Outreach Program Evaluation Report

EXECUTIVE SUMMARY

January 2018

Approach to the evaluation

The evaluation team interviewed RAW Board members, management and staff, clients and service providers to gather information about how the Outreach program is working and encourage suggestions for the future. The team also set up an on-line survey directed at service providers and undertook a paper survey seeking input from clients.

An overview of current literature about effective approaches to suicide prevention, rural areas and vulnerable groups was also undertaken.

The Evaluation Report covers key findings from all these sources of data and includes recommendations for the future developed from the literature and the data gathered.

The evaluation team obtained information by:

- Participation in the general activities of RAW including team meetings and training;
- In-depth face-to-face interviews with RAW CEO, board members and all Outreach and HaRC (Healthy and Resilient Communities program) staff;
- Twenty-four in-depth client interviews and paper based surveys that were conducted face-to-face, by phone or returned by Outreach Workers;
- An on-line survey directed to service providers, plus some brief interviews with others;
- A review of reports from the CASEY database;
- A review of the use of RAW's 24/7 crisis line.

Suicide in Tasmania

Tasmania is particularly vulnerable to poor health outcomes in general and the most recent information about suicide nationally and in the state is of particular concern. According to the Australian Bureau of Statistics (2016):

- Males aged over 85 and living in rural Tasmania are the group most at risk of completing suicide in Australia.
- Suicide is the leading cause of death in Australia for persons aged 15–44 years.
- Conservative estimates show eight people take their own life in Australia every day. This figure is unclear because of different practices for recording deaths.
- Suicide rates have progressively decreased in all states and territories except Tasmania where they have begun to increase in recent years. In the period 2012–2017, suicide rates in Tasmania have increased by 31%.

Research by Flinders University and ABS show that on average people living in rural areas experience additional risk factors such as mental illness, substance abuse, chronic pain or illness at higher levels than their urban counterparts. Returned military service personnel, who complete suicide at higher than average rates, are also more represented in rural areas. Tasmanian rural areas have a higher saturation of risk factor cohorts than national averages in that:

- there is a higher male to female ratio than urban areas, in some places up to 38% more males than females;
- 2.7% of the Tasmanian population are aged over 85 (the group at highest risk of suicide) compared to 1.9 % of the overall Australian population. More than 1 in 5 of all Tasmanians aged over 85 live in rural areas;
- 40% of Tasmanians using mental health services live in rural Tasmania;
- Of the four primary chronic physical illness categories:

- 37% of Tasmanians treated for heart conditions live in rural communities;
- 38% of Tasmanians treated for cancer live in rural communities;
- 36% of Tasmanians treated for kidney conditions live in rural communities; and
- 40% of Tasmanians treated for chronic arthritis live in rural communities.

Suicide risk factors in rural settings

Distinct cultural aspects exist in rural and remote communities that promote certain suicide risk factors, separating these communities from their urban counterparts, these risk factors include:

- the impact of natural disasters,
- industry changes and shutdowns,
- farming stressors,
- geographical isolation, and
- increased access to more lethal means to complete suicide.

In a Tasmanian context, these risk factors coupled with poorer access to services means that existing risks such as substance abuse, financial stress, family violence, and depression further increase the likelihood of suicide in rural areas. There is a cumulative impact of social, geographical and psychological factors that are specific to rural communities with particular emphasis on increased means to complete suicide within a rural context, with males completing suicide at a much higher rate than women.

Recent studies reveal a criticism of mental health services in rural communities in that they are not based within local communities and are rarely specifically aimed or funded to reduce suicide, but are focused on more general mental health and community wellbeing. In providing services that are not at the local or grass root level, limitation of access increases and services are less geared to supporting clients in the environment in which they live and work.

A Queensland evaluation of traditional medically-based suicide prevention programs found that a more enhanced holistic approach focussing on strengthening the fabric of the community was preferable. It was recommended that the capacity of health staff to complete assessments which were inclusive of the 'person in environment' be developed to ensure that care plans are inclusive of the whole situation.

