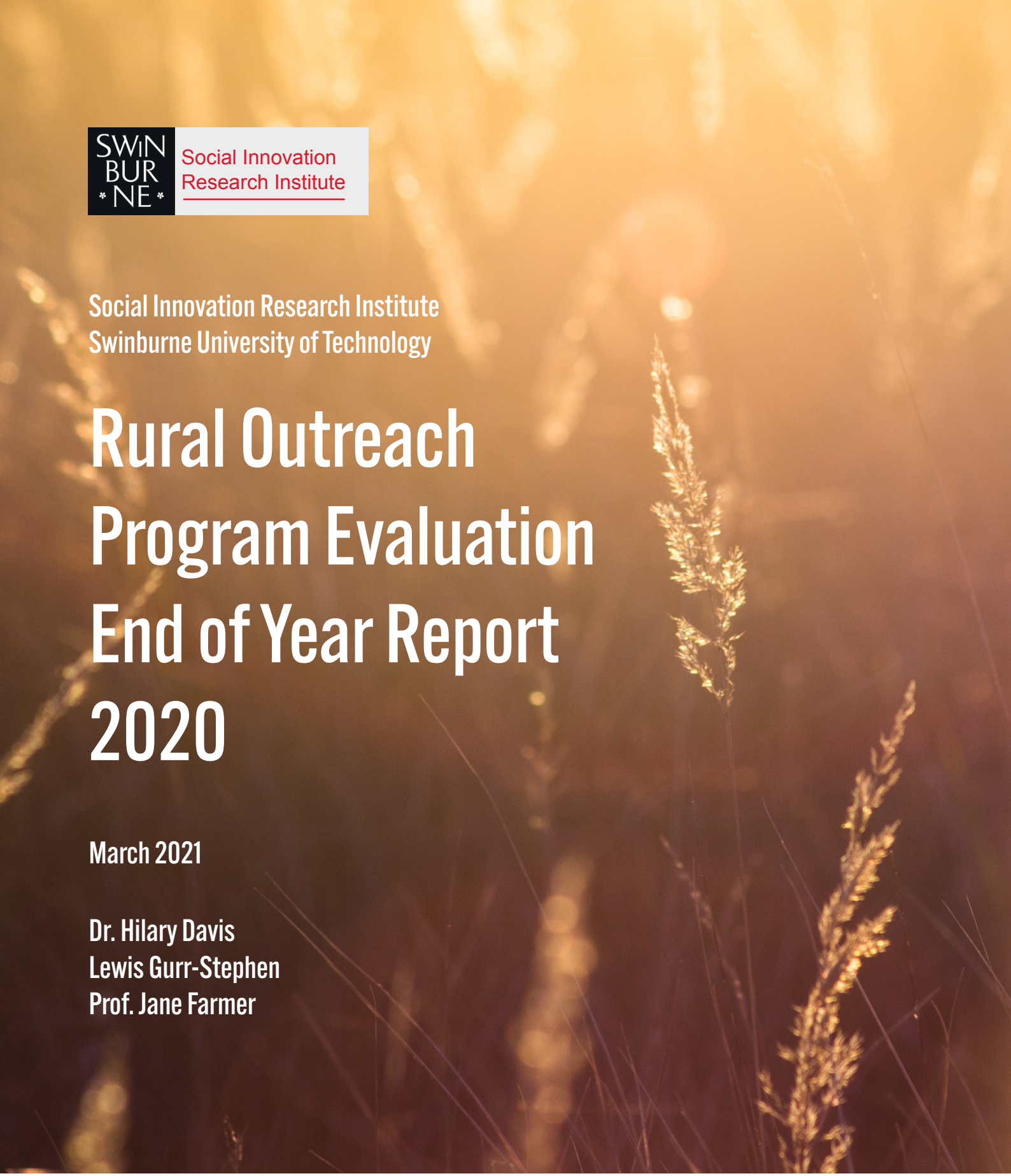

Social Innovation Research Institute
Swinburne University of Technology

# Rural Outreach Program Evaluation End of Year Report 2020

March 2021

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# 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.

## INTAKE WORKER

The Intake Worker manages the calls into the service and allocates to the Rural Outreach Workers. During the height of the coronavirus pandemic, the Intake Worker had a key role in guiding border communities through the complex issues associated with the South Australian/ Victorian border closure. They also support the team with record keeping, data entry and developing and maintaining relevant documentation.

# EXECUTIVE SUMMARY

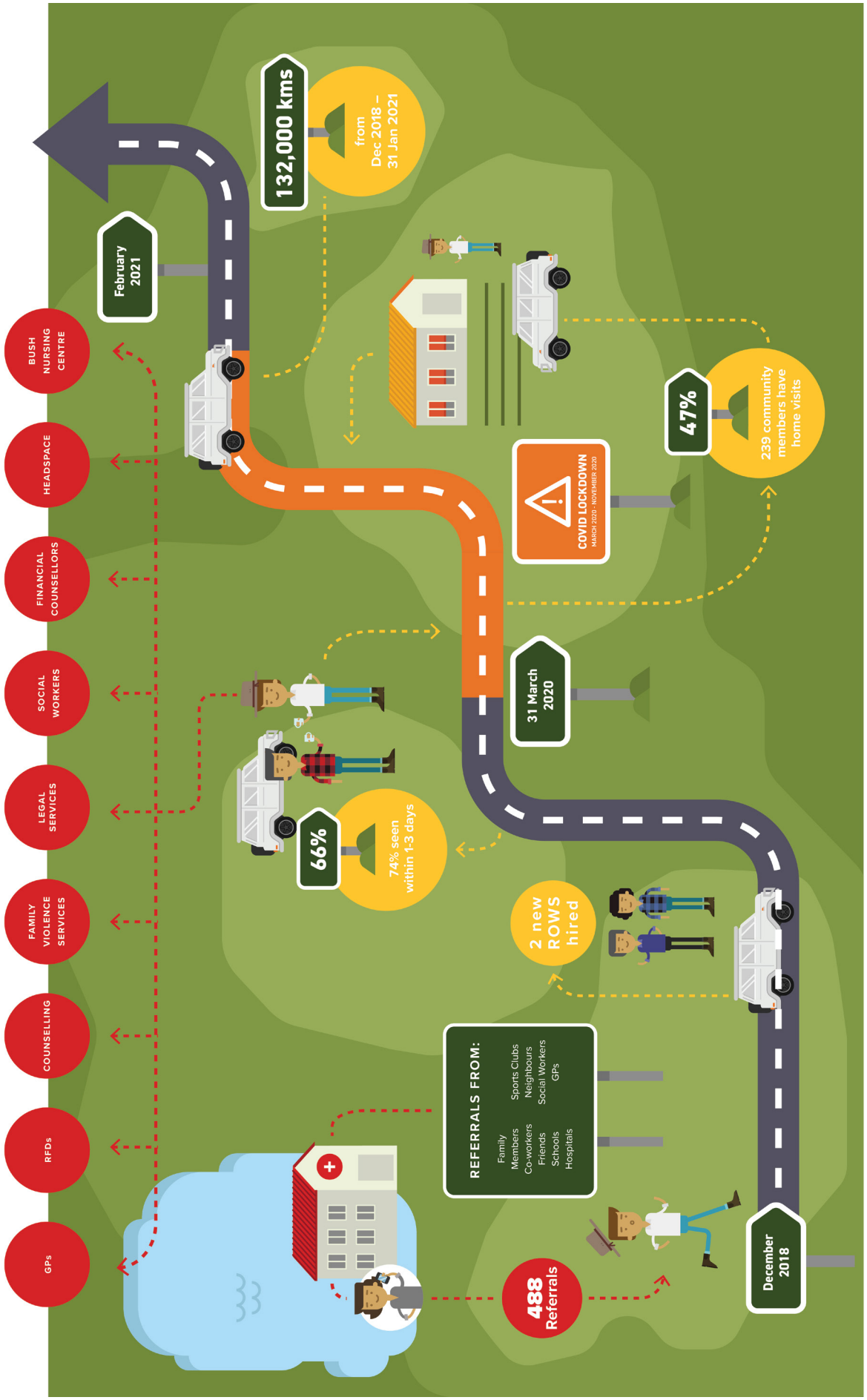
The evaluation assesses the effectiveness of the Rural Outreach Program and makes recommendations regarding its future development. This report presents data collected between **1 January 2019 to 31 January 2021** inclusive.

