**Talk and Tucker**

**Judy Gower**

*Discovery Coast Community Health Service*

Discovery Coast Community Health Service (DCCHS) (funded by Department of Health and Ageing) is a stand-alone small rural health service who delivers services through a multidisciplinary team of allied health professionals. DCCHS is located some 260km round trip to the nearest regional centre.

Many clients attending this service seek intervention for a variety of problems including many mental health issues. In the Family Support role listening to individual narratives occur on a daily basis and out of this dialogue, common themes emerge. Interestingly enough, these can be in isolation, and are made up of lack of support networks such as friends and family, financial constraints, limited or no transport and unemployment. The similarities presented here appear consistent for those suffering a mental health problem within our community. Making links is said to be a core community work skill (Kelly and Sewell 1998), as is having core knowledge and skills to investigate and assess community needs which is vital in this situation (Cleak and Wilson 2007).

The implementation of the ‘Talk and Tucker’ program was developed to address social isolation by forming new friendships, redefining a sense of self and identity and, building confidence and self esteem. As humans we are not meant to survive in isolation, let alone thrive. Humans are highly social animals in need of meaningful relationships and strong support systems, these essential ingredients support our emotional well being. Another aim in designing the Talk and Tucker program was health education surrounding the concept of ‘health body healthy mind’. Research suggests there is a fundamental link between the health of one’s mind and body, those with a mental illness have a greater risk and vulnerability to developing a range of physical health problems. Research by the World Health Organisation (WHO) report estimated that mental health and drug and alcohol contribute 20% to the burden of disease in society (Murray and Lopez 1996). The core vulnerable group had indicated a lived mental health experience and demonstrated high levels of depression, stress and anxiety which were evident in the Depression, Anxiety and Stress Scale (DASS 21). All participants lived alone with no indication of any social media other than a mobile phone. Participants reported little or no ownership of a computer or having access to the internet which leaves people disadvantaged.

The Talk and Tucker program involved the participants in designing a healthy cost effective menu, with a focus on fresh produce which could be obtained locally. A group discussion was held regarding food handling and hygiene, participants prepared the ingredients, assisted with the cooking and dined together in a non judgmental and supportive environment. Talk and Tucker looked at the critical perspective focusing on social inclusion and the ability to develop a sense of future. Another aim of this program was to eliminate or reduce the impact of illness or disability and to encourage greater skills and resources to make better choices over the decisions they make in their lives (Bland, Renouf and Tullgren 2009).

The ability to access programs which may assist mental health is not financially viable for those community members due to our geographical location. Issakidis et al. (1999) argue that while there is evidence for the treatment of mental health disorders, there are a number who do not get adequate support and are ultimately socially disadvantaged; these findings supported the idea for this program. Self reported instances of mental health with comorbidities such as substance misuse, indicated depression as being secondary to this (Teesson and Proudfoot 2003). Mueser et al. (1998) argue that risk factors such as poor social skills; poor social functioning and peer group influences are indicators for support. Bland, Renouf and Tullgren (2009) suggests social justice as fair and open to those in need of services and not the portrayal of stereotypical stigma and dehumanising labelling of one’s character and personality status (Bakshi et al. 1999).
Brown’s (1992) analysis of groupwork supported a looser groupwork theory such as the participants meet as a group but the worker does not try in an organised way to achieve change, however, assuming pragmatically the individuals who share a similar experience and circumstance could help one another (Payne 2005; Sheafor & Horejsi 2000). No identified therapeutic interventions were delivered during these sessions with the exception of incidental therapy and mutual support that addressed social isolation. In terms of self help Payne (2005) asserts that mutual support groups do not promote therapeutic change. The dialogue and collaboration within this group reinforces the human need for relationships with others.

The implementation of this program would not have been viable for this organisation, if not successful in sourcing funding through Self Help Queensland Inc. namely, the ‘Mercury Rising Project’. This program supports self help initiatives that support those suffering a mental health problem. Ethics formed part of this decision making process, the Australian Association of Social Workers (AASW) Code of Ethics and Practice Standards were referred to and the core standards of respect for person, social justice and professional integrity were implemented from the programs conception. Having an understanding of different mental health illnesses and how they may impact an individual was vital.

Thought was given to moving participants from individual sessions to a group environment, this required insight, planning and goal setting. In terms of group dynamics, being aware of what influences were present in the room during program sessions and, being proactive in addressing those influences, were anticipated. In group situations, being aware and sensitive, to the notion of power and powerlessness which can immerge within the group is helpful. The complexities of individual personalities can and did impact the group dynamics during the initial phases; this awareness was vital and acted upon to the success of the program.

Effective communication was encouraged between participants, and a fortnightly general topic subject was set for each session to avoid discomfort and the deathly silence. Historical information about the individuals assisted and encouraged communication and active listening skills, this allowed for common themes to immerge. Conversation flowed throughout each stage of the program, with a lot of incidental teaching and new language emerging. Confidentiality was a necessary component identified during the rule making process, any information divulged throughout the program was to remain within the room. Living in a small community and knowing other’s private business can be problematic to participant, and steering conversation to avoid embarrassment and conflict was necessary. Workplace Health and Safety issues were discussed and agreed upon at the commencement of the program. Participant’s rights and any cultural differences were to be respected and any problems were openly discussed within the group and resolved.

