provision issues in Ruraltown are the problems faced by mental health consumers which have been well-documented in the previous chapter. Of particular significance are the problems facing the Consumer Advisory Group in Ruraltown. This Group was to be the consumer's voice: "to assist in empowering consumers and carers, so that they are able to contribute and respond effectively to the National Mental Health Plan in the Ruraltown area". In addition, the CAG was to be an avenue for input and involvement in decisions made on policy, plans and services affecting Ruraltown (Ruraltown CAG brochure 2004). However, progress towards these goals has been considerably thwarted for Ruraltown consumers.

As discussed earlier, the CAG came under the auspices of the PHCU in June 2002. Prior to this time, they were making good progress towards formalising and organising as a CAG with the help of the former MHCDO at Anglicare. However, when the funding for the position was terminated, management was taken over by the PHCU. During the first six months under the management of a worker from PHC, the CAG was doing reasonably well. According to one of the original CAG members, *it was good in the first stages. The worker did the organising and supervising of the meetings and it was really professional, all our tasks were written down on an agenda and there was a lot of structure. After she left (December 2002), there was no structure or agendas anymore.*

She showed me how to do it all but being a mental health patient I couldn't stay in that position long enough to understand it all.

The Team Leader at PHC agreed with the time frame of problems for the CAG. She stated that *the CAG was quite large after the CAG Forum (2002) but it fell off and it probably now needs to be revitalised (May 2004)*. In the interim period of about eighteen months, according to consumers, the CAG received little administrative and no financial support from PHC and was left to flounder. The President of the CAG explained that *funding and encouragement seemed to stop. I was going to resign as President and other members were also going to resign from the Group because we weren't getting any help from mental health (the MHU)*. Another member of the Group rather cynically concluded that *it sounds like they want their CAG to run so they can get their recognition and their money — they need to say the CAG is running so they get their accreditation, that's all they want*. Obviously these consumers do not feel empowered or supported by PHC. All members were keen to keep the CAG going, however, were disappointed at the lack of support they received.

In terms of funding for the CAG, members stated that they had not received any financial support from Queensland Health or the PHCU. As mentioned in the last chapter, funding for CAG was to be distributed by at the local level by PHC. CAG members attempted to organise a fundraising event and other social functions in 2003 to get people involved and interested in the CAG. However, some members stated that, as no financial assistance or help to organise these events had been received, they had to be cancelled. As one consumer argued, *we're not asking for mountains of money, but just some guidance. After all, the Group is for consumers, not providers*. As discussed in the last chapter, the Team Leader from PHC stated in May 2004 that \$5,000 in funding had been received for the CAG and said that *I think they (the CAG) were feeling a bit lost and overwhelmed and this will show that they are*

valued within the mental health service and the community. However, during late May, the CAG president did not express much confidence that they would actually receive the funding. In a follow-up conversation with the President of the CAG in September 2004, it was revealed that no funding or additional support had been received from the PHCU.

The issue of funding was also raised at the CAG Conference (2003) in Brisbane and was expressed as a challenge facing many CAGs. Problems such as lack of funding from local mental health services, lack of clarity about how the funding can/should be used, and limited control over the use of the funding were recognised. It appears to be a bureaucratic financial dispute that needs clarification. Other problems identified at the CAG conference echo the Ruraltown CAG concerns: how to get a CAG started, how to keep a CAG running, particularly when most of its members have periods of unwellness, how to attract members, how to foster genuine partnerships, how to get a CAG listened to and taken seriously, and challenges around the interpretation of consumer participation (CAG Conference Proceedings 2003, p. 21).

The CAG president has expressed her desire to assist in setting up a Children's CAG in Ruraltown, however, was not hopeful of receiving any help from PHC. She stated that *we definitely need one here for kids because schools are riddled with aggression and depression. They need a support group to know they are not alone.* By establishing a CAG for children in Ruraltown, mental health issues can be addressed at an early age, increasing awareness, improving attitudes and reducing the stigma and likelihood of long-term problems. However, with all the other problems for the CAG and mental health consumers in Ruraltown, a Children's CAG may be difficult to establish.

All of the Ruraltown consumers are long-standing community members and have commented that they want to belong and be accepted as “normal residents”. However, the discrimination and rejection they feel from the community through their “assignment” as mental health consumers precludes this. When asked what can be done to help mental health consumers in Ruraltown, the consumer stated: *we need to break down the barriers. We need people to understand that it is a day to day battle. If this is happening to me, how many others are affected? We need help to progress through our mental illness and we need constant support, not just ‘bandaid’ treatment. They need to listen to us.*

It is important to obtain input from consumers at the local level. Strong et al (1998, p.104) argue that “local communities need to be consulted about their specific health service needs and how to make those services accessible in their geographic area. If consultation does not take place, the health services provided may not be used by people in the community”. This seems to be the case in the Ruraltown community, where it has been expressed that mental health consumers and local people have little input regarding their health services.

Concerns about the Community Connections Project

Of similar importance to mental health in Ruraltown is the Community Connections Project (CCP) being run by Anglicare, with its main aim to increase early intervention and prevention of suicide within the community. The Project targets rural isolated males, people with gender/sexuality issues and those with or at risk of mental illness as they have been identified as “at risk” (of suicide) groups. This Project commenced in October 2002 and was funded for a three-year period by the Commonwealth Department of Health and Ageing, under the National Suicide Prevention Strategy, until July 2005. There are three areas of concentration for the Project: case management in a non-clinical counselling brief, community capacity building, and education,

consultation and resource provision for local services and community members (Community Connections Report 2004).