A community approach to prevention improving mental health includes education and reframing the issue to assist in removing stigma, it encourages people to support one another within a community by learning how to open up a meaningful dialogue about these difficult issues and places less emphasis on 'illness'. Recognising barriers within communities such as privacy concerns and access to services are also important to ensure early recognition of the signs of stress and not coping.

Within rural and remote communities there are a range of barriers which prevent individuals from seeking help when they need it, even the interconnectedness of rural or remote communities which is often seen as a resilience factor, can prevent individuals from seeking support. While rural access to mental health and general health facilities or services is generally poor, and retaining mental health professionals can be problematic, it is the stoic independent attitudes, confidentiality and stigma within rural and remote communities that can discourage individuals from seeking help. These concerns, and the fear of being judged by others or feeling like a failure, impact on physical and mental wellbeing and limits capacity to disclose the need for help. These factors can also prevent early intervention for risk of suicide.

Services, and the people working in them, need to understand the cultural differences and influences of remote and rural communities, so that they can provide and enhance the service provision needed, promote help seeking through sensitive and appropriate discussions when working with rural and remote communities, and reduce the stigma of individuals accessing these supports.

There is some argument that there are evidence based e-health interventions available to help people self-manage illnesses and challenges and that online access has the potential to make a difference, particularly for those who are remote or who prefer not to use face-to-face services due to stigma.

However, there are substantial differences between rural and urban areas for digital inclusion. Research has found that it is principally wealthier, younger, educated urban Australians who enjoy greater digital access and there is a significant 'spatial digital divide' in our community across three indices – access, affordability and digital ability. Rural areas in Tasmania such as Burnie, the West Coast, and north-eastern Tasmania rank amongst the least digitally included areas in Australia, whilst Tasmania in its entirety is the lowest of any state or territory on the digital inclusion index. Age is a significant factor influencing digital inclusion with those over 65 years of age recording the lowest scores.

Men as a group at particular risk

Suicide rates for men in Australia are three times higher than for women. Older men in social isolation are one of the key groups vulnerable to high levels of suicide, their risk factors include loss of a spouse, retirement, and ill health and disconnection from social and family groups causing loneliness and anxiety.

Rural men in this report identified a strong sense of community and support and looking out for others as key help-seeking enablers, and a lack of services and privacy when accessing services as barriers. Male farmers over fifty, identified the feeling of safety ascribed to known local structures (such as men's sheds, agricultural groups, volunteer fire fighting organisations, sporting associations etc) as able to promote an environment where people are more attuned to seeking help.

What we found

It appears client satisfaction with RAW is intrinsically linked to relationships with, services provided by, response rate of, skills demonstrated by, and the professionalism of individual Outreach Workers. Major themes emerging from the client interviews were:

- overall client satisfaction with Outreach Workers;
- some suggestions for improvement in practice including:
    - ensuring regular and reliable communication;
    - actively managing caseloads so that clients are clear about what service they can expect; and,
    - respecting client privacy and confidentiality;
- upskilling of Outreach Workers by enhancing their counselling capacities;
- increasing the number of Outreach Workers and therefore the time available for clients;
- providing more Outreach Worker presence at community forums and within communities which currently have no or limited contact;
- the need for workers to facilitate more opportunities for clients such as social outlets.

Data indicates clients appreciated a general spread of Outreach service provision, this included Outreach Workers:

- being readily available for clients;
- engaging in genuine conversation;
- offering advocacy and interagency support;
- providing a professional, non-clinical approach;
- offering unconditional positive regard;
- being confidential;
- having the ability to go to places that other services will not; and,
- offering support and options to deal with suicidal thoughts.

Almost half of clients interviewed had used the 24/7 1300 HELP MATE phone crisis line, some when they could not reach their Outreach Worker. Those who had used the 24/7 line felt it provided a service to help calm them down and support them in a time of need. Some clients indicated they were unaware of this service. One client noted an unsatisfactory response to the 24/7 line.

Outreach Workers overwhelmingly identified RAW's strength as the fact that RAW does not have such a concept as *'out of area'*. RAW promotes itself as available to all of rural Tasmania, and '*clients do not have to tick a box, or have a mental illness to access RAW. They can just be going through a hard time.'* One Worker pointed out that '*every client gets a tailored approach, [there are] no hoops to jump through to be a client of RAW.'* Being a state-wide service, clients trust the RAW service and can access it regardless of which rural setting they live in.

