Home truths about mental health in Australian communities:
What we learnt about mental health from doorknocking conversations

Findings from the Assisting Communities through Direct Connection Project survey, Report update Round Two and Three

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 CSI UWA 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.

Centre for Social Impact

The Centre for Social Impact is a national research and education centre dedicated to catalysing social change for a better world. CSI is built on the foundation of three of Australia's leading universities: UNSW Sydney, The University of Western Australia, and Swinburne University of Technology. Our **research** develops and brings together knowledge to understand current social challenges and opportunities; our postgraduate and undergraduate **education** develops social impact leaders; and we aim to **catalyse change** by drawing on these foundations and translating knowledge, creating leaders, developing usable resources, and reaching across traditional divides to facilitate collaborations.

Disclaimer

Earlier ACDC Project Research Report (2023)

The current report provides key findings from aggregated data collected over the course of two Project rounds (Round Two and Round Three). This report builds upon our earlier work, published here, which examined preliminary research findings at the completion of Round Two of the ACDC Project.

See: Hooper, Y., Kaleveld, L. & Lester, L. (2022). *Home truths about mental health in Australian communities: What we learnt about mental health from doorknocking conversations. Preliminary findings from the Assisting Communities through Direct Connection Project survey, Round Two.* Centre for Social Impact UWA. https://doi.org/10.25916/dqsx-br39

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1. INTRODUCTION

This updated Report presents preliminary research 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 27 Australian communities over three Project Rounds. This Report provides key findings from aggregated data collected over the course of two project rounds (Round Two and Round Three; 23 sites). Throughout this Report, we will refer to the Round Two report for additional information and context, which can be accessed here.

During the ACDC Project, several 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 from Round Two, '*Doorknocking for mental health: Evaluating a novel outreach approach for addressing mental health'* [1] and Round Three[2].

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[3].

Round 1 of the ACDC Project was an opportunity to pilot the Project in four sites; to experiment with the proactive outreach approach, but also, test the applicability and suitability of the survey for Householders. In Rounds Two[4] and Three, the People Connectors visited an additional 17 and 6 sites (respectively). The survey was shortened and refined between all Rounds.

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[1] 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

[2] Kaleveld, L., Szabo L. & Hooper, Y. (2024). Doorknocking for mental health: Evaluating a novel outreach approach for addressing mental health. Round Three update of the Assisting Communities through Direct Connection Project. Centre for Social Impact, The University of Western Australia. https://doi.org/10.60836/bsm5-tz14

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

[4] 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.

2. RESEARCH DESIGN & METHODOLOGY

For a detailed description of the design and methodology employed in this Project, refer to our earlier research report publication. The Section below provides a very brief overview of the design and methodology employed for the ACDC Project.

Research and evaluation design
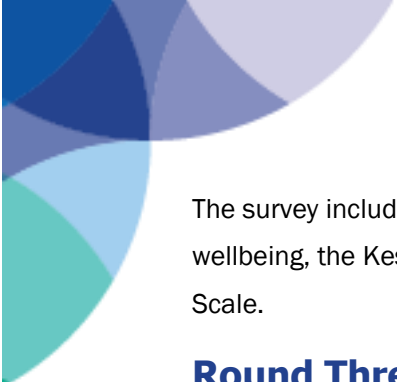
In summary, The Research and Evaluation Framework for the ACDC Project, developed by the ACDC Project Research and Evaluation Working Group, outlined two main tasks: evaluation and research (see Figure 1).

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

The evaluation investigated how effective the Project was for Householders and their communities, examining activities like pre-engagement and doorknocking processes. The research component focused on data from the ACDC Householder Survey (collected by People Connectors whilst doorknocking), which explored mental health needs, challenges, and experiences among respondents. The current report details the findings of this survey. Ethics approval was obtained from the University of Western Australia Human Research Ethics Committee (2020/ET000171).

The Householder Survey covered various aspects, including demographics, social determinants of mental health, wellbeing, psychological distress, loneliness, perceived support needs, barriers to access, current support systems, and preferences for additional support. While most questions used frequency or rating scales, respondents also had opportunities to provide open-ended responses. We examined open-ended responses from the survey to better understand and contextualise challenges and experiences with mental health support.

The survey included validated questionnaires like the WHO-5 Measure of Wellbeing (WHO-5) for wellbeing, the Kessler Psychological Distress Scale (K10/K5), and the UCLA Three-item Loneliness Scale.

Round Three survey revisions

The Householder survey underwent revisions prior to Round Three of the ACDC Project. This resulted in some additional questions presented for participants in Round Three, while other questions from Round Two were omitted. Changes to the Round Two survey were made for several reasons. Predominantly, the survey was lengthy – this was reported by People Connectors and Householders, the ACDC Project Team, and the ACDC Steering Committee. Analysis of all variables from Round Two suggested that many of the questions were collecting similar datapoints (e.g., concern about local community issues). Moreover, the ACDC Project Team and CSI UWA Team evaluated the precedence of each of the datapoints to assess which were most aligned with the key research questions and through this process, there was an acknowledgement that some (more time intensive) questions were less relevant. For example: where people sought support in the last 12 months; mental health condition diagnoses; several questions examining different aspects of employment satisfaction, etc, were removed from the survey. Questions added to the Householder survey for Round Three concerned: better defining mental health support barriers (informed by lived experience and qualitative data from Round Two); additional demographic information (disability, carers, LGBTQIA+ persons, first responders); and additional social determinants of interest, etc.

For the current report, we provide mostly amalgamated data from Round Two and Three to answer the research questions. We have also included questions/demographics pertaining exclusively to Round Two participants, and equally, only to Round Three. This is a direct result of survey revisions, though changes/revisions to reporting and analysis are presented both below and throughout the current report.

Round Three methodology

For Round Three, CSI UWA and the ACDC Project Team developed a means of tracking the proportion of paper-based to face-to-face survey submissions by asking People Connectors to specify the type of survey on Qualtrics prior to submission. We saw that most surveys completed were paper-based or online via the website (68%), and the remaining, face-to-face. Evidence has demonstrated that how surveys are completed has the potential to influence respondents' responses[5]. We tested for potential divergence across validated measures and demographic variables, finding significantly higher distress where people completed surveys face-to-face ($p > 0.05$). Additionally, Aboriginal and/or Torres Strait Islander respondents and those who spoke a language other than English at home

[5] Weijters, B., Schillewaert, N. & Geuens, M. Assessing response styles across modes of data collection. *J. of the Acad. Mark. Sci.* 36, 409–422 (2008). https://doi.org/10.1007/s11747-007-0077-6

and/or were born outside of Australia were more likely to complete surveys face-to-face with a People Connector than complete them independently (p>0.05).

Reporting Round Three updates

The current report builds upon our initial findings of Round Two. The key research questions considered for Round Two were:

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?

These same questions guided our analysis of amalgamated Round Two and 3 data however, we made some adjustments to how we examined these questions. In the Round Two report, to answer *who is accessing supports?* we compared differences across demographic variables and access to mental health supports (community mental health supports and/or support from a professional or service versus those not accessing any supports). Initially, the aim was to identify who was more likely to be accessing help for their mental wellbeing. This analysis considered the total sample and therefore did not reflect whether there was a mental health need. For the current report, we analysed data only where participants had identified a time in the last 12 months where they wanted to seek help: '*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?*'. The aim of this revised approach was to identify who was most likely to access support for a mental health need across different demographics.

Within this same research question (*who is accessing supports?),* the initial report sought to examine rate of access across *two* different types of support (community mental health supports or support from a professional or service) with the intention of investigating who is most likely to access which kind of help. Because people could also report accessing both supports, we examined frequencies as mutually inclusive across demographics. However, for the current report, we created mutually exclusive categories to examine help-accessing across the participants: (1) accessed a professional or service only; (2) accessed a community mental health support only; and (3) accessed both a professional or service and a community mental health support. The aim of this revised approach was to highlight the proportion of people who utilised both types, and only one type, of mental health support. There were no additional criteria imposed on the analysis.

3. WHO ANSWERED THE SURVEY?

3.1 Round Two

In Round Two (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. In previous reports, we stated the 'total sample' as all valid survey entries collected in Round Two n = 4,027 however, for our final analysis (combining Round Two and 3 data), we excluded any cases with a less than 75% completion rate, reducing the Round Two sample size to n = 3,882.

3.2 Round Three

In Round Three (6 sites), People Connectors collected 347 Householder Surveys through doorknocking bur the most significant proportion of Householder Surveys were completed via a paper-based option (n = 718) where People Connectors left the surveys with Householders to be completed and collected at a later stage (often Householders leaving completed surveys in their letterboxes for collection). Additionally, 32 people responded to the Self-Administered survey linked to the ACDC Project website. Together, the total sample for Round Three of the ACDC Project was n = 1,097. This sample excluded any cases with a less than 75% completion rate.

For the current report, we combined Round Two and 3 data (n = 4,979; 21 ACDC Project sites). Sample sizes varied across questions due to alterations made to the survey between Rounds, and because most survey items were optional (and only a very few forced responses from participants, e.g., consent to survey). The following Section presents demographics of the Householders who responded to the Householder Survey in Round Two and 3 of the ACDC Project. Table 1 shows the key demographic information captured by the survey.

Table 1. Key demographic data of survey respondents

Demographics	Finding
Gender n = 4,936	A total of 58.2% of respondents were female, 41.4% were male, and 0.4% identified another way.
Age n = 4,942	Most survey respondents were aged between 25 to 54 years (56.6%). A further 31.5% were aged 55 to 74, 9.9% aged 75 to 85, 7.9% 18 to 24 years, and the remaining 1.9% were older than 85 years.
Aboriginal and/or Torres Strait Islander peoples n = 4,804	9.2% of survey respondents indicated they were Aboriginal and/or Torres Strait Islander.

LGBTQIA+ Communities* n = 1,012	7.1% of respondents reported being a part of the LGBTQIA+ community.
Place of birth (n = 4,937) and language spoken at home (n = 4,946)	29.1% (n = 1,439) of Householders reported that they were born outside of Australia and 21.0% (n = 1,037) spoke a language other than English. Most surveys were completed in English (n = 4,951), 24 surveys were completed in Chinese, two in Arabic and two Vietnamese.
Mental health (n = 4,720) and disability (n = 1,052)*	31.3% (n = 1,480) of respondents reported having, or living with, a mental health condition (diagnosed or undiagnosed). 20.8% (n = 219) reported having a disability. Of these respondents, 25.5% (n = 54) were receiving support through the National Disability Insurance Scheme (NDIS). For those not receiving support, 22.4% (n = 33) had attempted to seek support through the NDIS.
Single or multiple person household n = 4,574	26.0% of respondents reported living alone.
Accessibility and remoteness (Accessibly/Remoteness Index of Australia; ARIA) n = 4,923	Most respondents resided in a Major City (51.2%), followed by Inner Regional (29.9%) and Outer Regional (18.9%).
Labour force status n = 4,919	Nearly half of all respondents were employed (49.0%). Many (46.9%) were not in the labour force, and 4.2% reported being employed.
Provides care or support to someone with disability, a chronic condition, or mental health concern* n = 1,011	23.2% of respondents reported they were a carer/support to someone with disability, a chronic condition, or mental health concern.

Note. *new demographic variables presented in Round Three of data collection.

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. For additional context, see our initial report.

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[6]. 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[7],[8]. 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.

The following analyses are provided in our initial reporting of Round Two data. All figures below have been updated to reflect the amalgamation of datasets however, we note that any changes made were minor[9].

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 = 4,887) perception of their mental health. Results, roughly, fall into three groupings: one third of respondents reported their mental health and wellbeing to be

> One third of Householders rated their overall mental health and wellbeing as fair or poor

'good' (33.4%); one third to be 'very good' (22.6%) or 'excellent' (10.4%); and the last third rated their mental health as either 'fair' (24.3%), or 'poor' (9.3%). This was consistent with Round Two findings.

