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When Men Miss Out: Mental Health Care in Regional Practice

Andrew McPherson (00:00:01):

Hello everyone. Welcome to When Men Miss Out: Mental Healthcare in Regional Practise. I'm Andrew McPherson, a founding director of Ballarat Men's Mental Health, and I'll be your moderator this evening. Next slide, please. Before we get started, I would like to, on behalf of the Mental Health Professionals Network, I'd like to acknowledge the traditional custodians of the lands, seas and waterways across Australia, upon which our webinar presenters and participants are located. We wish to pay our respects to the elders past and present and acknowledge the memories, traditions, culture, and hopes of Aboriginal Torres Strait Islander people.

(00:00:51):

Next slide, please. As a regional provider, Ballarat Men's Mental Health recognises the significant influence that location, identity, and local community resources have on men's perceptions and their capacity for help seeking. This evening, our panel will evaluate the implications of delayed help seeking and then explore the gaps between available services for men. We'll address factors contributing to disengagement and discuss strategies for improved communication and collaborative practises to enhance engagement and the continuity of care for men. Of course, we have some learning objectives. We want you to learn about the barriers and enablers to providing care to men experiencing mental health difficulties. We will describe strategies to engage men to support continuity of care and to navigate rural systems. We'll also help you identify service design features that minimise barriers to help seeking by men. And we'll show you how we have applied practical strategies to improve collaboration and referral processes across disciplines.

(00:02:18):

Next slide, please. The case study you all received illustrates how a man, Rohan, in this case in rural Australia, might face emerging mental health issues. Many will recognise elements of Rohan's story, and we'll guide you through his five-stage journey during this webinar. Before we do that, and given that so much of the content of this webinar involves the lessons and the experiences gathered during the development and growth of our service, Ballarat Men's Mental Health, we think it'd be instructive to provide you with a brief overview of the service. Mick, you've been involved in the beginning. Let's hand it over to you.

Mick Fryar (00:03:09):

Thank you, Andrew. Yes. Have been involved from the beginning. My name's Mick Fryer. My background, everyone, is in psychology and mental health nursing, and I've spent many years working in public psychiatry across a few different places in Australia, but more recently, originally in Ballarat, and then certainly the last 10 years or so back in Ballarat and regional areas. We are, of course, men's mental health. We're a non-for-profit voluntary organisation made up of volunteer directors. One of which I am, of course, in my portfolio really due to my clinical background is probably around the clinical aspects of care that we provide.

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We know that men traditionally have poor history in accessing services. We know that general health, we know that mental health as well, in particular, can be quite fragmented, can be quite difficult to manage. So we really wanted to set up a service that made it very easy for men to access services that perhaps otherwise wouldn't get into some sort of care, some sort of support, some sort of treatment. So we started off with one part-time triage clinician, and we obviously set up a website and had referral opportunities, and we had a phone, so we encouraged people. We advertise, of course, to say that we'd established and were providing care for men in particular. And then we wanted to make sure to make not only easy access, but quite a swift turnaround to get men who do make the call. And I'm sure we'll talk about how difficult that can be with some of the other panel members soon.

(00:04:53):

But we wanted to make sure we had a fairly quick turnaround. So we set out to recruit, I guess is probably the word, some clinicians who would work with Ballarat Men's Mental Health. So technically, I guess they are subcontracted clinicians. So we have a very simple service agreement that we get them to sign and they're very happy to do that. And then essentially, we've expanded a bit now. We've got two part-time triage clinicians. We'll talk about that process and how it works a little later, I'm sure, with some of the guys that are on the panel with me this evening, but then we can ... So we do the triage and get the information, and then we try and get a good fit very quickly, if you like, to a great group of clinicians that work on behalf of us. Their multi is brilliant nature.

(00:05:38):

There's some general counsellors. We've got some colleges. We've got some social workers as well, and we're able to do a comprehensive triage and handover as a way of streamlining access for many particular. Along with that, of course, goes some work with public mental health awareness and getting the message out there, working with clubs and those sorts of things. And I'm sure we'll get an opportunity to expand on some of those things as we go forward, Andrew.

Andrew McPherson (00:06:08):

Thanks for that, Mick. I think it's important for attendees to understand that we went through a pretty exhaustive evidence-based process to get to a service model that directly tried to address the reasons why men miss out on mental healthcare. And the main reasons that men, as Mick said, men are reluctant to reach out. They often find the service system opaque and hard to deal with. Sometimes the cost of services is exorbitant, they just can't afford it, and often the waiting lists are really long. So we did a consultation process to arrive at those four things, and not surprisingly to any of you, that list I wouldn't have thought. And it certainly was a list that also came out of the Victorian Government's Mental Health Royal Commission that happened at about the same time. So that's the basis of how we got started. Mick, I think you had some questions for the panel.

Mick Fryar (00:07:20):

Yeah, so you have, Andrew. So look, one of the things, I guess, in picking up the point that it can be difficult for men to access, and sometimes it's difficult for them to make that first call or that first contact. So I was going to ask our panel members, what is one of the common phrases that you hear as clinicians when men first present?



