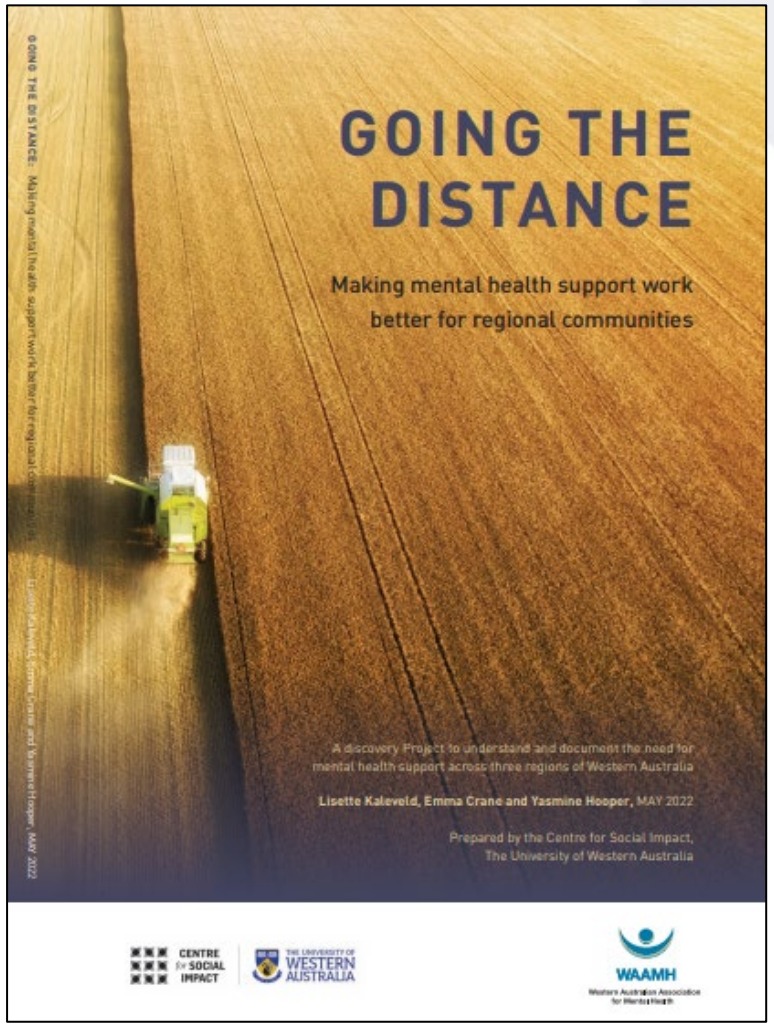
Going the distance

Making mental health support work better for regional communities

A presentation of findings

Lisette Kaleveld, Emma Crane and Yasmine Hooper



WAAMH
Western Australian Association for Mental Health

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Acknowledgement of Country

Acknowledgement that this meeting is being held on the traditional, unceded lands of the Noongar people

Thank you

Western Australian Association for Mental Health

Taryn Harvey

Colin Penter

Team at the Centre for Social Impact

Paul Flatau

Leanne Lester

Syarif Abdul-Wahed

Emma Crane

Yasmine Hooper

Research participants all over WA!

Outline

1. Key questions and methods
2. Four key findings
3. A case study of a remote community
4. Q&A and discussion
5. Next steps

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Guiding questions

1. What are the **lived experiences** of individuals experiencing mental health issues at various levels of severity in regional areas?
2. What are the **perceived gaps** in need versus access to mental health supports in regional areas?
3. What are the **unique factors of living regionally** that affect experiences of mental health, service access and funding, and **what do communities say needs to change**?

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Limitations

1. This work was exploratory. The views presented here are firmly grounded in the people we met who lived in the regions, especially the three study regions. There were no purposeful sampling methods for the consultation, and no-one who wanted to participate was excluded. The findings are not considered to be generalisable.

