Home truths about mental health in Australian communities:

What we learnt about mental health from doorknocking conversations

Prepared by the Centre for Social Impact

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This report has been prepared by the Centre for Social Impact (CSI) for Community Mental Health Australia (CMHA). The CSI are the evaluation and research partners for the Assisting Communities through Direct Connection (ACDC) Project, an initiative of CMHA. This report presents research findings, collected by CMHA, to provide a preliminary overview of findings relative to mental health, help-seeking, and unmet need.

We acknowledge the work of the ACDC Project Team from CMHA who have contributed to the development of the survey and research design. CSI also acknowledge the ACDC's Research and Evaluation Working Group for their expertise and guidance.

Acknowledgement of Country

We collectively acknowledge and pay respects to the Traditional Owners and Country on which we work, including the Traditional Owners of those Countries on which this work has taken place. We pay respects to these diverse Lands and Peoples and their Elders, past and present.

Acknowledgement of lived experience

We acknowledge the individual and collective expertise of people with a living or lived experience of mental health, alcohol and other drug issues, and the families and carers who provide support and have a lived/living experience. We recognise the vital contribution, and value the courage, of individuals who have shared their perspectives and personal experiences for the purpose of learning and growing together to achieve better outcomes for all.

For this project, people with lived experience contributed through various roles; on the ACDC Research and Evaluation Working Group, the ACDC Steering Committee, the ACDC Project Team and the Evaluation Team. Collectively, they have influenced the design of the survey, ensured the integrity of the approach and guided the research so the questions we seek to answer will have value beyond this project. We recognise this ongoing contribution which has made the project more relevant and impactful.

Research team members and supporters

Yasmine Hooper, Lisette Kaleveld and Dr Leanne Lester were key contributors to the analysis and writing up of the research results presented in this report. However, a wider network of researchers and supporters also made significant contributions, and we would like to acknowledge:

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Centre for Social Impact

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Disclaimer

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TERMS USED IN THIS REPORT

This section provides an overview of terms that are commonly used in this Report, and offers working definitions and understandings that have been applied. Some definitions are formally prescribed, which others represent our best attempt at communicating the usage and meaning that applies in the context of this project.

ACDC Project terminology

Delivery Partner Organisation: The organisations that implemented the ACDC project in their local communities.

Householder: The person or people who reside in the dwelling, and who are of age, at the time of the doorknocking activity initiative to be able to participate in the ACDC survey.

People Connector: A person who has been recruited for the purposes of delivering the ACDC Project. In this paid position, a People Connector will engage, build rapport and initiate conversations about mental health, social and emotional wellbeing quickly with people from a range of different identities and backgrounds, whilst undertaking doorknocking at selected sites.

ACDC Project Team: The team of people who had responsibility for leading, managing and implementing the project across multiple sites. The people in this team had various functions such as program design, managing contracts with various stakeholders and delivery partners, and delivering training.

Mental health terminology

Barrier: Factors that affect access to a support based on environmental circumstances. Low barrier refers to ease in accessing support; there are no constraints that make it difficult to seek help. Where there are many barriers existing together, accessing help is more difficult.

Community mental health support: Refers to various non-clinical options and services (both formal and informal) which respond to mental distress in a non-institutional or community setting. This may include grassroots, peer-led and family inclusive options. Some examples include safe spaces, peer support groups, open dialogue groups, Hearing Voices groups, and community run family supports.

Mental health: A state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life[1]. Understandings of mental health and social and emotional wellbeing

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[1] World Health Organization. (2022). *World mental health report: Transforming mental health for all.* World Health Organization.

vary among different cultures and communities, and some see distress or social and emotional wellbeing concerns as a response to adverse social conditions.

Mental health and wellbeing: When we talk about mental health and wellbeing, we are referring to emotional, psychological, and social wellbeing. These all affect how we how we think, feel and behave, and contribute to what is described as our 'mental wellbeing'.

Peer workforce (and peer support): Refers to the (usually) paid workforce engaged specifically for their lived or living experience of concerns relating to social and emotional wellbeing, or of mental health difficulties, or of using mental health services. Roles within this workforce include but are not limited to peer support workers, lived experience academics, peer advocates and advisors. This workforce complements and is distinct from other clinical and professional roles in the sectors relating to social and emotional wellbeing.

Psychosocial: Psychological and social factors that can impact or support a person's mental health and wellbeing. For example, access to meaningful activities, supportive relationships, belonging and safe housing can all be described as psychosocial factors affecting one's wellbeing and mental health.

Services and supports: These two words are used interchangeably throughout the report, and together are all-encompassing, referring to non-clinical options and services (both formal and informal) which respond to mental distress in a non-institutional or community setting (see community mental health supports) as well as public or private mental health services.

Social and emotional wellbeing: A multifaceted concept that refers to an individual's wellbeing determined by interrelated domains: body, mind, family, community, culture, Country, and spirituality. This is a preferred term among many Indigenous Australians and indicates a broad approach to wellness[2].

Social determinants of mental health: The recognition that mental health is shaped significantly by the social, economic, and physical environments in which people live.

Trauma-informed: An approach to service delivery whereby aspects of services and support(s) are organised around acknowledging existing trauma throughout society and among individuals who may access the service(s) and support (s). Trauma-informed services are aware of and sensitive to the dynamics of trauma that people may experience.

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[2] Dudgeon, P., Bray, A., D'Costa, B., & Walker, R. (2020). Decolonising Psychology: Validating Social and Emotional Wellbeing. *Australian Psychologist, 52*(4), 316-325.

Cohort terminology

Aboriginal and/or Torres Strait Islander: Aboriginal and/or Torres Strait Islander peoples are the Indigenous peoples of the country and surrounding islands we define as Australia. They are not one group, but rather comprise hundreds of different groups that have their own distinct set of languages, histories and cultural traditions.

Culturally and linguistically diverse: Individuals born in non-English speaking countries and/or those who do not typically speak English at home. Some people from culturally and linguistically diverse backgrounds face greater challenges accessing health and welfare systems. Language barriers, lower health literacy, and difficulties navigating an unfamiliar system put them at greater risk of poorer quality health care, service delivery and poorer health outcomes compared with other Australians.

Family members and carers: Refers to people with a lived experience as a carer, family member, friend or other supporter of a person with mental health concerns and/or condition. The term acknowledges that not all family members wish to identify as a 'carer', and there may be other important caring relationships in the life, or recovery process, of a person with lived experience. These terms are used interchangeably in this report.

LGBTQIA+SB: Refers to lesbian, gay, bisexual, transgender, queer, intersex, asexual, other sexually or gender diverse persons, and Sistergirls and Brotherboys (trans and gender diverse people in some Aboriginal communities).

Hardly reached: Traditionally, research defines "hard-to-reach" populations as difficult for researchers to access and recruit. However, that puts the onus on the communities rather than the researchers. Therefore, 'hardly reached' has emerged as a term to refer to cohorts whose voices and experiences are often missing from research.

Young people: People aged between 18 and 24 years. We recognise that in the Australian policy context, young people are often defined as between the ages of 12 and 24, however, we have narrowed the age bracket for this definition because young people under 18 years old were not eligible to complete the survey or participate in the research.

FOREWORD

The ACDC Project, through going door-to-door in a range of communities across Australia and having conversations about mental health and wellbeing, has generated a wealth of data and will continue to do so as the project continues.

The data show high incidence of poor mental health and wellbeing, but results also point to what could be driving the high levels of distress and low levels of wellbeing. Significant correlations were found between mental health measures (indicators of poor mental health) and a range of social determinants. Included amongst those was the impact of the COVID-19 pandemic, financial stress, concerns about physical health issues, climate change, social isolation or loneliness, housing, family relationships, unemployment, discrimination, alcohol and other drugs, and food insecurity.

When most people and politicians hear “mental health crisis” they think greater health expenditure (hospitals, GPs, psychologists, pharmaceutical benefits etc). While these are important, we also need people and politicians to think more broadly about the impact of the social determinants of mental health and, as demonstrated in a broad body of social research, the degree of relative poverty or inequality within communities.

To address poor mental health and wellbeing more effectively, we need a triple strategy of (a) addressing broad social issues through a Wellbeing Framework, (b) better distribution and availability of appropriate and affordable mental health supports, and (c) a greater investment in community-based, local supports; an inexpensive option to help prevent mental health crises and increase coping, resilience, and sense of belonging.

The findings reiterate the need for proactive outreach initiatives, such as the ACDC Project: people who need mental health and wellbeing supports face numerous barriers to accessing suitable, good quality care. Thus, where possible, future local mental health and wellbeing services should make every attempt to address these barriers, including proactive outreach approaches.

We look forward to collecting and analysing more data as the ACDC Project continues over the next 17 months, and sharing this rich database with other researchers to enrich these findings.

Bill Gye

Chief Executive Officer, Community Mental Health Australia

FOREWORD

The Centre for Social Impact (CSI) is very proud to have worked with Community Mental Health Australia in the production and publication of the Assisting Communities through Direct Connection (ACDC) evaluation and research reports. These reports add significant evidence to the critical importance of addressing mental health issues in the Australian community and highlight several gaps in the delivery of services to those in need.

The CSI reports also point to the benefits of direct connection with households. Survey recipients were reached directly through doorknocking, street by street, in a diverse set of communities in Australia. In total, 32,882 doors were knocked, 5,533 conversations were undertaken, and 3,811 surveys completed during Round Two. Time was spent face-to-face discussing the ACDC survey as part of a deeper, more meaningful engagement about mental health. Overall, people were highly responsive to having conversations about mental health with the ACDC People Connectors at their doorstep.

Because the ACDC survey was part of a proactive outreach approach, it represents a unique opportunity to hear different voices and potentially think about the data in different ways. To have data captured by local representatives who know their communities, and who may be bicultural and bilingual, is also invaluable, and an opportunity we don't always get in academic environments. This created conditions for good data quality, and for capturing authentic insights about people's mental health experiences.

The doorknocking approach, adopted in the ACDC Project, identified that people faced multiple barriers to accessing mental health supports, and these barriers varied significantly across the different communities that were visited by People Connectors. Of those who reported that they had struggled with their mental health in the last 12 months, almost half (43.2%) reported that they were unable to get the support they needed. Barriers related to cost, the availability of services, limited knowledge of services, poor past experiences of services, overcrowded households limiting private space, and poor digital infrastructure.

The CSI reports suggest that people facing significant problems or challenges are usually juggling multiple concerns, and frequently report higher distress and lower wellbeing. From a policy perspective, there is compelling evidence for the need for holistic, multidisciplinary support to address peoples' co-occurring needs (social, emotional, physical, financial, spiritual, etc.). We hope that the ACDC reports will generate positive, enduring community change in access to mental health services and mental health outcomes.

Professor Paul Flatau

Director, Centre for Social Impact UWA

1. INTRODUCTION

This Report presents preliminary findings from data collected during the Assisting Communities through Direct Connection (ACDC) Project – a proactive outreach initiative that utilised doorknocking to initiate conversations about mental health across 21 Australian communities.

In this project, teams of 'People Connectors' went door-to-door seeking to have conversations with people about wellbeing, mental health experiences, and support needs; relevant to themselves, their loved ones, and their communities and neighbourhoods. For more information about the ACDC Project and the effectiveness of the doorknocking approach, see the Evaluation Report, '*Doorknocking for mental health: Evaluating a novel outreach approach for addressing mental health'* [3].

As part of the doorknocking visit, Householders were invited to complete a Householder Survey – either through an interview with People Connectors at the doorstep, via an iPad device, or a paper-based survey that they could complete at their leisure. People were also offered the opportunity to complete the survey online, via a Qualtrics link provided on the ACDC Project webpage[4]. The survey asked Householders about their mental health, current challenges (for example, financial or housing stress and other social determinants of mental health), experiences of mental health support needs and barriers to getting help. The survey also included measures of Householders' wellbeing and psychological distress using validated psychometric questionnaires. In Round Two[5], 3,811 surveys were completed across the sites, following on from knocking on 32,892 doors and having over 5,500 conversations with Householders.

As a research team working in mental health, we know that many studies are based on data collected within clinical or service settings with participants often already connected to systems or supports in some capacity. Going door-to-door and asking people about their mental health, more broadly, provides a unique opportunity to capture more diverse experiences of mental health; for example, understandings of wellbeing that are not necessarily informed by an illness or biomedical model, and/or the views or perspectives of people who have not reached out for help, even when their needs are complex, or urgent.

In the conversational setting provided by the ACDC Project doorknocking experience, People Connectors sought to lessen some of the potential stigma associated with talking about mental health by offering a caring, safe, and validating space. The conversation also allowed for diverse ways to approach the topic of mental health, for instance not need to stick to illness orientated concepts of

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[3] Kaleveld, L., Hooper, Y., Crane, E. & Davis, H. (2023). *Doorknocking for mental health: Evaluating a novel outreach approach for addressing mental health. Round Two of the Assisting Communities through Direct Connection Project*. Centre for Social Impact: UWA, Swinburne and UNSW. https://doi.org/10.25916/gmrp-6579

[4] https://acdc.org.au/

[5] Round One of the ACDC Project occurred in four sites between February and August 2021. Round Two commenced in September 2021, concluded in September 2022, and was delivered in 17 sites.

mental health, provided a space for much a broader exploration of the other dimensions affecting wellbeing, such as the social determinants of mental health (employment, housing, safety, etc).

We also know that surveys, traditionally, tend to favour participants who have completed more education, or are more affluent[6],[7],[8] . Additionally, women, youth and white people are all more inclined to participate in surveys, compared to males, older persons, or people of colour[9],[10],[11]. We hoped that the door-to-door method of collecting survey data – although not without biases – would reach more diverse persons or experiences, and perhaps, individuals who would usually not participate in surveys about mental health and wellbeing.

This is especially relevant for the health equity values that were built into the ACDC Project model, namely, connecting with people who are 'hardly reached'[12]. This survey embedded in a proactive outreach model therefore provides a unique opportunity to uncover new learnings about mental health by hearing from who is accessing support, and also, importantly, *who is not*.

This Report has been prepared by the Centre for Social Impact (CSI) for Community Mental Health Australia (CMHA). The CSI are the evaluation partners for the Assisting Communities through Direct Connection (ACDC) project, an initiative of CMHA.

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[6] Curtin, R., Presser, S., & Singer, E. (2000). The effects of response rate changes on the index of consumer sentiment. *Public Opinion Quarterly, 64,* 413–428.

[7] Goyder, J., Warriner, K., & Miller, S. (2002). Evaluating socio-economic status (SES) bias in survey nonresponse. *Journal of Official Statistics, 18*(1), 1–11.

[8] Smith, W. G., (2008). Does Gender Influence Online Survey Participation? A Record-linkage Analysis of University Faculty Online Survey Response Behavior. *San José State University.*

[9] Moore, D. L., & Tarnai, J. (2002). Evaluating nonresponse error in mail surveys. In Groves, R. M., Dillman, D. A., Eltinge, J. L., & Little, R. J. A. (eds.), *Survey Nonresponse* (pp. 197–211). John Wiley & Sons.

[10] Goyder, J. (1986). Surveys on Surveys: Limitations and Potentials. *Public Opinion Quarterly, 50,* 27-41.

[11] Voigt, L. F., Koepsell, T. D., & Daling, J. R. (2003). Characteristics of telephone survey respondents according to willingness to participate. *American Journal of Epidemiology, 157,* 66–73.

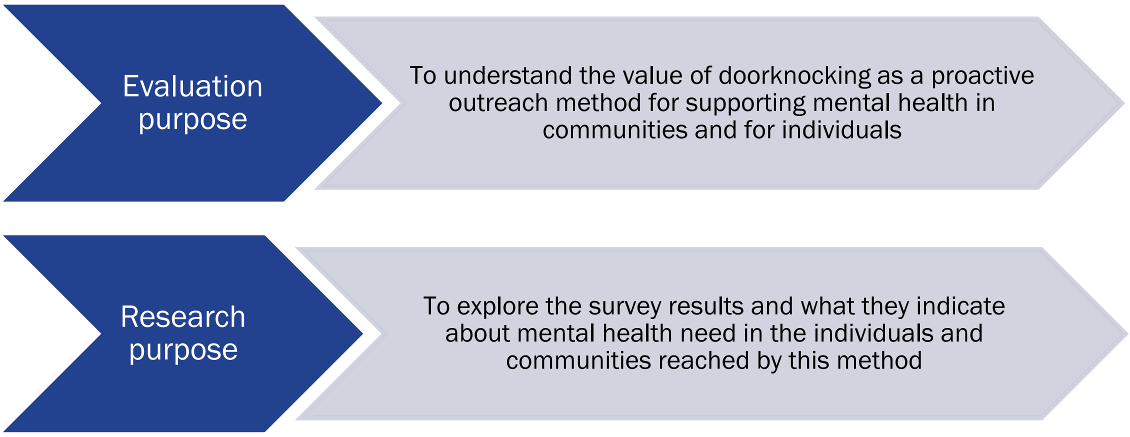
[12] Traditionally, research defines "hard-to-reach" populations as difficult for researchers to access and recruit. However, that puts the onus on the communities rather than the researchers. Therefore, 'hardly reached' has emerged as a term to refer to cohorts whose voices and experiences are often missing from research.

2. RESEARCH DESIGN

2.1 The Research and Evaluation Framework

The Research and Evaluation Framework for the ACDC Project, developed by the ACDC Project Research and Evaluation Working Group, specifies two related but distinct functions – evaluation and research – both with different purposes (see Figure 1).

Figure 1. Evaluation and research purpose



Evaluation purpose

To understand the value of doorknocking as a proactive outreach method for supporting mental health in communities and for individuals

Research purpose

To explore the survey results and what they indicate about mental health need in the individuals and communities reached by this method

Evaluation focus

The evaluation focused on the suitability and effectiveness of the project activity and its value for Householders and diverse communities. The evaluation described pre-engagement activities and supports as well as the doorknocking process – understanding the quality of engagements and conversations with Householders, dissemination of information products and follow-up use, and extent of the need for follow-ups, referrals and links to supports – and the outcomes and impact of these activities. Evaluation outcomes are presented in *Doorknocking for Mental Health*[13], a separate report produced by CSI at the conclusion of Round Two of the ACDC Project.

Research focus

The research focused on the findings from the responses collected via the ACDC Householder Survey. This survey data enabled a deeper understanding, and evidence for, the extent of the mental health

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[13] Kaleveld, L., Hooper, Y., Crane, E. & Davis, H. (2023). *Doorknocking for mental health: Evaluating a novel outreach approach for addressing mental health.* Round Two of the Assisting Communities through Direct Connection Project. Centre for Social Impact: UWA, Swinburne and UNSW. https://doi.org/10.25916/gmrp-6579

needs of Householders surveyed across the various sites. The following research questions informed and structured the analysis of data collected through a survey. The survey asked Householders about challenges that impact their mental health and wellbeing (for example, financial or housing stress and other social determinants of mental health), experiences of mental health support needs, and barriers to getting help.

