Can psychology student placements improve access to mental health services for Kimberley peoples?

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Background

Aboriginal and Torres Strait Islander people are almost three times as likely as non-Indigenous people to report high or very high levels of psychological distress [1]. The rate of hospitalization for mental health disorders, substance abuse and intentional self-harm is higher in rural and remote Australia than in metropolitan areas [2]. Within the Kimberley region, a remote area of northern Western Australia (WA), the prevalence for mental ill health is considerably higher than in metropolitan WA. It is reported that mood disorder occurrence is 1.3 times higher, substance use disorders 2.9 times higher, behavioural/emotional disorders in childhood and adolescence 2.6 times higher and intellectual disability 1.6 times higher in the Kimberley [3].

The numbers of suicide and self-inflicted injuries in the Kimberley are amongst the highest in Australia and are over 7 times higher than the Western Australian state average [3]. Young people are disproportionately at risk, and suicide and self-harm are the leading cause of death for Kimberley youth between 16 and 24 years of age. Between 2011 and 2015, 34 deaths due to suicide were reported for youth aged 15 to 24 years [3].

The poor health of Aboriginal people in the Kimberley is influenced by the continued legacy of colonisation and intergenerational trauma. This is compounded by social factors such as poor education outcomes, paucity of employment opportunities, endemic unemployment and consequential lack of income, limited access to culturally appropriate health services and social exclusion [4]. Government policy and legislation, the stolen generation, disconnection from country and culture, physiological health issues and social stressors impact the mental health status of Aboriginal peoples living in rural and remote Australia [1, 5]. Other stressors include a high prevalence of chronic illnesses and disability, poor health outcomes, housing overcrowding or homelessness, prevalence of incarceration and child removal, and unresolved trauma [1, 5].

Access to services

Within the Kimberly, a relative lack of access to primary care was reported with the proportion of children and adults accessing primary care being lower than those in metropolitan areas [3]. Regionally, one in seven (15%) of adults (aged 16 and over) were reported to have a diagnosed mental health problem. Despite this high burden of psychological ill health, however, only 8% reported that they had received mental health care services [3].

There are numerous barriers that may prevent the Aboriginal community from accessing mental health services. These barriers may include lower educational level, lack of knowledge of appropriate services, perceptions of stigma around seeking mental health, concerns around children being taken away/removed from care, and concerns around confidentiality [6, 7].

Despite high levels of government investment in mental health services and programs in the Kimberley, youth suicide levels remain high and services are still not able to address underlying issues and the needs of Aboriginal youth. In the report from the recent Coronial Inquest into the deaths of thirteen children and young persons in the Kimberley Senator Patrick Dodson, Yawuru native title holder, stated "current public sector arrangements that promote service delivery by non-indigenous NGOs with no regard for the Mabu Liyan (cultural and spiritual wellbeing) of their clients essentially remain assimilationist, utilitarian and cost risk adverse [4]."

As in other rural areas in Australia there is a low provision of mental health services and reduced access to such services for the people of the Kimberley [1, 2, 6]. A survey conducted in 2015 indicated a decreased proportion of psychiatrist, mental health nurses and psychologists in rural and remote areas. Respectively, these proportions were only 36%, 78% and 57% of the numbers of clinicians in metropolitan areas [2]. Despite the high need for clinical psychology services, there are very few clinical psychologists in the Kimberley.

Research emphasises the success of collaboration between medical care and psychological care in delivering mental health services [8]. Integrated care has been found to be highly valuable in ensuring that patients in rural and remote Australia gain access to services. This includes employing a psychologist as a member of a medical practice, and developing an internal referral pathway, whereby mental health care is provided alongside medical care. This is found to reduce the stigma associated with accessing mental services/or seeing a psychologist, ensuring a continuity of psychological care for patients [8].

Rural placements and internships for clinical psychology students have been reported to be a crucial step in building the capacity of psychologists in rural and remote settings [9,10]. Rural psychology placements have been found to deliver students with autonomy, independence, decision making and responsibility, strengthening their interest in practicing in rural and remote settings [9,10].