# 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.


GPs
RFDs
COUNSELLING
FAMILY VIOLENCE SERVICES
LEGAL SERVICES
SOCIAL WORKERS
FINANCIAL COUNSELLORS
HEADSPACE
BUSH NURSING CENTRE
February 2021
132,000 kms
from Dec 2018 – 31 Jan 2021
COVID LOCKDOWN
MARCH 2020 - NOVEMBER 2020
47%
239 community members have home visits
31 March 2020
66%
74% seen within 1-3 days
2 new ROWS hired
REFERRALS FROM:
Family Members
Co-workers
Friends
Schools
Hospitals
Sports Clubs
Neighbours
Social Workers
GPs
488 Referrals
December 2018

## KEY FINDINGS

- Between 1 January 2019 and 31 January 2021, a total of 1511 forms were completed.
- 65% of those using the Program, heard about it through word of mouth including from family members, friends or colleagues.
- Men were slightly more likely than women to use the service for both initial assessments (57 % to 43 %) and follow up visits (54% to 45%).
- Users tended to be aged between 31 and 70, though 37 community members under the age of 20 including 15 aged below 15 years old were seen by a Rural Outreach Worker.
- Community engagement activities yielded 141 referrals.
- Initial visits and assessment occurred in one to three days for 74% of community members.
- 63% of visits involved travel up to one hour, but 10% involved three hours or more travel.
- Around half of visits occurred in the community members' home.
- The Rural Outreach Workers made 159 referrals to other services on behalf of the community members during the January 2019-January 2021 time period.
- There were 1023 follow-up visits with community members. For one third of these, the community member said they had contacted the services recommended by the Rural Outreach Workers.

# 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 to 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.

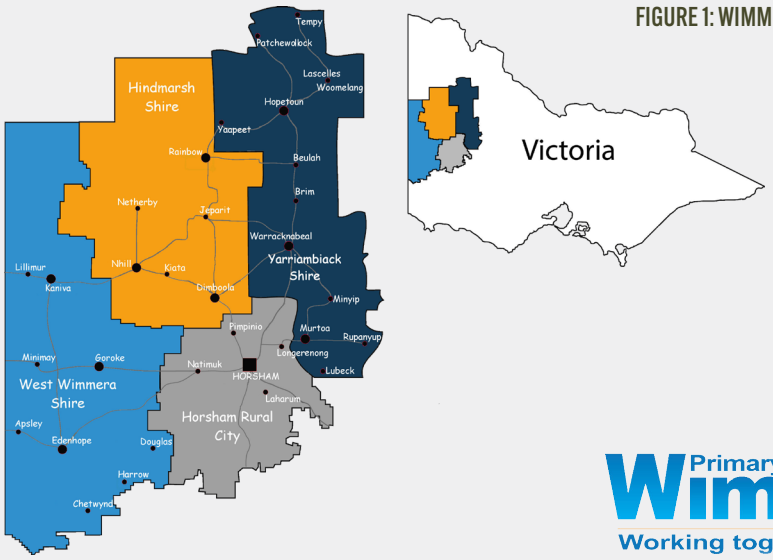



FIGURE 1: WIMMERA PRIMARY CARE PARTNERSHIP CATCHMENT AREA

Primary Care Partnership
Wimmera PCP
Working together for healthy communities

## The Covid-19 pandemic and the Rural Outreach Program

The **COVID-19 pandemic in Australia** is part of the ongoing worldwide pandemic of the coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first confirmed case in Australia was identified on 25 January 2020, in Victoria. National response to the pandemic included closure of Australian borders to all non-residents on 20 March and returning residents mandatory two weeks in supervised quarantine hotels from 27 March. Many individual states and territories also closed their borders, some remaining closed until late 2020. Social distancing rules, the closure of "non-essential" services, including social gathering venues such as pubs and clubs, and long periods of working from home and home-schooling followed. During 2020, Victoria experienced two waves of infections. The second wave, though largely localised to Melbourne, was much more widespread and severe than the first; at its peak, the state had over 7,000 active cases. Victoria underwent a second strict lockdown which eventually lasted almost four months. The wave ended with zero new cases being recorded in October 2020. A nationwide vaccination program began in February 2021, however brief lockdown periods may still arise in response to local outbreaks across the state.

The pandemic raised significant issues for local community members including, for those in border towns, challenges accessing local services including health services, shopping, transport and other essential services. Further, some community members experienced significant mental health challenges related to social distancing, and the pressures of home-schooling, working from home and food shortages. Wimmera PCP facilitated training for front line support workers in health services. The Rural Outreach Program received additional training in mental health crisis first aid. The Rural Outreach Program became a port of call for local border issues, and for community members, organisations and service providers struggling to cope with the changes bought about in response to the pandemic. This included assisting community members to find alternative services and health care. There were service wait lists due to the impacts of the pandemic on services, the Rural Outreach Program had an important role, providing a bridging service to these services during this time. The Rural Outreach Program changed their service delivery model. They transitioned from a face-to-face outreach service (except in the most urgent of cases), to one delivered primarily with the support of technology such as telephone, video-conferencing software, and social media. For example, the Edenhope District Memorial Hospital Facebook page and website promoted the Rural Outreach Program.

