# Designing a community-informed men's mental health service

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| **Presenters:** | Founding Co-Directors, Ballarat Men's Mental Health:<br>Host: Andrew McPherson<br>Guest: Maxine Troon<br>Guest: Mick Fryar |

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**Content warning** (00:00):

This podcast discusses content that may be distressing for some listeners. Please refer to the episode description for details about the topics covered.

**Host** (00:09):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary collaborative mental healthcare.

**Andrew McPherson** (00:26):

Welcome to Mental Health In Practice, a podcast from the Mental Health Professionals Network. In this episode, we're focusing on the difficulties faced by many mental health services, engaging men in their own mental healthcare. We want to explore the barriers that prevent help seeking and how a regional service, ours, Ballarat Men's Mental Health, was designed to lower those barriers and strengthen engagement of men and their families. I'm your host, Andrew McPherson. I'm a founding director of Ballarat Men's Mental Health, and I'm joined today by Mick Fryer and Maxine Troon, who are also founding directors of Ballarat Men's Mental Health.

(01:09):

Most of us are aware that men are not particularly good at engaging in mental healthcare. What is less often explored is what is it that moves people, in this case, men, to respond the way they do? This

conversation really matters because despite some improvements over the past decade or so, men still seek help at a much lower rate than women and suicide at a much higher rate also.

(01:36):

I'd really like to hear from each of you what brought you into the work of designing a service that tries to meet men where they are.

**Maxine Troon** (01:44):

Andrew, going from my background, tragically, I lost my husband, Michael, Michael Troon, to suicide in 2012. And at that time, our children were just six, just eight, and nine and a half. And for me, it was about initially protecting them, but I'd always felt I had a role in advocacy. Moving through the years, because this conversation, although that loss forever shapes my life, the cause of Ballarat Men's mental health is bigger than that. And the statistics around Ballarat drew me to feel I had a role in advocacy. And about six years after Mike's passing, there were two men from Ballarat Football Club who took their life, and the club reached out to the organisation, and they were told that they couldn't send any representatives up there for 18 months. And that alarmed me, and I just felt that we needed to do more than this.

(02:40):

We needed to do better for our community. And off the back of that, I launched a fundraiser, not really knowing what I was doing, but Bohemian Rhapsody was coming out as a movie, and I thought, who wouldn't want to go and see that? That's a given. So did a fundraiser, but it was meeting with a good friend of mine, Peter Blinkin. Peter was the one who said, "The funds need to stay in Ballarat Max." So with that, we started to sort of look how we could do something more locally after the fundraiser. We attributed the funds to survivors of suicide, a Ballarat organisation. But after that meeting with Peter, and he very quickly said, "You need to get in touch with Andrew McPherson, who's headed up headspace in Ballarat and Lockie Dodds, who was a urologist in Ballarat and Peter. And we had a few formative meetings. And that really is, I guess, my story into the beginnings of things with Ballarat Men's Mental Health.

**Andrew McPherson** (03:34):

Thanks, Maxine. And thanks for sharing that personal stuff. I know it's not easy.

**Mick Fryar** (03:39):

Andrew, for me, I guess having worked for 40 years in public mental health, so a tertiary service was an opportunity, I guess, to perhaps look to do something different and be involved in something new and what I hoped was going to be innovative. Certainly Maxine talked about some statistics and we do know that men aren't so good at accessing services, but also suicide at a much higher rate, as you mentioned. But one of the statistics that I became aware of too, and one of my roles was in the Grampians region. So that really goes from Bacchus Marsh right through the South Australian border. Picks up a few other towns in Ballarat, of course, Ararat, Horsham, Stawell. But in a period from 2013 to 2018, of the male suicides, 66% of those people had had no contact whatsoever with any health service at all. The other

thing from my experience, of course, is I know that there are long waiting lists and Maxine's right in pointing some of those things out.

(04:42):

So again, having an opportunity to work with some people and develop a service that could have a really quick turnaround to get men in particular into some sort of care was really important for me. And I guess the other thing too, and again, looking to move into more primary care type based care was an opportunity to maybe work and develop a model of care that was more like a social based and that was a bit more responsive and perhaps a lot more flexible as well. That's something I think to some degree we've been able to achieve, Andrew.

**Andrew McPherson** (05:12):

So Mick, I think it's really important that we get an understanding for our listeners where we are at right now in terms of service delivery. How have we grown? What's it look like?

