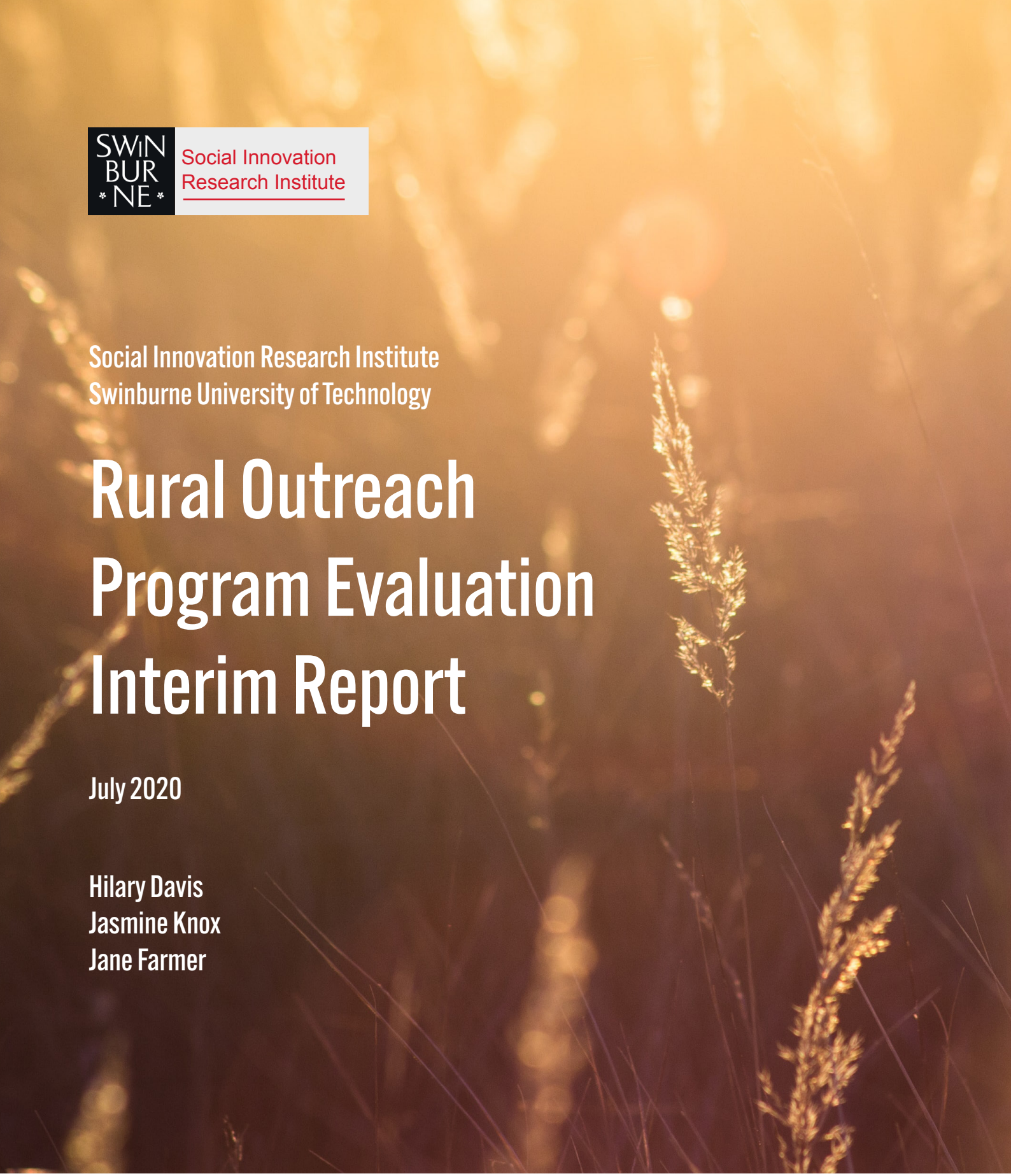


Social Innovation Research Institute
Swinburne University of Technology

Rural Outreach Program Evaluation Interim Report

July 2020

Hilary Davis
Jasmine Knox
Jane Farmer

CONTENTS

KEY TERMS

RURAL OUTREACH PROGRAM

The Rural Outreach Program is a Victorian rural mental health initiative, with local community- based Rural Outreach Workers responding to the immediate needs of people living in the Wimmera Southern Mallee Shires. The program aims to improve the wellbeing of community members who are struggling with tough times and to support them with navigating services. There are currently three Rural Outreach Workers and one Rural Outreach Program Coordinator. The Rural Outreach Program started in December 2018.