# Psychological First Aid

As a result of COVID19, the subsequent lockdown and stress on local health service workforces, the Wimmera Southern Mallee Health Alliance in collaboration with Wimmera Primary Care Partnership commissioned Phoenix Australia for the delivery of Psychological First Aid training online. As the Australian National Centre of Excellence in Posttraumatic Mental Health, Phoenix Australia provides evidence-based learnings enabling participants to develop strategies and gain confidence in providing assistance and support to individuals affected by trauma. Led by Wimmera Primary Care Partnership, this opportunity was undertaken by 250 frontline health workers (approximately 13% overall) in the Wimmera Southern Mallee region including members of the Rural Outreach Program. Participation in Psychological First Aid training has enabled the Rural Outreach Program workforce access to specific and relevant learnings in order to support its communities in the most responsive way and connects them with the peer support network across the region. During the lockdown periods from June to August 2020, the Rural Outreach Workers logged over 72 hours of wellbeing checks on community members as they struggled with isolation and cross-border issues.

### Victorian/ South Australia border crossing during lockdown period


COVID 19 led to some issues never experienced before. The closure of the borders tested the Rural Outreach team's ability to adapt to an everchanging environment. Access to psychiatrists and psychologists became a significant issue for community members, particularly if the community members had already been attending appointments over the border. The Rural Outreach team were able to support telehealth logistics with health professionals that agreed to telehealth appointments. Otherwise, they coordinated appointments with out of state health professionals willing to use telehealth, including Royal Flying Doctors Psychiatrists in Brisbane Queensland.

# FINDINGS

Note that percentages may not add to exactly 100% due to rounding.

## Initial Assessments

Initial assessments were conducted with 276 individual community members during 1 January 2019 to 31 January 2021.

### Travel time to visit community members

For 63% of visits, the Rural Outreach Workers travelled up to one hour. 10% (51 visits) required a journey of more than three hours. 117 visits required no travel as they were conducted via telephone or in the Rural Outreach Worker office. These are counted as '30 mins or less'. Between 1 January 2019 and 31 January 2021, the Rural Outreach Workers travelled 42,000 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 seventy-two (35%) community members self-referred. 102 (21%) were made by service providers, an indicator of awareness of the service by local service providers. Other referrals were made by family (66) or friends (64), by people at work (40), either employers or co-workers, and the remainder of referrals were from teachers (15), police (10), or community groups (9) such as sport clubs, social clubs, SES volunteers, or churches. 6 referrals came from Shire employees and 4 were not stated.

### Initial contact

66% of community members heard about the Rural Outreach Program through word of mouth (321) occurring mainly through family members, friends and colleagues. In other cases, community members were previously known by the Rural Outreach Workers (60, 12%) or had learned about the Program through another service provider (67, 14%). 26 community members (5%) learned

**FIGURE 2: TRAVEL TIME TO VISIT COMMUNITY MEMBERS**
(n=488)

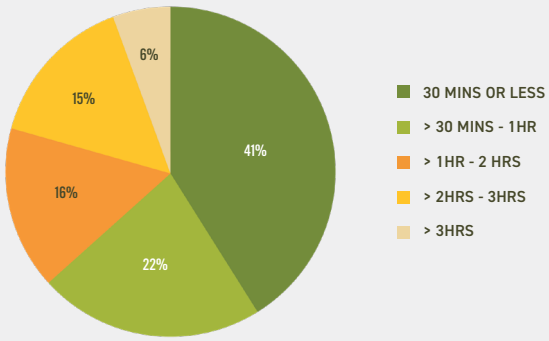



**FIGURE 4: COMMUNITY MEMBERS AWARENESS OF THE PROGRAM**
(n=510, multiple responses possible)

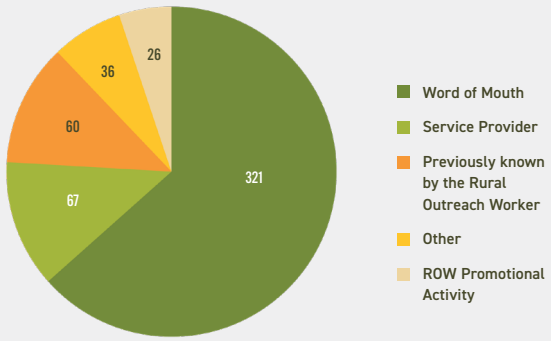
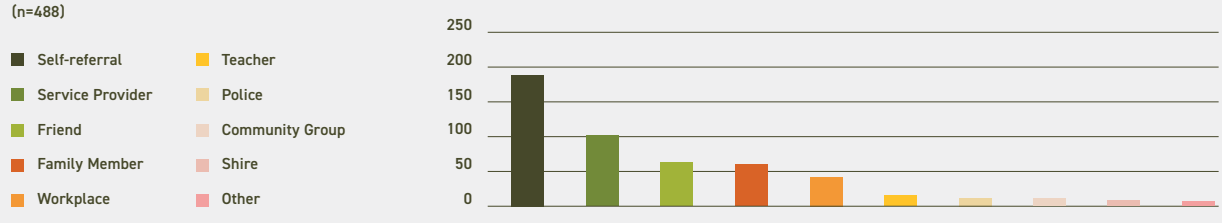



**FIGURE 3: REFERRALS TO THE PROGRAM**
(n=488)



about the program directly from a ROW promotional activity. 'Other' sources (26, 7%) included police, church, school, Facebook, and shire employees. Some community members listed multiple sources.

By phone was the most frequent way that initial contact was made to ROW by community members or referrers (358 instances, 73%). The majority of the other contacts were face to face (108, 29%). The remaining community members were contacted by email (five) or else it was not stated/unclear (17).

Nearly three quarters (361, 74%) of the time, a Rural Outreach Worker conducted an initial assessment with the community member within 1 to 3 days following a referral. Of these, 57 (12%) were by phone and 431 (88%) were in person.

## Age of service users

A wide range of ages of community members used the service, with the largest category aged 51 to 60 years. The most likely people to use the service were aged between 31 and 70.

## Location of service provision

The highest category of location for scheduled visits was in the community member's home (239, 49%). For other visits, some were by phone and others were in public spaces. Public space was split into community (cafes, football clubs, neighbourhood house, community centres) and public spaces (parks and lake). Some visits were conducted at community member's workplaces or at a health service.

For just under half of the visits, the Rural Outreach Workers spent longer than one hour with a community member during an initial assessment (218, 45%).