Clinical psychology placements in the Kimberley

The Australian Commonwealth provides 15 University Departments of Rural Health (UDRHs) across Australia with Rural Health Multi-Disciplinary funding to enable effective rural training for health students and to support rural health professionals to improve Aboriginal and Torres Strait Islander health. The Majarlin Kimberley Centre for Remote Health, formerly known as the Kimberley Rural Health Alliance, was established in 2018 as a UDRH for the remote region of north Western Australia to increase the number of nursing and allied health students, including psychology students, undertaking clinical placements in the Kimberley region. Majarlin is a local (Yawuru) word for "coming back" and the Majarlin Kimberley Centre for Remote Health is establishing well supported positive remote health placements for health students from all over Australia, in the hope that students will come back and contribute to the future remote health workforce.

In 2018 Majarlin successfully coordinated and supported 88 Allied Health students and 48 Nursing students from 13 universities for a total of 754 placement weeks. Service learning programs were commenced at 3 schools and 1 aged care facility in Broome with plans to expand these programs into other Kimberley towns in 2019. The Occupational Therapy (OT) and Physiotherapy (PT) service learning programs are delivering services to clients who previously have been unable to access allied

health services, due to the shortage of allied health clinicians in the region. In 2018 Majarlin facilitated three clinical placements for postgraduate psychology students from Murdoch University. There is no awareness of previous clinical psychology placements in the Kimberley region. The psychology program at Murdoch University has a commitment to social inclusion and equity. There was a recognised value and potential for clinical psychology placements in enhancing the capacity of the mental health workforce in rural and remote areas, both in terms of direct service delivery, but also in potentiating a future psychology workforce in those areas.

The psychology students on placement were provisional psychologists with supervised clinical psychology training and experience working in community based psychology clinics at Murdoch University. In addition, students had previous experience in mental health settings working with clients from diverse backgrounds. Although a number of organisations in the Kimberley employ psychologists to deliver services, identifying opportunities for psychology placements proved challenging, and there is a need to further explore these barriers and identify facilitators.

The majority of the workforce delivering mental health services in the Kimberley are general practitioners and mental health nurses. Many of the organisations approached had little understanding of the role of general or clinical psychologists, and despite being offered student supervision and support from the parent university, were hesitant to allow a psychology student to be placed with their organisation. Lack of clinician time, lack of space, staff turnover, complexity of patients and concerns that a psychology student would be unable to effectively interact with Aboriginal clients were all given as reasons why organisations felt unable to take a clinical psychology student on placement.

One specific barrier was the supervisory context. Clinical psychology placements are required to be supervised by appropriately endorsed clinical psychology supervisors, which are necessary to support clinical training as well as safe and effective psychological practice [11]. Ideally, this would occur with supervision on site, but this was not an option when placing students in the Kimberley due to the lack of appropriately endorsed supervisors. The challenge was to create a framework in which supervision, from both the host university and the local community, could be integrated in way that supported safe and effective practice, and was sensitive to the local cultural and community contexts.

In an attempt to address this, Majarlin in partnership with Murdoch University developed a pilot program, in which clinical psychology students were placed within organisations that do not currently have clinical psychologists (although may employ psychologists), such as an Aboriginal Drug and Alcohol rehabilitation centre and an Aboriginal Community Controlled Health Service. Psychology students were integrated within the primary health or mental health care setting, often locally supervised by the senior Aboriginal health workers, whilst also receiving remote supervision by videoconference from a clinical psychologist at their city based university. This unique and innovative, non- traditional way to supervise clinical psychology students, allowed psychology students to be placed in culturally safe settings where there is much client need. Importantly, this framework aimed to integrate and respect the diversity of expertise in supervision from different people, to enhance mental health service delivery in the local community within the parameters of a time-limited student placement.

Method

Majarlin assisted in the organisation of psychology clinical placements, acting as liaison between the university and placement sites. A number of times placements had to be re-organised due to

organisational staff turnover and subsequently being unable to supervise and support a student placement.