This means that approximately 34% 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

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[6] Victorian Department of Health. (2018). Mental illness and wellbeing. https://www.health.vic.gov.au/
[7] 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
[8] Kessler, R. C., et al. (2003). Screening for serious mental illness in the general population. *Arch Gen Psychiatry, 60*(2),184-9.
[9] Changes made to decimal places.

Figure 2).

Figure 2. Householders' self-assessed mental health and wellbeing (n = 4,887)

Figure 2. Householders' self-assessed mental health and wellbeing (n = 4,887)
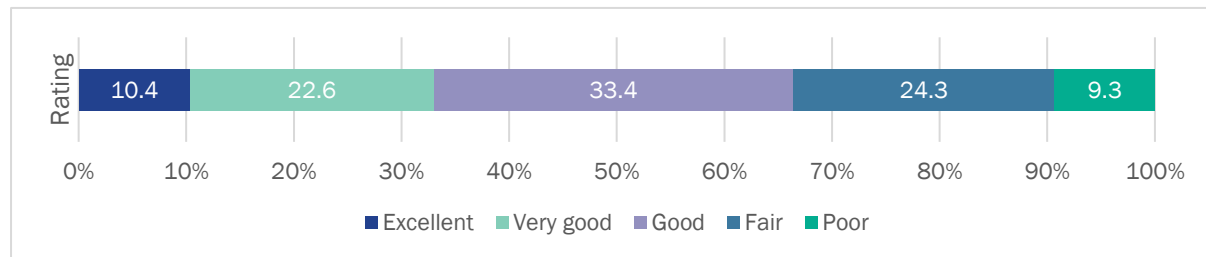
Wellbeing

Average wellbeing (WHO-5) scores of the ACDC Project sample (n = 4,765) was 53.0 (standard deviation = 25.5[10]) suggest that, on average, Householder wellbeing was consistent with what has 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

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

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 [11]. 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). Wellbeing findings were consistent with our earlier Round Two report.

Figure 3. Possible depression based on WHO-5 score (n = 4,765)

Note. Scores <50 suggest possible depression.

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 30 or over indicate very high distress[12]. The mean K10 score of all ACDC Project survey

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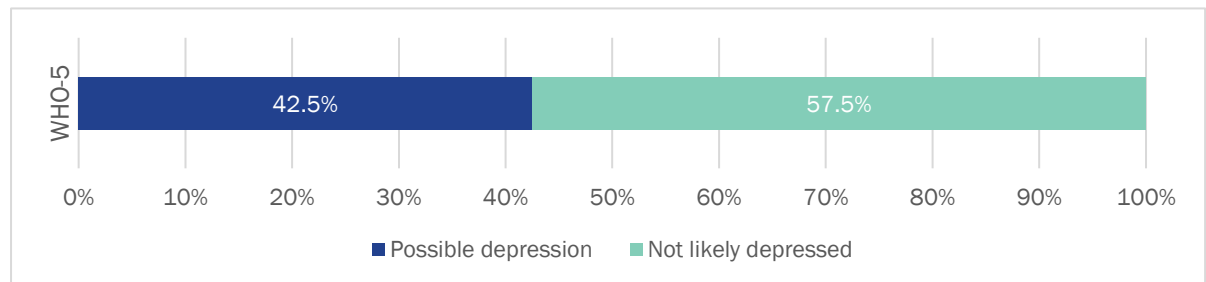[10] We acknowledge the wide range of values and therefore variability of WHO-5 scores within our sample.
[11] Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and Psychosomatics*, *84*(3), 167–176.
[12] 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).

respondents was 17.8 (n = 4,155; standard deviation = 7.9), indicating, on average, moderate levels of distress among Householders[13]. The combined proportion of respondents experiencing high or very high psychological distress was one in four (25.5%), approximately half of the respondents reported low distress (51.7%), and the remaining (22.7%), moderate distress.

Distress categories of the ACDC Project are presented in Figure 4, alongside ABS Census data collected between 2020 and 2021.[14] Significance testing suggested there were meaningful differences between low distress of Householders (43.2%) and ABS norms (63.3%; p<0.05) however no other categories were statistically different across the samples.

Figure 4. Psychological distress categories, ACDC sample against ABS data (n = 4,155)
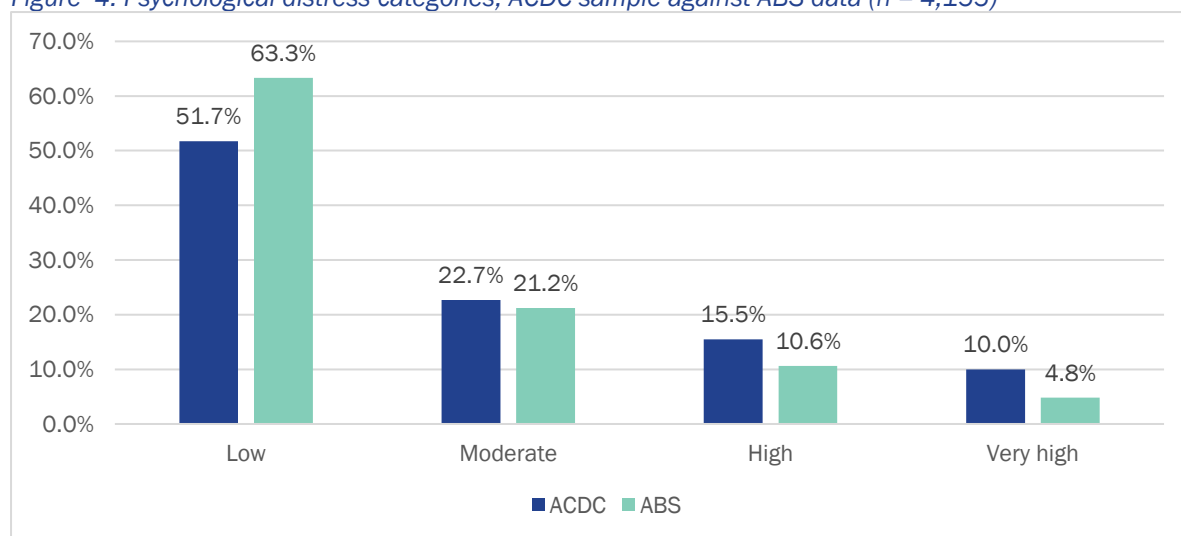
Note. K10 scores: Low = 10-15, Moderate = 16-21, High = 22-29, Very high = 30+; excludes K5 scores.

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[15] and was established through consultation with Aboriginal peoples. The average K5 score in our sample was 10.64 (n = 405; standard deviation = 5.09; 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

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

score of 10.7 was lower than the mid-point of the scale (15) suggesting that respondents could have been experiencing lower distress than what is 'typical' for this measure.

13 Excluded Aboriginal and/or Torres Strait Islander respondents who completed the K5.
14 Australian Bureau of Statistics. (2021). *First insights from the National Study of Mental Health and Wellbeing, 2020-21.* https://www.abs.gov.au/
15 Australian Bureau of Statistics. (2019). *National Aboriginal and Torres Strait Islander Health Survey methodology.* https://www.abs.gov.au/

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 (37.3%) 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[16]. 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 (n = 405)
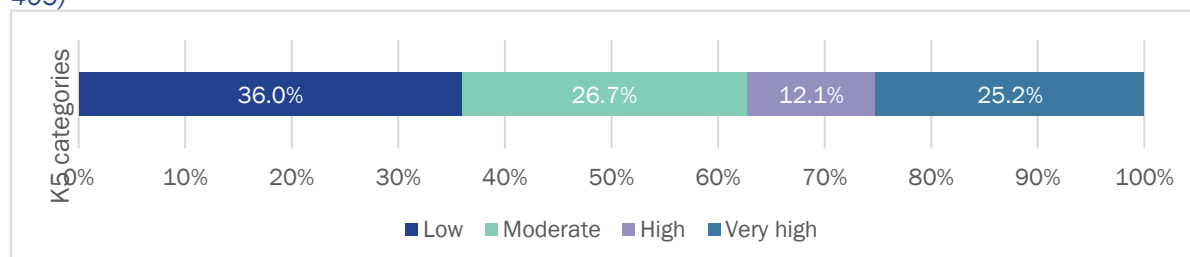
Note. K5 scores: Low = scores <8, moderate = scores 8 to 11, high = scores 12 to 14, very high = scores >15.

Psychological distress findings were consistent with our earlier Round Two report.

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 deemed reliable, but they only capture 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?'*).

> *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*

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:

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

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 (58.0%; n = 2,654) 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 (23.7%) of all respondents reported having their needs met, and the remaining 18.3% reported unmet needs (see Figure 6). These percentages are consistent with those presented in our initial report.

Figure 6. Percentage of Householders with no need, met need, and unmet need in the last 12 months (n = 4,578)
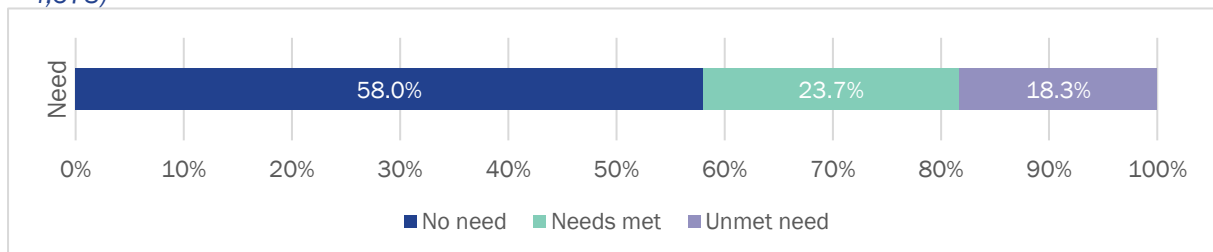
For Householders with unmet needs, we cannot infer from these two questions whether they were able to actively seek support. Some people may have avoided seeking help due to stigma, uncertainty about where to go or who to talk to, or concerns about cost. Others may have approached a service or centre, only to be turned away due to the high demand of services across the country. It is concerning that even 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 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*

> **The majority (68.2%) of Householders reported not accessing any supports in the last three months**

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 = 4,639). The majority (68.2%; n = 3,163) of Householders reported not accessing any supports in the last three months. Approximately 14%

accessed only a local community support; 9.4% accessed support from only a professional or service; and the remaining 8.3% accessed help from both a professional or service and a local community support. These data were similar to those presented in our initial report.

Figure 7. Householders connected or not connected to local community supports and mental health services (n = 4,639)
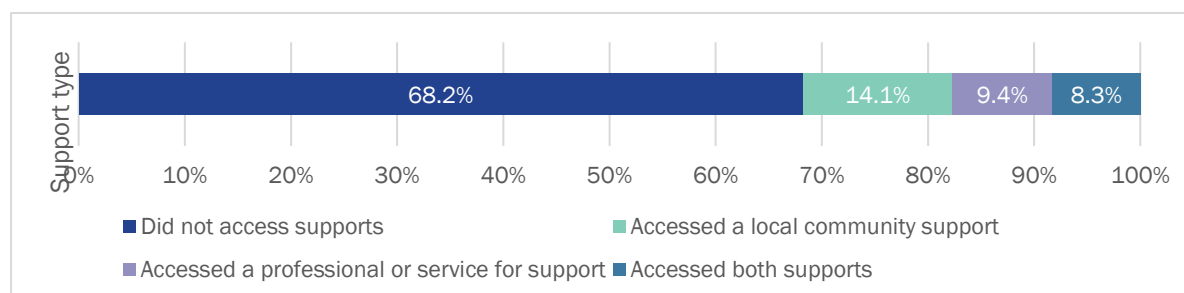
Who is accessing supports?