RURAL OUTREACH WORKERS

The role of the Rural Outreach Workers is to increase the capacity of services working in communities and to respond to community members who are in psychological distress and may be showing early signs of mental ill-health. The role responds to a person's need for immediate support and assists them to navigate and access services quickly. Anyone in the community with concerns for another can refer to the Rural Outreach Workers to conduct a wellbeing check. During this, Rural Outreach Workers record data such as demographics, location, motivations for accessing the service, etc. The Rural Outreach Workers do not provide therapeutic or clinical interventions.

RURAL OUTREACH PROGRAM CO-ORDINATOR

The Co-ordinator ensures that the Rural Outreach Workers have access to resources and networks necessary to perform their role. They manage the Rural Outreach Workers and work with researchers to gather data for evaluation. They engage with service providers and stakeholders to develop relationships and limit barriers for community members to access services.

EXECUTIVE SUMMARY

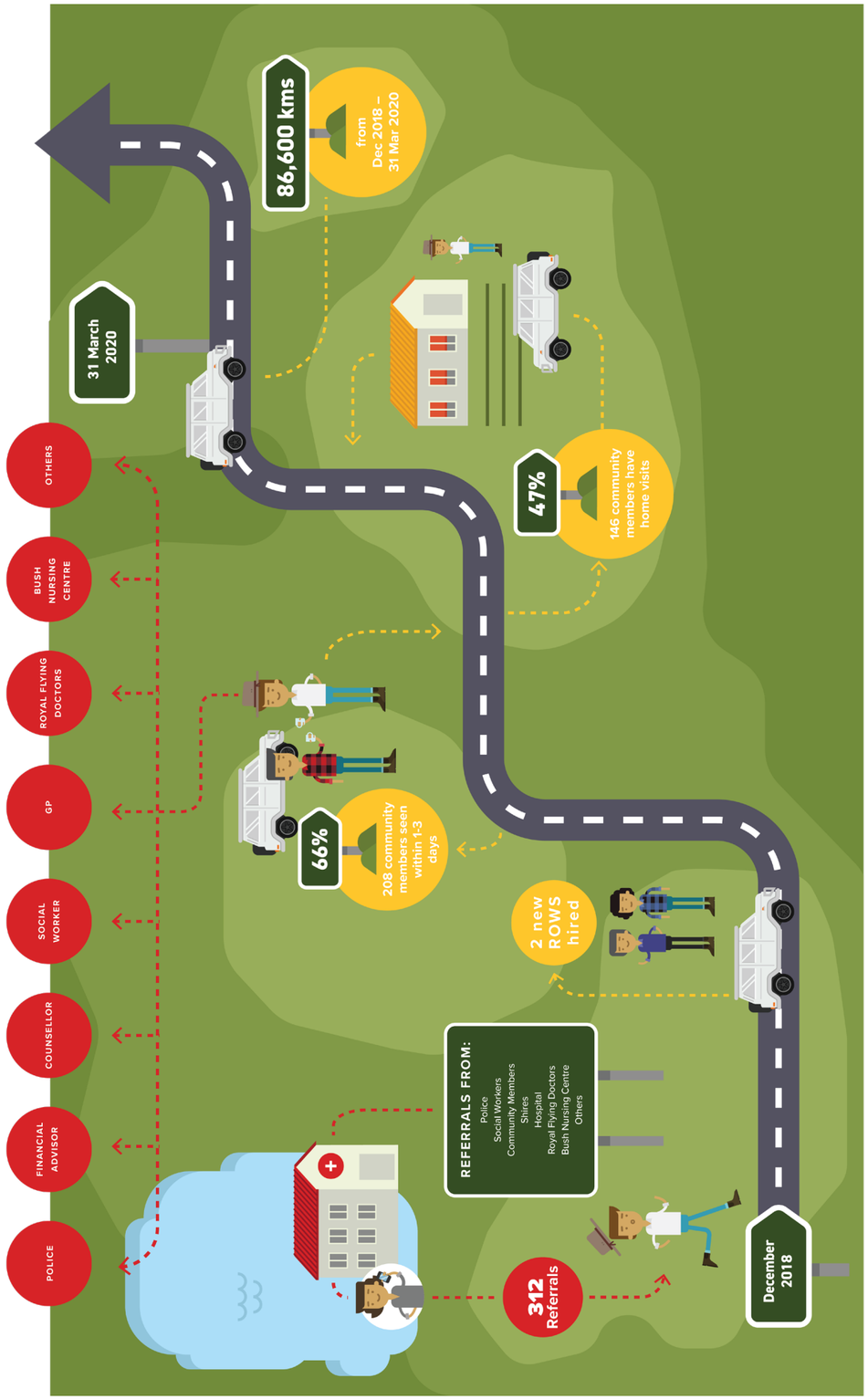
The evaluation assesses the effectiveness of the Rural Outreach Program and makes recommendations regarding its future development. This report presents data collected between **1 January 2019 to 31 March 2020** inclusive. A final report showing outcomes for the whole of the Rural Outreach Program including quantitative data, case studies, illustrations and digital stories will be delivered in 2021.