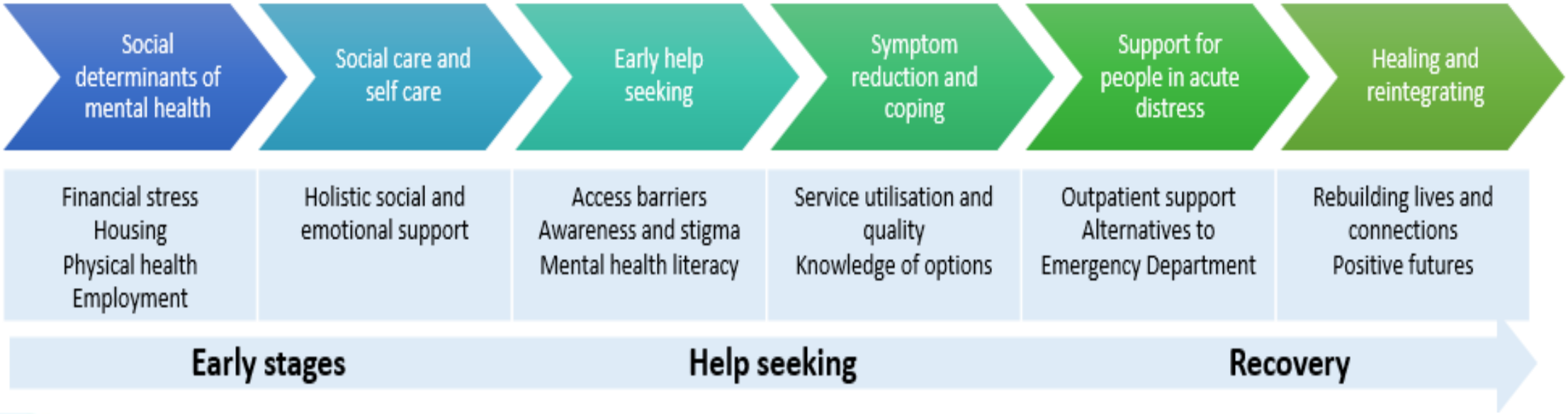
2. However summarising the experiences of those people we spoke to may be valuable for researchers, policy makers and funders to initiate more targeted approaches to gathering evidence.

Limitations

1. Examining the specific needs of any social group or cohort was not part of this Project - the scope was geographical. People (adults) who lived in those communities who agreed to participate, no matter their background or identity, were our primary interest.

2. Several Aboriginal communities were in this geographic area and wanted to participate. This Project was also limited in the extent to which we could explore systematically, comprehensively, with proper consultation and with culturally-adequate depth and understanding, the needs of Aboriginal communities.

Framework



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Methodology

The consultation focused on three regions, with emphasis on face-to-face visits, and, where possible, visits to smaller towns

Midwest n = 67	Wheatbelt n = 68	South West n = 166
Geraldton	Northam	Bunbury
Mullewa	Narrogin	Busselton
North Midlands	Narrambeen	Margaret River
	Moora	Collie
	Dalwallinu	Boyup Brook
	Pingelly	Manjimup
		Bridgetown

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Methodology

Community consultations	One-on-one interviews	Survey
320 participants	14 interviewees	410 respondents
16 communities	12 communities	122 towns/113 postcodes
3 focus regions only	3 focus regions, plus metropolitan-based peak bodies with a knowledge of the focus regions	All 9 WA regions, with more respondents from the 3 focus regions

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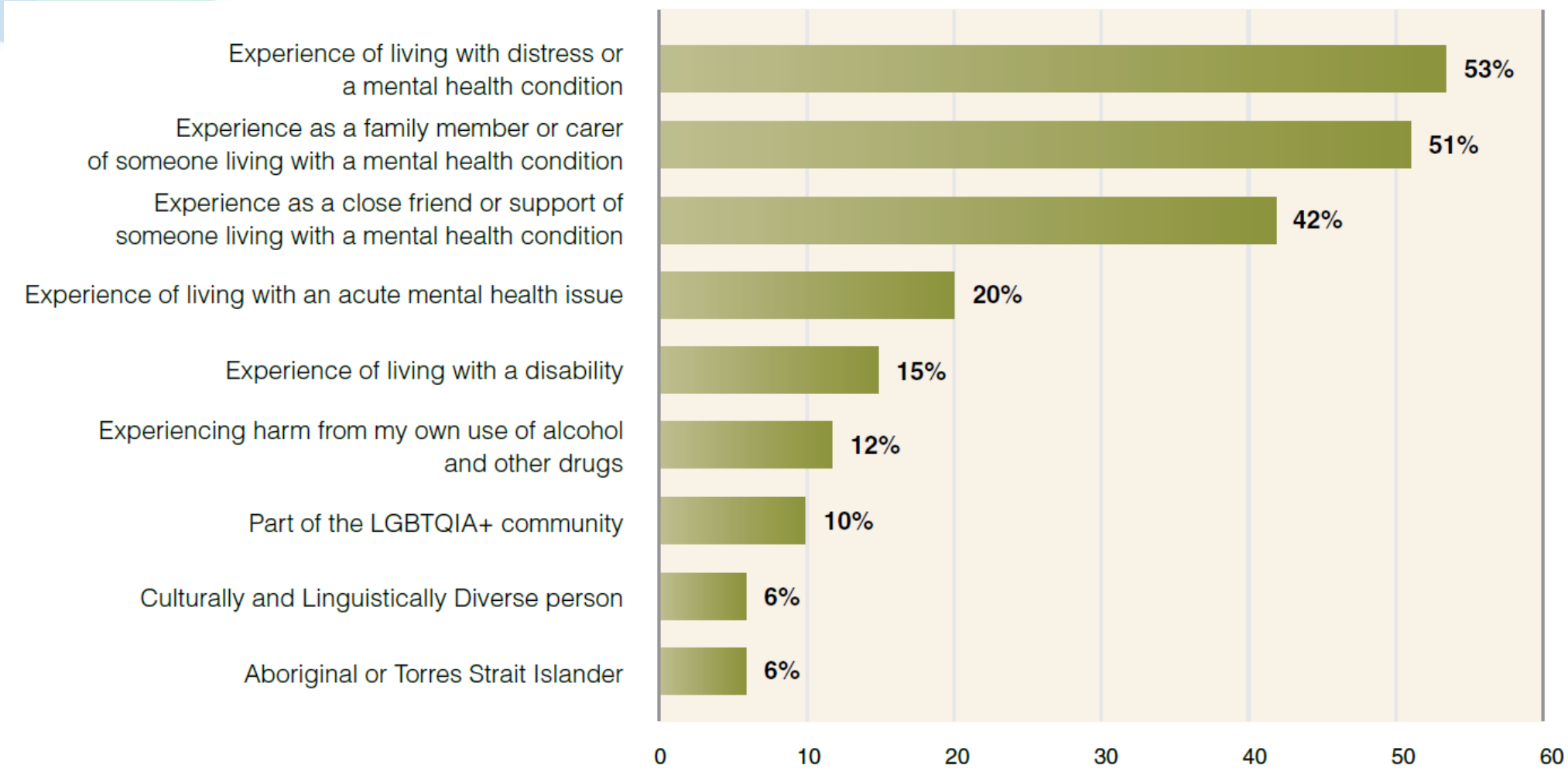
Survey respondents