In our Round Two report, we combined 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 to compare to those who were reportedly not accessing any supports. The aim of these following analysis was to identify who was most likely accessing help for their mental health and wellbeing, according to demographic data we collected from the survey. These findings can be found here.

For the current report, we added an additional condition to our sample; that people indicated that they had a **mental health need** (included respondents who selected 'yes' to *'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?'*). The aim of this analysis was to identify who was most likely accessing help, of those who reported a mental health need. Therefore, the following analysis considers connection to supports across different cohorts with an identified mental health need. This section provides novel data and thus we cannot draw any comparisons to our initial report.

Age

Some small discrepancies were identified between the Householders based on their age – see Figure 8 below. Around 61% of Householders aged between 45 to 54 were connected to a mental health support, and this was the highest proportion across different ages, suggesting this age group is more likely to access support where there is a need. There were no statistically significant differences found between the age ranges (p>0.05).

Figure 8. Connected to support by age (n = 1,898)
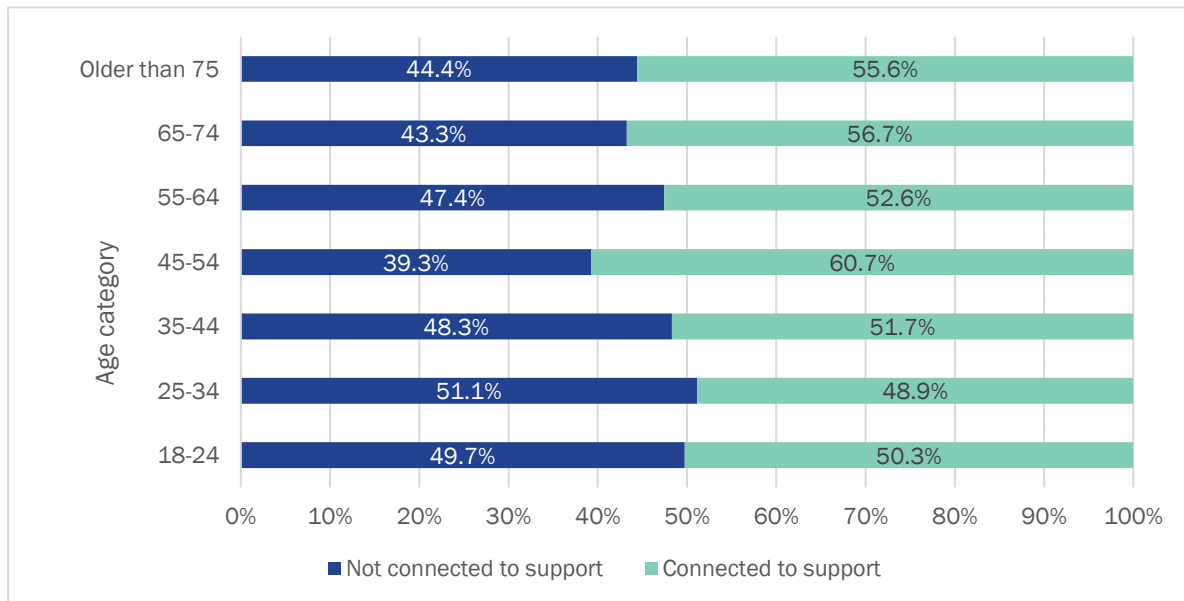
Gender

The rate of connection to mental health support was consistent across female and male respondents (54.2% and 51.7%, respectively; see Figure 9). There were no significant differences identified between genders (p>0.05). Non-binary respondents seemed to be the most connected to support (69.2%) compared to male and female respondents however, the sample size of this cohort was far too low to make true comparisons (n = 13).

Figure 9. Connected to support by gender (n = 1,892)
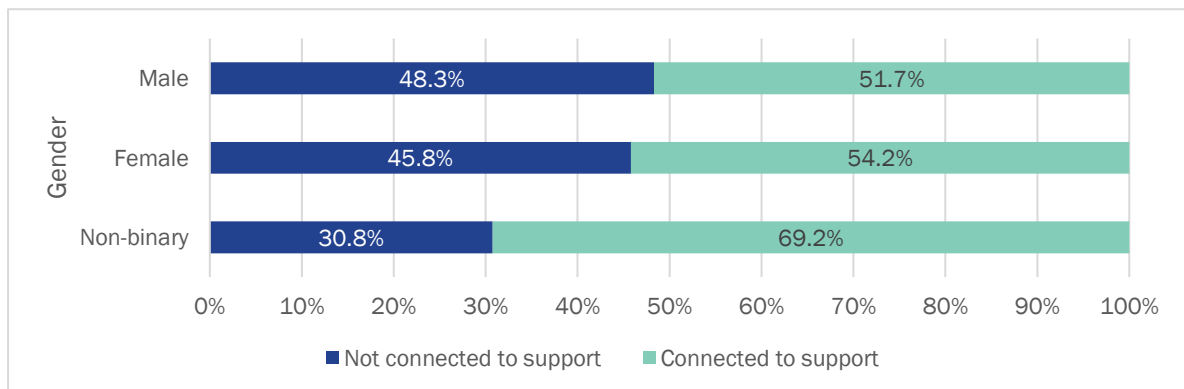
Cultural background

Of the 209 Aboriginal and/or Torres Strait Islander respondents with a mental health need in our analysis, nearly half were not connected to any supports in the last three months (Figure 10). No statistical differences were identified between Aboriginal and/or Torres Strait Islander and non-Indigenous respondents in terms of the percentage connected to supports (p>0.05).

Figure 10. Connected to support by Aboriginal and/or Torres Strait Islander peoples and non-Aboriginal and/or Torres Strait Islander people (n = 1,837)

Aboriginal status

| Aboriginal and/or Torres Strait Islander | 46.4% Not connected to support | 53.6% Connected to support |
| Not Aboriginal and/or Torres Strait Islander | 46.9% Not connected to support | 53.1% Connected to support |
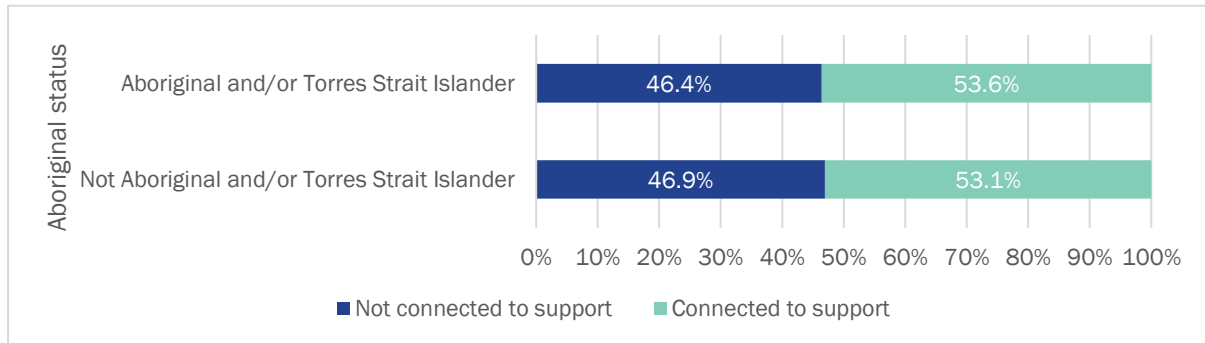
Frequency of connection to mental health supports differed across place of birth (Australia and outside of Australia), and language spoken at home. People born outside of Australia, and/or who spoke a language other than English at home, were less connected to supports despite a mental health need (Figure 11). These differences identified were statistically significant (p<0.05).

Figure 11. Connected to support by place of birth (born in or outside Australia; n = 1,898)

Born in Australia	44.0% Not connected	56.0% Connected
Born outside of Australia	55.7% Not connected	44.3% Connected
Language other than English	57.3% Not connected	42.7% Connected
Only English	44.4% Not connected	55.6% Connected
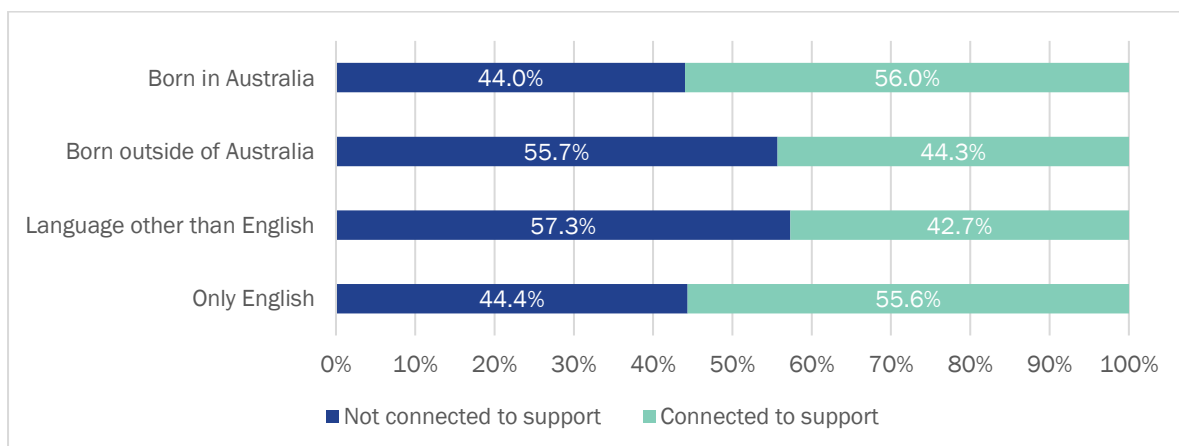
Labour force status

Frequency of connection to mental health supports differed across participants based on their labour force status (Figure 12). Respondents who reported being employed were the least connected to supports (52.0%). Those not in the labour force were the most connected to supports (60.3% reported connection to a support). Differences identified across the labour force categories were statistically significant (p<0.05).

Figure 12. Connected to supports by labour force category (n = 1,867)
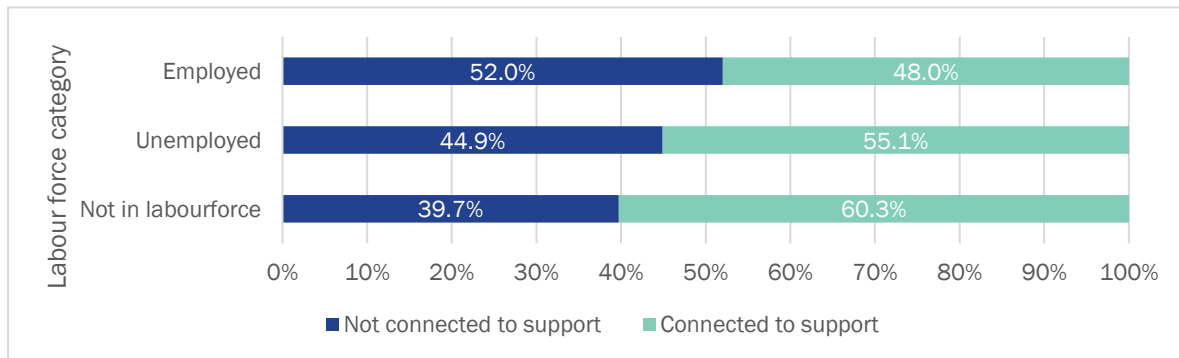
Mental health concerns

Having, or living with, a mental health issue/concern/condition significantly impacted whether respondents were connected to supports (p<0.05; Figure 13). Those who identified living with a mental health issue were most likely to be connected to supports (68.4%).