BACKGROUND

In November 2018, Swinburne University's Social Innovation Research Institute (SIRI) was commissioned to conduct an external evaluation of the Rural Outreach Program.

The Rural Outreach Program has been developed to increase the capacity of services working with local communities to respond to, and support, community members 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 might occur.

'Seasonal Condition Funds' were collectively pooled by four Local Government Areas (LGA's), to support local communities through the Rural Outreach Program. Agencies involved include: Edenhope and District Memorial Hospital (acting as lead agency), four LGAs and six additional health organisations.



KEY FINDINGS

- **Between 1 January 2019 and 31 March 2020, a total of 1044 forms were completed.**
- **More than 60% of those using the Program, heard about it through word of mouth including from family members, friends or colleagues.**
- **Men aged 31-70 was the group making highest use of the Program.**
- **Community engagement activities yielded over 100 referrals.**
- **Initial visits and assessment occurred in one to three days for 67% of community members.**
- **52% of visits involved travel up to one hour, but 8% involved three hours' or more travel.**
- **The highest number of scheduled visits occurred in the community member's home.**
- **The Rural Outreach Workers made 93 referrals to other services on behalf of the community members during the January 2019-March 2020 time period.**
- **There were 490 follow-up visits with community members. For over half of these, the community member said they had contacted the services recommended by the Rural Outreach Workers.**

INTERIM REPORT INTRODUCTION

Dealing with mental health and wellbeing is an ongoing challenge for rural communities. Data show that, although there is similar reported prevalence of mental ill-health across Australia, the rates of suicide, self-harm and emergency admissions for mental health conditions, is higher with remoteness. In 2016, the rate of suicides per 100,000 people in rural and remote Australia was 50% higher than in the cities (Hazell et al, 2017).

The Wimmera and Southern Mallee region in northwest Victoria is characterised by small communities sparsely located within very large landmasses. It covers 28,000 kms2 and has a population of 38,400 people. It includes the local government areas of West Wimmera, Yarriambiack, Hindmarsh and Horsham Rural City (see Appendix A for detail).

Responding to those who are in psychological distress and/or have emerging signs of mental ill health is a significant area of concern for councils across the Wimmera and Southern Mallee.

Evaluation of the Rural Outreach Program

The Program is evaluated on its capacity to influence and make an impact, for local people, on the following:

- 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.

Evaluation data are collected via forms completed by outreach workers and community members (See Appendix B for explanation of evaluation approach). Simple counts of episodes and qualitative comments inform the Findings section.