Life experiences and perspectives of 410 survey respondents



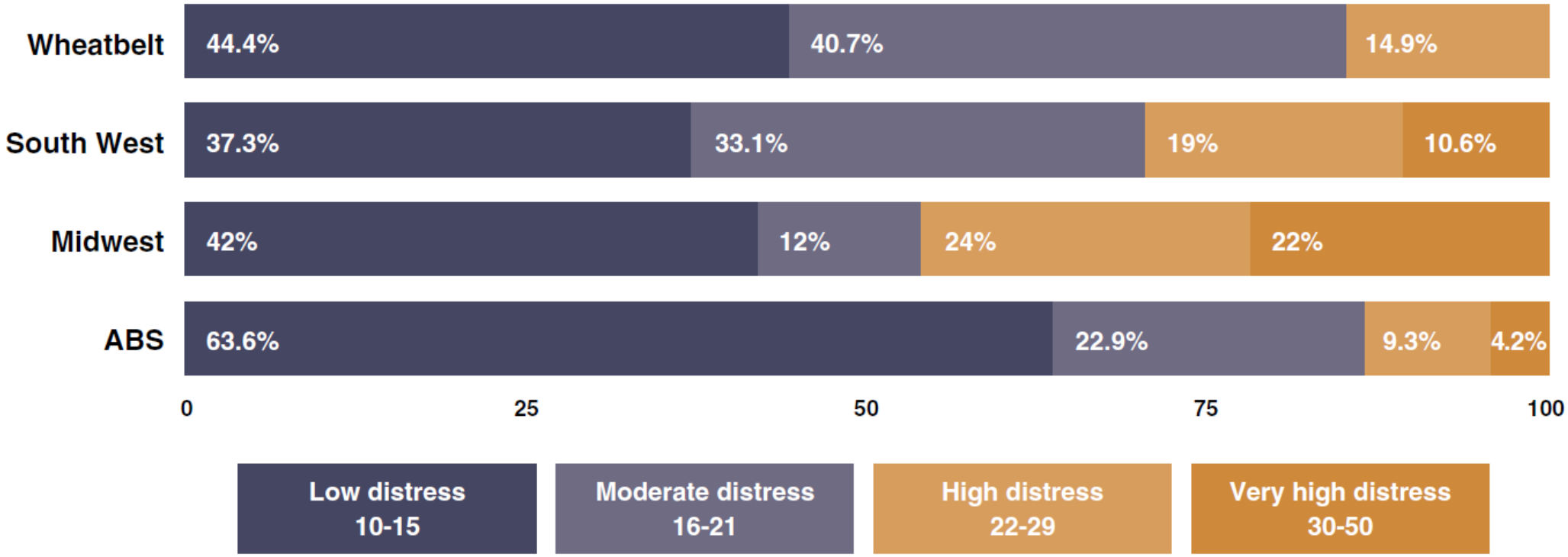
Finding 1 – indications of unmet needs

Indicators for wellbeing and distress

Wellbeing and levels of psychological distress were measured using the validated World Health Organization-Five Well-Being Index (WHO-5) and the Kessler Psychological Distress Scale (K10).