Research questions

1. What is the level of need for mental health support(s)?
2. Who is accessing support(s)?
3. What factors, including the social determinants of mental health, are contributing to mental health need?

Governance and supporting structures

Ethics and oversight

Community Mental Health Australia commissioned CSI University of Western Australia as the evaluation and research partner for the ACDC Project, therefore the ACDC Team provided project management for the evaluation and research deliverables. The research was also overseen by the ACDC Project Research and Evaluation Working Group and the ACDC Project Steering Committee, which is a panel of mental health research, policy and lived experience experts facilitated by the ACDC Project managers. Members of these groups regularly met to provide suggestions, critical advice and input into the research and evaluation design.

The evaluation and research components of the ACDC Project received ethics approval from the Human Research Ethics Committee at the University of Western Australia (2020/ET000171).

Culture supporting research

Other important foundations for the research function of the ACDC Project include:

- That CSI is independent of the ACDC Project Team and based at a university with governance oversight by the University of Western Australia Human Research Ethics Committee, providing conditions that help to ensure adherence to high quality and robust research design and methods and independent data management systems;
- The ACDC Project Team and members of the CSI Evaluation Team worked together to co-design various aspects of the research instruments and approaches, while incorporating the lived experience perspective, where appropriate; and
- The ACDC Project Team was supportive of an ‘action research’ approach where the preliminary findings from the data collected in Round One were used for refining the survey instrument for Round Two.

2.2 Methodology

The main data collection activities relative to the research focus were conducted by People Connectors while doorknocking. This consisted of a Qualtrics-based online survey (termed the Field Survey) where People Connectors could record location information, number of doors knocked and answered, and the details of any conversations had with Householders. People Connectors invited the Householders to complete either an online or paper-based survey about their mental health and wellbeing – the Householder Survey – which was embedded within the Field Survey. To engage with the People Connectors and to be eligible to complete the Householder Survey Householders needed to be over the age of 18. There was also the option of completing the Householder Survey online, via the ACDC Project website, named the Self-Administered Survey. Following Round Two of the project, the two datasets were merged to be analysed together.

Householder Survey

The Householder Survey was completed by respondents at the front door, with the People Connectors documenting responses on an iPad. Alternatively Householders were given the opportunity to complete a paper-based survey if more convenient. Components of the Householder Survey comprised:

- demographics;
- social determinants of mental health (relative to both Householders and the Householders' community);
- wellbeing measure;
- psychological distress measure;
- loneliness measure;
- perceived need and unmet need;
- employment satisfaction;
- housing
- barriers to accessing supports;
- current mental health and wellbeing supports; and
- preference for additional supports.

The majority of the Householder Survey consisted of frequency or rating scales (quantitative data collection) however there were several opportunities for respondents to provide to answer open-ended questions (qualitative data collection). These questions were well utilised and this allowed a much deeper understanding of the challenges, concerns, and experiences of distress, adversity, or resilience among Householders. These data are presented as quotes within Section 4.

Several validated questionnaires were embedded within the Householder Survey to identify wellbeing, psychological distress, and loneliness of respondents:

Wellbeing

The World Health Organisation Five Wellbeing Index[14] (WHO-5) is a valid and reliable measure used to identify respondents' wellbeing using self-report data. The measure comprises five statements, including, *"I have felt relaxed and calm"* and *"My daily life has been filled with things that interest me"* rated on a scale from zero (at no time) to five (all of the time). Respondents are asked to consider the statements in the context of the last two weeks. Scores are summed and multiplied by 4 to create a total score. A score of 100 represents the best imaginable wellbeing and zero represents the worst imaginable wellbeing. For clinical populations, a score equal to or less than 50 has been used to screen for depression, and in the general population, mean scores for the WHO-5 range from 53.7 to 70.1 across several European countries[15].

Psychological distress

The Kessler Psychological Distress Scale[16] (K10), another psychometric scale, measures level of psychological distress using self-report data. The K10 can be used across different populations, however, the K5 was developed to measure the psychological distress of Australian Indigenous peoples. Respondents are asked to select the frequency or extent to which they have experienced feelings of distress, anxiety, or depressed mood within the past month.

The K10 comprises 10 statements representing depression, stress, and anxiety symptoms (e.g., *"feeling nervous", "feeling hopeless"),* rated on a scale of one (none of the time) to five (all the time). Scores range from 10 to 50 and are categorised based on severity of distress[17]: low distress (10-15), moderate distress (16- 21), high distress (22-29) and very high distress (30-50).

The modified version of the K10 scale, the K5[18], was developed for use in the social and emotional wellbeing module of the National Aboriginal and Torres Strait Islander Health Survey[19] and was established through consultation with Aboriginal peoples. Within the ACDC survey, if respondents identified as being Aboriginal and/or Torres Strait Islander, they were directed to the K5 items, rather than the K10 items. Modifications to the scale included omission of K10 items 2, 3, 5, 8 and 9 (creating a 5-item measure), as well as slight word changes to remaining items to improve the

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[14] WHO. (1998). *Wellbeing Measures in Primary Health Care: The Depcare Project.* WHO Regional Office for Europe.

[15] Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and psychosomatics*, *84*(3), 167–176. https://doi.org/10.1159/000376585

[16] Kessler, R. C., et al. (2003). Screening for serious mental illness in the general population. *Arch Gen Psychiatry, 60*(2),184-9.

[17] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4817.0.55.001Chapter92007-08

[18] Australian Institute of Health and Wellbeing (2009). Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

[19] https://www.aihw.gov.au/reports/indigenous-australians/measuring-the-social-and-emotional-wellbeing/summary

understanding of these statements (*"restless or fidgety"* was changed to *"restless and jumpy"*; *"hopeless"* to *"without hope";* and *"past four weeks"* to *"last four weeks"*). Akin to the K10, scores are able to be categorised based on severity of distress.

Ratings for all items are summed to produce a total score and K10/K5 scores can only be calculated (by summation of item scores) where there are responses for all 10 items or five items for the K5[20].

Loneliness

The Three-item Loneliness Scale (Hughes et al., 2004[21]) provides a quick and succinct method to collect information about loneliness by asking respondents three questions: *"How often do you feel that you lack companionship?"*, *"How often do you feel left out?"* and *"How often do you feel isolated from others?"* on a three-point rating scale: (1) hardly ever, (2) some of the time, (3) often. Scores are summed to create a total score (ranging from 3 to 9) where higher scores reflect greater loneliness.

Data analysis

Quantitative data

A cross-sectional survey collected a broad view of mental health need, unmet need, and access to support across 17 Australian communities (the ACDC Project sites). Primary analyses were descriptive and considered participant demographics, including age, gender, ethnicity and locality. Rates of accessing supports, including types of supports, were presented to highlight possible proportion of help-seeking in our sample (and within subsamples that could be defined by demographic categories and/or sites). Further analysis examined mental health need, issues affecting mental health (individual and community challenges based around the social determinants of mental health), help-seeking, barriers to attaining suitable supports, and factors associated with mental health and wellbeing.

For the standardised questionnaires to assess perceived psychological distress, wellbeing, and loneliness, the data were analysed using appropriate scoring guidelines for each measure, and scores/results were interpreted in the context of existing evidence or, if applicable, the national average (e.g., ABS Census data relative to psychological distress). Reliability analyses were conducted to assess the internal consistencies of the measures using data obtained in the current survey and all psychometric measures revealed high internal consistency.

Decisions relative to statistical testing were partly determined by an analysis plan, developed between the ACDC Project Team, the ACDC Project Steering Committee, and the CSI Research Team, however, testing was exploratory and therefore, also informed by key findings that emerged from

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[20] McNamara, B. J., Banks, E., Gubhaju, L., Williamson, A., Joshy, G., Raphael, B., & Eades, S. J. (2014). Measuring psychological distress in older Aboriginal and Torres Strait Islanders Australians: A comparison of the K-10 and K-5. *Australian and New Zealand journal of public health*, *38*(6), 567–573. https://doi.org/10.1111/1753-6405.12271

[21] Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). Three-Item Loneliness Scale [Database record]. *APA PsycTests.* https://doi.org/10.1037/t29584-000

preliminary analyses. Average scores of psychological distress, wellbeing and loneliness were compared between Householders who had recently (in the last three months) sought mental health support, and Householders who had not recently sought support the Mann-Whitney U test to identify potential discrepancies. Spearman Rank correlations were used to determine the relationships between social determinants, loneliness, employment satisfaction and standardised measures of wellbeing and psychological distress.

Qualitative data

Qualitative data was sourced from the responses to the open-ended questions in the Householder Survey. Data were compiled into themes to illuminate the 'big picture', of some of the various issues and challenges facing the Householders in the survey sample, as well as experiences of mental health support across the various demographics.

Quotes were chosen to illustrate participants' perception of their mental health; current and past experiences of accessing support for mental health; barriers faced to accessing help; experiences of resilience and triumph; and any other relevant insights relative to mental health and wellbeing.

Although quantitative data was the primary evidence base of this research, the qualitative data provided a more in-depth understanding of some of the key findings from the survey. Triangulation of these data sources increased the robustness of findings and increased validity of the results.

Limitations

Sampling

As described in the introduction, going door-to-door and engaging people in a conversation as part of the recruitment of survey participants represents an opportunity to hear from survey participants that might otherwise not participate. However, this method of sampling was not without biases or limitations.

Naturally, people who were not at home at the time that People Connectors knocked on their door were not able to participate and the non-participants are more likely to include people who are normally out during the day, working in jobs outside of the home, studying, volunteering, or participating in other activities. As a result of the COVID-19 pandemic, however, more people were likely working or studying from home, which could have enabled a greater diversity of people in different life situations to be home and available to respond to a doorknock. Data from the HILDA (Household, Income and Labour Dynamics in Australia) Survey[22] report released in 2022 shows the proportion of Australians working 'most hours' from home jumped from around 6% before the pandemic to 21% in 2020. Unpublished data available to researchers shows a further jump to 24% in 2021. Based on these data, surveying may have reached more people than what was

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[22] Wilkins, R., Vera-Toscano, E., Botha, F., Wooden, M. & Trinh, T. (2022). *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 20.* Melbourne Institute.

possible pre-COVID-19 pandemic, and sample of people that was more inclusive of people with full time work or study.

Nonetheless, based on speculation, the doorknocking survey sample may have been biased towards:

- people who were home because they were un- or under-employed or retired;
- people employed but working from home and able/willing to engage during work hours;
- people who were not likely to be very busy – which may include people without caring responsibilities for babies and small children; or
- people with an interest in mental health, a personal need or experience of someone in their lives with a need.

Participation

While many people welcomed a conversation with People Connectors (and were happy to engage with the ACDC Project), the demands of a long survey, without pre-scheduling the time to do so, may have meant more people were unable or unwilling to complete the survey because it was not convenient. People Connectors tried to respond to this challenge by also offering paper-based surveys, and they offered to collect the completed survey later, therefore allowing people adequate time to fill in the survey, or the privacy to complete it on their own.

There were no incentive payments for completing the Householder Survey.

Generalisability

Findings presented in this Report do not compare data across the 17 sites as data are not generalisable; the ACDC Project sites are not representative of the collective in these locations and therefore, we cannot infer that differences identified are reliable. Further research would be needed to unpack the impact of geographical variability and provide deeper analysis of site-level results in relation to local contextual factors, and this work is not in scope for this Report.

Despite generalisability limitations, the findings presented in this Report have intrinsic value in helping to understand mental health need of those engaged through the ACDC Project and may also shed light on mental health need in Australia, more broadly.

Reliability

The survey was conducted outside of a clinical setting, often by people not clinically trained, and the extent of stigma and mental health literacy among Householders may have varied considerably – all factors which may have affected the reliability of survey results.

3. WHO ANSWERED THE SURVEY?

Across the 17 sites, People Connectors collected 3,811 Householder Surveys through doorknocking and a further 216 people responded to the online version of the Householder Survey (the 'Self-Administered Survey') linked to Qualtrics on the ACDC Project website. It was not known how many paper-based surveys were entered into Qualtrics online; after being collected from Householders by the People Connectors, as this was not tracked over the course of Round Two.

Where we state the 'total sample' we refer to all cases (N = 4,027) however, sample sizes across questions will vary as most items were optional (and only a very few forced responses, e.g., consent to survey).

The following Section presents demographics of the Householders who responded to the Householder Survey in Round Two of the ACDC Project. Table 1 shows the key demographic information captured by the survey.

Table 1. Key demographic data of survey respondents

Demographics	Representation in survey respondents
Gender	A total of 58.4% of respondents were female, 41.1% were male, and 0.5% identified another way.
Age	Most survey respondents were aged between 25 to 64 years (64.2%). A further 16.6% were aged 65 to 74, 9.8% aged 75 to 85, 7.5% 18 to 24 years, and the remaining 1.8% were older than 85 years.
Aboriginal and/or Torres Strait Islander peoples	A substantial proportion, 9.3%, of survey respondents indicated they were Aboriginal and/or Torres Strait Islander (the remainder did not indicate that they were either Aboriginal or Torres Strait Islander). This is considerably higher than the 2021 national average (3.2%; ABS, 2021[23]).
Culturally and linguistically diverse persons	Approximately 26% of Householders reported that they were born outside of Australia and around 10% spoke a language other than English. Many survey respondents spoke different languages. These included Arabic (3.5%), Mandarin (2.4%), Vietnamese (2.4%) and Cantonese (1.7%), among many others. Most surveys (n = 3,999; 99.3%) were completed in English, 24 surveys (0.6%) were completed in Chinese, two in Arabic (<0.0%) and two Vietnamese (<0.0%).

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[23] https://www.abs.gov.au/articles/australia-aboriginal-and-torres-strait-islander-population-summary/

Mental health conditions	Of the total sample, 73.0% did not report having a mental health condition, 9.0% reported having one mental health condition, 11.0% two conditions, 5.0% three conditions, 2.0% four conditions, and the remaining 0.5% with five or more conditions. On average for the sample, respondents reported 0.6 conditions. Anxiety and depressive disorders were the most common conditions reported (69.8% and 66.9%, respectively) which are both high prevalence disorders – and the most common mental health conditions experienced globally. Trauma related disorders were the third most common mental health condition experienced by householders. Exactly 22% of respondents reported living with PTSD[24], and 11.2% with complex trauma/C-PTSD[25]. Approximately 10% of respondents reported living with a substance use disorder. Of the respondents who reported having, or living with, a mental health condition, 70.3% of people indicated that they had received a formal diagnosis (i.e., diagnosed by a clinician).

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[24] Post-traumatic stress disorder.

[25] Complex-post traumatic stress disorder.

4. WHAT DID WE LEARN ABOUT MENTAL HEALTH NEED?

4.1 Extent of need for mental health support

For this project, the broadest understanding of mental health and wellbeing was applied, and therefore 'mental health need' could not be narrowly defined or measured. To understand the level of need for mental health support, we utilised multiple measures and indicators, some of which asked the Householder to reflect directly on their own mental health and articulate a need for support if relevant (questions which may have required a level of mental health literacy and lack of stigma), while other measures focused on indicators of need such as symptoms and coping.

We sought to identify the extent of respondents' need by measuring wellbeing and psychological distress using validated scales, the WHO-5 and K10/K5, respectively. We know that poor wellbeing and psychological distress are related to problems with mental health[26]. We also know that when there is an unmet need, this is likely to produce poorer mental health outcomes and symptoms, therefore these selected validated measures are likely to detect poor mental health[27],[28]. We hypothesised that if people were experiencing a mental health need, it was likely that they were experiencing lower wellbeing and/or higher psychological distress.

Indicators of mental health need

Overall mental health and wellbeing

We asked respondents, *'How would you rate your overall mental health and wellbeing?'* using a 5-point scale to measure Householders' (n = 3,877) perception of their mental health. Results, roughly, fall into three groupings: just over one third of respondents reported their mental health and wellbeing to be 'good' (34.4%), one third to be 'very good' (25.1%) or 'excellent' (9.4%) and just under one third rated their mental health as either 'fair' (21.9%), or 'poor' (9.2%).

> ***3 out of 10 Householders rated their overall mental health and wellbeing as fair or poor***

This means that approximately three out of 10 Householders assessed their mental health and wellbeing negatively, indicating a significant proportion of people who may have had a need for mental health support at the time they were visited by a People Connector (see Figure 2).

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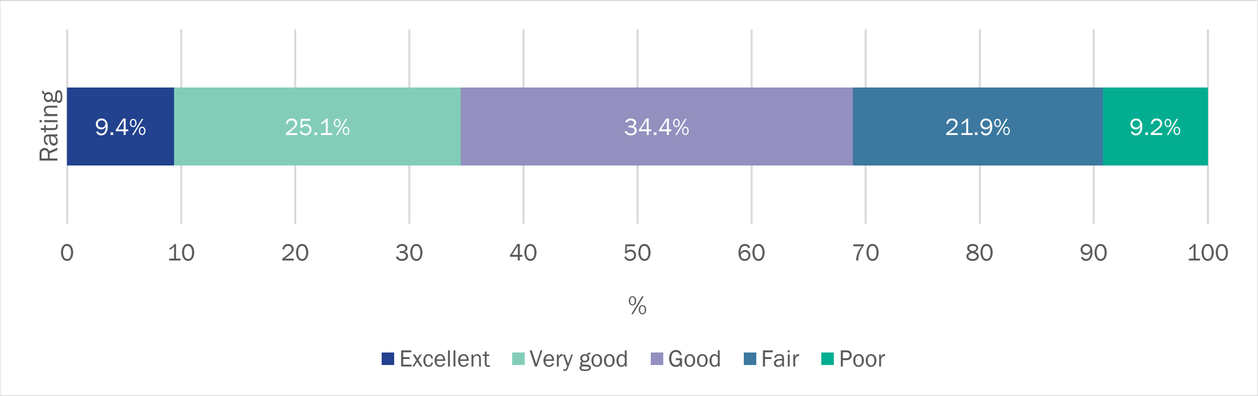
[26] Victorian Department of Health. (2018). Mental illness and wellbeing. https://www.health.vic.gov.au/

[27] Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and psychosomatics*, *84*(3), 167–176. https://doi.org/10.1159/000376585

[28] Kessler, R. C., et al. (2003). Screening for serious mental illness in the general population. *Arch Gen Psychiatry, 60*(2),184-9.

