DOORKNOCKING FOR MENTAL HEALTH

Evaluating a novel outreach approach for addressing mental health

Round Two of the Assisting Communities through Direct Connection Project

Prepared by the Centre for Social Impact

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Lisette Kaleveld, Yasmine Hooper, Emma Crane, and Dr Hilary Davis

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THE UNIVERSITY OF WESTERN AUSTRALIA

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. This report synthesises evaluation information collected by CSI, and administrative and survey data and program information collected by the ACDC Project, to provide a summative evaluation of Round One and Round Two of the ACDC Project.

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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.

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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 Evaluation Team. Collectively, they have influenced the design of the model, ensuring the integrity of the approach and guiding the research and evaluation 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.

Evaluation team members and supporters

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Dr Meera Varadharajan

Address for Correspondence

Lisette Kaleveld
Centre for Social Impact the University of Western Australia
Business School
The University of Western Australia
35 Stirling Hwy, Crawley, WA, 6009 Australia
Lisette.Kaleveld@uwa.edu.au

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Centre for Social Impact

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Disclaimer

The opinions in this report reflect the views of the authors and do not necessarily reflect those of the Centre for Social Impact or Community Mental Health Australia.

Report design

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CONTENTS

List of figures

List of tables

This is a project that should happen everywhere.

FOREWORD

Its findings underline the need to transform mental health and wellbeing services and supports, so that the social determinants of psychological distress are addressed, more community-based alternatives to hospital provided, peer support is properly recognised and funded, and more citizens are engaged with.

The Assisting Communities through Direct Connection (ACDC) Project moves outside of the mental health service system. Going door-to-door in selected communities is an innovative method of intentionally and proactively connecting with people and communities who, for a variety of reasons, may not otherwise be aware of, or seek out information or assistance for, psychological distress or improving wellbeing.

People have a right to access the care or resources they need, especially when facing multiple life crises, difficult transitions, have several coexisting needs, or are generally in distress and unable to cope. This Project has highlighted that mental health services and supports are difficult to navigate with significant barriers to access (e.g., finding the right option for suitable support, eligibility, cost, transport, waitlists, administrative work), especially for people in distress, experiencing the impacts of disadvantage, and/or living in under-resourced communities.

The Project connected with many people experiencing high levels of distress who have either never considered seeking support, or people who have tried but became stuck at various stages of trying to access help or have had poor experiences with services in the past and have given up.

Having a conversation with people about their support needs, and where possible, finding help for people who need it, is exciting, as are the learnings from connecting with these people – what are their experiences with mental health, their support needs and preferences, and reasons why they are not connected to services?

From a health equity and human rights perspective, there is a need to 'take the risk' of connecting meaningfully with people who are not receiving care and support or engaging in "help seeking" behaviour. A doorknocking approach offers an exciting opportunity and a simple novel way to do this.

Kerry Hawkins
Commissioner, National Mental Health Commission

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.

FOREWORD

These reports show the value and potential of the proactive, outreach model used by the ACDC Project, but they also add significant evidence to support the importance of addressing mental health issues in Australia, and highlight several gaps in the delivery of services to those in need.

The CSI reports 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 across Australia. Over the course of two Rounds of the project, more than 37,000 doors were knocked on, more than 6,600 conversations were had, and 4,200 surveys completed. Teams of two People Connectors spent time face-to-face completing 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 on their doorstep.

The outreach approach provided a unique opportunity to hear directly from Householders and learn more about each of the communities visited by the People Connector Teams. Given the mental health impacts of various challenges in Australia over the past few years – the COVID-19 pandemic, environmental events caused by climate change – the timing of delivery was opportune.

As this report suggests, Householders, often, were welcoming, receptive and willing to engage with the Project. The outcomes of visiting people at the doorstep were varied – for many, a simple conversation from a caring stranger was validating and reassuring. For others, it was transformative – and encouraged people to seek support for their mental health and wellbeing, sometimes for the first time.

We hope that the ACDC reports will generate productive conversations about changes that are needed so that all communities and all people within different communities can access to mental health services if needed, and enjoy improved mental health outcomes as well.

Paul Flatau
Director, Centre for Social Impact UWA

EXECUTIVE SUMMARY

INTRODUCTION

A safe space to talk about mental health at the doorstep; the ACDC Project turned this simple idea into a large-scale program implemented in diverse communities across all states and territories. In teams of two, 'People Connectors' set out to knock on doors, have conversations about mental health with Householders, deliver mental health information and, if needed, discuss options to link to local services and supports. In Round One and Two of the project, People Connectors knocked on over 37,000 doors across 21 communities. Over 6,600 conversations were had about mental health and social and emotional wellbeing, and more than 4,000 Householders completed a survey about social and emotional wellbeing, mental health support needs and experiences of accessing supports.

This evaluation report (the Report) was prepared by the Centre for Social Impact (CSI) for Community Mental Health Australia (CMHA)[1], and presents evaluation findings related to the ACDC Project's effectiveness and impact on participants and communities.

PROJECT AIMS AND OBJECTIVES

The ACDC Project objectives were:

- to connect with people, including with people not currently engaged with services and supports, or with people who were hardly reached;
- to increase awareness and provide information about mental health supports and services through conversations and information products;
- to build the skills and capacity of local services and communities to conduct outreach through doorknocking; and,
- to build community capacity (for local services and other stakeholders) to better understand and meet their community's specific needs.

The overall aim of the ACDC Project was to promote community-wide awareness of mental health, increase mental health literacy, and normalise conversations about mental health, helping to widen engagement in mental health services across diverse social groups, and potentially increase access to support for those who need it most.

[1] The CSI are the evaluation partners for the Assisting Communities through Direct Connection (ACDC) Project, an initiative of CMHA.

RELEVANCE OF A NOVEL PROACTIVE OUTREACH APPROACH TO MENTAL HEALTH

Despite Australia having a system to support people experiencing mental health issues, many people who need support cannot access appropriate, high quality care, treatment or support to manage their mental health, or know about opportunities to reduce their burdens and levels of distress and improve their wellbeing. Barriers to accessing services and supports are numerous and can include both personal barriers (such as stigma, a lack of awareness of one's own mental health support needs and not knowing help is available) and systemic barriers (such as the cost of services and waitlists).

A literature review highlighted how some socio-demographic groups are particularly disadvantaged by obstacles to receiving healthcare, and based on the literature search results, these are: people from culturally and linguistically diverse communities, people living in lower socioeconomic communities, regional and rural communities, and men. We understand from consulting with stakeholders that Aboriginal and Torres Strait Islander peoples may also face obstacles to receiving support for mental health.

The concept of 'hardly reached' groups points to the fact that service systems serve some groups more effectively than others, and that those with the highest needs are not always guaranteed access to mental health care, in fact they might be less represented across all health services.

Given the mental health crisis facing Australia and recent shocks to mental health experienced across large sections of the population– including the impacts of severe weather events, COVID-19 and financial stresses – waiting for people to be in crisis before they can access any support is not cost efficient or sustainable.

This project, which seeks out informal conversations about mental health needs, helps people overcome barriers to seeking support and brings awareness to people about diverse support options that are locally available, including low cost or free community supports, is highly relevant within the strategic context. The health equity lens of the project, as well as the potential learnings from implementing a novel proactive outreach approach have significance in the current political conditions and calls for mental health reform.

See Section 1 for more information about the strategic and political context in which the ACDC Project was developed and delivered.

RESEARCH AND EVALUATION DESIGN

Purpose

The ACDC Project's Research and Evaluation Framework specified two related but distinct functions – evaluation and research. The evaluation focused on the suitability and effectiveness of the ACDC Project and its value for Householders and diverse communities, whereas the research component focused on analysis of data collected via the ACDC Project Householder Survey to gain a deeper understanding of, and evidence for, mental health need across various sites, and overall.

Overview of methods

A mixed methods approach ensured a range of information could be collected to inform the evaluation and research. This included a review of the literature; an overview of ABS data for each community; focus groups with People Connectors; interviews with the Delivery Partner Organisations[2], interviews with ACDC Project Team members, engagement metrics recorded by People Connectors (i.e., number of doors knocked, number of conversations had); an evaluation survey sent to Householders a month after the visit; follow-up interviews with Householders and impact stories recorded by People Connectors.

The Householder Survey

The Householder Survey included a mix of standardised, validated questionnaires (such as the Kessler Psychological Distress Scale and the 5-item World Health Organisation Well-Being Index) and bespoke questions that were co-designed with ACDC Project Team members and working groups, which included the input of people with lived experience expertise. The survey asked Householders about challenges that impacted 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.

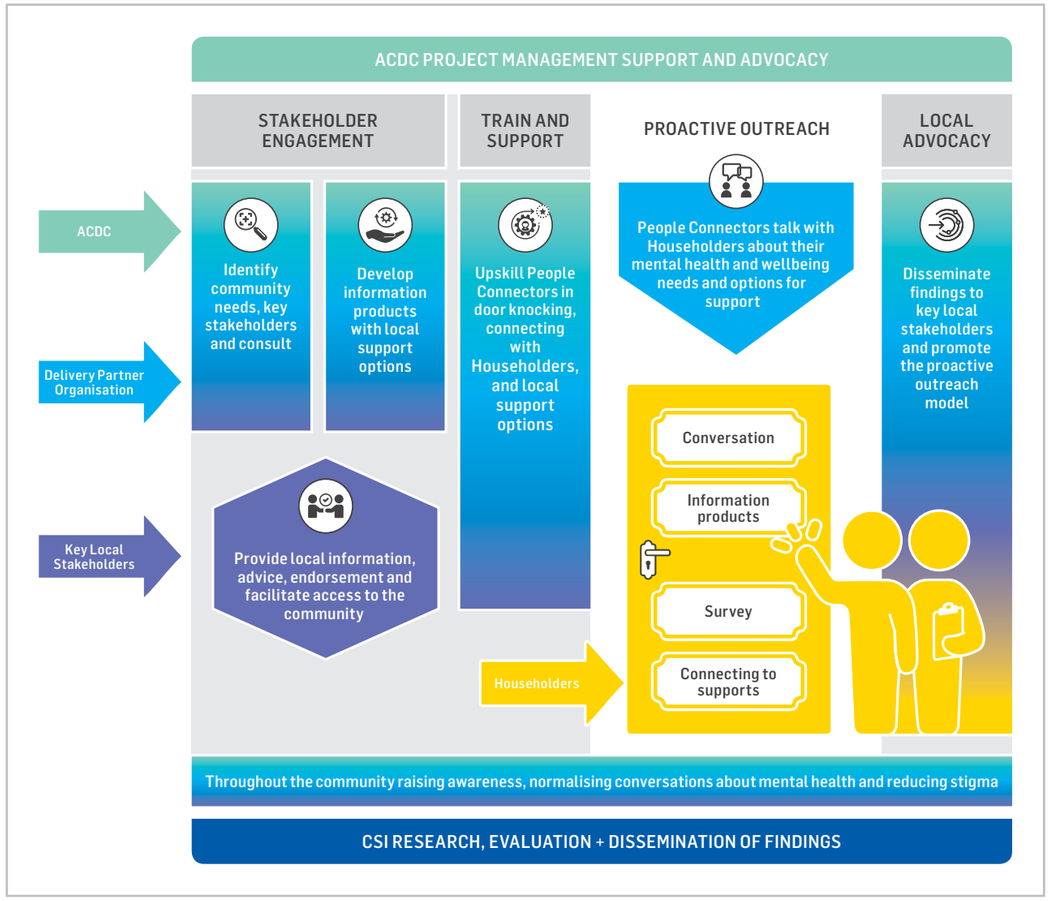
[2] Locally-based organisations who delivered the initiative in their communities.

The survey results are explored in a related report Home truths about mental health in Australian communities[3], while this report focuses on evaluation findings.

See Section 2 for more information about methodology, data collection methods and limitations.

PROJECT IMPLEMENTATION

The ACDC Project Team, based in Sydney, engaged locally-based organisations – Delivery Partner Organisations (DPOs) – across each of the 21 sites to implement this model in their regions and towns. People Connectors were recruited by the DPO and trained by the ACDC Project Trainer[4] to doorknock in selected suburbs of their communities over 13 weeks. During the fieldwork, the People Connectors continued to receive support from the ACDC Project Trainer, attended a fortnightly Community of Practice meeting with other People Connectors, and also had regular support meetings with their Line Manager within the DPO. Following the doorknocking, a summary of local-level Householder Survey results was shared with the DPO, who often distributed it within their local service provider networks to promote conversations about the community's most urgent mental health needs and what is needed to better meet those needs. See the following diagram for an outline of the ACDC Project implementation process.



[3] 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.

[4] A consultant engaged by CMHA.

Several factors made the implementation of the ACDC Project complex: the innovative proactive outreach approach that has not often been used or tested in the community services sector in Australia; the diversity across the 21 communities (including diverse geographic characteristics and sociocultural contexts); and, varying, localised experiences of disruptive events in different sites before and during project implementation (for example, the uneven impacts of the COVID-19 pandemic and related lockdowns and restrictions, and severe weather events such as flooding).

See Section 3 for further descriptive information about project implementation.

PARTICIPATING COMMUNITIES

The contextual diversity across and also within sites was significant. Whether it was the physical landscapes, remoteness and distance to services, dwelling types, levels of advantage or disadvantage, or social issues within the community, multiple factors influenced project implementation, the responsiveness of the community, as well as the very reasons that doorknocking for mental health was embraced as an idea. Even variations in the personal qualities of community leaders – their appetite to try new approaches or perhaps an adversity to risk – had an impact on which communities engaged and why. The 17 Round Two sites usually comprised two to three suburbs, these are presented below:

ACDC PROJECT SITE	SUBURBS VISITED (Postcodes)
New South Wales (NSW)	
Cabramatta	Cabramatta (2166)
Clarence Valley	Maclean (2463), Yamba (2464)
Greenacre	Greenacre (2190)
Hurstville	Hurstville (2220)
Wollondilly	Picton (2571), Tahmoor (2573)
Wollondilly	Picton (2571), Tahmoor (2573)
Northern Territory (NT)	
Palmerston	Johnston (0832), Moulden (0830), Woodroffe (0830)
Queensland (QLD)	
Ipswich	Ipswich (4305), North Ipswich (4305), West Ipswich (4305)
Mareeba	Mareeba (4880)
Redcliffe	Margate (4019), Redcliffe (4020)
Toowoomba	Harristown (4350), Kearneys Spring (4350)
Roma	Roma (4455)
Toowoomba	Harristown (4350), Kearneys Spring (4350)
South Australia (SA)	
Port Adelaide	Alberton (5014), Rosewater (5013)
Tasmania (TAS)	
Burnie	Burnie (7320), Upper Burnie (7320)
George Town	George Town (7253)
Victoria (VIC)	
Macedon Ranges	Gisborne (3437), Riddells Creek (3431), Romsey (3434)
Bendigo	Bendigo (3550), Eaglehawk (3556), Golden Square (3555), Kangaroo Flat (3555), Long Gully (3550), North Bendigo (3550), White Hills (3550)
Fitzroy	Fitzroy (3065)
Western Australia (WA)	
City of Swan	Beechboro (6063), Ballajura (6066)

According to the Index of Relative Socioeconomic Advantage and Disadvantage[5] (IRSAD), the majority of suburbs (25 suburbs; 69.4% of all suburbs) that were doorknocked fell within the lowest three out of 10 categories of advantage, which indicated that People Connectors generally doorknocked in suburbs with lower levels of advantage than is 'average' in Australia. However, there were also suburbs in the highest three categories of advantage (7 suburbs; 19.4% of all suburbs). People Connectors reflected on how they experienced their role differently across suburbs where levels of wealth differed, and some patterns and observations were noted (see Section 7 for discussion).

However, People Connectors also reflected on how localised relative advantage/disadvantage could be, with noticeable and signifi cant wealth discrepancies between neighbouring suburbs, streets and even between houses on the same street.

See Section 4 for more information about the communities and contextual factors influencing the project.

OVERVIEW OF FINDINGS

The following diagram presents activity and outcomes data in Round One and Round Two[6].