WHO-5 measure for wellbeing: Half of the survey respondents scored less than 50, suggesting possible depressive symptoms
K10 measure for distress: Over one third of survey respondents had scores that suggested high or very high distress

Finding 1 – indications of unmet needs



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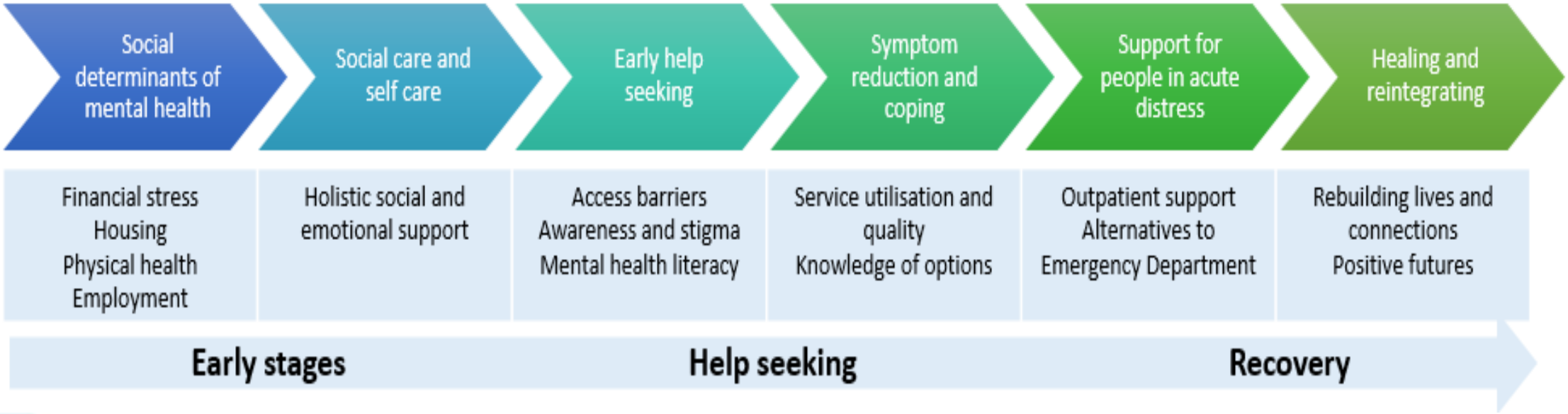
Finding 1 – indications of unmet needs



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Finding 1 – indications of unmet needs

- Social determinants: A quarter of survey respondents experience challenges with housing, one in four also experience financial stress and one in four report physical health issues. One in five are struggling with social isolation or loneliness.

> The key message... was that unaddressed social vulnerabilities are inseparable from experiences of poor mental health in the regions

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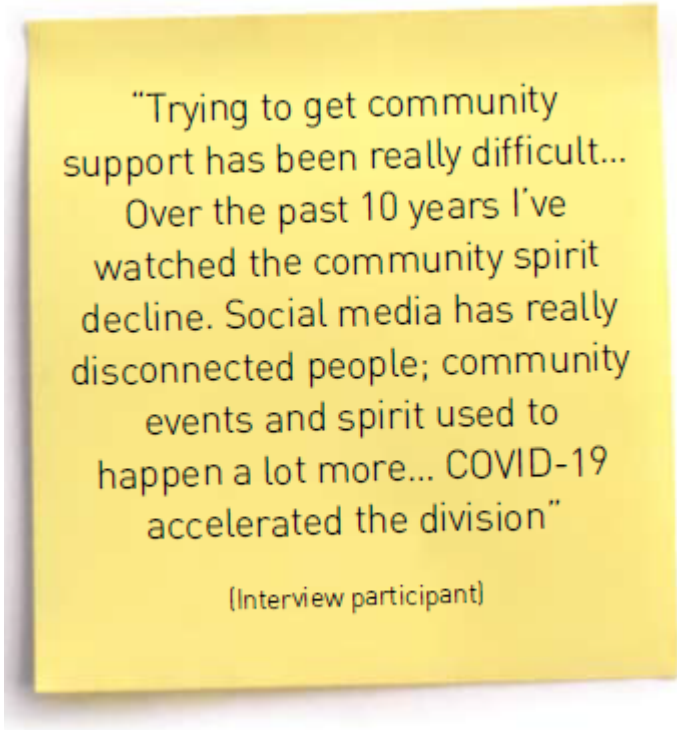
Finding 1 – indications of unmet needs

- Social care and self-care: About one third of people surveyed were not getting as much social support as they felt they needed, which is problematic because increased social supports are associated with lower distress.