Another recurring theme was the Workers having diverse backgrounds, and understanding the rural communities they work in. Workers frequently described their own backgrounds as important to connecting with rural communities, and one Worker identified that this helps them to work *'on a level peg with clients.'* Another Worker noted RAW's strength in how they '*understand the rural mindset, deal with all cohorts, and speak professionally but down to earth.'*

RAW has had many changes in a short period, and one Worker encapsulated what many said in saying that RAW *'shouldn't lose sight of why [they're] there, we've [been] caught up in this flurry of activities but why are we doing them? Are they meeting our core values?*' Public understanding of who RAW services was mentioned by almost all of the Workers as an issue that needs clarification.

It was a general consensus that more Workers are needed: '*We were a team of twelve, we are now only a team of eight or nine, and so having more Workers on the ground would be good.'* Workers feel they are '*being asked to do more and more with less Workers.'*

Isolation has been a difficulty for Workers, and the isolation of clients is also difficult. The isolation of clients means that transport is an issue for many people, and this provides challenges for prioritising work with clients.

Alcohol and drug issues were highlighted as an area of high need. One Worker identified that about half of their clients '*are experiencing drug and alcohol issues.'* Another Worker identified that older men were particularly over-represented regarding drug and alcohol issues.

Board discussion highlighted other areas of clarification such as 'is RAW a mental health or a suicide prevention service'. It was discussed that there is a relationship between mental health and suicide but the process of working with clients can be quite different. RAW is coming from an entry point of suicide prevention which means a focus on assessing context and environment, identifying strengths and natural supports rather than the more traditional mental health services based on the clinical model of service and an 'illness' framework.

For RAW to be sustainable and move strongly into the future there are two aspects the Board believes need attention. One is the lack of resources that RAW has access to, particularly regarding funding. While passion and enthusiasm are vital, adequate funding is critical.

Board members emphasised working collaboratively with other services in the mental health and suicide prevention sector, such as Lifeline, and with industry leaders in the rural sector. They noted the importance of aligning the strategy of RAW with key policy directions of government especially in relation to mental health and suicide prevention.

Two strong elements that emerged from the interviews with Board members was the need to improve data collection so that the Board and management had the information to govern well, advocate for improved funding and diversify those sources of funding. These are key elements of ensuring sustainability for the organisation.

Responses to the on-line service provider survey within this evaluation showed that 75 responders rated the Outreach program at 4.42 in a range from 1 - 5 (4 =pretty good, 5= excellent).

When asked what RAW does really well, respondents identified the following areas.

1. Unique; culturally useful; (relates to country blokes particularly well) (18 comments)
2. Rural Outreach (for suicide prevention); giving people a voice (advocacy) (15 comments)
3. Face to face; accessible; (15 comments)
4. Support – mental health and practical (13 comments)
5. Networking with providers/referrals; supporting providers; collaborative (11 comments)

Overwhelmingly the reason given for referring people to RAW was due to suicide risk or crisis from events such as financial difficulties, fire, flood or drought. Also emphasised was the capacity of RAW and the Outreach Workers to:

- collaborate with other services and have a strong connection to rurality and culture across all facets of rural life;
- relate in a positive way to farmers, both men and women; and
- access rural and remote areas with their flexible style of service delivery.

Service providers said that uptake time was prompt and the accessibility of Workers within rural areas was very effective due to the flexibility and helpfulness which is built into the framework of RAW. This model was also identified as very beneficial during times of community crisis. While services are stretched during such challenging times (such as the global financial crisis or natural disasters), the RAW service model allows for a collaborative approach with other service providers and together they can apply a triage approach to isolated clients who may be struggling with current and ongoing issues.

Data Findings

(Unless noted otherwise data is for the period 1.7.16 to 30.6.17)

1. 58.6% of all clients identify as male which supports qualitative feedback indicating a higher than industry average of men interacting with the service.
2. The majority of direct client contacts are occurring with a single individual (94.7%) rather than with a family group (5.3%).
3. Approximately 97% of direct client contact is either face to face (74%) or via phone (23.4%). This supports the assumption that RAW staff ‘go to the client’ in the majority of circumstances.

