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KEY TERMS:

THE RURAL OUTREACH PROGRAM
The Rural Outreach Program is a rural Victorian mental health initiative, with local community-based Rural Outreach Workers who have the capacity to respond to the immediate needs of people living in rural and remote communities across the Wimmera Southern Mallee Shires. The program is designed to improve the health and wellbeing of community members who are struggling to deal with tough times in their lives and support them with service navigation and collaboration with a network of local services. The Program in its current iteration is modelled from an earlier program in its system design and service delivery with the addition of a Rural Outreach Program Coordinator. Two additional Rural Outreach Workers have been employed since April 2019. There are now three Rural Outreach Workers and one Rural Outreach Program Coordinator currently employed. The Rural Outreach Program has been in operation since December 2018.

THE RURAL OUTREACH WORKERS
The role of the Rural Outreach Workers is to increase the capacity of services working with rural communities and to respond to individuals who are in psychological distress and may be showing early signs of mental ill-health. The role is designed to respond to the person’s need for immediate support and assist them to navigate and access services in a timely manner and before a crisis may develop. Anyone in the community with concerns for another can refer to the Rural Outreach Workers to conduct a wellbeing check. During this wellbeing check, the Rural Outreach Workers will record important information such as demographics, location, motivations for accessing the service, mode of service delivery, referrals and recommendations provided. The Rural Outreach Workers do not provide therapeutic or clinical interventions.

THE RURAL OUTREACH PROGRAM COORDINATOR
The role of the Rural Outreach Program Coordinator is to ensure that the Rural Outreach Workers have access to the tools, resources and networks necessary to perform their role. They provide day to day management of the Rural Outreach Workers and work with researchers from the Social Innovation Research Institute to facilitate the provision of information required to conduct the evaluation. Main duties involve providing leadership to the Rural Outreach Workers who are responsible for responding to and helping to identify, people at risk of self-harm or mental ill-health in the region. It is the Rural Outreach Program Coordinator’s responsibility to engage with service providers and stakeholders to develop relationships and limit barriers for client access to services. The Rural Outreach Program Coordinator supports and provides supervision of the Rural Outreach Workers to ensure levels of stress are managed and to minimise risk to staff, clients and the Program.
1. **EXECUTIVE SUMMARY**

This is the half yearly report for the evaluation of the Rural Outreach Program. This report presents data collected March to June 2019 inclusive. A final report showing outcomes for the whole of 2019 including quantitative data, case studies, illustrations and digital stories will be delivered in December 2019.

2. **BACKGROUND**

In November 2018, Swinburne University’s Social Innovation Research Institute (SIRI) was commissioned by a collective of agencies, including the Local Government Areas of Horsham Rural City Council, Hindmarsh, West Wimmera, Yarriambiack Shires; health agencies of Rural Northwest Health, West Wimmera Health Service, Harrow Bush Nursing Centre, Woomelang District Bush Nursing Centre, Wimmera Primary Care Partnership (PCP), Western Victoria Primary Heath Network and the Edenhope and District Memorial Hospital (which acted as lead agency); to conduct an external evaluation of the Rural Outreach Program. All agencies involved, collectively pooled *Seasonal Condition Funds* allocated to the four Local Government Areas (LGA’s), to support local communities through the Rural Outreach Program.

The Rural Outreach Program has been developed to increase the capacity of services working with local rural communities to respond to, and support, individuals who are in psychological distress and may be showing early signs of mental ill health. The Program is designed to respond to the person’s need for immediate support and assist them to navigate and access services they need in a timely manner and before a crisis could develop.

3. **AIM**

The aim of the evaluation is to examine the effectiveness of the Rural Outreach Program and make recommendations regarding its future development.

4. **OVERVIEW OF INTERIM REPORT**

The Rural Outreach Program evaluation is currently in the second quarter of the data collection phase. This interim report reflects on data collected for the Rural Outreach Program evaluation (20 March 2019-30 June 2019 specifically).

The focus of this interim report is on the wellbeing data collection phase, case studies and interviews conducted with community members, council members and health staff during this time period.

The design of the quantitative data collection tools was a collaborative effort between SIRI Researchers, the initial Rural Outreach Worker and the Rural Outreach Program Coordinator. This was an iterative process to try and best capture the relevant data during
the initial consultation, follow up visit and community engagement activities. All three forms were designed to be completed by the Rural Outreach Workers and the Rural Outreach Program Coordinator after a consultation with a community member or a community engagement activity. A fourth form, the Community Satisfaction form is completed by a referrer, community member or community member’s family member, after a visit takes place.