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Michael Grimes (00:07:41):

Well, I think the most common ... Should I introduce myself first

(00:07:45):

Or? Yes. Yes. My name's Michael Grimes. I've got a teaching background originally, but I had a midlife career change, got into the welfare field. I worked for Centrelink for 13 years and then moved to a community welfare agency where I did welfare case management with all sorts of different people, victims of crime, families at risk of losing their children because of child protection concerns, long-term unemployed people. But then I obtained a counselling qualification and moved eventually into exclusively counselling. And I've been doing that for roughly 20 years now. And I think the most common phrase that I hear from men is, "I've never talked about this before." I never talked to anyone about this before. And sometimes it can be really, really serious stuff like a history of childhood sexual abuse that might've gone on for many years, but they might be in their 50s, even 60s, and have never spoken to anyone about it before.

(00:09:05):

But also, there are lots of men who have just never considered counselling before, never considered that it's for them. So that's the most common one for

Mark O'Brien (00:09:16):

Me. Thanks, Michael. My name's Mark O'Brien. I'm a social worker. I've been doing this for quite a while now and most recently spent a couple of decades working in public health. I'm hearing a lot of common themes from men when they contact, and particularly a lot of gratitude and thank you for listening. And also, it's hard to find something that's going to be affordable. The financial pressures is something which is so true now, probably more than ever. But one thing which I've heard from probably every person that I've spoken to through that triage process is that I just don't feel worthy. And there's this real sense of lack of self-worth as a man, as a person, a father, a husband, a family member, just trying to find their place within that. And a real sense of, yeah, I just don't feel that I'm able to give as much as I really should be doing or need to.

Ben Gillet (00:10:19):

Thanks, Mark. My name's Ben, Ben Gillet. I'm a mental health clinician with an occupational therapy background. I've worked predominantly in public mental health for the last 20-odd years. So I suppose one of the common statements or things that I hear from men through triage is I've got a lot going on and I think that can be applied twofold for this cohort in terms of a lot going on that's impacting on my mental health, whether that be life stress, work, finances, relationships. And also, I've got a lot going on, and that's why this is perhaps the first time that these fellows are reaching out because there's a lot that can get in the way of these men to reach out for help. So I've got a lot going on. I hear it a lot. Yeah.

Andrew McPherson (00:11:25):

Thanks, Ben. Thanks everybody. That's a good introduction to the way we operate and what we hear. We're now going to start on the first stage of Rohan's five stage journey as referenced in the case study.



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So to get us going, I'd like to ask the panel, what are the signs of distress visible in Rohan's situation that may not look like depression?

Michael Grimes (00:11:57):

Well, there's a sense of failure, a sense that he sees himself as a failure because he's struggling to make a go of the farm and it's a family farm that's been passed down to him. It's like he's the last of the line. There's his withdrawal from community in general, but also there's a suggestion there that he's withdrawing from his kids and even from his partner. The sense of failure, I think, leads to shame. There's a belief that he expresses the belief that he should be able to deal with all this stuff himself. And there's a sense that he's ashamed of the fact that he can't do so. They're the things that stand out for me.

Andrew McPherson (00:13:08):

What about you, Mark? What's your perspective?

Mark O'Brien (00:13:10):

Yeah, I think certainly Michael's captured most of the things. I guess that just perceived responsibility that he carries everything's on his shoulders. And it's not seen probably as being a mental health issue, but more just that it's my responsibility and I need to carry this on. This farm's been in the family for generations and I don't want it to be me, the one where things fail and don't work.

Ben Gillet (00:13:38):

Thanks, Mark. I think Mark and Michael really sum it up well. And I think what's striking to me about Rohan's case is that a lot of the things that are, the pressures on him are everyday stresses that a lot of men are facing, that they don't necessarily add up to a clinical diagnosis of depression, though there are depressive symptoms. And I think that is a great commonality in this case, as with many other cases we see, is that the real life stressors, the relationships, the pressures of the farming in this case, et cetera, these all add up to real life stresses. And then much like the stress vulnerability model where we've got our bucket and we can only fill our bucket with so many stresses, it starts to spill over and we start to see mental health symptoms. And then that starts to lead onto things like what Michael's talking about, the shame, the guilt, the I could have, I should have.

(00:14:37):

These are all very common aspects of the presentations that we come across at Ballarat Men's Mental Health.

Mark O'Brien (00:14:46):

And I think we could also add, if I could just add in the social isolation, withdrawing from friends, networks, having contact with probably being someone who's been involved with the community, the football club and everything in the past, but having those things drop off or not having the energy or motivation to engage with people is certainly an indicator that things aren't well. And without the support of just friends and family, sometimes things can spiral out of control.



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Michael Grimes (00:15:13):

And I could add one more thing, I suppose it's implied there that his children don't seem to have much interest in carrying on the family farm as well. So it's not just his feeling of that he's not succeeding as a farmer. It's also that he may be the last of the line for that reason as well.

Andrew McPherson (00:15:40):

Does anybody in the panel believe that Rohan has personal beliefs that could be delaying his help seeking?

Ben Gillet (00:15:54):

I'll go into that one. I think there's a huge emphasis on diagnosis and label, and I think sometimes some of the men we see feel like perhaps what they're experiencing, they should be able to overcome it or they should be able to deal with it and that perhaps I'm not unwell enough or what I'm going through is not significant enough for me to need to reach out that I should have to be able to deal with this on my own. And I think those sorts of beliefs are pretty common in this case and I think in other cases that we see. So I think some of those beliefs can really get in the way and be a barrier to reaching out and getting help.