ACTIVITY DATA FOR ROUND ONE + ROUND TWO

22 Communities engaged

21 Communities commenced doorknocking

37,595 Doors knocked

6,683 Conversations had

SURVEY SAMPLE SIZE

3,811 Round Two surveys completed

ENGAGEMENT DATA FOR ROUND TWO

Where People Connectors knocked, **34%** of households answered the door

Of those who answered the door, **52%** of Householders had a conversation with a People Connector

Of those who had a conversation with People Connectors, **69%** of Householders completed a survey

PROJECT OUTCOMES DATA ROUND ONE + TWO

80% of people put the fridge magnet on their fridge

82% of people read the information given by the People Connectors about mental health

61% of people talked with a friend/family member about their own mental health and wellbeing as a result of the visit

63% of people talked with a friend/family member about their friend/family member's mental health and wellbeing as a result of the visit

As a result of the visit, **32%** of people contacted a professional, a service or a community organisation to ask about support for their mental health or wellbeing

A further **24%** of people were planning to do this

As a result of the visit, **21%** of people had contacted a professional, a service or a community organisation to ask about support for someone else's mental health or wellbeing

A further **23%** of people were planning to do this

[5] Australian Bureau of Statistics. (2018). *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016.* https://www.abs.gov.au/ausstats/

[6] Round One and Two data were combined where possible, and at other times this was not possible because the data point was only collected during Round Two.

OUTCOMES FOR HOUSEHOLDERS

For most Householders the People Connectors' visit was generally seen as a valued, validating and comforting experience, however for a smaller number of Householders the experience was quite powerful with real impacts on their lives. Others benefited from a 'potential impact', such as greater awareness, which may not be realised in terms of behaviours for some time. In analysis of the data we categorised the outcomes findings into immediate, short term and long term outcomes.

Immediate outcomes – Householder's experience of the visit

Overall, experiences of the ACDC Project were very positive. Householders welcomed the opportunity to connect with People Connectors. The interpersonal qualities of the People Connectors, their skills, and their training set them up for providing safe and positive experiences – and this was noted by most Householders in the evaluation survey. In interviews some Householders reflected on how they felt the visit improved their wellbeing; People Connectors' attentiveness, kindness and the caring conversation had a powerful immediate impact for some Householders.

Short term outcomes – actions taken as a result of the visit

As a direct result of the ACDC Project, Householders felt encouraged or empowered to act following their discussion with People Connectors. Most Householders (about 80%) utilised the fridge magnet and/or read the information that had been provided by the People Connectors, Many Householders (about 60%) talked with someone about their mental health/wellbeing as a result of the visit, and many (also about 60%) spoke to a friend/family member about their mental health/wellbeing because of the visit. Notably, over half of all survey respondents reported that the ACDC Project had prompted them to either seek supports, or make a plan to seek supports. And over two in five Householders indicated that they had, or planned to, contact support for someone else in their lives.

Long term outcomes – changes in wellbeing, attitudes, knowledge or awareness

Although we do not know the true extent to which this happened, several Householder interviews indicated increased and sustained wellbeing resulting from the visit. There was a sense of feeling 'better', often due to the unique opportunity to discuss concerns, challenges, or feelings of distress with a caring stranger who had the skills to ensure this conversation was safe, productive and supportive. Increased motivation for change was also apparent for some Householders as a result of the visit, and there was a feeling of comfort gained from the knowledge and information they now had about where to go for help and what types of help was available. Householders also noted their intention to help others, or a de-stigmatisation of their attitudes toward mental health.

See Section 5 for more information about outcomes for Householders, measured quantitatively and qualitatively through survey results and interviews.

OUTCOMES FOR PEOPLE CONNECTORS

In focus groups, the People Connectors reflected on the 'connecting skills' they had gained through doorknocking. Anyone, in any circumstances, could be on the other side of the door. When the door opened they were greeted by Householders that were curious, welcoming, pleasant and friendly, or – although less often – sometimes unfriendly, cautious, suspicious, busy and impatient or fearful. Navigating these first moments involved highly skilled, responsive interpersonal skills and emotional intelligence. Interestingly, some People Connectors noted that when practiced everyday these connecting skills can improve over time and this was very empowering, as they were now confident in 'connecting with anyone'.

People Connectors were sometimes personally impacted by speaking with Householders in crisis (i.e., experiencing mental health or other crises) and with very urgent and complex needs, or people facing difficult life circumstances. Some people wanted to talk for a few hours.

People Connectors learnt, in more depth, of the challenges and concerns that risked the mental health of the people in their community, and were also able to see the service system from the standpoint of the people they had visited. They gained insights about the common systematic and personal barriers people face when attempting to seek help.

Whether it was an intended or unintended outcome of the project, many People Connectors became personally aligned with the project's values and objectives, even though they might not have thought too much about them at the start of their contract. After walking through neighbourhoods and having conversations with Householders (and with one another), People Connectors came to understand that people facing difficult times need support and should not have to cope on their own. They often felt strongly about the need for diverse support options and more mental health services in their communities and could clearly articulate who was missing out and where the most urgent needs were in their communities. Some People Connectors said they gained understanding of the insufficiencies and injustices within Australia's service systems, which were not apparent to them at the start of the project. Through their experiences of going door-to-door, People Connectors also in some cases developed the motivation to pursue more meaningful work that connected to community, and to continue to build on the understandings gained through the ACDC Project.

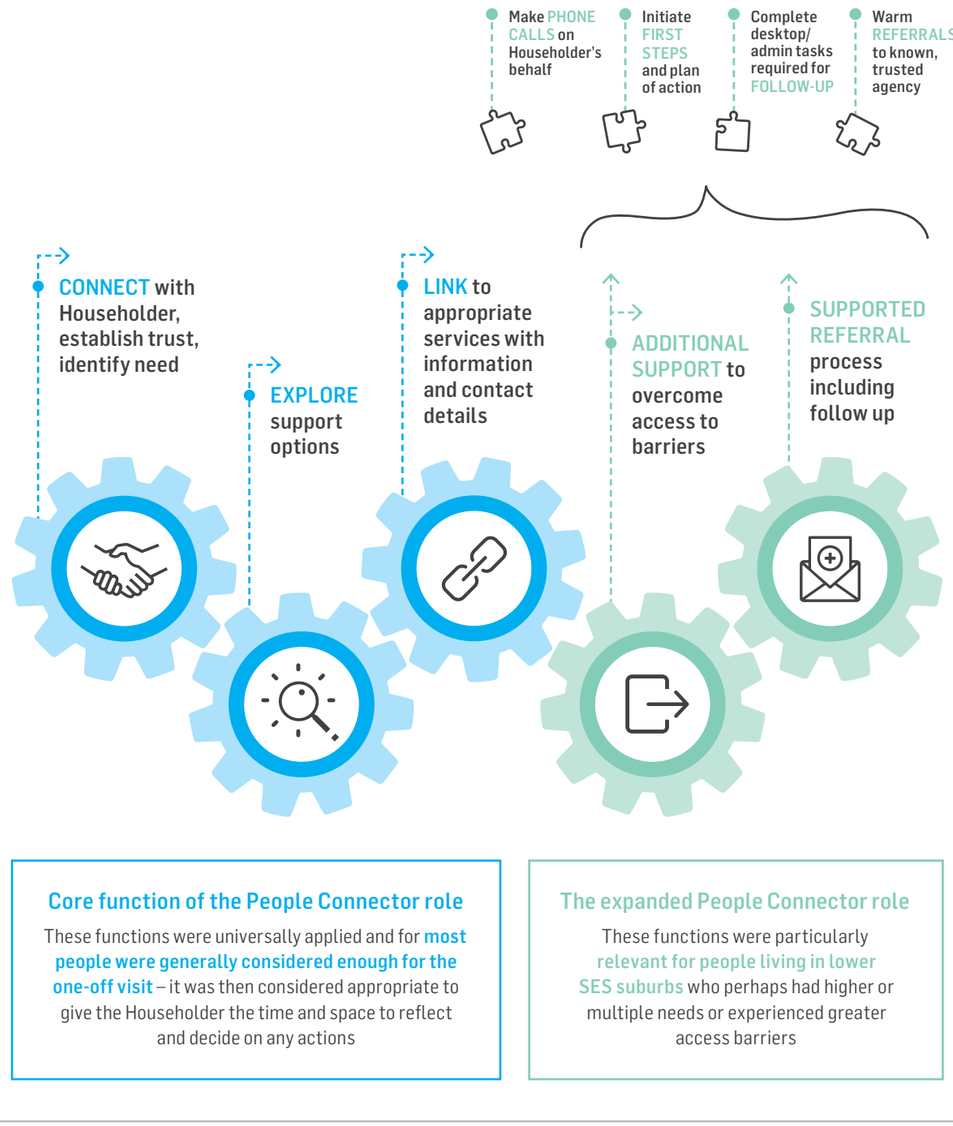
See Section 6 for more information about People Connectors' views and experiences of the project.

EFFECTIVENESS OF DOORKNOCKING

The demographic data collected across the sites indicated that the doorknocking approach was able to reach a diverse range of people. Overall, people were highly responsive to having conversations about mental health with someone unknown to them at their doorstep. This could indicate a lack of existing opportunities to informally discuss mental health and consider one's own support needs.

Analysis also considered the effectiveness of the ACDC Project in terms of applicability to two overlapping groups: people who are hardly reached and people living in communities experiencing higher levels of disadvantage. In one example, a Householder who was hardly reached and living in a lower SES suburb, was effectively helped by People Connectors, despite having multiple needs and prior failed attempts to seek support. This person suffered from social anxiety which prevented him from being able to talk to strangers on the telephone. People Connectors were able to make the phone calls on his behalf, to connect him to a case worker in an organisation that could provide more sustained support, and also to connect him with NDIS supports. This illustrated that the actions taken by People Connectors during and after visiting Householders, could be transformative and lead to practical outcomes for Householders who would not have otherwise got the help they needed.

In this example, the People Connectors extended their role to meet a higher needs circumstance. Typically, People Connectors provided guidance and information about possible supports. However, the doorknocking approach was flexible enough to accommodate for additional support when needed (see figure overleaf), which was appropriate particularly for Householders experiencing disadvantage or overwhelm from having multiple needs to address.



While People Connectors at times needed more support, or more strategies to help address some of the coexisting crises facing people in disadvantaged communities, some People Connector teams were able to be highly responsive and resourceful about how to help.

Strengthening the enabling conditions for People Connectors to work more deeply with the Householders who need it – for example ensuring there is leadership support for additional hours spent organising referrals, and working closely with local service options that could be called on if needed – could strengthen the ACDC Project doorknocking approach to make it even more impactful for vulnerable people and communities.

See Section 7 for more information about the effectiveness of doorknocking, and its appropriateness for addressing mental health needs of people who are hardly reached and/or living in disadvantaged communities.

CONCLUSION

Our learnings about doorknocking conversations about mental health are based on analysis of multiple data sources, and overall they demonstrate that:

- Doorknocking is an effective means of discovering people with unmet mental health support needs;
- This approach can effectively link people into supports, and there is evidence it can do that for people who are otherwise not supported, by addressing the 'soft' barriers to help-seeking such as attitudes to mental health, rarely having the time or space to be able to reflect on their own needs, or not knowing that supports exist;
- Due to the flexibility and innate responsiveness of the method, it can be effective for addressing a very diverse range of needs and access barriers, including the needs and barriers experienced by people who are hardly reached, and people living in lower SES communities.

The ACDC Project's focus on, and investment in, the 'connector role' is notable, and a project such as this puts a spotlight on the power of connecting, and its possible significance in the mental health context.

Findings point to the need to dedicate more resources to purposeful, skilled connecting work, given its potential to contribute positively to the overall functioning of the mental health system. In Australia's crisis-driven and specialisation-focused mental health system, the dedicated resources for quality connecting work are not embedded, and the work and skills can be overlooked or undervalued. The ACDC Project has shown that outreach-focused connecting work is necessary if we want Australian healthcare to be inclusive, accessible, and equitable, and to adequately meet the mental health support needs of Australia's diverse population.

This section provides an overview of terms that are commonly used in this report, and offers working definitions and understandings that have been applied.

TERMS USED IN THIS REPORT

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/s: The person or people who reside in the dwelling where the door is knocked, and who are at least 18 years of age, and therefore able to participate in the ACDC Project.

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/s: Factors that affect access to a support based on personal or 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 supports 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.

Lived experience experts: Refers to people who have personal experience, currently or in the past, of a mental health condition, distress, or challenge, as well as knowledge and understanding of lived experience discourse within the global community of practice. People with a personal experience of mental health issues may either represent a perspective based on their own personal lived experience, or may represent a specific cohort (such as an Aboriginal perspective) or a collective of people with lived experience.

Mental health: A state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life[7]. Understandings of mental health and social and emotional wellbeing vary among different cultures and communities, and some see distress or social and emotional wellbeing concerns as a response to adverse social conditions.

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

Mental health and wellbeing: Emotional, psychological, and social wellness. These factors affect how we think, feel and behave, and contribute to what is described as our 'mental wellbeing'.

Natural helpers: People who others naturally turn to in times of need and crisis. They might be a friend or even a teacher or colleague. Natural helpers are diverse, they can be skilled or unskilled, and formally educated or not formally educated. Often, natural helpers are positioned between those in need and the services that are available to meet that need. They have also been labelled 'lay educators' and 'lay health workers.'[8]

Peer workforce: 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.

Proactive outreach: A model of engagement where attempts are made to connect with people without needing to rely on them coming to the service or be in an acute phase of difficulty. A proactive approach focuses on prevention, and on ways to engage with people outside of service settings.

Psychosocial: The 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[9].

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

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: ***P***eople 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 participate in the ACDC Project.

EVALUATION TERMINOLOGY

Action research: An action research approach involves actively participating in a change situation while simultaneously conducting research. An action research approach uses cycles of planning, action and review to ensure that early findings can be used to refine the model and inform later states of its implementation.

Evaluation: Systematic inquiry to inform decision-making and improve programs. Systematic implies that the evaluation asks critical questions, collects appropriate information, and analyses and interprets the information for a specific use and purpose.

Outcome evaluation: An outcome can be both the results/effects expected by implementing a program/initiative/strategy and the changes that occur in attitudes, values, behaviours or conditions. Changes can be immediate, intermediate or long-term.

Place-based: A collaborative, long-term approach to building a thriving community, delivered in a distinct location. A place-based approach responds to complex, interrelated, or challenging issues and is usually characterised by partnering, co-design, and shared accountability related to outcomes.

Process evaluation: A process evaluation describes, documents and analyses the implementation activities of a project or intervention.

Qualitative data: Seeks to understand how the world is understood, interpreted and experienced by individuals, groups and organisations (usually through the eyes of people being studied and in natural settings). It unpacks the 'why', is often richly descriptive, flexible, relative and subjective. Qualitative data is usually text or narrative.

Quantitative data: Seeks to explain something by using numerical data: how many, much, often, change etc. It is highly structured and based on theory/evidence and is usually objective, but can also capture subjective responses (e.g., attitudes and feelings). It provides findings that can often be generalised and can greatly enhance understandings at a population level because it determines the breadth and scale of an issue.

Theory of change: A theory of change is a representation of how a program or initiative should work. It links inputs (the resources that go into a program), activities (what the program does), outputs (the number of people, places, supports, activities the program has produced), outcomes (what changes have occurred) and impact (long term change).

Wave 1 and Wave 2: A research term to indicate the time points where a research participant may be engaged. For example, an individual may be engaged initially in a 'Wave 1 survey', then again at a second time point for a follow-up survey – referred to as a 'Wave 2 survey'.

[8] Drew, N. (2015). Social and emotional wellbeing, natural helpers, critical health literacy and translational research: Connecting the dots for positive health outcomes. *Australasian Psychiatry, 23*(6), 620–622.

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

"We've revived the old-fashioned way of people coming to the door, a little bit like the way a country pastor used to do his rounds going door-to-door just to do pastoral check-ups. Admittedly, that was in a semi-religious context, although I think a lot of the time it was quite humanistic and just a nice way of keeping people connected. We don't have that facility in our modern world right now. And so, the ACDC Project is a kind of a flashback to the way people used to do it before." (Bill Gye, CEO Community Mental Health Australia)

1. INTRODUCTION

1.1 A NEW IDEA FOR PROACTIVE OUTREACH?

The act of knocking on a door to check in on the household is not new. As a show of care, this has presumably worked to keep people well and connected to natural supports throughout history and across diverse cultures. In 2021 and 2022, the ACDC Project turned this simple idea into a large-scale program adapted to the contemporary Australian context and implemented across multiple community settings.