The quantitative data collection tools were entered into Formitize, a software application designed for creating and storing forms online. The Rural Outreach Workers and Rural Outreach Program Coordinator enter information into the online forms. The SIRI researchers have analysed this data.

During the March to June 2019 period, the Rural Outreach Workers (ROWs) and the Rural Outreach Program Coordinator have submitted 136 online forms documenting this data. These include:

- Rural Outreach Initial Assessment Forms (64)
- Rural Outreach Follow-up Forms (47)
- Community Engagement Forms (23)

Community members have submitted 14 Community Satisfaction Forms.

This report uses case studies to showcase typical interactions that the Rural Outreach Workers had with community members.

Key findings from the Interim Report:

- Nearly 50% of the community members who accessed the Rural Outreach Program, heard about it through word of mouth. This occurred mainly through family members, friends and colleagues.
- The group that made highest use of the program were men, within the ages of 31-50.
- The most common occupations of the community members who accessed the program included; retired people, students, farming occupations, and unemployed.
- Once a referral was made, the Rural Outreach Workers were able to visit a community member and conduct an initial assessment within a time frame of one to two days.
- In two thirds of cases, the Rural Outreach Workers travelled up to one hour to visit a community member and conduct an initial assessment and a follow up visit. In some cases, the Rural Outreach Workers travelled over three hours to provide assistance.
- The allocation that saw the highest number of scheduled visits was the community member’s home.
- In most cases, the Rural Outreach Workers spent 30 minutes to one hour with a community member to conduct an initial assessment.
- Of the 31 community members who received a follow-up visit, 23 had contacted the recommended services made by the Rural Outreach Workers.
5. INTRODUCTION

Mental health and wellbeing are a crucial issue in rural and remote communities. Recent data shows that although mental health issues occur at the same rate across Australia, the rate of suicide is much higher in rural communities. In 2016, the number of suicides per 100,000 people in rural and remote Australia was 50% higher than in the cities (Hazell et al, 2017, p.2).

The Wimmera and Southern Mallee region in northwest Victoria is characterised by small communities set within regions of a large area. Wimmera and Southern Mallee covers some 28,000 square kilometres and services a population of 38,400 people. It includes the local government areas of West Wimmera, Yarriambiack, Hindmarsh and Horsham Rural City.

5.1 Evaluation of the Rural Outreach Program

The Rural Outreach Program is evaluated on the program’s capacity to influence and make an impact on the following, for local people:

- Awareness about, and response to, local mental health and wellbeing challenges;
- Community based response for people experiencing trauma, psychological distress or at risk of self-harm or suicide;
- Service navigation and appropriate referral; and
- Collaboration between health services, local government and other agencies to support and build resilient communities.
5. 2 Evaluation Sites

The Rural Outreach Program currently services the Wimmera and Southern Mallee region. This includes the Local Government Areas of West Wimmera, Yarriambiack, Hindmarsh and Horsham Rural City. Below, we provide brief overviews of these areas.

5. 2.1 West Wimmera

According to the Australian Bureau of Statistics (ABS), in 2016 there were 3,937 people living in West Wimmera. Aboriginal and/or Torres Strait Islander people made up 0.9% of the population. The median age was 47.7 years and children aged between 0-14 years made up 17.9% of the population, while those aged 65 years and over made up 23.9%.

The population of the community aged over 15 who completing year 12 or equivalent was 32.6%. Residents who had completed a certificate was 20.3% and 8.1% had completed an advanced diploma or diploma. Community members who had a bachelor’s degree level or above was 10.4%. Participation rate in the labour force for person’s aged 15 years and over was 59.7% and the unemployment rate was 3.7%.

The most common occupations included: managers (38.5), labourers (15%), professionals (12.2%), technicians and trades workers (8.5%), community and personal service workers (8.3%), clerical and administrative workers (6.8%), machinery operators and drivers (5.6%) and sales workers (4.3%). The median equivalised total weekly household income was $673.