As stated earlier, the first community worker was successful in establishing contact with 118 members from the target groups. It was noted in the CCP report (2004, p.17) that “the largest group engaged was that of gay, lesbian, bisexual and transgender young people, confirming the integrity of the anecdotal research which led to the establishment of this project” (also see Roberts 1995 & Frere et al 2002). The Ruraltown CCP aims to address some of these mental health issues for youth with sexuality issues. As the former manager of Anglicare stated *there will be scope to meet anywhere, or linking to chat via email or the Internet. We’re looking at preserving anonymity if that’s what people want but it would be a contact point at least which is a lot more than people have ever had out here.*

Rural isolated men and people with a mental illness also contend with community detachment and loneliness, and are considered to be vulnerable “at risk” groups. Reaching isolated men remains a challenge for the Project due to limited communication or access points. People with mental illness are equally isolated and it is difficult to establish contact with clients. The second community worker who commenced in January 2003 continued to engage and support clients from all three target groups, counselling and assisting individuals to make contact with others in similar positions. Links with several community groups were established to broaden contact opportunities and set up referral mechanisms. Flyers and brochures about the Project were left for collection at public venues and the Project was introduced to communities throughout the Southwest via inter-agency meetings, regional newsletters and the local media. Despite the second worker making considerable headway with the Project, he was forced to leave in January 2004 due to ill health. Before leaving the position, he noted in

the CCP report (2004, p 23) that “the barriers identified in engaging members of the target groups still hold true. They are:

- community attitudes towards people with mental illness and towards people identifying as being gay, lesbian, bisexual and transgender;
- lack of appropriate services for people from these target groups;
- travelling distances to services and supportive individuals and resources;
- computer/internet illiteracy;
- lack of knowledge/understanding of available supports and resources.

A replacement for the position was found and a female worker commenced in March 2004. She was interviewed in the final visit to Ruraltown in May 2004. Because she was the third person in the job since it began eighteen months previously, she stated that this has not inspired community confidence in the Project. She also said that the fact that she was female could interfere with the targeting of isolated men. This worker considers the main problems with the Project to be lack of funding and distance. She said that *to service my two districts properly, I would have to spend two weeks here (Ruraltown) and two weeks at the other district but there is not enough money for accommodation and travel*. The action research component of the Project also takes up a considerable amount of her time. A focus group made up of interested community workers and members (not consumers) has been established to discuss ideas and methods to facilitate the project.

In an email received from the worker in July 2004, she believed that progress has been steady. The worker mentioned that, for the first time, Ruraltown would commemorate World Suicide Prevention Day on 10th September 2004. She had organised a barbeque lunch, followed by key speakers covering themes such as mental health, domestic violence, suicide prevention, employment and education, and other suicide intervention models employed by the CCP (*Ruraltown Paper* 22nd August

2004, p.3). Although she has made some headway with the Project, difficulties are still being experienced engaging youth and isolated men, and also with breaking down the barriers surrounding the issues of mental health and sexuality. The worker maintained that a major problem was that *the community is not willing to accept or tolerate difference. Making people more accepting and unprejudiced is not easy.* Another concern for the CCP worker was that funding for her position runs out in less than a year and there was still much to be done for the target groups in the area of suicide prevention and improving attitudes to mental health in the community.

The results from the Ruraltown study supports the argument that bush identity does, indeed, have an influence on attitudes to mental health. In the following chapter, conclusions from the research in Ruraltown have been drawn and recommendations have been made to improve attitudes to mental health in the community. Service provision and utilisation problems have also been summarised as they too impact on attitudes to mental health.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

*As societal safety nets have worn and frayed,
and as benefits and access to health care have constricted,
people with serious mental illness have found themselves
on the margins of an unwelcoming society (Davidson et al 2004, p.11).*

*Although they are not a panacea, strong rural communities
can provide meaning, a sense of belonging, social identity
and care to those who live in them (Cheers & Luloff 2001, p.142).*

The purpose of this study has been to explore bush culture and identity and to determine its influence on attitudes to mental health. In addition, it has added to knowledge about mental health in rural areas through the results of the Ruraltown study. These results illustrate that the characteristics that were popularised through the bush legend in the late nineteenth and early twentieth century such as stoicism, self-reliance, independence, pride and resilience remain entrenched in bush culture today. While it is recognised that some of these characteristics are common to other rural societies, it is the circumstances in which these characteristics became embedded in Australian culture that make bush identity unique.

Bush identity was explained through the use of Social Identity Theory (SIT) in Chapter 3. The theoretical perspectives about social identity, explained there, have been supported in this study. Social Identity Theory (SIT) maintains that the fundamental determinant of identity is through group affiliation or membership (Tajfel 1982). This research has demonstrated that there is a collective bush identity and that the popular characteristics of this identity do affect attitudes to mental

health in rural areas. SIT and other identity theories have helped to explain how and why bush identity remains strong in contemporary times and why this identity influences attitudes to mental health in the bush. However, it is also recognised here that SIT does have its limitations. It lacks a social or historical context, does not adequately explain the gender implications of identity or recognise the fact that identity is multi-dimensional, and it fails to problematise identity. The use of other alternative frameworks in future research could address these issues. For the purposes of this research, however, the application of SIT demonstrates how bush identity became embedded in Australia.

The bush identity also has a direct impact on mental health service utilisation in rural areas. The way mental health is perceived and treated in rural areas is influenced by the historical and contemporary traits of bush identity. This has been demonstrated through an extensive literature review and the responses to questionnaires and interviews conducted in the Ruraltown study. Generalisations from this study must be undertaken with caution as the sample size was relatively small. However, due to the weight of evidence from the Ruraltown study and from previous studies, it can be argued that the results are representative and can be applied to other Australian bush communities.

As discussed in Chapter 2, Australian national identity and culture have their foundation in the bush. It was believed that the bush was where a unique identity could be found and so the bush legend was popularised through the arts and literature of the late nineteenth century. Cultural formations such as the *Bulletin* and the Heidelberg School of artists were very influential mediums in the transference and popularising of bush images and characteristics in the late nineteenth and early twentieth centuries. The writers and artists of this period were conscious of finding a unique Australian identity in an attempt to unify the new nation. It was believed that the harshness of bush life fostered

qualities such as the stoic self-reliance and independence mentioned above. To endure life in the outback it was essential to possess these characteristics in order to “conquer the environment”. The bush was also idealised and portrayed as the place where the new settlers could distinguish themselves from their old British ties. The idealisation of the bush was also juxtaposed with negative impressions of urban life thus highlighting its utopian qualities.