Teams of two or three people – referred to as 'People Connectors' – knocked on over 37,000 doors in 21 communities around Australia to ask Householders about their wellbeing. They had conversations about mental health and social and emotional wellbeing, collected data through a survey, responded to any needs that arose, and provided information and assistance by suggesting support options or linking people to services.

In the mental health space, proactive outreach activities such as this, especially those that go directly to people in their homes, are few and far between. Where they do exist, they are typically narrowly defined for target populations, rather than universally applied. A handful of other known programs, such as the Rural Outreach Program[10], proactively reach people in their homes but these are often implemented in just a few communities, Local Government Areas or Shires. There is no other national approach to proactively reach people at a scale similar to the ACDC Project.

As an engagement method, doorknocking is largely untested and underutilised within social programs in Australia.

Doorknocking itself may seem a simple idea, but it is also highly innovative in that it involves some risk and a departure from contemporary norms. As an engagement method, doorknocking is largely untested and underutilised within social programs in Australia. It might even be viewed by some as suspect; an intrusive approach associated with religious groups or unwelcome salespeople. However, the determination of this project to reach people who are hardly reached, meant that any risks inherent in the doorknocking approach were accepted and managed through program design.

An openness to learning was also fundamental to this project. Often, programs are tightly scoped and designed to hone in on a specific need. However, the ACDC Project allowed Householders a fairly unrestricted exploration of their wellbeing, without being limited by overly-determined project goals. Mental health was the key focus, however People Connectors held this 'agenda' loosely, and let the Householder lead the discussion. Conversations covered topics including mental health, social and emotional wellbeing, community wellbeing and mental health of friends and family members, psychosocial support and individual struggles with basic needs, safety concerns, burdens and life stressors such as work, money, family, housing

[10] Davis, H., Gurr-Stephen, L., & Farmer, J. (2021) *Rural Outreach Program Evaluation End of Year Report: Report of an evaluation of an outreach program in rural Victoria*. Social Innovation Research Institute.

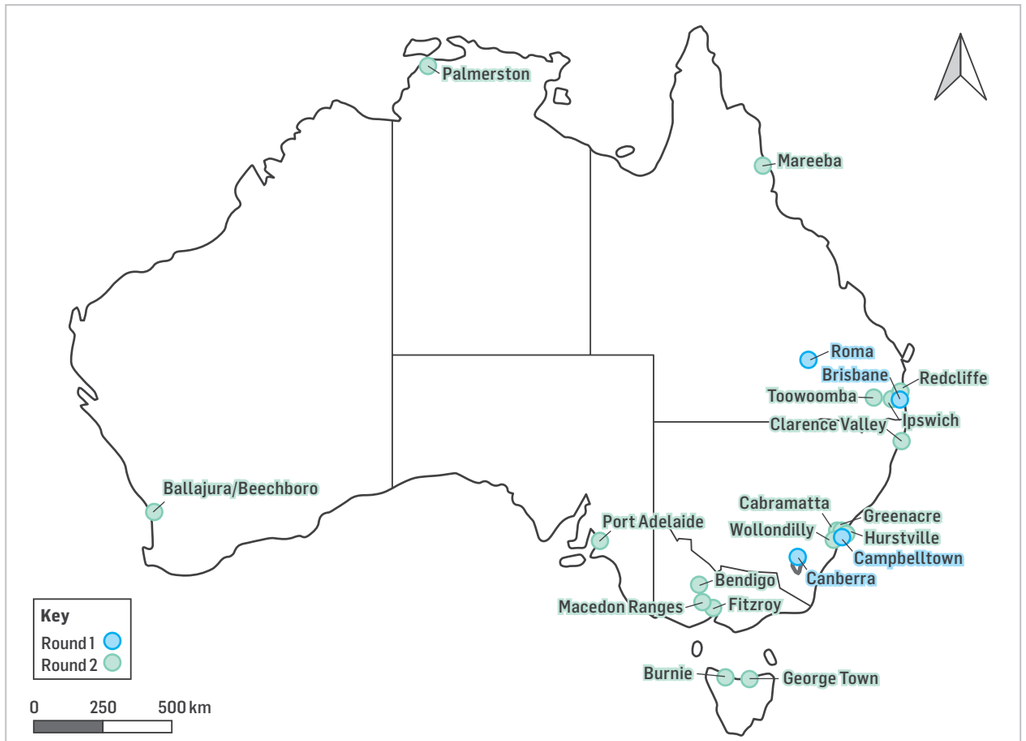
and health problems (see Section 2.3 for a fit-for-purpose conceptual framework of mental health and wellbeing).

This evaluation report (the Report) has been prepared by the Centre for Social Impact (CSI) for Community Mental Health Australia (CMHA)[11]. The Report aims to assess the ACDC Project in terms of its effectiveness and impact on participants and communities. To make this assessment, a typical range of evaluation questions, methods and tools were used. However, we hope that the sense of discovery informing the project goals, flows through this Evaluation Report as well. The Evaluation Team have been curious partners from the start, walking alongside the ACDC Project Team and wondering what can be learnt. What is the value of hitting the pavements, climbing the hills, sending teams out to face the heat of the day or winter rain, to go street-to-street and door-to-door? This question is answered in many different ways and through a range of views and voices, and as the ACDC Project moves from Round Two to Round Three of implementation, we hope to use this Report as an opportunity to pause, reflect, and capture what can be learnt from this Project as an innovation in the mental health space.

1.2 THE ACDC PROJECT

The ACDC Project was implemented in 2021 and 2022, in 21 metropolitan and regional sites across all Australian states and territories (see Figure 1). 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. Over the course of Round One and Round Two, the People Connectors knocked on over 37,000 doors, and had conversations with over 6,000 Householders. Round Three is expected to commence in April 2023.

FIGURE 1: ACDC Project site locations



[11] The CSI are the evaluation partners for the Assisting Communities through Direct Connection (ACDC) Project, an initiative of CMHA.

The ACDC Project Team, based in Sydney, engaged locally-based organisations across each of the sites – Delivery Partner Organisations (DPOs) – to implement this model in their regions and towns. People Connectors were recruited and trained to doorknock in selected suburbs of their communities over 14 weeks[12], seeking out conversations about mental health and social and emotional wellbeing with Householders at their front door. A survey was also completed by willing Householders, to capture critical information about mental health needs and preferences.

Several factors made the implementation of the ACDC Project complex: the innovative proactive outreach approach that has not often been used or tested in Australia; the diversity of communities, all with extremely unique characteristics and social contexts; and, specific, localised experiences of major and unexpected events in different sites before and during project implementation (for example, the uneven impacts of the COVID-19 pandemic and related lockdowns and restrictions, and severe weather events such as flooding).

The project relied on DPOs to interpret the model and make it suitable to localised contexts, whilst also adhering to core operational protocols to ensure safety, sound governance and a standardised (enough) approach to support robust research outcomes.

Project goals and activities

The ACDC Project aimed to achieve several interrelated goals: to reach Householders where they are and no matter who they are (i.e., regardless of their current level of mental health literacy or level of engagement with mental health support), to engage in conversations that can uncover mental health need (including unmet needs and under-met needs), to normalise and simplify help-seeking, and to provide resources and empower people to take the steps to have their needs met.

Expressed as objectives, the ACDC Project aimed to:

1. Connect with people, including people who were not currently engaged with services and supports, and/or who were 'hardly reached';
2. Provide awareness and information about relevant support options;
3. Build the skills and capacity locally to conduct proactive outreach through doorknocking; and
4. Build community capacity to help local services and stakeholders better understand their community's need for mental health support and potentially uncover more effective ways to meet those needs.

These objectives were achieved through several core phases and activities at each site in Round One and Two, summarised below:

Phase 1: Community engagement (8 weeks)

The initial phase of Project delivery involved community engagement. This meant reaching out to key local stakeholders to better understand the community context, and partnering with these stakeholders to develop information resources that reflect local services. The ACDC Project was also promoted through these partnerships, so that communities were made aware that the ACDC People Connectors would be visiting. People Connectors were recruited locally and trained by the ACDC Project Team.

Phase 2: Training (1 week)

People Connectors and their Line Manager undertook one week of intensive training in the proactive outreach model of the ACDC Project. The training was designed as an in-person face-to-face course delivered by a Project Trainer[13] to People Connectors at the site.

Phase 3: Fieldwork (13 weeks)

Doorknocking activities commenced, with teams of two or three People Connectors walking through selected suburbs and streets to connect directly with Householders at their front door. People Connectors were trained to have an empowering, nurturing and supportive conversation about wellbeing.

[12] This included 1 week of training and 13 weeks of doorknocking. There were variations in the time spent doorknocking, and one site implemented the project with two teams over 8 weeks.

[13] The Project Trainer was a consultant engaged by CMHA.

Where Householders indicated a need for further support, People Connectors could facilitate access to services and supports by either providing general information about mental health support, providing personalised information about suitable and available supports, assisting with contacting services, or obtaining consent to follow up directly to link people to appropriate local or national support services. In addition, a survey was completed with or by the Householders (Householder Survey).

Phase 4: Advocacy (ongoing)

The Householder Survey data were analysed at the community level and a quantitative summary report which presented key, preliminary findings was provided to local stakeholders. The summary reports comprised local statistics about the impact of social determinants of mental health, mental health distress and wellbeing indicators, support needs, unmet needs, and preferences for support, all of which could provide insight about community characteristics that may impact on mental health and wellbeing need and local experiences of getting help. These data also provide evidence for advocacy and improving and increasing supports and services available.

Theory of change

The ACDC Project responds to an understanding that many people who need support for their mental health and social and emotional wellbeing are not accessing suitable supports or services and are unlikely to reach out to get help by themselves.

Going directly to people at their homes, having conversations about mental health and providing practical information and assistance to link people to services and supports may mean that people (who would otherwise not access support) can get the help they need to improve their wellbeing or mental health.

The ACDC Project Team spoke about 'crossing a threshold' as shorthand for the idea of a border or barrier that an individual must break through to make initial contact with a service; to seek help again after a previous, poor experience with a service/clinician; or, after having given up trying to get the right help. Well-known access barriers include cost, waiting times, eligibility criteria and a lack of transport to access services.

This 'threshold' into services however can also be less visible and more personal and individualised, varying greatly depending on the person needing support. It may consist of strongly held beliefs such as, 'I can't ask for help and must go it alone'; 'Services are for others who need them more than me'; 'I am not sick enough/worthy enough to be supported'; 'I will be judged or controlled'; 'It is not safe for me'; 'Support is a luxury I cannot afford'. Through conversation with a validating stranger at the front door, some of these beliefs that make accessing support so out of reach can be expressed or challenged in a safe space. Practical strategies to overcome other access barriers can also be explored through conversation.

As part of the ACDC Project, Householders are also asked if they would like to complete a survey about their mental health and support needs and preferences. After the project has been completed in a community, local-level survey findings are disseminated (i.e., via Community Reports – a series of reports which illustrate survey findings of each site[14]), which may also have the impact of improving mental health awareness through a deeper understanding of what it might take to address needs in a particular community.

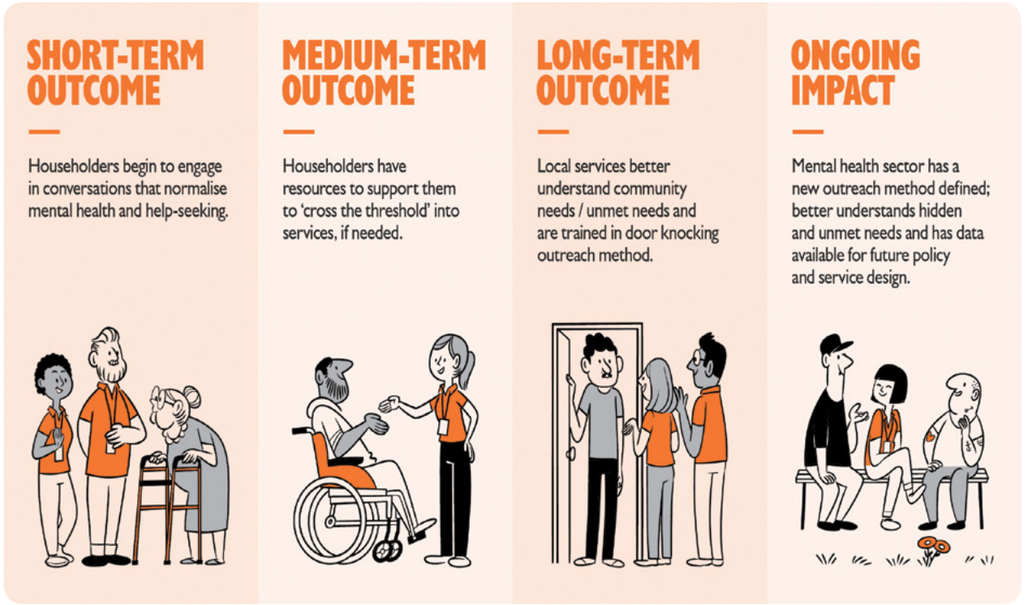
These survey findings add value when analysed at the local level, as well as more generally provide insights about need across diverse communities which can help to inform policy and/or system change, based on new evidence and understandings of mental health experiences, needs and preferences for support.

The ACDC Project also aimed to promote community-wide awareness of mental health, increase mental health literacy and normalise conversations about mental health. This happens as a result of the ACDC Project's presence in the community, local promotions and media activities, and potentially, the flow-on conversations that happen after the visit between Householders and their family or others in their social network.

Figure 2 illustrates a summary of these anticipated changes as a result of the ACDC Project, across the individual, service and community levels, and over time.

[14] For the Community Reports see https://acdc.org.au/reports/

FIGURE 2: Theory of Change for the ACDC Project



1.3 STRATEGIC CONTEXT

"Mental ill-health affects all Australians, either directly or through our families, colleagues, friends and loved ones. It does not discriminate. But Australia's mental health system has not kept pace with our needs." (Productivity Commission, 2020)

This section provides an overview of the socio-cultural and strategic/political context in which the ACDC Project was developed and delivered. While only a brief outline can be presented here, considering the broad strategic conditions is critical for situating the findings of the project, understanding their significance and for helping to inform the project's potential longer term legacy.

Is there a mental health crisis in Australia?

Yes, yes there is!

In recent years, references to Australia's 'mental health crisis' have emerged in various public discourses. What people mean when they talk about the mental health crisis is multifaceted, evolving, and difficult to define, however some of the key issues underpinning the crisis include:

- the declining mental health of the population in general, as shown through indications of increased distress (especially in children and young people);
- the inability of the existing health care service system to meet demand, particularly public mental health services;
- problems with the quality of care provided, including difficulties finding appropriate care, and also harm and trauma caused by the system due to stigma and discrimination within services, or punitive approaches to treatment;
- related to the above point, calls for more trauma-informed, culturally-sensitive, caring and compassionate approaches that can work holistically with people experiencing mental health concerns;
- the lack of affordable care options and ongoing barriers to access services (transport, location, long waitlists, narrow eligibility criteria, etc.);
- the inappropriateness of services as they currently are designed and delivered; and/or
- the urgency of the problem, suggesting that we cannot ignore this crisis without disastrous consequences for people's mental health, wellbeing and quality of life.

There is also a well-known concern in the public realm around the 'missing middle', a term that refers to the ineffectiveness of the mental health system for catering for people 'in the middle' of the spectrum/severity of mental health issues, due to being 'not sick enough' to receive help[15] (even though we know that receiving care early in the experience of symptoms is best practice and more cost effective).

Calling out these issues was once the work of advocacy bodies and consumer groups, but more recently, these concerns have been echoed by institutions with the political authority to demand change. In recent years the "Not for Service" report[16], the Senate Select Committee Report on Mental Health[17], the Royal Commission into the Mental Health System in Victoria[18] and the Productivity Commission report into mental health[19] have all expressed urgency about addressing deficiencies in the mental health system. In 2021, CSI conducted an analysis of the alignments between the Productivity Commission report[3], and the report on the Royal Commission into Victoria's Mental Health System[20] (two high impact publications) as well as the then current policy documents of all Australian state and territory governments[21] to uncover the reform areas recognised across all documents. Findings were presented as problem statements, summarised in Table 1.