5. 2.2 Yarriambiack

In 2016 the population of Yarriambiack was 6,743. Aboriginal and Torres Strait Islander people made up 1.2% of the population. The median age was 49.9 years and children aged between 0-14 years made up 16.5% of the population, whilst those aged 65 years and over made up 26.5%.

Residents aged over 15 who reported completing year 12 or equivalent as their highest year of school completion was 28.4%. Community members who had obtained a certificate accounted for 20.9% and 7.4% had an advanced diploma or diploma. Those who had completed a bachelor’s degree or above was 8.2%. Participation rate in the labour force for person’s aged 15 years and over was 49.2% and the unemployment rate was 4.9%.

Common occupations of employed persons included: managers (28.6%), professionals (12.8%), community and personal service workers (12.6%), labourers (12.4%), technicians and trades workers (10.5%), clerical and administration workers (8.3%), machinery operators and drivers (6.7%), sales workers (6.2%). The median equivalised total household weekly income was $592.
5. 2.3 Hindmarsh

In 2016 the population of Hindmarsh was 5,784 with a median age of 49.2 years. Aboriginal and Torres Strait Islander people made up 1.4% of the population. Children aged 0-14 years made up 15.7% of the population, whilst those aged 65 years and over made up 25.7%.

Hindmarsh residents aged over 15 who reported completing year 12 or equivalent as their highest year of school completed was 28.7%. Those who had obtained a certificate accounted for 19.9% and 6.8% had an advanced diploma or diploma. Community members who had attained a bachelor’s degree or above was 9.1%. Participation rate in the labour force was 49.8% and the unemployment rate was 5.1%

Occupations of employed residents included: managers (25.1%), labourers (16.3%), professionals (13.2%), technicians and trades workers (11.2%), community and personal service workers (9.8%), clerical and administrative workers (9.1%), machinery operators and drivers (7.7%), sales workers (5.9%). The median equivalised total household weekly income was $615.

5. 2.4 Horsham Rural City

According to the ABS census, in 2016 there was a population of 19,884 in Horsham with a median age of 41.1 years old. Aboriginal and Torres Strait Islander people made up 1.5% of the population. Children aged 0-14 years made up 19.5% of the population, whilst those aged 65 years and over made up 19.4%.

Residents aged 15 and over who reported completing Year 12 or equivalent as their highest year of school completed was 37%. The population who had completed a certificate was 22.4% and 8.7% had attained an advanced diploma or diploma. Residents who had completed a bachelor’s degree or above was 13%. The participation rate in the labour force was 60.2% and the unemployment rate was 4.9%.

Occupations of employed residents included: professionals (17.2%), managers (16.1%), technicians and trades workers (14.3%), clerical and administrative workers (11.6%), community and personal service workers (11.4%), sales workers (11.2%), labourers (10.9%), machinery operatives and drivers (5.9%). The median equivalised total household weekly income was $720.

6. DATA COLLECTION METHODS

6. 1 The Rural Outreach Initial Assessment Form

The Rural Outreach Initial Assessment Form is completed by the Rural Outreach Workers after an initial consultation with a community member. This form includes information about who referred the community member, community member’s socio demographics,
length and time of the initial consultation, nature of issues, triggers, what was discussed during the visit, recommendations or referrals given, whether a follow visit is necessary and any other information considered important by the Rural Outreach Workers.

6.2 The Rural Outreach Follow Up-Form

The Rural Outreach Follow Up-Form is completed by the Rural Outreach Workers, after a follow up consolation with a community member. This form includes the socio demographics of community members, location of visit, length of visit, what was discussed during the follow up visit, outcomes or actions since initial consultation, what recommendations were followed, were recommended services contacted, if not why not, whether a return visit was required, any comments or additional notes made by the Rural Outreach Workers.

6.3 The Rural Outreach Community Engagement Form

The Rural Outreach Community Engagement Form is completed by either the Rural Outreach Workers or the Rural Outreach Program Coordinator, after a community engagement activity. This form documents the name and type of client or organisation, the type of activity, location, number of hours of delivery, length of travel and whether any referrals were made to the Program through the community engagement activity.

6.4 The Community Satisfaction Form

The Community Satisfaction Form was created by researchers at SIRI in collaboration with the Rural Outreach Team. These forms are distributed by the Rural Outreach Workers to referrers, friends or family members of the community members or to the community members themselves. The form documents general levels of satisfaction with the service, including issues of timeliness, and access. The form records service referral and whether the community member found this helpful. Finally it documents suggested improvements to the service and whether they would recommend it to others. Satisfaction form responses may be anonymous.