Due to Covid-19, the proportion of visits conducted by phone increased from 8% before March 2020 to 19% between March and November 2020.

**FIGURE 5: AGE OF COMMUNITY MEMBERS WHO ACCESSED THE PROGRAM**
(n=312)

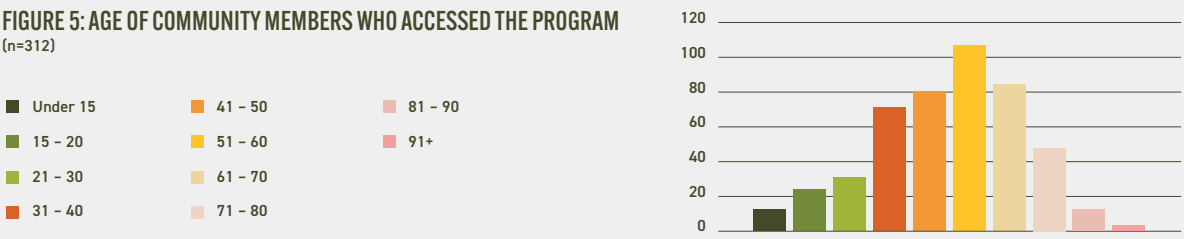
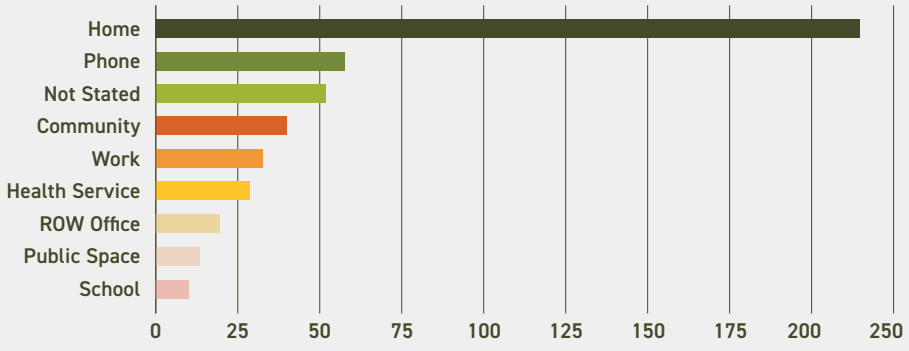



**FIGURE 6: LOCATION OF VISIT**
(n=488)



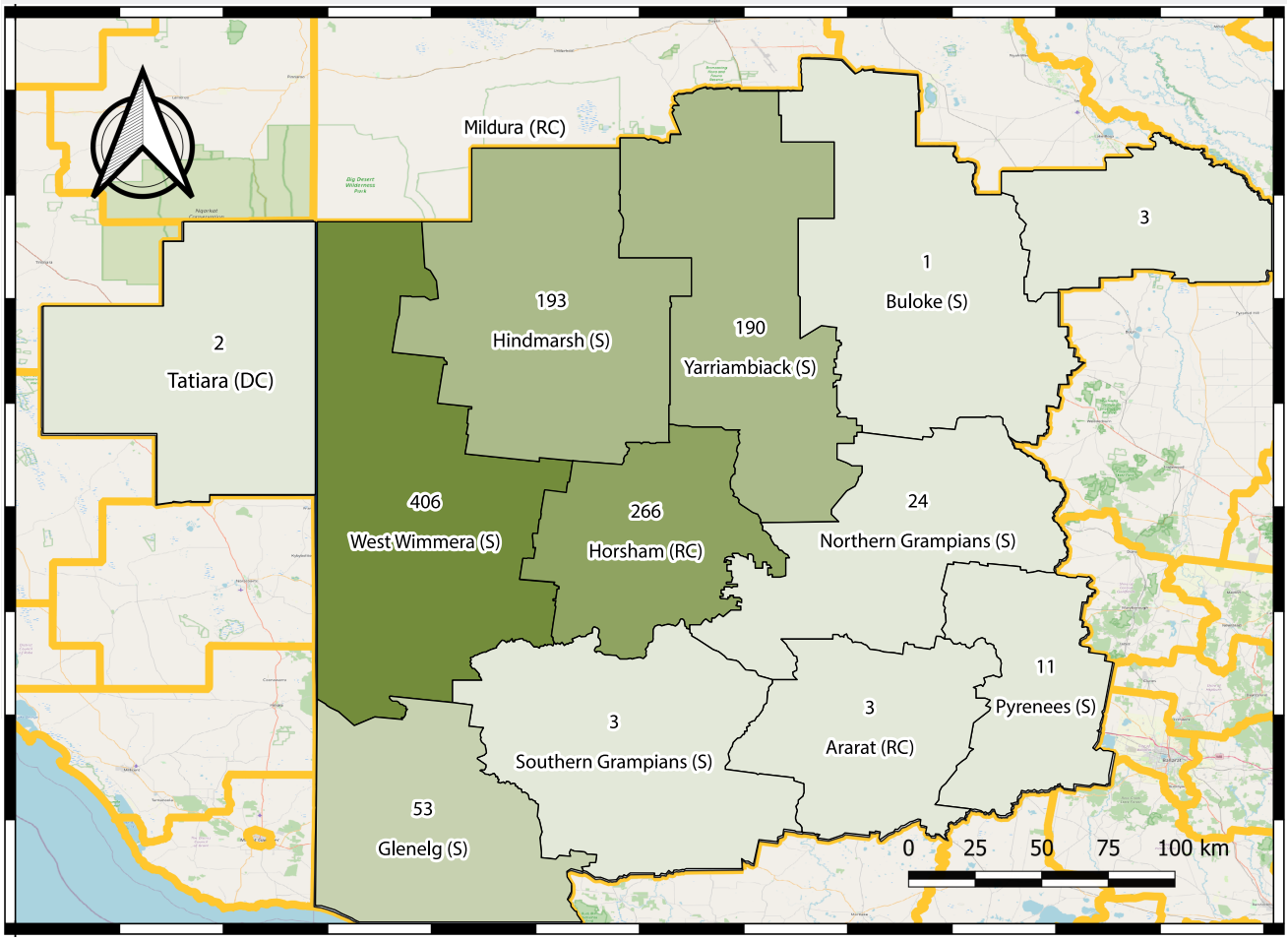
## Initial assessments by Local Government Area

To gather more detailed information on Rural Outreach Program interventions by Local Government Areas (LGAs), we used UNITI, a hospital-based client management system. This has provided information that has assisted with identifying trends, gaps and service diversity.