Figure 13. Connected to supports by living with a mental health issue (n = 1,610)
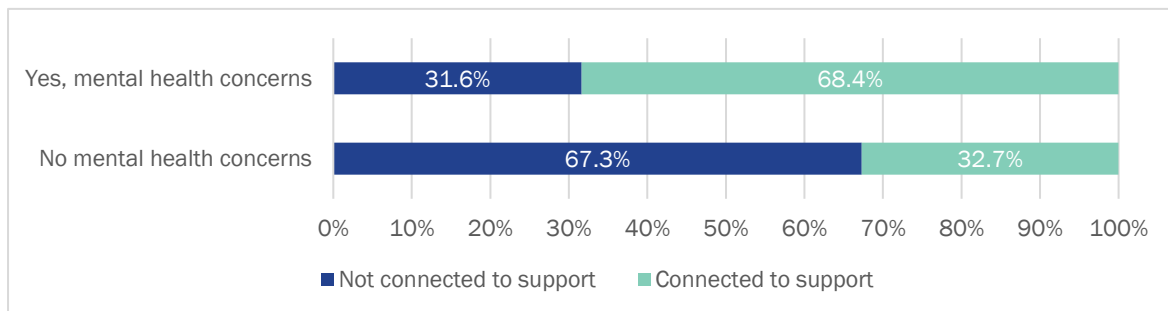
Disability

Respondents with disability were significantly more likely to be connected to mental health supports than those without disability (75.9% and 41.0%, respectively; p<0.05; see Figure 14).

Figure 14. Connected to supports by disability (n = 364; Round Three data only)
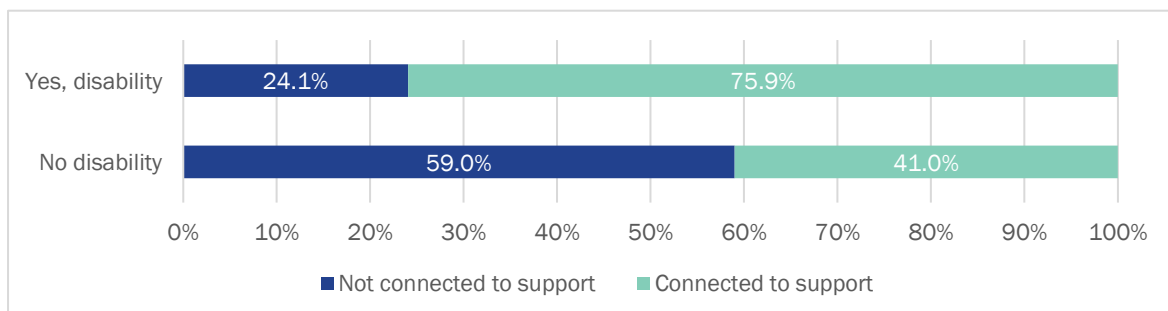
Caring

The Round Three survey asked Householders, *'Do you provide support to someone with disability, a chronic condition, or mental health issue?*'. Those with a need who reported caring for someone were significantly more likely to be connected to supports than those who were not caring for someone (p<0.05; Figure 15).

Figure 15. Connected to supports by caring (n = 370; Round Three data only)
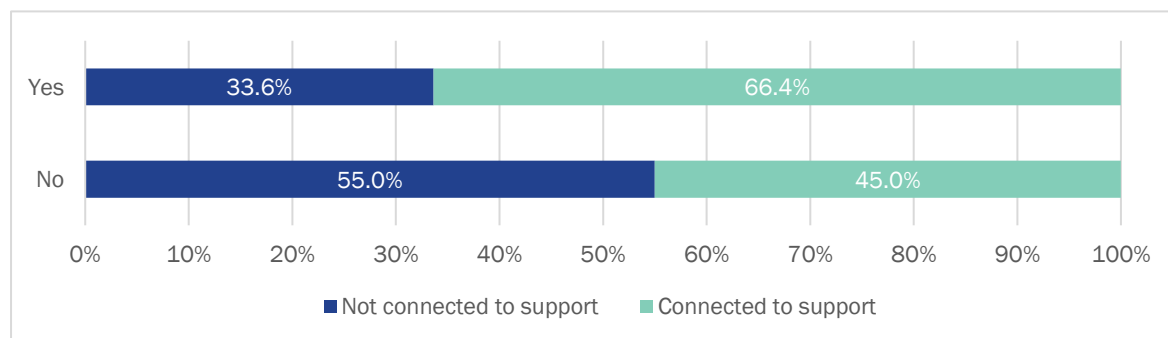
Geographical remoteness

The ABS Accessibility and Remoteness Index of Australia[17] (ARIA) measures remoteness relative to a location's access to services[18] (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'.

Respondents living in the most regional (Outer Regional) were less connected to supports compared to those in less remote areas – both Inner Regional and Major City areas (see Figure 16). These differences across ARIA classifications were statistically significant ($p<0.05$).

Figure 16. Rate of connection to support by remoteness (n = 1,869)
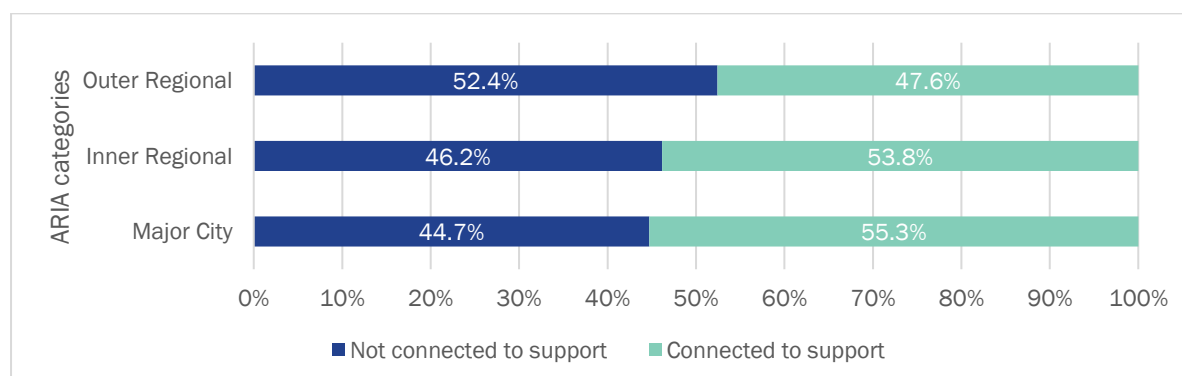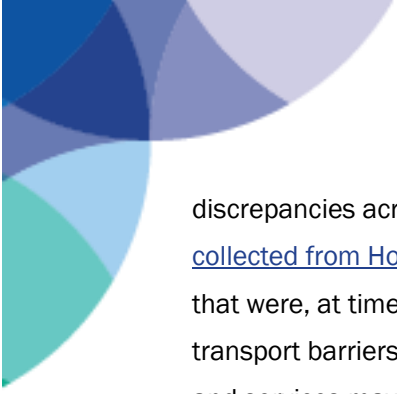
Site level variation

The proportion of connection to support varied significantly across the ACDC sites (see Figure 17; $p<0.05$). Of those who indicated a mental health need, Householders residing in the City of Stirling were among the most connected to supports (69.3% had accessed supports in the last three months) whereas only 37% of Householders in Cumberland had recently accessed supports.

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

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[17] Australian Bureau of Statistics. (2016). *Remoteness Area index.* https://www.abs.gov.au/statistics/
[18] Specifically, access to service centres along road networks.

discrepancies across sites. This is not in the scope of the current Report. However, qualitative data collected from Householders in Round Two described difficulties accessing services and supports that were, at times, based on the conditions in their local communities (e.g., distance to services and transport barriers), which lends additional evidence to suggest that rate of connection to supports and services may vary considerably across sites.

Figure 17. Rate of access to supports – ACDC site

ACDC Project site	Not connected to support	Connected to support
Cumberland	63.0%	37.0%
Cabramatta	60.9%	39.1%
South Burnett	59.3%	40.7%
Georgetown	59.1%	40.9%
Bendigo	55.3%	44.7%
Clarence Valley	52.4%	47.6%
Dandenong	52.0%	48.0%
Mareeba	51.9%	48.1%
Greenacre	51.2%	48.8%
Salisbury	50.0%	50.0%
Palmerston	50.0%	50.0%
Port Adelaide	50.0%	50.0%
Tonwsville	48.7%	51.3%
Burnie	46.0%	54.0%
Ballajura/Beechboro	41.9%	58.1%
Wollondilly	40.7%	59.3%
Toowoomba	40.2%	59.8%
Redcliffe	39.6%	60.4%
Fitzroy	36.5%	63.5%
Ipswich	34.7%	65.3%
Macedon Ranges	33.9%	66.1%
Stirling	30.7%	69.3%

■ Not connected to support ■ Connected to support

Does support utilisation vary across different cohorts?

In Round Two, we examined the rate of access to 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 and disability. The aim of these analyses is to present the frequency of access across these subsamples. Because people could also report accessing both supports, we initially examined these frequencies as mutually inclusive categories – as found here in our previous report.

For this current report, we created mutually *exclusive* categories to examine accessing help by demographic variables, including: accessed a professional or service only; accessed a community mental health support only; and accessed both a professional or service and a community mental health support. The aim of this revised approach was to highlight the proportion of people who utilised both types, and only one type, of mental health support. As these analyses are also novel to what was presented in our first report, we are unable to draw any comparisons between findings.

Figure 18 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=1,476). Forty-four percent of these respondents reported accessing a local community support only, 30% a professional or service only, and approximately one in four had accessed both.

Figure 18. Type of support accessed across the sample of Householders accessing support (n = 1,476)
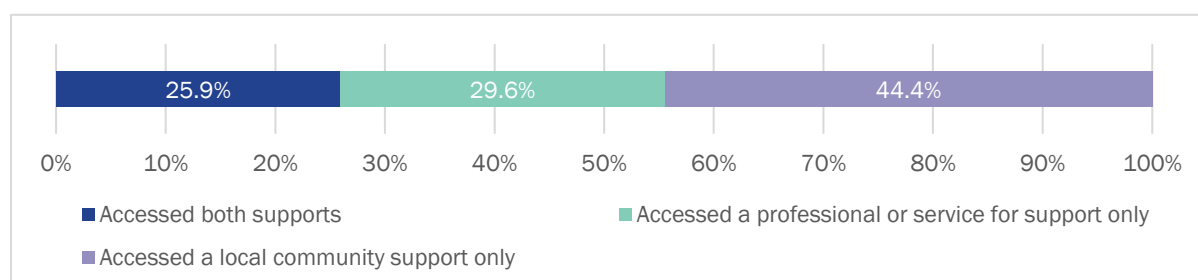
Types of supports accessed by age

As illustrated in Figure 19, type of support accessed was fairly consistent across age – excluding 35–44-year-olds and 65- 85-year-olds who more frequently accessed support exclusively from a professional or service in the last three months. Differences observed were statistically significant across the age ranges ($p<0.05$)