7. FINDINGS FROM WELLBEING DATA COLLECTION

7.1 Findings: Rural Outreach Initial Assessments

All initial assessments were conducted with individual community members. Initial assessments were made with 64 individual community members during the second quarter of the evaluation period. These assessments are conducted by the Rural Outreach Workers only.
7.1.1 Travel time to visit community members

In two thirds of cases, the Rural Outreach Workers travelled up to one hour to visit a community member and conduct an initial assessment (n=43).

Other times ranged between less than 30 minutes (19), over one-two hours and (12), over two-three hours (six). At times the Rural Outreach Workers travelled a distance of more than three hours to remote locations to provide access to a community member (three).

Estimated kilometres were calculated at 80 km/h due to road conditions in rural and remote areas. In total the Rural Outreach Workers travelled an estimated 5,327 kilometres conducting initial assessments exclusively.

7.1.2 Referrals to the Rural Outreach Program

Figure 2: Time spent by the Rural Outreach Workers to visit a community member (64 cases).

Figure 3: Who referred the community member to the Rural Outreach Program (64).
In most cases, community members self-referred to the program (17).

Other consistent sources of referrals were a service provider (12), family member (eight), friend (seven) or teacher (six). Other referrals (33) included a very wide range, including colleagues, employers, and the local police.

7.1.3 Initial contact with the service

Nearly 50% of community members heard about the Rural Outreach Program through word of mouth (31) occurring mainly through family members, friends and colleagues.

In some cases, community members learnt about the program from service providers (14) and at times the community members were previously known by the Rural Outreach Workers (six). Other sources (13) included the local police, media, and through finding the program’s business cards in local shops and cafes.

Figure 4: How community members heard about the program’s existence (64 cases).

Figure 5: How community members made initial contact with the Rural Outreach Program
The highest number of initial contacts from community members was by phone (40).

Other ways for initial contact included approaching the Rural Outreach Workers out in the community (14), or a walk-in to the program’s office (four). Other methods (six) included email or via a family member.

### 7.1.4 Length of time between referral and scheduled visit

![Timeliness of service delivery](image)

Figure 6: The length of time between the referral and the visit.

In more than half of cases the Rural Outreach Workers were able to visit a community member and conduct an initial assessment within one-three days (36), once a referral was made.

83% of community members were seen within 7 days.

### 7.1.5 The community members

![Age](image)

Figure 7: The ages of community members who accessed the program (n=64 cases).

Forty-three males and 21 females used the services. The age of community members was diverse, ranging from young people less than 15 years old (eight) to one community member who was over 90 years old.
The occupations of the community members who accessed the program included; retired people (n=10), student (10), farming (nine), unemployed (eight).

There was a wide range of other occupations (27) including administrators, teachers, labourers and public servants.

7.1.6 The location and length of service delivery

The highest number of scheduled visits were conducted in the community member’s home (23).

Locations also included; a school (seven), bush nursing centre (four), community members’ workplace (four), rural outreach office (four). Other locations were the hospital, in a nursing home and within the Rural Outreach Workers’ vehicles.
In some cases there was a person other than the community member present during the initial assessment (19). These people included family members, spouse and friends.

![Length of the visit](image)

**Figure 10:** The length of scheduled visits (n=64 cases).

In just over half of cases the length of time that the Rural Outreach Workers spent with a community member during an initial assessment was between 30 minutes to one hour (35). In some cases the Rural Outreach Workers spent more than two hours with a community member (12).

### 7.1.7 Triggers

In most cases, the Rural Outreach Workers identified one main trigger as the reason for the community member to be referred or self-referred to the program (57). However, at times there were multiple triggers, including two triggers (six) and three triggers (one).

The highest occurring triggers in the 64 noted on the Initial Assessment forms as identified by the Rural Outreach Workers included: family/friends are concerned (nine), community member upset (seven), health service recommendation (six), family issues (five), social isolation (four). Other triggers (33) included hospital admissions, suicidal thoughts, death of a loved one, anxiety and depression.
7.1.8 Nature of issues

![The nature of issues identified by the Rural Outreach Workers for the 64 initial assessments.](image)

The Rural Outreach Workers identified family issues (22) as being the theme with highest number of mentions amongst the 64 forms submitted. These were cases that related to relationship issues with family members, concerns about family members welfare and wellbeing, and separation from family members.

