Maintaining hope: the intrinsic role of professional support.

> The decision to locate in a rural practice setting occurs largely from outside that setting. The decision to remain takes place from within the practice setting and arises from the stream of experience there (Cutchin, 1997, p.1662).

Introduction

Mental Health professionals work in varied settings worldwide and this diversity increases the need for highly skilled, but adaptable professionals who can meet the needs of their clients while balancing the requirements of governments and professional bodies (Perkins, Larsen, Lyle, and Burns, 2007). In remote regions, providing quality health services is costly (Chisholm *et al*., 2011; Haswell *et al.,* 2013) and turnover of health professionals is high, adding pressure to a system already challenged by geographical adversity (Hunter *et al*., 2013; Weymouth *et al*., 2007; Garnett *et al*., 2008). Where there is high turnover, there are impacts on the continuity of healthcare for vulnerable populations with complex health needs (Hunter *et al*., 2013; Perkins *et al*., 2007).

Health outcomes are reported to be poorer the more remote the area (Health Workforce Australia, 2013; SCRGSP, 2011). In fact, it is reported that the further people live from major cities, the less healthy they are likely to be (Australian Institute of Health and Welfare, 2012) and poor health outcomes for Australia's Indigenous population are reported across a spectrum of indicators (SCRGSP, 2011). Improved access to appropriate services is essential for remote populations who often do not access traditional mental health services (Australian Health Ministers, 2009). Perkins *et al*., (2007 p.94) found that excessive turnover in rural areas impedes 'improvements in access, quality and continuity of service'. Access to reliable, consistent, appropriate health services is paramount in remote areas; where compared to urban areas there is often a broader spectrum of illness, fewer opportunities for referral and the geographical constraints of remoteness (Perkins et al., 2007; Muga 2015).

According to Gillespie and Redivo (2012b, p.21) the challenges associated with retention for 'mental health professionals show strong similarity to retention issues for healthcare

providers in general.' These challenges are multi-faceted; however, for health professionals working in rural and remote areas there are additional push-pull factors influencing retention (Gillespie and Redivo, 2012a; Onnis and Pryce, 2016). A review of the literature suggests that retention factors include lifestyle, previous rural/remote experience, local community connections, financial incentives, intrinsic rewards, supportive work environments, career opportunities, professional autonomy and family connections (Gillespie and Redivo, 2012a; Hegney, McCarthy, Rogers-Clark, and Gorman, 2002a; Onnis and Pryce, 2016). In contrast, the absence of many of these factors increases the likelihood of turnover, with health professionals reporting that professional and personal isolation, lack of career opportunities, inadequate management support, scarce resources and family connections as reason for leaving remote practice (Gillespie and Redivo, 2012b; Hegney, McCarthy, Rogers-Clark, and Gorman, 2002b; Onnis and Pryce, 2016). In reviewing the literature Onnis and Pryce (2016, p. 18) found that the reasons that influence whether health professionals stay or leave 'are not only diverse, they are inconsistent, that is, one health professional's reason for leaving may be another one's reason for staying.' This finding further emphasises the need for local managers to implement localised retention strategies (Perkins et al., 2007).

The increasing demand for child and youth mental health services 'has key implications for workforce planning, and improving outcomes for children and young people requires an adequately resourced, trained and motivated workforce' (Nixon, 2007, p.40). Workforce planning at the macro level involves government policy and strategy, analysis of trends and predictive modelling for future workforce needs (Nixon, 2007; Anderson and Nixon, 2007). Furthermore, it involves the translation of these findings into micro level plans and localised implementation by local health service managers to ensure regional suitability (Perkins et al., 2007). Anderson and Nixon (2007, p.50) emphasise the need for 'local knowledge and information as it relates to specific workforce groups and how these together will meet the needs of the local population.' Furthermore in locations where workforce challenges are significant and the demand high, mental health services must be embedded within national plans as well as be congruent with local mental health service capacity and cohesive with local health services (Anderson and Nixon, 2007; Nixon, 2007; Perkins et al., 2007).

