The flying psychologist

Robert Williams describes how his career literally took off in Australia

Robert Williams, a UK-trained clinical psychologist, reflects on nearly 20 years of mental health service delivery with the Royal Flying Doctor Service of Australia

I trained as a clinical psychologist in London, completing my training in 1985. I was fortunate to participate in an in-service training scheme with plenty of practical experience. This was to serve me well in taking on psychology roles in isolated locations. Similarly my training was eclectic in nature, and this provided me with a diverse set of psychology tools to draw on when working with a wide range of people, age groups and presenting problems.

I had emigrated previously to Australia as a teenager in 1969 but returned to attend university in the UK and, as it turned out, to spend 12 years in London, nine of which were taken up with preparing for and completing clinical psychology training. Family connections, a warmer climate and a desire to seek out new challenges in psychology led me to apply to emigrate a second time to Australia.

At my leaving party in 1986, a psychology colleague gave a farewell speech and remarked that I was heading off to Australia to become a flying psychologist! It was meant as a joke but a seed was sown, an ambition formed.

Rural and remote

When contacting the Victorian state psychology representatives, prior to emigrating, I received a less than encouraging response. Put in a straightforward Aussie manner, the suggestion was that I shouldn't bother to come to Australia due to an oversupply of psychologists – at least in Melbourne.

However, for the overriding reasons I've mentioned, I was going anyway. I arrived in June 1986 and enjoyed the reunion with my family – parents and three siblings and their new families – catching up on 12 years away from home.

I took the opportunity to travel around Australia, and this journey led me up through the centre of the continent (Adelaide to Darwin via Alice Springs) and then around the Western Australian coast to Perth, back across the Nullarbor to Adelaide and eventually returning to Melbourne. This trip opened my eyes to the wonderful Australian outback and the potential for life and work outside the major metropolitan centres along the eastern seaboard.

When I returned I recontacted the Victorian psychology people, letting them know that I was now here and could we meet up. To my surprise a voice at the end of the line said – 'thank goodness you are here – there is a vacant job up in Beechworth which we haven't been able to fill for 15 months!'

Beechworth is about three hours' drive north of Melbourne and is an old gold mining town steeped in history – part of Ned Kelly country. I worked as the only psychologist in Beechworth and the surrounding region for three years. The work was challenging and rewarding and gave me a taste of the benefits of working in more rural areas of Australia.

Following a 12-month stint in Melbourne I applied for a senior psychology position in Alice Springs, starting there in 1993. This job extended my growing specialisation in rural and remote psychology, exposed me to working with Aboriginal clients and the huge challenges that this work entails. I also flew to a fortnightly outreach clinic in Tennant Creek, a remote township 500km north along the 'Track'. This was my first taste of flying in a light aircraft.

Then an advertised job caught my eye – 'Seeking a clinical psychologist to conduct a 12 month study to assess the feasibility of providing mental health services in conjunction with the Royal Flying Doctor Service'. Location: Cairns, in far north Queensland.

Introduction to the RFDS

The Royal Flying Doctor Service (RFDS) has been in operation since 1927,

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For other Society careers resources, see www.bps.org.uk/careers.

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providing emergency and primary health care services across Australia. Today it operates over 60 aircraft from 23 bases and employs more than 1000 staff to deliver a wide range of health services.

The RFDS is a federated organisation composed of a small coordinating National Office in Sydney and five operating divisions providing health services via small aircraft – Queensland Section, South Eastern Section, Victorian Section, Central Operations and Western Operations. A small Tasmanian Section serves a primarily fundraising role.

In the early 1990s the RFDS commissioned an extensive review of its operations nationally, and the resulting report 'The Best for the Bush' heralded a new era for the service with recommendations that it continue its well-known emergency role but expand its range of primary health care services to include mental health, health promotion and the employment of Aboriginal and Torres Strait Islander health staff.