**Mick Fryar** (05:22):

Yeah, sure. It's a good question, Andrew. So of course, we started off with one part-time triage clinician. We've doubled that now. We have two. So we monitor our bookings, our appointments, and our calls every day. So the longer someone has to wait before they get a call back, it's usually 24 hours or the next day. Obviously, if it's late Friday, then it won't be responded to until the Monday. And we've grown our counsellors and our clinicians to 14 now. So our triage clinicians have the ability to refer on to 14 different clinicians that work in and around the Ballarat community or just outside, which is nice to have as well. And they vary greatly in terms of their experience and their qualifications. We've got mental health social workers, we've got mental health nurses, one becoming a mental health nurse practitioner. We've got psychologists, we've got some general counsellors.

(06:13):

So we've got a real mix. We've got a couple of people with experience working with men in terms of behavioural change and some experience with some domestic violence. It's not a specialty area for us, but we're able to provide that. So because we've got such a great number and a variance in clinical experience, we're able to get someone an appointment within 72 hours. If it's not needed, then the triage clinician will negotiate a bit longer. So not everyone gets seen within 72 hours, but that's a very proud stat.

**Andrew McPherson** (06:40):

Thanks, Mick. And your experience in mental healthcare has been invaluable to this organisation. My background is neither in mental health, nor do I have a lived experienced story to tell. I was involved in setting up Headspace in Ballarat, but it's more as a Ballarat resident. You just cannot help be aware of the statistics in and around Ballarat. So we really felt that we needed to try and do something. And Maxine, you were there right from the start. How'd we get started?

**Maxine Troon** (07:13):

I think initially our idea was we might look down the track to offer something more than just mental health. And we also had a very big idea that we needed a bricks and mortar place to run this entity from. I think for me, COVID probably showed us that really we didn't need bricks and mortar, that telehealth was really being embraced throughout COVID. And I think those kind of things helped us very quickly understand that maybe the familiar structures with service delivery models that we're used to might not necessarily be what we were after.

**Mick Fryar** (07:50):

Yes. Yeah, I'd agree with that, Maxine, too. And I think that some of the discussions talked about having improved access, but being able to set a service up where we could respond really quickly and recognise that sometimes it's really difficult for people in general, but men as well, to actually reach out. And that if we had a service that responded quickly when someone did reach out, that we were much more likely to get some care and some treatment in place. And of course, we know with all healthcare, it's no different in mental health that early intervention and early care early treatment really does improve outcomes.

**Andrew McPherson** (08:25):

Yes. Thanks, Mick. And so really what you're both describing is a situation where we had a group of local people who wanted to do something. So what did we do? The first step of that was to seek input from existing services, individual practitioners and people with lived experience. We really wanted to know what worked well, but more importantly, what wasn't working well. We felt that the answer to that question in particular was the key to understanding why men in our community so often didn't get the mental health care they needed when and where they needed. At the end of that process, we found that there were four main barriers to men accessing mental healthcare. Interestingly, they were consistent with some of the findings of the Victorian Royal Commission into mental health that occurred around about the same time. So let's work our way through those four barriers. Max?

**Maxine Troon** (09:30):

Well, accessibility, I think trying to get an appointment was always really difficult. So waiting lists, getting a mental health care plan, finance, they were three of the four of the barriers that we were looking at and just trying to get people in to see a professional as quickly and as smoothly as possible.

**Mick Fryar** (09:49):

Yeah. The good things, of course, Maxine, to be able to do something about for sure. We thought too that even people do receive appointment and they have a referral that often they don't follow through as well. And I think you're right, Maxine. The waiting times were a big one. In regional areas, they tend to be even longer than a metro service, but it's not uncommon for someone to have to wait four, five, six weeks for an appointment. So that was something we really wanted to address. And that's often due to waiting lists. So one of the things we really wanted to do, as Maxine's pointed out, was do away with waiting lists and have a really responsive service when people did actually contact.

**Andrew McPherson** (10:24):

Thanks, Mick. So really, as you've already mentioned, reluctance to seek help. We know this already. We've mentioned it a number of times. Men not following through after first contact, inability to navigate a difficult service system, long waiting lists. And last one is that in many cases, there's an inability to pay, which is a huge blocker for some men. So before we talk about how we then designed our service to address those four barriers, I think that, Mick, given that our audience will primarily be mental health clinicians, perhaps we'd better describe the kind of clinical services that we offer.