Figure 2. Householders' self-assessed mental health and wellbeing

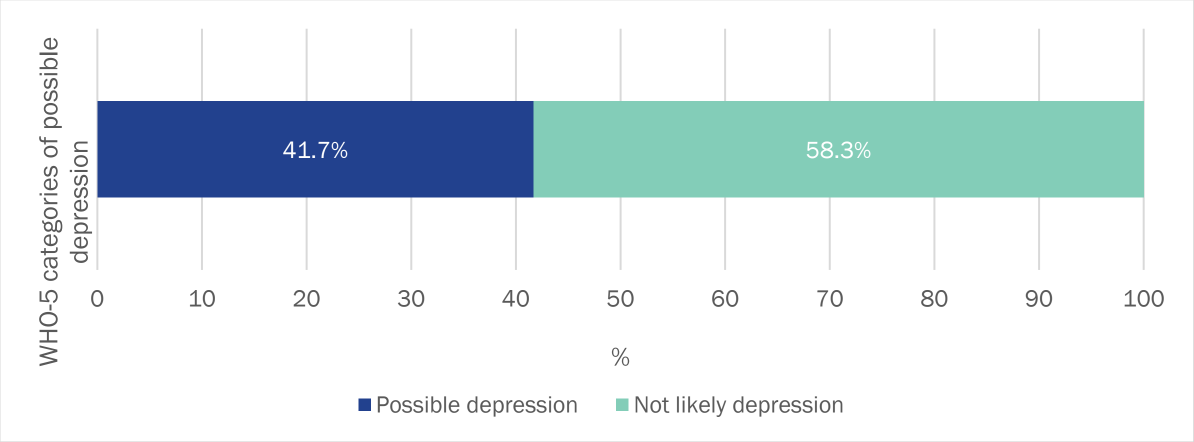


Wellbeing

> ***Wellbeing was low among Householders surveyed, and 2 out of 5 respondents were possibly experiencing depression***

Wellbeing (WHO-5) scores of the ACDC Project sample (n = 3,733; mean = 52.5; standard deviation = 24.9[29]) suggest that, on average, wellbeing was lower among Householders than what has typically been reported in the literature (a systematic review by Topp et al., 2015 found that wellbeing scores ranged from 53.7 to 70.1 across several populations). In a clinical setting, the WHO-5 measure can be used to screen for depression, with a score equal to or less than 50 indicating possible depression [30]. When this calculation was applied to the ACDC Project sample, results suggest approximately two out of five Householders were likely experiencing symptoms consistent with clinical depression; see Figure 3).

Figure 3. Possible depression based on WHO-5 score



Note. Scores <50 suggest possible depression.

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[29] We acknowledge the wide range of values and therefore variability of WHO-5 scores within our sample.
[30] Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and Psychosomatics*, *84*(3), 167–176.

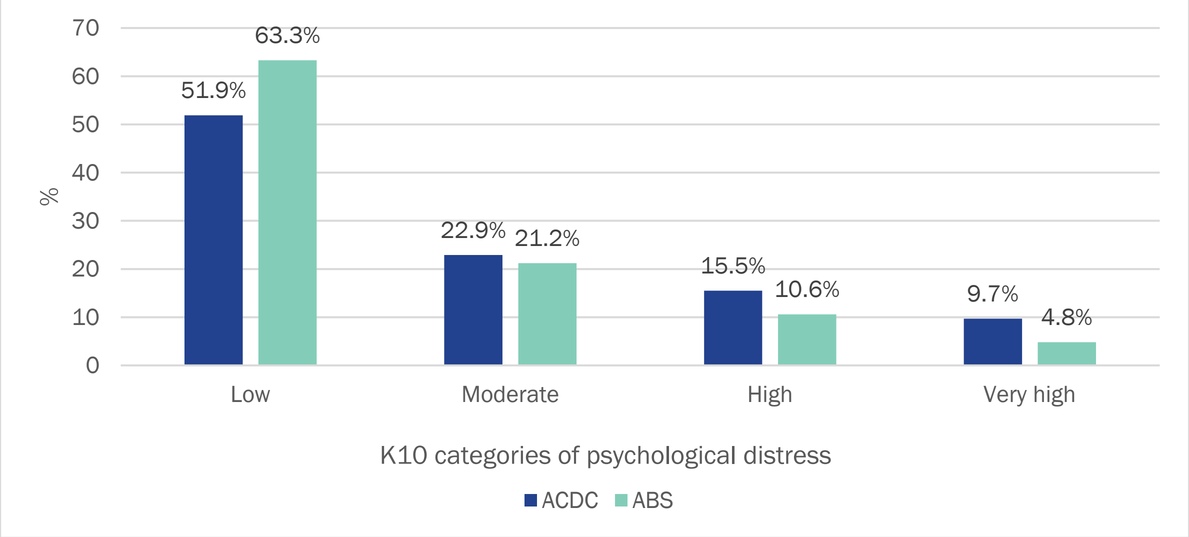
Psychological distress

Psychological distress (K10 score) was categorised based on severity of distress. A raw score from 10 to 15 indicates low distress, 16 to 21 indicates moderate distress, 22 to 29 indicates high distress, and scores over 30 indicate very high distress[31]. The mean K10 score of all ACDC Project survey respondents was 17.7 (n = 3,130; standard deviation = 7.7), indicating, on average, moderate levels of distress among Householders[32].

The combined proportion of respondents experiencing high or very high psychological distress was one in four (25.2%), half of the respondents reported low distress, and the remaining (15.5%), moderate distress. Distress categories of the ACDC Project are presented in Figure 4, alongside ABS Census data collected between 2020 and 2021[33]. A statistical comparison between these samples found there to be a significant difference between distress categories (p<.001) suggesting that Householders across the 17 sites were experiencing higher levels of distress than the national average[34].

> ***Psychological distress among Householders was significantly higher than the national average***

Figure 4. Psychological distress categories, ACDC sample against ABS data



Note. K10 scores: Low = 10-15, Moderate = 16-21, High = 22-29, Very high = 30+; excludes K5 scores.

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[31] the score groupings and categories of psychological distress were developed drawing on an amalgam of the work of the Clinical Research Unit for Anxiety and Depression (CRUfAD), Andrews and Slade (2001).

[32] Excluded Aboriginal and/or Torres Strait Islander respondents who completed the K5.

[33] Australian Bureau of Statistics. (2021). *First insights from the National Study of Mental Health and Wellbeing, 2020-21.* https://www.abs.gov.au/

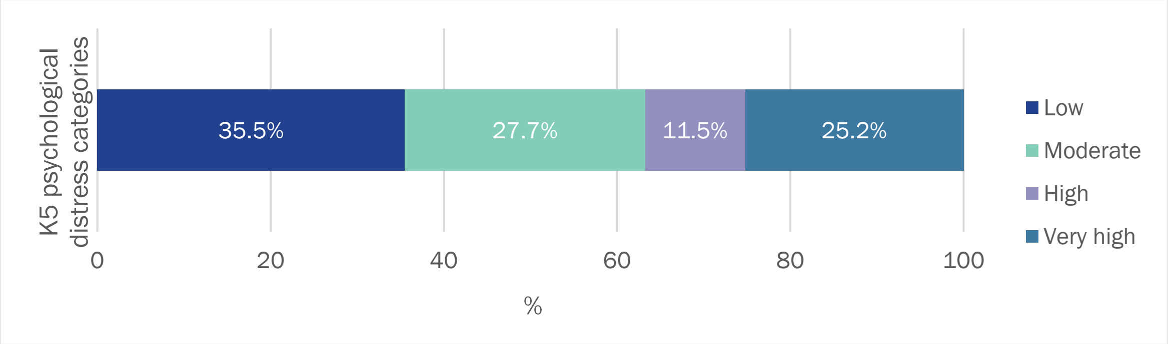
[34] This comparison should be interpreted with caution – the ABS data is weighted to be reflective of the national average whereas, the ACDC data is not, and therefore it is not necessarily representative of the people in the areas where data were collected, nor of Australia more generally.

The modified version of the K10 scale, the K5, was developed for use in the social and emotional wellbeing module of the National Aboriginal and Torres Strait Islander Health Survey[35] and was established through consultation with Aboriginal peoples. The average K5 score in our sample was 10.6 (n = 321; standard deviation = 4.9; a range of 5 to 25). Data are currently lacking from the general population, which makes it difficult to define 'typical' levels of distress in Aboriginal and Torres Strait Islander cohorts, however, the mean score of 10.6 was lower than the mid-point of the scale (15) suggesting that respondents could have been experiencing significant levels of distress at the time they completed the survey.

> ***1 in 4 Aboriginal and/or Torres Strait Islander respondents were in very high distress***

Categorisation of K5 scores yields more information about the psychological distress of Aboriginal and/or Torres Strait Islander respondents; analysis revealed that close to four in 10 (36.7%) Householders were in high or very high distress (see Figure 5), which is slightly higher than the estimated national average (31%) reported by the ABS between 2018 and 2019[36]. Most concerning, one in four Aboriginal and/or Torres Strait Islander peoples in the ACDC sample were experiencing very high psychological distress (25.2%).

Figure 5. K5 categories of psychological distress in Aboriginal and/or Torres Strait Islander peoples



Note. K5 scores: Low = scores <8, moderate = scores 8 to 11, high = scores 12 to 14, very high = scores >15; excludes K10 scores.

Self-identified need for support

Findings of the Householder Survey suggest concerning levels of psychological distress and wellbeing, which reflected the respondents' mental health and wellbeing at the time of survey completion. The validated measures are reliable, but they only capture

> ***Of the Householders who needed mental health supports, more than 2 out of 5 respondents reported not getting the help they needed; this suggests a large proportion of people with significant, perceived unmet needs***

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[35] Australian Bureau of Statistics. (2019). *National Aboriginal and Torres Strait Islander Health Survey methodology.* https://www.abs.gov.au/

[36] Australian Bureau of Statistics. (2019). *National Aboriginal and Torres Strait Islander Health Survey.* https://www.abs.gov.au/

information within a brief timeframe (i.e., the past four weeks for the K10/K5 and the past two weeks for the WHO-5). As mental health is known to fluctuate, we also asked Householders if they had wanted to seek help in the last 12 months. We asked, *'In the last 12 months, was there a time when you wanted to talk to someone, or seek help about, stress, depression, or problems with emotions?*', and whether they were able to receive supports when needed (*Did you get the care you needed?*').

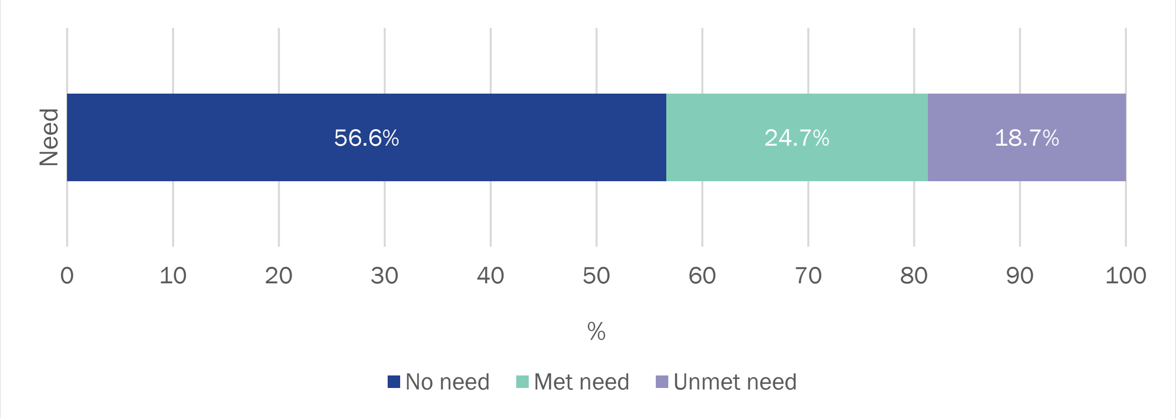
The term 'care' was not narrowly defined, and in the context of this question it was up to the respondent to interpret what it meant for them (i.e., natural supports, group or peer support or clinical services).

These questions allowed us to understand whether respondents perceived a need for support, but also, if there was a need, whether they had their needs met during this period. From asking these two questions, we could establish three distinct groups:

1) those who had not experienced an identified mental health need in the past 12 months (no need);
2) those who had identified a mental health need in the past 12 months but over that period were able to have their needs met (met need); and
3) those who identified having a mental health need in the last 12 months but felt their needs over this period had not met (unmet need).

The majority (56.6%) of survey respondents reported no identified need to seek help for their mental health and wellbeing. The remaining respondents conveyed that they did want to seek help in the last 12 months for their mental health or wellbeing. Close to a quarter (24.7%) of all respondents reported having their needs met, and the remaining 18.7% reported unmet needs (see Figure 6).

Figure 6. Proportion of Householders with no need, met need, and unmet need in the last 12 months



Of the proportion of respondents who identified a need to seek help, more than two in five (43.2%) were not able to get the care they needed indicating a substantial percentage of Householders with unmet mental health needs.

For Householders with unmet needs, we cannot infer from these two questions whether they were able to actively seek support. Some people may have avoided seeking help due to stigma, uncertainty about where to go or who to talk to, or concerns about cost. Others may have approached a service or centre, only to be turned away due to the high demand of services across the country. It is concerning that even with though the concept of care was not narrowly defined in the question, and could be inclusive of natural and informal supports, people with a mental health need still reported not being able to get support for their mental health need, over what was potentially a significant time period.

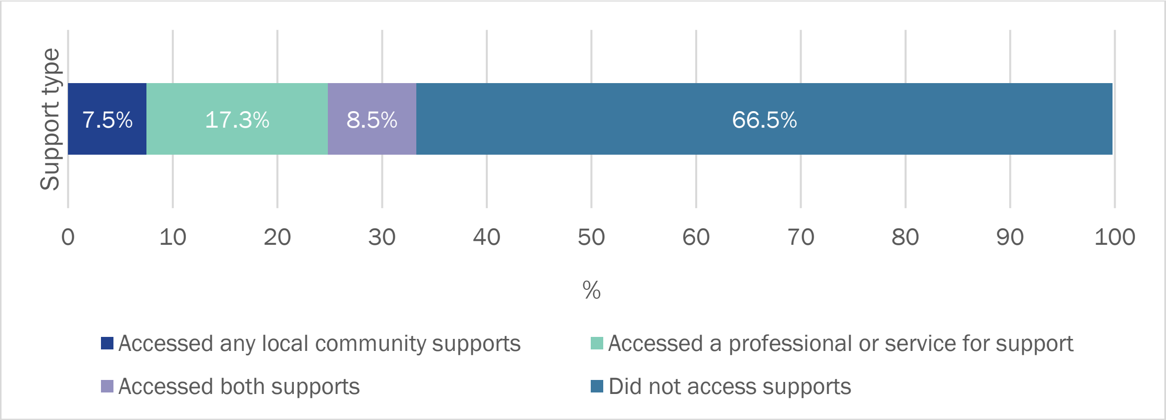
4.2 Extent of connection to mental health supports

The survey asked*, "In the last three months have you accessed any local community supports that help you with your mental health and wellbeing? (e.g., a safe space, a support group, youth group or Men's Shed?)"* and *"In the last three months did you receive help for your mental health and wellbeing from a mental health professional or a service? (e.g., a counselling support, a GP, or psychologist?)".*

Figure 7 illustrates the proportion of Householders who had, and had not, recently accessed supports (n = 3,702). The majority (66.5%) of Householders reported not accessing any supports in the last three months. Close to one in five Householders reported seeking support from a professional or service, 8.5% accessed help from both a professional or service and a local community support, and the remaining 7.5% accessed only a local community support.

The majority (66.5%) of Householders reported not accessing any supports in the last three months

Figure 7. Householders connected or not connected to local community supports and mental health services



Who is accessing supports?

Of those who had sought help in the last three months for their mental health and wellbeing, over half (52.0%) reported accessing support from a professional or service, approximately one in four

(25.6%) had accessed both a professional/service and local community supports, and the remaining had accessed only community supports (22.4%).

We combined those Householders who had accessed community mental health supports and/or support from a professional or service to create a category of people connected to supports (n = 1,235). Then we calculated the proportion of people connected to supports out of the total sample of Householders. The aim was to identify who was most likely accessing help for their mental health and wellbeing, according to demographic data we collected from the survey.

Connection to support by gender

The rate of being connected to support was consistent across male and female respondents (32.5% and 33.8%, respectively). Of the 18 gender queer/diverse persons who responded, 10 (56%) accessed mental health support. Gender diverse persons face disproportionate discrimination[37], are more likely to suffer from mental health issues[38], and often struggle with gender dysphoria, which typically produces psychological distress. Given the many challenges faced by this community, it is not surprising that gender queer respondents often sought out supports for their mental health.

> *"[I have] difficulty navigating my transness in the family context; going outside, dressing in the way I can feel like myself (as it is a safety concern)." (Householder)*
>
> *"I am non-binary and I often feel unaccepted." (Householder)*

We did not ask further questions about Householders' gender identity in the Householder Survey, and we are not able to establish the proportion of transgender (trans) people in our sample (because, depending on preference, trans Householders may have identified with male or female gender options). This additional question would be valuable to any Round Three revisions of the Householder Survey to allow a more robust analysis of help seeking in this cohort.

Connection to support by age

The proportion of people accessing support was fairly consistent across age ranges – see Figure 8 – and only very small discrepancies were identified between the Householders based on their age. Those aged 45 to 54 years accessed the most supports (38.1%), and those aged 65 to 74 years accessed the least (30.1%).

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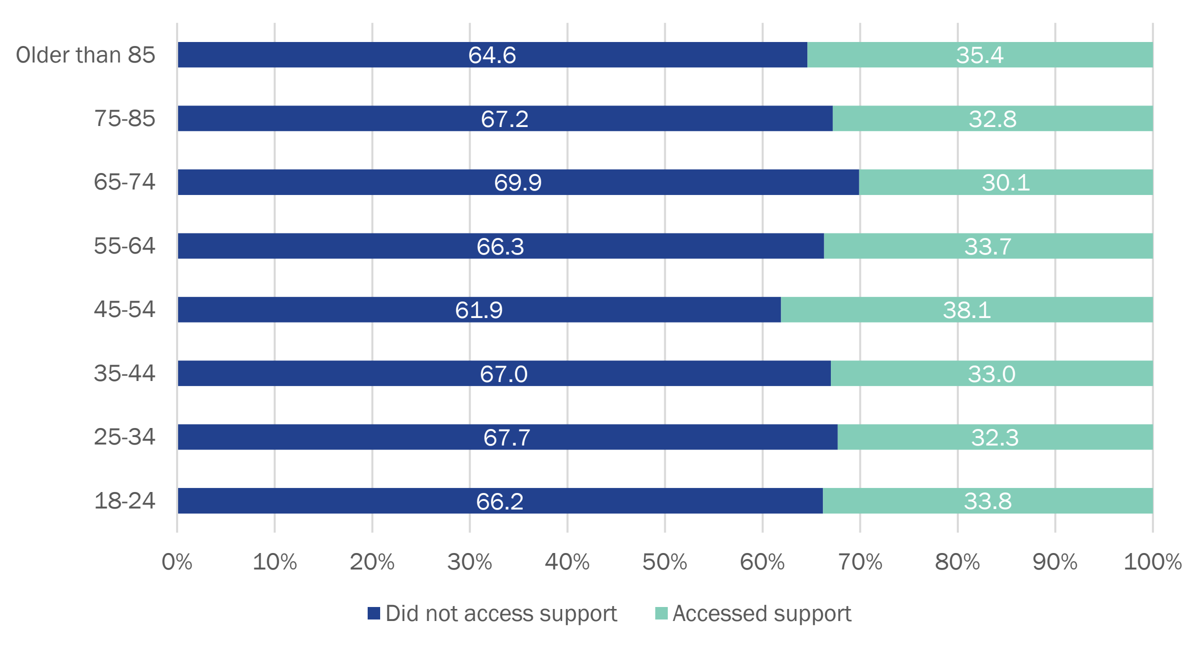
[37] Australian Human Rights Commission (n.d.). Sexual Orientation, Gender and Intersex Discrimination. https://humanrights.gov.au/

[38] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2020). Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: findings from Trans Pathways. Psychol Med, 50(5), 808-817.