Placements were also made possible through financial assistance from Majarlin who assisted students with travel and substantial accommodation subsidies. Majarlin also offered students a wide range of support through social networking opportunities, regular debriefing and reflection sessions, including art therapy. Majarlin also provided opportunities for students to deliver multi- disciplinary educational sessions to Kimberley youth about social and emotional wellbeing.

On arrival in the Kimberley the psychology students were provided with orientation, an overview of regional health and cultural awareness training. They also participated in a clinical yarning workshop and a cultural immersion experience, facilitated by Majarlin.

Case Study: Psychology student 8 week placements at a Kimberley Aboriginal Health Service

Students were integrated into the clinical team and attended case meetings and team meetings with other clinical staff. A local induction and opportunity to meet the clinical team was built into the beginning of the practicum. A flexible inter-professional model of care was implemented, as appropriate to the context for the clinic. Students worked closely with social wellbeing and clinical staff including GPs, midwives, Aboriginal health workers, social workers and support staff.

Supervision: Local operational support, consultation around risk and supervision was provided by an onsite psychologist. Additional supervision by an endorsed clinical supervisor at the university, specific to clinical training requirements, was provided by phone or videolink. Regular clinical supervision included review of cases, formulation and treatment planning, debriefing and reviewing management around risk, emotional support and supporting self-reflection and learning of the students. Students also received ad hoc clinical supervision through email requests, review of logbooks and could phone for additional support as required over the course of the placement.

Local supervision from clinical staff was instrumental in ensuring that existing practice could be effectively translated into the local context in culturally appropriate and safe ways. Supervision from endorsed clinical supervisors focused on developing competencies in clinical psychology practice, emphasising consultation and collaboration with local health workers and supervisors in clinical planning, assessment, and implementing interventions. In particular there was an emphasis on working collaboratively with the existing staff to build capacity and optimise sustainability of benefits gained beyond the term of the placement.

Following the placement experience by the clinical psychology students, the following observations were made:

- The referrals included patients presenting with high levels of psychological distress, physical health problems, and social problems including stress, anxiety, depression, and crisis issues such as housing, domestic violence, concerns around removal of children from parental care.
- Referrals were made across the developmental range including many children with significant disability and neurodevelopmental symptomatology who had been unable to access assessment and diagnosis services. These presentation were consistent with Autism Spectrum Disorder (ASD), Attention deficit hyperactivity/impulsivity disorder (ADHD), Foetal Alcohol Spectrum Disorder (FASD) as well as a range of attachment, emotional and behavioural difficulties.
- Psychological services were delivered in a number of different patient contexts including: regular outpatient attendance at clinic, follow up appointments, home visits accompanied by another

social care worker. Patients were also supported to attend clinic through outreach and dedicated patient transport services.

The clinical psychology placements aimed to add value to the existing service, by providing evidence based clinical assessment and intervention, taking on a case management and consultation role and working closely within the multidisciplinary team in providing psychological care for the community. The assessments and interventions were conducted with a broad understanding of psychological medicine, adjustment to medical problems and diagnoses, developmental processes, and systemic understandings of illness and distress. All interventions were evidence-based and based on complex case formulation and accounted for co-morbidities and context of care. Psychologists also integrated best practice for culturally responsive and respectful care [10]. Interventions included psychoeducation, individual psychotherapy, brief therapy and behavioural interventions with adults, children and families.

Results

The psychology students were placed within the clinical team working out of the family centre at the Aboriginal Health Service and seeing patients from across the developmental range with a large proportion of caseload being children and teenagers. Whilst on placement the student implemented a wide range of evidence based assessments and interventions working with clients presenting with difficulties such as:

- Depression, anxiety, stress
- Trauma and adjustment problems
- Suicidal ideation/intent and harm
- Substance use and addiction
- Developmental disabilities: ASD, ADHD, intellectual disability (ID) and learning difficulties
- Externalising and behavioural problems in children and adolescents
- Emotional regulation problems and anxiety in children
- Comorbid mental health difficulties which may be a result of, or play a role in physical health problems and chronic diseases