There were, however, some exclusions in the bush legend. It was portrayed as a white, male, British domain with rare acknowledgement of women or Aborigines. Mateship was the creed of the bush and men were the main participants. The strength of this creed was consolidated in World War I at Gallipoli, with its origins firmly planted in the bush. Throughout the twentieth century, especially the 1950s when Australia was “riding on the sheep’s back”, the bush remained at the forefront of Australian culture. It was credited, and excessively so, with creating the nation’s wealth. The popularising of the bush legend also continued through the arts and media.

However, the true situation in the bush was changing (see Chapter 4). In the last few decades of the twentieth century and in the early twenty-first century, rural areas have been facing substantial problems stemming from structural alterations such as government deregulation, globalisation and service withdrawal. Unemployment and poverty are widespread. Much of Australia has also been affected by prolonged drought. However, many rural people feel there has not been corresponding government assistance, recognition or empathy for the extreme hardship they are facing. Despite these problems and the gulf that exists between rural and urban Australia, the bush is still romanticised as having a pre-eminent place in Australian cultural history.

In the context of the changing situation in rural areas, and in conjunction with recent government initiatives, the mental health of rural Australians is now on the political and social agenda (see Chapter 5). Mental health services are present in many rural communities; however, the utilisation and acceptance of these services have been problematic. The concept of mental health is misunderstood and perceived negatively almost universally, but especially in the bush. To bush men in particular, mental health is considered a negative, even foreign, concept and, combined with the fear of being labelled, ridiculed or exposed for needing help, many men would be extremely reluctant to seek treatment. They seem to believe there is a considerable amount of shame attached to the issue of mental health. As this research suggests, bush identity and the characteristics it upholds is still recognised by both men and women as being a male identity.

There is a widespread stigma attached to the term "mental health" and this is a major barrier to seeking help for mental health problems. This stigma is more pronounced in the bush due to the cultural assignment of qualities such as stoicism, resilience and self-reliance, and the utilisation of mental health services in the bush is thus affected by this stigma. Other impediments to seeking help include lack of adequate services, isolation, distance, pride and confidentiality concerns. It has been demonstrated in this research that many of the obstacles to service utilisation are a result of the poor attitudes to mental health in the bush which stem directly from the specifications of bush identity.

It is also recognised that promotion of mental health in the bush needs to be undertaken cautiously. As Herrman (2001, p.711) argues, "the promotion of health requires changing the place that health has on the scale of values of individuals, families and societies". Educating rural people about mental health issues requires a unique approach; one which takes into consideration the cultural aspects that influence attitudes and decisions to seek treatment. Morrow (2002, p.5) also

argues that “contexts — that is to say social, political, economic and cultural realities — should be central to our understandings of mental illness and to how social connectedness can impact on such complex realities”. Judd et al (2002) propose a provisional model for mental health research in Australia. They (Judd et al 2002, p.300) conclude that, “to understand why rural Australians might be ‘at risk’, we need to develop a systematic and detailed appreciation of place not just as a geographical construct but as an environment that shapes the social worlds that individuals experience. There is a need to understand how place variables contribute to psychological wellness or morbidity” (also see Wainer & Chesters 2000, Fraser et al 2002). The current research contributes to this model by attempting to understand how bush identity (that is, “place” and “cultural” variables) influences attitudes (which in turn affect service delivery and utilisation) to mental health in bush areas. It is through a more thorough understanding of Australian bush lifestyle and traditions, which especially affect bush men, that a culture-sensitive approach to mental health can be provided.

Conclusions from the Ruraltown study

The problems faced when addressing attitudes to mental health in Ruraltown included the pejorative connotation attached to the concept of mental health, stigma and rural culture, rural circumstances influencing mental health, problems with service provision, and mental health consumer issues in Ruraltown. Attitudes to mental health in the community were influenced by all of these factors. The concept of mental health was perceived as a negative one. From the results of this study it would seem that, in the short-term at least, there is little chance of improving the image of mental health in rural areas due to the intractably pessimistic connotation attached to the concept.

The stigma attached to mental health problems, as supported by this study, also precluded many from seeking help. The associated shame

and embarrassment of admitting to a mental health problem, stemming from the bush ethic of stoic self-reliance, often immobilised people from seeking outside help. This stigma, resulting from bush identity, was recognised by both men and women in the study as being particularly prominent in rural men. Confidentiality and anonymity concerns were also recognised as being related to the pride and self-reliance of bush people. Service provision problems impacted on how mental health problems were perceived and managed in Ruraltown and, thence on attitudes to mental health.

Finally, the negative reports from Ruraltown consumers and the expressed alienation they feel in their community certainly supports the proposition that bush culture and identity do influence attitudes to mental health (see Judd et al 2002). It was recognised that relationships need to be improved between the community, mental health consumers and workers in Ruraltown before any real progress can be made in this area. Improving attitudes to mental health is fundamental to the acceptance and utilisation of these services.

For mental health consumers to feel truly empowered, these concerns need serious consideration, to prevent CAGs becoming another example of “token” support for mental health consumers. Although these problems are not isolated to Ruraltown, they need to be addressed before CAG members in this community feel they have some control over the management of their Group. If private patients continue to be excluded, financial and administrative support not delivered, encouragement remains in short supply and unreasonable restrictions are in place, the alienation and “otherness” that consumers experience in the community will be compounded. The Ruraltown study demonstrates that mental health clients feel that they are a marginalised group, not fitting in or accepted in the community and that this is a direct result of the prevailing negative attitudes to mental health in Ruraltown.