Figure 19. Type of support accessed across age categories
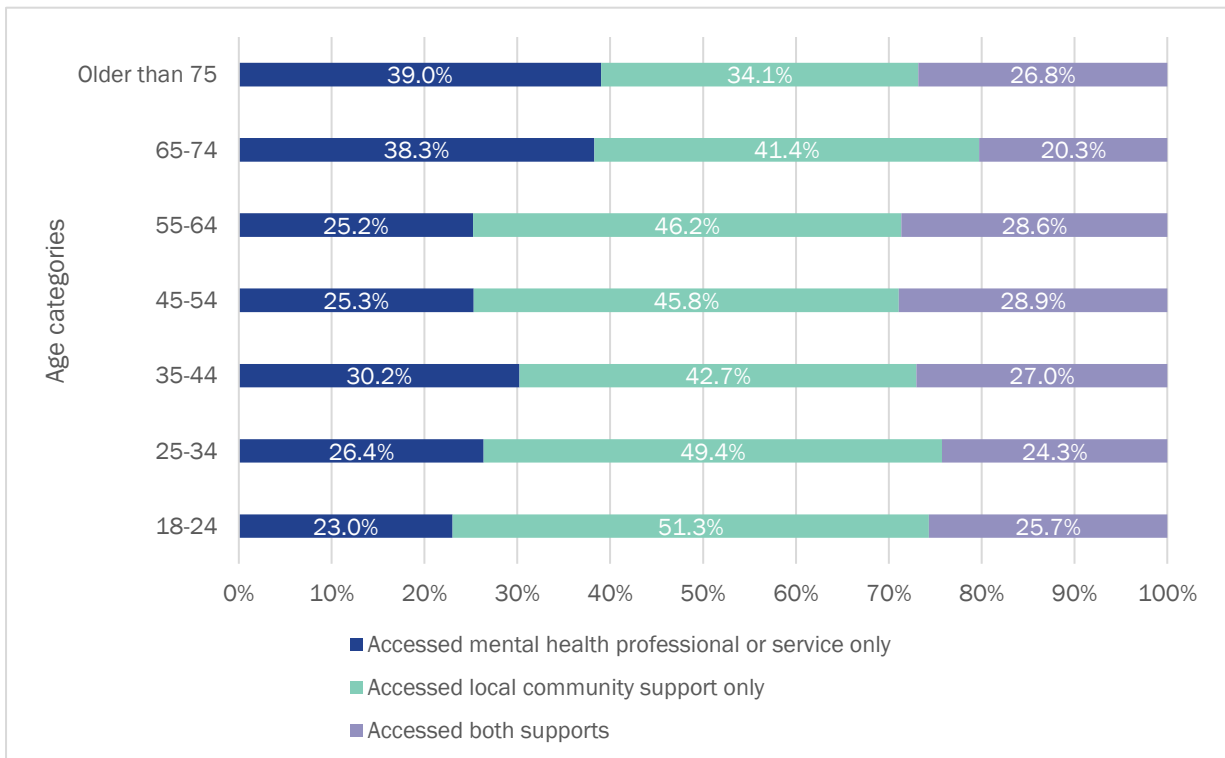
Types of supports accessed by gender

All genders indicated they had greater access to (or preference for) combining both support types – see Figure 20. Males and non-binary folk reported more frequent use of community supports only, compared to females. However, gender diverse Householders were significantly underrepresented (n=10) and therefore meaningful comparisons cannot be inferred. No significant differences were observed between genders and type of support accessed (p>0.05).

Figure 20. Type of support accessed across gender categories
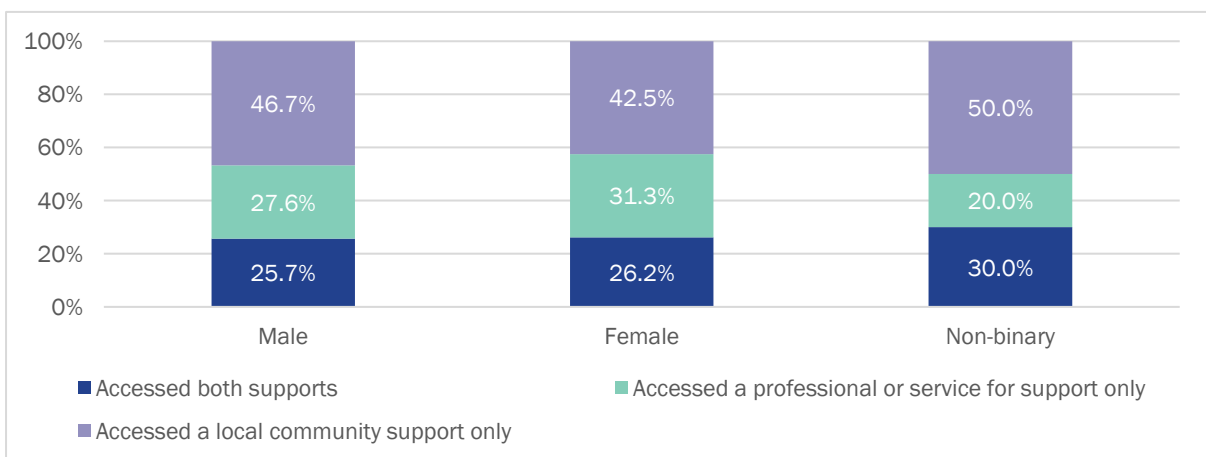
In Round Three of the Project, we collected demographic data concerning LGBTQIA+ folk. These are presented below in Figure 21 (Round Three data only; n = 245). Although our sample of people in the LGBTQIA+ community was very low (n = 27), this group seemed to be much less connected to only a

community support only, compared to those who did not identify as LGBTQIA+. Differences were not statistically different (p>0.05).

Figure 21. Type of support accessed across LGBTQIA+ status
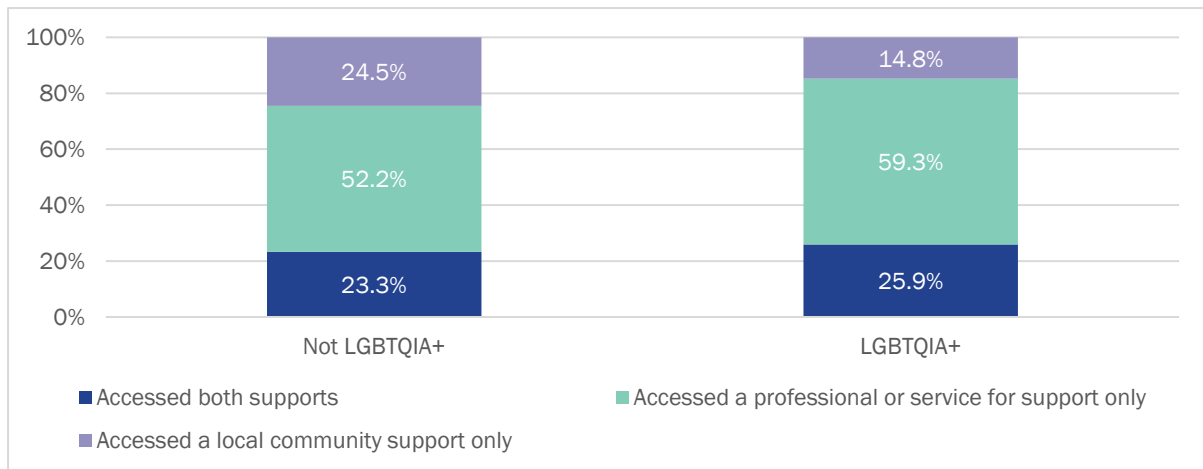
Cultural background and types of support accessed

Aboriginal and/or Torres Strait Islander respondents were more frequently accessing both types of supports compared to non-Indigenous respondents (see Figure 22). Differences between support accessed presented below were statistically significant (p<0.05).

Figure 22. Type of support accessed across Aboriginal and/or Torres Strait Islander status
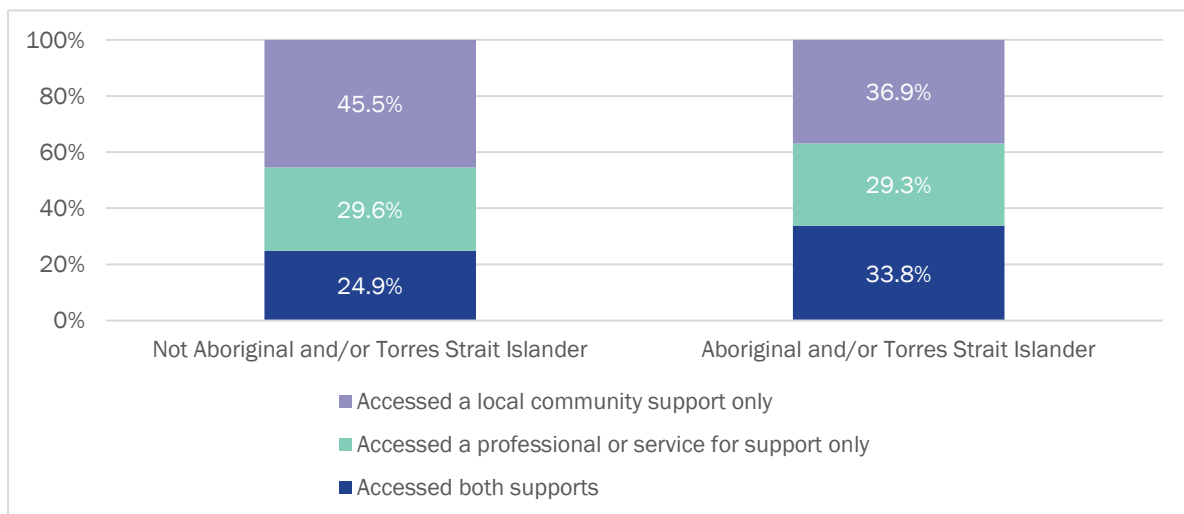
Types of support accessed were similar among those born within Australia, and those born outside Australia, and the most common support accessed was support from a professional or service – see Figure 23. Moreover, these proportions were similar against language spoken at home (only English versus a language other than English). Differences observed between place of birth and languages spoken at home were not statistically different (p<0.05).

Figure 23. Type of support accessed across languages spoken at home & place of birth
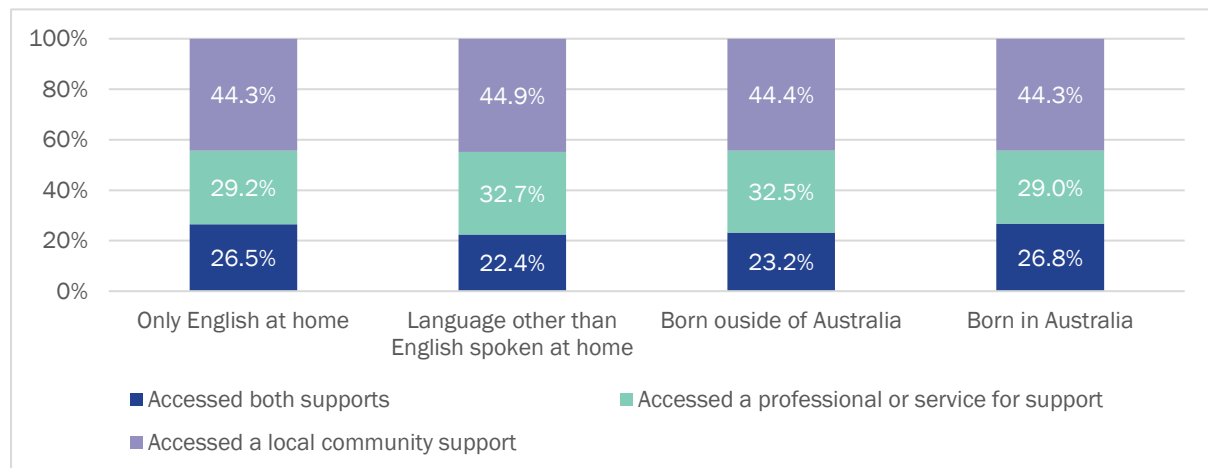
Types of supports accessed by mental health and disability

Type of supports accessed differed significantly across mental health (p<0.05) and disability (p<0.05). Those without a mental health condition or concern, and those who reported being unsure, were most frequently utilising a professional or service only (45% and 54%, respectively; see Figure 24). Householders who identified with a mental health condition or concern were the most likely to be accessing both types of supports.