**Mick Fryar** (11:05):

Yeah, sure, Andrew. So I guess it'd be no surprise that we probably targeted our service at what the Royal Commission in Victoria anyway called the Missing Middle. So essentially, if you've got a fairly severe mental health problem, then you find your way into the tertiary service. The very mild conditions can go untreated and they can become more serious, of course, but there's many people that are in that moderate mental health problem area, if you like, that need a lot of care and don't get it. So no surprise to our clinicians who might be listening on us. That's really the high prevalence disorders that one we treat and one that come through and make up the bulk of our referrals in terms of anxiety, depression. And obviously people wouldn't be surprised that there's an increasing comorbidity of substance use in there as well. The idea, I suppose, was to design a service that people could access really quickly.

**Andrew McPherson** (11:56):

Maxine, I think it was your initiative for grocery cards, was it? It doesn't matter. Tell them about it.

**Maxine Troon** (12:02):

I think again, some stories about people that were finding it hard if they were having their children and their marriage had gone south, even just to put food on a table. So for men to be able to provide for their children when they had the parental time with them. So very quickly we moved to distributing grocery cards to GPs and these grocery cards had a stipulation, so they were just going to be used for those necessities. And I think just knowing that there was someone out there who cared, there was something tangible, something really practical that was an answer to a really pressing, "This is happening right now," problem.

**Andrew McPherson** (12:40):

That's right. And it's an example of how we've tried to do more than just be a clinical service provider. One of the things that we did early was to make sure that we had some decent outreach and practical supports. We engaged the social worker very early on in our history, and Mark has been great at addressing some of those issues that a typical mental health service simply can't do for perfectly reasonable reasons. Examples of the things that he's done, he's helped a person find accommodation. We had a person who was receiving services through us remotely whose phone died and he had no money to replace it. So Mark found him a cheap phone and dropped it out to him. He's helped really complex cases to access NDIS. He's been really instrumental in so many ways in broadening our ability to meet the needs of men once they have found their way to us.

(13:38):

Mick, you've got a really interesting story about outreach, I guess.

**Mick Fryar** (13:43):

Yes, a couple that spring to mind, I suppose. Was one guy who was not travelling very well at all, and he was suffering with depression, and he rang up the clinician, was able to stay on the phone with him for 40 minutes or so while he got himself up to the local urgent care centre and then stayed on the phone, did a hand over to the nursing staff. And we've had a really good outcome with that fellow. He's on some medication, getting some treatment as well from us, but also from the area mental health service locally as well. And he's doing actually really, really well. There was another thing that Mark followed up to. He rang me down. He said, "Mick, I need to engage with this young fellow. The mother's doing the referral. He won't see anyone." Said to Mark, "Look, what about we go out and will you go out and just have a cup of coffee with his mom?" And if he's in the house and he won't leave, he's going to see you there.

(14:26):

He got just to talk to him very briefly when he was leaving, but he's agreed for Mark to come back in a couple of weeks and catch up with him again. So we'll see how that goes, but it's great that we're able to be really flexible and innovative in doing what we need to get the care to people that need it.

**Andrew McPherson** (14:41):

Yeah, that's a great example of how we have tried to shape our service to be more responsive to what's exactly happening in the life of potential clients. You mentioned waiting lists. Our strategy for incorporating the elimination of waiting lists into our service design was quite simple. Find enough qualified practitioners so that there will always be someone with space on their schedule to see a client when they need to be seen. As clinicians will know, sometimes people need to be seen very quickly and sometimes they can wait a week or two. Our triage people tell us this, but so far we've been really lucky in being able to not have a waiting list problem.

**Mick Fryar** (15:24):

Yeah, we've been lucky that Ballarat Men's Mental Health triage clinicians do the triage, but they get the demographics, they get the presenting problems, they get some history. They obviously get permission from the client themselves to send that through. But the council then gets a whole lot of information where then they can just ring and that's much easier to establish a bit of rapport. And we can make that happen early if needed, but usually within 72 hours in almost every case. So that really does eliminate waiting times and waiting lists, which I think is really important.

**Andrew McPherson** (15:52):

Yes, it is. The last aspect of those four barriers is the ability to pay. And quite simply, the way that we incorporate that into our service design is if people can't afford to pay, then we will pay. So we got started and we learned quite a few things along the way about engagement. We felt that we were going to need to engage directly with men where they were, but Maxine had a very different insight and experience to that.