Inviting participants to be involved in the rule setting process for the program empowered the group and made it easier to state the rule surrounding the sessions. Chenoweth and McAuliffe (2005) suggest that empowerment is a collaborative process between practitioners and their clients and argues that individuals are inherently capable and competent given the right opportunities and resources. Confidence, self-determination and resilience were evolving throughout the 8 month program. Participants were given a chance to select the menu on a rotational basis, this helped to meet objectives and achieve individual change through a shared and co-leadership approach (Brown et al. 1982).

Most participants did not have a vehicle so the need for transportation was an essential component of this program, therefore, professionalism was essential. The use of self in relationship building is a vehicle for change in assessing, engaging, encouraging and sustaining others in planned activities (Bland, Renouf and Tullgren 2009).
Evaluation

As part of program, participants were asked to complete an Outcome Rating Scale (ORS) this scale allowed them to rate their:

- individual—personal well-being
- interpersonal—close relationships
- social—work, friendships
- overall—general sense of well-being.

This gave a good indication of what changes were occurring, if any, and allowed concrete evidence for reporting purposes. Also as part of the evaluation process a weekly evaluation form was issued to gauge the outcome of the individual sessions for reflective purposes.

Questions raised were:

- Were the participant’s needs met?
- How do I know this?
- What process could be handled differently?

Pre and post program rating scale

<table>
<thead>
<tr>
<th>Evaluations from the initial intake of 17 participants the following was reported</th>
<th>0-10 scale: 0 being the worst and 10 being the best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individually—personal well-being</td>
<td>0-3</td>
</tr>
<tr>
<td>Interpersonally—family, close friends</td>
<td>0-2</td>
</tr>
<tr>
<td>Socially—work, friendships</td>
<td>0-3</td>
</tr>
<tr>
<td>Overall—general sense of well being</td>
<td>0-4</td>
</tr>
<tr>
<td>After the 6 month duration the participants reported</td>
<td>0-10 scale: 0 being the worst and 10 being the best</td>
</tr>
<tr>
<td>Individually</td>
<td>5-9</td>
</tr>
<tr>
<td>Interpersonally</td>
<td>4-7</td>
</tr>
<tr>
<td>Socially</td>
<td>6-9</td>
</tr>
<tr>
<td>Overall</td>
<td>6-9</td>
</tr>
</tbody>
</table>

The session evaluation reflected a rating between 0-10 overall with a result of 8.5% over the 6 month period.

Overall, the Talk and Tucker program was extremely successful, however, as relationships formed between the participants and myself the evaluation outcomes would be flawed as the participants may not have been entirely honest and open with their answers. ‘Accountability in human services involves being responsible not only for what is being done but also for improving the quality of what is being done’ (Brill and Levine, 2002 p. 252).

During the last session one of the participants had organised for the program to continue at his home monthly. The participants agreed that each would bring an ingredient to minimise the cost. Feedback received indicated that 7 out of the 17 participant turned up on the night and to date approximately half still keep in touch.

From its conception Talk and Tucker was carefully planned in terms of identifying the need, applying for the grant and coordinate each session for start to finish. Planning the menu, budgeting and shopping for ingredients was essential. Setting up the room with cooking equipment, utensil and
allocating jobs for the participants. Ensuring participant understood the rules, workplace health and safety procedures, hygiene, safe food handling, identifying nutritious ingredients, basic cooking skills.

Statistics were compiled which allowed for changes within the organisation to better suit service user’s needs. This has now been actioned though a reviewed model of organisational practices by initiating a holistic intake process which evaluates service user’s needs, and appropriate health professional appointments initiated. Allied health professionals can now provide an interdisciplinary team service model (Jessup 2007).

**Communication theory**

People are all exposed to different forms of communication throughout their lives. Communication is at the forefront of our existence and survival. Satir (1983) suggests that communication is the cornerstone of family life, however in some instance communication does not come easy, and one can be born a good or bad communicator. In this program the communication theory is relevant in terms of encouraging individuals to expose a little of their lives in a sharing caring environment.

**Strengths perspective**

The strengths perspective focuses on the client's ability to recognise their strengths and capabilities, it also allows individuals to articulate and work towards future hopes and goals, rather than focusing on past or present problems they are experiencing (Healy, 2005, p.152). During the program the participants were ask to nominate three positive things that happened during that day prior to going to bed, all reported positive feedback from that exercise (Seligman et al. 2005).

**Anti-oppressive theory**

Anti-oppressive theory deals with individual's private troubles and the social systems that cause these troubles through oppression (Chenoweth and McAuliffe 2005). The principles that underpin this theory are helping individuals take more control over their lives through empowerment and by supporting inherent worth through encouraging self-determination this can assists in combating oppression. This empowers individuals to achieve their goals however, always being mindful of not slipping into the doing cycle, rather than allowing them to do for themselves.

**References**


Bland R, Renouf, N & Tullgren, A 2009 *Social work practice in mental health an introduction*, Allen & Unwin, Crows Nest, NSW.