Mental health promotion is essential to improving the plight of mental health consumers in Ruraltown. With regards to mental health promotion, Stacey and Herron (2002, p. 13) point out that consumer involvement is critical and argue that “respectfully acknowledging consumers means enacting existing policy through proactively addressing barriers, and both harnessing and strengthening resources”. These were the aims of forming CAGs in Queensland; however, as demonstrated in this study, the task has been problematic. Humphreys et al (2002, p. 10) argue that “it is very easy to talk about ‘real consumer involvement at all levels’ ; it is quite another matter altogether to put it into operation effectively”. It is evident from this study that this is what is urgently needed for consumer empowerment in Ruraltown.

Summary of what the Ruraltown study has revealed

The results from the Ruraltown study have provided answers to the research questions which have been restated below:

1. What, if any, is the impact of bush identity on attitudes to mental health?
2. How “real” is this identity in the bush today?
3. What are the implications of this identity for mental health service provision and utilisation in rural Australia?
4. How can attitudes to mental health be improved in the bush?

The information below provides answers to these questions and has highlighted the problems for acceptance and treatment of mental health issues in Ruraltown:

- The concept of mental health is seen as a pejorative term that is not accepted or understood in an appropriate manner. All respondents and interviewees in the Ruraltown study recognised this misunderstanding as significant. Minimal education and exposure to the concept of mental

health in rural areas is a major factor in this naivety.

- The stigma attached to mental health issues in Ruraltown is significant and acts as a major deterrent to seeking help for mental health problems. This stigma is linked to the ethic of self-reliance, stoicism and resilience that characterises bush people and often prohibits them from seeking outside help or confronting issues of an emotional or psychological nature. This stigma was recognised as being particularly prominent in bushmen, as was bush identity.
- In addition to the stigma, there are unique conditions of bush life that affect the recognition of mental health problems and utilisation of mental health services. These are isolation, distance, seasonal factors, confidentiality concerns, lack of anonymity and privacy, and financial issues. All of these conditions negatively influence attitudes to mental health.
- Service provision problems in Ruraltown also highlight the difficulties faced when treating mental health problems in rural areas. Firstly, although the services in Ruraltown are busy, it was reported that they are under-utilised due to the stigma and poor attitudes to mental health. Other service provision problems include the recruitment and retention of staff and inadequate staffing levels, cooperation and collaboration difficulties between services, and funding issues for on-going positions and services. Adequately and appropriately qualified staff at Anglicare, the Mental Health Unit, the Neighbourhood Centre and the hospital were in short supply, service collaboration was found to be lacking, and funding for on-going positions within the services was inadequate. As a result, the effectiveness of mental health programmes and services was considerably reduced and, at times, counter-productive, affecting attitudes to mental health in general.

Of particular concern was the dissatisfaction expressed with regards to

the treatment of mental health consumers at the Ruraltown hospital. Several providers, consumers and community members in this study discussed the inability of the hospital to adequately treat mental health patients with the appropriate levels of knowledge or respect. In turn, consumers felt alienated and reluctant to attend the hospital unless absolutely necessary. The dissatisfaction with the hospital was also supported by the recent negative publicity in the Ruraltown newspaper. The results from this study indicate that the problems with service provision affect the way people perceive and deal with mental health issues in Ruraltown.

- The final and perhaps most important finding of this study is that the mechanisms in place in Ruraltown to support mental health consumers are clearly not working as effectively as they might. The Ruraltown CAG, formed in 2002 under the auspices of the PHCU, was to provide empowerment and encouragement for consumers. However, despite some initial progress, the Group is struggling to remain viable. I pose the question: how are attitudes to mental health in rural areas to be improved when those most in need appear to be neglected by the very service that is supposed to be assisting them?

Also, as discussed in Chapter 7, the CAG is not open to all consumers in Ruraltown, that is, it is only for the public patients who are seen through the MHU at PHC. If the purpose of the CAG is consumer empowerment, why not *all* consumers? The Team Leader from PHC had previously expressed concern about the waste of funds and resources as some services were doubling up on responsibilities. Might not the same argument apply to the formation of another group for private consumers? All consumers in Ruraltown should be supported through the CAG.

The Ruraltown Community Connections Project also aims to empower those consumers with potential or actual mental health problems, to

increase early intervention opportunities, and to educate about the prevention of suicide in the community. However, as discussed in the last chapter, this Project has faced considerable setbacks through lack of position continuity and funding, stigma in the community, and difficulty engaging members of the target groups.

Research significance of this study

Through a theoretical analysis of collective rural identity using the principles of Social Identity Theory this study adds to the understanding of bush identity and attitudes to mental health in the bush. It examines the current political economy of the situation and gender issues in the bush that may also affect these attitudes. The most important contributions this study makes are that it demonstrates how and why bush identity and culture influence attitudes to mental health, and it highlights the implications this has on service provision and utilisation in rural areas. As supported by the findings in this study, bush people, especially men, *do* exhibit characteristics of the historical “bush identity” such as stoicism, independence, self-reliance and pride, and therefore are reluctant to seek help for mental health problems.

The results of this study also seem to confirm that, both historically and currently, bush identity is perceived as a male one. As discussed in Chapter 2, a female presence in the bush was muted in historical chronicles and their present status, though improved, is still subordinate to males. What effect the bush identity has on female attitudes to mental health remains problematic and warrants further investigation. Participants in this study identified these characteristics as influencing attitudes to mental health and thus as being significant barriers to the recognition and treatment of mental health issues in the bush. Therefore, it can be concluded from this research that “bush identity” is not only one that is assigned to bush people by others; they

too recognise this identity and its associated characteristics as being valid.

The findings of this study will be useful for improving attitudes to mental health in the bush, and also the delivery of mental health services in rural areas, making them more accessible, efficient and acceptable. By restructuring and reorienting services in Ruraltown, delivery, access and utilisation will be improved, and attitudes to mental health enhanced. The findings also highlight the importance of delivering mental health education and treatment in a culturally appropriate way. Education and promotion must be sensitive to the mores and traditions of rural areas to reduce alienation and skepticism. Once all of these areas have been addressed, mental health consumers in Ruraltown, the group most affected by the negative attitudes to mental health in the bush, may be closer to achieving the acceptance, understanding and support they need.