In 1995 the Australian Commonwealth government funded a number of 'projects of national significance', and one of these involved assessing the feasibility of providing mental health services in conjunction with the RFDS. I conducted this 12-month project, which involved assessing the need for mental health services in the remote communities served by the Cairns RFDS base.

The project was commissioned because of rising concerns about the mental health effects of a continuing severe drought, with a consequent alarming increase in rural suicides. There were also high levels of trauma in Aboriginal communities, often fuelled by high levels of alcohol abuse and extreme social disadvantage.

The vast area served by Cairns RFDS base includes remote communities stretching up into Cape York Peninsula, those dotted west of the Atherton Tablelands towards the Gulf of Carpentaria and remote properties and mine sites south of the main highway between Townsville and Mount Isa. The types of remote locations vary in the Australian outback, including pastoral stations/properties, rural support towns, Aboriginal and Torres Strait Islander communities, mining towns, tourist resorts and national parks. The size of the communities also varies, ranging from a few dozen to around 1000. The RFDS provides regular and emergency services to all of these, with visit frequency being determined by population size and degree of health problems.

The feasibility study, as well as assessing mental health service needs, was to consider mental health training needs of RFDS and remote area generalist health staff, and support needs of health staff exposed to trauma, as well as taking advantage of my clinical training to provide professional supervision to Cairns psychologists.

The report was titled 'Breaking the Mind Barrier', and it found that the provision of mental health services was feasible provided alongside the regular RFDS primary health care GP and nursing services. A number of patients were seen during the feasibility study with commonly presenting mental health issues, such as depression, anxiety, drug and alcohol problems and relationship difficulties. Treatment could be provided on regular clinic visits to remote locations and, if infrequent, supplemented by telephone and (as the technology matured) videoconference sessions.

Staff training was conducted, which mainly focused on identification of mental health problems in the medical consultation, sometimes by simply asking the question 'How are things at home?', thereby allowing mention of current stressors and any impacts on mental wellbeing. Other practitioner skills included learning how to provide a rationale to patients for a CBT approach to depression to facilitate referral to a psychologist.

Staff who worked remotely, including RFDS staff, often encountered stressful situations, particularly related to traumatic events, and part of the project involved devising a critical incident stress debriefing programme geared to the RFDS context. The field has now changed, and a less direct interventionist approach would be taken.

The report recommended that the RFDS should employ a psychologist on a full-time basis to provide clinical, training and support services required in response to the demonstrated mental health needs.

RFDS psychology role

Following the feasibility study the RFDS Queensland Section sought to obtain funding to employ a psychologist, and I was keen to stay on with the service. I had found the work with RFDS to be stimulating and challenging as well as varied. It was a unique way to spend a working day, which required an early start around 7am, flying for a couple of hours by light aircraft to our first destination, catching up with the locals over a cup of tea and then seeing any patients who needed to be seen. Counselling was carried out in a room in the clinic, at a patient's home or sometimes side-by-side leaning over a fence. Presenting problems were extremely varied, ranging from a child with a behaviour problem to a request to make a differential diagnosis between dementia and depression in an elderly patient. Referrals were made by a remote area nurse if in existence or by the RFDS GP. Other members of the mental health team could join flights – we employed a social worker and occupational therapist. The area psychiatrist also accompanied RFDS flights on occasion.

What is perhaps surprising is that the RFDS hadn't employed mental health staff earlier. The Best for the Bush was one of the first reviews to extensively interview people who lived in remote areas, and it called for submissions from a wide range of external stakeholders. This in-depth community consultation perhaps raised mental health for the first time, and this was supported by external government reviews that highlighted the growing recognition of the need to address mental health issues and in particular to improve service access to rural and remote residents.

The result was that I became the first 'Flying Psychologist' to be employed by the RFDS, taking up the position in 1996.