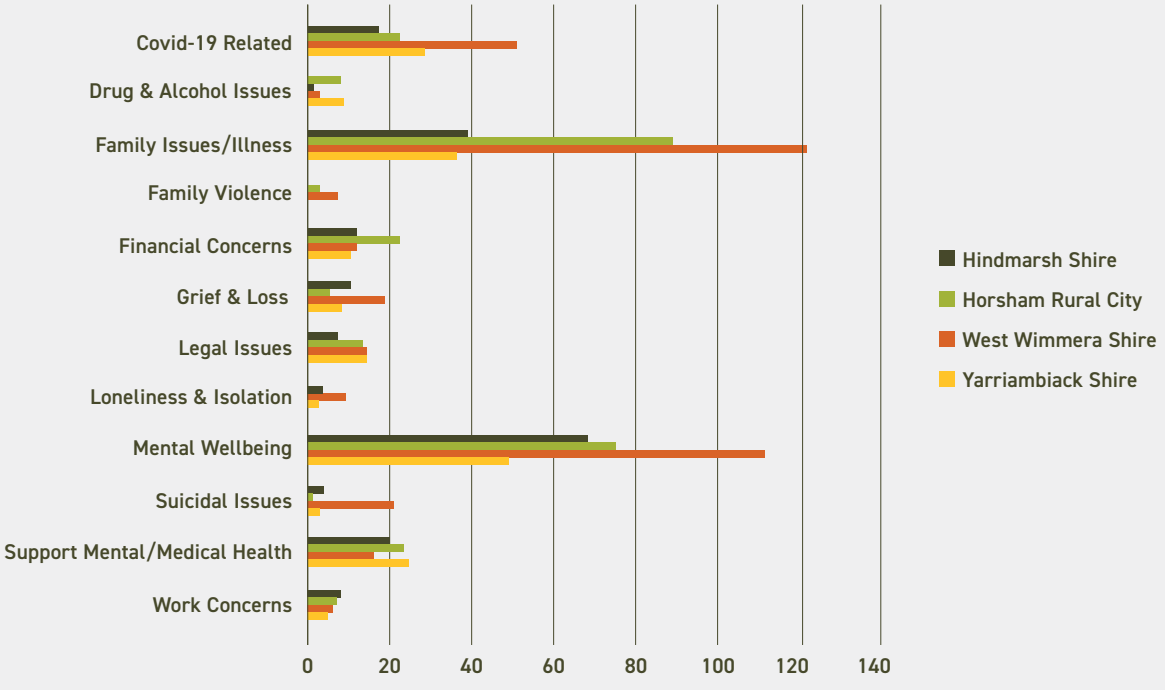
The map shows the LGAs in which the community members live, based on the number of initial assessments. The lighter colours represent smaller numbers of people, darker is higher. The white areas are those with small numbers of people.

Figure 8 shows the interventions by category in each of the LGAs. Most of the interventions are for family issues/illness and mental wellbeing. The interventions are consistently higher for West Wimmera Shire, despite the lower population. Horsham has the second highest, but also a higher population by far. Considering per capita interventions, Hindmarsh and Yarriambiack are close to each other and above Horsham in all categories. The plot shows Rural Outreach Program interventions by LGA and intervention type between January 1, 2020 and December 31, 2020.

## FIGURE 7: TOTAL NUMBER OF INTERVENTIONS BY LOCAL GOVERNMENT AREA




## FIGURE 8: TYPE OF INTERVENTION BY LOCAL GOVERNMENT AREA



## Triggers for the visit

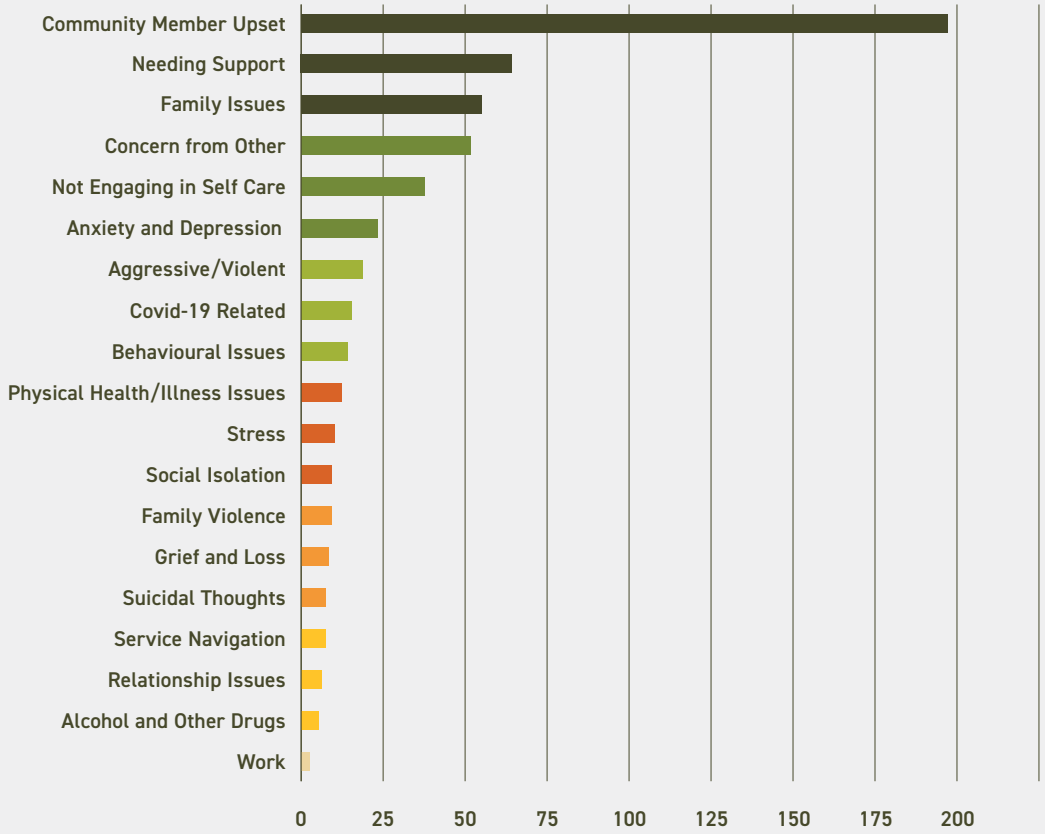
Often, one main trigger was the reason for the community member to be referred or self-referral (204, 42%). The rest of the time there were multiple triggers. The highest occurring triggers were that the community member was experiencing distress (190, 39%) or needing support (68, 14%) and this led them to seek out or be referred to the ROW. 'Needing Support' includes people who just wanted someone to talk to, or who were not sure where to go next with an issue. The most common specific triggers were family issues, which were a mixture of ongoing issues with family members including chronic mental health or interpersonal problems within the family, plus specific incidents or hardships experienced by other family members.