Andrew McPherson (00:16:42):

Thanks, Ben. There's a question about rural men who strongly identify with independence and the provider role. What engagement strategies would help shift the conversation from, "I just need to work harder to recognising stress and burnout without triggering

Mark O'Brien (00:17:03):

Shame?" I guess from my perspective, it's about encouraging the men to see that it's not a fault. It's not a failing of themselves as a man or a person. You can point out, looking at the synopsis here of what Rohan's going through is things that a lot of people are going to struggle. It would not just be him. It's normalising some of the things that he's bringing to the table and saying it's not a failing just on his behalf. It's just not this only Rohan who's experienced this. Not to minimise anything for him, but to just, I guess, get him to externalise it somewhat, just to put it out there that these things would turn most people into a state of depression or just questioning themselves and their ability to cope. And obviously there must be some strengths there for him to get to where he's got and trying to focus on those.

Andrew McPherson (00:18:02):

Thanks, Mark.

Michael Grimes (00:18:04):

Yeah, we could talk about what he can and can't control and the fact that some of this is about him, sure, but a lot of it is about other factors that are outside his control, to some extent his partner and family, the broader economic framework that he's operating within, all of those factors that are outside his control help to give him a sense that it's not all about him.



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Mick Fryar (00:18:37):

Yeah, good point, Phyllis. I think one of the things that you're getting there too is that stress and the symptoms and the way that comes out in men in particular, being able to let men know that that's really a normal response to a set of abnormal circumstances, someone who's obviously had a lot of pride in the farms we talked about and identified very closely with that. So him being stressed because he's losing a control of some of those things, he's quite understandable.

Ben Gillet (00:19:07):

I think the concept of the perfect storm, that there's this convergence of vulnerabilities, personality factors, and circumstances that come together to create this storm in the individual, and this is what we have before us. And I think putting that out there nice and early is a nice analogy that I think a lot of men can relate to, that a lot of things, as Michael said, that are out of their control and also some intrinsic elements of their own personalities or whatever, have led them to this point, and it's all very legitimate.

Andrew McPherson (00:19:45):

Thanks, Ben. I think that the barriers to seeking help in Rohan's case are quite complex and quite varied, but they are, as mentioned, so typical of rural and regional men and the stresses that they're facing. We would hope that for every barrier that there is to a man going to seek help, that there should also be an enabler if we're really going to get men past the first stage of help seeking. In terms of learning objectives regarding barriers and enablers, we've certainly mentioned a lot of the barriers at the moment and some of the enablers, and we'll move on with some more examples of both as we move into the next section. So we're into the first contact and intake, reducing friction. In this stage, Rohan takes a step that can be very difficult for men, and it's often delayed because of that difficulty. Rohan is reaching out for his assistance, but he's not really sure of what he might experience.

(00:21:10):

There are a number of aspects to Ballarat Men's mental health service model that we design specifically to reduce friction at this critical point. In terms of service design, Mick, what do you think are the most effective features of our service model?

Mick Fryar (00:21:29):

Andrew, I think one of the things that we've tried to do and have done reasonably well is streamline and make contact, particularly the first contact, as easy as we can. So we've got a number of ways. I think I mentioned a little earlier, we've got a couple of part-time triage clinicians which do a great job for us. And of course people can make an appointment online, they can phone if they want, they can pick their own time. We've got on our website, the ability for people to pick a time when we can call them back. So if they're working and Rohan's goes, if he's very busy on the farm, it may well be of an evening. So we'll always get back to someone within 24 hours. So we're well aware that the service model we have needs to be really responsive because if someone's difficult to access services and they make the call, you've got to make the most of it.

(00:22:15):



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So we'll call back people within 24 hours. And the great group of clinicians I spoke about earlier that work with us, we're able to get an appointment if needed within 72 hours. And I think that's a really important part of our service model as well. All mental health services are resource and time poor, we know that. So I think it's really important that our model is able to make sure that we link someone who contacts us via a triage clinician to a council for some support or some treatment or some care within 72 hours if need be. And if it's not needed and it's negotiated a bit longer, then that can be negotiated too. But I think it's really important to use the farm analogy to make a while the sun shine. So if someone's contacting, we'll need to get our skates on and get some follow up for them.

Andrew McPherson (00:23:11):

Thanks, Mick. I think the next questions were to come from you.

Mick Fryar (00:23:18):

Yeah. So I suppose leading on from that to the other panel members, I guess it's really important to respond quickly, as I've said. What do you think is the most important thing in your experience that we've got to do that's got to happen when someone really makes their first interaction? Recognising that it may be a really big deal for them. They may have spent months and weeks thinking about whether to contact or not. What have we got to get right?

Ben Gillet (00:23:48):

Thanks, Mick. I think the concept of meeting men where they're at, we're talking about men who have a lot of demands. You'd look at Rohan's case, managing farms, managing kids, employment. I think that idea of having the booking system where we can meet them where they need to be on their time and having that rapid response, I think is really crucial. I think there's nothing worse than the feeling of screaming into the void, asking for help and getting radio silence. And I think hearing something back rapidly is really something I think in the feedback that I've received is a bit of surprise. "Oh, you've got back to me so quickly, or we've been able to get an appointment so rapidly." And I think that's a real strength to the model that we have. So really, really being responsive and having that rapid turnaround is really important, I think.

Michael Grimes (00:24:53):

And that gets things off to a very positive start too.

Mark O'Brien (00:24:57):

Absolutely.

Michael Grimes (00:24:58):

Yeah.