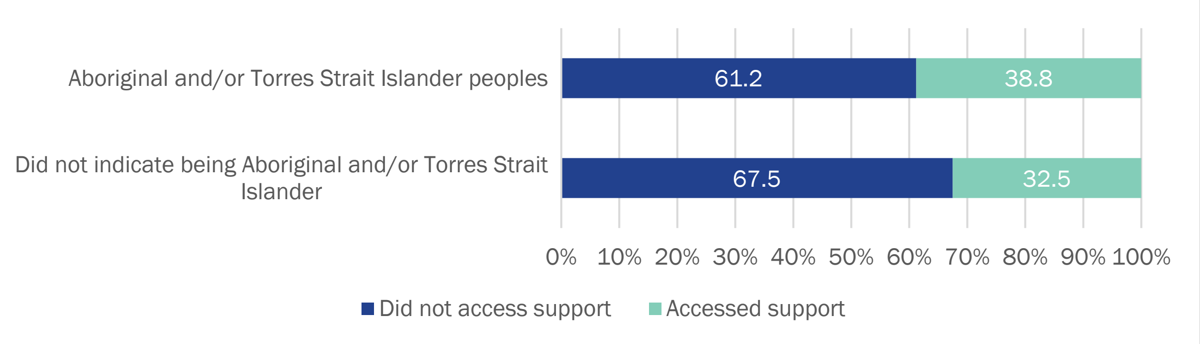
Figure 8. Rate of help-seeking across age categories



Cultural background and connection to support

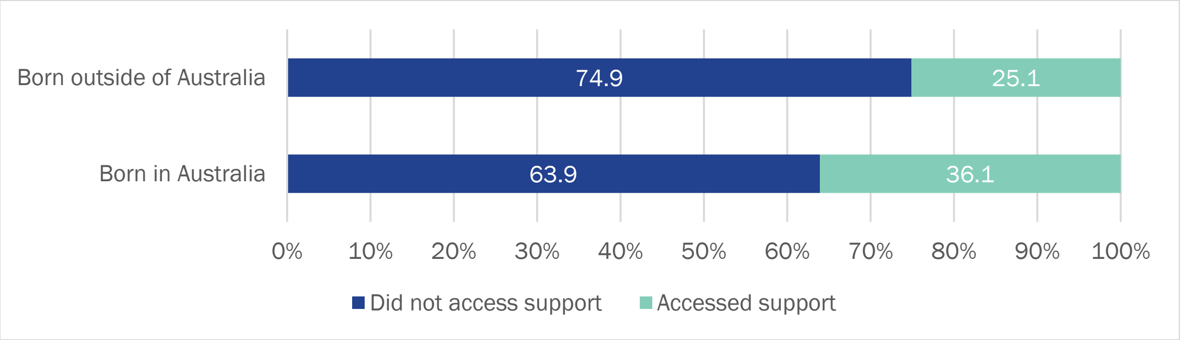
Of the 322 Aboriginal and/or Torres Strait Islander respondents, close to two in five reported accessing help for their mental health in the last three months (38.8%) compared to 32.9% of the 3,248 respondents who did not specify that they were Indigenous (Figure 9).

Figure 9. Rate of help-seeking for Aboriginal and/or Torres Strait Islander people and non-Aboriginal and/or Torres Strait Islander people



Of the 913 respondents born outside of Australia, 25.1% accessed support in the last three months, whereas 36.1% of the 2,789 respondents born in Australia accessed support (see Figure 10).

Figure 10. Rate of connection to support by place of birth (born in or outside Australia)



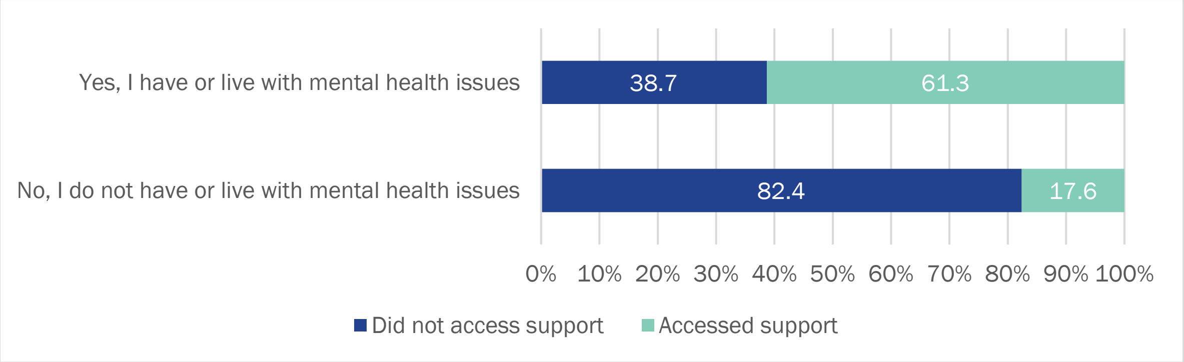
Individuals born in non-English speaking countries and/or those who do not typically speak English at home do not have as many options for mental health supports, as these need to be culturally appropriate, safe, and ideally, delivered in their own language. Some people from culturally and linguistically diverse backgrounds face greater challenges accessing health and welfare systems. Language barriers, lower health literacy, and difficulties navigating an unfamiliar system put them at greater risk of poorer quality health care, service delivery and poorer health outcomes compared with other Australians.

Asking about country of birth does not reliably indicate cultural diversity (for a more reliable indicator, several variables are needed, combining country of birth, language spoken at home and ancestry), and further analysis is needed (combining the languages spoken at home variable, for example) before robust conclusions can be drawn. However, despite this variable being a blunt instrument for assessing cultural diversity, the results do indicate that people born overseas (and potentially with culturally and linguistically diverse backgrounds) were not often accessing supports to maintain their mental health and wellbeing.

Living with a mental health issue and connection to support

As Figure 11 illustrates, of the 1,157 people who reported having or living with a mental health issue, 61.3% reported being connected to supports in the last three months. Although encouraging to see the pattern where people living with mental health issues are more likely to be accessing supports, 38.7% of people who have or live with mental health issues were not connected to any community supports or mental health services. However, mental health is multifaceted and having a mental health issue is only a single reason to seek support. Additionally, not everyone with a mental health issue needs (or wants) to access support, or needs to access it regularly (i.e., within the last three months). More analysis is needed to understand if this group was experiencing high levels of distress or low wellbeing, for example, or if it was by choice that they were not connected to any support.

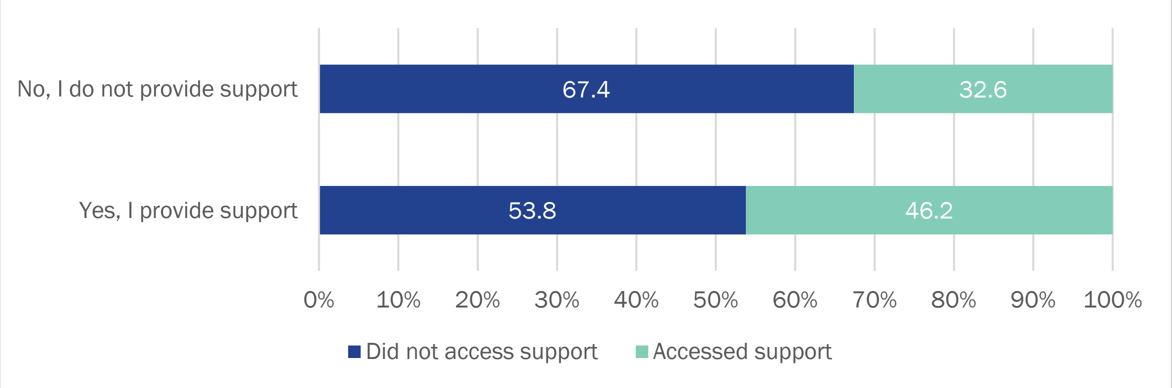
Figure 11. Rate of connection to supports by living with a mental health issue



Connection to support by those who provide support to others

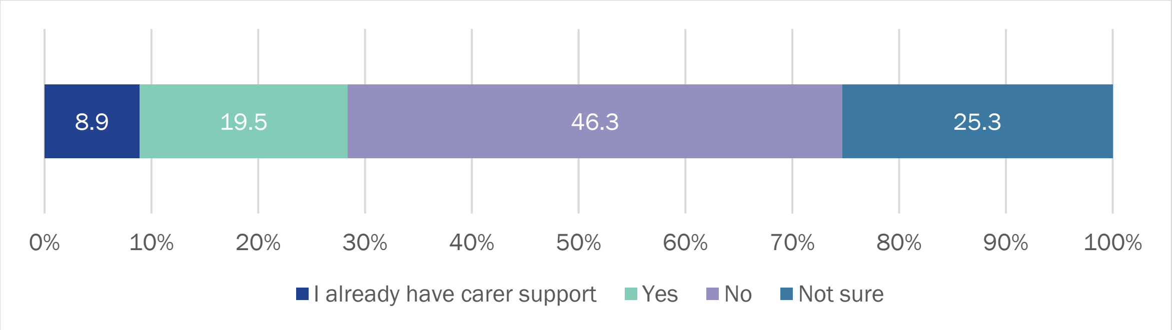
Approximately 29% (n = 1,068) Householders indicated that they provided support to someone else with a mental health condition or issue but also indicated that they accessed support themselves in the last three months (46.2%) – see Figure 12.

Figure 12. Rate of connection to support among those providing support to others and those not providing support to others



Of those who were supporting another, 8.9% indicated that they were currently accessing carer support, 19.5% reported wanting to access carer support, a quarter were unsure, and the remainder did not wish to access carer support – see Figure 13.

Figure 13. Desire for carer support (among those who were supporting others)



Caring or supporting responsibilities can take a large toll on individuals' mental health. Qualitative data indicated that Householders caring for others felt their resources were stretched – people were burnt out, feeling hopeless, and in some cases, not able to effectively care for themselves. Poor mental health outcomes for carers were compounded by a lack of mental health services, especially in regional communities.

> *"I find supporting my wife difficult – this relates to the lack of mental health support in regional Victoria." (Householder)*
>
> *"I have a son who suffers from serious mental health [issues]. I myself have mental health issues. There is a lack of support for our community." (Householder)*
>
> *"I have been looking after my elderly mother and aunty for the last six months and I have not seen my own family. I am trying to help them get services to help them on a daily basis but services are very hard to find in this community. Trying to find the right service is a challenge. [Caring] is becoming mentally draining." (Householder)*

Geographical remoteness and connection to support

The ABS Accessibility and Remoteness Index of Australia[39] (ARIA) measures remoteness relative to a location's access to services[40] (i.e., more remote locations have less access to service centres) and divides Australian towns and cities into five classes: 'Major Cities of Australia', 'Inner Regional Australia', 'Outer Regional Australia', 'Remote Australia' or 'Very Remote Australia'. There were no ACDC Project sites that met the classification for 'Remote' or 'Very Remote'.

As illustrated in Figure 14, the rate of accessing supports appeared similar across ARIA categories. Approximately one in three Householders reported being connected to support for their mental health, irrespective of remoteness.

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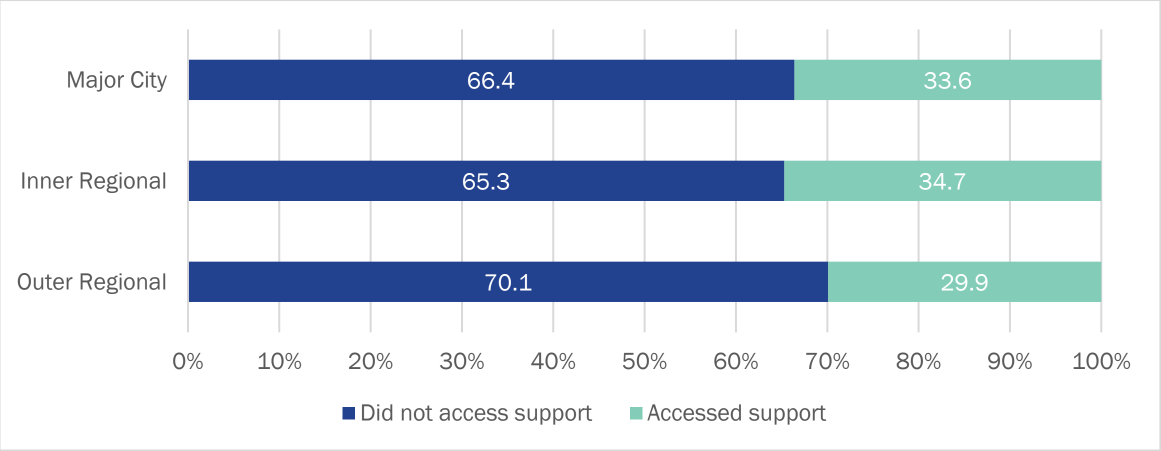
[39] Australian Bureau of Statistics. (2016). *Remoteness Area index*. https://www.abs.gov.au/statistics/

[40] Specifically, access to service centres along road networks.

Figure 14. Rate of connection to support by remoteness



Site level variation in connection to support

The proportion of connection to support or access to services differed across the 17 Round Two ACDC sites (see Figure 15). In Ipswich, more than half of Householders who answered the survey reported recently accessing supports. Householders from Burnie followed– 48.6% of respondents reported accessing supports in the last three months. In contrast, 22.8% of Clarence Valley and 25.6% of George Town Householders had accessed help.

While connection to supports across demographic variables was fairly stable, aside from expected variation that could be explained by other confounding variables, the variation in rates of connection to supports across different sites did not seem to follow a pattern. Some sites with high rates of service connection were smaller towns, others were metropolitan areas, some had known vulnerable populations and others did not. There were, however, significant variations in the survey response rates across the 17 sites (ranging from 89 to 359), and the community contexts and factors influencing mental health need also varied significantly.

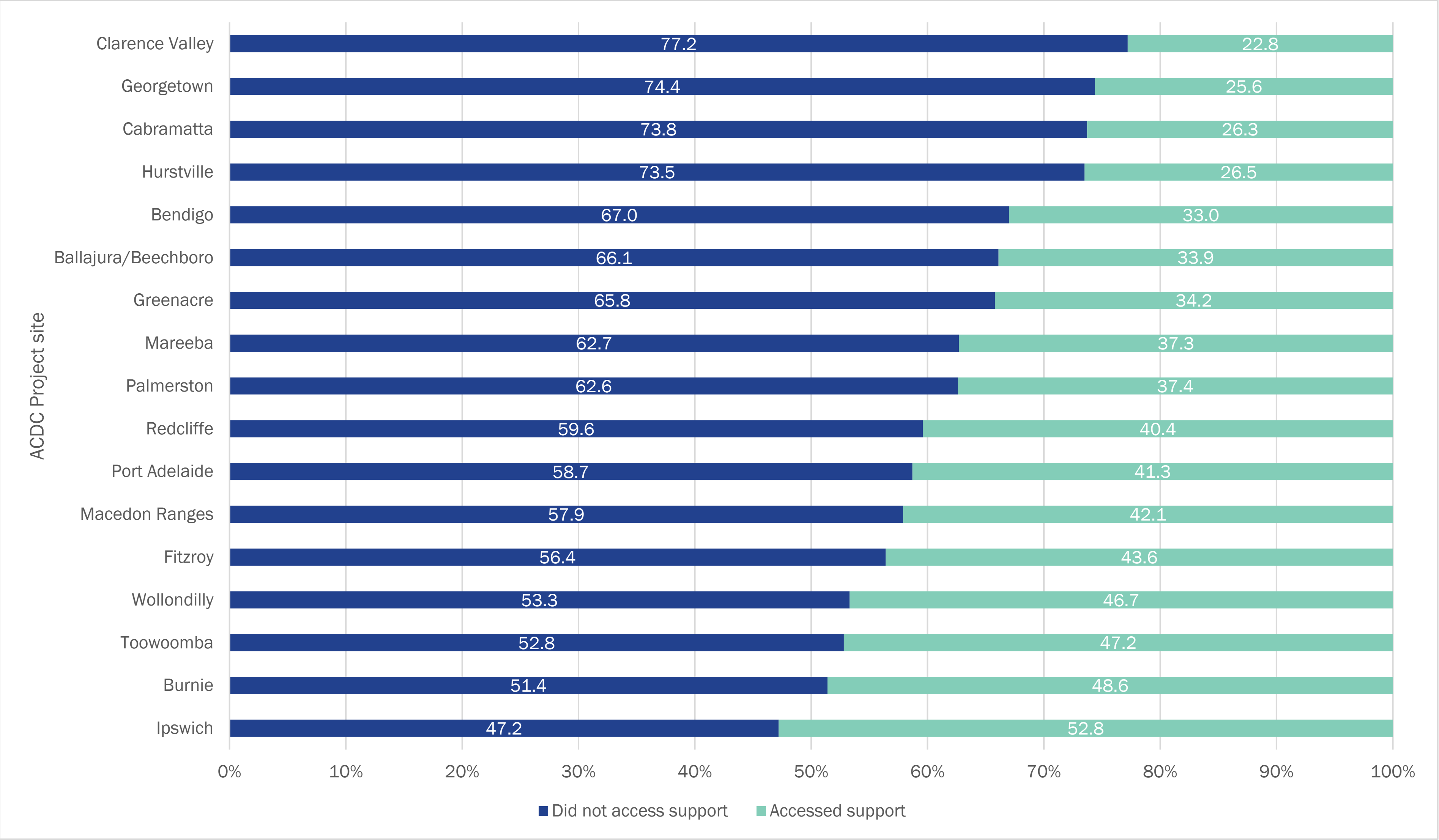
Although data is presented across sites, further research would be needed to acknowledge the impact of missing data and geographical variability and integrate domain experts that could provide estimates based on these data, the literature, and their own knowledge to accurately test for discrepancies across sites. This is not in the scope of the current Report. However, the qualitative data from Householders describing difficulties accessing services and supports can offer additional evidence about levels of connection to supports across these sites. Often, what prevented people from being connected to services was based around the local service infrastructure (i.e., what was available locally) and conditions (i.e., distance to travel).

Many Householders described traveling long distances for supports and services, enduring unrealistic wait times for psychologists and counsellors, and high costs associated with local services which ultimately made them inaccessible for many residents.