While on placement the psychology students faced challenges that contributed to the overall learning experience. These challenges were mainly related to:

- Referrals and establishing referral pathways
- Complexity of client presentations
- Culture shock and adapting skills and knowledge to fit the culture
- Acceptance by healthcare team
- Limited understanding of the role of clinical psychologist/clinical psychology student by the organisation and healthcare team

Challenges and considerations for future clinical psychology placements

The implementation of clinical psychology placements in rural and remote contexts are not without challenges, and there are important considerations for future placements. Regular and responsive supervision, both locally and remotely, was imperative for students to feel adequately supported on placement and to ensure safe practice. One of the challenges to delivering effective clinical supervision included intermittent internet and Wifi access and limited ability to have direct oversight of clinical notes due to the supervisor being offsite and external to the service. These challenges were remedied during the placement, but appropriate levels of resourcing across multiple domains are key for the success of such placements.

Although supervisors were experienced, the relative difference of the remote setting and the challenges of effective service delivery and psychological working in these contexts needed strong consideration. Relevant issues were better understood after supervisors were able to visit the placement site and observe the student in the clinical setting. The cost of these supervisor visits were subsidised by Majarlin. Ideally, clinical psychology supervisors should either be local or have extensive experience working in similar settings. The number of clinical psychology supervisors with remote backgrounds however is extremely limited. . Optimising supervision competencies in future is a key consideration moving forward.

Overall, the clinical psychology placements described here added value to the delivery of mental health services, although it is recognised that using clinical psychology students is not a panacea, nor a complete solution to increasing access to mental health services in the region. Future evaluation and research will need to include reviewing how clinical psychology placements best fit and integrate within mental health service delivery, as well as revise the structure, process, and method of supervision to simultaneously meeting clinical training requirements and optimise clinical practice in placements.

Conclusion

The psychology students became valued members of the Aboriginal Health Service clinical team and patients were referred to them for psychological assessment by the other clinicians. The student conducted specialist interventions and assessments which otherwise patients may not have been able to access locally. The feedback from the health service has recognised the value of the students' service delivery to their clients and has requested more psychology students. The University is hoping to be able to place two students each semester to provide ongoing access to psychology service in the region.

The placement provided the psychology students with unique learning experienced, as there were opportunities to work with a broad range of complex client presentations and models of service delivery. The placements provided the students with an opportunity to adapt and utilise existing knowledge and skills and further enhance these skills whilst closely working within a multidisciplinary team. Working within a multidisciplinary team also facilitated acquisition of clinical knowledge, broadened problem solving skills and fostered an interdisciplinary understanding. It also cultivated the students' understanding and knowledge of the culture of Aboriginal peoples and how to use this knowledge to deliver psychological care in the best interest of the patient/client. The placements further provided the students with a platform to enhance their knowledge and skills in professional and ethical practice relevant to a rural/remote community setting.

Recommendations

1. Develop opportunities for all psychology students to undertake placement experiences in non-metropolitan settings
2. Psychology placements are difficult to organise in areas where there is a dearth of psychologists who can supervise students. Funding needs to be made available to University Psychologists to enable them to travel with students to rural areas and assist with supervision.
3. Developing supervision models and frameworks that facilitate completion of clinical training requirements and support safe and effective practice being translated into local community contexts
4. Establishing sufficient resources to undertake responsive remote supervision in conjunction with onsite visits

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Presenters

Lindy Swain is the Director of the Kimberley Rural Health Alliance (KRHA). Lindy and her team are establishing innovative student health placements across the Kimberley, in an attempt to improve recruitment and retention of workforce, and health outcomes. The KRHA goals include to increase health students' understanding of rural and remote health inequity, to improve cultural safety practices of health professionals and students, to increase the skills and attributes needed by health professionals for remote practice and to support research into rural workforce and innovative models of care. Lindy's particular area of interest is working with Aboriginal and Torres Strait Islander people to assist with medication management, optimising treatment and outcomes. Lindy's PhD thesis was entitled 'Improving medication management for Aboriginal and Torres Strait Islander people through investigating the use of Home Medicines Review'.

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