REGIONAL VICTORIA MENTAL HEALTH INITIATIVE

Concept Paper: Supporting the Mental Health of People in Rural and Remote Communities

February 2018

This proposal is for a conduit… a person who can come to the farm and share a cup of tea when times get tough … who knows and appreciates the challenges and rewards of rural life… and whose presence is valued and respected by those we trust. Someone who listens and hears what you've got to say… Someone who can support and guide people to the help they need.

Background

The Wimmera and Southern Mallee region in northwest Victoria is characterised by many small communities over large distances. The region covers some 28,000 square kilometers and services a population of 38,400. It includes the local government areas of West Wimmera, Yarriambiack, Hindmarsh and Horsham Rural City.

Mental health, specifically the capacity to respond to those who are in psychological distress and/or the emerging signs of mental-ill health is a significant area of concern by councils across the Wimmera and Southern Mallee. At a regional forum in 2015, concerns were voiced about the impact of factors upon the provision and delivery of mental health services including changes in funding, scope of service provision, the layering of philanthropic, state and commonwealth programs; coupled with the impacts of climatic conditions, political change and economic constraints.

There are many challenges associated with supporting the socio-emotional health and wellbeing of rural and remote communities including social isolation, the navigation of the mental health system, transport and access to support.

Work completed by Wimmera Primary Care Partnerships (PCP) in 2016 [i] show that the main services and support available for people experiencing psychological distress and/or the emerging signs of mental illness are primarily health services including urgent care centres, social workers, bush nursing centres and General Practitioners (GPs). These services are responsible for the delivery of primary healthcare and in the case of bush nursing centres; work closely with the community to promote social connections in a rural environment.

These services have a limited capacity to respond to people who are experiencing a crisis and may be at risk of self-harm or suicide. Anecdotal evidence indicates that although staff members at these services respond the best they can, the limited capacity for a 'resourceful response' in the region is a continuing source of frustration.

The exception was the Rural and Remote Engagement (RARE) program, a rural outreach program that operated across the Hindmarsh and West Wimmera shires. The program was developed in 2010 to assist people in rural and remote areas who needed support that may not otherwise seek it. The worker spent time in small communities with a focus on developing connections with locals. When a person was struggling with the challenges of everyday life they could call in on the worker to chat about what was happening for them. As issues were identified the worker could support the person to access the services they needed.

In the six years it operated, the program developed a strong profile in communities across the service area. Importantly, the Rural Outreach Worker worked closely with staff of local councils and health services which enabled more formal supports to be arranged. The program was discontinued in December 2016 and its absence continues to be noted by service providers, local government and community members in 2018.

Drawing on the success of the RARE program and current best practice in system design and service delivery, this paper proposes a community-based role for a **Rural Outreach Worker** that has the capacity to respond to the immediate needs of people living in rural communities who are struggling to deal with tough times and support them to get the help they need.

In the more formal language of health and social support systems, the role of the Rural Outreach Worker has been developed to increase the capacity of services working with rural communities to respond to individuals who are in psychological distress and may be showing early signs of mental ill-health. It is designed to respond to the person's need for immediate support and assist them to navigate and access services they need in a timely manner and before a crisis may develop.

Key issues

Mental health is an important issue in rural and remote communities. Recent data shows that although mental health issues occur at the same rate across Australia, the rate of suicide is much higher in rural and remote communities. In Victoria the suicide rate in regional and rural areas is **47% higher** than in Melbourne. [ii]

Drawing on the experience of service providers and communities in the West Wimmera Shire in northwest Victoria and the work done by Wimmera PCP across the Wimmera and Southern Mallee region, the following issues have been identified.

Seeking help

A common preconception is that people in rural and remote communities, specifically men, are reluctant to seek help when experiencing psychological distress, sometimes to the point of contemplating suicide. This has been discounted by research that indicates that rural men are not less likely to communicate their intent than men who live in major towns.[iii]

The research found that rural men are more likely to tell someone '*I need help'* rather than '*I need a service to help me*'.[iv]

This resonates strongly with anecdotal evidence from across the Wimmera and Southern Mallee. Service providers reported that the rural outreach worker had developed a strong profile and was known as someone whom people could… and did talk to.