This study examined the experiences of a child and youth mental health team working in a geographically remote region of Australia. Moore, Sutton and Maybery (2010) report that

few studies have investigated turnover and retention from the perspective of health managers or senior mental health practitioners/clinicians, citing only three previous studies. This study includes interviews with senior remote health professionals and endeavours to provide empirical evidence to somewhat address this gap in the literature.

Reporting on one component of the fourth phase of a larger study that facilitated service improvement through stakeholder and client feedback, the role of a supportive team is emphasised. Supportive management practices and supportive peer relationships are frequently cited as key factors in workforce retention (Fisher and Fraser, 2010; Onnis, 2015). The intrinsic role of support described by this team of remote mental health professionals is critical for many multi-discipline mental health teams irrespective of their geographical location. This child and youth mental health team understands that '[f]or Child and Adolescent mental health services to develop, it is vital to recruit and retain good quality staff and services need to be seen as an attractive place to work' (Nixon, 2007, p.42). This child and youth mental health team seeks to maintain service relevance through continuous improvement. This article considers the key factors that support workforce stability for remote health services, and focuses on the experience of one child and youth mental health team. This team travels to regional centres and remote Indigenous communities providing outreach services to young people and their families living in this region.

The child and youth mental health team ('the CYMH team')

In 2001, the establishment of a dedicated remote child and youth mental health service was identified as a key priority to address the unique needs of remote services for young people. The need for a comprehensive service model to include early intervention and community capacity strengthening activities, in addition to quality clinical interventions, emerged as critical themes during the team's establishment phase (Santhanam and McEwan, 2007). During the next phases a best practice service model was developed and subsequently implemented (Santhanam and McEwan, 2007). Successful mental health services have 'the ability to bring about and sustain new models of service and to improve the overall mental health of children and young people' (Nixon, 2007, p.46). They are a multi-disciplinary team of health professionals (psychologists, social workers, mental health nurses, occupational therapists and Indigenous Health Workers) with a specialist child and adolescent psychiatrist as the clinical leader. As McAllister (2011, p.117) reports it is 'common place for mental

health services to operate using multidisciplinary teams (MDTs) where several health professionals simultaneously maintain their disciplinary distinctiveness and assume complementary professional roles. This requires awareness of other team members' disciplines and good team-work skills. For this team, the multi-disciplinary team is considered an aspect of the supportive approach.

Team members were invited to reflect on their role, the way they work in remote settings and how the team's approach supports them personally and professionally. Contrasting the research that describes why health professionals leave rural and remote practice (Chisholm *et al.,* 2011; Hegney *et al*., 2002; Humphreys *et al.,* 2002), we seek to describe the supportive aspects of a team approach for those who remain in remote practice, those with experience working as mental health professionals in remote regions. While we acknowledge that these findings are not generalisable, we propose that the experience of this team and the subsequent supportive factors are not unique. Consequently, these supportive aspects would be transferable to other multi-disciplinary team settings.

Methods

Since its inception, a continuous improvement, participatory research approach has been applied to facilitate ongoing evaluation of the CYMH team's development (Santhanam, 2005; Santhanam *et al*., 2009; Santhanam *et al.,* 2006; Santhanam and McEwan, 2007). This article is written during the fourth phase of evaluation.

This article examines the reflections of team members on their role, and job characteristics through informal interviews. Semi-structured interviews (n=9) of approximately one hour each were conducted by one of two members of the research team who were known to participants but not part of the clinical team. The CYMH team members were offered the opportunity to review the interview transcript and could clarify viewpoints or add further information. Participation was voluntary. The interview transcripts were reviewed by two of the three members of the research team and thematic data analysis was undertaken using NVIVO 9 to identify extant themes.

Ethics approval was obtained from the Cairns and Hinterland Health Service District Human Research Ethics Committee (HREC/11/QCH/71#744).