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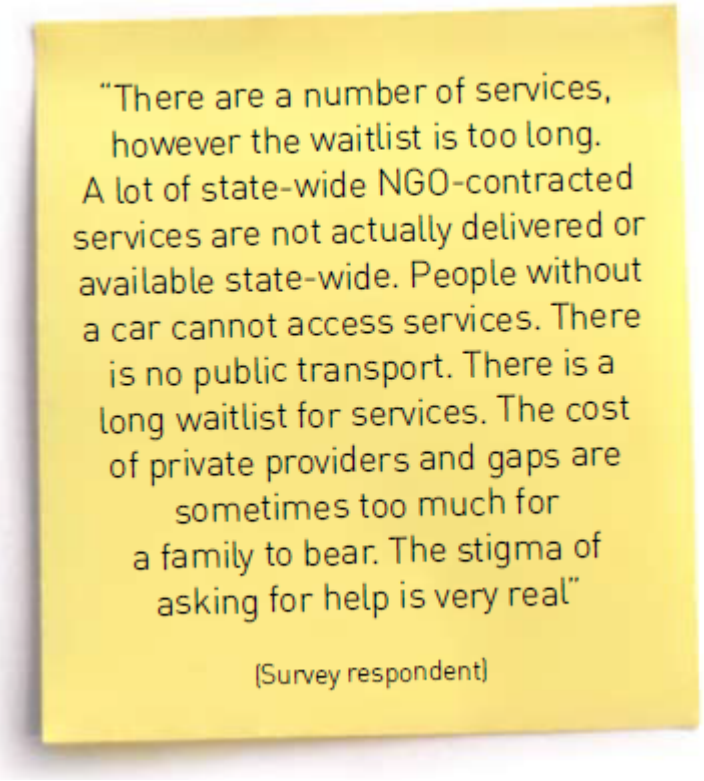
Finding 1 – indications of unmet needs

- Early help-seeking: Stigma and cultural barriers prevented people living in regional and rural settings from getting help early (internalised stigma as well as stigma in services), as did transport and logistical barriers such as distance to travel, pressures of living and cost.



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Finding 1 – indications of unmet needs

- Symptom reduction and coping: 76% of people surveyed said that in the past 12 months there was a time where they wanted to talk to someone or seek help about stress, depression or problems with emotions. However, 39% of these people reported that they did not get the care they needed.

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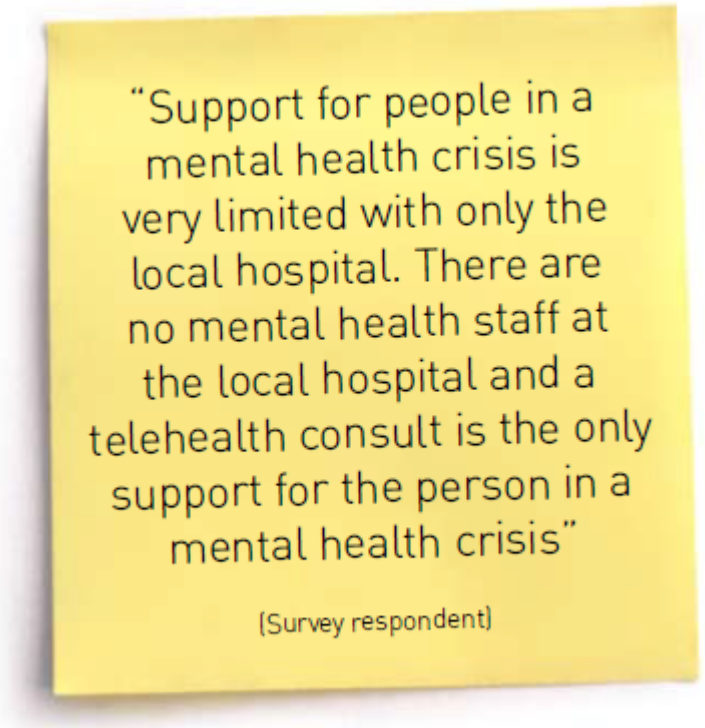
Finding 1 – indications of unmet needs

- Support for people in acute distress: people experiencing a mental health crisis were not adequately supported in regional areas. This is particularly so in smaller towns.