Figure 24. Type of support accessed across mental health concerns/conditions
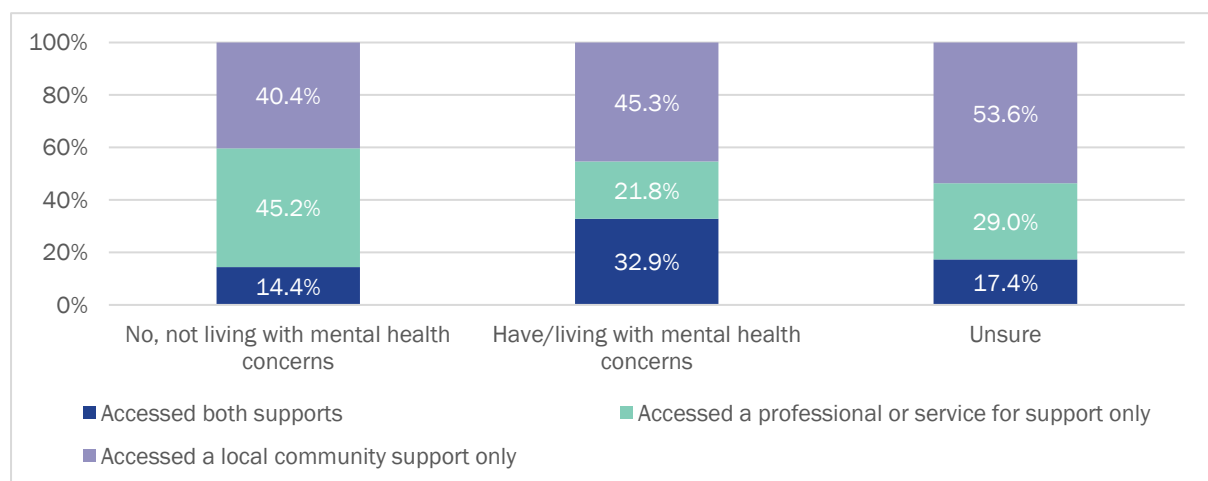
We found significant variation in support type across those with and without disability (see Figure 25). About a third of Householders with disability were accessing both types of supports, compared to only 18% of people without disability. Moreover, a much smaller proportion of Householders (16%) with disability were accessing a local community support only, compared to 31% of Householders without disability.

Figure 25. Type of support accessed across disability
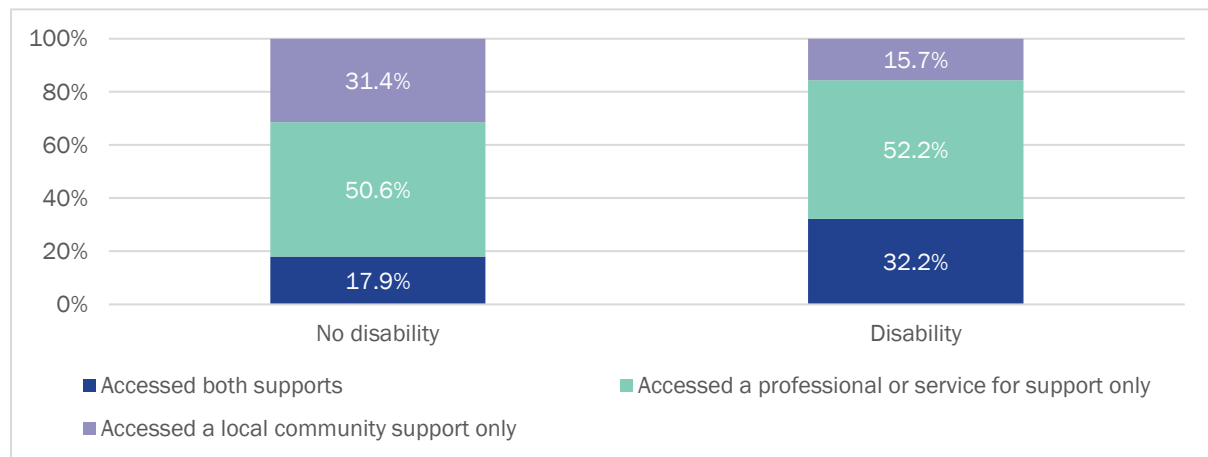
Types of supports accessed by caring responsibility

Those caring for someone with disability, a chronic condition or mental health issue accessed similar support types than those who were not caring for someone (p>0.05; see Figure 26).

Figure 26. Type of support accessed across caring for someone
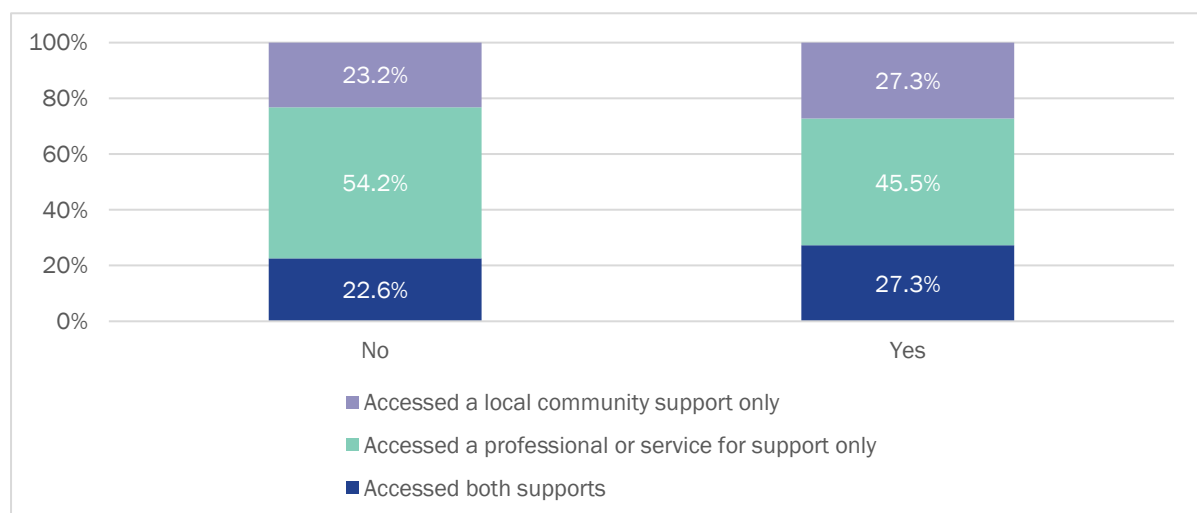
Types of supports accessed by geographical remoteness

Figure 27 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 differed statistically across ARIA categories (p>0.05). Those residing in an outer regional area were most frequently accessing exclusively a community support and least frequently accessing only a mental health professional or service. Rates of access to both types of supports were fairly consistent across areas.

Figure 27. Type of support accessed across remoteness (ARIA)
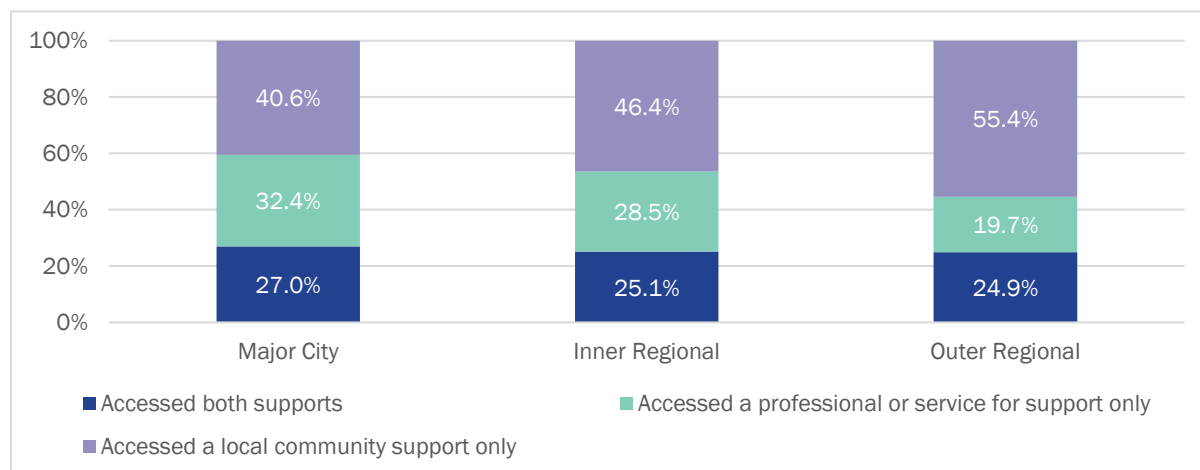
Sources of mental health support

Round Two respondents were asked about their use of mental health supports, *"In the last 12 months, have you received support for your mental health and wellbeing from any of the following?"*, with respondents permitted to select all choices that applied. 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. For an overview of these supports, please see our initial report.

Is there a need for additional support?

Both Round Two and 3 asked respondents to consider whether they would benefit from additional supports for their mental health and wellbeing. Figure 28 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 (58.3%), followed by peer support (52.4%) – and this was consistent with our initial findings. Still important, but less of a priority, was support in the form of practical assistance (37.6%) and having an alternative to emergency departments (30.0%; though, not everyone will need to access emergency/crisis support for their mental health). In Round Three, we added additional options for people to select (if applicable): access to a pet/animal companion and support to strengthen cultural ties. As illustrated below, these were noteworthy preferences for additional supports, according to Householders.

Figure 28. Additional supports that would benefit Householders who had recently accessed support
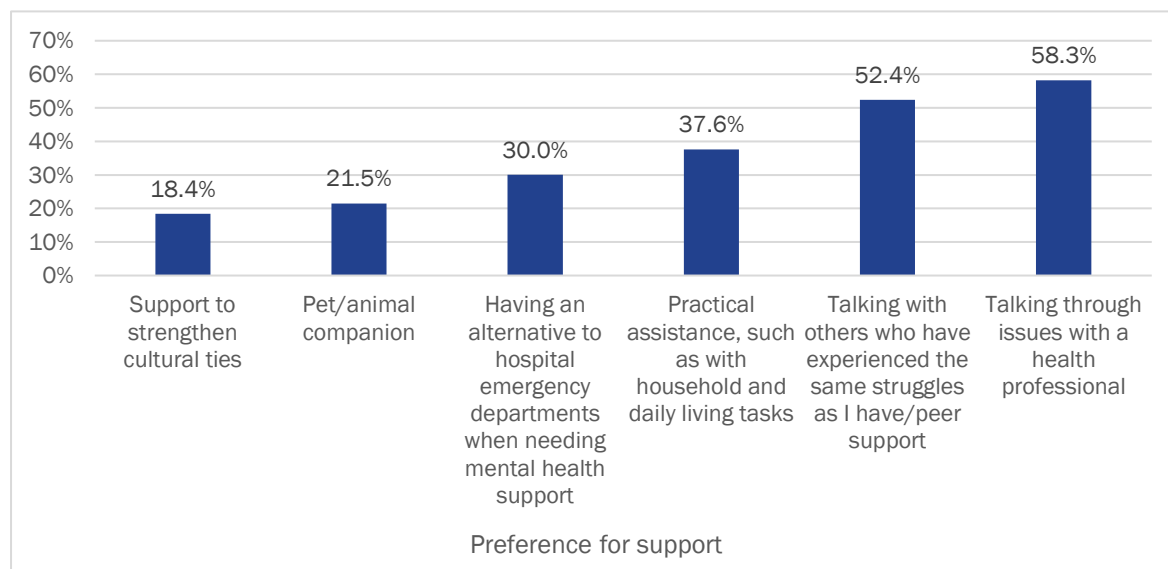
Note. Multiple responses permitted. 'Support to strengthen cultural ties' and 'Pet/animal companion' were only asked in Round Three (and % was calculated using the respective total sample size n = 261).

Notably, of the Householders who reported not being connected to any clinical and/or local community supports in the last three months (n=2,835), 22.3% felt that they would benefit from more support for their mental health and wellbeing, and a further 23.6% were unsure. This was lower than our Round Two reporting where approximately 30% of people felt they would benefit from additional supports.