> ***The rural outreach worker was someone who was approachable in the community… people could contact or could just approach them at an event and talk about how they were feeling.***
>
> - **Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre**

Another provider suggested that there is a concern within the community about being judged by others for going to a mental health professional which the rural access worker had overcome.

> ***There's a culture around being seen to be seeing a social worker or mental health worker… people are reluctant to access that type of service. People weren't reluctant to talk to [the* rural outreach *worker] because you could've been talking about footy or you could have been talking about having a hit of golf on the weekend***
>
> - **Andrew Saunders, Acting CEO, Edenhope and District Memorial Hospital**

What is apparent is that the informal and non-clinical nature of the former outreach program was the preferred type of support sought after by community members.

This is not an isolated example; there is evidence that a large proportion of people who die from suicide have seen a GP or other health practitioner in the weeks before their death.[v] The reason why the person does not get the support they need at the time is beyond the scope of this paper, however as one registered nurse said *sometimes we just don't see it* (Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre).

Whether it is the stigma associated with approaching formal services or the accessibility of a trusted 'local' able to talk in the perceived safe environment of their own home or community setting, the positioning of a Rural Outreach Worker outside of the service system and within the community appears to be associated with the willingness of community members to seek help when times get tough. Further, anyone in the community with concerns for either a loved one or someone else in the community can 'self-refer' the person of concern for the Rural Outreach Worker to essentially conduct a welfare check and intervene before a crisis situation prevails.

Access to services

> ***The Rural Outreach Worker opened doors for people who needed a referral***
>
> - ***David Leahy, CEO, West Wimmera Shire***

The CRRMH position paper[vi] demonstrates that the impact of mental illness on the lives of rural Australians is greater than those who live in major cities. This is due in part to differences in access to and the uptake of effective treatments and services.

Both access to and the uptake of mental health services and support are issues across the West Wimmera Shire. The Harrow Bush Nursing Centre supports a community of up to 500 people in the area[vii] and relies on visiting services from larger centres for services including GPs, social work and psychology.

The resignation 3 months ago of a social worker, who also provided the funded psychology services has left a real *gap in the community*. Until a new social worker is recruited, or an alternative visiting service can be secured, people from the Harrow district are required to travel for psychological support.

> ***There's been a shortage of social work and psychology services in recent months and we haven't been able to fill those positions again. It means people need to look further afield for the help that they need. They have to drive at least an hour to get those services or they're not actually approaching services because it's all too hard.***
>
> - **Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre**

More recently, one of the three GP's who currently visit the centre has indicated that they will be leaving the area leaving a greater gap in services for what is anticipated to be an extended period.

Waiting times are also of significant concern for service providers in the West Wimmera Shire. A service capacity audit of mental health services across the Wimmera and Southern Mallee in June 2016 found that there was up to a 12-week wait for some counselling services and a 1-3 week wait for social work.[viii]

Commonwealth funded psychological therapy services require a GP referral and an appointment is expected to be made within 3 working days. However, a waiting period may be required for clinicians with a full caseload. In July 2017, the average time between the referral being accepted and the initial appointment was 13 working days (almost 3 weeks).[ix]

The concern in rural areas such as Harrow is that getting an appointment with the weekly GP service, the time taken to do a mental health plan and referral and additional waiting time for an appointment can significantly delay any help the person may need. The availability of a rural outreach worker can significantly shorten the length of time it takes to get assistance.

> ***The Rural Outreach Worker can ring them and say I'm coming out tomorrow for a cup of tea… just take that first step… then they will refer them onto the right service. The person feels like they've been heard when they've had the rural outreach worker straight away or within a short period of time and the interaction can take place in a safe and non-threatening environment.***
>
> - **Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre**

Local health services are conscious of the increased workload on other primary health workers when jobs are unfilled and positions are unfunded.