Mark O'Brien (00:25:00):

And I think as all clinicians and those listening tonight, it's using the skills that we have. I mean, I will do things one way, and I'm sure others will do other things the other way, but it's being aware of what skills



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we bring in our qualities that help engage people. And so I might talk about a few ideas now about what I might do. It might be something else and the ability of someone really to succinctly put back into a conversation what someone's explained so that they know that they've been heard. But I find engaging with men when we make contact is actually inviting them into a two-way dialogue, that they're involved, that they can ask questions of me. They can ask, "Why am I asking this question?"

(00:25:43):

What's that about? Why would this need to be known? "And they might also have the ability and the permission to say," Look, that's something which I will probably discuss at some stage, but I don't really want to be noted at this point. "I find also that explaining that the process will be assisted, that they're not just going to be handed a form to take to a counsellor, that the counselor's going to be lined up for them. There's going to be someone helping with that process. I've seen a couple of mental health care plans recently, and this is not a criticism of our GPs, but most of them are just addressed to generically psychologists. They don't know anyone or haven't got someone actually lined up for this individual that they're giving a mental healthcare plan to. And so there's that onus upon the man or person, woman, whoever, to go out and try to negotiate and find someone that hopefully will fit and be able to be of benefit for them.

(00:26:39):

And I guess that in what the model that we do have at role of triage and is to walk with the participant and to do so until that referral is confirmed. So making contact and saying, "I will be back in touch with the details once now that we've had our moment to get some information, we'll find someone who's available and can respond quickly. And if not being able to see them immediately, say within a week, but at least to make a time so that there's a time that's been booked and that the participant knows that this is going to be something which is going to be followed through.

Andrew McPherson (00:27:12):

"Michael, do you have any strategies that you try to address in that first interaction? What are you careful to make sure that happens to get the man on board to make sure he engages?"

Michael Grimes (00:27:28):

Well, there's something that I think it probably should go without saying, but it doesn't always. And that is just approaching people with a conversational style, with friendliness, avoiding any jargon, all that kind of stuff. I think that's really positive. But once we get down to an actual session, I think, and I've kind of found this by experience having lost a handful of people here and there after an initial session, that it's vitally important that they feel heard that the most pressing issues for them, the things that have brought them into counselling or seeking help of some kind are addressed in that first session and that you don't really get too far into the kind of background issues like family history or any of that sort of stuff until you've given them a hearing and made them feel that they are heard and understood and that you are treating their issues with the urgency that they deserve.

Andrew McPherson (00:28:59):



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Thanks, Panel. What about friction reduction strategies that you may have engaged in your practise? What ideas can you provide the viewers as far as trying to reduce friction, particularly in that initial contact?

Mark O'Brien (00:29:24):

From my perspective, it's sometimes just you've just got to listen and not interrupt. I think men, traditionally, you need to sometimes draw out information, but with the experience I'm having at the moment within the triage scenario is that people, men are willing to talk. And it's important, I've noted for myself to make sure that I don't interrupt too early or that I might just have to jot down a thought and come back to that later, but just allow them to be able to just get stuff off their chest if they need to, and then come back and I guess work through what the major points might be that have been revealed and divulged by in that sort of practise.

Ben Gillet (00:30:09):

I think a real avoidance of assumptions about what they want is really important and taking the time to understand what they've done before. My experience is a lot of guys have come and had maybe not so good experiences. So trying to just flesh out, well, without judgement, what was it about that first appointment that you had with another provider that didn't work and what were you looking for? And I think really taking that time to understand what it is they're looking for so that we're not repeating mistakes that have already, not mistakes, but just going over the same sort of ground or assuming that they want a psychotherapeutic approach when really what they're looking for is a practical approach to help overcome some psychosocial stresses. So I think really avoiding assumptions and really exploring what it is they're looking for and giving them credit for understanding what they want, I think is really important.

Andrew McPherson (00:31:16):

Yeah. Thanks, Ben. Many of our participants today may not have access to some of the service model design features that our organisation has created, but I'm sure that all understand how critical that first interaction can be. There are a number of strategies that were highlighted by the panel, but the thing that came through to me is how important it is to listen, to meet men where they are, and to make sure that you avoid assumptions and give them a chance to talk. Our goal in this section was to teach viewers how to break down barriers at first contact and hopefully keep the client engaged in his own care journey. So just give me a second here. So we're now moving to the next stage of Rohan's journey, and I think it's reasonable to say that either during intake or shortly after, the complexity of Rohan's situation becomes visible.

(00:32:36):

And I think from the case study, I think you can all agree that Rohan's problems are complex, but again, not that unusual in a rural or regional context. Over to the panel again, what are the main risk indicators here?

Michael Grimes (00:32:53):



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Well, I think there's a suggestion there that he's having suicidal thoughts. There's a real crisis of identity. His identity is very much bound up with the idea of being the farmer who is carrying on the family tradition, but his identity is under threat in all sorts of other ways as well. His identity as a husband, as a father, as a mate to some of the friends that he seems to be withdrawing from, all of those things, and of course the threat of relationship breakdown with his partner, all of those things point to a high level of risk potentially. And the suicidal thoughts are probably the ones that need to be addressed initially, most urgently, I think. They're the main risk indicators that stand out for me.

Ben Gillet (00:34:24):

And I think that leads onto the importance of effective triage, good triage, good risk assessment, and being very open about what Barrett Mental Health can do, and at what point those risks become at a level that we need to refer up and escalate. And being very open and transparent about that early on, that when there are risks that need to be managed up, that we do need to refer, but also not trying to frighten them away, just recognising that is a reality, that there's the risk component, there's the practical elements that they might need help with, and there's the therapeutic aspect. So I think I roughly, in my practise, break it up into those practical elements, the therapeutic elements, and then the risk, and then try and present that and talk about what we can do at Barrett Men's Mental Health and the sorts of referral options we've got.