'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. Covid-19 was a very common reason for people to get in touch with the ROWs, most often for help with bureaucratic requirements such as border crossing forms. Less common but still present was social isolation triggered by Covid-19. These are separately represented in the 'Social Isolation' category. Relationship issues refers to breakdown of intimate relationships, including divorce. Issues with service navigation included with Centrelink, the Department of Health and Human Services, and the court system.

Figure 9 records 488 responses, representing community members visited by

**FIGURE 9: TRIGGERS FOR ROW INVOLVEMENT**

n=554 (multiple responses possible)



the Rural Outreach Workers. Sometimes the ROW identified multiple triggers for the visit.

## Nature of issues as assessed by Rural Outreach Worker

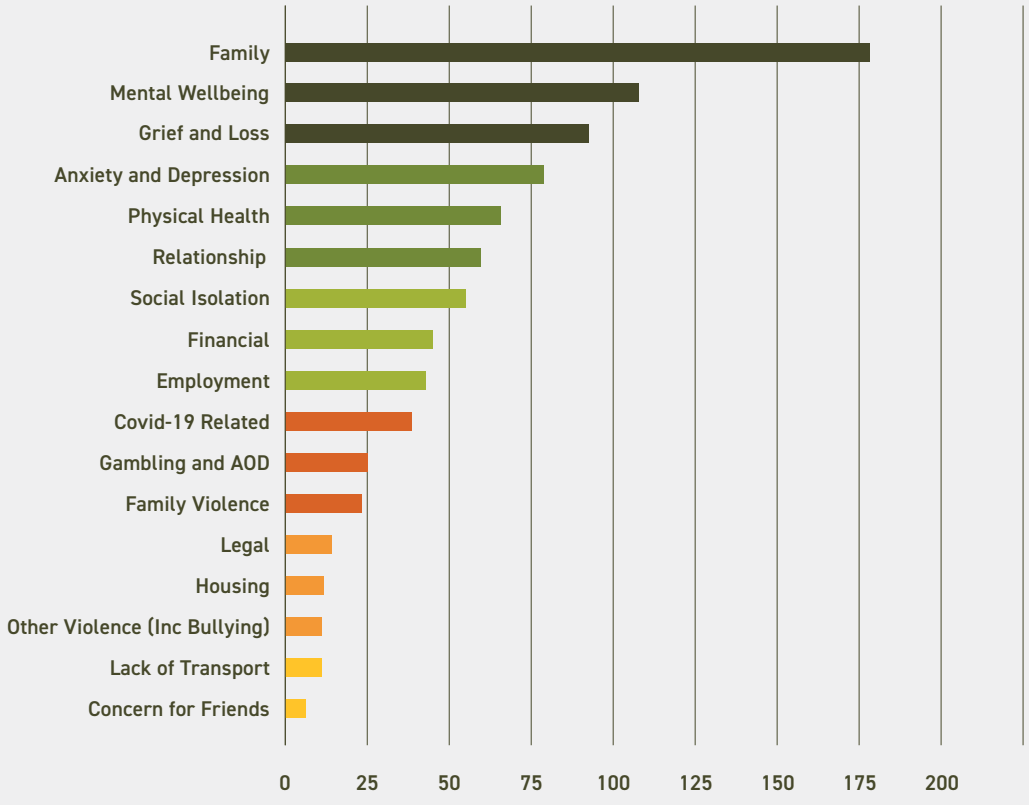
In more than half of cases (250) the Rural Outreach Worker identified more than one issue.

The ROWs identified family issues (176, 36%) as being the theme with highest number of mentions. These mentions related to interpersonal issues with family members, concerns about family members' welfare and wellbeing, and carer exhaustion. For many community members, multiple issues were identified. Other issues included mental wellbeing (108). Mental wellbeing was a broad category for mental health issues that were not specified, or not related to anxiety or depression. Other issues included grief and loss (87), anxiety or depression (77), physical health (68), relationships (64), financial issues (43), social isolation (58), employment (42), coronavirus (37), gambling, alcohol and other drugs (25), family violence (24), legal issues (14), housing (11), violence or bullying (10), lack of transport (10), and concerns about friends' wellbeing (eight).

The relationships category refers to issues within spouse/intimate partner relationships, such as breakdown, distance, difficult dynamics, and divorce. It does not include intimate partner violence, which is included under family violence, or issues within the family dynamic as a whole.

**FIGURE 10: NATURE OF ISSUES IDENTIFIED BY THE RURAL OUTREACH WORKERS FOR THE INITIAL ASSESSMENTS**

n=866 (multiple responses possible)



## Suggested referrals by the Rural Outreach Worker

Rural Outreach Workers suggested 318 referrals for 231 community members. Some community members had more than one referral. Services recommended included – contact and/or visit: counselling services (138), GP (90), council support services (27), other health services including hospitals and physiotherapy (11), legal advice or support including the police (10), family violence services (nine), local charities (eight), Government services like centrelink, NDIS, and department of housing (seven), and financial advice or counselling (six), and social work (four). The 'other' category (seven) included services for Aboriginal and Torres Strait Islander Peoples, and professional services such as funeral directors and banks.

Rural Outreach Workers made 168 referrals with or on behalf of 121 community members. These included for a counselling service such as the Royal Flying Doctors psychologist or headspace (78), GP (39), council support services (12), health services including the bush nursing centre or hospital (10), social workers (six), legal services (five), charity organisations (five), family violence services (four), financial advisor (four). 'Other' referrals (five) included services for Aboriginal and Torres Strait Islander Peoples and the 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.

## Travel time to visit community members

There were 1023 follow up visits conducted during the period 1 January 2019 to 31 January 2021. For 43% (n=435) of follow up visits, a Rural Outreach Worker drove for more than one hour to conduct the visit, with ten per cent (n=99) requiring more than three hours' travel. In total the Rural Outreach Workers travelled 90,505 kms conducting follow- up visits exclusively. Travel time was calculated at 80 km/h due to road conditions in rural and remote areas.