In some cases, multiple issues were identified. Other issues included mental wellbeing (17), social isolation (14), financial issues (12), grief and loss (11) and family violence (nine).

**New or existing issue noted**

![Whether the community member’s issues are new or existing to the Rural Outreach Program (n=64 cases).](image)
In most cases, the community member’s issues were previously unknown to the Rural Outreach Program (57).

Of these existing issues, the length of time since the issue last arose ranged from less than one year (four), one to three years (one), more than three-five years (one), more than five years (one).

7.1.9 Advice given by Rural Outreach Workers

Advising community members to talk to a respected other e.g., talk to family members (29) was the highest occurring strategy provided by the Rural Outreach Workers.

Other strategies included: self-care (19), continue to seek counselling (13), contact the Rural Outreach Program when needed (seven), contact health services (five), contact social worker (four).

In some cases, community members were provided with multiple strategies by the Rural Outreach Workers. This included: one strategy (30), two strategies (19), three strategies (six), more than three strategies (four), undisclosed (four).

Of the 64 cases, the Rural Outreach Worker advised community members to other specific services (14 referrals). Of these, a referral to see a personal counsellor was the most frequent referral (nine).

Varying numbers of referrals were made, as follows, one referral (10), two referrals (three), and three referrals (one). Other than a counsellor, referrals were to: general practitioner (GP) (three), psychologist (three), family counselling services (one), family violence services (one), financial counselling (one) and council support (one).

In 42 out of 64 cases, a return visit was scheduled by the Rural Outreach Workers, after the initial assessment.

In 29 of the 64 cases, a ‘wellbeing phone check-up’, to be conducted by the rural outreach worker, was scheduled at a time relevant to the community member’s attendance at a service, e.g. before a court appearance, after GP appointment or visit to a psychologist.

7.2 Findings from Rural Outreach Follow-up Form

After the initial assessment, in cases where they assessed it appropriate, the Rural Outreach Workers scheduled a follow-up visit with a community member. This appointment was made at the end of the initial assessment or after a phone wellbeing check to find out if a follow up visit was required. In some cases a follow up visit was assessed to be not needed.

There were 47 follow up visits conducted during this period, 31 of which were individual community members. At times multiple follow-up visits made by the Rural Outreach Workers were required: one visit (21), two visits (seven), three visits (one), more than three visits (two).

7.2.1 Time and distance travelled

In most cases the Rural Outreach Workers travelled 30 minutes to one hour to visit a community member and conduct a follow-up visit (20 visits). In some cases, the Rural Outreach
Workers travelled over three hours to provide assistance to a community member living in a remote location (three visits).

In total the Rural Outreach Workers travelled an estimated distance of 3,589 kilometres between the 20th of March 2019 and the 30th of June 2019 for follow-up visits exclusively.

7.2.2 Location of the service
Just under half of the follow-up visits were conducted in the community member’s home (23).

Other locations (24) included, over the phone, hospital, school, football grounds, and the Rural Outreach Program office.

7.2.3 General themes
In most cases the general themes of the follow-up visit included a general wellbeing check (14), counselling (13), family issues (nine), financial issues (nine), and service navigation (nine).

Multiple themes were recorded by the Rural Outreach Workers. Other themes included grief and loss, mental wellbeing, employment issues, suicidal thoughts, and school issues.

7.2.4 Recommendations made by Outreach Workers, Outcomes and Actions
Services recommended by the Rural Outreach Workers included contacting a counselling service (17), building on relationships (14), no changes to circumstances (10), contact a health service (eight), reconnect with old friends (four), and visit a GP (four).

7.2.5 New services Involved
Of the 31 community members who received a follow-up visit, 23 community members had stated that they had contacted the services recommended made by the Rural Outreach Workers since the previous consultation.

The recommended services that were contacted by the community member included counselling (10), psychologist (four), Centrelink (three), GP (three), legal assistance (three).

7.2.6 Return visits
Twenty-three of the 47 people seen, were assessed as requiring a further follow-up visit.

For the 23 community members who were assessed as requiring a further follow up visit, in seven cases, future wellbeing checks were scheduled via phone conversations. In these cases, the Rural Outreach Workers made several wellbeing checks via text messages and phone conversations.