Recommendations from the research to improve attitudes to mental health in the bush

The recommendations from this research are based on the findings in Ruraltown; however, they can be extended to other Australian regional and rural communities, as previously indicated.

1. That an alternative term to "mental" be found for referring to mental health services, programmes or consumers, or dispense with the term altogether. People are unaccepting of this term and of the people so labelled, and its use does little to enhance community acceptance. It creates a real fear in people who are not familiar with the true positive meaning of the concept. Changing the term may make help-seeking more acceptable or appealing to those in need. "Health" needs to be viewed holistically and the division between physical and mental health has proven to be counter-productive in

perception and practice in rural areas.

2. That community education about mental health becomes a priority to reduce the stigma and assist people in recognising potential problems. Education needs to be accessible and delivered in a manner that will not inhibit people from being involved. This does not mean jettisoning the “culture of self-reliance” so valuable to the bush but perhaps relaxing the creed to enable acknowledgment that outside help is warranted in certain circumstances and for certain conditions, as it is with financial assistance. In addition, it would be valuable, as suggested in the last chapter, to have a mental health worker attached to an agricultural organisation such as Agforce or the Rural Financial Service to make treatment more anonymous, accessible and desirable to those on the land. It is also recommended that an alternative to the concept of “mental health” be used for any public meetings, seminars or workshops to enhance attendance.

3. That programmes or initiatives continue to target rural men and people with sexuality issues. The fact that bushmen are the ones most affected by bush identity, are isolated and the least likely to ask for mental health support or seek treatment has been extensively documented in this research. Youth with sexuality issues and people with mental illness are also alienated in the community. Therefore, it is recommended that the Community Connections Programme in Ruraltown receive ongoing funding for an additional period of five years, after its expiry in July 2005, and that even more innovative ways be found to reach isolated rural men and youth with gender or sexuality issues in the Ruraltown district.

4. That funding be sought for a health promotion officer who is responsible for mental health promotion and improving attitudes to mental health in Ruraltown. This employee should be an independent representative and be affiliated to all mental health

services and consumers in Ruraltown. The primary responsibilities of this worker would be to the CAG; to organise financial issues, provide membership and administrative support, ensure that members have input into the planning and delivery of mental health services in Ruraltown, and be available for guidance and encouragement. The CAG should also be involved in any educational or promotional activities in Ruraltown. The health promotion officer can also act as a first point of contact for potential clients or referees, provide information on request, organise promotional activities, and be available for mediation between services, if required. Involvement with a number of different sectors in the community will ensure that mental health promotion is widespread, as suggested by Moodie and Verins (2002).

5. That the CAG be open to *all* consumers in Ruraltown and not only those who are treated by the MHU. This would provide support and encouragement for all those affected by mental illness and enable them to be empowered and gain mutual benefit through shared experiences. Other community agencies should also be able to offer support and be involved in CAG-related activities. This may also help in improving their individual mental health conditions as those most affected by negative attitudes are being supported and included in the community.
6. That an agreement to facilitate the integration of services be negotiated between the mental health services in Ruraltown regarding the responsibilities of each agency, their referral mechanisms and feedback expectations. A representative from each mental health agency and other community agencies should attend the Inter-Agency meetings for clinicians and workers to improve knowledge, communication and referral between the services, enhance collaboration and cooperation, and reduce the duplication of services. It is clear from this research that services in Ruraltown

are not collaborating as effectively as they might, thus having an affect on general attitudes to mental health.

7. That funding for mental health programmes and positions be reassessed and monitored to ensure there is minimal duplication of funding and functions between government and non-government services, thus enhancing opportunities for integration. It is also recommended that positions or programmes run for a minimum of five years to allow adequate time for progress to be made. It has been found in this study that positions or programmes that have been funded for three years or less in Ruraltown have been ineffective due to lack of time for education about the services, community acceptance, and to gain the trust of clients. This, in turn, affects attitudes to mental health. Consumers also do not receive on-going support due to these staff changes or cessation of programmes.

8. That the Telemedicine trial be continued and widely advertised to community members, doctors and services in Ruraltown. This facility has the ability to considerably improve access to psychiatric treatment for mental health consumers. The problems that are being experienced with delivery, cost and acceptance of this service need to be addressed so that it can be recognised as a valuable resource for consumers and take the pressure off the other mental health services and GPs in Ruraltown. As argued in the Commonwealth Telepsychiatry Initiative Overview (2002), "telepsychiatry is an attractive option for some consumers who may otherwise have to travel significant distances to see a psychiatrist and who may not be able to afford the travel costs and possible overnight stays associated with such consultations".

9. That the hospital be allocated a permanent bed for mental health patients and, as suggested by Clark (2003), adequate mental health training and education be provided to staff at the hospital. The

hospital is often the first point of contact for mental health patients in crisis and, therefore, needs to be able to adequately treat and house mental health patients, at least for the short-term. Triage and retrieval triage for mental health patients also needs to be vastly improved by the hospital for the benefit of both medical personnel and consumers. A mental health triage education programme needs to be effected to enhance the capability of assessing and treating patients effectively.

10. That on-going evaluation of mental health services be carried out to avoid duplication, determine the effectiveness of programmes and work practices, and identify strengths and weaknesses through a more formal and constructive process. As Buss (2004, p.92) argues, “what is lacking in rural services is the ability to effectively evaluate, quantify and report at a level that will make a difference, not only in that particular community, but also at a State and National level”. Mental health services need to play an active role in overturning the negative attitudes to mental health issues, therefore, there needs to be regular evaluation of their role in this area.

Suggestions for further research

1. More research into the value of true consumer involvement in mental health promotion is needed. Most study participants suggested more education and promotional activities for mental health in Ruraltown to overturn this negative impact and improve the mental *health* of community members. The problems that have been confronted by the Ruraltown consumers indicate the difficulties and barriers to be overcome. However, if providers are truly committed to ensuring consumer empowerment and understanding, surely some progress can be made here. As Herrman (2001, p.716) concludes, “promoting *community understanding* about the nature of mental health and mental illness is the key to changing the policies and practices in education, employment, law and health which are critical to mental

health. Respect for the *human rights* of those with mental illness is the first step to improving treatment and care services”.