4. It is assumed that the data stating the number of case planning interactions by Outreach Workers with client's extended family, friends and colleagues is reflective of safety planning sessions. It is noted that only 44 of these were recorded in the reporting period while in contrast 126 instances of case planning with other professionals was recorded.
5. Only 8 instances of case management review were recorded for the year across the entire program. It seems unlikely that there were only 8 case reviews with Team Leaders, the Practice Consultant, or senior management.
6. In total the program received 496 referrals in the reporting period.
7. Three areas accounted for one third of all referrals to the program, being Midlands inclusive of Southern Midlands and Northern Midlands areas (11.7%); Huon Valley (11.3%); and Break O'Day (9%).
8. When analysing the inbound referrals it was found that only 3% came from Tasmania Police and 5.4% from health professionals (GP's, Nurses). This was not consistent with qualitative feedback which placed referrals from police and medical staff at a much higher level. It is not clear if the data recorded is accurate.
9. There was a high number of self-referrals to the program, 27% of all referrals, with a further 11.5% from direct family. This is consistent with the perception that the program has a higher than industry average of self-referral.
10. In contrast, the primary services that Outreach Workers are reporting they refer clients to are health providers (14.3%), mental health providers (20%) and community/social services (27.8%). In total the program made 504 referrals to external service providers.
11. At the time of reporting there were 414 files listed as open. Of these, 68% (282) were active files. On further discussion with Outreach Workers it became clear that there were differing perspectives on what constituted an 'active file' as opposed to an 'open file'.
12. In reviewing the reasons for files being closed, 46.4% were listed as having their needs met with the remaining 53.6% listed as needs partially met, not met, or ineligible for service.
13. Data on risk of suicide showed that 86.5% of clients were assessed as not being at risk of suicide or self-harm, however, this still indicates that 119 clients (13.5%) were considered at risk.
14. A further 55.1% of clients were also assessed as experiencing isolation or loneliness which correlates with the qualitative data that indicates isolation is a major issue in rural Tasmania.

Summary of Recommendations

Development of Outreach Worker Role and Capacity

1. Maintain RAW's key focus on providing direct services to support rural people who are 'doing it tough';
2. Ensure clear and consistent job descriptions for all Outreach positions which include organisational expectations around boundaries, professionalism and confidentiality;
3. In response to organisational demands and client feedback, identify core Outreach Worker skill sets and provide professional development and training opportunities as required (e.g. reporting, administration, counselling etc.);
4. Provide additional training for Outreach Workers to reinforce good practice, ethical guidelines and legal responsibilities in relation to professional conduct, confidentiality and privacy;
5. Introduce performance benchmarks and KPI's for Outreach Workers;
6. Facilitate Outreach Workers to provide local support to the HaRC program including by participating in HaRC committees and activities in their area;

7. Develop resource kits for clients including information on RAW and its services, mindfulness, service provider lists and internet addresses, information about mental health including depression and anxiety, information about suicide prevention etc;
8. Facilitate Outreach Worker attendance at a diverse range of community forums and network meetings in order to develop effective local collaboration;
9. Introduce dedicated positions into RAW to build the capacity of Outreach Workers to support client groups with high levels of unmet need, including:
    a. Young people;
    b. Older people (65+ years);
    c. People with alcohol and other drug issues; and,
    d. Aboriginal people.
10. Allocate regular Outreach Worker time to be spent with Outreach Workers in other areas to improve their understanding of practice and build teamwork;
11. Enhance staff induction processes for new workers including using a 'buddy' system.

24/7 HELP MATE Crisis Service

12. Senior management review and determine the primary purpose for the 24/7 phone service and consider options to restructure or outsource the service;
13. Should the 24/7 phone be retained as a crisis line then;
    - it should be promoted as such with clear direction that general enquiries should be made during working hours;
    - Outreach Workers should be trained further in phone based trauma support;
    - a policy and procedure document be developed which clearly outlines the expectations of 'on call' staff to ensure that the phone is with them at all times and incoming calls are responded to promptly.
14. If it is decided that the 24/7 phone service is not sustainable, that RAW advises clients of other services such as Lifeline and works closely with other crisis line services to ensure a good understanding of RAW services and referral processes.