7.3 Findings from the Community Engagement Form

7.3.1 Type of Activities
There were four main types of community engagement activities. These activities included promotion of the Rural Outreach Program (13), increasing community awareness (five), increasing community engagement (three), and mental health training (two).
Promotion of the Rural Outreach Program involved a general discussion or presentation about the program, the referral process and strengthening connections with community services, groups and individuals. This was mainly conducted at sporting clubs, bush nursing centres, and men’s sheds.

Increasing community awareness involved discussions around ‘mental health, suicide prevention and the importance of community’. The Rural Outreach team raised community awareness at sporting clubs, at a local hardware store, at a community exposition day, and at men’s sheds.

Increasing community engagement activities included the Rural Outreach team strengthening relationships with local council, with an agricultural action group and a health service.

Mental Health Training involved a five hour ‘refresher course’ for a local council office and a community group with ‘16 community members in attendance, three of which were close to a person in the community who had recently committed suicide’ as stated by the Rural Outreach Worker in a Community Engagement form.

7.3.2 Rural Outreach Program Community Engagement

Engagement activities were with the following: community groups (13), organisational groups (three), sporting groups (three), organisational staff (two), and organisational management (two).

The Rural Outreach Team engaged with a large number of community groups, including men’s sheds, charity events groups, and local community organised groups.

The Rural Outreach Team engaged with organisations such as an agricultural action group, a bush nursing centre and an Indigenous Australian Co-operative. Various sporting groups were also engaged, including golf clubs and football and netball clubs.

Organisational staff engagement included a presentation at an outreach organisation that specialises in health promotion amongst tradespeople, and council staff.

Community engagement with organisational management took place at a bush nursing centre and a health service.

The comment in the box below depicts a typical Rural Outreach event of this type and how it came about:

“In December 2018, following a suicide in a local community a concerned community member felt it was necessary for us to come together as a whole and increase awareness around mental health and suicide. The community member raised funds to cater for the event and invite guest speakers and entertainment. Over 100 people attended the event, local community members and those from the surrounding townships. The Rural Outreach Worker displayed a banner, spoke to attendees over the course of the night and handed out contact details and promotional postcards”.

- The Rural Outreach Team, comment taken from Community Engagement form.
7.3.3 Hours of Delivery
A total of 100 hours was spent on community engagement activities.
This included promotion of the Rural Outreach Program (64 hours), increasing community awareness (15), increasing community engagement (12), and mental health training (nine).

7.3.4 Location of the Service
Community engagement activities took place at various locations within the Wimmera Shire. These occurred at sporting clubs (six), men's shed (four), bush nursing centre (two), and council offices (two). Other locations included: hospital, community hall, health service, and an Indigenous Australian co-operative.

7.3.5 Time and distance travelled
The Rural Outreach Workers and the Rural Outreach Program Coordinator collectively drove a total of 4,727 kilometres conducting community engagement activities.

7.3.6 Referrals to the Rural Outreach Workers
According to the Community Engagement Form there were a total of five referrals made to the Rural Outreach Workers through community engagement activities.

7.4 Community satisfaction forms
Community satisfaction forms were distributed ‘at the discretion’ of the Rural Outreach Workers, for this reason it is unknown how many forms were distributed to community members.

As of the end of July 2019, there were 14 satisfaction surveys completed and returned for analysis.

All 14 satisfaction surveys reported that community members rated ‘trust-worthiness’ as being the most important quality for the Rural Outreach Workers role.

Other qualities that were rated as important included: caring (13), empathy (13), respect (13), honesty (13), and kindness (11).

The satisfaction surveys revealed that 93% of community members agreed or strongly agreed that they were satisfied with the service/program. The same percentage agreed or strongly agreed that they were satisfied with their Outreach Worker and that the service was timely and easy to access. Seventy-one percent of respondents agreed or strongly agreed that they felt they were listened to. In three cases, the satisfaction form was filled out by a referrer and the question was not applicable.

In 93% of the surveys, community members agreed or strongly agreed that they would contact or use the Rural Outreach Program again and would recommend this service to others.
Comments regarding how the service could be improved highlighted concerns relating to the instability of short-term funding and the need for service expansion to meet the growing demands of the community. Comments from community members included:

“Some of the students I referred to the service only had one or two sessions- (it) may be better if sessions were more ongoing”
- (Anonymous community member).