> ***It stretches the services provided by GP's, social workers and mental health clinicians… if stretched too far we won't be able to cope with the needs of the community***
>
> - ***Andrew Saunders, Acting CEO, Edenhope and District Memorial Hospital***

One of the measurable impacts of the loss of the rural outreach worker in December 2016 was the increase in demand on primary health services in the West Wimmera Shire.

Staff at the Edenhope Medical Clinic have reported that in the eight months following the cessation of the rural outreach program there were 36 presentations for urgent assistance associated with psychological distress and/or potential for self-harm.[x] The West Wimmera Shire also received requests for assistance. In the same period, sixteen people contacted the shire for assistance, including eleven males[xi] seeking support from the Rural Outreach Worker specifically.

Navigation and collaboration

A crucial element of the rural outreach role is to establish good working relationships with service providers to ensure that referrals are made in a timely manner and 'triaged' based on the level of urgency. The rural outreach worker does not provide therapeutic or clinical interventions, their responsibility is to respond to

the person's immediate needs and connect them with the service or supports that best meet the needs of the person concerned.

The Centre for Rural and Remote Mental Health (CRRMH) recommends the development of 'gatekeepers' in rural communities. In the context of the CRRMH position paper, gatekeepers are community members who have the skills and knowledge needed to recognise the signs of suicide and assist them to access the most appropriate service.[xii]

The Rural Outreach Worker role has a 'gatekeeper' component. The worker has the knowledge and capacity to respond to someone who is considering self-harm or suicide, however this role has a broader scope.

As previously indicated the Rural Outreach Worker has a significant role during the interim period between seeking help and securing an appointment with mental health services, particularly if the person is not eligible for urgent assistance.

The Rural Outreach Worker also has the capacity to respond to the needs of family, work mates and other community members who are dealing with the loss of someone they know.

> ***There was a suicide in our town that had a large impact on the community… a lot of people were left floundering and questioning. 'How could this happen'… how can they do this?'***
>
> ***The rural outreach worker was fantastic; they worked with the bush nursing centre and the local CFA. We had an evening for community members. The Rural Outreach Worker spoke very openly about suicide and its impact… the worker talked to people about looking after their mates. After that event so many people came up to me and said that was just what we needed to hear…***
>
> ***It gave them an opportunity to talk about how they were feeling following this person's death. It was a really successful evening in terms of connecting with those community members and allowing them to speak about their feelings more openly … the worker also followed up with a number of people who had expressed concerns. Together we were able to provide the support people needed and refer others on to more formal supports if they needed them.***
>
> - **Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre**

The Rural Outreach Worker also had a role in health promotion, supporting community events and information sessions that the local health services delivered.

> ***The Rural Outreach Worker took part in hospital education and health promotion activities, the worker regularly worked with the community health nurse... it gave people from the wider community access to the worker at a different level***
>
> - ***Andrew Saunders, Acting CEO, Edenhope and District Memorial Hospital***

As an accredited Mental Health First Aid (MHFA) instructor, the Rural Outreach Worker was also able to deliver MHFA training to a range of community members across the shire including people who worked in local business, health services and local government. This ensured that the Rural Outreach Worker was not the sole 'gatekeeper' in these communities and worked towards building the competency of the general community to identify the signs of a developing mental illness.

Sustainability

> ***Linking funding to extreme conditions is a flawed model… the seasonal conditions are the trigger points. There are underlying issues there.***
>
> - ***David Leahy, CEO, West Wimmera Shire***

One of the significant concerns of the service providers across the West Wimmera Shire has been the sustainability of the rural outreach role. As indicated, the former Rural Outreach Worker role ceased in 2016 when funding was discontinued. This was just 6 months after the role had been duplicated and extended across four shires with commonwealth and state drought funding grants.