Over a period of four years I provided clinical psychology services to remote communities served by the Cairns RFDS base. Initially this was primarily in the non-indigenous communities. There were common mental health problems such as depression, anxiety and drug and alcohol abuse; various stress-related issues; and some serious mental health conditions, where I either facilitated referral to a psychiatrist or provided support upon discharge from hospital.

Training of rural and remote area health professionals, including RFDS staff, got under way with the use of face-to-face teaching sessions and via videoconferencing, and culminated in the production of an interactive CD-ROM 'Psychological First Aid Kit'. This enabled staff to access training material outside the 'classroom', even working through the CD-ROM whilst in-flight. A critical incident stress debriefing programme was set up for RFDS exposed to traumatic incidents.

During this time applications were also made for further government funding to expand mental health programmes within the RFDS. From 2000 to 2007 expansion of RFDS mental health programmes occurred, as well as commencement of general health promotion sessions in remote

communities and the employment of Aboriginal and Torres Strait Islander staff. In relation to the latter it became clear early on that to maximise the effectiveness of psychology services to Indigenous patients it was of great benefit to employ and/or train Indigenous people in mental health skills. This initiative was very successful, providing cultural awareness training for RFDS staff and facilitating acceptance of the services in Aboriginal communities. Stigma was further tackled through the use of indirect activities; for example, a fishing competition for men and boys in an Aboriginal community, and holding a men's health night at the local pub. These activities introduced mental health in a less threatening way and facilitated referrals.

Commonwealth and state funding enabled the expansion of mental health services in Cairns as well as in other RFDS Queensland bases (e.g. Mt Isa). The mental health staff in RFDS Queensland went from one to 20-plus staff over this period. This enabled a more focused and regular service to a particular set of communities as well as some degree of specialisation (e.g. the appointment of staff focusing on child and adolescent mental health issues). I moved into a team management role, appointing and supervising staff and conducted some additional projects, such as the production of a second interactive CD-ROM, this one aimed at increasing mental health literacy in the general population.

My position title became Manager of Allied Health Services and included mental health, health promotion and Aboriginal and Torres Strait Islander health. I relocated to Brisbane, where the head office of the RFDS Queensland section resides.

A mission to educate

Ian Florance talks to clinical psychologist **Jane McCartney** about her book, her background and her media work

Jane McCartney has just written her first book *Stop Overeating: The 28-Day Plan to End Emotional Eating for Good*. Look her up in Google and you'll find an impressive list of academic achievements (on her Dr Jane website) as well as a variety of other mentions: articles about her book in the *Telegraph*, *Independent* and *Mail*; quotations on issues as varied as weight loss, romance and cleaning; her own pieces for magazines and newspapers. She is a Chartered Psychologist, has worked for the NHS for 11 years and in her own private practice for nine. Given this huge amount of activity, it's not surprising that we had difficulty setting up a phone interview.

We started with her book. Why had she written about that topic in particular?

'A lot of people present with problems associated with overeating. Around a quarter of the UK population are obese and there's a lot written about eating problems, but very little of that is written from a true psychological perspective. Put that together with the fact that I'm a former overeater myself and I felt I was in a good position to write something that genuinely helped, combining knowledge and experience. It's not a trivial problem either for the overeaters and their families or for the country, given the costs involved in, say, treating related conditions like diabetes.'

Jane's school achievements didn't bode well for a career. 'I left with a sorry set of qualifications. I ended up living on my own at 16 and had to work to keep the wolf from the door. But I suppose two things spurred me on. First, I'd always been good at working people out. I did every sort of job from tending bars and working as a croupier and you see all human life. At one stage I worked as a page planner and reporter for a local paper: when asked exactly why I was doing the job I answered "to see what makes people tick". Anyone who is training as a psychologist or is thinking of studying it will benefit from any job they take. Second, one of my flatmates was on a placement in a college in Essex. That influenced me. The start of my qualification journey was an A-level at night school.'