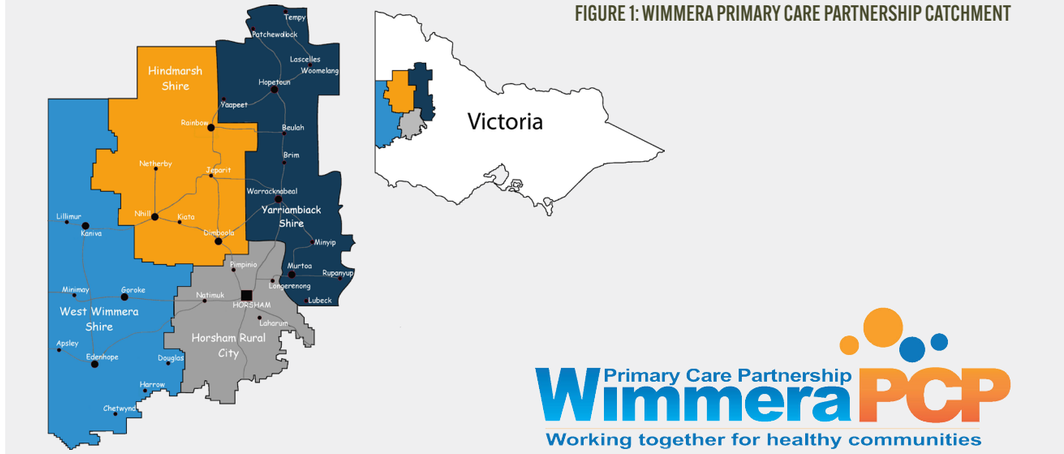


FIGURE 1: WIMMERA PRIMARY CARE PARTNERSHIP CATCHMENT

FINDINGS

Initial Assessments

Initial assessments were conducted with 276 individual community members during 1 January 2019 to 31 March 2020.

Travel time to visit community members

For 52% of visits, the Rural Outreach Workers travelled up to one hour. Eight per cent (n=23 visits) required a journey of more than three hours duration.

Thirty-six visits required no travel as they were conducted via telephone or in the Rural Outreach Worker office. These are included in the '30 mins or less' category.

In total, between 1 January 2019–31 March 2020, the Rural Outreach Workers travelled 31,654 kms solely to conduct initial assessments. (Kilometres travelled were calculated at 80 km/h due to road conditions in rural and remote areas.)

Referrals

One hundred and four (33%) community members self-referred. 86 (26%) were made by service providers, an indicator of awareness of the service by local service providers. 'Other' referrals (23, 7%) include those by a community member, a member of a community or sporting group, or police.

Initial contact

Sixty-two per cent of community members heard about the Rural Outreach Program through word of mouth (193) occurring mainly through family members, friends and colleagues.

In other cases, community members were previously known by the Rural Outreach Workers (50, 16%) or had learned about the Program through another service provider (40, 13%). 'Other' sources (29, 9%) included a Rural Outreach promotion or engagement activity or mental health first aid training conducted by Program staff. By phone was the most frequent way that initial contact was made (66%, 204 people).

'Other' methods (5%, 16 people) included by email, the Rural Outreach Worker made initial contact or undisclosed.

For two-thirds (208) community members, a Rural Outreach Worker visited to conduct an initial assessment within 1 to 3 days following a referral.

Use of the service

A wide range of ages of community members used the service, with the largest category aged 51 to 70 years.

Location of service provision

The highest category of location for scheduled visits was in the community member's home (47%, 146). Other locations included, over the phone (22), the Rural Outreach office (11) and schools (11). For half of the visits, the Rural Outreach Workers spent longer than one hour with a community member during an initial assessment (49%, 156).

FIGURE 2: TRAVEL TIME TO VISIT COMMUNITY MEMBERS
(n=267)

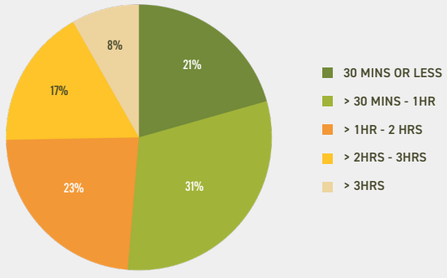


FIGURE 4: COMMUNITY MEMBERS AWARENESS OF THE PROGRAM
(n=312)

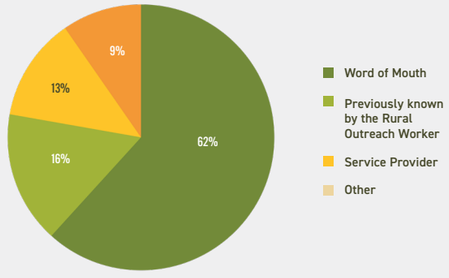
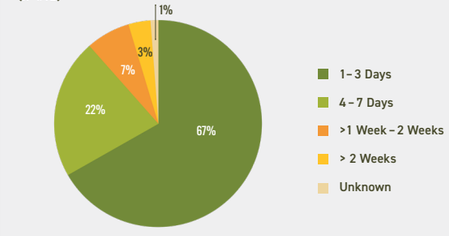