Mark O'Brien (00:35:31):

Thanks. And I would also note, I guess that sense of isolation, isolating himself from his friends and network, possibly isolating himself from his children, and then also how that transcends into him isolating himself from actually seeking help and just being aware of that as a risk which just underlies everything else that's been spoken about just now. But it's that encouraging the individual to engage rather than just, "I'll be right if I'm on my own," which is probably not going to work as well as actually being able to share that issue or problem in a counselling model or just through the triage or being able just to talk about what's happening.

Mick Fryar (00:36:17):

I think also it's important to recognise that things change. So with someone like Rohan and some of the stresses he's got, I mean, some of the potential risk factors, some will be static and they're ones that are quite predictable, but there's some dynamic things that can change. And of course, if we pick that he's having more increasing arguments with his wife and she's hinted that there might be a breakup, then that is highly likely ... Won't happen in session if he's seeing a very good counsellor. In fact, it's likely to happen one late night one night, isn't it? When he's come back from work and have had an argument about a bill or something like that. So things can change. So I think it's really important when we think about risk is not so much to think about cross-sectionally risk, but more longitudinally and more if what circumstances can change.

(00:37:05):

And as Ben and Mark were saying, have a bit of an open discussion with Rohan about what would that look like if this happened? What would your plan be? What sort of support can we put in place to make sure that we mitigate that?



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Andrew McPherson (00:37:22):

There's a question from the audience who is a person who's looking for tips for assessing suicide risk even when the client presents with stress rather than depression, at least in their mind.

Ben Gillet (00:37:41):

It's a good question. And I think at triage at intake, that exploration of history, trying to understand what's come before, are these the sorts of thoughts that may have these thoughts occurred before and under what circumstances? And drawing some parallels to that, to what's happening at the moment, I think pointing out that under enough stress and enough pressure, this is a relatively common experience for men with depressive symptoms to have these sorts of negative cognitions and thoughts. So I think trying to take some of the scariness out of it and having very open conversations with men and really normalising it, saying that this is-

Michael Grimes (00:38:37):

Yeah, normalising

Ben Gillet (00:38:37):

It. Yeah.

Mark O'Brien (00:38:40):

And I think so also, Ben, is that looking at the protective factors as well, balancing the thoughts, the risks that may be apparent, but also just exploring with the individual what protective factors are there in family and partner, children, the things that people are looking forward to and what they want to engage with. And that gives a reassurance at times in that risk assessment sort of model.

Ben Gillet (00:39:07):

I think the reassurance and providing a bit of the hope when people are feeling hopeless is really important. And I use the concept of scaffolding, getting around someone, being that support, drawing on the positive factors in their life, even during a time when they are feeling low and feeling hopeless. So I talk about scaffolding or getting around someone and kind of being the hope when they're feeling hopeless.

Mick Fryar (00:39:37):

And I think then they're the sort of things you can put in place when you are doing your assessment or you're asking the what if questions. And if I go back to the example I gave earlier about the relationship problems, what would that mean? Rohan, if there was a temporary separation, what would that mean for you? What would you do? What would your plan be? How would you feel about that? The what if questions, and then you can put some of that scaffolding, which is quite a nice term, a plan with Rohan to say, "Oh, well, look, if that happened, I'd get my son to come up, or I've got a very supportive neighbour I can stay with." Or having a plan around that. And I think your line of questioning to tease out some of those things needs to be along the lines of the, what if this happened?



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(00:40:14):

What would this happen? What would you do? And then you get a bit more of an in-depth understanding, I guess, of a person's likely thought processes and then behaviours if things change as often they do.

Mark O'Brien (00:40:26):

Yeah. I think also exploring where the depression is coming from or the risk of symptoms as well. I think what we try to do in Belarus Men's Mental Health is look at the bigger picture, look at the systems where the participant finds themselves in, and sometimes the practical must come first, whether people need medications, they need housing, they need food, and we can't underestimate the impact practical matters can have on mental health. And just probably moving forward, but as we may come back to, but this is why I guess we see referrals coming back, say to social work from the counsellors once they've been referred into the counselling model.

Mick Fryar (00:41:04):

Andrew, I might just add one of the scary statistics that I was made aware of maybe about a decade ago now, and we know that the percentage of people who take their life, 75% on average are men, but I can share with the audience that back in the late teens, so maybe 15 to 19, I'm not sure of the exact dates, but there was a report that came out that articulated that of the percentage of men that took their own life over that five-year period, 66% that had, this is in the Granpion region, which is Ballaratis around 66% of those people had had no contact whatsoever with any counsellor, any urgent care centre or an emergency department, not a GP, not Lifeline, not Beyond Blue, no contact with any sort of health or help seeking person at all in the previous 12 months before they took their life.

(00:42:07):

That's a really scary stat. And it just, again, summarises how important it is at first contact to maybe have to ask the difficult questions and the what ifs and be really open and honest as the rest of the panel have talked about to get a bit of a sense of what the plan and the support needs to look like.

Andrew McPherson (00:42:26):

You may have already covered some of this, but my question is, should we, and if we should, how do we address practical relationship and psychological needs together when a reasonably complex case presents, as in Rohan's case?