TABLE 1 Politically recognised problems with the mental health system

SUMMARY OF POLITICALLY RECOGNISED PROBLEMS WITHIN THE MENTAL HEALTH SYSTEM			
1	2	3	4
Social inequalities exacerbate mental health issues for the least advantaged groups, and are further amplified by the significant access barriers in the mental health system which work to exclude many diverse and more vulnerable groups.	**Waiting for people to be in crisis** and access acute care as their first contact with the mental health system is not working well (for individuals or the system).	**Care is fragmented;** it is difficult for people to find holistic support for where they are at, to find support early, and to find the appropriate support to help them move through their experience to recovery (and sustain their recovery).	**The mental health crisis in Australia is not improving** despite continued investments. Heavy investment in acute, tertiary care is expensive and not cost-effective, contributing to the inadequate spread of resources and supports across other areas.

[15] The Office for Mental Health and Wellbeing. (2022). Final Report: Understanding the 'Missing Middle': Children and young people with moderate to severe mental health concerns who experience difficulties accessing services. ACT Government, Health.

[16] Mental Health Council of Australia. (2005). *Not for service: Experiences of unjust and despair in mental health care in Australia.* Australian Human Rights Commission.

[17] Senate Select Committee on Mental Health (2006). *A national approach to mental health: From crisis to community.* Commonwealth of Australia.

[18] State of Victoria, Royal Commission into Victoria's Mental Health System. (2021). *Final Report: Summary and recommendations.* State of Victoria, Royal Commission into Victoria's Mental Health System.

[19] Productivity Commission. (2020). *Mental health: Productivity commission inquiry report.* Australian Government.

[20] State of Victoria, Royal Commission into Victoria's Mental Health System. (2021). *Final Report: Summary and recommendations.* State of Victoria, Royal Commission into Victoria's Mental Health System.

[21] Elmes, A., Kaleveld, L., Olekalns, A. & Clark, K. (2021). *Mental Health Deep Dive: Strategic context and problem definition report.* Centre for Social Impact.

A view of the mental health service system in Australia

Australia's mental health system is highly complex. Public healthcare is funded and delivered through federal systems such as Medicare, Primary Health Networks and disability services, while state/territory systems primarily facilitate access to specialist public mental health care in hospitals and in the community[22,23]. Private health insurers provide mental health treatments for their customers through private hospitals or by private healthcare providers. To a lesser extent, there are also non-government organisations (NGOs) that offer wellbeing, psychosocial and recovery-oriented supports (rather than clinical mental healthcare) to people with a mental health condition[4].

> ***Some services are 'high barrier', involving significant out-of-pocket costs, rigorous application processes and narrow eligibility criteria. People can have difficulties trying to get help, and then give up completely without realising that there are other services that are free, and relatively accessible to everyone.***

It is estimated that one in ten Australians accessed Medicare-subsided mental health services in 2020–21, which is 11% of the population (2.9 million Australians) and a 7% increase of service use from 2010–11[1]. However, these statistics do not capture a complete picture of mental health need or the utilisation of service systems across the country. Findings from the former Bettering the Evaluation and Care of Health[24] survey suggest that mental health related Medicare statistics yield a significant undercount of actual mental health related services provided by practitioners. For example, many General Practitioners may use standard consultation items when consulting with people whose mental health is being 'managed'. Additionally, Medicare-subsidised mental health programs are capped, meaning Medicare data alone is unable to capture individuals who rely on private health insurance, or those who are paying for services out-of-pocket. It is likely that the proportion of people actively seeking or engaging with mental health related services is much higher than the estimate reported in Medicare-subsidised service data.

The National Disability Insurance Scheme (NDIS) also provides support for people living with mental health conditions. It is estimated that every year the NDIS supports 56,559 people who have psychosocial needs such as need for social supports and informal connections[25]. However, a substantial number of people are not connected with the NDIS, despite having significant need for psychosocial and mental health support. The NDIS has been described as 'an oasis in the desert': those who are ineligible for the scheme are virtually left with nothing[26]. The Productivity Commission estimates that approximately 690,000 people with a mental health condition would benefit from access to psychosocial support services, and around 290,000 of these people have a severe and persistent mental health condition[27]. However, only approximately 34,000 people with a primary psychosocial disability receive psychosocial supports under the NDIS, and 75,000 people receive psychosocial support directly from other federal, state and territory government-funded programs.

The interaction of the various disjointed service systems and funding streams mean that it can be difficult to get a true estimate of how many Australians are currently accessing mental health support, or have unmet needs. This complexity also can also make services difficult to navigate as they lack integration and coordination. Many services are 'high barrier', involving significant out-of-pocket costs, rigorous application processes and narrow eligibility criteria. People can have difficulties trying to get help, and then give up completely without realising that there are other services that are free, and relatively accessible to everyone.

[22] Australian Institute of Health and Welfare. (2022). *Mental health services in Australia.*

[23] Cook, L. (2019) cited by Elmes, A., Kaleveld, L., Olekalns, A. & Clark, K. (2021). *Mental Health Deep Dive: Strategic context and problem definition report.* Centre for Social Impact.

[24] Britt, H., ...et al. (2016). *A decade of Australian general practice activity 2006–07 to 2015–16.* Bettering the Evaluation and Care of Health. Sydney University Press.

[25] National Disability Insurance Scheme. (2022). *Data and Insights.*

[26] Burton, T. (2022, April 29). *'An oasis in the desert': Why the NDIS is a mess.* Financial Review.

[27] Productivity Commission. (2020). *Mental health: Productivity commission inquiry report.* Australian Government.

Understanding social determinants is critical for recognising that risk factors for mental health conditions are not equally distributed and are strongly associated with social inequities.

Health equity and the social determinants of mental health

In 1971, Julian Tudor Hart famously published a paper, 'The Inverse Care Law'[28], asserting that the availability of good medical care tends to correlate inversely with the need for it in the population served. Hart argued that inequalities in health are compounded by inequalities in access to care as the poorer members of society cannot afford to pay, or the services are just not as available in their local communities. Hart's widely cited paper remains relevant decades later.

The paper also highlighted the correlation between poorer health outcomes and 'deprived environments', or what we might today call the social determinants of health. Since the publication of Hart's paper, and especially in the last decade, there has been greater focus on the impacts of the social context on health, and the ways in which broader systems and structures, from policies and the healthcare system to workplaces and neighbourhoods, influence people's quality of life and therefore health outcomes[29]. These dynamics apply to mental health to a large extent: in addition to individual biological and psychological factors, a broad range of social, political, economic and environmental factors impact mental health outcomes[30,31].

Understanding social determinants is critical for recognising that risk factors for mental health conditions are not equally distributed[32] and are strongly associated with social inequities[33]. This is further exacerbated by system design; people most at-risk of a mental health condition are least likely to want to, or to be able to, find supports that feel safe or are accessible.

There is a lack of visibility, data, and clear understandings about the support needs of those who are impacted by social inequities and are also least likely to seek and receive support – including young people, people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people and people from the LGBTQIA+SB community.

Thus, while there are problems with the mental health system, a much broader range of systems and services intersect with, and influence, mental health – Australia's income support system, housing assistance and employment programs, for example. Provision of mental healthcare is part of the picture, but attention to social and economic circumstances is also important for addressing health inequities, as recognised by Australian and international mental health researchers, by the recent public inquiry processes into mental health in Australia[34,35], and by organisations focused on more effective investment into mental health[36].

Lived experience

The ACDC Project Team recognise and acknowledge the contribution of people with a living or lived experience of mental health issues, experiences of trauma, alcohol and other drug issues, and the families and carers who provide support. Shedding light on, and channelling political will towards, the limitations in the mental health system (as described through Section 1.3) could not have occurred without the critical voices of people with lived experience informing all aspects of mental health policy development, service delivery and design, as well as research and evaluation.

[28] Hart, J. T. (1971). The Inverse Care Law. *The Lancet, 297*(7696), 405–412.

[29] United Nations. (2020). *World Social Report 2020: Inequality in a rapidly changing world.* Department of Economic and Social Affairs of the United Nations Secretariat.

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

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

[32] Productivity Commission. (2020). *Mental health: Productivity commission inquiry report.* Australian Government.

[33] Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392–407.

[34] Productivity Commission. (2020). *Mental health: Productivity commission inquiry report.* Australian Government.

[35] Victorian Government. (2021). *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations.*

[36] Future Generation Investment and EY. (2021). *Australia's mental health crisis: why private funders are not answering the call.*

People with lived experience expertise have not only been critical for the design and implementation of this project (see Section 3), but in a broader sense, the way mental health is understood and responded to in Australia has benefitted from years of their advocacy.

While the significant contribution of the 'lived experience movement' sounds very much like something to celebrate, it also needs to be recognised that the lifting up of these perspectives is part of a difficult recovery journey from last-century approaches to mental health. Historically, the voices and choices of people with mental health issues were largely ignored and dismissed, especially within overly-institutionalised settings. This has resulted in hard-to-shift power imbalances, such as between clinicians and consumers, and, consequently, reduced efficiencies and effectiveness of supports.

> ***"Mental health consumers have been witness to decisions made on their behalf, often without consultation. This has meant that a system of inequity is embossed on service delivery and representation." (Maggie Toko, Co-Chair, Lived Experience Expert Reference Group, 2021)***

Things are rapidly changing as mental health advocates and leaders realise that without understanding what it is that people need to recover, and to feel safe and well supported, a system cannot effectively respond to those in need. As lived experience has gained currency and influence, we believe that this has created enabling conditions for trying new approaches – especially investing in more inclusive and humane methods to connect with diverse people outside of institutional settings. Not only do lived experience voices tend to support out-of-the-box ways of working, but the lived experience perspective can also remind us why it is imperative to do so.

The impacts of climate change and the COVID-19 pandemic

This project has been delivered during a challenging period for many Australians, as the impacts of climate change and severe weather events, including floods, bushfires and drought are beginning to be felt with a new intensity.

Furthermore, this project took place during a significant period of global disruption arising from the COVID-19 pandemic. Lockdowns and extended lockdowns, school closures and border closures between various states and territories, and in some cases, food shortages, as well as the impact of the illness itself on human health and local economies, have disrupted the patterns of everyday life in Australia throughout the project timespan. This has had diverse impacts on the mental health of Australians, depending on their personal interaction with a range of factors, and the changing influence of federal, state, and local policies and regulations, as well as personal and familial circumstances.

Emerging research on the mental health impacts of COVID-19 point to both a worsening of symptoms associated with pre-existing mental health conditions, and also high psychological distress in the general population during this time[37,38].

Within Australia, rapid policy and practice changes were made to respond to the impacts of COVID-19 on mental health, with implications for access to mental healthcare[39]. Major developments included increased outreach and support for those at risk of suicide, the expansion of digital and telehealth services, increased coordination between primary and acute care services, and greater focus on responding to other basic needs, such as housing for people experiencing homelessness, and meeting social, emotional and cultural needs at a time when people may have had very restricted access to their usual social activities and supports[40].

Not only do lived experience voices tend to support out-of-the-box ways of working, but the lived experience perspective can also remind us why it is imperative to do so.

[37] National Mental Health Commission. (2020). *National mental health and wellbeing pandemic response plan.* Australian Government.

[38] Rossell, S. L., Neill, E., Phillipou, A., Tan, E. J., Toh, W. L., Van Rheenen, T. E., & Meyer, D. (2021). An overview of current mental health in the general population of Australia during the COVID-19 pandemic: Results from the COLLATE project. *Psychiatry Research, 296*, 113660.

[39] Victorian Government. (2020). *Framework and guidance for mental health care during COVID-19. Department of Health & Human Services.*

[40] National Mental Health Commission. (2020). *National mental health and wellbeing pandemic response plan.* Australian Government.

The Better Access initiative, which provides Medicare rebates to people accessing psychological support, was extended to offer telehealth sessions to everyone (regardless of geographical location), and to provide an additional 10 sessions of support per calendar year to people experiencing ongoing mental health impacts from the pandemic[41].

Cultural conditions have also changed. With the collective struggles of climate disasters and the pandemic, there is more recognition of mental health as a valid concern or, at minimum, a less stigmatised issue. Possibly more people are responsive to informal discussions about mental health as there is a greater acceptance of the need for mental health support, or at least to talk about mental health, during these times.

1.4 WHO IS MISSING OUT ON SUPPORT AND WHY?

Barriers to accessing mental health support

Despite Australia having a system to support people experiencing mental health conditions, many who need support are not accessing appropriate, high quality support services, and sometimes are not accessing any supports at all. We know, for example, in the case of suicide prevention, many prevention and early intervention activities focus on people who access hospitals, but, as researchers point out, a significant proportion of people who die by suicide have not attended hospital in their last year of life[42].

Barriers to access are numerous, and can include both person barriers (e.g., not knowing when or where to seek help; not feeling safe to seek help) and systemic barriers (e.g., services and supports are not accessible by public transport; high costs are associated with mental health supports; a lack of specialised services or supports for specific needs).

Barriers to access are numerous, and can include: not having awareness of poor mental health and/or the knowledge of when to seek help; not knowing how to get help; not feeling safe getting help; not being able to access the support needed (transport, burdens of life, waitlists, costs, eligibility criteria); and, not being able to find the good quality, appropriate care that may be required for specific needs.

While the problem is known, the extent of the problem is not well understood. Responses to address mental health barriers have included the utilisation of mental health promotion campaigns to encourage help-seeking and the wide promotion of easy to access, low threshold support options, such as Lifeline. However, very few activities are targeted to the needs of specific groups, let alone personalised to the circumstances or beliefs of an individual. There is more and more interest in the use of peer workers who could help address some of the identified barriers using more individualised approaches, but again, these models rely on individuals with mental health concerns making the first move and actively seeking out supports.

This section summarises a literature review that sought to identify the social groups who face additional barriers to seeking supports and therefore, are more likely to be unrepresented within the mental health system. It presents academic evidence about what the barriers might look and feel like for these groups, and considerations for the ACDC Project design responded to these understandings in order to make the project more relevant and effective. Please note, this summary is based on published academic literature that reflects very specific search criteria, and therefore, due to biases in the research community, the literature and search terminology, certain cohorts and needs are not necessarily represented in the results. However, the overall approaches and principles can apply more broadly.

With the collective struggles of climate disasters and the pandemic, there is more recognition of mental health as a valid concern.

[41] Australian Government. (2021). Better Access initiative. *Department of Health*. https://www.health.gov.au/ initiatives-and-programs/better-access-initiative

[42] Clapperton, A., Spittal, M. J., Dwyer, J., Garrett, A., Kolves, K., Leske, S., ... Pirkis, J. (2021). Patterns of suicide in the context of COVID-19: Evidence from three Australian states. *Frontiers in Psychiatry, 12*, 797601.

Doorknocking as a way to address access barriers: a literature review

Between Round One and Round Two, CSI conducted a literature review[43] which aimed to unpack the following:

1. The barriers people face accessing mental health and social and emotional wellbeing supports and services, and how these barriers intersect with different socio-demographic characteristics; and
2. The extent to which a doorknocking approach has the potential to address these barriers.

A search strategy was established based on the key concepts from the research questions above. These key concepts were used as search terms, searched in academic and other relevant search engines. Relevant references are provided in Appendix A.

The literature review indicated that the two most common barriers that impact the use of mental health services are:

- stigma around poor mental health and around discussing mental health; and
- the inaccessibility, unaffordability and inadequateness/inappropriateness of services when trying to access mental health care.

These barriers apply universally, but have an even greater impact for certain groups of people – those from culturally and linguistically diverse backgrounds (culturally and linguistically diverse persons), low socio-economic households, Aboriginal and Torres Strait Islander peoples, and people who live in rural settings. The literature also indicated that males are more likely to experience stigma around mental health and are less likely to connect with services than females.

The review considered a 'what works' approach to understand how to address these barriers and drew some evidence-informed conclusions about where the focus should be on the implementation of the ACDC Project to ensure that these barriers were adequately considered. Many of these recommendations were effectively implemented, to some extent, when the project was reviewed between Round One and Round Two. However, the extent to which the recommendations could be adopted across the remaining 17 sites did vary.