Findings

The interviews included questions of both a clinical and non-clinical nature. This article examines their responses to the three non-clinical questions that sought to understand the nature of the CYMH team's work in terms of: 1) a typical day; 2) their role characteristics including the similarity of their role to the role described in their formal job description; and 3) their response to five emotive descriptors.

Context: A typical day in a remote community

> Well it varies from day to day ... you just don't know what's going to happen from day to day. (Indigenous Mental Health Worker (IMHW))

When describing their role, team members explained that it was difficult to say exactly what the role is as each clinician works in their own way and every remote community is different. Despite these claims, the description of a typical day was strikingly similar.

> Get up early, go straight to the clinic, sit in on the clinic meeting they have every morning at 8:00 ... go out and start seeing some clients ... or we will go straight to the school ... we will go out and see a few parents at their homes ... go to the clinic ... do some paperwork ... and then [in the] afternoon we would go out again. (IMHW)

> I'm usually up at 6 ... I will check my emails ... go to the hospital around 8:00 ... then usually head to either the school ... or do an assessment, then I've got to go back into the hospital to write that up. (Senior Mental Health Practitioner (SMHP))

> [W]ake up ... go to the handover at the clinic and then ... go down to the school ... try to catch up with families ... You might have some appointments within that time, do a walk around and go and try to see them again. (Mental Health Practitioner (MHP))

> Health Centre meeting, 8:00 every morning is the handover and update meeting ... then we go do paperwork ... client work or group work ... Then one-on-one client work whether it be at the school or at home ... or they come to the clinic. (IMHW)

They usually commenced their day by connecting with others at the primary healthcare centre's morning handover meeting. From that meeting they described the day in various ways and had different approaches; however, the common activities were: engaging with the community and other service providers; supporting clients and colleagues; and navigating health management systems.

One team member explained that it is difficult to set a time for each activity and that time in a remote setting is often consumed trying to locate clients. This contrasts with mainstream mental health services where clients arrive at a set appointment time and location. One clinician said that sometimes 'you get to community and from the time you hit the ground nothing works', which is where the different approaches and level of engagement of team members with their clients and the community has an impact. The team often described the need to be flexible and adaptable, saying 'It's a way of engaging with a child to start with ... and then you can change it, it's about being creative and flexible with it all'. Furthermore they suggested that team members working together with congruent styles of clinical practice may find the challenges of working in remote communities less daunting. Some team members ended the day with a quiet reflection, which they described as beneficial to both their personal wellbeing and their professional practice.

Role characteristics

Team members were asked to describe their role, not as it is written in their job description, rather, in terms of what they understand to be their role. They referred to their role in terms of their clients (e.g. 'a wide variety of things ... case management of clients ... therapeutic care of some clients ... crisis managements working alongside the psychiatrist in medication reviews (MHP)); the remote community (e.g. I have seen my role as advocating and I guess as a link to the community as well because I am Aboriginal (IMHW)); and their collaboration with other service providers (e.g. service provider catch-ups ... the wellbeing centre ... police station ... the justice group ... just touch base and let them know we are in town ... they let us know what's happening' (MHP)). There were some differences between clinicians and

IMHWs. For the IMHW the focus is on community engagement and for the clinician it is clinical and therapeutic support. However, both highlighted the importance of engagement and flexibility in working partnerships, themes that were repeated throughout the interviews.

Obligations for their role included clinical responsibility, administrative tasks, collaborating with other service providers and providing support to other services, particularly for staff living in the remote community or regional centre.

> ...you are not just going out to the community dealing with your job, you end up supporting some of the nurses and the clinic staff ... they can then support the children and the families within the community better than if they are feeling burnt out and stressed. (MHP)

In summary, team members described their role as varied, diverse, involving varying proportions of clinical, therapeutic and engagement activities and benefiting from a flexible supportive approach.