2. There has been a gradual increase of government attention to rural areas in recent years and also in the sector of mental health. Both State and Federal governments have recognised the extent of mental health problems and official assistance has been directed to rural areas through policy and funding. Evaluation of the effectiveness of this official intervention will need reviewing, as will the relationship between past government inattention and the perceived “self-reliant, independent” public image or identity of Australian bush people. Do the assumptions in rural policy and structure reflect the ideology that “rural people can cope”? Perhaps the general acceptance of traditional rural social identity has limited government consideration for the bush or thwarted help-seeking by rural councils or residents. It will be interesting to determine what implications, if any, bush identity has on policy formation. Little and Jones (2000, p 638) concluded from their study in England and Wales that there is a need “...to unite a consideration of identity with an interest in the formulation and implementation of rural policy”. This same argument can be applied to Australian rural policy.
3. As discovered in this research there is a difference in the perception of mental health and in the presentation for mental health support between people who live on the land and those who live in rural towns. It has been suggested that there is perhaps a separate identity for those who live on the land (Dale 1994). Further investigation is needed to tease out the differences between these two rural groups. The purpose of this proposed research would be to determine the repercussion of these differences on attitudes to mental health, to ascertain the most appropriate service structure to enhance provision and utilisation by both groups, and to encourage

a more holistic approach to health issues for those on the land.

4. Another area that warrants further investigation is the area of rural women's mental health. Bush identity was mostly recognised as a male one and, therefore, was influential in its affects on bushmen's attitudes to mental health. However, it was not clear what influences bush identity had on female attitudes to mental health in the bush, or how rural women cope with their own mental health problems, in light of their family and work responsibilities. This area needs further attention.
5. As the Mid-Term Review of the *Queensland Mental Health Strategy (QMHS)* was not available to the public at the time of writing, future research could revolve around evaluating the effectiveness of the *QMHS* in addressing mental health concerns in Queensland.

In conclusion, I reiterate Yellowlees (2000) argument: "we need to understand more about the qualities that make up a rural culture and use these to better inform our health planning". It is hoped that this study, and the recommendations proposed, are instrumental in enhancing understanding about bush culture and identity; improving attitudes to mental health in the bush and, in turn, the services for rural people. It is clear from this research that bush identity does indeed influence attitudes to mental health. Although this identity has been altered due to the current difficulties being faced in rural areas, many of the popularised characteristics of the historical bush identity are evident today and, as demonstrated by this research, some of these qualities do influence attitudes to mental health.

APPENDIX 1

PROJECT INFORMATION SHEET

"The Influence of Bush Identity on Attitudes to Mental Health in a Queensland Community"

***PhD Research by Lisa McColl
Griffith University, Brisbane.***

PURPOSE OF STUDY

This study will be exploring whether there is a connection between bush identity and attitudes to mental health. The project seeks to discover how people in the bush feel about mental health issues, where these attitudes stem from, and what affect, if any, these attitudes have on service utilisation and provision. In summary, the main aims of the study are to:

- undertake a comprehensive analysis of historical and contemporary bush culture;
- investigate if there is a correlation between bush identity and attitudes to mental health;
- assist in reducing the stigma attached to mental health issues in the bush and help promote the positive aspects of "mental health"; and
- encourage a more holistic approach to policy formation which acknowledges the unique cultural, social and environmental aspects of the bush.

METHOD

In addition to the review and analysis of primary and secondary sources, a study of Ruraltown will be undertaken to gain opinions on mental health at a local level. Some informal semi-structured interviews will be conducted with members of the community, and health and service providers. Questionnaires will also be distributed to various rural groups. It is hoped that after obtaining a significant body of primary data, a more detailed understanding of the issues, attitudes and concerns of rural people and their lives will be gleaned.

**** Please note, my interest in this topic is purely academic and will be confined to exploring general rural perceptions and attitudes to mental health, where these attitudes stem from and how they affect service usage. All participation is entirely voluntary and participants may withdraw from the study at any time. All answers will be treated**

in the strictest of confidence. All answers will be anonymous and interview results will be used *only* for their intended purpose.

Participants are invited to contact my supervisor Dr. Sally Rickson or myself on the following numbers if you have any concerns or questions about the research process or issues that may arise:

Dr. Sally Rickson: (07) 3875 7268

Lisa McColl: (07) 54 766 823.

The University requires that all participants be informed that if they have any complaints concerning the manner in which a research project is conducted it may be given to the researcher, or, if an independent person is preferred, either:

The University's Research Ethics Officer, Office for Research, Bray Centre, Griffith University, Kessels Road, Nathan, Qld 4111. Ph: (07) 3875 6618

Or

The Pro Vice-Chancellor (Administration), Bray Centre, Griffith University, Kessels Road, Nathan, Qld 4111
Ph: (07) 3875 7343.

Thank you very much for your assistance with this research project.

Yours sincerely,

Lisa McColl

APPENDIX 2

Questionnaire Information Sheet

The Influence of Bush Identity on Attitudes to Mental Health in a Queensland Community

***PhD Research by Lisa McColl
Griffith University, Brisbane.***

PURPOSE OF STUDY

This research project is primarily concerned with the relationship between bush identity and attitudes to mental health. It seeks to discover how people in the bush feel about mental health issues, where these attitudes stem from, and what barriers, if any, these attitudes impose on treatment, service provision and utilisation. In summary, the main aims of the study are to:

- undertake a comprehensive analysis of bush culture and identity
- investigate if any correlation exists between bush identity and attitudes to mental health
- encourage a more holistic approach to policy formation which acknowledges the unique social, cultural and environmental aspects of life in the bush.