FIGURE 3: REFERRALS TO THE PROGRAM
(n=312)

FIGURE 5: LENGTH OF TIME BETWEEN REFERRAL & SCHEDULED VISIT
(n=312)



When the Rural Outreach worker has received the referral, contact is made within 1-2 days and a time is arranged for a scheduled visit. This may take some time up to 1-2 weeks depending on the urgency to speak to the Rural Outreach Worker or convenience for the community member.

FIGURE 7: LENGTH OF SCHEDULED VISITS
(n=312)

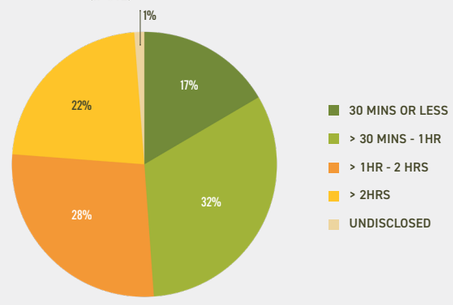
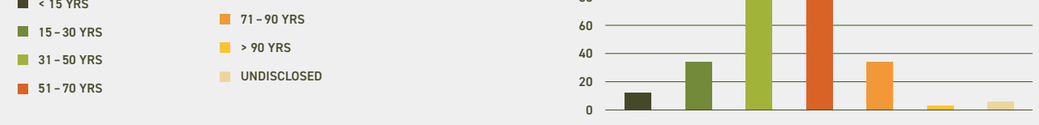


FIGURE 6: AGE OF COMMUNITY MEMBERS WHO ACCESSED THE PROGRAM
(n=312)



Triggers for the visit

Often, one main trigger was the reason for the community member to be referred or self-referral (25%, 77). However, at times there were multiple triggers.

The highest occurring trigger was that the community member was 'upset' (25%, 77). Other triggers included community member needed support (46), family issues (46), family/friends were concerned (42), anxiety or depression (23), not engaging in self-care (22), aggressive behaviour (14) physical health issues (13), stress (12), family violence (10), grief and loss (10), behavioural issues (10), suicidal thoughts (seven), service navigation (six), relationship issues (six), alcohol and drugs (five).

Relationship issues included breakdown of intimate relationships, including divorce. 'Concern from other' includes referrals by another community member including a family member, health professional, or work colleague. Occasionally referrals came from teachers, police, and employers. Behavioural issues included self-harm and not engaging in their regular activities. Issues with service navigation included with Centrelink, the Department of Health and Human Services, and the court system.

Figure 8 records 312 responses, representing community members visited by the Rural Outreach Workers.

Nature of issues as assessed by Rural outreach Worker

The Rural Outreach Workers identified family issues (20%, 126) as being the theme with highest number of mentions.

These mentions related to relationship issues, e.g. with family members, concerns about family members' welfare and wellbeing, and carer exhaustion. For some community members, multiple issues were identified. Other issues included mental wellbeing (90). Mental wellbeing was a broad category for mental health issues that were not specified, or not related to anxiety or depression. Other issues included anxiety or depression (71), physical health (64), grief and loss (63), relationships (51), financial issues (49), social isolation (41), employment (34), family violence (21), gambling, alcohol and other drugs (19) violence or bullying (eight), legal issues (seven).