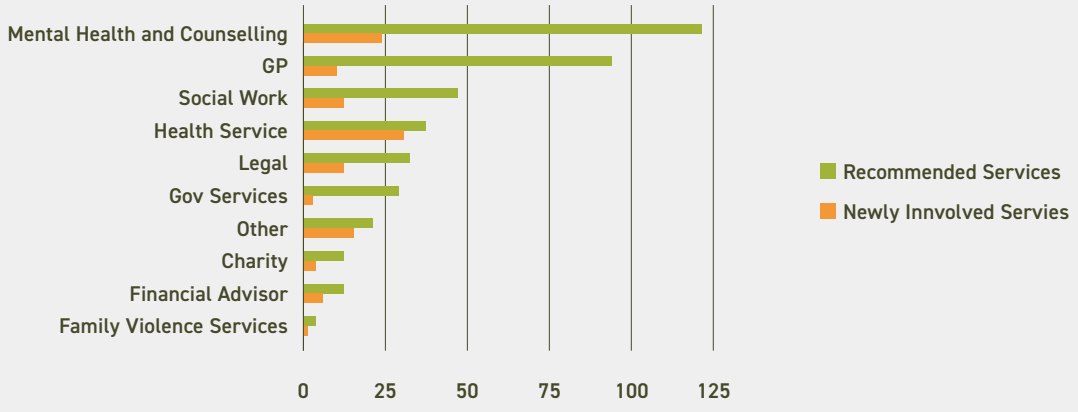
## Service recommendations

The Rural Outreach Workers reported during follow-up visits that 356 (35%) of community members had contacted a recommended service since the last visit.

The types of recommendations are shown below. The most common category of recommendation was mental health or counselling services, followed by GP visits, social work services and other health services. This is similar to the referrals suggested in the initial assessments, except for the much higher proportion of social work referrals in the follow-up visits. This may be due to the complexity of issues that the community members are experiencing, that require follow-up.

While the proportion of referrals to mental health and counselling services are similar from the initial assessments to the follow-up assessments, the specificity of the suggested services increases. For example, in the initial assessments, the referrals were mostly to psychologists or psychiatrists, with specific mentions of headspace, grief and loss counselling, drugs and alcohol, and family counselling. In the follow-up assessments, referrals were to specific services such as headspace, Lifeline, CASA, RFDS, Relationships Australia, anxiety support groups, and specific venues like Swan Hill Community Mental Health Service, Sexual Assault and Family Violence Centre Wimmera, and so on.

FIGURE 11: SERVICES RECOMMENDED DURING FOLLOW-UP VISITS



## Further visits required

Of the 1023 follow up visits, 486 required another return visit, and 415 times the ROW stated that it was unknown whether a follow-up was required. In only 122 cases (12%) was a return visit not required. This suggests that many of the community members visited by the ROW require ongoing support and commitment.

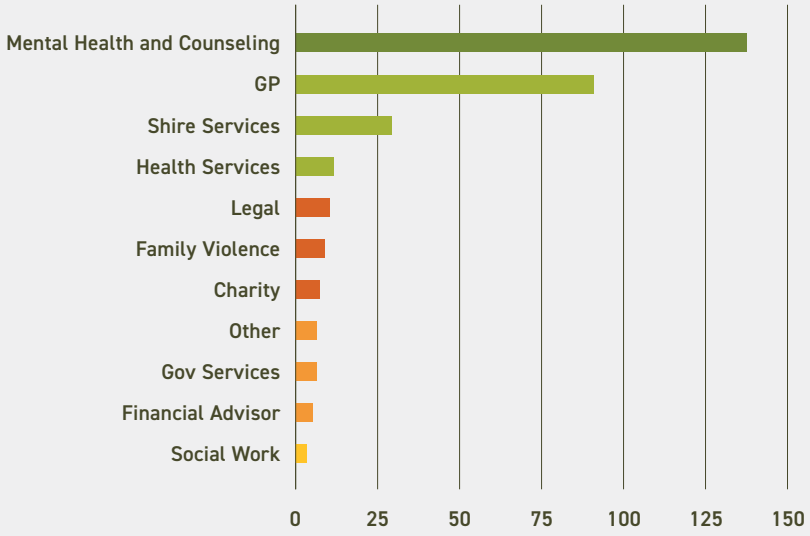
## Community Engagement

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 (147). 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 (35), including hospitals, bush nursing centres, and clinics, community spaces or sporting groups (27), local business (26), council offices (23) or men's sheds (10). Other locations included local events such as fairs or fundraisers and schools. Mental health training was conducted at health services (seven), by phone (six), schools (five), community or sporting groups (two), council offices (two) and a neighbourhood house (one). A total of 865 hours was spent on community engagement activities, with workers travelling approximately 49,000 kms solely to conduct community engagement activities (assuming average travel speed of 80 km/hr).

According to the Community Engagement Form, completed by the Coordinator and Workers, 141 referrals were made to the Program, through community engagement activities.

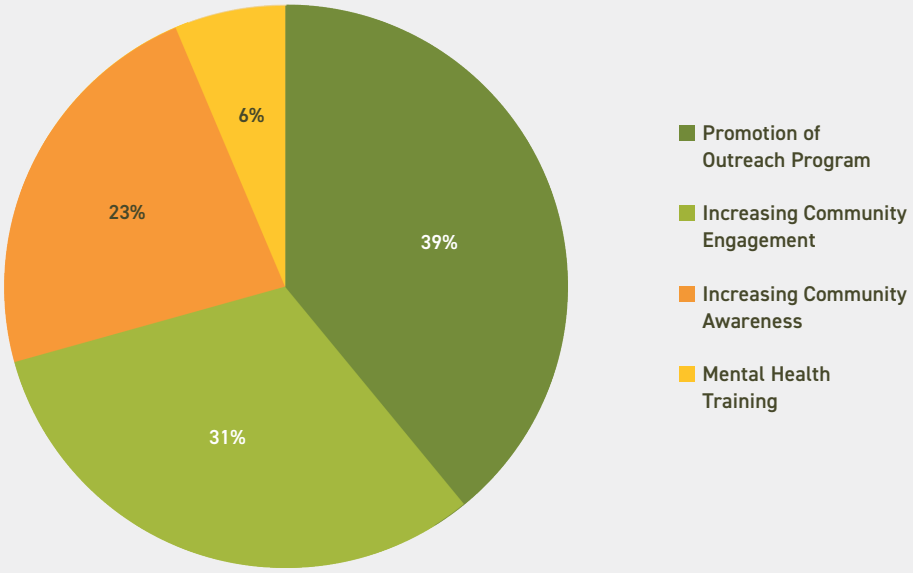
## FIGURE 12: SUGGESTED REFERRALS MADE BY THE RURAL OUTREACH WORKER

(n=323)




## FIGURE 13: OUTREACH EVENT TYPES

(n=347)



### *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 2019 and 31 January 2021, there were 41 satisfaction surveys completed and returned for analysis. The percentage of responses to the statements are shown below.

Of responses, 90% reported that 'trust-worthiness' is the most important quality for a Rural Outreach Worker. Other qualities that were rated as important included: caring (76%), empathy (76%), respect (76%), honesty (86%), and kindness (70%).

## COMMUNITY MEMBER TESTIMONIALS

The following testimonials are taken from the satisfaction surveys and telephone interviews conducted with various community members.