The linking of funds for mental health support to the declaration of drought and other disasters is seen to be counter-productive. Reflecting upon the drought funding that was granted in 2016, one service provider suggested that the short-term nature of the funding *actually did more damage than good...*

> ***It was really short term, 3 to 6 months. We didn't have sustainable funding to keep this service on… while there were some short-term links made with community members, some people were still struggling. Then the funding finished…. What happens for these people and who follows them up?***
>
> - **Ann Vaughan, Centre Manger, Harrow Bush Nursing Centre**

The CRRMH support these concerns. For many people in rural and remote areas economic security is somewhat out of control. Unlike people in larger centres who may have greater opportunities to gain alternative or complementary employment, those on farms and the businesses that provide goods and services are subject to the realistic risks of adverse conditions.[xiii]

> ***There are bigger issues out there than just droughts for regional and rural communities… we had a late frost and 80% of the chick pea crop is gone… these issues are always here.***
>
> - ***Andrew Saunders, Acting CEO, Edenhope and District Memorial Hospital***

Proposed Role: Rural Outreach Worker

The Rural Outreach Worker has been developed in response to the concerns associated with gaps in the availability and accessibility of mental health services in the Wimmera and Southern Mallee region of Victoria.

The outcome of the role is to improve the health and wellbeing of people who are psychologically distressed or are at risk of or have a diagnosed mental illness and address concerns where possible before a crisis ensues. As it is with the provision of care for people with chronic disease, the role would be part of an integrated multidisciplinary team that work together to address the individual's physical, social, emotional and mental health needs.

The Rural Outreach Worker would be positioned within a health service but work primarily with communities across a local government area. The role would include:

- Health promotion and community education in the areas of mental health and wellbeing
- Community based response for people experiencing trauma, psychological distress or at risk of self-harm or suicide
- Service navigation and referral
- Collaboration with health services, local government and other agencies to support and build resilient communities

The proposal is informed by the Wagner Model of Care and the principles that guide the delivery of care for chronic disease within the Community Health Program in Victoria.[xiv] These principles call for high-quality and supported person-centred care that:

→ is culturally responsive
→ is goal-directed
→ encourages health literacy
→ is health promoting
→ facilitates self-management
→ focuses on early intervention
→ uses evidence-based practice, and
→ takes a team approach.

Within the chronic disease continuum of care advocated by the Victorian State Government (Fig. 1), the Rural Outreach Worker would engage primarily at the secondary prevention level (targeted prevention), the individual level of early intervention and the established disease level with a focus on:

- Early intervention and focus on self-management (initial contact/response), and
- Self-management support with some care co-ordination (support and assist navigation for mental health services).