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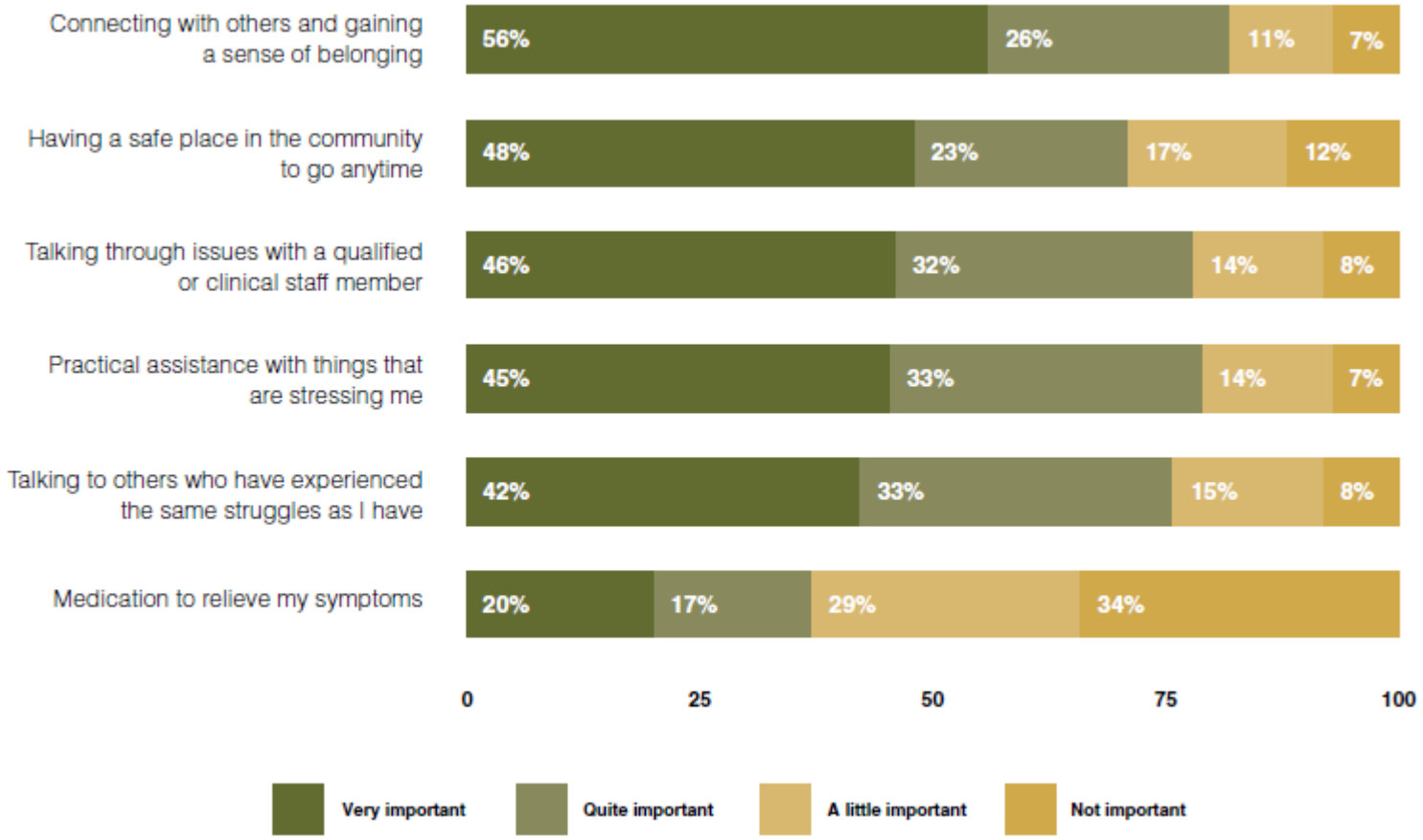
Finding 1 – indications of unmet needs

- Healing and reintegrating: people experience a lack of choice around social and recovery supports to keep them well and socially connected.

What would make a difference to mental health and wellbeing?



Finding 2 – more support for help-seeking

Greater mental health literacy is required to reduce stigma, **normalise getting support for mental health**, and encourage people to seek and accept help – early in life and at the onset of experiencing challenges with mental health

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Finding 2 – more support for help-seeking

Over half of the survey respondents (55%) felt that stigma about mental health issues was a barrier in their community and that this impacted peoples' ability to seek help to a great extent

- *"Generally I think many people are confused about when and where to seek help, tending to dismiss their problems until they are very serious. Seeking psychological help is seen as too large a step, and asking friends for support is seen as 'burdening them'"* **(Survey respondent)**

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Finding 2 – more support for help-seeking

- *“The stigma is as huge part of what's stopping most people I know reaching out to access mental health [services]. Plus, I've experienced in the past that there can even be judgement from the ‘professionals’”* **(Survey respondent)**

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Finding 3 – clinical care alone cannot meet needs

Regional communities face additional barriers to getting care.

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Finding 3 – clinical care alone cannot meet needs

Existing clinical services in the regions are necessary but not sufficient in terms of accessibility, quality and relevance, and communities would like more support options beyond clinical care.