Stigma as a barrier to mental health help-seeking

The literature illustrated how stigma surrounding mental health, or discussing mental health, is one of the greatest barriers people face in accessing or utilising mental health services. Evidence suggests that seeking mental health support is particularly difficult for certain communities, such as culturally and linguistically diverse persons and males. Culturally and linguistically diverse persons can harbour different beliefs about social and emotional wellbeing, which can often make help-seeking more difficult, particularly if support is not culturally relevant or safe. Males are disproportionally impacted by stigma as social systems can often perpetuate negative stereotypes about the relationship between masculinity and mental health which can cause the internalisation of harmful ideologies and therefore reduce the ability to seek supports (see Table 2).

[43] Meltzer, A., Varadharajan, M. & Kelly, M. (2021). *Barriers to using mental health services from the community*. Report produced by the Centre for Social Impact, The University of New South Wales.

TABLE 2 Stigma – Addressing these barriers and the implications for the ACDC Project

BARRIER	HOW TO ADDRESS THIS BARRIER	IMPLICATIONS FOR THE ACDC PROJECT
Stigma within culturally and linguistically diverse communities	It is important to shift responsibility away from the individuals to seek professional help, and instead, approach people in a way that is accessible, sensitive, and culturally appropriate to their needs. Mental health education and campaign strategies in the community should specifically aim to enable culturally safe and inclusive ways of engaging with mental health services (for instance, delivering information using different languages; Blignault et al., 2008; Onyx & Bullen, 2000; Omer et al., 2008). Identifying local needs of communities can be achieved by employing doorknockers who are either from that community, or of a similar demographic (Greenberg, 2006; Hillier et al., 2014; Harley et al., 2020; De Cotta et al., 2021).	The ACDC Project needs to offer an easily accessible, culturally informed, and sensitive approach to connect with people from culturally and linguistically diverse backgrounds and communities. For example, by providing resources in different languages, or linking people to service options that are delivered in their language. The doorknocking approach should be tailored, culturally appropriate, user-friendly, and provide resources face-to-face. The ACDC Project needs to ensure People Connectors recognise the cultural contexts and local needs of the communities they are door-knocking. The ACDC Project needs to build a climate of trust and establish positive relationships and engagement with cultural leaders in the communities where it is being delivered.
Increased stigma among males	At the system level, there needs to be a societal shift that redesigns masculinity, removes stereotypical views of male-centric attributes, and normalises help-seeking behaviour. This could be initiated through stronger social marketing and gender-sensitised public health campaigns that encourage emotional disclosure (Seidler et al., 2020). Literature suggests there is potential for face-to-face interactions to initiate a change relative to stigmatised health topics (Integrated Health Project Plus, 2018; Massachusetts Institute of Technology, 2020). Building rapport through gender matching could reduce stigma and possibly normalise health topics by encouraging casual or informal discussion between men (Harley et al., 2020; Integrated Health Project Plus, 2018; Massachusetts Institute of Technology, 2020). In community health settings, a stronger delivery of male-focused services, which specifically challenges gendered stigma, should be implemented (Bilsker et al., 2018). More transparent provision of information about different types of therapy and male-focused services should be promoted (e.g., Men's Sheds; Seidler et al., 2020) and an emphasis on the confidential nature of mental health services should be reiterated (Rickwood et al., 2005).	The ACDC Project needs to hold in mind the stigma and shame males feel regarding mental health, and specifically implement strategies to enable more engaging conversations at the door (e.g., gender matching where male People Connectors are encouraged to initiate engagement with male Householders, if appropriate). The ACDC Project needs to offer clear and specific information that is aligned with men's needs, including different types of community support groups available. The ACDC Project needs to utilise the services of local organisations relevant to men where possible, including social marketing strategies and campaigns that promote the importance of men's mental health.

Inaccessibility and unaffordability of services

The inaccessibility and unaffordability of services is another significant barrier faced by people who need mental health supports. In some cases, mental health supports may be inadequate/inappropriate for certain groups of people – for instance, people from low socioeconomic households, those who live in rural areas, or people who are from culturally and linguistically diverse backgrounds. Table 3 illustrates these barriers, how they could be addressed, and their implications for the ACDC Project.

TABLE 3 Service barriers – Addressing these barriers and the implications for the ACDC Project

BARRIER	HOW TO ADDRESS	IMPLICATIONS FOR THE ACDC PROJECT
Inaccessibility and unaffordability as barriers for people from low socio-economic households	To make mental healthcare more accessible and affordable across different income levels, government-funded services should be expanded. There is also a need to create more meaningful connections with community members as a means of getting past barriers faced by those who are from low socio-economic communities (Park et al., 2020). This includes stronger utilisation of community mental health workers in low socio-economic communities who possess greater interdisciplinary training and collaboration between different specialists, such as psychiatrists, psychologists, nurses and social workers (Campo et al., 2018); and more diverse and affordable options, such as routine mental health screening in physical health care settings (Ayres et al., 2019).	The ACDC Project needs to proactively engage with healthcare and allied health professionals who are involved in providing services to the communities being doorknocked to improve mental health assistance to low socio-economic and hardly reached groups. The ACDC Project needs to consider different ways in which services and service access routes can be improved for people from low socio-economic communities.
Inaccessibility and unaffordability as barriers for people living in rural settings	More equitable distribution of mental health services in rural locations is needed. This could include: targeted investment and resources to strengthen community care in rural areas (Hinton et al., 2015); and better infrastructure and support to encourage stronger utilisation of alternative forms of mental health care (e.g., online or over-the-phone care) to tackle challenges surrounding physically accessing care. Evidence suggests that many people are not aware that online and phone services are available to them, and so, strengthening awareness through offline mediums could be beneficial (Bowman et al., 2020).	The ACDC Project needs to establish strong links with local service providers to maximise resource efficiency in rural settings. The ACDC Project needs to equip People Connectors with appropriate information and knowledge about online/phone support and access to online/phone services to inform Householders, especially in more rural communities. People Connectors may also require information about services which can assist Householders to access the Internet or use technological devices.
Inadequate/ inappropriate services as a barrier for culturally and linguistically diverse communities	A holistic, transcultural approach with greater recognition of diverse styles of mental health care is more appropriate for culturally and linguistically diverse persons (Yeung et al., 2017). There is a need for mental health services to be delivered in a variety of languages, and provided by culturally diverse staff (Blignault et al., 2008), as well as for training in cultural nuances for Western practitioners (Memon et al., 2015; Tulli et al., 2020). Routine mental health screening should be implemented across all cultures, with continual research into how this can be improved and be culturally-appropriate for different groups (Holden et al., 2020).	The ACDC Project needs to ensure People Connectors have cultural diversity, community language skills and local community connections and cultural knowledge, where possible. It is important that the People Connectors have good knowledge of which culturally informed services they could refer culturally and linguistically diverse Householders to. This will ensure the best chance of services properly meeting their needs.

As the literature review findings presented in Table 2 and Table 3 illustrate, a doorknocking initiative, such as the ACDC Project, has the potential to address many of the barriers identified by the literature, provided that barriers can be adequately addressed. In light of the findings of the review, Round Two of the ACDC Project took the follow points into consideration, as much as was practicable (which varied across the sites):

- The careful matching of sociodemographic/cultural background and language skills of People Connectors, as well as their knowledge, skills and experiences, to meet the needs of the communities they were doorknocking in;
- The investment of time and training to ensure People Connectors in rural areas knew about self-directed mental health literacy, education and online resources that could help meet the gaps in service delivery;
- The guarantee that People Connectors in culturally and linguistically diverse areas were well-informed and knowledgeable of relevant culturally appropriate service options available to Householders;
- That time and effort was invested to establish thorough and effective community engagement practices and structures within each local community to support doorknocking work (preferably prior to the beginning of the doorknocking period); and
- Consideration of strategies to supplement doorknocking, such as follow-up.

Overall, the findings of the literature review suggest that, with a continually improving focus on these considerations above, the doorknocking approach of the ACDC Project has the capacity to help to address some of the main barriers to use of mental health services from the community, including for socio-demographic groups who are shown to be particularly disadvantaged by these barriers.

1.5 RELEVANCE: HOW THE ACDC PROJECT RESPONDS TO NEEDS AND PRIORITIES IN MENTAL HEALTH

The strategic context in which the ACDC Project has been developed and delivered underpins the project rationale in many ways. The need to look beyond the boundaries of the mental health service system as is, responds to various calls for reform.

People who are already connected to services may have understandings of mental health – and consequently the language, awareness and help-seeking behaviours – that are compatible with current service designs. However, as indicated by lived experience perspectives, health equity researchers, policy specialists and evidence in the literature about service access barriers, there is a significant portion of the population beyond this segment, who are not actively seeking support, may have tried and not been successful or may not know they need support or how to get it. The ACDC Project's starting position is that we cannot assume they are doing OK just because their needs are not visible.

"If people don't go to your service, then they're not on your waiting list. You're not picking up on the need, so you're planning your services based upon people exercising help seeking behaviour." (ACDC Project Team member)

There are few mechanisms for identifying the full extent of mental health need in the community, especially at the community level. System data reflects a sample of people who are going to services directly, or who access services through referrals (while overcoming sometimes multiple barriers such as those listed in Section 1.4) and is therefore not an adequate way to provide services to a population, or to understand the extent of support needed.

"If you go proactively out into community…you will get a real selection of people because there's a lot of people that don't go into help-seeking behaviour or they're quite averse to being connected to traditional mental health services. Sometimes they've been there, but they've had bad experiences and don't want to go back again." (ACDC Project Team member)

Connecting with someone who might be isolated, in emotional distress, or having a hard time could help that person in that moment, but also connect them to ongoing support after which, ***"they might not end up down the track in an emergency department or in a worse situation." (ACDC Project Team member).*** In addition, learning about the needs of people who are not currently connected to supports can inform mental health leaders and advocates about changes that can be made to build a mental health system that is more accessible and responsive to need.

This section has provided an overview of the strategic context that helps to understand how the ACDC Project is relevant to, and coherent with, mental health reform directions and priorities, and how the learnings could potentially contribute to broader system changes.

The rest of this Evaluation Report will unpack questions around effectiveness of the project and its impact on participants and communities. We will present evidence to explore both the risks and the value of the doorknocking method: what we uncovered about mental health need, how Householders experienced the approach, and, importantly, whether unscheduled doorknocking, provision of information, and informal conversations about mental health are effective in helping people to address the needs they describe, especially people who are not currently connected with any services or supports.

The Research and Evaluation Framework for the ACDC Project, developed by the ACDC Research and Evaluation Working Group, specified two related but distinct functions – evaluation and research – both with different purposes (see Figure 3).

2. RESEARCH AND EVALUATION DESIGN

2.1 THE RESEARCH AND EVALUATION FRAMEWORK

FIGURE 3 Evaluation and research purpose

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 interactions with Householders, relevance 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 questions

1. Is a proactive outreach approach through doorknocking an effective means of discovering people with unmet mental health support needs?
2. What are the learnings about how to best implement this approach?
3. What has been the impact of the ACDC Project on Householders, People Connectors, and Delivery Partner Organisations?
4. Can this approach be effective for linking people into supports, especially people who would otherwise not be supported?
5. Under what conditions, and for whom, does it provide the most benefit?

Research focus

The research focused on data collected via the ACDC Project Householder Survey. Survey responses enabled a deeper understanding of, and evidence for, mental health need across the various sites. Key findings subsequent to these data are presented in *Home truths about mental health in Australian communities*[44], a supporting report published by CSI for Round Two of the project. The survey asked

[44] 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.

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 for Householders across communities (sites), in both people currently connected to local community supports and mental health services, and people who are currently not connected to local community supports and mental health services?
2. What factors, including the social determinants of mental health, are contributing to unmet need, and what is the variance of need for Householders across the different sites?

Note: While a summary of the research output is presented in this report (Section 8), the dataset is very comprehensive and rich. Research outputs will be ongoing and continue into Round Three. Research outputs will include, but are not limited to, academic publications co-authored with researchers across sectors and universities, and potentially a series of short reports and policy briefs.

Governance and supporting structures

Ethics and oversight

Community Mental Health Australia commissioned CSI as the evaluation and research partner for the ACDC Project, thus the ACDC Team provide project management for the evaluation and research deliverables. The evaluation is also overseen by the 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 meet to provide suggestions, critical advice and input into the research and evaluation design. Moving into Round Three, the Research and Evaluation Working Group and the ACDC Project Steering Committee will continue to oversee and advise on various components of the evaluation and research.

The evaluation and research component of the ACDC Project received ethics approval from the Human Research Ethics Committee at the University of Western Australia (2020/ET000171), and this ethics approval has been ratified by ethics committees based at Swinburne University and the University of New South Wales.

Culture supporting research and evaluation

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

- That CSI, the research and evaluation partner, is independent of the ACDC Project team while also enjoying a close working partnership, which provides conditions that help to ensure high quality and robust findings;
- The ACDC Project team and members of the CSI Evaluation Team have worked together to co-design various 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 preliminary findings could be presented with recommendations to help inform ongoing project design (e.g., Round One findings informed Round Two), bringing a strong utilisation-focus to the evaluation.

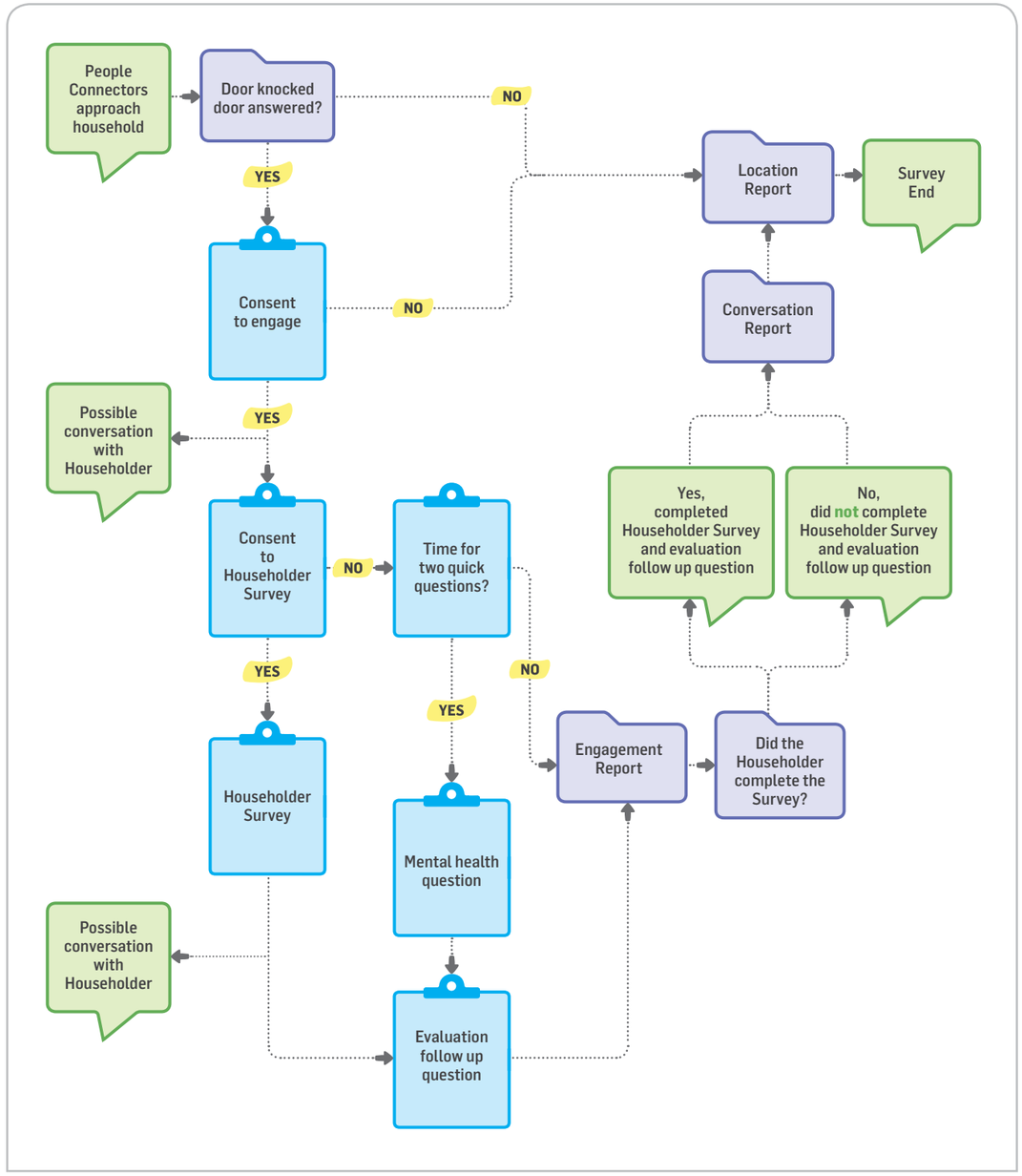
2.2 METHODOLOGY

Data collection

Field survey

The main data collection activities were conducted by People Connectors while doorknocking. This consisted of a Qualtrics-based survey to capture key engagement information such as number of doors knocked, and number of doors answered. Where the door was answered, and a Householder engaged with the People Connectors, information about the conversation was collected, including whether a Householder Survey was completed. The following flow diagram (Figure 4) indicates the stream of how information was captured through Qualtrics while the People Connectors were in the field.

