‘Rural in Reach’: delivering health and wellbeing services to regional Western Australia

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Abstract

Building the capacity of an existing health agency to service rural and remote areas across Western Australia presented enormous challenges for Women’s Health and Family Services. Within three years however they were delivering Rural in Reach, a service providing high quality health promotion, counselling and professional development services across the state. Evaluation indicates high levels of use, trust and confidence in the service. WHFS achieved this by the use of virtual technologies delivered through existing community hubs, by establishing layers of feedback loops with rural communities to ensure relevance of content and format and by supporting in situ generation of creative solutions to local issues.

Context

Women’s Health and Family Services (WHFS) opened in 1977; the first women’s health centre in Western Australia providing quality health care to socially disadvantaged women. It quickly evolved into a fully integrated primary health care organisation and is now the largest specialist gender-specific health service in Western Australia. In 2011 WHFS was funded by the Government of Western Australia, Department of Health, for three years to pilot a project offering a range of services to women, their families and local agencies in rural and remote Western Australia. The service, Rural in Reach, now provides community education, professional development and one-to-one ‘virtual’ counselling sessions through video-conferencing to women and their families living in rural areas across the state.

To ensure the rural and remote community was best served WHFS contracted Kurongkurl Katitjin, the Centre for Indigenous Australian Education and Research at Edith Cowan University to undertake an ongoing evaluation of Rural in Reach. This project report describes the processes, impact and outcomes of Rural in Reach.

Issues

There were three aspects to the design of Rural in Reach, which were crucial for its success. Firstly it needed to be delivered opportunistically, via an existing, trusted community hub. Secondly the content and format of professional development and community education services offered needed to be constantly reflexive of in situ needs and thirdly virtual counselling sessions needed to be delivered with extraordinary levels of responsiveness and flexibility.

A small, dedicated multi-disciplinary team was formed within head of office of WHFS, all members had lived or worked in rural or remote Western Australia. Rural in Reach partnered with the WA network of Community Resource Centres (CRCs). CRCs, previously known as Telecentres, are local community hubs providing video conferencing, education and training programs as well as access to business facilities and government services. There are over one hundred across the state. Once a CRC accepted an invitation to partner with Rural in Reach an agreement was developed in which roles, responsibilities and payments are made explicit. This forms the basis of a collaborative relationship. Rural in Reach contracted a local software company ‘Being There’ to provide a confidential videoconferencing link, which allows for up to eight centres to participate in interactive conferencing.

By June 2014, 48 CRCs had formed partnerships with Rural in Reach including two located in Aboriginal communities. During the first year of establishment all CRC Managers canvassed spoke very positively about the Rural in Reach, the agreement and the ongoing relationship with Rural in Reach.

The Rural in Reach team developed a community education program, Community Talks, a series of interactive workshops delivered through the CRC by WHFS staff or invited experts. If interactive sessions are over subscribed, podcasts of the workshops are available in real time and made available on the Rural in Reach Website and YouTube channel. Popular topics are professionally recorded and broadcast through West Link, a regional West Australian satellite TV station. To ensure the content and format of Community Talks constantly reflects in situ needs Rural in Reach embedded a number of reflexive feedback loops within the delivery system. In the first instance they developed the program in line with recommendations of material developed from consultation with rural communities. They established a 'Community Champions' reference group, which includes rural based health and community service providers and metro based specialists. The ensuing cross-pollination generates ideas about the content and format of Community Talks. Additionally all service recipients are asked to complete evaluation forms, which help to shape the content of future Community Talks.

The Community Talks program has quickly established itself as a lively, relevant and well-attended community event. Subjects include health related topics such as post-natal depression, dementia, menopause, breast care, parenting support such as bullying and nutrition as well as generic well-being talks such as self-esteem. When the interactive workshop is full it is not unusual for the podcast to be used to support a small local community event. Demand for Community Talks was such that WHFS created its own YouTube channel through which Rural in Reach Podcasts and Westlink episodes can, and are, viewed.

One Community Talk on Dementia was evaluated as a case study. There were 37 'live' attendees and a further 12 CRCs hosted the talk at a similar time. It was clear from the responses of those taking part in the evaluation that direct benefits included an enhanced understanding and communication about dementia, improved capacity to spot early signs and to care for some one with dementia and reduced fears about dementia and decrease in dementia related social isolation. Indirect benefits included enhanced knowledge of modifiable risk factors, wider access to trusted health and well being related information and a greater willingness to access other services particularly counselling. One participant talked about the format being just right, 'when someone explains with the pictures, it is better than a pamphlet that says nothing or a book that says too much in a language you don't understand'. This participant commented that after the talk he and his friends had their first ever conversation about dementia.

In the initial phase of development virtual face-to-face counselling was considered to be something that would be resisted because rural populations were ageing and distrusted technology. The prediction was unfounded, in the first year Rural in Reach delivered on average 145 counselling sessions per quarter, in the second year this had risen to 239 sessions per quarter and in the third year 266 sessions.

In the set up phase questions were also raised about whether WHFS would be able to engage socially disadvantaged women in rural areas. Rural in Reach developed a three pronged approached. They supported the capacity of CRCs to respond to socially disadvantaged cohorts. They ensured smooth client access pathways, and, aware of the power of word of mouth in small communities, they built a trusting relationship by being effective.