Of the respondents who wanted to seek help and attempted to access a service, 30% did not have transport (or the service was not close enough)

Finding 4 – local leadership needs to be engaged in planning

Mental health support options need to be ‘place-based’; i.e., context-specific, and community-driven.

Local leadership needs to be actively involved in decisions around mental health needs. This is critical for ensuring funded supports are effective, relevant and sustained.

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Finding 4 – local leadership needs to be engaged in planning

Some experiences were specific and unique to remote communities – which were common across all three regions

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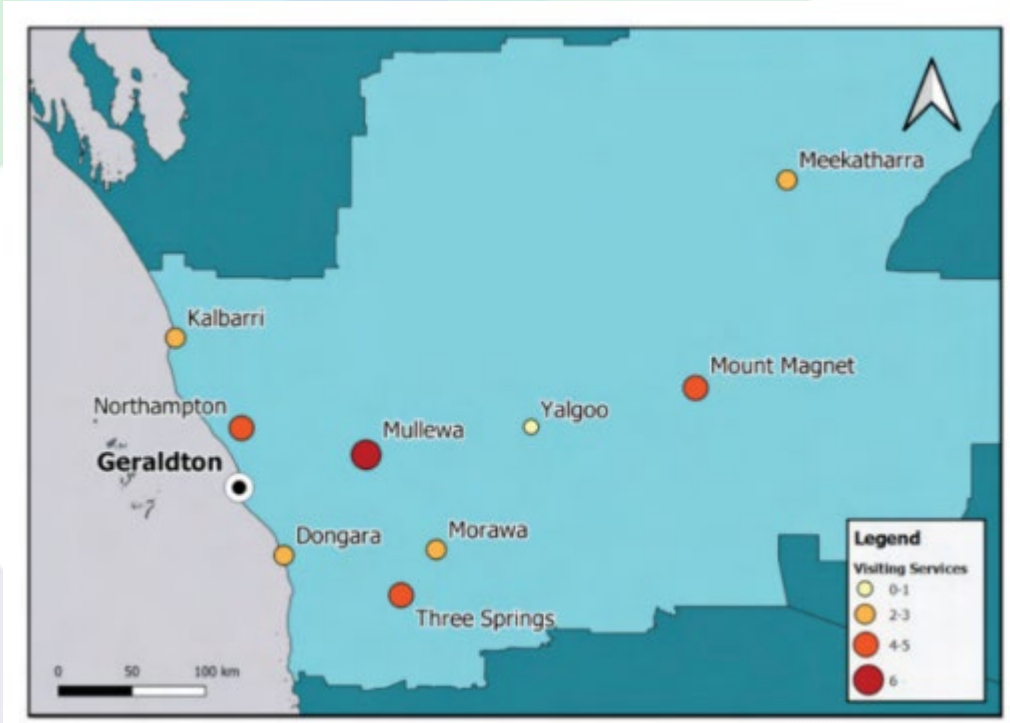
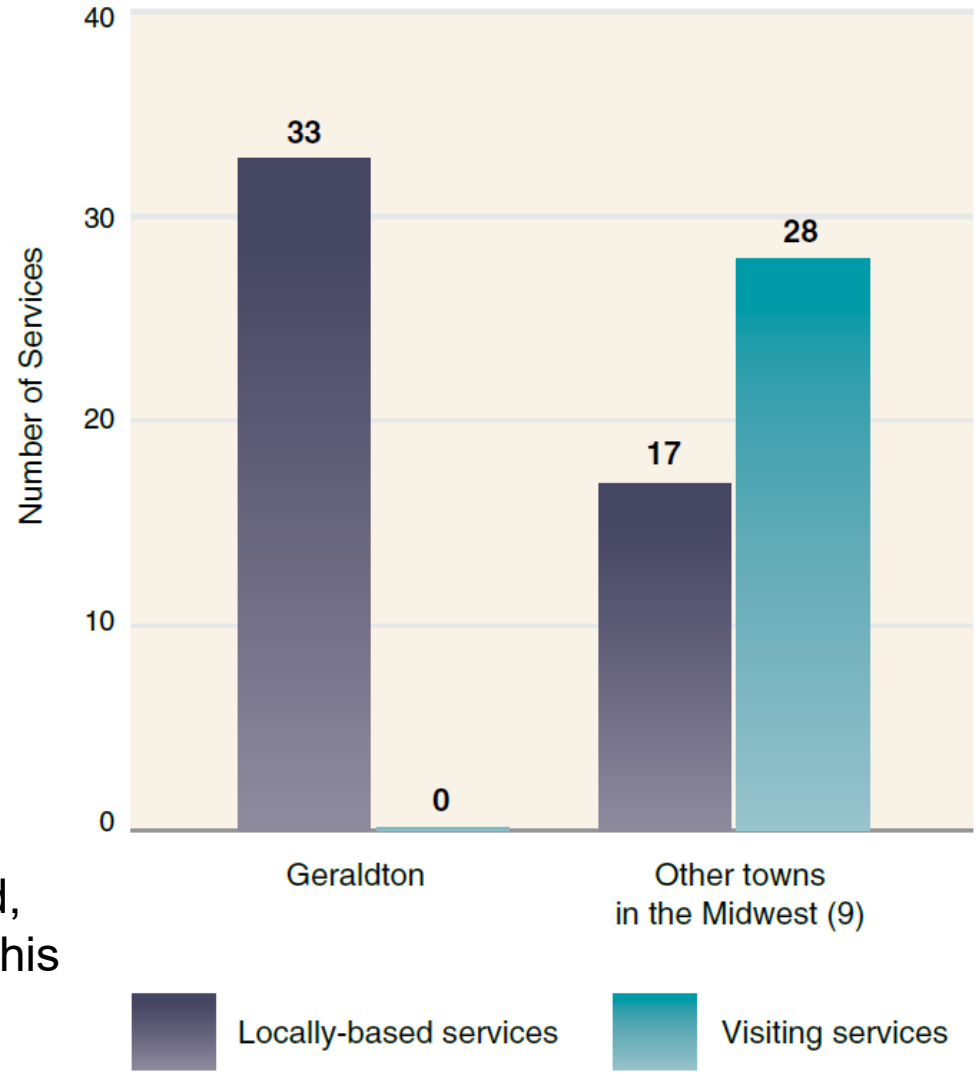
Case study: Midwest