Michael Grimes (00:42:48):

Well, I suppose I covered some of that in an earlier answer, but when I was talking about framing Rohan's situation holistically and sort of breaking it down into the parts that he may have some control over and the parts that are sort of bigger problems that everybody faces. But what I would add to that is that in this particular case, I would consider, or I would ask him if it is possible to invite his partner to be included in the counselling process at some stage further down the track, perhaps, whether she would be open to that possibility, but also I'd discuss other forms of support that may be available like financial advice or social work support or medical interventions or Centrelink assistance as alternatives to counselling or concurrently with the counselling.



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Andrew McPherson (00:44:04):

Thank you. The panellists provided a number of examples of how to engage and how to support continuity of care by addressing all of the different aspects of the person in front of them. And that was certainly one of our learning objectives and thank you for the examples that you've provided. So we're going to move on to section four, and there are still a number of ongoing risks that complicate the next stage of Rohan's journey. Many of the issues raised already or that might be outlined in this section can occur almost anywhere from intake to subsequent counselling sessions. Our focus in this section is to discuss the provision and coordination of care and how to prevent, drop off or disengagement, which is something that happens far too frequently when men reach out for help. Many of you, of course, will have experienced these issues through your practise and will have already developed your own strategies, but there are still many points at which disengagement can occur.

(00:45:21):

Ben, what do you think those critical points for potential disengagement might be?

Ben Gillet (00:45:28):

Thanks, Andrew. I think whilst triage is vitally important at that initial stage, it doesn't end there with our triage role. I think a strength of Ballarat Men's Mental Health is what comes after. So I think when we triage and refer off to a service provider, whether it be for social work or psychotherapy or whatever it might be, traditionally that happens, we step away and that's the end. And often we don't know what happens. I think what we strive to do at Barrett's Mental Health is stay connected, have that strong relationship with our service providers. So they do have that mechanism that if a session hasn't gone well or the person has not returned after the first session, the service provider comes back to triage, we call it circling back and exploring what might've happened. And so then we at triage then can then follow up the individual and say, "Okay, well, what's happened here?"

(00:46:33):

Have we missed the mark?" So I think that sort of referring on and ending there, we try to stay involved and make sure we've got those relationships with our service providers that they know that they can circle back so that people aren't just going for one session and dropping off, we can problem solve. And it can be really practical stuff. It might be a scheduling or a timing issue or just, I use the analogy of speed dating. Sometimes you just don't gel in that first interaction and that's okay. Always stress to the person that I'm triaging, if it doesn't work, it doesn't feel right, come back. So giving the service provider the option to come back and recontact, and also giving the individual to say the permission to come back and say, "Hey, that didn't work for me. Is there a different option?" So that circle back I think is really important and a real strength of our model.

Mark O'Brien (00:47:36):

I agree, Ben. I think it is a model which tries to let people know that they're worth it. We want to welcome men into a partnership and really, this is probably a word people might not use much, but celebrate their initiative and the effort that goes into seeking help. Even when they may have dropped off or they haven't, there's been a non-attendance or something and we're following up as part of the triage, it's actually just saying, look, things can bounce back to where they were. You don't lose ground.



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You're able to recontinue. And looking at those factors which might be preventing someone from actually engaging, is it because of travel and cost and getting there and all that sort of thing, or could telehealth be an option, which we know we can offer as well?

Ben Gillet (00:48:23):

I think that the idea that a person could be coming to us for the first time or their last attempt, that there could well be a very small window of opportunity, and if we're going to take the time, we should make sure we're going to that next step. So we're not wasting that opportunity, that window that's open, we're exploiting it to its full. And so that we need to make sure that we are taking that opportunity and making the most of it, because it could be their first and only, or it could be their last attempt at really reaching out. So that sits in the back of my mind when I'm wanting to make sure that people are connected.

Mark O'Brien (00:49:05):

Yeah. And circling around is a process of helping that connection become real. And people to see that it's not just an industry, this is a service and that we want to make sure that those that we've referred on, and when things do pop up that may complicate that, that there is support to work through it.

Mick Fryar (00:49:26):

One of the other things we're able to do, of course, too, Andrew, is, and it's a simple thing, but it can make a big difference. And Rohan, of course, in his case, he's under financial pressure. So the first three sessions with Barrat Men's Mental Health clinicians and service providers are free. So that's another way, I guess, of encouraging people at least to come back a second and hopefully third time. And then more often, if need be. Certainly their ability to pay doesn't preclude from accessing the services that we need to get. So that's negotiated individually if need be, and can be more ongoing.

Andrew McPherson (00:50:01):

Yeah, that's a good point to raise, Mick, because we have found that that is so important to getting men engaged in their care. The inability to pay is a real issue. You've highlighted the critical points for potential disengagement, and you've also talked about a number of follow-up strategies. Our service has introduced a number of those to prevent men missing out. And Mark, you've been absolutely instrumental in delivering a lot of that support. So over to you.

Mark O'Brien (00:50:39):

Oh, thank you. Yeah, I guess social work is a passion, and I think it fits really well within the model of Barratt Men's Mental Health, and certainly has been lots of opportunity to use the social work skills to assist men, particularly with just the practical things, if we go back to that theme. So I just wrote down a list of the different things, and thinking back through over the last four years, things and examples of what I've been involved with, a lot is to do with housing and registering for priority housing via the Department for Families, Fairness and Housing, helping people through the MyGov process and sometimes providing computers and access to MyGov, which is now the link for housing here in Victoria, and also referring to the housing support such as Winteringham and Uniting Care within Ballarat, and advocating for participants to these services, follow-up conversations.