In the formation stage of partnership with CRCs a profile of each area was constructed. Many are identified by ABS statistics as socially and economically disadvantaged. Typically they are areas away from tourist routes with marginal agricultural capacity. In some places unemployed people from the city seeking cheap housing swell the population. Rural in Reach supported CRC staff through mentorship and professional development to build capacity to respond to these cohorts and engage them in health and wellbeing activities.

To ensure smooth client access Rural in Reach established multiple points of entry and a no wrong door approach for anyone seeking help. A potential client can self refer, seeking an initial consultation via the telephone, a virtual face-to-face appointment or are referred by CRC staff or an allied health professional. The first Rural in Reach counsellor to speak with the client forms a collaborative relationship and helps the client articulate the problem. They may introduce and collaborate with other

specialist providers if required and support the client to implement an intervention plan. Collaborative assessment tools are used to measure change.

Varying degrees of remoteness and strength of Internet access means Rural in Reach needs to offer multiple methods of service delivery. The CRC offers a confidential quiet space for virtual face-to-face counselling, in some circumstances where this is not possible this was offered at home or other suitable location via 'Being There'. In other contexts telephone was the sole method of contact. The steady increase in the uptake of counselling services across the state indicates a growing trust in the service.

The range of issues presenting in counselling indicates people with multiple factors of social disadvantage access help. The most common presenting issue is mental health, the subject of 36.5% of presentations with over half concerning depression, suicidal ideation and post-natal depression. In an evaluation case study a very remote new mother sought help because she felt emotionally overwhelmed. She said the counsellor helped her develop a language and communicate. She went on to make positive changes that benefited herself and her family. This client could not have dealt with her issues alone or with friends or relatives because she did not have the emotional vocabulary to articulate her feelings or the psychological process map to make judgements about their intensity or value.

Family relationships are the second most prevalent issue concerning 25% of presentations. In most cases Rural in Reach was used to help couples improve their relationship and to co-parent more effectively. It would be easy to say that families would get through without professional help however a number don't, 1.5% of presentations concern domestic violence and 9.5% concern grief and loss issues including a number of cases involving teenage suicide.

The professional development stream of Rural in Reach, particularly mentorship and supervision was available from the beginning. This was accessed by a number of isolated health professionals. The provision of courses designed for the rural setting began to be developed in the third year. A persistent theme in the first round of community consultations was vicarious trauma and effective responses to mental health presentations; this was reiterated in the feedback from Community Talks. In this context vicarious trauma is the distress felt by certain people in the community who are used as *de facto* first line mental health professionals, this includes CRC staff, hair dressers and teachers. Rural in Reach considered a number of possibilities and decided to develop their own training package using the principles highlighted in Mental Health First Aid Training. Using action research methods they developed the content in collaboration with established mental health service providers and they developed the format in collaboration with CRC managers.

There were three issues to consider in the provision of training of this nature, knowledge acquisition, skill development and accountability in practice. This was managed by the provision of a three-stage training package. Participants have to sign up to the course and receive a login. They can access the first of ten online learning modules, which they must each complete within three weeks. At regular intervals closed interactive video conferencing forums are hosted by Rural in Reach, which participants must attend. At these forums discussions and case examples are used to help people consolidate what they have learned and develop the skills to put this into practice. Participants must be able to demonstrate knowledge, skill and a capacity to manage in various situations before they are provided with a certificate.

Rural in Reach continues to grow, it is currently trialling a Trauma Informed Professional Development Course which is specifically for professionals and a virtual peri-natal support group to compliment the work of remote based child health nurses.

Lessons learned

There are two new 'technologies' at play in the establishment of Rural in Reach, the development of rural inspired services and the use of virtual technology to deliver traditional face-to-face services. At this stage in the development of these technologies in this context all Rural in Reach activities need to be considered essentially experimental. Consistent feedback was required to ensure efficacy.

Rural inspired services are those designed by and for rural based practitioners and communities, in this context Rural in Reach acted as a facilitator and resource developer. To achieve this Rural in Reach consistently used collaborative enquiry and action research methods to develop their services and embedded an ongoing evaluation system.

The use of virtual technology to deliver traditional face-to-face services is relatively new and competencies are still being developed. Rural in Reach choose a small local system and maintained a flexible response to a variety of contexts. This made the conduit for service delivery accessible and manageable by a wide range of people.

The use of an embedded evaluation system enables constant feedback to inform WHFS and the funding body of the relevance and effectiveness of the new service. Evaluation reports consistently indicate Community Talks is widely used and enhances knowledge and enhances capacity and that counselling improves coping skills, emotional wellbeing and relationships. All clients completing follow up surveys had a positive experience of Rural in Reach.

Presenter

Fiona Reid has worked in community health and social services for 15 years and has extensive experience with a diverse range of communities and sectors across West Australian. In her current role as Special Projects manager at Womens Health and Family Services she oversees a variety of unique and innovative programs including the Rural in Reach program. A masters qualified family therapist (M.So.Sc), and Graduate of the Australian Institute of Company Directors (GAICD), Fiona has a wealth of professional, academic and community experience. She has a strong commitment to volunteer service and is a member of a number of Local Government committees, community advisory groups, consortia and boards. Fiona was elected to the City of South Perth Council (COSP) in 2011 is a West Australian Local Government Association (WALGA) State Councillor. A past sessional lecturer at Edith Cowan University and accredited clinical supervisor (counselling), she has significant experience in delivering adult education and training. She has presented at international, national and local conferences on a range of health and well being topics. Fiona is a mother of two teenagers and in her spare time she enjoys travelling, reading and when possible being still.