**Maxine Troon** (16:22):

I've done quite a few public speaking forums on behalf of Ballarat Men's Mental Health. And probably from my perspective, when I get up to speak about this, it's often something you can feel a shift, particularly in the men are feeling, "Oh no, this is making me feel uncomfortable." There's people not wanting to engage eye contact, but I felt more comfortable approaching women saying, "These are for the men in our lives who we know might be struggling." They will know of the men in our community who are hurting and who their behaviour might be a little bit changed. They may not be sleeping well, just things just aren't quite right. I think in all my conversations when we were doing one of the fundraisers, so often I'd start meeting with council workers or with people from football clubs and they'd reach across the table and said, "My brother passed to suicide or I've had someone struggling." So I guess my experience has been you really just have to scratch the surface and mental health really touches all of us.

(17:24):

There's always someone that we know of or a family member who's struggling.

**Andrew McPherson** (17:28):

Yeah, it's so right, Maxine. And we've all been learning along the way about how we need to change what we're doing. Probably the most important aspect of trying to remain focused as an evidence-based organisation is a study by Professor Suzanne Chambers from ACU and Associate Professor Nicole Heneker from the University of Southern Queensland. We engaged them relatively early in the life of the service, and they have been instrumental in informing us about quite a few things. First thing we learned was when they did a study of like services across Australia, New Zealand, and the United Kingdom is that there is no one anywhere doing what we do or operating according to the service model that we have been operating on. The second part of their study was to interview stakeholders, and that part has now been completed. The most important part is to get feedback from the clients themselves because we really want to know, are we reaching our target?

(18:34):

Are we reaching those hard to reach men? And are we doing a good job of meeting their needs? And until we're done with that part of the evaluation, we can't really say that. What we can say, anecdotally from our triage clinicians, that of the 300 or so men that have gone through our service since we began operating, almost all of them would not be receiving services if not for us. So what that means is either they simply couldn't afford to pay or the waiting lists were way too long, or they just didn't engage with any service except for ours because they saw that ours was directly designed for men. That kind of information is really encouraging to us that at least anecdotally, we appear to be hitting the mark, but sustainability and funding are ongoing challenges. We had a very successful event 12 months ago that is worth telling you about.

**Maxine Troon** (19:35):

So my daughter, Delaney, got into her mind that she would like to do something, and because of losing her dad, she decided that she wanted to run 2121s. So 21 kilometres every day for 21 days around Lake Wendouree. It's a 6K running path around the outside of the lake that's not far from the CBD of Ballarat. So running three and a half laps meant that people could join in, people could walk, people could come to all the full 21, or even just the last three kilometres. That journey was amazing with so many people

telling their stories. We had put it out to all sporting clubs in Ballarat to join us along the way, and it just slowly grew and grew in momentum. We had the football coach who went to school with my late husband. He came up and lent his support to the event and turned up five times.

(20:29):

Tony Lockett, who also played junior football with my late husband, was at the finish line one day. The fire brigade joined us one morning. There were so many fire trucks around there that one of the businesses around the lake thought that they were on fire. So again, a really innovative way to raise money and just probably took us all by surprise how well it was received in the community.

**Andrew McPherson** (20:52):

And it's a fantastic example of how this has been a community-based response through our organisation, but an extraordinary effort by Delaney and by Maxine, I should say, to get that up and running and to support it for 21 days. I hope we've made it clear that we have attempted to balance innovation and organisational strategy with evidence, and particularly with an evidence-based service model. It's hard to stay on track. Ongoing pressure and expectation from the community to respond to local challenges such as family violence, natural disaster, et cetera. We have to be careful that our responses, if any, need to be both measured and sustainable. We can't be all things to all people. We have to stay focused on the mission. An interesting occurrence a couple of years ago made us change the way that we communicated during triage. When a potential client indicated to our counsellors that they couldn't afford mental healthcare and we offered them free sessions, they refused them because they didn't want to take charity.

(22:03):

And so we realised that we had to refocus that by saying that free sessions are available to anybody, and so it's not charity if it's available to everybody, and that made a change. Most of you have probably experienced how hard it is to change administrative or clinical practices in a long established business or organisation. We are in a very different situation. We had the opportunity to create our own culture with a startup mindset, and without government funding, we were not being directed by funders on how we should operate. The only real non-negotiables for us are clinical safety, clinical standards, and clinical governance. Everything else is open to redesign or re-imagining, and we hope to continue that into the future. The other thing that I hope we've also demonstrated to you is that engagement is an unpredictable and a movable challenge, but it has to be anchored in the community and in what we learn along the way.