To cut a long story short, Jane took a degree in psychology at the University of Kent before taking PG Dips, an MA and a PG/Dip at London Guildhall and Metropolitan Universities. She was awarded her Doctorate in Clinical Sciences by the University of Kent in 2010.

As is often the case in these interviews, Jane's story is as much about personal experience as it is about intellectual achievement. 'When I did my degree in applied psychology the two topics that grabbed my attention were Jung and behaviourism. And, despite my less than stellar school career, I'm very determined. Once I start something I finish it, and that took me through the 16-year journey between starting a BA and achieving a doctorate.'

Jane is enthusiastic about her doctorate in clinical science. 'Clinical science courses tend to be less restricted than psychology ones. I worked on aspects of postnatal and post-traumatic conditions and had a marvellous supervisor, Dr Georgia Lepper.'

On a journey to work it out

Jane started working in the NHS in 2003 and still has a role there. 'My first NHS position after qualifying was in an adolescent unit, which was very trying as I have children. In that situation it's very difficult for any worker to keep the correct emotional distance. In my NHS work I describe myself as a general psychologist, not a syndrome, population or approach-specific practitioner. I address what presents, and get clients to think about the syndromes.' She has one very specific wish for the service. 'Many GPs are very psychologically minded and do very good work. But some aren't and therefore don't. They fill in their checklists, apply a label, prescribe a drug and recommend just CBT-based services. There's an element of clock watching to get on to the next patient. All of these things – pharmaceutical treatment, CBT, identification of specific syndromes – have their critical place but a more psychological approach to this would help. When clients say "I've never thought of it like that before" it means they're on a journey to working out what's going on. It's

In 2007 I applied for the post of National Health Programme Manager at RFDS National Office in Sydney, relocating to a not so rural and remote office near Circular Quay! Soon after arriving I was successful in applying for further Commonwealth funding to commence mental health services to remote communities around Broken Hill and southeast of Alice Springs. As well as contract management for these new mental health services my National Office role broadened to include coordinating the health component of the federally funded Traditional Services contract (emergency, GP clinics, medical chests and telehealth consultations) and Rural Women's GP Service.

The future

I finished up with the RFDS in August 2013 after an 18-year association with the service in various roles. Mental health services are now an integral part of the health service mix in Queensland Section, South Eastern Section and Central Operations. Victorian Section and Western Operations are looking at developing services. Longreach base, established solely to provide mental health services, is still operational after 10 years, and services are well established in Cairns, Mt Isa, Broken Hill and Alice Springs. It is expected that the flying mental health workers will continue to be a part of RFDS well into the future.

Robert has now returned to the UK and is a Registered Clinical Psychologist based in London. robwilliams21@hotmail.com

my favourite quotation.'

Jane started her private practice in 2005 and, not being one to rest on her laurels, started media work. 'As I mentioned I'd worked on a local paper. I'd also been a researcher for a TV company. So, when I saw a piece in *The Psychologist* about a BPS media panel. I am now on the permanent list of commentators for certain programmes and I've appeared on *This Morning*, *Sky News* and BBC World TV as well as being interviewed in a lot of national papers.' Many professionals are suspicious or critical of such activities. 'You have to stay within your boundaries even if there's pressure to comment on areas outside them. I've refused to comment on certain issues on air for that very reason. We also need to educate programme editors to stop using people who aren't qualified. They muddy the water and, at their worst, give a totally erroneous view of what psychological science says and psychological practice does. That's why psychologists should get involved in public discussions, with other areas of activity and, of course, writing.' So, another book is on the cards? 'Maybe next year. At the moment we're developing a website linked to the overeating book.' It's at www.stopovereating.co.uk.

There's obviously a link between Jane's desire to educate other health workers in psychology, her approach to client work (in which she helps clients to think about their issues) and her aims in writing books and appearing on the media. She is a psychological educator trying to improve general psychological literacy and input psychological understanding into adjacent practices.

It sounds like a busy job, so I was glad we found time to talk.