Role Experience (using emotive descriptors)

Finally, each respondent was provided with five emotive descriptors to each of which they were asked to respond by reflecting on their role and day-to-day activities (Table 1).

[Table 1 approximately here]

The emotive descriptors focused the participant's thoughts, clarifying their responses about their role. In contrast to the previous questions this one elicited some negative comments, for example frustration and disappointment with the system in which they worked. However, they continued to remain client focused and generally positive.

In summary, the CYMH team described aspects of their role, the team approach and the environment in which they work that contribute to job satisfaction, retention and minimised turnover for their particular team. They provide child and youth mental health services in remote areas where the challenges are immense, yet the according to them, are outweighed by the sense of purpose they experience. This CYMH team suggested that a supportive team

approach, connections with local community, and peer support (within the CYMH team or through collaborations with other service providers) have contributed to the stability this CYMH team has experienced.

Discussion

The circumstances surrounding the development and implementation of the team, a series of phases each followed by evaluation and publication (Santhanam, 2005; Santhanam *et al*., 2006; Santhanam and McEwan, 2007; Santhanam *et al*., 2009; Hunter *et al.*, 2013), provide longitudinal commentary on the team's evolution including aspects that provided the strong foundation. Santhanam *et al.,* (2009) in discussing the outcomes of the third phase of evaluation included the dimensions of practice: engagement and therapeutic care alongside clinical care. In describing this modification the authors explain that 'the need for a culturally oriented and contextually sensitive, yet comprehensive, service model' (Santhanam *et al.,* 2009, p.10) includes community engagement, and the fostering of relationships with community members and other service providers working in remote regions. It may be this philosophy and its widespread implementation that contribute to the connection that the team experience and the way that they describe their role. The environmental impact on turnover is significant and this team's approach is consistent with the literature that found that a connection to the remote region and a supportive work environment influenced retention (Gillespie and Redivo, 2012a; Devine, 2006; Hegney *et al*., 2002).

Developing a supportive culture

Many aspects of individual health are related to wealth; current evidence indicates that with increasing social disadvantage come poorer health outcomes (Australian Institute of Health and Welfare, 2012). The team work with clients who experience social and Indigenous disadvantage, and it is their persistence to provide professional mental health services even when the impact of the social determinants of health would appear to minimise the likelihood of making a 'real difference' for their young clients and their families that should be admired. Team members showed awareness of the financial, political, environmental and social constraints, within which they work, yet continued to provide narrative around the ways that they support their clients, the remote community, other remote workers and each other, both personally and professionally.

Senior clinicians suggest that it is the formation of critical mass and a 'lower-frequency model of outreach visits' (Haswell *et al.,* 2013, p.149) that provided support and enabled them to continue to operate for almost ten years with reasonable stability and low turnover (Hunter *et al.,* 2013; Haswell *et al*., 2013). Basing the team in a regional city, and delivering a dedicated outreach service contrasted other approaches where the workforce was relocated to the very remote community or provided outreach from already established remote services. The team approach minimised the impact of challenges often faced by health professionals based in remote regions who experience heightened feelings of personal and professional isolation and reduced access to support networks (Greenwood and Cheers, 2002; Lenthall *et al*., 2011). The CYMH team approach championed peer support which was integral to the team's model of service. 'There is no universally accepted definition of peer support but the term generally refers to mutual support provided by people with similar life experiences as they move through different situations' (Repper and Carter, 2010 in Lawton-Smith, 2013, p.152). Furthermore, the 'published literature demonstrates that, in its various forms, peer support has widespread benefits for both people experiencing mental health problems and peer support workers themselves' (Lawton-Smith, 2013, p.157). For this team, who worked in isolated areas, team (peer) support and the peer support they were able to offer their remote-based colleagues strengthened their engagement capacity and further supported their capacity to competently provide mental health services while simultaneously maintaining the wellbeing of the clinicians and health workers themselves.