Data and Information Management

15. CASEY to be reviewed by senior management to:
    a. determine what data RAW requires for what purposes including case planning and implementation, contract compliance/reporting, and resource modelling/service planning;
    b. develop a data dictionary to ensure more consistent data entry across workers, regions and time periods; and
    c. review and develop policy and guidelines concerning the input, collection and reporting of client data and services provided;
16. Ensure the data dictionary provides comprehensive and consistent definitions of the terms used in CASEY (eg open file, active file, attended client, contacted client etc.) to ensure staff are correctly using the appropriate descriptors and that reporting is uniform across all areas;
17. Ensure that Outreach staff list all the required information in relation to client demographics in order to ensure robust data to underpin accurate recording of service delivery activities, use of resources, and funding contract reporting;
18. Establish a policy to clearly outline the required level of data entry in relation to 'one off' contacts to ensure consistency across data reporting and to limit the effect of insufficient information entry on files;

19. Provide training to all staff about the requirements for data entry including, but not limited to, the timing of such entries and the minimum content required;
20. Link CASEY reporting structures and processes to required reports for funding service agreements including RAW KPIs and strategic goals.

Board, Management, and Corporate Support

21. Clarify and promote RAW's role – what services can be offered to clients and communities given current capacity;
22. Develop MOUs with significant stakeholders about collaborative service responses, in particular Tasmania Police, AMA and mental health and other service providers in the community;
23. Explore potential arrangements around sharing sensitive or personal information in order to allow inter-agency and inter-service sharing of data in specific circumstances;
24. Develop tailored training plans for each Worker as part of their performance review process including the option of accessing formal or external training as appropriate;
25. Implement regular team building opportunities across the organization including providing more opportunities for face-to-face connection of staff and increased peer support activities across the Outreach program (such as within regional meetings);
26. Provide clear guidelines on the prioritisation of Outreach Worker tasks through ongoing line supervision in order to ensure that Outreach Workers are able to manage their work load and are engaging in appropriate self-care given limited staff resourcing and high client demand;
27. Provide 'mental health days' for Outreach Workers taking into account the level and complexity of their client caseloads;
28. Provide more reliable ICT resources for Outreach Workers;
29. Develop guidelines and standards to promote clearer communication between staff around matters such as email response times, calendar communication processes, and program delivery timelines etc;
30. Provide regular policy and procedure update sessions for all workers;
31. Introduce protocols and procedures for RAW meetings to ensure that everyone has the opportunity to speak, for their opinions to be valued, and for decisions to be made, documented, and acted upon;
32. Provide regular opportunities (e.g. a day a month) for management staff and Board members to spend time in the field with Outreach Workers.

Quality Assurance and Ongoing Quality Improvement

33. Attain quality accreditation for the service;
34. Conduct regular audits of client feedback to assist in quality assurance and improvement of the Outreach program;
35. Include opportunities for clients to share experiences at social gatherings or at RAW promotional events.
36. Ensure smooth transition when Outreach Workers change geographical areas or leave, by implementing protocols and practices to ensure client well-being.

Future Directions for RAW:

37. Actively seek out alternative funding opportunities including engaging major rural businesses and leaders as donors, seeking philanthropic grants, and lobbying government for secure ongoing

funding to put more 'feet on the ground' in order to address client identified need, extend service range and areas covered, and prevent staff burn out or loss of client engagement;

38. Seek additional funding streams to maintain and expand the program's capacity to travel to remote clients and assist rural communities in other states;
39. Continue to focus on flexible service delivery as the key to RAW's distinctiveness;
40. Provide clear guidance from the Board and CEO that RAW is a suicide intervention, prevention and postvention service rather than a generalist mental health service;
41. Clarify for the public and service providers that RAW is not just for 'farmers' and 'men';
42. Promote the services provided by RAW to existing and potential clients, service providers and communities;
43. Maintain RAW's rural focus including spelling out and advocating for the particular needs of rural people and the delivery of accessible and culturally safe services to rural communities.