> *“No local psychologists, I have to travel 40 minutes [into] the city to see someone. I’ve been on a waitlist for over two years. Too expensive to see a professional without Medicare or a mental healthcare plan.” (Householder)*
>
> *“Lack of services in [my] area for mental health, suicide, and anorexia in the Macedon Ranges. I’m not able to see someone consistently due to COVID. I am separated from family.” (Householder)*
>
> *“Lack of services in this area. One mental health drop-in centre in Palmerston but now they have moved and don’t have funding from the government to [operate].” (Householder)*
>
> *“Need more mental health support that is free or affordable in the Palmerston region.” (Householder)*

What supports are available close to where people live, and how they can be easily accessed and sustained over time, really matters and can possibly affect rates of people accessing supports.

Figure 15. Rate of access to supports – ACDC site



Does support utilisation vary across different cohorts?

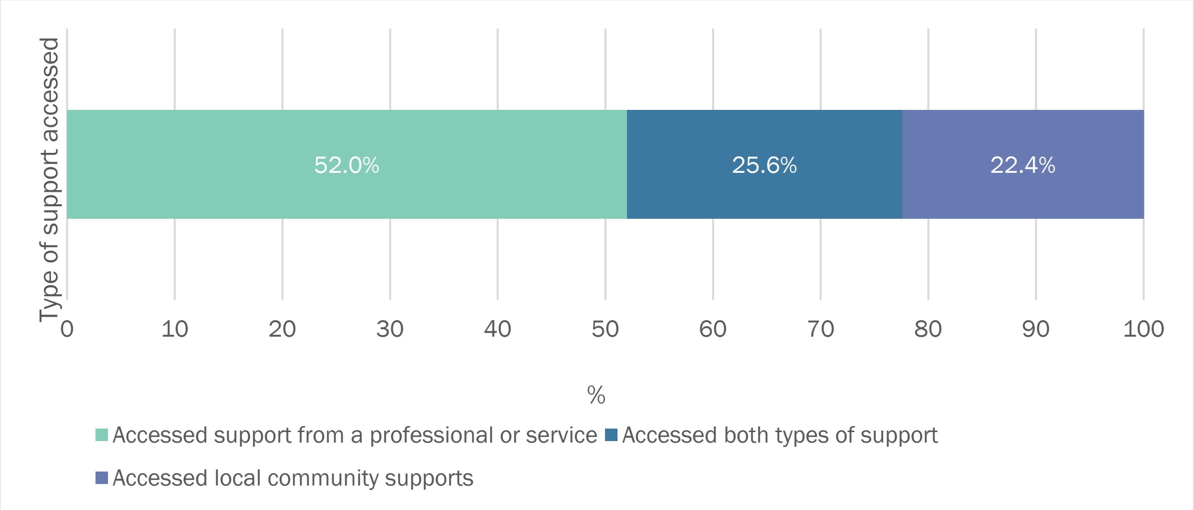
The above section examined ‘connection to supports’ as a category in and of itself. However, within that cohort there are people accessing community supports – defined in the survey as local community support options such as safe spaces, a support group, youth group or Men’s Shed – as well as people accessing mental health professionals or services – such as counselling, a GP or psychologist.

We know there are vast differences in both types of support, in terms of their suitability for different cohorts, the cost of operation, as well as cost for individuals to access, as well as the availability of those supports in different communities. The cost of accessing mental health professionals and services can be prohibitive for some people and in some areas the waitlists are a significant access barrier. We also know that community supports can be underfunded, underutilised and people might not be aware of these options.

Here, we examine the rate of access in both types of (support from a professional or service and/or community mental health support) across various demographics, including age, gender, Aboriginal and/or Torres Strait Islander status, birthplace, remoteness of residence, and identified mental health issues. The aim of these analyses is to present the frequency of access across these subsamples.

Figure 16 provides an overview of the types of support accessed by the total sample of Householders who identified seeking help for their mental health and wellbeing in the last three months (n=1,235). Over half of the respondents reported accessing support from a professional or service, approximately one in four had accessed both a professional/service and local community supports, and the remaining had accessed only community supports.

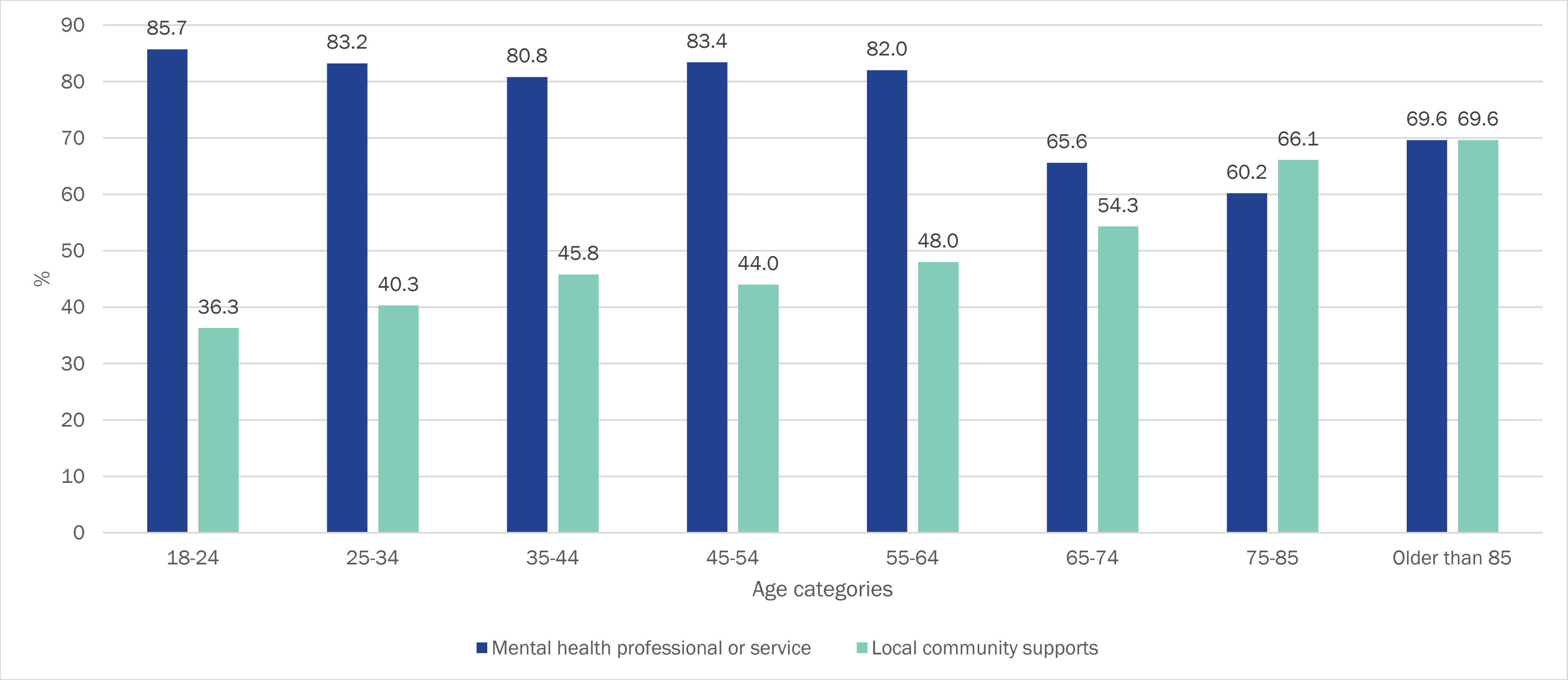
Figure 16. Type of support accessed across the sample of Householders accessing support



Types of supports accessed by age

As illustrated in Figure 17, Householders aged over 85 most frequently accessed local community supports, whereas Householders ages 18 to 64 most frequently accessed mental health support that was provided by a professional or service. Across all age ranges, excluding those over 75 years, Householders were more inclined to use support provided by a professional or service. Those aged 75 to 85 more frequently accessed local community supports, and those older than 85 years reported frequently utilising both supports.

Figure 17. *Type of support accessed across age categories (% of those accessing support)*



Note. Multiple responses permitted.

Qualitative data suggest that different age groups faced different problems and challenges associated with their mental health, but also, they indicated preferences for different ways of addressing mental health need. Older adults often described the value of social connection and relationships, but sometimes felt uncomfortable discussing their own mental health and clinical, structured support was discussed less frequently. Sometimes, older Householders revealed that their desire for social groups was prompted by feelings of loneliness and isolation.

> *"[it's important] being able to get out and socialise. A lot of people around me have passed on now...I miss meeting with my old group." (Householder)*
>
> *"I get lonely at times but the social groups I attend do help me. There should be more focus on supporting these services as older people need a personal touch and [this] interaction." (Householder)*

Younger people appeared to be confident accessing mental health professional support or services, however in some communities it was reported that there was a lack of informal supports or peer support models for young people to connect and support one another.

On the other end of the spectrum, Householders indicated a desire for professional, clinical, and reliable mental health support for youth. Data suggest that young people were facing a mental health crises; many young people had severe, complex mental health needs, and services could not meet the demand. Parents described anxiety about the lack of support available for their young people. Often, where services were not accessible, parents were left to support their child's mental health without help.

One Householder did have access to youth mental health support for their child, but the care did not suffice.

> *"[My] 19-year-old son has mental health issues and we are horrendously understaffed and lack people on the ground to help our local kids – it's frightening! This has been [like this] for the past three years my son has needed help. They try hard at CAMHS[41] but it's not enough." (Householder)*
> *"Lack of suicide prevention services for young adults and teenagers." (Householder)*

Types of supports accessed by gender

All genders indicated they had greater access to (or preference for) support provided by a professional or service. Males and females reported similar proportions of access to both types of support. For gender diverse Householders (n=18), survey data suggest a preference for professional

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[41] Child and Adolescent Mental Health Service

services and supports, however, support utilisation is always dependant on the availability of services or groups.

Qualitative data suggested that local, targeted community supports were missing – for both males and females. Householders described the importance of connecting with others based on their gender identity, but they did not feel that doing gendered activities was the best way to establish, or maintain, these groups.

> *"It's tough in our community due to a lack of men's' groups and supports, especially for older males who may not be interested in the one type of group avaliable – the Men's Shed. It would be beneficial to have more targeted programs, groups and social [support] in the community. There is also a need for women's support groups – not just craft groups…" (Householder)*

> *"I have battled with my mental health since having children. There is plenty of help out there for new mothers, but nothing for new dads." (Householder)*

Consistent with findings from the literature[42], some men were struggling to navigate accessing mental health supports. Householders described this being a social issue – specifically, toxic attitudes about masculinity (i.e., seeking help being seen as a weakness, believing that it is mostly women who have mental health needs). The internalisation of these harmful attitudes is likely to reduce help seeking, especially in more clinical-orientated spaces, where males may feel like they are less welcome to access these supports.

> *"Some community organisations still don't recognise that men have needs, as well as women." (Householder)*

One Householder attempted to seek help for their mental health, only to have their concerns minimised and dismissed by their GP:

> *"My old GP told me to 'man up' and 'stop making my problem other peoples' problem'." (Householder)*

Gender diverse Householders reported a lack of local, LGBTQIA+SB community-orientated groups, which could explain an inclination to access clinical supports[43]. Several Householders described a desire for safe, comfortable environments where they felt accepted, celebrated, and understood.

> *"There is no LGBTQIA+ stuff - no events, awareness, or groups. There especially isn't for my age group. It's a massive stigma here still. I would love to see rainbow,*

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[42] Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gündel, H., Becker, T., Frasch, K., Panzirsch, M., Schmau, M., Krumm, S. (2020). Masculinity and Help-Seeking Among Men With Depression: A Qualitative Study. *Frontiers in Psychiatry, 11*. https://doi.org/10.3389/fpsyt.2020.599039

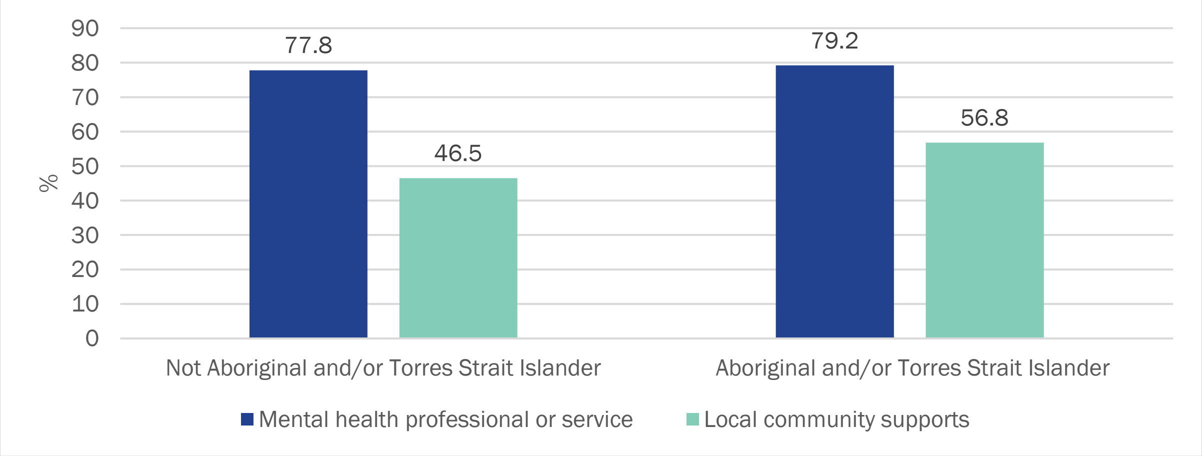
[43] To be interpreted with caution due to small sample size.

> *community friendly groups/services here in the community to connect and educate.” (Householder)*

Cultural background and types of support accessed

Regardless of Indigenous status, the most frequently accessed support was that provided by a professional or service. Fifty-seven percent of Aboriginal and/or Torres Strait Islander Householders reported accessing a local community support, in comparison to 47% of Householders who did not indicate they were Indigenous – see Figure 18.

Figure 18. Type of support accessed across Aboriginal and/or Torres Strait Islander status



Note. Multiple responses permitted.

It is important for mental health supports to be culturally appropriate, competent, and safe. The lack of cultural responsivity within the Australian health system is a current barrier faced by Indigenous peoples attempting to access mental health support[44]. Given many mental health professionals and services operate from a Western understanding of mental health and wellbeing, it is reasonable that Indigenous peoples may feel more comfortable seeking local community supports, particularly if this provides an opportunity to connect with Community and culture.

> *“The system keeps people broken and reliant instead of bringing healing. There should be support for Indigenous people to return to Country for healing.” (Householder)*

The Householder Survey highlighted the views of respondents who were Aboriginal and/or Torres Strait Islander. They discussed their connection to Country, the trauma of being displaced, and enduring current-day racism and discrimination. The preference for support, based on data from the Householders surveyed, seemed to be for groups facilitated by other Aboriginal and/or Torres Strait

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[44] Australian Institute of Health and Welfare. (2022). *Indigenous Australians and the health system.* https://www.aihw.gov.au/

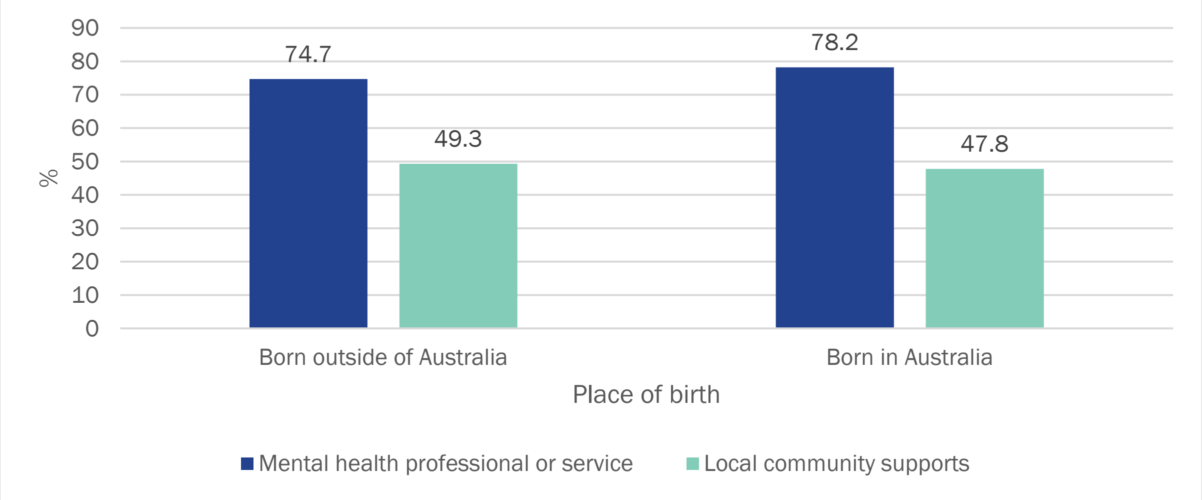
Islander peoples. One Householder stated that some Aboriginal people would not feel comfortable seeking mental health support provided by a professional/clinician:

> *"[I'm] bored and lack money to do groups. Aboriginal people are hands-on, and we are not all the same to talk to total strangers about emotions, feelings, or loss." (Householder)*

As well as costs, it is likely that a lack of Aboriginal-led groups is a barrier to Indigenous people seeing appropriate mental health support.

The proportion of types of support accessed was similar among those born within Australia, and those born outside Australia, and the most common support accessed was support from a professional or service – see Figure 19.

Figure 19. Type of support accessed across place of birth



Note. Multiple responses permitted.

Householders described challenges in accessing mental health support due to language barriers and this was identified as a significant barrier for those from culturally and linguistically diverse backgrounds.

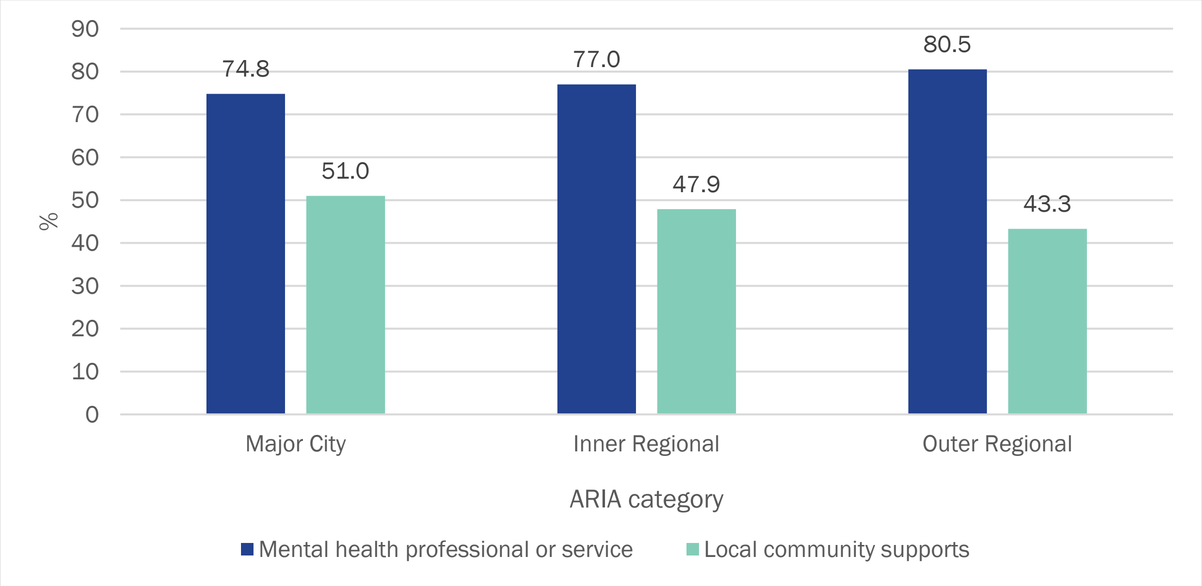
> *"I wish there would be more initiatives that provide information in my language." (Householder)*
>
> *"I don't understand English and I'm too embarrassed to bother other people…" (Householder)*

Another Householder also noted that, as a carer who was not fluent in English, it was also difficult to understand information provided by professionals and services in regard to their wife's health and treatment.