Santhanam and McEwan (2007) discussed the alignment of the team's model to the Key Performance Indicators for the Australian Public Mental Health Service. This included criteria such as expedient recruitment of vacant positions, professional development, performance management, reducing voluntary turnover and providing adequate resources. These workforce management responsibilities can be challenging for child and youth mental health services in general, and far more challenging for those working in remote regions given reported high turnover and poor resourcing (Hunter *et al*., 2013; Garnett *et al*., 2008; Devine 2006). The integration of these criteria into the team's model further enhanced the supportive aspects of the team approach and improved workforce stability.

Job satisfaction

In the second phase of evaluation, the team members reported positive aspects of their role, such as rapport with the community; management and peer support; professional development; and family matters that contributed to their job satisfaction (Santhanam and McEwan, 2007). Similarly, in the fourth phase, these factors were linked to job satisfaction. In the second phase, the issues that detracted included personal reasons, being away from family, travel fatigue, lack of support on the ground and voicing opinions but not seeing change. These issues are all consistent with those reported through other studies (Onnis and Pryce, 2016; Greenwood and Cheers, 2002; Lenthall *et al*., 2011; Hegney *et al.,* 2002; Kruger and Tennant, 2005). However, their impact is not consistent with this team reporting low turnover (Hunter *et al*., 2013; Haswell *et al*., 2013).

While staff turnover is frequent in remote areas, high job satisfaction is also reported (Wakerman *et al*., 2012). Herzberg's motivation-hygiene theory (Herzberg, 1966) may offer insight into this phenomenon. Herzberg's motivation-hygiene theory suggests that where intrinsic factors promote job satisfaction, it is only when extrinsic factors prevent dissatisfaction that the individual will be sufficiently motivated, in this case, to remain with the mental health service (Campbell *et al*., 2012; Nadkarni and Stening, 1989). It may be that the intrinsic incentives motivate the team members sufficiently to provide job satisfaction and that the extrinsic factors minimise dissatisfaction to the level that they remain with the team for lengths of time beyond those experienced by other Australian remote health services (Haswell *et al*., 2013; Garnett *et al*., 2008; Weymouth *et al*., 2007). Intrinsic motivation is defined as 'doing of an activity for its inherent satisfactions' (Ryan and Deci, 2000, p.56), in other words, the reward is in the activity itself (Baard *et al*., 2004; Gagné and Deci, 2005; Ryan and Deci, 2000). This is consistent with the responses from the team members who described 'satisfying' in terms of intrinsic rewards and success in terms of positive outcomes for their clients. This inherent satisfaction that arises from undertaking meaningful work may be influencing job satisfaction (Giancola, 2011). In all likelihood, the inherent satisfaction together with the aspects of support are reducing voluntary turnover for this multi-disciplinary CYMH team.

Experience

Cutchin (1997) suggests that the decisions about continuing employment are made from within the work setting. Therefore, when the objective is to improve retention, empirical

evidence can inform mental health service providers about aspects of remote practice that influence retention. From within the practice setting, members of the CYMH team describe their role and their experience working as a mental health practitioner in a remote area. They describe aspects of their work that are rewarding and others that are not as rewarding.

Gillespie and Redivo (2012a) found that retention was improved when mental health professionals had prior experience and/or exposure to rural and remote areas. Therefore, the benefits of supportive and positive remote work experience have implications beyond the current employment relationship in terms of retention. There is substantial evidence that previous similar work experience and/or a rural background increases the likelihood of success in improving retention in remote workplaces (Gillespie and Redivo, 2012a; Onnis and Pryce, 2016). For remote service managers, this CYMH team's experience highlights the benefits that local management practices have on workforce stability and ultimately, access to services for remote populations (Perkins *et al*., 2007).

Recommendations

The CYMH team members describe the positive impact of the supportive team environment on the stability of the team. Further research is warranted to ascertain whether the findings of the paper are common to child and youth mental health services or whether they are more relevant to child and youth mental health teams located in geographically remote areas.