FIGURE 4 Data collection activities in the field



Mixed methods

In addition to the Field Survey, a mixed methods approach ensured a breadth of information could be collected to inform both the evaluation and research outputs. For a broad overview of all data collection activities and how each method informs the evaluation and research outputs; see Table 4.

TABLE 4 Overview of methods

METHOD	BRIEF DESCRIPTION	RESEARCH OUTPUTS	EVALUATION OUTPUTS
DATA COLLECTED INDEPENDENTLY BY CSI			
Literature review	Summary of cohorts who are less engaged in services and strategies to reach	✓	✓
Community overviews	Summary of ABS data for each site	✓	✓
People Connector Focus Groups	Focus Groups with People Connectors at each site (N[45]=38)	✓	✓
Delivery Partner interviews	Interviews with supervising manager of People Connectors at each site (N=17*)	✓	✓
ACDC Staff interviews	Interviews with ACDC staff about implementation learnings (N=7)		✓
Wave 2 Householder Survey (incentive)	Follow-up evaluation survey for Householders who provide consent and contact details, with $20 incentive payment (N=274)		✓
Wave 2 Householder Survey (non-incentive)**	Follow-up evaluation survey for Householders who provide consent and contact details, with no incentive payment offered (N=11)		✓
Wave 2 Householder interviews	Follow-up interview with Householders who provide consent and contact details (N=9)	✓	✓
DATA COLLECTED BY THE PROJECT OR ACDC PROJECT TEAM			
Engagement data from Field Survey	Data to inform doorknocking activity and engagement metrics (N = 10,605)	✓	✓
Householder Survey	Survey of Householders' mental health and needs (N=3,811)	✓	
Exit surveys for People Connectors	Brief survey designed and administered by the ACDC Project Team for all People Connectors exiting the program (N=28)		✓
Site activity reports	Summary of doorknocking activity and Householder engagement by Delivery Partners (N=16)		✓
Impact stories	Story template designed by CSI, and story collection from People Connectors facilitated by the ACDC Project team	✓	✓

*Some interviews covered two sites at once and some DPOs did not engage therefore there were less interviews than sites;

** Householders who spoke to a People Connector in the field were directed to the Wave 2 Householder Survey (with incentive payments attached) and Householders (or others) who completed the Householder Survey online (also called the Self-Administered Survey) were directed to the Wave 2 Householder Survey (no incentives). No incentives were offered through the online path as the participants could not be verified.

[45] N = sample size.

Approaches to data analysis and interpretation

To support a complexity-sensitive evaluation of an innovative project, as well as the research outcomes and purpose, the following methodological and analytic frameworks informed the data collection, synthesis of data, interpretation and sense-making of findings (see Table 5).

TABLE 5 Methodological and analytic frameworks informing the evaluation and research

COMPLEXITY-SENSITIVE APPROACHES TO EVALUATION AND RESEARCH	
1	A mixed methods approach (e.g., looking for alignment between quantitative and qualitative data or plausible explanations for misalignment).
2	Triangulation of findings across more than one data source (e.g., People Connector Focus Groups and Householder interviews), or measure (e.g., measure of wellbeing and measure of psychological distress).
3	Situational analysis (e.g., understanding impacts of adverse events in context, such as community experience with COVID-19 lockdowns or severe adverse weather events).
4	Accommodating various stakeholder perspectives on findings, including lived experience.
EVALUATION APPROACHES TO INNOVATION AND IMPACT	
1	A focus on stakeholder impact based on evaluation criteria (e.g., impact on Householders, capacity building for People Connectors, capacity building for communities).
2	Realist evaluation/success case method approaches (e.g., description of who this works for and under what conditions, case studies to depict optimal conditions).
3	Consideration for legacy and advocacy (e.g., what information will uncover learnings that can be applied to better support mental health of the Australian population?).
EQUITY-BASED ANALYSIS	
1	Analysis by remoteness using the Accessibility and Remoteness Index of Australia (ARIA+)[46] a remoteness index that assesses rurality as well as accessibility/distance from services.
2	Analysis by advantage and disadvantage using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)[47].
3	Cohort analysis (e.g., what are the cohorts of interest, how are they engaged, who is overrepresented or underrepresented?).
4	Understanding variance across communities (e.g., findings are influenced by contextual factors, limits on generalisability, no one-size-fits-all solutions).
5	Understanding the findings of the ACDC Project sample with reference to the national context (e.g., ACDC Project data compared to ABS data where appropriate).

[46] Australian Bureau of Statistics. (2016). Remoteness Structure: *The Australian Statistical Geography Standard (ASGS) Remoteness Structure*. https://www.abs.gov.au/

[47] Australian Bureau of Statistics. (2016). *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA)(No.2033.0.55.001).* https://www.abs.gov.au/

Limitations

Limitations to who engaged with the project

Participation in the ACDC Project was inclusive and very low threshold – for example, all that was required of someone to participate was that:

- they be at home when the People Connectors knocked;
- they not be isolating due to COVID-19;
- they be 18 years old or older; and
- they have the time and willingness to engage.

Naturally, people who were not at home were not able to participate, and this could mean people out during the day working in jobs outside of the home, studying, volunteering or participating in other activities were not able to be reached. However, as a result of the COVID-19 pandemic, 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[48] 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.

Limitations to Householder Survey participation

While many people welcomed a conversation with People Connectors, the demands of a long survey to fill out without pre-scheduling the time to do so, meant that some people may have been unable or unwilling to complete the survey because it was not convenient. People Connectors responded to this challenge by also offering paper-based surveys, and they offered to collect the completed survey at a later time or day, thus allowing people adequate time to fill in the survey, or the privacy to complete it alone. Based on speculation, the survey sample may have been biased towards:

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

There were no incentive payments for completing the Householder Survey.

Limitations to Evaluation Survey and Evaluation Interview participation

Householders engaged in the field were asked to complete an Evaluation Survey to capture their experiences of the ACDC Project. Participants for the Evaluation Survey were all recruited from the sample of Householders who spoke with People Connectors. They were recruited in two ways:

1. Through a question at the end of the Householder Survey, 'would you be interested in participating in an evaluation survey?'; or,
2. If they did not agree to complete the Householder Survey they were asked whether they had time for two quick questions – one of which was 'would you be interested in participating in an evaluation survey?' Thus participation in the Householder Evaluation Survey was offered to all Householders, regardless of whether they completed the Householders Survey.

If people agreed to the Evaluation Survey they were then required to provide their contact details – asked to give their email address or phone number to a stranger – so this may have been a barrier for some people to participate in the Evaluation Survey. There was also a $20 incentive payment attached to completing the Evaluation Survey.

The Evaluation Survey was sent out a month later, potentially meaning that people with stronger memories or experiences of the ACDC Project were more likely to be on the lookout for the survey link, and to engage.

There may be a bias in the sample of people who filled in the Evaluation Survey – people more likely to engage with a People Connector, and people more motivated to remember and reflect on their experience, whether it was positive or negative.

[48] 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.

When a Householder described themselves as 'down in the dumps', this was taken as valid and not necessarily interrogated further to align with diagnostic criteria or specific mental health categories.

However, there was an incentive payment for this survey, which would have helped reduce the bias, and encourage people with more neutral experiences to also participate. Some respondents commented that by the time they did the survey it had been too long to remember details – another data quality limitation.

At the end of the Evaluation Survey people were asked whether they would like to be contacted by a researcher from the CSI for a follow-up Evaluation Interview. They could select some preferences such as whether the interviewer was someone with lived experience, or a specific gender. There were no incentive payments for the interview. The Evaluation Interview sample is likely to be biased towards people who were most engaged in all aspects of the project.

Generalisability limitations

The selection of sites and suburbs was informed by the Expression of Interest (EOI) process and practicalities of organisations willing and capable who could successfully undertake the project. Sampling of communities was not informed by research design, except to a limited extent.

Because the data collected across the sites showed significant variation in survey response rate (minimum n = 104; maximum n = 370), and as the sampling procedures were biased, the results of the Householder Survey cannot be generalised to the community as a whole, as they do not accurately represent the collective experience of each site. Data are only representative of the Householders who were home, willing, and able to answer the survey. In addition, there were vastly different contextual factors in play across all sites, and analysis of all data in a localised way with the full context in mind is out of scope for this work.

Despite these limitations, the findings of the Householder Survey data offer significant intrinsic value, as the patterns across and within this variance provide valuable insights into mental health need. For example, understanding the extent of the variance in itself has significant utility in terms of advocacy for more community-led service planning.

2.3 DEFINING MENTAL HEALTH AND WELLBEING

"The complexity of mental health cannot be adequately dealt with by an illness model." (Helen Milroy)

One challenge for the ACDC Project was arriving at a definition of what we mean when we talk about 'mental health'. This project deliberately sought out non-clinical conversations outside of clinical settings, and to engage with Householders on their terms and according to their levels of mental health literacy, in a person-centred and informal way. The project also aimed to accommodate diverse cultural, social and philosophical understandings of health and wellbeing.

Self-described understandings of mental health that emerged from diverse conversations were naturally fluid, and reflected individuals' various levels of mental health awareness, self-reflection, personal expression and life experience. When a Householder described themselves as 'down in the dumps' for example, this was taken as valid and not necessarily interrogated further to align with diagnostic criteria or specific mental health categories. People Connectors were primarily interested in natural and informal conversations, and so we may never know, for example, what 'down in the dumps' represented for that individual in terms of validated constructs (i.e., low mood, low self-esteem, mental health condition, dissatisfaction with quality of life, or many other possibilities). Note also, that while the People Connectors had diverse experience across a range of community, health, and service backgrounds they were not (with a few exceptions) generally clinically trained.

A fit-for-purpose conceptual framework

While we know that many conversations did not shy away from people's experiences of diagnosed mental health problems, People Connectors facilitated discussions that purposefully drew on broader understandings of mental health and wellbeing. The following table (Table 6) illustrates six related, overlapping, but distinct concepts related to mental health that we believe captures the diverse experiences of Householders when they spoke about their mental health and wellbeing.

TABLE 6 Relevant mental health and wellbeing concepts

Concept	Definition	Example experiences and conversation topics that emerged	Corresponding indicators in survey data
Mental health	A state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life (World Health Organization, 2013).	– Inability to cope – Experiencing distress – Lack of support – Managing symptoms	The Kessler Psychological Distress Scale (K10)[49]
Wellbeing	A state in which an individual can realise their own potential, cope with normal stresses, work productively, and contribute to their community (WHO, 2013).	– Low mood – Lack of motivation – Low resilience – Quality of life concerns	The World Health Organisation- Five Well-Being Index (WHO-5)[50]
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.[51]	– Country (loss of Country) – Community and kinship – Language and cultural practices – Impacts of historic injustice and intergenerational trauma	The Kessler Psychological Distress Scale (K5)[52]

[49] Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E., & Zaslaysky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*, 959–956.

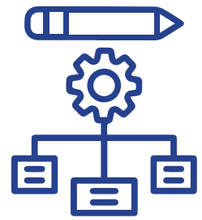
[50] In its original form from 1998 developed by the WHO Regional Office for the DEPCARE project on well-being measures in primary health care.

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

[52] The K5 is a shortened version of the checklist that has been adapted for Aboriginal and Torres Strait Islander people.

TABLE 6 Relevant mental health and wellbeing concepts – continued

Concept	Definition	Example experiences and conversation topics that emerged	Corresponding indicators in survey data
Social determinants	The recognition that mental health is shaped significantly by the social, economic, and physical environments in which people live.	– Stressors and burdens – Challenges – Life problems – Personal difficulties – Family or relationship stress	Social determinants questions
Stress experiences in neighbourhood and social environments	Chronic environmental stressors, especially those related to neighbourhood environments.[53]	– Experiences of being unsafe – Direct or indirect experiences of violence – Noisy neighbourhoods – Threatening neighbours or conflict with neighbours	Social cohesion scale[54]
Employment satisfaction	Chronic environmental stressors related to workplace or making a living.	– Workplace stress or bullying – Satisfaction with work duties, pay, job security, hours worked, and flexibility – Overall work satisfaction	Employment satisfaction measure



[53] Chrisinger, B. W., & King, A. C. (2018). Stress experiences in neighborhood and social environments (SENSE): a pilot study to integrate the quantified self with citizen science to improve the built environment and health. *International journal of health geographics, 17*(1), 17.

[54] Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy. *Science, 277*, 917–984.

3. PROJECT IMPLEMENTATION

3.1 THE ACDC PROJECT PROCESS MODEL

This section presents process information to describe the ACDC Project model. The analysis draws upon operational documents prepared by ACDC Project Team[55] and evaluation interviews by CSI with ACDC staff[56], People Connectors and DPOs.

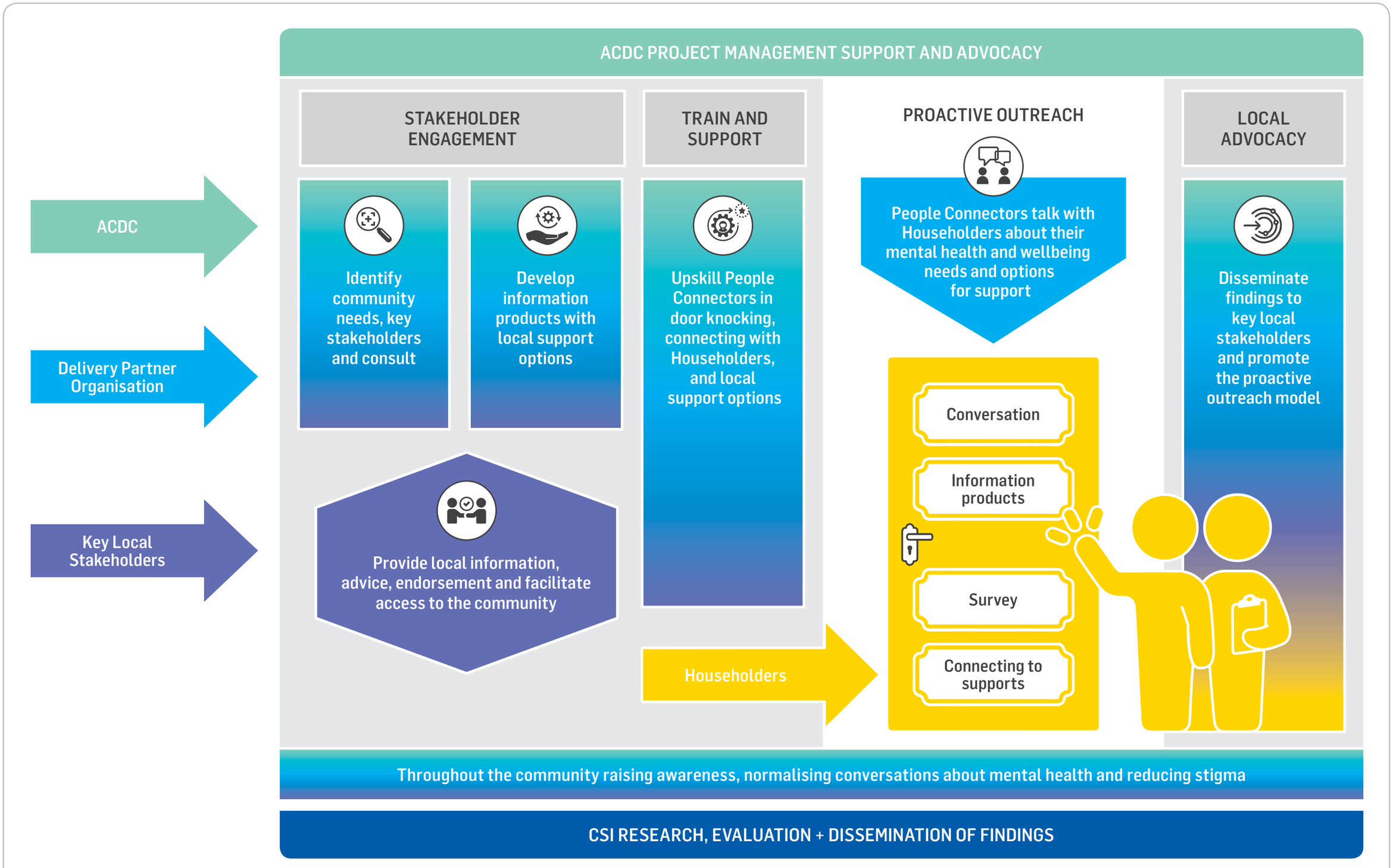
A summary of the implementation process in any given site is outlined in Figure 5. As shown, project delivery involved a close working partnership between the ACDC Project Team and the DPO, especially in the initial stage, as they engaged local stakeholders, developed localised information products, and promoted the project in the community.