Geographical remoteness

Figure 20 illustrates the proportion of different types of support sought across geographical location – major cities, inner regional, and outer regional areas. Type of mental health support was consistent across ARIA categories. Approximately half (51.0%) of Householders located in major cities accessed local community supports, 47.9% in inner regional, and 43.3% in outer regional areas. Eighty-one per cent of those from outer regional areas accessed support from a professional or service compared to 74.8% in major cities and 77.0% in inner regional areas.

Figure 20. Type of support accessed across remoteness (ARIA)

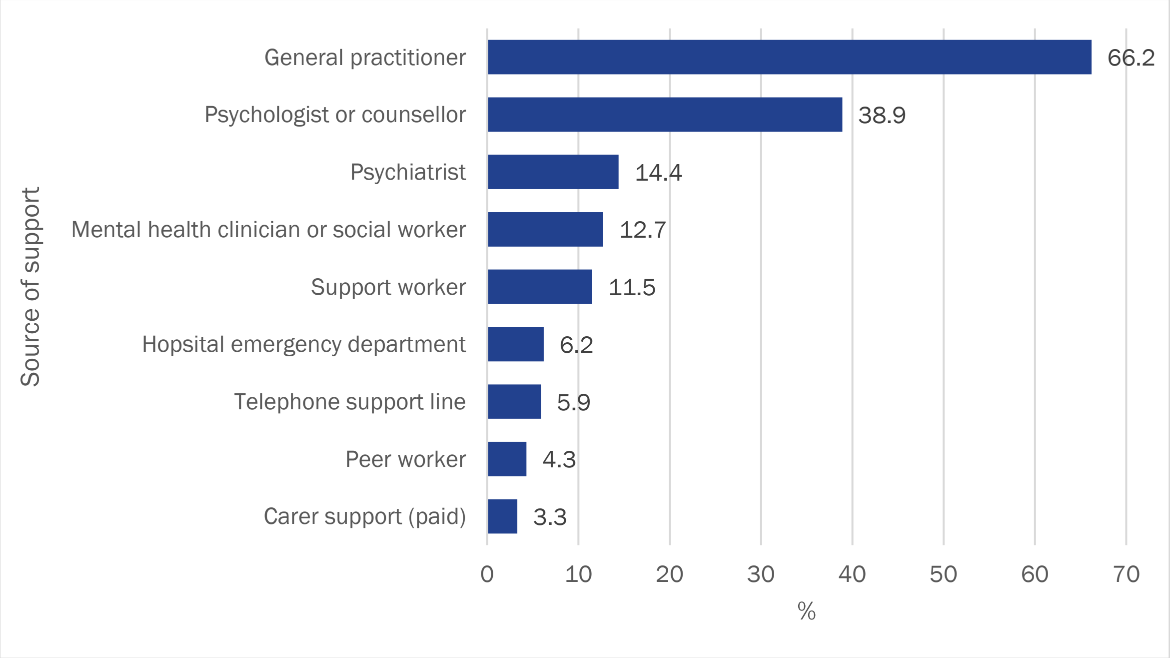


Note. Multiple responses permitted.

Sources of mental health support

Of the Householders who had recently accessed supports, we were interested in identifying the specific sources of mental health care. The survey asked, *"In the last 12 months, have you received support for your mental health and wellbeing from any of the following?"* and respondents were permitted to select all that applied. As Figure 21 illustrates, the most common source of support was from General Practitioners, followed by psychologists or counsellors. Very few Householders reported accessing paid carer supports or peer support workers.

Figure 21. Sources of mental health support



Note. Multiple responses permitted.

Qualitative data indicated that attending GP clinics was the easiest avenue for Householders to find mental health support. More often than not, people were wanting to access psychologists and psychiatrists for their mental health concerns, but these options were not available due to high demand, or the costs associated.

> *"There are no psychologists available for months. Other services turn me away." (Householder)*

> *"Major depressive disorder, generalised anxiety disorder, complex PTSD [but] no psychology appointments available." (Householder)*

> *"[A barrier] is the cost of counselling and medication for mental health." (Householder)*

GPs were often described as a stable, trustworthy source of support:

> *"Coming out of isolation [COVID-19] drinking too much so I'm in treatment under my GP." (Householder)*

> *"I could do with some help around the house because it takes me so long to do things but there are no carers available. I have a lovely GP, though. He is like a dad to me." (Householder)*

Householders who had complex needs faced additional challenges in finding appropriate, high-quality care:

> *"My physical health, PTSD, bipolar and depression [are challenges]. I don't really know what support there is and my first experience with the NDIS wasn't good, they just messed me around and were not helpful. My old psychiatrist retired and my new one who took over can't access my file. It's very traumatic to have to retell every detail." (Householder)*

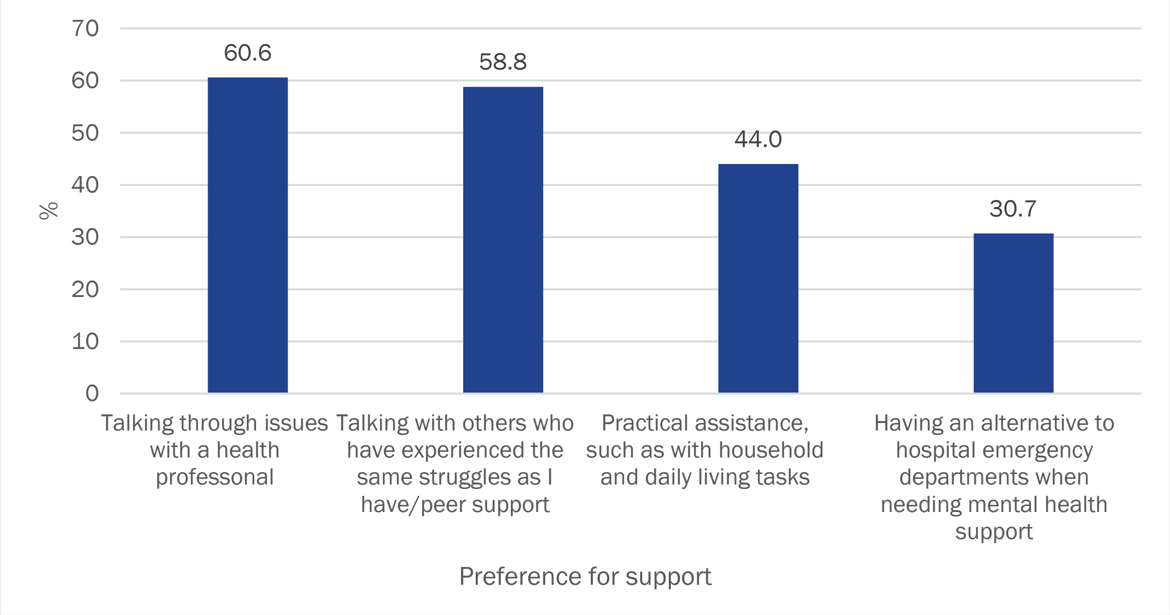
Is there a need for additional support?

Despite 1,235 Householders having accessed some type of mental health related support in the last three months, half of these Householders indicated that they would benefit from more help, in addition to what they were already accessing.

> *"Not enough staff to see me. I have moved from seeing a psychiatrist and psychologist fortnightly (and OT/social worker when needed) to barely being able to see my psychiatrist monthly, my mental health has been such a struggle. Managing daily life is so much harder. Not enough staff or services unless you're rich." (Householder)*
>
> *"One of my friends struggles with her mental health, badly. She sees a psychologist but it's definitely not enough support for her." (Householder)*

Below (Figure 22) illustrates the varying supports Householders felt they might benefit from to address their mental health and wellbeing. The preference was for support provided by a health professional (60.6%), followed by peer support (58.8%). Still significant, but less of a priority, was support in the form of practical assistance (44.0%) and having an alternative to emergency departments (30.7%). There continues to be a need for clinical supports and services, and/or supports delivered by peers for people who are already connected to other support options, and it is possible that different services and support options are unable to meet the ongoing demand. Due to long waitlists and out of pocket costs, many people are not able to connect with a psychologist or counsellor.

Figure 22. Additional supports that would benefit Householders who had recently accessed support



Note. Multiple responses permitted.

Notably, of the Householders who reported no help seeking in the last three months (n = 2,467), 28.8% also felt that they would benefit from more support for their mental health and wellbeing.

Mental health need and accessing support(s)

We sought to examine differences of mental health wellbeing (using standardised measures) between Householders who had recently (the last three months) connected with supports, and those who had not. No other inclusion criteria were imposed. Of the ACDC sample, 1,235 people were defined as being currently connected to supports, and 2,467 were not currently connected to supports (33.4% and 66.6%, respectively). Table 2 presents K10/K5, WHO-5, and loneliness across the two groups.

Table 2. K10/K5, WHO-5, and loneliness across those currently accessing supports and those not currently accessing supports

Measure	n	Mean	Std. Deviation
Currently accessing supports			
WHO-5	1178	43.4	24.1
K10	1006	21.1	8.7
K5	117	12.6	5.0
Loneliness	1195	5.4	1.9
Not currently accessing supports			
WHO-5	2366	57.1	23.9
K10	2107	16.1	6.7
K5	182	9.5	4.6

Loneliness	2405	4.4	1.7

Analysis to test for difference between mean scores found that Householders who were currently accessing supports were experiencing significantly lower wellbeing (p<.001), and greater loneliness (p<.001) than those who were not accessing supports during this time. Similarly, the Householders accessing supports were experiencing significantly higher psychological distress (p<.001) than those who were not accessing supports.

More research analysis is needed to understand the relationship between high distress, low wellbeing, loneliness, and service utilisation. On the one hand, these data indicate that people with mental health need are accessing services; that people accessing mental health support have more challenging or severe mental health concerns than those who do not. On the other hand, are the services they are accessing effective in reduce their distress, increase their wellbeing? These questions are too complex to be answered by the limited data we have.

However, it does identify a gap in our understanding. Round Two did not ask respondents about the appropriateness, quality and satisfaction associated with the supports they were connected to or had accessed, and it could be useful to do so.

Would Householders who are not connected to mental health care benefit from mental health supports?

Not accessing help does not mean the absence of a mental health need. Sometimes, those who need mental health care are more likely to be disadvantaged by social systems and therefore, have the most difficulty accessing and affording quality care[45].

The following section explores data pertaining to all the Householders who were not accessing mental health related support in the last three months (n = 2,467). We were interested in identifying whether any of these people may have needed support, and perhaps, why they were unable to receive it. Of the Householders not connected to mental health supports, three in 10 (N = 703; 29.7%) Householders reported a need to seek help in the last 12 months[46]. Of those 703 Householders who reported a need, 53.9% did not get the support they needed – a fairly large proportion of unmet need.

Barriers

Barriers refer to both internal (person barriers) and external factors (systemic barriers) that make it difficult for people to seek (or access) mental health support. Internal factors relate to an individuals' unique circumstances, for example, feeling shame or discomfort about seeking help. As well as

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[45] State of Victoria, Royal Commission into Victoria's Mental Health System. (2021). *Royal Commission into Victoria's Mental Health System: Final report, summary and recommendations.*

[46] We asked, *'In the past 12 months, was there a time when you wanted to talk with someone, or seek help about, stress, depression, or problems with emotions?'*

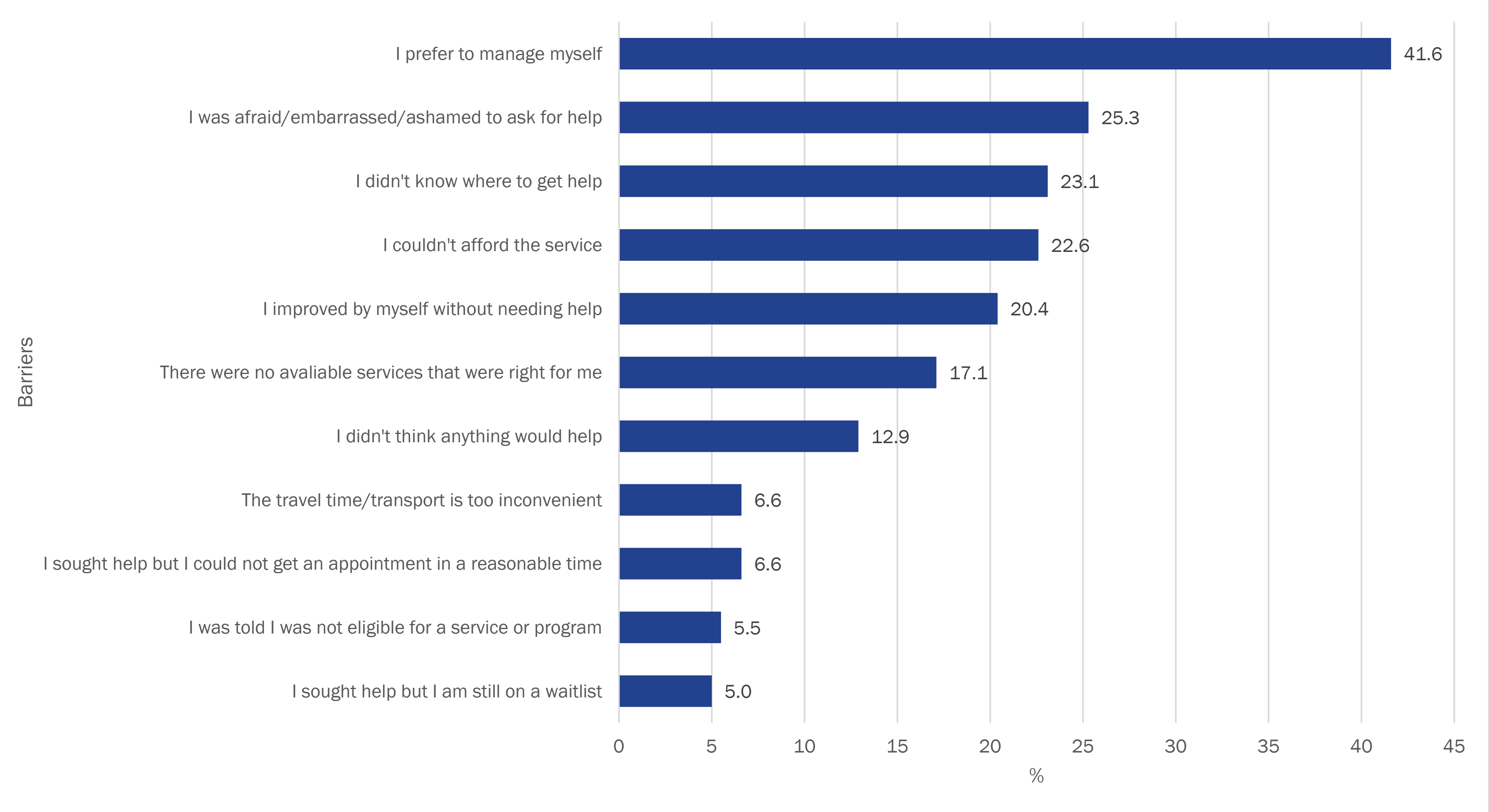
individual variables, barriers can also exist in mental health services which create additional hurdles for people attempting to attain support. These barriers can include strict eligibility criteria, triage systems (i.e., access to care depends on severity of symptoms), long waitlists, and the costs associated.

We asked Householders, *"Why did you not get the care you needed?"* and respondents were able to select all that applied. We analysed the barriers identified by Householders who stated they were not currently seeking mental health support (n = 363) in the last three months at the time of completing the Householder Survey.

As Figure 23 shows, the primary reason for not receiving mental health support was due to Householders preferring to self-manage. We acknowledge that interpreting 'I prefer to manage myself' is difficult, as it could point to both the productive and empowering use of self-help resources and general resilience in the face of difficulties, and, on the other hand, 'preferring to self-manage' could indicate unhealthy stoicism or feeling the inclination that one must carry one's burdens in isolation and without support. The second most common reasons for not receiving support was fear and embarrassment associated with asking for help. Although we can only infer, taking these two data points together, it is possible that wanting to self-manage (despite wanting to seek support) could be associated with shame. Regardless, these data suggest that stigma about mental health continues to be a significant barrier to seeking support when it is needed.

Figure 23 also provides information about external barriers – approximately two in five Householders wanting mental health support reported not knowing where to go to get help, and the same proportion of people could not afford any mental health services. These barriers highlight the need for information about local, low-barrier mental health support options available across the country, but also, a better allocation of funds to close the out-of-pocket costs associated with accessing mental health support. Eliminating the costs associated with seeking mental health care also supports prevention and early intervention.

Figure 23. Barriers to accessing mental health care



Note. Multiple responses permitted.

Qualitative data suggest additional barriers keeping Householders from accessing the mental health supports they needed. Broadly, these barriers could be categorised into four themes: distrust of mental health professionals/services, stigma, lack of services, and unhelpful past experiences.

One of the primary barriers identified by Householders was a distrust of mental health professionals and services. Respondents described fear and hesitancy associated with trying to access services – they believed that the system did not have their best interests at heart, so they avoided trying to seek support.

> *"I don't believe there is anyone genuinely interested in helping me or understanding me enough." (Householder)*

> *"The system doesn't care." (Householder)*

Stigma about mental health issues was a large concern for many Householders. This created anxiety about seeking support and talking to family and friends about their mental health. It was also a reason why people felt apprehensive about accessing the support they needed. Stigma resulted from poor experiences from mental health services, or comments made by family; one Householder stated:

> *"My mum thought I was faking it." (Householder)*

It was apparent to Householders that there was a high demand for mental health services. An overwhelming proportion of respondents reported unacceptable waiting periods – usually three to 12 months – which often created a feeling of hopelessness for Householders.

> *"Psychologists have a long wait list. I self-harm, I am suicidal, and there is no help here. Waitlists. No family. I am isolated here." (Householders)*

Other issues relating to accessibility included knowing exactly how to access help (e.g., what paperwork was needed, where to go, who to call, etc.), or costs associated with specific services.