The research is being conducted in partial fulfillment of the requirements for the Degree of Doctor of Philosophy at Griffith University. **All participation is entirely voluntary and participants may withdraw from the study at any time. All answers will be treated in the strictest of confidence.**

If you are interested in assisting further, please leave your contact details. A Reply-Paid Envelope has been provided for the return of questionnaires. Thank you very much for your assistance with this research project

Yours sincerely,

Lisa McColl

APPENDIX 3

CONSENT FORM

Chief Investigator: Dr. Sally Rickson
(07) 3875 7264

Assoc. Investigator: Lisa McColl
School of Humanities
Nathan Campus
Griffith University
Brisbane Qld 4111

Email Address: lmccoll@flexinet.com.au

This research project is primarily concerned with the relationship between bush culture and attitudes to mental health. A number of interviews will be undertaken with residents and health/service providers in the Ruraltown community to determine the nature and impact of this relationship.

This research is being conducted in partial fulfillment of requirements for the Degree of Doctor of Philosophy at Griffith University under the supervision of Dr. Sally Rickson and Professor David Burch.

Please be aware that your participation in this research is entirely **voluntary** and you are free to withdraw from the study at any time without explanation. All interviews will be entirely confidential and used only for the stated purposes of this study. Personal records identifying you or your responses will not be disclosed. Feedback on the overall outcomes of the research work will be provided upon request.

Consent statement

"I have read the information sheet and the consent form. I agree to participate in the project **"The Impact of Bush Culture on Attitudes to Mental Health"** and give my consent freely. I understand that the project will be carried out as described in the information statement, a copy of which I have retained. I also realise that I can withdraw from the project at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction"

Signatures:

Participant

Date

Investigator

Date

APPENDIX 4

QUESTIONNAIRE

1. Gender: Male Female (Circle one)

2. Age:

3. Contact Details:(Optional)

4. Do you think the term “mental health” is a positive or negative concept?

POSITIVE NEGATIVE UNSURE (Circle one)

5. Can you give a reason for this?

.....

Please answer the following 4 questions by rating the statement on a scale of 1 – 5 by circling one (where 1 = Strongly Agree, 2 = Agree, 3 = Unsure, 4 = Disagree, 5 = Strongly disagree)

6. Rural people are inclined to seek help for mental health problems.

1 2 3 4 5

7. The major barriers to seeking help are:

Lack of confidentiality	1	2	3	4	5
Lack of knowledge	1	2	3	4	5
Lack of time	1	2	3	4	5
Lack of services	1	2	3	4	5
Financial reasons	1	2	3	4	5
Concern over embarrassment	1	2	3	4	5
Shame of exposure	1	2	3	4	5
Fear of illness	1	2	3	4	5

Other

8. There is sufficient public information about mental health issues in my community.

1 2 3 4 5

9. There is a stigma attached to the concept of "mental health" in the bush.

1 2 3 4 5

10. If you agree or strongly agree with this last statement, why do you think this is the case?

.....

11. Are there unique conditions in rural life that affect people's mental health?

YES NO UNSURE (Circle one)

12. If yes, what do you believe these are?

.....

13. Are you aware of what mental health services are in your area?

YES NO UNSURE (Circle one)

14. Do you believe these are adequate?

YES NO UNSURE (Circle one)

15. If no, why not?

.....

16. Can you make any suggestions to encourage awareness and promote mental health in rural areas?

.....

THANK YOU KINDLY FOR YOUR ASSISTANCE.

APPENDIX 5

QUESTIONNAIRE FOR HEALTH & SERVICE PROVIDERS

1. Gender: Male Female (Circle one)

2. Age:

3. Occupation

4. Contact Details: (Optional)

1. Do you think the term “mental health” is a positive or negative concept?

POSITIVE

NEGATIVE

UNSURE

(Circle one)

2. Can you give a reason for this?

.....

3. Do you think rural people are inclined to seek help for mental health problems?

Yes

No

(Circle one)

4. If no, what do you believe are the major barriers to help-seeking?

.....

5. Do you believe there is a stigma attached to the concept of mental health in the bush?

Yes

No

(Circle one)

6. If yes, why do you believe this to be the case?

.....

7. With regards to mental health, what do you believe are the major problems with service delivery?

8. Can you make any suggestions to encourage awareness and promote mental health in rural areas?

.....

THANK YOU KINDLY FOR YOUR ASSISTANCE.

APPENDIX 6

INTERVIEW SCHEDULE FOR HEALTH/SERVICE PROVIDERS

1. What are the major problems facing rural areas?
2. What do you think are the main concerns for the Ruraltown community at the moment?
3. Do you think that there are conditions unique to the bush (compared to the city) which influence mental health?
4. Do you think many seek help for mental health problems?
5. What do you believe the major barriers are to help-seeking?
6. Is there a difference in presentation between townspeople and those who live on the land?
7. If yes, how would you account for this disparity?
8. Are people very concerned about issues of confidentiality?
9. Is there a stigma attached to mental health issues in the bush?
10. If so, where do you believe this stigma comes from?
11. Do you think that the stigma in the bush is stronger than in the city?
12. Do you think there are adequate mental health services in the area?
13. How often do psychiatrists visit the area?
14. Is telemedicine used for counselling and information exchange with specialists?
15. Do you consider this to be an effective way of counselling people with mental health problems, especially for people on the land?
16. Do more women than men present for support or counselling?
17. If so, how can more men be encouraged to present for psychological assistance?
18. Do you believe the pressures on young people in rural areas have increased in recent years?

19. What do you think these pressures are?
20. Are you aware of any specific programmes or strategies available in schools or youth community groups to help young people cope with problems?
21. How effective have these responses been?
22. Do you believe government support to rural areas is adequate?
23. What about in relation to mental health?
24. Do you think the government understands the problems facing rural communities?
25. How do you think people have generally coped with recent changes in rural areas such as restructuring, service withdrawal, deregulation, unemployment etc.
26. What have been the major repercussions of these problems eg. Financial, health, divorce, substance abuse, poverty?
27. It was recently reported in Queensland Country Life that, due to drought and financial hardship, many farmers have become chronically depressed. Would you agree with this statement?
28. It also reported that stress levels and workloads are higher for rural health workers – do you agree with this statement?
29. Do you believe that mental health consumers should be actively involved in decisions about the treatment they receive, as advocated in the 2nd NMHP?
30. Did you attend the Rotary Mental Health Forum in Ruraltown (24.04.02)?
31. Do you think it had any long-term affect on community attitudes to mental health and would more community education sessions be valuable?
32. Can you make any suggestions to enhance the acceptance and treatment of mental health concerns in the community?