People Connectors were then recruited by the DPO, after which the ACDC Project Trainer delivered a week of training to prepare them for doorknocking. During the fieldwork, the People Connectors continued to receive support from the ACDC Project Trainer as needed, attended a fortnightly Community of Practice meeting with other People Connectors (facilitated by the ACDC Project Trainer) and received regular, often weekly, and sometimes daily, support meetings with their Line Manager within the DPO. Following the fieldwork, the CSI Evaluation Team prepared a brief, summary overview of key findings from the Householder Survey for each site. This was presented to the DPO who often shared it with the local service provider networks. The local-level data promoted shared understandings of the local community's mental health needs and could be used to support local advocacy. This Section outlines the key activities in more depth, and provides reflections and learnings from the ACDC Team and stakeholders.

[55] To access Project documents visit acdc.org.au/

[56] Interviews with key management and operational staff were conducted by the CSI Evaluation Team during 2021 and 2022.

FIGURE 5 ACDC Project implementation process diagram



3.2 PREPARING FOR DOORKNOCKING

The DPOs who were successful in their application for the ACDC Project could be organisations such as NGOs specialising in community support services, neighbourhood centres or mental health services. The project commenced in the 22 different sites – different areas across the country each with varying characteristics (see Section 4) – and all with various levels and types of community assets to draw on, which therefore affected what the pre-doorknocking phase would look like across each of the sites. One site was badly affected by flooding and could not go ahead with the doorknocking, although they had developed local information products and trained People Connectors (the products developed still proved useful to inform people in the community affected by floods about local supports), hence data was collected in only 21 sites. Another site did not complete the intended duration of the fieldwork and finished early due to the team not being able to effectively sustain the work.

This section outlines an idealised process of implementation, although on the ground, the ACDC Project involved continual problem solving, different levels of investment and uneven success (or, different kinds of success), across the diverse communities.

Recruiting the Delivery Partner Organisations

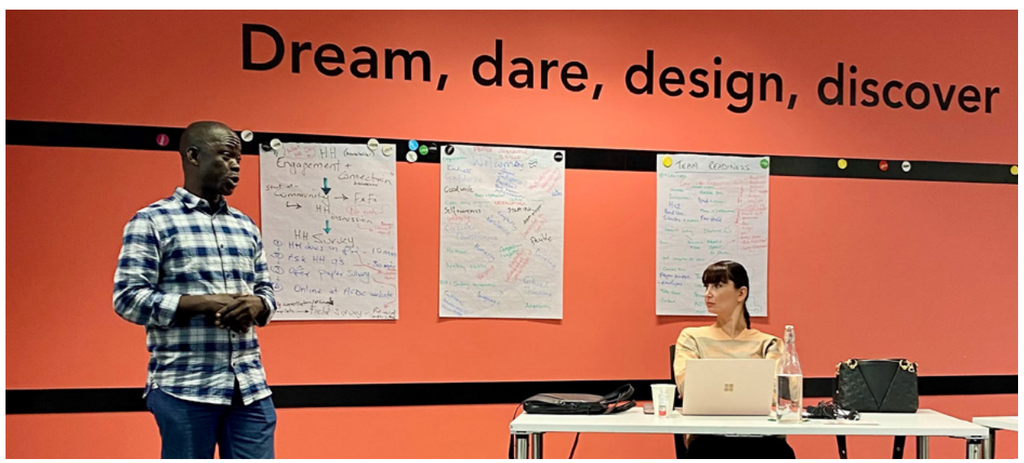
To procure and recruit the DPOs to partner with, the ACDC Project Team distributed a call for Expressions of Interest and circulated this amongst community-based organisations through newsletters and email distribution lists of Primary Health Networks and state and territory community mental health peak organisations. A transparent procurement process followed, where applications were reviewed by the ACDC Project Team and the Steering Committee.

Applications were assessed based on the availability of appropriate skilled and experienced staff to fill the People Connector roles, the appropriateness of the site that was proposed, the extent to which the organisation had experience with delivering mental health services in the proposed site, and their existing relationships with other community organisations and local stakeholders.

Stakeholder engagement

The first substantial phase of work for each community was undertaking what was called a 'stakeholder engagement strategy'. This involved a close partnership between the DPO and the ACDC Project Community Engagement Team and took about eight weeks. During this time, CSI provided an overview of key statistics, based on ABS Census data, which helped start the conversation about the demographic profile of the area and any anticipated community needs.

Much of the learning however happened through consulting local organisations for advice and guidance around community need, safety concerns and engagement strategies. Stakeholders consulted could include the community mental health team, local NDIS area coordinator, and community managed organisations working in mental health, aged care, alcohol and other drugs, carer support, multicultural services, housing, youth education, employment, sport or disability. Elected Members of Parliament and local government representatives (the Mayor, Councillors, and Community Development Managers) were also consulted and the DPOs often relied on their commitment to the project.



During the consultation, information was captured in a 'Site Briefing' document, which could include details about community networks and events, historical or environmental factors affecting the community; information on safety and engagement; and DPO's existing relationship with, key stakeholders in the selected site.

It was critical that both culturally and linguistically diverse community leaders and local Aboriginal and Torres Strait Islander community leaders were aware and encouraging of the ACDC Project. It was also important that Elders were consulted before doorknocking commenced as respect for the local peoples and their Land. By creating an awareness of the ACDC Project and a link with the Elders and community leaders, it was anticipated that the community would feel more trusting of the People Connectors through word of mouth. The DPOs hoped that, if issues arose, this relationship would permit the People Connectors to directly contact local community leaders and Elders for advice and support to resolve concerns. While all stakeholders agreed and supported how critical this was, often the time was not available for meaningful cultural engagement activities, as will be explored further in this report.

This project could not have been successful without the participation of supports and services beyond the DPO. These provided, for example, the 'ecosystem' of services to draw on – for example to put in the information products, or for People Connectors to talk about as options when helping Householders think about supports they might need.

Developing local information products

Information products for Householders included a brochure and a fridge magnet with contact details of local supports and services (including online and telephone services). These were offered to every Householder, left in letterboxes when people were not home, and were also made available in public spaces, such as libraries and community centres.

The products were adapted for each community. For three sites the brochure and magnet also contained information in the community language significant for that site, i.e. in Arabic, Chinese, or Vietnamese. Thirteen services were included in the brochure, with eight for the magnet, so decisions needed to be made about the most relevant and suitable services. Consulting with the key local stakeholders informed decisions about the most relevant services to let people know about. Through this process they developed a list of trusted, applicable services, ideally with capacity to take on new clients.

Promoting the ACDC Project

The ACDC Project Community Engagement team worked closely with the DPO to raise awareness of the ACDC Project in each site, based on local advice. Depending on the community, promotion could be, for example, through word-of-mouth, events, social media, print media and/or local radio.

Stakeholders were also asked to publicise and promote the ACDC Project through their channels – including social media, print media, newsletters and/or websites.

Throughout the life of the project, People Connectors would also be encouraged to participate in community outreach and promotion activities, for example, attend community festivals; set up a table in a shopping centre, the main street or at an expo; or attend events dedicated to key dates related to mental health and wellbeing, such as, Carers' Week, or Mental Health Month.

The eight weeks or so spent on stakeholder engagement was critical for the ACDC Project's local successes. It ensured that services and residents were primed to expect doorknocking conversations, the project information and resources were applicable for the community, and People Connectors also had the backing of local services, and the 'local intelligence' needed for the task ahead.

3.3 RECRUITING, TRAINING, AND SUPPORTING PEOPLE CONNECTORS

Recruiting People Connectors

Each People Connector brought unique skills and expertise to the role and their prior experience varied. Some had certificates in mental health or peer-work, or had worked in helping professions (e.g., as a paramedic), whereas others had minimal or no experience providing support to others. According to the ACDC Project Team, having a related qualification was preferred, but not essential. It was peoples' personality and communication skills that were crucial. Applicants needed to have the ability to put a stranger at ease, while showing genuine compassion and understanding and making sometimes rapid decisions about how to best support someone in real time.

Recruitment issues

Finding the right person with availability at project commencement however was not always easy.

> ***"The biggest thing that we want to get right is the recruitment of the People Connectors into those roles. Because that's the number one thing that's going to mean that we can get the project off the ground at the right time." (ACDC Project Team member)***

One obstacle to attracting and recruiting People Connectors was the incredibly short contract (13 to 14 weeks). Particularly in regional and rural areas where there is generally less work, this likely caused apprehension for prospective applicants, reducing the pool of applicants. One learning from DPOs was that it much easier to recruit existing staff to these roles to ensure People Connectors had stability of employment by returning to their substantive position after the ACDC Project. In other cases, People Connectors were recruited externally but had a permanent role elsewhere. In one site, the DPO reported difficulty finding appropriate people to fill the People Connect and Line Manager position/s.

Across five different ACDC sites, retaining staff was difficult with some People Connectors and/or Line Managers reportedly leaving their positions during the doorknocking phase. Staff turnover was mostly due to reasons outside of the ACDC Project, however in one site the People Connectors stepped away from their role due to the demands of the work and/or the negative impact of the job on their mental health. If an emotionally and physically demanding job takes a toll it is always reasonable to step away, and we understand that the employing organisation and ACDC Project Team were supportive of this decision, acknowledging the insight, self-awareness and courage needed to prioritise one's own wellbeing in these circumstances.

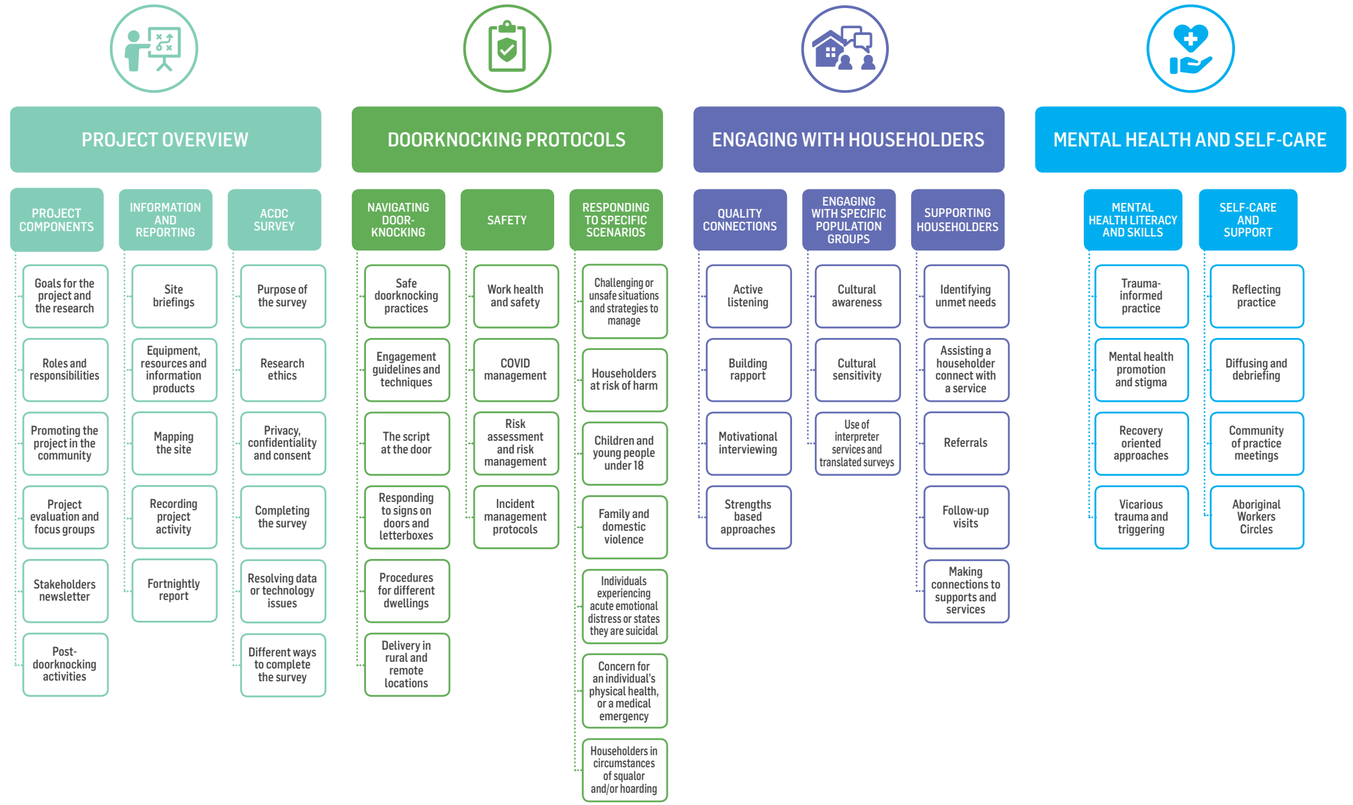
Training People Connectors

> ***"The training was good. I didn't mind the training. It was very, like interactive and asked questions and it wasn't one of those training where you went, 'Oh god what time are we finishing?' It was just very interactive." (DPO interview)***

The ACDC Project Team provided five days of intensive training to People Connectors and Line Managers before doorknocking began. This training week was designed as an in-person face-to-face course, however, travel restrictions related to the COVID-19 pandemic, or adverse weather events, necessitated the training be delivered online in two sites.

From the perspective of the ACDC Project Trainer, key components of the training were: ensuring People Connectors' and Householders' safety; creating connection with Householders at the door; being flexible and adaptive with communication and engagement; educating about mental health and wellbeing and discussing with Householders about their unmet needs; being trauma aware and culturally sensitive; maintaining self-care strategies; and, feeling confident to handle confronting or challenging situations. Responding to challenging situations could be, for example, knowing how to act or report when encountering: householders at risk of harm; family and domestic violence; children or young people under 18 years; an individual who is experiencing acute emotional distress or states that they are feeling suicidal; and/or concerns for an individual's physical health or an emergency. A list of training topics is presented in Figure 6.

FIGURE 6 Training topics for People Connectors



People Connectors described these first few seconds as crucial, with the Householder perhaps assessing the 'agenda' and trustworthiness of the People Connectors, while the People Connectors were alert to the potential responsiveness (or not) of the Householder.

Supporting People Connectors

The People Connectors received support from the ACDC Project Trainer throughout the course of their employment (i.e., the initial training week and role-modelling doorknocking in the field, and then through visiting sites to doorknock with and support People Connectors, when needed), their Line Manager (an assigned supervisor based on the DPO), and from other People Connectors during fortnightly Community of Practice meetings, facilitated by the ADCD Project Trainer.