> *"I'm still trying! All the psychiatrists specialising in ADHD are booked out for weeks or months and as are many of the psychologists, especially in this area. Relationship counselling is pricey and not covered by Medicare which is ridiculous." (Householder)*

Unfortunately, many Householders had previously tried to access suitable support but were not provided with appropriate, quality care. Although not explicitly stated, it was clear that these Householders were not willing try again due to the mistreatment they had experienced.

Experiences of these Householders varied. One Householder described feeling traumatised by the support they had tried to access:

> *“My experience with a counsellor/therapist in Australia has not been great and it left me traumatised. I’m hesitant to try again as it leaves me very vulnerable, and it is mentally/emotionally exhausting.” (Householder)*

Other Householders were rejected from supports or services.

> *“I had to self-manage and stop medication on my own due to lack of professional support. I have made contact, but I am passed around. Lifeline is terrible. Local service is terrible too.” (Householder)*
>
> *“My doctor did not offer me anything.” (Householder)*
>
> *“The hospital turned me away when I wasn’t safe.” (Householder)*

And, the remaining, felt forgotten.

> *“They promised to call back, but they didn’t.” (Householder)*

These poor experiences would likely reduce future help-seeking. This would also be congruent with the findings of the quantitative data (presented in Figure 23) which found that 41.6% of people indicated that they would rather self-manage than try to access external mental health support.

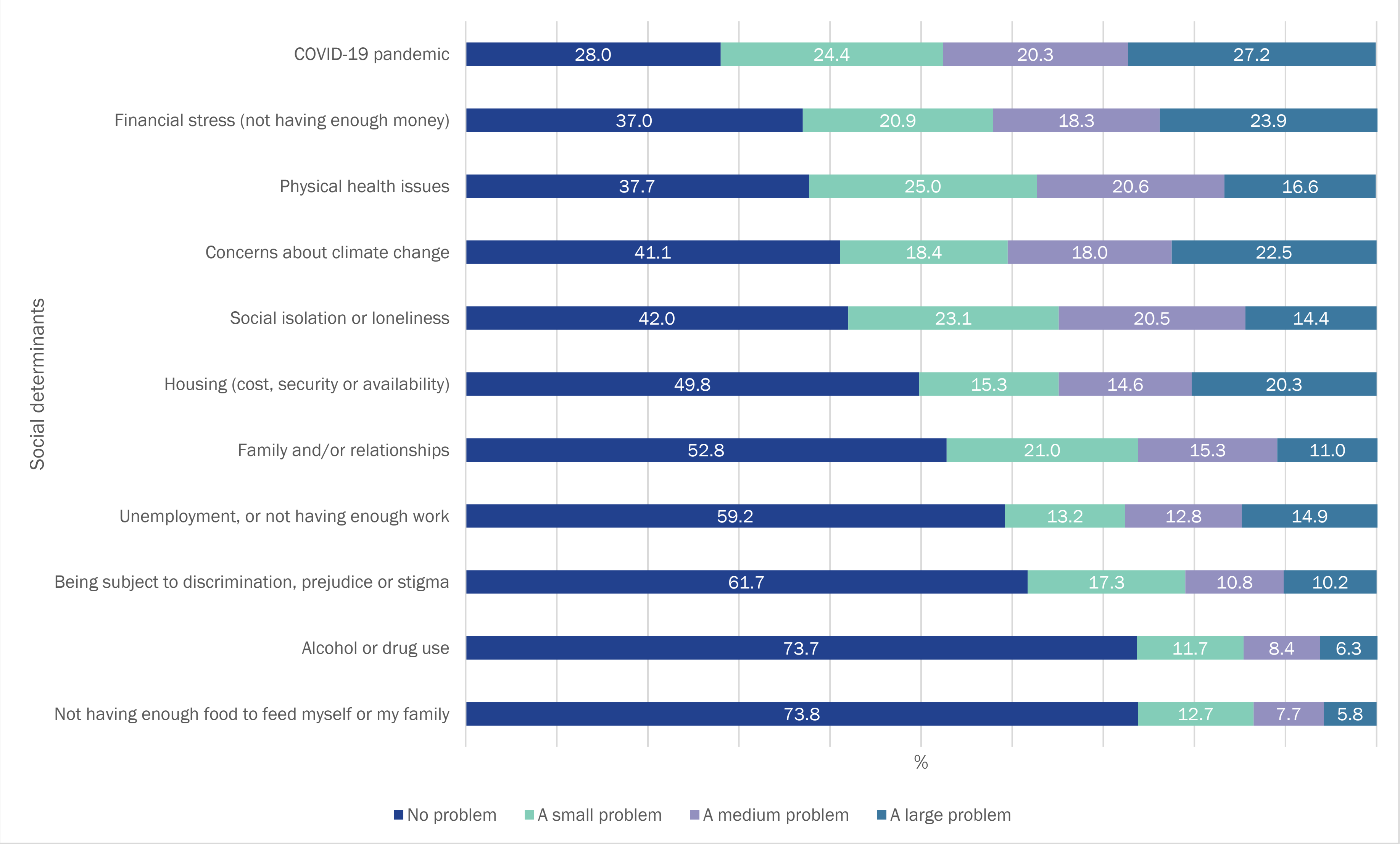
4.3 Factors associated with mental health and wellbeing

Social determinants of mental health

The social determinants of mental health (e.g., financial security, employment, fulfilling relationships, safety), and having emotional and social needs met, are important for maintaining good mental health and wellbeing. Survey respondents were asked *‘In the last 12 months, were any of the following [social determinants] a challenge or problem for you and what was the extent of the problem?’* on a 4-point scale from ‘no problem’ to a ‘large problem’ (presented in Figure 24).

In addition to the list of response options, Householders were asked to describe any other factors in their lives that were impacting their mental health and wellbeing. This was an open ended question: *“Are there any other issues affecting your mental health and wellbeing?”*. More often than not, Householders expanded on the social determinants we presented in Figure 24. Consequently, this long-answer survey question provided an in-depth understanding of how several of these factors can result in poor mental health outcomes, but also illustrates how the same social determinant can affect Householders in a variety of different ways. Rating the social determinants showed one in four respondents felt that the COVID-19 pandemic and financial stress were large problems, and one in five stated climate change and housing (cost, security, or availability) were large problems. To varying degrees, each of the social determinants were identified as a significant challenge for Householders, and this was congruent with what we found in the collection of qualitative data.

Figure 24. Extent of social determinants as a problem



COVID-19 pandemic

Householders described several ways that the pandemic had negatively impacted their lives and created considerable challenges. Lockdowns and restrictions created social isolation from friends, families, and social groups, and this was a contributing factor to the deterioration of Householders' mental health and wellbeing. The most significant issue raised in response to the pandemic was the lack of health services available to Householders. Survey respondents reported continuous cancelling of services, surgeries, and procedures, having to endure incredibly long waitlists due to increased demand for mental health services (one Householder had been waiting for six months when they were visited by the People Connectors), and in some instances, self-managing their mental health following the closure of services and clinics which resulted in Householders losing access to external supports during lockdown.

> *"I'm doing better now, but I did lose my job (contract ended when it would usually roll over). I got another job, but I had so much uncertainty and COVID-19 really exacerbated some prior things I was dealing with or ignoring. I tried to get help, but the waitlist was huge. I was on a waitlist for many different mental health services and the first one rang me after eight weeks. I was in a crisis when I first reached out for help. My partner helped me a lot and things solved themselves but not everyone would be so lucky." (Householder)*

Householders who were essential workers also described the strain that COVID-19 had created on the healthcare system, adding that, because of their healthcare role, they felt completely burnt out, hopeless, isolated, and unable to care for themselves due to severe exhaustion. One Householder described the fear associated with spreading the virus to their family and they also worried about sharing their concerns about the pandemic with their loved ones. Instead, they did not speak to their social network about the stress and anxiety they were experiencing, which often created more distress. This Householder reported feeling deeply impacted by the deaths they had witnessed in their role, and they continued to worry about more of their patients losing their lives.

> *"Working night shift in the ED has caused mental and hygiene fatigue, anxiety and loss of appetite, depression, uncertainty around whether the PPE was appropriate for my safety. I'm not feeling safe to go home in case I contracted COVID-19 and gave it to my family. I didn't have enough support from my workplace around looking after COVID-19 patients. I became largely underweight, couldn't eat due to sickness from anxieties, panic attacks, breakdown of relationships. Unable to look at myself in the mirror as I didn't recognise myself. Seeing sick patients all the time and never knowing if they recovered or passed away. The fatigue leads to mistakes at my place of employment." (Householder)*

Householders described how they struggled to manage challenges and traumas whilst living through the pandemic. Parents discussed the challenges of caring for children during this time, particularly single parents, who experienced burnout due to being unable to access child-care, while juggling expenses and bills on a single-person income. Other Householders spoke about caring for others with disability, many of which, did not have respite options due to the strain on healthcare providers.

> *"I am unable to get respite care for my brother due to COVID-19. The company I use has gone down south so they have no idea on what happens up here and the lack of services we [have]. I have been passed around trying to get answers and am extremely frustrated. I already have mental health issues, and this has added onto it. Due to not having respite, I am unable to attend my support group in Cairns. I am a well-educated person and know what to do, however I am also concerned about those that don't know what to do or where to start in relation to this." (Householder)*

Managing illness and death was also raised as a significant stressor – COVID-19 restrictions resulted in several families not being able to spend time with sick and dying loved ones, or attend funerals.

> *"Grieving the loss of a child during COVID--19 and being unable to visit and spend time in hospice before [their] death. This has left me feeling bitter." (Householder)*

Financial stress and access to food

Financial stress was another significant worry for Householders, and this concern was often closely related to other social determinants of mental health such as COVID-19, housing, unemployment (or under employment), access to enough food, and physical health.

> *"Still at a loss from losing my restaurant during COVID-19. I owned a restaurant inside of a university which I had to close." (Householder)*

Many Householders noted anxiety about the rising costs of living – bills, groceries, and housing. The housing crisis created worry for a large proportion of people surveyed. One Householder stated that the rental crisis was keeping them homeless:

> *"We have been homeless for over two months now and unable to get affordable rental accommodation here in Redcliffe." (Householder)*

Although the social determinant 'not having enough food to feed my family' was most frequently reported as 'no problem' by Householders, and one of the least common problems identified, nonetheless approximately a quarter of all survey respondents reported that it was a problem – at least a small problem and sometimes a large problem. This indicates that a considerable proportion of families are potentially going hungry, or at least sometimes. This is quite a confronting finding, especially as going without food is also a proxy indicator for potentially going without other wellbeing needs being met such as recreation, social connection, or transport. Qualitative data echoed this concern among Householders.

> *“I work part time, which makes my rent dearer because I get money off Centrelink as well. If I don’t get enough hours, then I don’t have enough money for food and bills. My kids come first, then I get behind with bills; it’s bloody hard.” (Householder)*

People described needing to budget to meet all their basic expenses, and accessing government financial supports (i.e., payments access through Centrelink, the pension) did not necessarily guarantee that all costs of living (e.g., food, medication, bills, rent) could be covered. Making hard decisions about how to spend a very limited amount of money, and which basic needs to miss out on that week, were major sources of stress and anxiety.

> *“When the COVID-19 supplement was offered, I had more money for food, medication, rent and bills, but now that’s gone, I’ve been struggling financially. I’ve been having to choose every week between food, medication, rent, or bills - constantly juggling all four and sometimes missing out [on what I need]. Very stressed about money, the pension isn’t enough.” (Householder)*

Health, access to care, and issues with alcohol and other drugs

Mental health and physical healthcare, for some Householders, was out of reach due to the out-of-pocket costs required for these services. The price of appointments and specialists impacted several respondents because they were unable to access the help, they needed to maintain good mental health and wellbeing.

Another Householder reported not being able to afford essential medication to manage their condition:

> *“No bulk-billed mental health options. No bulk-billed psychiatrist who can give me my ADHD[47] meds. Two years unmedicated because I cannot afford it. I cannot focus at work without medication and I am about to start TAFE and am worried I won’t be able to focus.” (Householder)*

Where Householders’ needs were not being met, people reported using substances to cope. Close to a quarter of Householders also noted concerns related to alcohol and other drugs, and most described the need to self-medicate using drugs or alcohol to manage their mental health. However, counter to providing relief, alcohol and drugs typically exacerbated the negative impact of their problems or concerns:

> *“I self-medicate with alcohol; my nephew probably doesn’t want me around all the time, I’m thinking about going back home. After a while you just feel like you don’t fit in.” (Householder)*

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[47] Attention Deficit Hyperactivity Disorder.

> *"My biggest thing at the moment is that when I drink so much, I don't have bad dreams and can forget the trauma. [However], I also lose my memory of the good things." (Householder)*

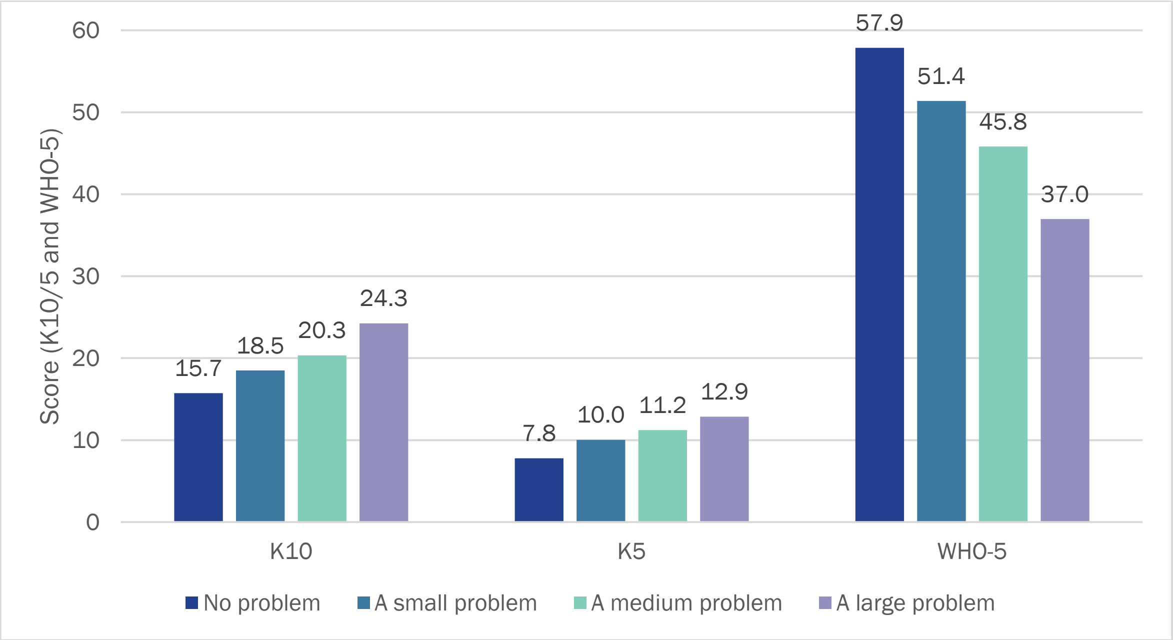
Evidence for the influence of social determinants on mental health

> ***Increased concern about all social determinants of mental health were significantly associated with lower wellbeing and higher distress.***

Considering the presence of each of these problems for Householders (and potentially others in their community), we wanted to know whether Householders' degree of concern about these determinants had an impact on mental health outcomes. Analysis showed that as concern about of each of the social determinants increased, distress (K10 and K5) significantly increased, and wellbeing (WHO-5) significantly decreased (<.05), which would suggest that **high concern about social determinants is significantly related to poorer wellbeing and higher distress. These findings indicate a significant correlation between the social determinants of mental health and measures related to mental health and wellbeing.**

As an example, Figure 25 illustrates the relationship between perceived under-employment challenges, and psychological distress and wellbeing measures. As the negative extent of unemployment (or not having enough work) increased, psychological distress, as measured by the K10 and K5 significantly increased, and wellbeing, measured by the WHO-5, significantly decreased. Approximately 13% of Householders perceived unemployment as a medium problem in their lives, and 14.9% a large problem.

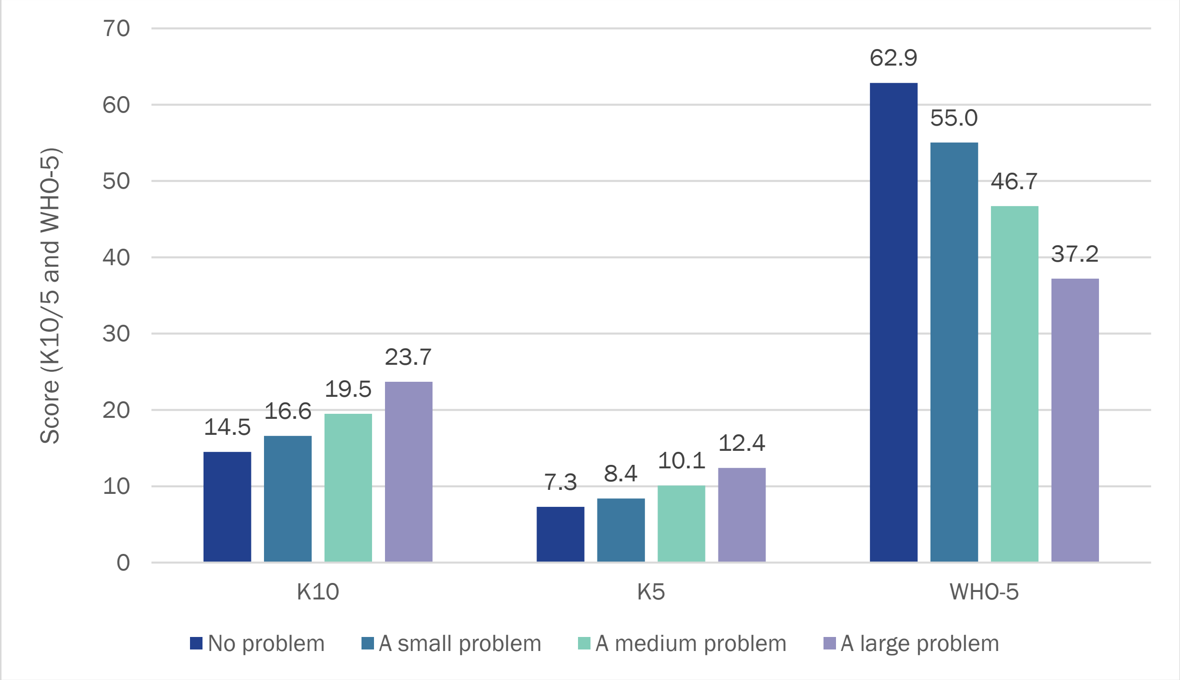
Figure 25. Extent of under-employment challenges by distress (K10) and wellbeing (WHO-5)



Note. K5 (min = 5, max=25), K10 (min = 10, max=50), WHO-5 (min = 0, max=100).