(23:13):

One of the innovations of ours was an ambassador programme. Maxine, you had a bit to do with that.

**Maxine Troon** (23:20):

Yes, Andrew, that program was launched by Scott, and we had a dinner at a restaurant and invited local clubs to come along. And basically, we were asking the clubs to join Ballarat Men's Mental Health as ambassadors, and we would provide them with two mental health messages a year. So just trying to access their social media and I guess broadcast our good work and make people available of the resources in the community that they can access. The dinner was really well received. We had people

there from football clubs wanting our banners. The distribution of the messages, however, has just taken a little bit longer, and we just need to rethink how we can work with clubs because we know that they're a really good social fabric in our community. Accessing their databases would be fantastic and accessing the people behind those, the families that support the players.

(24:15):

It just would help get our message out there.

**Andrew McPherson** (24:17):

Thanks, Maxine. That has been a real learning process for us. I would invite you both to perhaps give our listeners an individual reflection on something that you've learned or that you want to do or did do, just something that is important to you.

**Maxine Troon** (24:34):

I think for me, Andrew, it's keeping our minds open. I have got a rural background and I'm very aware of the hardship in rural communities and I'm working with Commerce Ballarat in some of the initiatives there. But I think it's being able to change what we do and having a really good hard look at ourselves and going, "Is it working?" And it's sometimes really hard when we've put time and energy. And more recently, we had one where we called one of our events that was going to be a fundraiser. We called that off because it just wasn't looking like it was going to get the support. So it's being able to be flexible enough and redirect our energies where we think they'll be most used.

**Andrew McPherson** (25:15):

Yeah, it's a really good point. I think we've all been learning that lesson Max.

**Mick Fryar** (25:19):

Andrew, for me, I guess having a long time in public psychiatry, it's been very rewarding really to do something different and see the service expand. And so many people come in that probably wouldn't get care and treatment otherwise. One of the interesting things though, I guess, reflecting for me, which is a great positive, of course, is that the fundraising is by the Ballarat community, the services we provide for the Ballarat community, and of course the clinicians that provide those services are part of the Ballarat communities and surrounds, which is really rewarding from my perspective. The other interesting thing I think that we continue or I continue to have to think about is the importance of juggling some of those different pillars. So it's not just about the quality of the clinical service we provide, although that is absolutely fundamentally important, of course, but the ability to get the message out there to people so that we get the referrals and we get the hard to reach men is really, really important.

(26:10):

And then the interlink between those two things with the fundraising. And the 2121 Maxine was just an unbelievable and just a fantastic event. It generated funds. We got a lot of referrals out of it, and therefore we were able to reach a whole heap of people that probably wouldn't have accessed service

otherwise. So linking those pillars and having oversight of those, I think is something that has been really important to me.

**Andrew McPherson** (26:34):

Thanks, Mick. For me, what I've learned is how to stay or how important it is to stay focused on the mission of the organisation. As I mentioned before, we get a lot of suggestions from the community and feedback from others about things that they believe we should consider doing. How do you make the right decision when confronted with a number of options about activities that we may or may not want to take up? What we have done along the way have remembered the importance of focusing on evidence and strategy and of anchoring every decision we might make on answering some key questions, questions that are central to the mission. Those questions have been, will this proposed change or action enhance our ability to engage with hard to reach men? Another question we always ask is, will this enable us to address an unmet need for men?

(27:32):

And the last question that we ask is, is this consistent with our service model? If the answers are yes, then we make the change. If not, well, then not. I hope that Maxine, Mick, and I have given you an understanding of how we went about our particular response to the men's mental health issues in our community. We're not here to challenge you to do the same thing in your communities. Different situations should always drive different responses, but what we would like you to reflect on is this. Based on what you learned today, or perhaps thoughts that might've been stimulated by this conversation, what are the opportunities for changes that you could make in your own clinical practice or in your organisation to better engage with men? What could you do better to ensure that more men in your communities get the mental health care they need when and where they need it?

(28:35):

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**Maxine Troon** (29:27):

Goodbye from me.

**Mick Fryar** (29:29):

And it's goodbye from me. Thanks everyone.

**Host** (29:32):

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