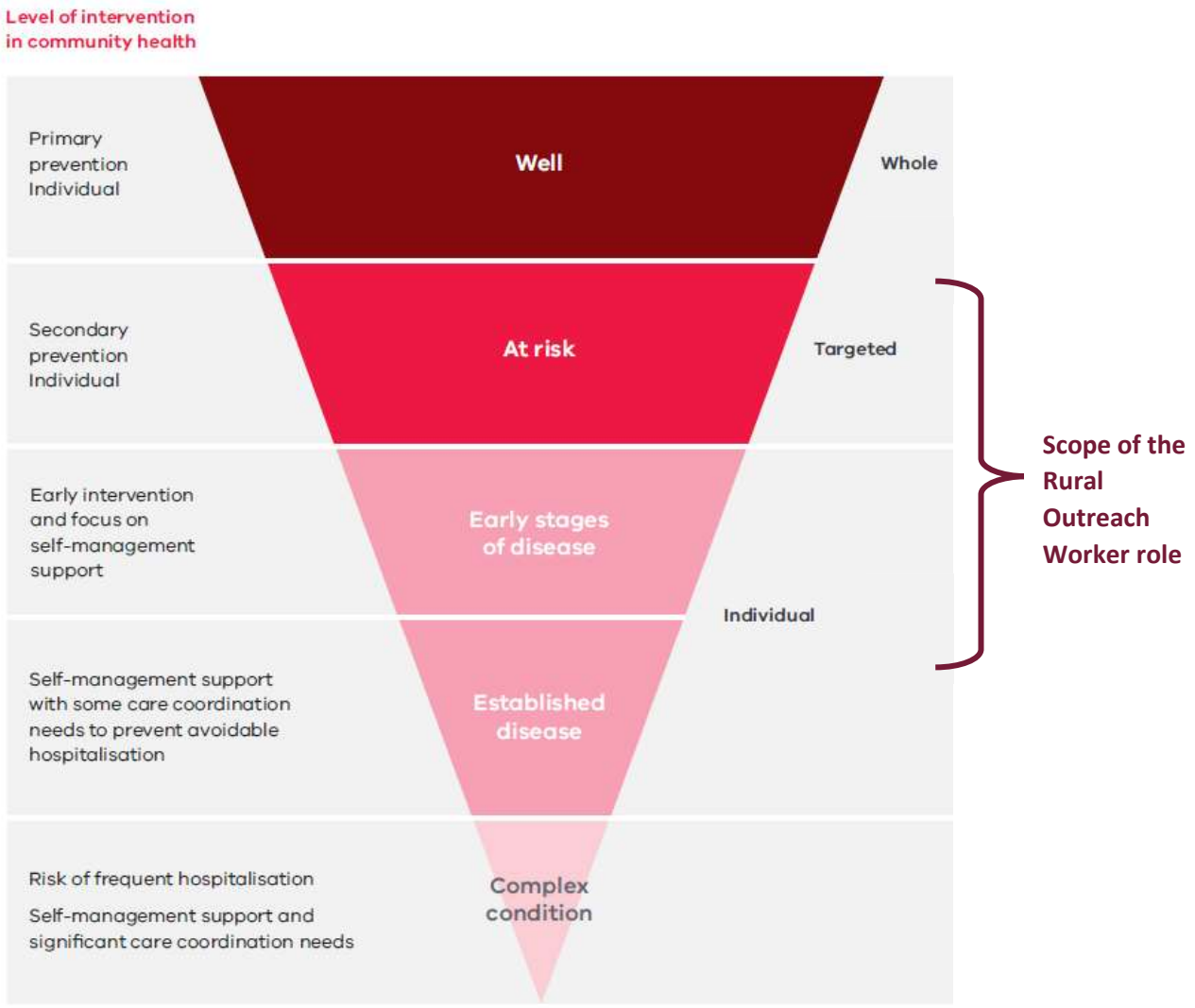

Figure 1: Chronic Disease Continuum of Care

Functions and activities

The key functions of the Rural Outreach Worker include:

- Community education and mental health promotion
- Community based response, and
- Service navigation and referral

The range of activities the Rural Outreach Worker might engage in is listed in Table 1.

Level of Intervention	Target population group	Activities
Primary prevention *Strategies to promote resilience and wellbeing*	Rural communities	Presence and promotion at community events
		Work with local providers to share and develop local resources for mental health promotion and mental illness awareness
	Frontline workers and other community members who interact regularly with neighbour and peers	Mental Health First Aid courses
Secondary Prevention *Targeted Strategies to promote resilience and prevent the onset of mental ill-health*	Selected groups who are at risk (eg. Landowners and rural business during difficult seasonal conditions)	Information sessions (eg. Let's Talk) Planned local event – CFA shed night
	People with low levels of wellbeing who are isolated from community	Support to engage with community or access local events e.g. Machinery Field Days
Early Intervention *Initiatives and strategies to lower the severity and duration of mental ill-health through early intervention*	People in psychological distress or at risk of self-harm or suicide	Outreach response - Provide support - Identify issue(s) - Service navigation and referral
	People waiting for an appointment with a mental health professional	Regular support - Check in/provide support to individual and family - Develop plan and identify self-management strategies with the person - Develop a response plan with key stakeholders in the community

System design

The Rural Outreach Worker is anticipated to be positioned within a rural health service as a member of a multi-disciplinary team. This would ensure that the worker is able to access the resources and processes that have previously been established around service co-ordinations.

Despite being positioned within a health service, the scope for collaboration extends beyond a single agency. In addition to a good understanding of service coordination, the worker will require strong communication and networking skills.