(We would like)
“More people in the field”
- (Anonymous community member).

“Make sure it is ongoing”
- (Anonymous community member).
8. CASE STUDIES

The following case studies are examples of interactions between the Rural Outreach Workers and community members. The case studies highlight different things that can be happening in the community and how the outreach workers can help to deal with these. Note: all names are pseudonyms.

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**Crisis management**

Cheryl walked into the Rural Outreach office. She had heard about the program from one of her colleagues at work. Over a cup of tea, Cheryl explained that her husband has dementia and is becoming more controlling in his behaviour. Cheryl told the Rural Outreach Worker that her husband is both verbally and physically abusive. The Rural Outreach Worker and Cheryl discussed the importance of safety in the context of family violence. After some discussion, the Rural Outreach Worker made a referral for emergency accommodation and contacted the police on her behalf, to assist her to retrieve her personal belongings. After the session with the Rural Outreach Worker, Cheryl made an appointment to see her local GP to discuss future referrals to local health services.

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**Providing personal support**

Simon had lost his job and his relationship had broken down. His mother was worried and contacted the Rural Outreach Program. That same day, the Rural Outreach Worker visited Simon at his home. After a general discussion about how Simon was feeling, Simon agreed to make an appointment with a GP and gave permission for the Rural Outreach Worker to make a referral to see a counsellor. Three days later, the Rural Outreach Worker met Simon at his home and drove him to the counselling session. After introducing Simon to the counsellor, the Rural Outreach Worker left the two of them to talk in private. Afterwards, Simon and the Rural Outreach Worker discussed what strategies Simon had learnt, and plans were made for regular sessions with the counsellor in the future. After the follow up visit with the Rural Outreach Worker, Simon contacted the GP to organise a mental health plan and to discuss whether medication was an appropriate course of action.
9. COMMUNITY MEMBER TESTIMONIALS

The following testimonials are taken from the satisfaction surveys and telephone interviews conducted with various community members. Where actual names are given below, this is because the person quoted agreed to be named.

“Service Navigation

Hannah was looking forward to her birthday in September. Her grandmother was concerned as she was easily upset and her teachers had informed her that Hannah’s grades were dropping and she was getting into trouble at school. Her grandmother decided to contact the Rural Outreach Worker to find out whether there were any locally available services for children nearby. The Rural Outreach Worker visited one afternoon when Hannah was playing at her grandmothers. Hannah told the Rural Outreach Worker that she was not happy at home. The Rural Outreach Worker scheduled a visit with Hannah’s mother and supplied her grandmother with details of a family counselling service nearby.

We need... mental health services from people we know and trust in regional and remote areas because we don’t have access to mental health services like the major regional centres... or capital cities.
- Jason Gordon, President of the (Inquire) Football Club.

“My [Rural Outreach Worker] is a very effective communicator, he has a ‘no frills’ style... which is important given the rural client demographic. He makes a difference in the area of mental health. Rural areas need this service”.
- Anonymous community member.
“It was great having [the Rural Outreach Worker] come to the house, especially for the kids. Now my boys have a bond with [the Rural Outreach Worker]. I’ve been able to ring [the worker] any time - day or night which I have done a couple of times, in tears. He has been a lifesaver.”
- Anonymous community member.

“The Rural Outreach Worker... builds up the rapport so that people are comfortable (enough) to give him a call if they need to. Nothing is too hard (for him)”.  
- Monica Revell,

“The service was ongoing and very supportive. The [Rural Outreach Worker] contacted me on a regular basis to see how I was going and to give me further advice regarding extra services (available). There should be more support like this for women escaping domestic violence. This service gave me the support and courage to leave and to believe in myself again”.
- Anonymous community member.

Very kind and caring attitude from the Rural Outreach Worker. Always very happy to accommodate [community members]. Nice cheerful demeanour. Easy to refer [community members] which definitely makes the process more user friendly. Great service - well done.
- Anonymous community member.
Issues have been de-escalated before problems arise. This meets a gap in service[s] that has been sadly missed for nearly 2 years. Thank you for being available.
- Anonymous community member.

“The follow up phone calls have been really good and being able to talk to someone anytime I needed to, has really made a big difference in my life. Thank you so much”.
- Anonymous
10. REFERENCES