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(00:51:42):

I'm a real big one on actually not just sending an email or a referral, but actually following through with the phone call, much like we do with Belat Men's Mental Health, of course, and having those conversations rather than just assuming that the referral's been received and accepted and will be enacted. We've been finding emergency accommodation. One of the gentlemen we worked with was at risk of being burnt out through the fires over the last couple of years in a town outside of Ballarat, and we were able to find accommodation-free minute local SRS. There's been lots of dealings with Centrelink assisting with claims for benefits and payments. Dealing with access request processes with the NDIS has been a big one, and one which I think has been a rewarding situation for myself, but one that has been ... I mean, people do struggle a lot with is negotiating the NDIS and the access request paperwork, demonstrating the impact of the disability, getting together medical information and other assessments, and sometimes even negotiating funding for assessments has happened.

(00:52:49):

For example, people with autism or suspected traits of autism are needing neuropsychology assessments. I mean, they're hard to come by and sometimes there's a great deal of cost involved.

(00:53:03):

I've also been dealing with NDIS participants and assisting with reviews and advocacy with their support coordination, coordinating care between GPs, and as an example, job network providers and other community services. Sometimes it's just knowing where to go to get funding for medications. And that sometimes is one of the big practical things people need as what goes in with food and other things that people just need to sustain themselves and knowing where they can go. And the appreciation that has been shown has been quite humbling from people when we've been able to provide and source fuel cards for people who need and have really demonstrated financial hardship.

(00:53:46):

We're also building connections with existing services such as the Salvation Army and the Swinson DePaul Society here in Ballarat, just so that people know that it's not coming back to Ballarat's mental health, but also these are the agencies out there that can provide assistance. And at times, also advocating to public health for allied health services. And something also maybe providing boxes, finding boxes for someone who's trying to pack up because they're moving house, and just little things like that can mean a lot to people. And in one case, a gentleman just needed things to be stored. And so yep, I was able to go and get boxes, and that was just a simple act, but something also which meant a lot to the participant at the time.

Andrew McPherson (00:54:33):

Thanks, Mark. I always remember a story. You told me about a gentleman who was couch surfing and his cheap phone died, and he was getting counselling care via the phone outside of Ballarat. And you found a new cheap phone for him and took it out to him so that he can continue to receive his counselling through our service. And it was only a hundred dollar phone, I think, but it made a huge difference to that man. And those are great examples of those kinds of things that you've been able to do. And really, Rohan's case illustrates the convergence of multiple stressors that really do or can necessitate an integrated approach across disciplines.

(00:55:29):



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Keeping men involved, some of the comments that you made about always keeping the care journey in the front of your mind as you're going through the process with the client, staying involved in their story wherever possible, and giving the individual permission to come back, to circle back. And I particularly liked your comment, Mark, about welcoming a man into a partnership. All of those things I think are critical in supporting continuity of care across disciplines. So the next slide in terms of ... I think we need to go on one more, I'm sorry. Yeah, multidisciplinary clarity. Thank you. Now look, we understand that access to a social worker or the ability to implement certain support strategies to prevent disengagement and drop off are not universally available to our viewers, but however, where the involvement of others in a care journey like Rohan's needs to happen, a lack of role clarity can really lead to fragmented care.

(00:57:01):

So it might be instructive at this point to consider the system level issues. Next slide, there we go, sorry, facing most men and service providers. The deliberate use of the strategies that Mark outlined in supporting continuity of care was absolutely integral to our service design, and it was aimed to address as many contributing factors to men missing out as possible. Those challenges were evident in Rohan's experience and reflect common issues in rural and regional Australia. Some of those issues we've talked about, limited access to general practitioners and qualified mental health professionals, extensive waiting periods, high cost of services, and the complexity of navigating a sometimes opaque service system. These factors significantly impact help seeking among men, increasing risks of engagement.

(00:58:09):

Next slide, please. So we're drawing towards the end of our webinar. We're going a little bit ahead of time, which I think is fine, but the key takeaways we want you to reflect on is the critical importance of responding promptly when men seek assistance and to be flexible in your approach. You must seize the moment. There might not be another chance. We've shown how reducing friction at intake and during a care journey increases engagement and enhances follow through. And we've discussed how continuity of care really requires some coordination. It must be intentional. We've mentioned warm referrals, how important it is to make sure that the first contact with a counsellor that you might be referring to or another support that you might be referring to actually hope happens. We can't leave our men swinging. We have to support the next step in their journey, whatever that might be.

(00:59:22):

I think we've underscored the value of effective communication and collaboration between service providers and the importance of role clarity. Who's doing what to support this man? All of these themes align with our objectives to describe barriers and enablers, outline strategies for engagement and continuity, identify service design features that reduce barriers and apply practical strategies to improve collaboration and referral processes. Our hope is that these strategies offer valuable insights and support efforts to improve access to mental health care for men within your practise. Finally, to the panel, what is one practical referral improvement our viewers could apply immediately to prevent men from missing out?

Michael Grimes (01:00:23):

Well, Mark has used the phrase circling back several times, and I think we're already doing this pretty well, but it can always be improved. And that is the process of liaising with councillors about the



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suitability of particular referrals prior to the referrals being made and a continuing dialogue if other concerns arise along the way. I think that circling back aspect really needs to be emphasised. And as I say, we can always improve that, I think.