In addition, research into the supportive aspects of the team approach from the perspective of the health service manager would provide further evidence in an area where a dearth of information is reported (Moore *et al*., 2010).

Conclusion

Support for existing experienced mental health professionals will contribute to workforce stability in remote regions where needs are complex and continuity of care for mental health clients is improved when a consistent, reliable service is available. Attraction and retention of competent mental health professionals practising in remote Australia is challenging and mental health, like other remote health services, experience high turnover. The extant themes identified as supportive aspects of the team approach included engagement and both personal and professional support. The intrinsic role of flexibility and support in remote work

environments, and the impact of intrinsic job satisfaction through client-focused practices further supported low turnover and improved stability and consistency of service provision.

If decisions to remain in remote practice come from the experience of those already there (Cutchin, 1997), it follows that where health professionals working in remote Australia report high levels of job satisfaction; the next steps involve minimising dissatisfaction through effective workforce support mechanisms such as this CYMH team's approach. The CYMH team, health professionals already working in remote regions, suggest that this is about engagement with the community and remote-based health professionals; personal and professional peer support; and flexible work systems appropriate for the remote setting.

At the end of the day, it's about systems and people supporting each other. One team member (IMHW) reminds us that 'even in the harshness of reality, it's imperative to maintain hope.'

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Table 1: Emotive descriptors used to reflect on CYMH team roles.

Satisfying	Some participants questioned what satisfying meant saying, 'What might be satisfying for me might not be satisfying for you' (SMHP) or provided a balanced response saying 'At times it is very satisfying, other times it is not' (MHP). In contrast one provided a direct response saying 'Yes, the job is very satisfying' (MHP). Most team members described personal satisfaction in terms of intrinsic rewards. For example, 'I love working with Aboriginal and Torres Strait Islander people it fulfils my sense of purpose,' (IMHW) and I have 'a lot of autonomy in [my] role and a lot of trust.' (MHP)
Successful	Many team members tried to define success and how to measure it before relating it to their role, saying 'successful according to whatever definition people put on that is another question' (SMHP) In addition, most team members thought about what success would look like for their clients with personal success rarely mentioned. They said ' I'd say the majority of the time we are successful in our work' (MHP); 'I was getting more self referrals ... people within the community want to come to you for support' (MHP) and 'success is when they no longer need you anymore' (MHP)
Disappointing	Responses ranged from disappointment with service provision, saying 'parents expecting a certain amount from us, expecting certain things and you know we can't deliver and they are disappointed' (SMHP); policy and processes, saying 'the disappointing thing is the recruitment of people and there's not enough thought ... people can sound good on paper' (MHP); and lack of cohesion when working with other service providers, saying 'I am often disappointed with other services and their lack of cohesion'). Some also discussed disappointment with systemic barriers such as promotion opportunities, saying, 'not being able to have a career path here' (IMHW) and organisational systems, saying 'I have felt a sense of sadness about the encroachment of mainstream CYMHS ... their practices influence our practice in remote areas ... led by systems rather than by understanding the need to be creative in where we work' (SMHP)
Frustrating	Responses included frustration with environmental challenges, saying 'it takes

	so long to do our work' (MHP), limited resources, saying 'some of the frustrating things are the environment if it's really, really hot and you don't have a car' (SMHW) and systems, saying '5 days a fortnight ... we are just entering data into the system so there must be another way' (SMHP); and 'if they'd be in mainstream you'd be able to put all this support around them' (MHP).
Exciting	Most team members conceded that travel, meeting new people and seeing new places was exciting; however, after a few years 'the excitement of the travelling away is long gone'(MHP). Other aspects included new experiences, opportunities, saying 'seeing people who are blossoming' (MHP); and 'My role is exciting. I'm constantly being exposed to experiences I didn't expect' (MHP) and others were realistic in their responses, saying, 'Look work can't always be exciting it's going to be as boring as cardboard at some stage' (SMP).