In Round Three, 26 Householders responded to an open-ended survey question that queried what other supports might be helpful. Financial concerns were highlighted by several Householders (n = 6), and most felt that they would need these concerns managed to improve their mental health:

> *"I am struggling to afford to keep my cat and would love a dog, so I feel safer in my home"* – Householder (Round Three)

For one Householder, they felt that the options previously utilised had been unhelpful, but they were unsure of what they needed to address their wellbeing:

> *"Nothing given to me has worked, I'm not an expert I just need help"* – Householder (Round Three)

Three people discussed concerns related to physical health conditions; suggesting improving mental health and wellbeing would be associated with addressing physical pain/symptoms. For others (n = 3), reducing loneliness and increasing social connection was identified as a priority.

Mental health need and accessing support(s)

We sought to examine differences in mental health wellbeing (using standardised measures) between Householders who had recently (the last three months) connected with supports, and those

who had not. Of the Round Two and 3 ACDC sample, 1,476 people were defined as being currently connected to supports, and 3,163 were not currently connected to supports (31.8% and 68.2%, respectively). Table 2 presents K10/K5, WHO-5, and loneliness across these two groups.

Table 2. n, mean and SD of K10/K5, WHO-5, and loneliness scores across those accessing and not accessing supports

Measure	n	Mean	Std. Deviation
WHO-5*			
Currently accessing supports	1,415	43.8	25.0
Not currently accessing supports	3,051	57.7	24.4
K10*			
Currently accessing supports	1,211	21.4	9.0
Not currently accessing supports	2,701	16	6.7
K5			
Currently accessing supports	146	12.5	5.1
Not currently accessing supports	230	9.6	4.8
Loneliness*			
Currently accessing supports	1,432	5.4	2.0
Not currently accessing supports	3,061	4.4	1.7

Note. *Significant difference $p < .001$

Analysis to test for difference between mean scores[19] 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, based on K10 scores (p<.001), than those who were not accessing supports. K5 scores were not statistically different between the two groups. This is consistent with findings from our initial report, excluding K5 differences; K5 means were not found to be statistically significant at the completion of Round Two. As we noted in the Round Two report, more analysis is needed to understand the relationship between high distress, low wellbeing, loneliness, and service utilisation. This could indicate that people with mental health need are accessing services; that people accessing mental health support have more 'severe' mental health concerns than those who do not. On the other hand, are the services they are accessing effective in reducing their distress, and/or increasing their wellbeing? These questions cannot be answered by data we have.

Disability

For Round Three, we asked respondents '*Do you have a disability?*' where 20.8% responded yes. Analysis of mental health measures found that people with disability reported significantly higher distress scores (K10; p<.001) and significantly higher loneliness scores (p<.001) than those without

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[19] Bonferroni correction applied (0.05/4) $p = 0.0125$.

disability[20]. There were no statistical differences found between WHO-5 Wellbeing scores across these groups. We did not test for difference between K5 scores due to low sample sizes (n = 32 Yes, disability and n = 54 No disability). See Table 3 below.

Table 3. n, mean and SD of K10/K5, WHO-5, and loneliness scores across those with and without disability

Measure	n	Mean	Std. Deviation
WHO-5			
Do you have a disability? Yes	206	42.3	28.1
Do you have a disability? No	807	59	26.5
K10*			
Do you have a disability? Yes	160	23.7	10.3
Do you have a disability? No	708	16.3	7.3
Loneliness*			
Do you have a disability? Yes	196	5.7	2.2
Do you have a disability? No	783	4.4	1.7

Note. *Significant difference $p<.001$

Of the Householders with disability (n = 219), only a quarter were receiving support from the NDIS. Those who were not receiving NDIS support, 22.4% had attempted to seek support via this scheme. We searched "NDIS" across open-ended/string variables to identify potential problems surrounding the scheme.

Lack of access to appropriate, effective NDIS services was identified by several Householders (n = 8) when asked about local community issues/concerns.

> *"The lack of service providers for care under the NDIS scheme. It is very limited for personal assistance care up here and a lot of the staff seem to be unqualified or lack of experience to care for clients." – Householder (Round Three)*

In the context of issues affecting mental health and wellbeing, 13 people noted concerns directly related to the NDIS. For many, poor wellbeing was exacerbated by being rejected by the NDIS scheme, despite really needing more help to cope.

> *"Tried to access the NDIS but was rejected and I have not enough support or family around here." – Householder (Round Three)*

For others who were engaged with the NDIS, they felt unsupported, distressed, and invalidated by their experience with the scheme.

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[20] Bonferroni correction applied (0.05/3) *p* = 0.016.

"… I don't really know what support there is and my first experience with NDIS wasn't good. They messed me around and were not at all helpful." – Householder (Round Three)

"… I nearly gave up on the NDIS because of the structure and disrespect. The support workers can be so disrespectful, and they just don't listen or care. A lot of them are just doing the job with no experience/understanding of what people are actually going through. Initially the whole process made my mental health worse." – Householder (Round Three)

The NDIS was only viewed favourably by one Householder who simply noted that they were doing OK because they had access to the scheme.

When *asked "what kind of support do you think would be helpful in improving your mental health and wellbeing?'* four people specified the NDIS. This was in the context of gaining access to a support that would assist with coordination of services, help to secure employment, or financial assistance.

Overall, the NDIS was perceived very negatively by Householders in Round Three of the Project; not only was the scheme not able to meet peoples' needs, but in some instances, it perpetuated distress and poor wellbeing.

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. Often those who need mental health care are more oppressed by systems/institutions and therefore, face inequalities in healthcare outcomes and access to resources[21]. Of the Householders not connected to mental health supports, three in 10 (n = 887; 29.3%) reported wanting to seek help in the last 12 months[22]. Of those Householders who reported a desire to seek mental health support, 53.5% did not get the support they needed – a large proportion of unmet need, and consistent with our findings following completion of Round Two.

Barriers

In Round Two, we asked Householders, *"Why did you not get the care you needed?"*, and provided a list of barriers to accessing help, with respondents able to select multiple responses. 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. These data are presented here, in the Round Two report.

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[21] 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.*
[22] 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?'*

4.3 Factors associated with mental health and wellbeing
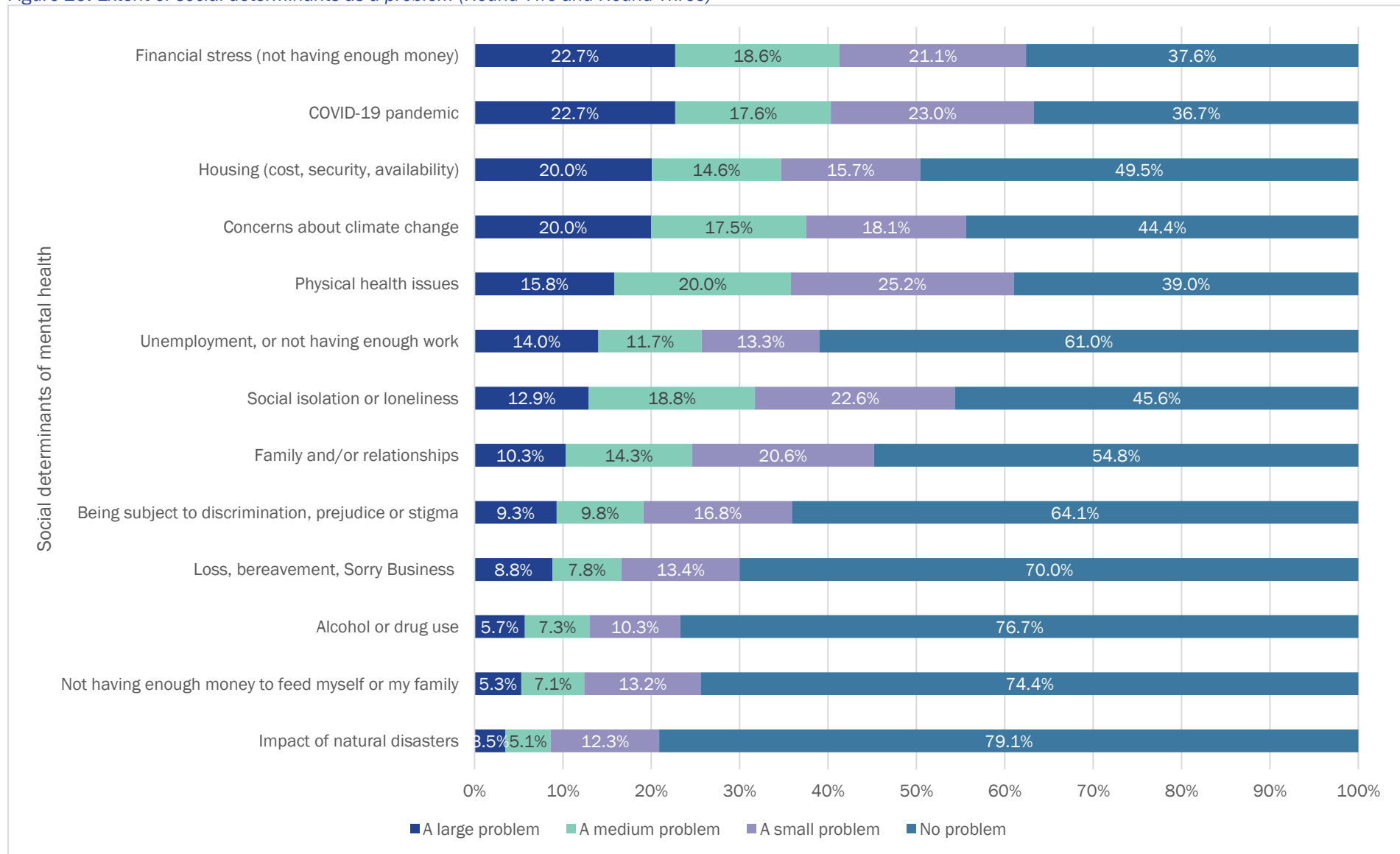
Social determinants of mental health

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 *29*).

In addition to asking respondents to rate the extent that each of the social determinants were problematic for them personally, we also provided Householders with an opportunity to describe the impact of other social determinants of mental health and wellbeing by asking, *"Are there any other issues affecting your mental health and wellbeing?"* and collecting their qualitative responses, written by Householders (quotes). 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 different ways. The Round Two report also explored concerns in greater depth utilising qualitative responses. Common challenges related to the following: the COVID-19 pandemic; financial stress and food affordability; and health, access to care, and issues with alcohol and other drugs.

For Round Three, we added two additional social determinants to the Householder survey - Loss, bereavement, Sorry Business; and Impact of natural disasters. These are presented below (calculated using Round Three sample sizes)[23].

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[23] All other social determinants presented are combined (Round Two and 3 data)

Figure 29. Extent of social determinants as a problem (Round Two and Round Three)

Chart: Social determinants of mental health (y-axis) vs percentage (x-axis 0%–100%)

Social determinant	A large problem	A medium problem	A small problem	No problem
Financial stress (not having enough money)	22.7%	18.6%	21.1%	37.6%
COVID-19 pandemic	22.7%	17.6%	23.0%	36.7%
Housing (cost, security, availability)	20.0%	14.6%	15.7%	49.5%
Concerns about climate change	20.0%	17.5%	18.1%	44.4%
Physical health issues	15.8%	20.0%	25.2%	39.0%
Unemployment, or not having enough work	14.0%	11.7%	13.3%	61.0%
Social isolation or loneliness	12.9%	18.8%	22.6%	45.6%
Family and/or relationships	10.3%	14.3%	20.6%	54.8%
Being subject to discrimination, prejudice or stigma	9.3%	9.8%	16.8%	64.1%
Loss, bereavement, Sorry Business	8.8%	7.8%	13.4%	70.0%
Alcohol or drug use	5.7%	7.3%	10.3%	76.7%
Not having enough money to feed myself or my family	5.3%	7.1%	13.2%	74.4%
Impact of natural disasters	3.5%	5.1%	12.3%	79.1%

### Evidence for the influence of social determinants on mental health

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 (<0.05), 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. This was consistent with findings from Round Two of the Project.