Mark O'Brien (01:01:08):

I think conversations and that theme of talking and circling back is vital. I mean, for me, a practical improvement is highlighting the value in conversations between practitioners. Ballarat Man's Mental Health not only provide a clear and prompt referral process, but we take the time to speak with counsellors receiving the referral to ensure they have capacity that they can respond quickly or at least book a time. And there's so much value in that direct discussion to clarify the right fit with the counsellor and participant. In my experience, unfortunately, over many years as seen, is the perspective that once referrals are made and let go, that's the end of it. There's not much follow-up, and sometimes referrals don't get followed through. How often men face a situation in which they've had no further information about the progress of a referral. I like to think the model that we use is that there's follow through and that we keep people informed of the process until we know that the referral has been accepted and then time's going to be offered to them.

(01:02:15):

And if there's no contact, the participant sometimes can follow up. And if they know that they haven't heard anything, my invitation to them is to actually make contact with me to say, "Look, what's going on?" So they've got some participation with this as well.

(01:02:35):

Our referral process is not one of assumptions and that something is going to happen. So it's really ensuring that the plan agreed upon is being followed through.

Ben Gillet (01:02:48):

Thanks, Mark. Yeah, I think just going on from similar points, the circling back process, it can be embedded. And I think it's contingent on the strength of your relationships with your service providers that there's no failed referral. There's always a contingency to circle back. And so I think setting the expectations with the individual and also having that strength of relationship with service providers so that it is just seen as business as usual, that someone may come for one session, it may or may not work, but let's not leave it at that. If it's not working, embed that process of reaching out back to triage to follow up. And I think that's something that I think most services could probably implement relatively easily. I know not everyone viewing tonight will have a mirror service to what we've got going on, but that kind of strengthening relationships, embedding that circle back processes are, I think, a really practical strategy that can be implemented.

(01:03:58):

Andrew-

Michael Grimes (01:03:59):

Also, this is not specific to the referral process, but just as a general comment, I think what is vitally necessary at every stage of the process is personalising the service of tailoring it to each individual.



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Andrew McPherson (01:04:20):

Thanks, Michael.

Mick Fryar (01:04:21):

Andrew, for me, it's a simple one. It's about time. It's about a short time, and I think it's about a long time. And I think the short time needs to be to get back to someone if you get a referral. That's crucial. I think if someone finally reaches out, they need to be contacted really in a short time. And then the long time is to be able to have enough time when you do have a chat to them or you meet them, whatever, to be able to be a good listener, and then to be able to make sure then you instil that all those things we talked a bit about hope and ongoing follow-up and those sorts of things.

Andrew McPherson (01:04:52):

Thanks, Mick. One last question without notice. Is there any key takeaway that any of you would like to share with our audience?

Mick Fryar (01:05:09):

Andrew, look, for me, I really do think it's about that ease of access. Men are very reluctant to reach out. We know that. We've got some statistics we've talked about earlier on. It's well documented more so in rural areas, of course, but nonetheless, so it's really about seizing the opportunity. When the windows open, you need to do something about it. So it's all about prioritising those sorts of early contacts, I think.

Mark O'Brien (01:05:37):

For myself, it's about the one main thing for us is that we don't focus on criteria. Anyone's welcome and everyone can contact and we can sit, we can listen, we can talk about strategies or ways to assist people. So we're not that criteria focused, which I welcome and find a breath of fresh air.

Andrew McPherson (01:06:01):

Anyone else? I

Ben Gillet (01:06:03):

Think the idea of holding a person's hand, walking them through the process, not just pointing them in a direction, actually walking with them. And if that's not been the right direction, let's take a step back, reassess, and go again. And I think that's an idea that resonates with me, and I hope it does with others.

Michael Grimes (01:06:30):

And I probably jumped the gun a bit with my comment about personalising the service, but I think that bears reemphasizing it's a very important part of what we do, I think.

Andrew McPherson (01:06:43):



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Yeah, it is. It is. And we're quite proud of that. My takeaway is not so much from this discussion, but something that I asked one of our triage clinicians last night, it was Mark in fact, one of the things that we're proud of is that we believe that the people who have come through our service in the last four or five years would not be accessing care, if not for us. That's certainly been true for the first two or three years. I hadn't asked the question for six months or so. Mark was able to assure me that that is in fact the case. Would you like to elaborate on exactly what you told me, Mark?

Mark O'Brien (01:07:28):

Well, look, I think just from the experience of working and the feedback you get, the positive feedback is something which has been quite reassuring for me. And hearing from people saying, "No one's been able to help us before really or get this done." And practical side of things, I guess, from the social work experience, but just to say, look, and usually it's a long process to get in to see someone. There's a sense that there's action, and I think that's where we make a difference and we're reassuring people that things will happen. We don't make promises we can't keep. We're not there to give misleading information, of course, but I think we're providing honest assistance that's reassuring and that actually, once again, holds people's hands at times just to get a few things done to get someone to the point where they can access the supports they need.

(01:08:26):

But just from the feedback I've been getting, I just feel that this is a breath of fresh air for some of the men that we're working with.

Andrew McPherson (01:08:36):

I think that's a great place to finish it, Mark. Thanks for that. This brings our webinar to a close. Thanks to all of you who've attended and to the panel for their participation and insights. Goodnight, everyone.

Ben Gillet (01:08:53):

Goodnight everyone.