FIGURE 8: TRIGGERS FOR THE RURAL OUTREACH VISIT

Responses n=312

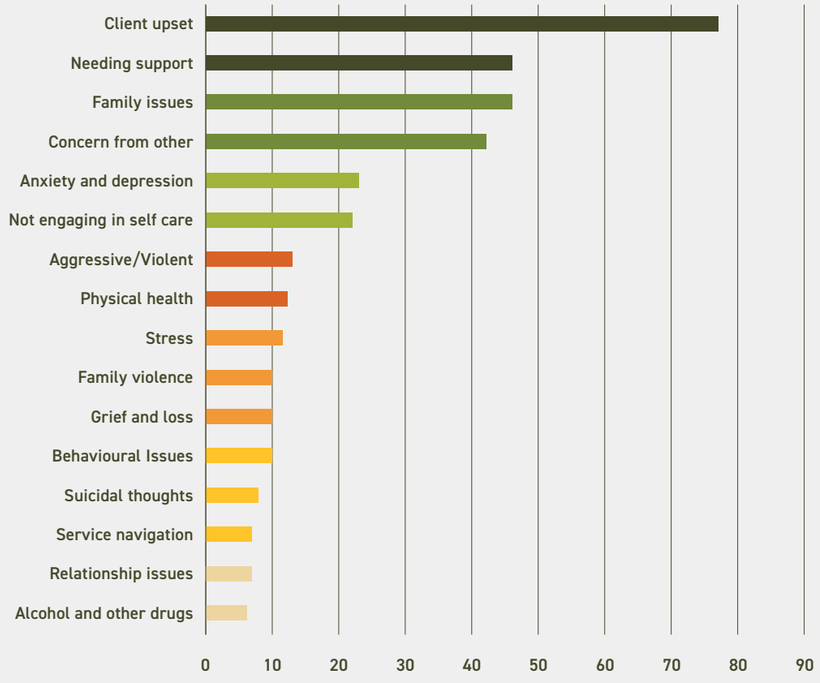
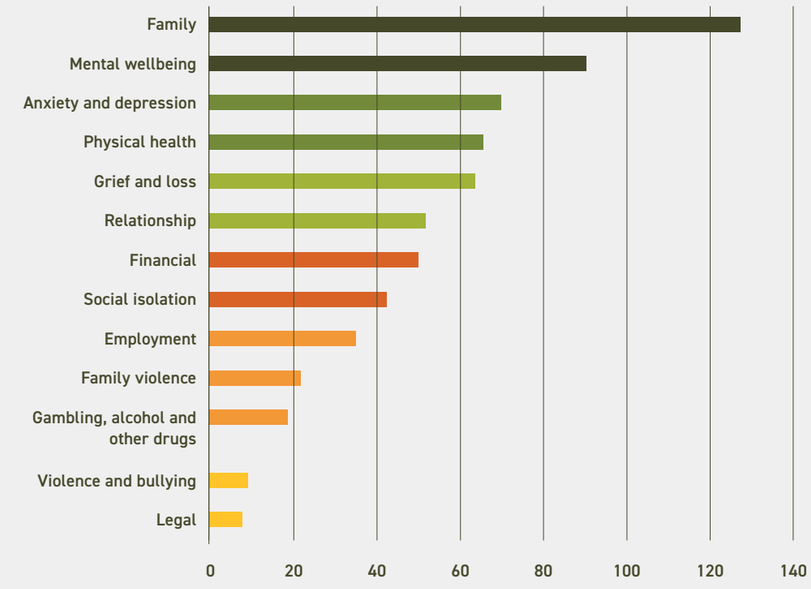


FIGURE 9: NATURE OF ISSUES IDENTIFIED BY THE RURAL OUTREACH WORKERS FOR THE INITIAL ASSESSMENTS

Responses n=312 | Number of issues



Suggested referrals by the Rural Outreach Worker

Services recommended included – contact and/or visit: counselling service (90), GP (52), council support services (eight), family violence services (five), financial advisor (five), legal advice (five), Centrelink (four).

The 'other' category included – contact and/or visit: emergency accommodation, social worker, bush nursing centre, services for Aboriginal and Torres Strait Islander Peoples, charity organisation, physiotherapist or dietician.

At times, the Rural Outreach Workers made a referral with or on behalf of the community member. These incuded for a counselling service such as the Royal Flying Doctors psychologist (45), GP (20), council support services (six), financial advisor (four), headspace (three), bush nursing centre (two), family violence service (two), social worker (two) and a charity organisation (two). 'Other' referrals (seven) included for: legal services, services for Aboriginal and Torres Strait Islander Peoples and National Disability Insurance Scheme (NDIS).

Follow-up visits

After the initial assessment, 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 assess if a follow up visit was required. Sometimes an assessment was made that a follow-up visit was not needed. There were 490 follow up visits conducted during the period 1 January 2019 to 31 March 2020.