Similarly, Figure 26 shows the relationship between financial stress (not having enough money) and psychological distress and wellbeing. As the negative extent of financial stress increased, psychological distress, as measured by the K10 and K5, significantly increased, and wellbeing, measured by the WHO-5, significantly decreased. Approximately 18% rated financial stress as a medium problem in their lives, and 23.9% a large problem.

Figure 26. Extent of financial stress challenges by distress (K10) and wellbeing (WHO-5)



Note. K5 (min = 5, max=25), K10 (min = 10, max=50), WHO-5 (min = 0, max=100).

High concern about the social determinants suggests that Householders' mental health is directly impacted by these issues or inequities. The Social Determinants of Mental Health report[48], published by the WHO, discusses how individual social factors (i.e., housing, financial stability, physical health) can trigger the onset of mental health issues or mental health conditions. Greater inequality is strongly associated with mental health concerns. Where an individual is struggling to feed their family, they are enduring or at risk of homelessness, or they are under financial stress, psychological distress, low wellbeing, and possible social isolation are the likely consequences.

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[48] World Health Organization. (2014). *Social determinants of mental health.* https://www.who.int/

Loneliness

> *Approximately one-third of survey respondents reported that they felt lonely some of the time, and one in ten reported they felt lonely often.*

Loneliness can be harmful to mental health[49]; it has been linked to dissatisfaction with life[50], mental health conditions, psychological distress, suicide,[51] and poor wellbeing[52]. We define loneliness as a subjective state of negative feelings about having a lower level of social contact than desired[53]. People that are socially connected can still experience loneliness. We assessed loneliness using the Three-item Loneliness Scale (see Section 2.2).

Just over half of all Householders surveyed reported hardly ever feeling lonely, approximately one-third reported they felt lonely some of the time, and one in 10 reported they felt lonely often. The mean loneliness score was 4.7 (n = 3,783; standard deviation = 1.8) which would suggest a moderate degree loneliness, however there is no standard accepted score for which a person would, categorically, be considered lonely. Instead, literature suggests that scores above six could warrant follow up with clinical supports (i.e., GP, clinician) for further assessment[54]. Therefore, the average level of loneliness at the cohort level appeared relatively low according to standardised measures and their clinical interpretation. However, the frequent experience of loneliness and the known negative impacts are a concern for one in 10.

A related finding was around Householders' perceived need for social connection. Through asking Householders what they needed to feel safe and well[55], we found 'increasing social connection' to be crucial for improving quality of life according to Householders, and several Householders stated in their comments that they were currently enduring feelings of loneliness.

> *"I feel safe, but lonely." (Householder)*
>
> *"[I need] more connection with community and to feel support." (Householder)*
>
> *"[I need] to have someone to talk to that is of the similar/same age and culture that I can connect with." (Householder)*

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[49] Australian Institute of Health and Welfare. (2021). Social isolation and loneliness. https://www.aihw.gov.au/

[50] Schumaker, J., Shea, J. D, Monfries, M. & Groth-Marnat, G. (1993). Loneliness and life satisfaction in Japan and Australia. *The Journal of Psychology, 127,* 65–71.

[51] Hawthorne, G. (2006). Measuring social isolation in older adults: development and initial validation of the friendship scale. *Social Indicators Research, 77,* 521–48.

[52] Shankar, A., Rafnsson, S., & Steptoe, A. (2015). Longitudinal associations between social connections and subjective wellbeing in the English Longitudinal Study of Ageing. *Psychology & Health 30*, 686–98.

[53] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). *Loneliness: A sourcebook of current theory, research, and therapy.* Wiley.

[54] Hughes, M., Waite, L., Hawkley, L., & Cacioppo, J. (2004). A Short Scale for Measuring Loneliness in Large Surveys: Results from two population-based studies. *Research on Aging, 26*(6), 655–672.

[55] Survey question, *"In your own words, what do you need to feel safe and well?"*

Similarly, when survey respondents were asked to provide insight about issues troubling them[56], Householders often described feelings of loneliness and isolation resulting from various challenges or circumstances. Often, connection to family, social groups, and community was absent for these survey respondents.

> *"English language barrier – cannot communicate with others, I am lonely." (Householder)*
>
> *"Feeling lonely since my partner died and I have not been able to see my kids or grandchildren." (Householder)*
>
> *"Grieving over death of son. I am isolated from my family." (Householder)*
>
> *"I miss not being able to trust my neighbours and feeling isolated when I'm in pain. I can't push my body to get out sometimes and I'm afraid of my neighbours." (Householder)*
>
> *"I'm alone and living day-to-day." (Householder)*
>
> *"I'm lonely as I must live in shared accommodation. I have psychotic episodes and due to this, I am not allowed to live with my parents." (Householder)*

Influence of loneliness on mental health

We wanted to know whether the degree of loneliness experienced by the Householders who completed the survey was related to mental health outcomes. When levels of distress (K10 and K5) significantly increased, loneliness also increased (<.05; see Figure 27). When wellbeing (WHO-5) increased, loneliness significantly decreased (<.05).

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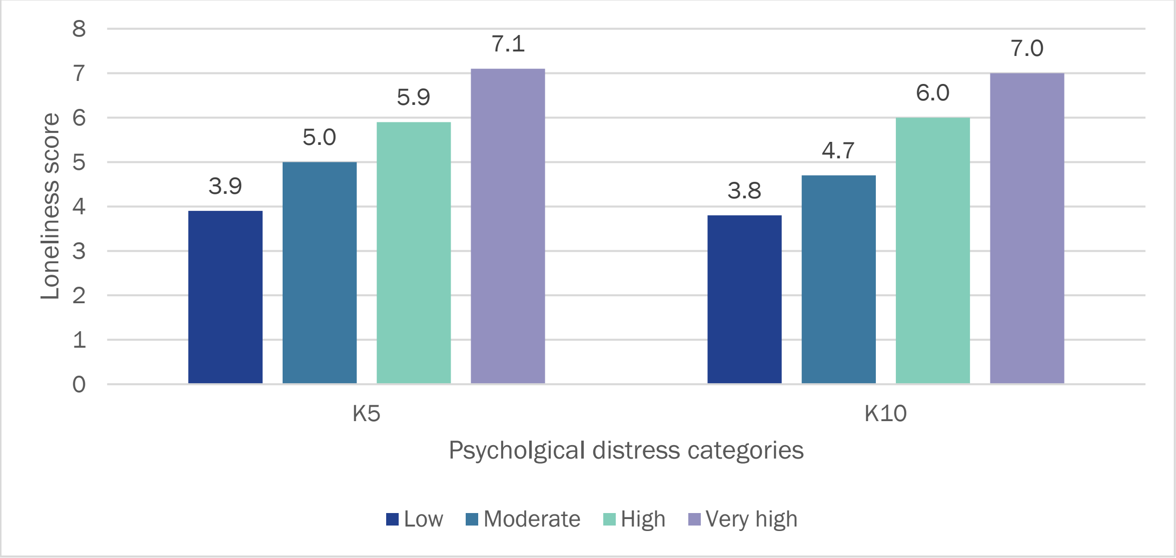
[56] Survey question, *"Are there any other issues affecting your mental health and wellbeing?"*

Figure 27. The relationship between loneliness and psychological distress (K5 and K10)



These findings indicate a significant correlation between loneliness and measures related to mental health and wellbeing. Householders who reported greater loneliness also reported higher distress and lower wellbeing.

These findings are also consistent with the literature; increased loneliness can have devastating impacts on mental health (and, by the same token, poor mental health can increase social isolation or feelings of loneliness). Although mean scores did not indicate a high incidence of loneliness among Householders, it is likely that certain cohorts within our sample would be more impacted than others. For instance, gender, age, household composition and relationship status are all possible mediators of loneliness[57]. Controlling for these variables was not in scope for this report. Other factors impacting loneliness, for example, connection via social media which was found to play a part in reducing loneliness, particularly for young people[58], were not included as part of the ACDC Project Householder survey. Additionally, loneliness is not static. Changing circumstances, including the changing impacts of COVID-19 pandemic (and subsequent lockdowns and border closures) experienced over the data collection period, can have drastic impacts of peoples' perceived loneliness.

Employment satisfaction

If relevant to their employment status, respondents were asked how satisfied they were with their total pay, job security, the work itself, the hours worked, the flexibility available to balance work and non-work commitments, and overall job satisfaction, on a scale of 1 to 10.

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[57] Australian Institute of Health and Welfare. (2021). Social isolation and loneliness. https://www.aihw.gov.au/

[58] Cauberghe, V., Van Wesenbeeck, I., De Jans, S., Hudders, L. & Ponnet, K. (2020). How adolescents use social media to cope with feelings of loneliness and anxiety during COVID-19 lockdown. *Cyberpsychology, Behavior and Social Networking, 24*(4), 250-257.

Overall, respondents were mostly satisfied with the work they do (mean score 8.6), overall job satisfaction (mean score 8.6) and job security (mean score 8.5), and least satisfied with their total pay (mean score 8.3). A total employment satisfaction score was created by averaging the individual items.

Despite mean satisfaction being high amongst the Householders, several people stated they were struggling to find worthwhile, meaningful, and secure employment[59]. Others described employment in a high demand, stressful positions which negatively impacted their wellbeing.

> *"Work stressors and demands." (Householder)*
>
> *"Anxiety about the stability of my job." (Householder)*
>
> *"An environment of bullying in my workplace and [concerns] about job security." (Householder)*
>
> *"I worry I might lose my job as some days I am not physically well enough to get up." (Householder)*

Influence of employment satisfaction on mental health

We found that unemployment (or not having enough work) and the security and quality of employment experiences were key social determinants of mental health that could negatively influence mental health outcomes (see above). We also wanted to test whether there was a significant relationship between employment satisfaction and psychological distress and wellbeing. Analysis found that as employment satisfaction decreased, distress (K10 and K5) significantly increased (Figure 28; <.05) and, as employment satisfaction increased, wellbeing (WHO-5) significantly increased (<.05).

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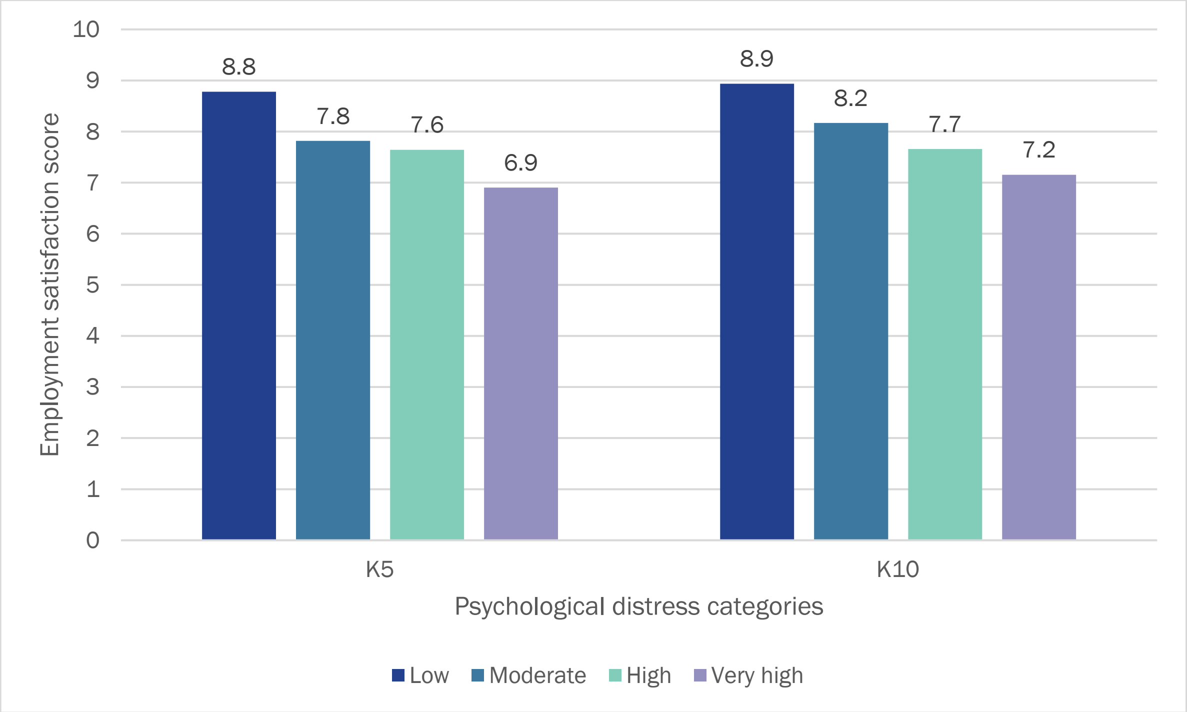
[59] Survey question, *"Are there any other issues affecting your mental health and wellbeing?"*

Figure 28. The relationship between employment satisfaction and distress (K5 and K10)



Results indicate a significant correlation between employment satisfaction and measures of mental health. Respondents with greater employment satisfaction reported lower psychological distress and higher wellbeing.

This outcome is not surprising, given many people spend most of their time in the workplace. If people are unhappy with the work they do or the culture of their workplaces, they worry their job is insecure, or they do not feel they are appropriately reimbursed for their time and expertise, this is likely to have poor outcomes for peoples' wellbeing. This finding is also consistent with published evidence[60].

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[60] Faragher, E. B., Cass, M., & Cooper, C. L. (2005). The relationship between job satisfaction and health: a meta-analysis. *Occupational and environmental medicine*, 62(2), 105–112.

5. CONCLUSION

The findings from the ACDC Project Householder Survey revealed very significant levels of mental health need. About one in three respondents rated their mental health negatively – as either fair or poor – and a similarly, a significant proportion of people, between 25% and 40%, were experiencing symptoms of high or very high distress (one in four) or low wellbeing (two in five).

The Householder Survey results also helped to uncover some of the potential drivers behind the poor mental health and wellbeing of survey respondents. Householders' concerns about various social determinants of mental health were found to be significantly correlated with high psychological distress and low wellbeing scores. Financial stress, un/underemployment, loneliness, physical health issues, housing stress, discrimination, alcohol and other drugs and food insecurity were all issues impacting the social and emotional wellbeing and mental health of people across the 17 communities. In addition, two emerging issues were also identified by survey participants as directly impacting their mental health – the impacts of the COVID-19 pandemic, and concerns about climate change.

This evidence confirms what we already know: that, in addition to individual biological and psychological factors, a broad range of social, political, economic and environmental factors impact mental health outcomes[61,62]. Addressing the social determinants of mental health means ensuring people have adequate resources to maintain quality of life and wellbeing. This means financial resources, as well as social and employment opportunities, and, importantly, a safe, secure house and neighbourhood in which to live. The significant correlations across these factors suggest that this remains key to improving the mental health of Australia's population.

People also need help when they are not coping. Whether it be clinical, professional mental health services, or community supports, people need support options to help improve their wellbeing and reduce distress, The survey sheds light on the extent to which people are already connected to services: about two thirds of people were not currently connected to any community supports or professional mental health supports.

We looked at who was more likely to be connected to supports and found fairly even service participation rates across various cohorts. Roughly 30 to 40% of people were accessing services, and between 60 to 70% of people were not, and, with some variations, these general rates seemed to apply to both men and women, to all age groups, people born in Australia or overseas, and Aboriginal people as well as non-Aboriginal people. Demographic factors did have some influence however on the types of services they were connected to. For instance, some groups, such as older people, Aboriginal and Torres Strait Islander People, were more likely to access community-based supports

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[61] Patel, V. … et al. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet, 392*(10157), 1553-1598.

[62] Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.* World Health Organization.

than younger people or non-Aboriginal people (perhaps because there are more community support options that cater for these cohorts).

Survey respondents who identified as having, or living with a mental health issue, were more likely to access supports (60%) than people without a mental health issue (17%). People living with mental health issues presumably have times when they need support to manage their condition and are more likely to be connected to the supports available, which is expected. However, around 40% of people living with mental health issues were not accessing a service or support, indicating potential unmet need. People providing support to someone with a mental health issue also were more likely to be accessing mental health supports than people who were not.

While connection to supports across demographic variables was fairly stable, aside from expected variation that could be explained by other confounding variables, there was significant variation in rates of connection to supports across the different sites. In Ipswich, for example, more than half of Householders who answered the survey reported accessing supports in the last three months. In contrast to the 22.8% of people from Clarence Valley who were connected to services and supports.

Interpreting the site-level variations in service use was challenging. Some sites with high rates of service connection were smaller towns, others were metropolitan areas; some had known vulnerable populations and others did not. More analysis is needed to properly understand the dynamics of how where someone lives impacts on access to services. This finding does suggest, however, that the community context – the social and environmental factors influencing mental health combined with the adequacy of the local service infrastructure – do influence the extent to which people access support.

In Australia's disjointed mental health system, it can be difficult to get a true estimate of how many Australians are currently accessing mental health support, making this survey data intrinsically valuable. While it cannot provide definitive statistics around service use rates in Australia, the findings do suggest that the likelihood of being connected to services does depend, partially on who you are, and to a greater extent, on where you live.

Mental health needs must be understood within their community context – they cannot be abstracted or determined in isolation from the local conditions that enable or inhibit people's wellbeing and mental health. Local level planning and community-led design of mental health services and supports is needed to ensure that the mental health supports available within a community are appropriate and in line with peoples' need.

Survey findings also indicate that to meet the gap in unmet mental health need, clinical supports are not the only answer. Across the board, people were less connected to community supports than clinical services, possibly reflecting the lack of funding available for community supports, a lack of awareness of these low cost and low threshold support options, and possibly more limited options for community supports in some communities or for some cohorts. When a sub-sample of respondents were asked about preferences for additional supports, equal preference was expressed for peer support and talking to a health professional. There may be scope to address unmet need by providing more support options, and in particular more community support options, which are sometimes preferred.

While there are multiple access barriers preventing people from getting the help they need, the survey findings also point to opportunities to intervene. Of the Householders who had wanted to seek help for their mental health in the last 12 months, nearly half (43.2%) were unable to get the care they needed. When asked about the reasons for this, survey respondents said ‘preferring to self-manage’, ‘fear, embarrassment or shame’, and ‘not knowing where to get help’ were the most common barriers. These barriers can be addressed through community awareness and promotion activities. As the ACDC Project has demonstrated, initiating opportunities to have informal conversations about mental health in community settings, directly reaching out to people, and providing information about mental health supports and services, can go a long way in allowing more people to find the support they need.

The significant correlation found between the social determinants of mental health and mental health and wellbeing is also a reminder that the risk factors associated with developing a mental health condition are not equally distributed[63] and are often associated with social inequities[64]. Providing affordable, easy to access and low threshold supports and services in communities that are under-resourced or experiencing disadvantage could effectively reduce the high levels of psychological distress experienced across Australian communities, while also reducing the access barriers that effect so many people experiencing mental health need.

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[63] Productivity Commission. (2020). *Mental health: Productivity commission inquiry report.* Australian Government.
[64] Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry,* 26(4), 392-407.