Analysis of data concerning the two additional social determinants supplied to participants in Round Three of the Project suggested a relationship between loss, bereavement and Sorry Business and psychological distress and wellbeing (see Figure 30). As concern relative to loss, bereavement and Sorry Business increased, psychological distress, as measured by the K10 and K5, significantly increased, and wellbeing, measured by the WHO-5, significantly decreased. Around 8% of Householders reported this as a medium problem and 9% as a large concern.
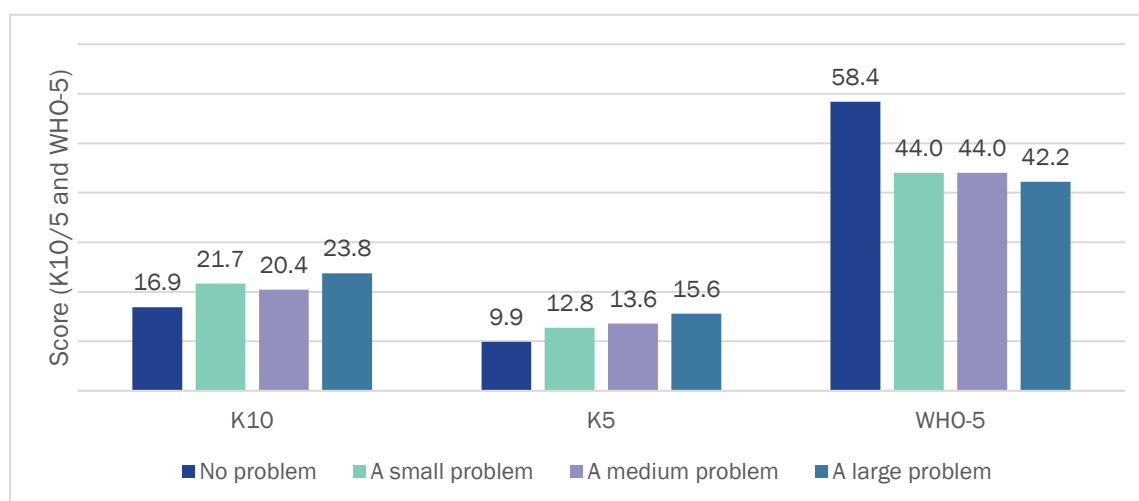
Figure 30. Loss, bereavement, Sorry Business by distress (K10) and wellbeing (WHO-5)
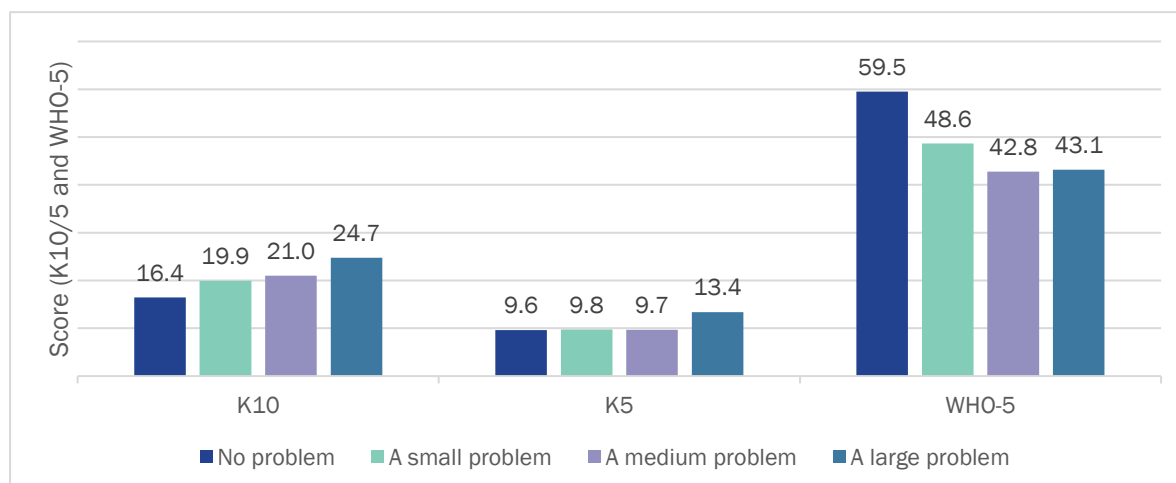
Note. K5 (min = 5, max=25), K10 (min = 10, max=50), WHO-5 (min = 0, max=100).

As the negative impacts of natural disasters increased, psychological distress (K10 and K5 scores), significantly increased, and wellbeing (WHO-5 scores) significantly decreased – see Figure 31

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[24], 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 experiencing homelessness or at risk of homelessness, or they are under financial stress, psychological distress, lower wellbeing, and possible social isolation.

Safety and cost of living crisis

Analysis of Round Three qualitative data concerning the *question "Are there any other issues in your local community that you are concerned about?"* found that two additional reoccurring themes: concern about safety and concern about the cost of living.

Safety was a primary concern at the local community level for Round Two respondents; 72% noted that safety (crime, feeling comfortable with people in the neighbourhood) was a problem. Of these Householders, 24% felt this was a medium problem and 27% felt it was a large problem. Due to time constraints in Round Three, the survey did not ask about community problems in the same manner (instead opting for an open-ended survey item). However, without prompt, approximately 47% of Householders in Round Three detailed difficult and enduring issues surrounding their sense of safety in the community. This comprised worries about crime – mostly home invasions and petty theft – and there was a general sense of anxiety about people's sense of safety within their own homes.

> *"General safety, opportunistic crimes [is a concern]. I have had to start chaining things down as I have an open garage and people steal my tools from there. We don't have a gate or*

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

anything. I have had to put cameras up too, but the police don't do anything about these smaller crimes." – Householder (Round Three)

"Crime – houses in my street regularly targeted e.g., attempted break ins, property damage, theft. Police – believe that several of them aren't doing their job e.g., abuse their power, lack integrity, lack the experience or common sense for situation." – Householder (Round Three)

The cost-of-living crisis was a significant concern for Householders; qualitative responses described general stress related to finance, worry about groceries/bills, and the increasing cost of housing (both rentals and owner-occupied mortgages).

"Housing is too expensive. Apartments or units not worth about that price has been out and people of rentals do not have a say with high rise / inflation." – Householder (Round Three)

Loneliness

Loneliness can be harmful to mental health[25]; it has been linked to dissatisfaction with life[26], mental health conditions, psychological distress, suicide,[27] and poor wellbeing[28]. We define loneliness as a subjective state of negative feelings about having a lower level of social contact than desired[29]. People that are socially connected can still experience loneliness. We assessed loneliness using the Three-item Loneliness Scale.

The mean loneliness score was 4.7 (n = 4,787; standard deviation = 1.9) 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[30]. 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. These findings concerning loneliness are consistent with what was presented in Round Two of reporting. This section of our initial report also provided a more in-depth analysis of the link between loneliness, social connection, and wellbeing.

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

If relevant to their employment status, respondents were asked how satisfied they were with their job overall, on a scale of 1 to 10. Respondents were mostly satisfied with the work they do (mean score 7.6) however despite mean satisfaction being higher amongst the Householders, several people stated they were struggling to find worthwhile, meaningful, and secure employment[31]. Others described employment in high demand, stressful positions which negatively impacted their wellbeing.

Consistent with Round Two findings, there was a significant relationship between employment satisfaction and psychological distress and wellbeing in the amalgamated dataset. As employment satisfaction decreased, distress (K10 and K5) significantly increased (<0.05) and, as employment satisfaction increased, wellbeing (WHO-5) significantly increased (<0.05). Respondents with greater employment satisfaction reported lower psychological distress and higher wellbeing.

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

5. CONCLUSION

The current report builds upon what was inferred in our initial report where the ACDC Project Householder Survey revealed significant mental health need. The amalgamation of Round Two and Round Three data did not result in any significant changes to our key findings, or the answers to the research questions posed. Akin to what has been previously stated, the ACDC Project Householder Survey has shown that many people rate their wellbeing fairly negatively (when asked to consider their overall mental health and wellbeing), a significant proportion of people reported low wellbeing (WHO-5), and moderate to high psychological distress (K10).

New analyses of collated Round Two and Round Three data sought to identify who was most likely accessing (and not accessing) help of those who reported a mental health *need* across different demographic variables. No significant differences were identified between age groups, genders, or Aboriginal and/or Torres Strait Islander householders. However, we identified the following:

- Those born outside of Australia and spoke a language other than English at home were less connected to mental health supports, despite experiencing a possible need.

- Those who were employed, and experiencing a mental health need, were significantly less connected to mental health supports compared to those who reported being unemployed or not in the labour force. Those not in the labour force were the most connected to supports.

- Those who did not identify with having a mental health condition or concern, or who were unsure, were significantly less connected to a mental health support.

- Those with disability were significantly more connected to supports.

- Those caring for someone with disability, a chronic health condition or a mental health issue were significantly more connected to supports than those who were not caring for someone.

- Those living in outer regional areas visited by the Project were significantly less connected to mental health supports than those living in inner regional or metropolitan areas.

Moreover, when we looked at difference across support type (local community only, professional or service only, or both) by demographic variables, we found there to be no significant differences among genders, or those born outside of Australia and/or who spoke a language other than English at home. Significant differences were found among the following groups:

- Aboriginal and/or Torres Strait Islander respondents were more frequently accessing both types of supports, in comparison to non-Indigenous respondents.

- Those without a mental health condition or concern, and those who were unsure if they had a mental health issue, were most frequently accessing support from a professional or service only. Householders who identified a mental health condition or concern were most likely accessing both types of supports.

- About a third of Householders with disability were accessing both types of supports, compared to only 18% of people without disability.

- Those residing in an outer regional area were most frequently accessing exclusively a community support and least frequently accessing only a mental health professional or service, compared to those living in inner regional or metropolitan areas. Rates of access to both types of supports were fairly consistent across areas.

The Householder Survey across both Rounds uncovered some of the potential drivers behind poor mental health and wellbeing of survey respondents, including concern about the various social determinants of mental health, which 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 are all issues impacting the social and emotional wellbeing and mental health of people across the communities. In Round Three, we also identified that Loss, bereavement, Sorry Business and the Negative impact of natural disasters were two other distinct social determinants driving significantly poorer mental health and wellbeing across the six Project sites.

This report also presented data suggesting significant concerns relative to the NDIS – including barriers to access and receiving adequate supports. Only a quarter of people in our Round Three sample with a disability were engaged with the NDIS. Approximately 22% of people not accessing the NDIS had tried to. Analysis of mental health measures also found people with disability reported significantly higher distress and significantly higher loneliness those without disability. Higher level analysis (and possibly more data) is needed to make inferences about unmet need in the disability community.

The aim of the current report was to present findings relative to three research questions: 1) what is the level of need for mental health supports? 2) who is accessing supports? and 3) what factors are contributing to mental health need?. We found evidence to suggest that many Householders visited by the ACDC Project had significant mental health need. Unsurprisingly, given the current climate where many communities are battling with a housing crisis, most Householders were experiencing distress due to a cost-of-living crisis, and welfare services such as the NDIS were not able to meet their needs. Who accessed supports (and what types of supports) did differ across several demographic variables, however, other variables and more sophisticated analyses are required to make assertions about what these findings mean. Moreover, relationships were identified between the social determinants of mental health, loneliness, employment satisfaction and standardised measures of distress and wellbeing, lending evidence to commonsense understandings of how social and cultural contexts have a significant impact on individual and collecting wellbeing.