For 46% (n=225) of follow up visits, a Rural Outreach Worker drove for more than one hour to conduct the visit, with six per cent (n=3) requiring more than three hours' travel.

In total the Rural Outreach Workers travelled 54,945 kms conducting follow-up visits exclusively. (Kms. travelled were calculated at 80 km/h due to road conditions in rural and remote areas).

Community Engagement

One goal of the Rural Outreach Program is to build community resilience via community engagement and outreach activities. The Workers or Co-ordinator visits community groups and organisations to deliver presentations including about mental health promotion and mental health wellbeing training.

The largest proportion of activities concerned promotion of the Rural Outreach Program (114). This involves a general discussion and presentation about the Program, the referral process and strengthening connections with community services, groups and individuals. This was mainly conducted at health services (31), local business (18) and community or sporting groups (15). Other organisations for which community engagement was provided included local council and at local events. Mental health training was conducted at schools (five), heath services (three), community or sporting groups (two), council offices (two) and a neighbourhood house (one).

A total of 550 hours was spent on community engagement activities, with workers travelling 37, 237 kms solely to conduct community engagement activities.

According to the Community Engagement Form, completed by the Coordinator and Workers, 104 referrals were made to the Program, through community engagement activities.

FIGURE 10: SUGGESTED REFERRALS MADE BY THE RURAL OUTREACH WORKER
(n=179)

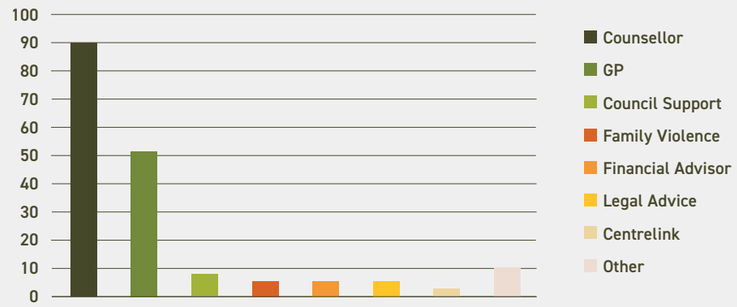
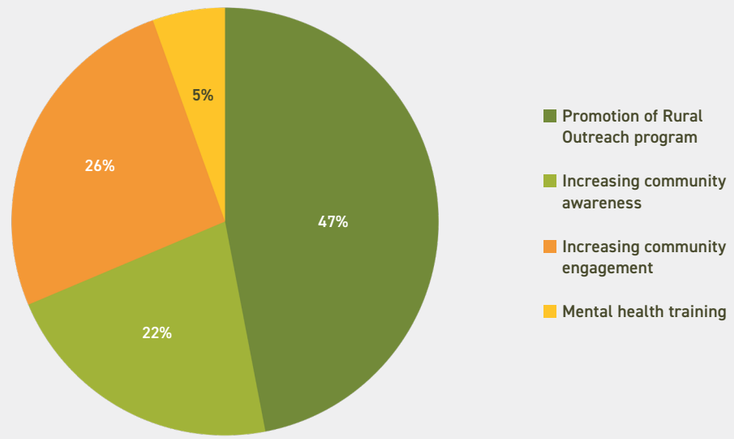


FIGURE 11: TYPES OF COMMUNITY ENGAGEMENT ACTIVITIES
(n=179)



Community Satisfaction Forms

Community satisfaction forms were distributed to community members and referrers at the discretion of the Rural Outreach Workers – consequently we do not know how many forms were distributed. Between 1 January and 31 March 2020, there were 31 satisfaction surveys completed and returned for analysis.

Responses showed that 70% strongly agreed that they were satisfied with the service/program. Additionally, 73% strongly agreed that they were **satisfied with the Outreach Worker. Eighty per cent strongly agreed** that the service was **timely and 73% strongly agreed that it is** easy to access.

Seventy percent of respondents strongly agreed that they **'felt they were listened to'.**

For 80% of responses, community members strongly agreed that they would contact or **use the Rural Outreach Program again** and 76% strongly agreed that they would **recommend this service** to others.

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 agreed to be named.

"I have had positive feedback about this service - it has been very useful" Bush nurse

"The Outreach Worker presence has been utilised well. Issues have been de-escalated before problems arise. This meets a gap in service that has been sadly missed for nearly 2 years. Thank you for being available"

"Extremely valuable conduit to mental health services that are difficult to access in our area."