**"It was great having the ROW come to the house specially for the kids (...) He has been a life saver".**

**"The service was ongoing and very supportive. The case worker contacted me on a regular basis to see how I was going and to give me further advice regarding extra services in the location I was now in. 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".**

**"The follow up phone calls have been really good and being able to talk to someone anytime I needed has really made a big difference in my life... thank you so much".**

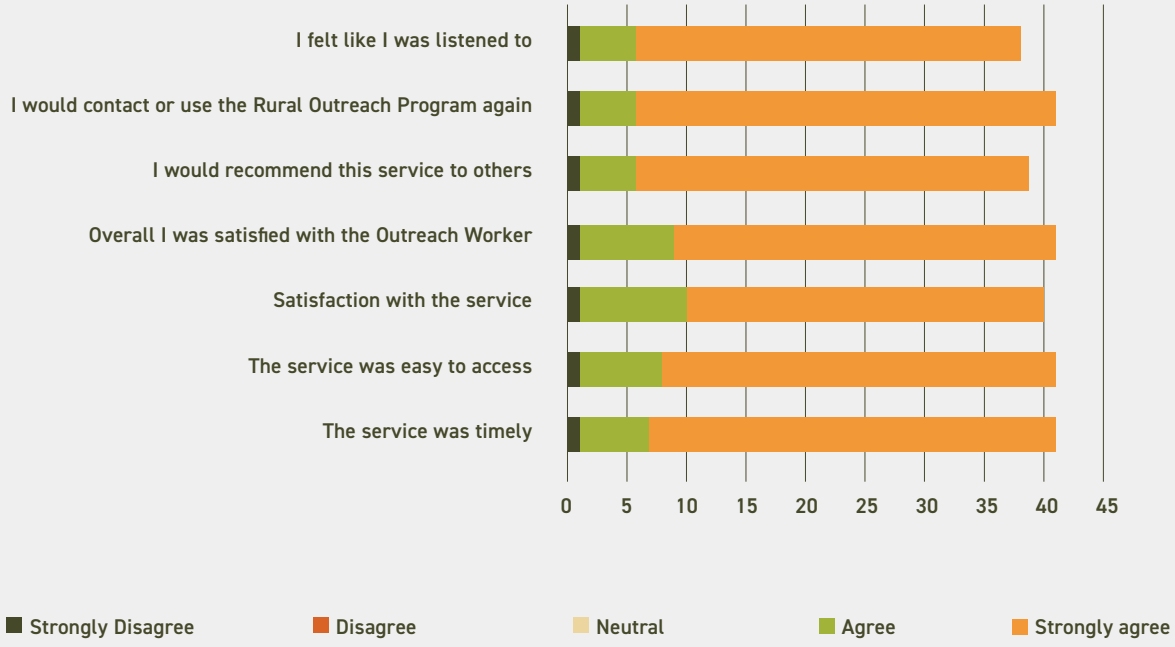
**"The ROW was professional in every aspect. I would recommend him to anyone. He is a good listener. I'm very happy with the service."**

## Providing Personal Support

The following testimonial is from a community member outlining how the Rural Outreach Program helped her, providing personal support in time of crisis.

> "Fantastic, best thing I have done for myself to make the phone call contact Rural Outreach, I heard about the service through my workplace. I had a lot going on in my life and was feeling really overwhelmed and didn't know who or where to go to get help. They've done referrals to a psychologist to support me and continued to support me to make sure it is working for me. The best advice I would give someone is if you are thinking of contacting them, Just do it, just reach out and you won't be sorry. They've been really good, they gave me good strategies that I've applied and I feel stronger in myself... I would recommend the Rural Outreach Program to anyone."

**FIGURE 14: SURVEY RESPONSES**
(n=42)



## CASE STUDY 1: ROW PROGRAM SUPPORTS CAPACITY BUILDING IN COMMUNITY MEMBERS

Wimmera Community Options falls under Wimmera Healthcare group banner, providing case management for homecare packages with Government funding. They organise service provision, provide assistance to appointments, and help people to stay at home as long as possible, thereby alleviating pressure on families.

Wimmera Community Options contacted the Rural Outreach Program asking them to visit a community member Sue*. Sue has complex mental and physical health issues and is supported by her adult children. One adult child is moving inter-state this is causing some anxiety for Sue who is concerned that might lose familial support and connectivity. The Rural Outreach Worker met with Sue regularly over a number of weeks. The Rural Outreach Worker supported Sue to help manage anxiety, family relationships, and organise a budget plan. The Rural Outreach Worker referred Sue onto additional services including a financial adviser through the Salvation Army, and shopping co-ordination through the Wimmera Community Options carer respite team. Practical assistance included supporting Sue to set up service-related apps on her phone, and sitting with Sue while she made phone calls for service support, thus building decision-making capacity in Sue. Sue is proud of the way she has taken on new tasks, and made decisions about her future. She has begun to imagine opportunities from the family member moving interstate, and has begun planning a holiday to visit.

The Wimmera Community Options case manager, Joan Hargreaves, reported that the Rural Outreach Program was particularly valuable for Sue. She said:

> ***"Taking the time to sit with her, and show her these services... (encouraging) self-praise, and raising her confidence levels. You can see it, and hear it in her voice. The change in her is amazing".***

*Sue is a pseudonym

## CASE STUDY 2: ROW PROGRAM SUPPORTS COMPLEX NEEDS

The Woomelang Bush Nursing Centre has regular contact with a community member, Margaret* who has experienced childhood trauma, lives with complex health issues and needs ongoing support. Margaret is the carer of a young child with a behavioural disorder. Margaret was becoming concerned that she might lose her home, due to no fault of her own. This was causing Margaret a great deal of anxiety and was impacting on her mental health.

The Woomelang Bush Nursing Centre contacted the Rural Outreach Program for advice and support. The Rural Outreach Worker met with Margaret in her home and established rapport. Margaret particularly warmed to the female Rural Outreach Worker. The Rural Outreach Worker provided ongoing social and emotional support. She supported Margaret in accessing transport to travel to key appointments with a range of services including mental health support through the Royal Flying Doctors Service, financial advice, civil court, and police. Margaret still sees the Rural Outreach Worker regularly. The Woomelang Bush Nursing Centre has been able to focus on Margaret's health issues, rather than her personal and financial concerns. Margaret is still living in her own home, is caring for her child, and has ongoing support in place to manage her mental health and other issues.

Carol Paech, Centre Manager for Woomelang Bush Nursing Centre reports that:

> ***"This is an ongoing thing, it is not going to go away. If Margaret needs something else they (Rural Outreach Program) are linking her in. It's not a one-shop stop for this situation. When you are dealing with complex needs we all need to work (together) as a team..."***

*Margaret is a pseudonym

# 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) community engagement activities. Community satisfaction information is entered directly into a specially designed form.

### 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.

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