Geraldton had 33 services that were all locally-based, whereas all the other nine towns mapped as part of this analysis had a total of only 17 locally-based services

Case study: services to remote towns

Limitations of visiting services for remote communities:

- Drive-in-drive out services are often not known about, and there is no time for local promotional work
- Driving time is often included in the ‘service delivery costs’, leaving limited time for providing support
- Sometimes visiting services are not used and are not sustained
- Sometimes visiting services are not relevant or not what the community wants

> Inevitably, the disruption and disappointment that sporadic, unsustainable or non-existent/ withdrawn service provision can cause to a population is a significant problem when it comes to supporting mental health.

Mullewa

A local service is better able to engage with the community, develop lasting relationships, observe changes and concerns, see opportunities to connect, and encourage help-seeking in innovative ways that are appropriate for that community.

Operational and funding support should be given for community-based support options which are designed and led by the community in response to local needs and experiences

Telehealth with no local connection	Geraldton-based service that visits neighbouring town	Geraldton-based organisation that 'may' visit (sporadically, or as needed)	Geraldton-based organisation committed to a regular time slot for visits	Geraldton-based organisation delivering a program locally	Locally-based organisation delivering a program locally	Locally-based organisation providing ongoing access to support
1. WACHS based in Geraldton provides telephone counselling	**1.** Desert Blue Connect provides family counselling, based in Geraldton but visits Morawa (but not Mullewa)	**1.** WACHS public mental health and AOD service provides counselling and treatment for children and young people	**1.** WACHS Public mental health and AOD service supports people with AOD issues, visits on a fortnightly basis **2.** Ngala based in Geraldton but provides family counselling in Mullewa four sessions per fortnight **3.** Geraldton Regional Aboriginal Medical Service provides NDIS support through regular visits	**1.** WA Centre for Rural Health UWA delivers health-related programs locally (e.g., women's program) **2.** Geraldton Sporting Aboriginal Corporation delivers health and social and emotional wellbeing initiatives **3.** Centacare delivers programs such as school-based support, Yarning Circle, on-Country support for young people **4.** MEEDAC provides NDIS support, support for job seekers, support to help people clear fines, aged care	**1.** Mullewa Community Resource Centre delivers local community mental health awareness and promotion initiatives e.g. A night with the Blokes in partnership with Checkmate	**1.** WACHS Mullewa Hospital provides a 24-hour nursing station

Local responses

- Community-led responses to address mental health issues have emerged in some communities.
- Some examples presented include community collectives, placed-based multipurpose centres, supports that encourage help-seeking, supports that address housing and financial stress, alternatives to hospital crisis care and supports designed for young people.
- In some cases these initiatives were very well supported and sustained at the local level.

Local responses

• The strengths of these initiatives developed by the community, is that they utilise existing community settings, such as ‘gathering places’, and community partners who work outside the mental health sector, creating positive environments for delivering non-stigmatising and holistic support.

- These models are solutions to many of the issues uncovered by this Project

- They are also what people consulted have asked for more of

Questions and discussion

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Next steps

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