"In my role as the lone police officer, I have referred multiple people to this service. Each one has been a success. With this area being remote, it is difficult to have any services attend in the field. Not only that the workers follow up with clients to reach a satisfactory result. A fantastic program I would hope will expand further."

CASE STUDIES

Anonymised case studies provide examples of interactions between the Rural Outreach Workers and community members. The case studies highlight how the Outreach Program can help to deal with the variety of scenarios that community members might face.

CASE STUDY 1: SUPPORT AFTER CRISIS

During work hours, a staff member of a local organisation received a telephone call informing her that a family member had taken their own life. The staff member was understandably very upset. Their work colleagues, who had worked with the staff member for some time, and had met the family member, were impacted. This was at a time where the organisation was under pressure to complete an important piece of work on time. The CEO of the organisation had heard of the Rural Outreach Program through a discussion with other CEOs in the region. The CEO decided immediately that they had to support the worker and other people in the office. They called the Rural Outreach Worker who attended the same day. The Rural Outreach Worker spoke with and listened to the organisation workers. The CEO reported that the Rural Outreach Worker was a local person, who 'spoke locally', and that made a difference to the workers. The Rural Outreach Worker did not leave until they felt that everyone on-site had 'taken a deep breath', was feeling more relaxed and comfortable. The CEO said that the workers knew that after the Rural Outreach Worker had left the workplace, they could call them back anytime, if needed. The CEO reported that "the service was invaluable; it was really great".

CASE STUDY 2: 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 revealed 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 Worker made a referral for emergency accommodation and contacted the police to assist her to retrieve her personal belongings. After the session with the Worker, Cheryl made an appointment to see her local GP to discuss future referrals to local health services.

CASE STUDY 3: 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 Worker to make a referral to see a counsellor. Soon after the Worker met Simon at his home and drove him to the counselling session. 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 Worker, Simon contacted the GP to organise a Medicare Mental Health Plan and to discuss whether medication was an appropriate course of action.

CASE STUDY 4: MEDIATING BETWEEN SERVICES AND COMMUNITY MEMBERS

Local Police had noticed that Sam's been driving erratically in the streets. Sam is in his early 20s and has grown up in the rural town. The Police contacted the Rural Outreach Worker and asked if he could have a conversation with Sam before the matter escalated and the Police are forced to intervene. The Worker visited Sam at his home and explained that the Police are aware of his behaviour. The Worker explained the consequences to the young man, stating "They'll impound your car and you'll lose your license. You know how important it is in the bush to have your license". Due to a personal connection with the young man, the Worker was able to ask Sam why he was behaving this way. Sam explained that he was struggling to handle his parent's domestic disagreements and this was a means to vent his frustration. After the conversation with the Worker, Sam discontinued driving erratically and returned to playing in the local football team.

*note all names are pseudonyms

REFERENCES

1. Hazell T, Dalton H, Caton T, Perkins D (2017) Rural Suicide and its Prevention: a CRRMH position paper. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.
2. QuickStats 2019, Australian Bureau of Statistics, accessed 1 June 2019, >https://www.abs.gov.au/websitedbs/censushome.nsf/home/quickstats?opendocument&navpos=220<

APPENDIX A - DEMOGRAPHICS

West Wimmera

In 2016, 3,937 people lived in West Wimmera. Aboriginal and/or Torres Strait Islander people were 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 %. Community members who had completed 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.

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.

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.

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.

APPENDIX B - METHODS

APPROACH

Evaluation tools were codesigned by Swinburne Researchers and the Rural Outreach Program staff and include data collection about: 1) initial consultations with a community member; 2) follow up visits with a community member; 3) After community engagement activities; Community Satisfaction Information is entered directly into a specially designed app.

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-up visit is necessary and any other information considered important by the Rural Outreach Workers.

The Rural Outreach Follow Up-Form

The Rural Outreach Follow-Up Form is completed by the Rural Outreach Workers, after a follow up consultation 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 was required, any comments or additional notes made by the Rural Outreach Workers.

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.

The Community Satisfaction Form

The Community Satisfaction Form was created by researchers 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.

Enquires please contact:

1300 688 732
info@ruraloutreach.org.au