APPENDIX 7

INTERVIEW SCHEDULE FOR COMMUNITY MEMBERS, CONSUMERS AND OTHER KEY INFORMANTS

1. What are the major problems facing rural areas?
2. What do you think are the main concerns for the Ruraltown community at the moment?
3. What does the term "mental health" mean to you?
4. Do you think it is a positive or negative concept?
5. Do you know about services such as counselling or psychological support in the district?
6. Do you think they are adequate?
7. What is the general attitude to stress, mental health issues and counselling?
8. Do you think people feel comfortable asking for help or seeking the support they may need?
9. What do you think affects them seeking help?
10. Do you believe there is a stigma attached to psychological or emotional problems?
11. If so, where does this come from?
12. What do think needs to be done to overcome this and to encourage people to seek help if they need to?
13. Do you think that education about emotional or mental health issues would encourage more people to seek help?
14. Do you think people would attend educational sessions about mental health?
15. Do you think that, if there was no risk of others finding out, more would seek help for stress or emotional problems?
16. Do you think there are conditions unique to rural life that affect mental health?

17. Do you know of any other support groups that offer assistance in times of need or hardship?
18. Did you attend the "Promoting Mental Health Awareness" Forum in April 2002?
19. Do you think it was a worthwhile event for the promotion of mental health in the community?
20. Are there any additional comments you would like to make or questions that you may have?

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INTERVIEW LIST

First visit to Roma 21.4.02 – 25.4.03

1. Kim Agostinelli, Rural Family Support Officer at the Roma Neighbourhood Centre – 9am, 23.4.02
2. Neil Farley, Manager of *The Western Star*, at his office – 12.30pm, 23.4.02
3. Carlie Dean, Mental Health Promotions Officer at Anglicare, 2pm, 23.4.02
4. Margot Hicks, Adult Mental Health Worker at the Mental Health Unit, Primary Health Care Unit – 9am, 24.4.02
5. Marissa Byrne, Child and Youth Mental Health Worker at the Mental Health Unit – 10am, 24.4.02

Second visit to Roma 6.10.02 – 10.10.02

1. Kim Agostinelli, Rural Family Support Officer, at the Roma Neighbourhood Centre – 9am, 7.10.02
2. Carlie Dean, Mental Health Family Support Worker, at Anglicare – 2pm, 7.10.02
3. Margot Hicks, Adult Mental Health Worker, and Shonah Bradford, Social Worker at the Roma Hospital, at the Mental Health Unit, Primary Health Care Unit – 11am, 7.10.02
4. Nikki Thompson, local therapist and ICPA President at a local coffee shop – 12 midday, 7.10.02
5. Gayle Baldwin, Roma QRWN President and local councillor, Lyn Kajewski at a local café – 1 pm, 7.10.02
6. Sharyn Garrett, QRWN Administration Officer at a coffee shop – 11am, 9.10.02
7. James Curtain, Manager, at Roma Anglicare – 2.30, 9.10.02

Third visit to Roma 21.9.03 – 25.9.03

1. Nikki Thompson, local therapist and ICPA president at a café – 12 midday, 22.9.03
2. Dawn Connolly, registered nurse and ICPA member at a café -- 1.00pm, 22.9.03
3. Joint interview with manager Vince O'Donnell, mental health workers Debbie Garrett and Toni Basset, and Centacare psychologist Marguerite Lumsden, held at Anglicare -- 3.00 pm, 22.9.03
4. Margot Hicks, Adult Mental Health Worker, at the Mental Health Unit, Primary Health Care Unit – 9.00 am, 23.9.03
5. Joe Titchborne, CAG member, at a local café – 1.00 pm, 23.9.03
6. Kim Agostinelli, Rural Family Support Officer, and Terri O'Donnel, Housing Officer from the Neighbourhood Centre at a local coffee shop – 4.00 pm, 23.9.03
7. Bernie O'Mara, Men's Health worker at the Neighbourhood Centre – 4.30 pm, 24.9.03.

Fourth visit to Roma 9.5.04 – 14.5.04

1. Mark Turner, CAG secretary, at his home – 11.00 am, 10.5.04
2. Debbie Maunder, Mental Health Nurse, and Karen Mills, Practice Manager, at the Telemedicine Unit at Dr. Loraine Wheeldon's surgery -- 12 midday, 10.5.04
3. Col Neal, Rural Financial Counsellor, at the Maranoa Rural Management Centre -- 1.00 pm, 10.5.04
4. Margot Hicks, Adult Mental Health Worker, at the Mental Health Unit, Primary Health Care Unit – 8.15 am, 11.5.04
5. Kerry Capes, Family Support worker, at the Neighbourhood Centre -- 9.30 am, 11.5.04
6. Debbie Garrett, former Anglicare worker, at a local coffee shop -- 10.30 am, 11.5.04

7. Jessica Denton, The Community Connections Project worker at Anglicare – 3.00 pm, 11.5.04
8. Chris McGuire, Team Leader at the Primary Health Care Unit – 2pm, 12.5.04
9. Vince O'Donnell, Manager of Anglicare, and Terri O'Donnell Housing Officer from the Neighbourhood Centre, at a local bistro -- 12 midday, 13.5.04
10. Toni Bassett and Raine Telford, mental health workers at Anglicare – 3.00 pm, 13.5.04
11. Wendy Clark, Coordinator of the 'Big Brother Big Sister' mentoring programme at Anglicare – 4.00 pm, 13.5.04
12. Chanelle Clark, a researcher at the Ruraltown Office of Rural Health – 9.30 am, 14.5.04.