The key components of service design that services supporting the Rural Outreach Worker role require, reflect the Victorian guidelines for the care of people with chronic disease. They include:

- The capacity to identify people who are experiencing low-levels of wellbeing and/or emerging signs of mental ill-health with clear information about referral processes.
- Agreed referral pathways - for mental health services that support the nature and complexities of the individual's issues as well as their care preferences
- The development of an assessment protocol that the Rural Outreach Worker can use to share information about an individual with service providers/clinicians that includes lifestyle factors, social and psychological supports.
- When necessary, a standardised approach to care planning that includes:
    - → The nomination of a key worker
    - → The capacity (and established processes) to develop a common shared care plan when more than one provider is involved, to ensure a key worker is identified and shared care plan protocols are in place that clearly communicate consent, treatment strategies, mutually agreed goals, timeframes and review dates.
    - → A clear process to communicate and share care plans with other clinicians and health professionals (including GPs).
    - → Clear criteria for when a person's care needs have been met, service/supports have reduced or/and the patient is discharged from the service.

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[i] Wimmera PCP 2017, *Wimmera and Southern Mallee mental health service mapping project,* accessed 12 February 2018, <wimmerapcp.org.au/wsmmhmp/>.

[ii] CRRMH 2017, *Rural suicide and its prevention*, accessed 22 January 2018, <www.crrmh.com.au/news-item/position-paper-recommends-strategies-save-lives-decrease-rates-rural-suicide/>.

[iii] McPhedran, S. and De Leo, D. (2013), Miseries suffered, unvoiced, unknown? Communication of suicidal intent by men in "Rural" Queensland, Australia, *Suicide and Life-Threatening Behaviour*, 43: 589–597.

[iv] CRRMH 2017, p. 13

[v] CRRMH 2017, p. 17

[vi] CRRMH 2017, p. 6

[vii] Harrow Bush Nursing Centre 2017, *About us,* accessed 12 February 2018, <www.hbnc.org.au>.

[viii] Wimmera PCP 2016, *Service capacity*, accessed 12 February 2018, <http://www.wimmerapcp.org.au/wp-gidbox/uploads/2016/08/WSMMHSM-Project-Service-Capacity.pdf>.

[ix] Wimmera PCP 2017, *Mental health service directory,* accessed 12 February 2018, www.wimmerapcp.org.au/wp-gidbox/uploads/2016/08/WSM-MENTAL-HEALTH-SERVICE-DIRECTORY-NOV-2017.pdf

[x] West Wimmera Shire, 2018, *Rural and regional outreach program for the West Wimmera region of Victoria*, WWS, Edenhope, p. 5.

[xi] West Wimmera Shire, 2018, p. 4.

[xii] CRRMH 2017, p. 18

[xiii] CRRMH 2017, p. 18

[xiv] Department of Health and Human Services 2016, Care for people with chronic conditions, Victorian Government, Melbourne.

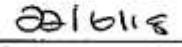
SIGNATORY PAGE

Edenhope & District Memorial Hospital - Kevin Mills – Chief Executive Officer

28/06/2018

Signature | Date

Harrow Bush Nursing Centre - Ann Vaughan – Centre Manager



Signature | Date

Hindmarsh Shire Council - Greg Wood - Chief Executive Officer

18/06/2018

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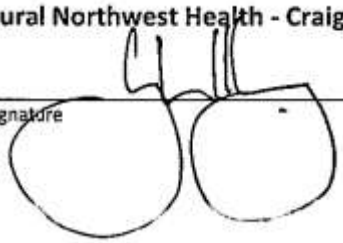
Rural Northwest Health - Craig Wilding – Interim Chief Executive Officer



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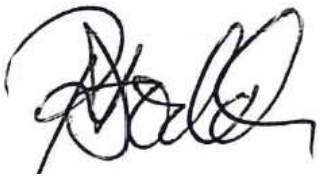
West Wimmera Health Service - Ritchie Dodds - Chief Executive Officer



28/06/2018

Signature | Date

West Wimmera Shire – David Leahy - Chief Executive Officer

13 June 2018

Signature | Date

Wimmera Primary Care Partnership – Geoff Witmitz - Executive Officer

Signature

28/06/2018

Date

Woomelang Bush Nursing Centre – Carol Paech - Centre Manager

Signature

13/6/18

Date

Yarriambiack Shire Council – James Magee - Acting Chief Executive Officer

Signature

15 June 18

Date