The Community of Practice meetings were useful check-in points in which to reflect, share and debrief with other People Connectors. The teams of People Connectors had different levels of experience in the role (some having doorknocked for nearly the full 13 weeks, whereas others had only just commenced fieldwork), providing an informal space for guidance, advice, and shared problem solving. Experiences of training and support are explored in depth from People Connectors' perspectives in Section 6.

3.4 WHAT HAPPENS AT THE DOOR

"Every time someone opens a door, they think, 'What are you selling me?', or 'What is it that you're trying to convince me about?' And then the realisation that we're just here to have the conversation about community wellbeing. Not only that, but also checking with you to see how you are going and talk about your experience and just wanting to get to know you and hear your voice. It's a sense of relief for them." (People Connector)

When doorknocking commenced, teams of People Connectors walked the streets of selected suburbs with the aim of speaking with willing Householders at their front door. People Connectors were careful to approach doorsteps respectfully (e.g., walking on pathways not lawns, standing back from the door after knocking etc.), as outlined by the ACDC Project training.

This subsection explores what happens once the door is opened, describing a typical encounter between a People Connector and a Householder. We highlight the activities that happen at the door, as per the project design, and based also on reflections from People Connectors' experiences. This subsection is for people who are curious about what the 'doorknocking for mental health methodology' is all about.

Establishing legitimacy

Householders opened the door to two people who were wearing matching white ACDC Project t-shirts, and lanyards, holding Information Packs and an iPad. They presented as somewhat official, yet friendly and casual. People Connectors described these first few seconds as crucial, with the Householder perhaps assessing the 'agenda' and trustworthiness of the People Connectors, while the People Connectors were alert to the potential responsiveness (or not) of the Householder, and any environmental circumstances that they needed to accommodate (e.g., the Householder being preoccupied with a baby, an excited dog, a household member working from home, or rushing on their way out the door etc.).

One of the first messages from People Connectors was that they were not from a faith-based organisation and not selling anything.

"Every time someone opens a door, they think, 'What are you selling me?', or 'What is it that you're trying to convince me about?' And then the realisation that we're just here to have the conversation about community wellbeing. Not only that, but also checking with you to see how you are going and talk about your experience and just wanting to get to know you and hear your voice. It's a sense of relief for them." (People Connector)

"Making sure that they know we're not there to sell anything... we really see their facial expression change once we say that... Other than that, announcing that we're there as a national program. We're not just some strangers who decided to do this." (People Connector)

Many Householders were already aware that the People Connectors intended to visit their homes, as they had received the ACDC postcard in their letterboxes a few days to a week prior (which let Householders know they could expect a visit within the week), or they had heard about the program via the ACDC poster, community newspaper articles, radio interviews, or the community Facebook page, etc. Often, having some awareness of the visit and what to expect meant Householders felt more prepared to engage.

"...if they've recognised the mail drop that they've received from us, or they've seen us in the newspaper...it made it easier to connect with them because they recognised this straight away." (People Connector)

"Within the first 30 seconds... if they've recognised the mail drop that they've received from us, or they've seen us in the newspaper... it made it a lot easier to connect with them because they recognised this straight away." (People Connector)

People Connectors reported that local promotional activities helped to establish legitimacy in the first moments after the door was opened, and it created an important point of difference from the "solar panels and the electricity companies and everyone else who was trying to sell things":

"...They immediately recognised that, 'Oh, great, you guys are doing the mental health project'." (People Connector)

This local promotional work done prior to doorknocking also gave the Householders time to consider if they would like to engage or not, rather than feeling 'put on the spot'.

Experiences of rejection and no interest

Although Householders were usually informed of the visit via a letterbox drop, doorknocking by nature involves a visit without prior agreement or arrangement. Naturally, many people were not responsive to a knock at the door. Besides not being home to answer, people may not have heard the doorknock, or were not able to answer in that moment. In other instances, people might not feel keen, or able to, engage with strangers at the door. Or perhaps they were not interested in engaging with the content and/or aims of the project (as they understood it).

"Some people just will not engage, because they don't engage with doorknockers. Full stop. Some of them don't, you don't get a chance to start the conversation. They're just like 'Nup, nup, we didn't welcome you here'." (People Connector)

The visit was also unscheduled and may have happened at an inconvenient time.

"A lot of time we can hear them, they'll be cleaning, and we can clearly see the cleaning. [Or] they're on the computer, we can see the computer in the window." (People Connector)

People Connectors came to experience the instances of rejection or lack of interest as a necessary part of the job, and accepted that engagement through doorknocking will be uneven.

> *"There's a lot of social isolation... some people talk to us for three hours, some people talk to you for ten minutes, some people didn't want to talk to us... you get all kinds of responses." (DPO)*

However, as will be explored in other sections of this report, generally people were willing to engage, or respectfully declined.

"Occasionally there were slammed doors and things like that, but I don't think there were any terrible encounters for our People Connectors." (DPO)

"Probably 95–98% of people wanted to have a chat. We had a few that wanted to chat that were working and couldn't as well. Just a few that purely didn't want to have a bar of anything." (DPO)

If Householders did not wish to talk (or continue talking) to the People Connectors (for whatever reason), the People Connectors would offer to leave the information brochure and the fridge magnet. If the Householder was not home, the People Connectors left these products in the letterbox with a 'Sorry we missed you' card.

Personalising engagement strategies

After greeting the Householder, one of the People Connectors in the team might then take the lead in the interaction, perhaps based on cues from the Householder or team agreements about who would take the lead and under what circumstances – for example, gender matching the Householder who answered the door, with either the male or female People Connector, or just a gut feel about who might be more relatable in that moment.

Some Householders were initially hesitant and needed more explanation about the ACDC Project before being comfortable enough to participate. Some Householders met the People Connectors with a cautious curiosity and wanted to chat a little before they fully relaxed into the conversation. Other Householders were keen to talk from the outset, including about mental health.

Although the ACDC Project training resources provided a script to follow, the People Connectors explained that the first 30 seconds of every doorknock was quite dynamic as their intuition and judgement helped them engage with the Householder in the most natural way. Often, the script was used as a general guide, and the People Connectors learned their own ways of working which allowed them freedom to approach each Householder individually and authentically. Also, depending on their knowledge of the local culture, the street, or even their first impressions of the Householder, they sometimes decided not to mention 'mental health' upfront. Instead, they talked about wellbeing, or simply said 'we want to see how you are doing', or 'we are here to talk to the community about what is needed to help people stay well'. Through the course of the conversation, however, People Connectors looked for ways to bring up the topic of mental health.

Sometimes, Householders reported being 'fine' and had nothing to say about mental health, however, when prompted and as the conversation progressed, they shared concerns about mental health for their loved ones, people in their social network, or their community. Sometimes, after chatting for a while, they revealed (or perhaps even realised) they were not fine after all.

> *The People Connectors explained that the first 30 seconds of every doorknock was quite dynamic as their intuition and judgement helped them engage with the Householder in the most natural way.*

"They would say, 'No, mate, I'm fine, see you later ...' Then we say, 'So, do you know somebody else who has been doing it tough?' And they go, 'Oh yeah, so–and–so down the road or this person here'. So that then opens the conversation around mental health and then we can easily then put it back to them and say, 'Oh, so have you had the need to access mental health services?' So all of those kind of conversations really work well." (People Connector)

Conversations and addressing support needs

People Connectors were trained to have an empowering and supportive conversation with Householders and, if appropriate, to ask direct questions about their wellbeing or community wellbeing, or the mental health of themselves or their loved ones. People Connectors were also willing and empathetic listeners for Householders who wanted to talk about anything troubling them. People Connectors listened for indications of needs that could be met through local support options, and, if it felt appropriate to do so, they discussed these options with Householders.

> *"We're not going to tell you to do anything... We just want to have a chat and see if there's a way that we can assist and support before the wheels really fall off..." (People Connector)*

Where Householders had a need for further support, the People Connectors could provide information about local services or community supports, assist with contacting services, or obtain consent from the Householder to follow up with them at another time – if more follow-up work or more complex referrals were needed.

"We're not going to tell you to do anything... We just want to have a chat and see if there's a way that we can assist and support before the wheels really fall off. Or if they've fallen off, let's do a bit of work for you and we can come back to you with some really informed choices and things like that. So I think trying to address the issue at the door just breaks down that barrier of people, the stigma of trying to get out and access a service." (People Connector)

Householders were also invited to complete the Householder Survey, which, in some cases – after responding to survey questions about mental health experiences, barriers to getting help and support preferences – could prompt more personal disclosures about mental health and wellbeing.

"We're not inclined to rush into the survey, I think we try to engage with them, and find some conversation, ask them how their family is, how they've been coping, and if they've got other relations in the area, how long they've been in the area. So we try to engage with them. And sometimes those stories start to come out before we even start talking about mental health. And that I think once we've got past that first 30 seconds to two minutes of trying to engage them, we really haven't had anyone drop out of the survey." (People Connector)

Attempts to discuss mental health were not forced or directive; Householders steered the conversations, but skilfully, People Connectors found the opportunities to ask directly about mental health or wellbeing, and identify support needs.

"We met a guy today who had PTSD from the military… he was getting great support. He said, 'Oh, I've got a gold card. I can just get whatever I want whenever I want… I don't need anything else'. But then I noticed on the way out, he had a disability sticker on his car and he said, 'Oh yeah, my son's got [a disability]'. And so I was like, 'Oh, have you heard of Carer's Gateway?'". (People Connector)

In this case, the Householder had not known about the carer supports available to him that would potentially reduce his carer burdens and possibly support his recovery from PTSD.

People Connectors enjoyed the dynamic, individualised doorknocking approach – the chance to be creative about exploring what a Householder might need and what could make their lives better.

"[The ACDC Project Trainer] did a really good job of providing three or four pages of really good quality national sort of services, but those local ones were really up to us… Next time, I'd say, okay, well, these are the kinds of services that most people really wanted to access. And they were: carer support, aged care plans, NDIS, legal services, rental and housing assist, food assist, those kind of services could have been pretty much [included in the Information Packs]" (People Connector)

In this regard, the ACDC Project was not just a project that helped people link to mental health services; when people discussed their wellbeing and mental health, sometimes it was a broad range of needs for which Householders required assistance.

> ***"…These are the kinds of services that most people really wanted to access. And they were: carer support, aged care plans, NDIS, legal services, rental and housing assist, food assist…" (People Connector)***

Attentive listening, not counselling

"Sometimes [People Connectors] will stand at the door for two hours with a person because that is what they need." (ACDC Project Team member)

Some Householders experienced the presence of two caring, attentive people at the door as a much needed chance for in-depth reflection on their past or present struggles. In training, People Connectors were reminded that they were not expected to be counsellors, and they were advised to not become emotionally involved in Householders' lives and experiences (as many People Connectors did not have qualifications that would allow them to do this safely or effectively). Maintaining the boundary between an authentically caring conversation and counselling sometimes was tricky – both in an abstract sense as well as in a practical sense. The tension is well described by this People Connector:

"I think it's difficult because you can't help but do accidental counselling with people. You are asking questions, questions specifically regarding mental health, which then goes to people's traumas, people's crisis that they may be in then or were last week. So I think it can be a lot more than what it sort of is made out to be as well. I think luckily we have each other's support and the experience in the field as well, which definitely helps. But I think you just can't help but do accidental counselling with people. And especially with people like us, we're so caring and passionate about helping people in our community… We're fixers. You know?… People want to unload and you can't help that. And you have to listen." (People Connector)

The Community of Practice sessions and ongoing support (see Section 6) helped to ease the burdens associated with more emotionally intense conversations that no doubt emerged from doorknocking conversations about mental health. People Connectors also reported getting better at managing this boundary and the expectations of their role.

"…just to sort of keep it light and keep it simple and don't go too much into [the trauma] as well to avoid re-traumatising. And some people that we engage with, too, they're in a state where they're just not wanting to talk, but they do need the support as well. And keeping it brief and in a supportive way, just to get the message of support across to them." (People Connector)

"I think we've sort of found a happy medium with being able to have people debrief with us but also doing it in a way where it doesn't go in too deep." (People Connector)

The Householder Survey

All Householders were invited to complete the Householder Survey, which was designed to be comprehensive, and therefore, long. People Connectors often struggled with the time commitment involved, especially as it was usually completed on the back of a doorstep conversation; Householders had been talking and standing for some time when they were asked to do the survey. While the survey was designed with 'skip logics' to minimise the number of questions asked by skipping those that were not relevant, People Connectors reported people wanting to complete the survey thoroughly.

"If you say [it will take] around 10 minutes or so, depending on what [your responses are]… They tend to want to start it and then time gets away from them then, because they do then engage with the full questions, and they want to answer the questions and answer them meaningfully. So that usually does turn out to be on half an hour. But they've fully engaged then [and] because they see the value in what we're doing." (People Connector)

> ***…the doorknocking methodology was highly adaptive and personalised, which worked well in the context of initiating conversations about mental health.***

"There are a lot of people who, once we bring out the survey, a lot of them don't do it, because they generally are busy." (People Connector)

Although there were no mandatory targets for the number of Householder Surveys completed in a given community, there was an incentive payment attached to completing 320 surveys, and the number of surveys completed was also monitored weekly. Thus, People Connectors were motivated to have Householders complete the survey. People Connectors, and Householders alike, also found meaning in the survey and understood its significance for collecting local level data about mental health need.

The People Connectors regularly offered to leave a paper-based copy of the survey in an envelope with the Householder and collect it at an agreed time. This seemed to work well in providing a more comfortable experience for the Householder, whilst also increasing the number of survey completions for a strong evidence-base for advocacy (and activity metrics).

More detail and examples of the doorknocking experience – from both the People Connectors' and the Householders' perspectives – will be explored in Sections 5, 6 and 7. However, this walk-through of what typically happened at the door highlights that while there are some clear guidelines, the doorknocking methodology was highly adaptive and personalised, which worked well in the context of initiating conversations about mental health.

3.5 INFORMATION SHARING AND ADVOCACY

When the doorknocking activity ended, the CSI Evaluation Team disseminated a summary of local-level survey findings, in the form of Community Reports. Householder Survey data collected through doorknocking, provided a snapshot of that community in terms of: demographics; key mental health indicators (such as psychological distress, which allowed for comparisons to the 2021 national averages); support needs and unmet needs; and preferences for more support options in their communities. While the number of surveys completed did vary across communities, generally, sample sizes were at least a few hundred, lending reliability to the results.

For some communities, having this community-level data was a much-awaited outcome of the ACDC Project, or even the reason they had chosen to participate.

"The goal for [our organisation] was research to find out what's lacking in these areas, what people are really in need of, and I think we did that, we've quite clearly found what's lacking in those areas. We've been able to inform Public Health Networks and an MP within the Bayside Council who are looking at funding programs in the area. As well as that, because of the ACDC Project we have been able to facilitate numerous referrals for community members and gain very valuable feedback." (DPO)

"Well, the ultimate goal is, if you get decent enough data to hopefully make some change... and get further services out here and governments to recognise what is going on out here." (DPO)

"I believe it's given us a good opportunity and grounding to seek Government funding for outreach programs to support different communities. We now have data on where the gaps are to be able to say that more services need to be provided." (DPO)

Other communities did not think much about the data until they received their report. Generally speaking, DPOs were enthusiastic about the summative survey data, and utilised it as a prompt for further conversations with other stakeholders in their community about how to understand community needs, and make changes.

"So this is why this project is really good for us, because we have always been screaming out for help. And a lot of services are funded for our area, but they concentrate on the areas that have larger population, that are more city-like. We're more rural, so we get left in the dark. And we've been screaming out for so long, 'We need it, we need it, we need it,' and now we have the evidence to back up what we're saying, which is really good for funding opportunities too." (People Connector)

"I mean, we're basically researchers, aren't we, that's what we are. And so, our role is really to enable the potential for the community to get greater funds for mental health and wellbeing in their area." (People Connector)

The Round Two evaluation was not able to systematically capture how communities used the data, as the interviewing was completed before they received the reports. However, we do know that some communities went on to share the initial findings with local stakeholders, such as through presentations at local interagency meetings, or planned to use it for advocating for more local services.

"...we understand that the surveys are really important for lobbying for government influence, funding, informing services and supports as well." (People Connector)

"We're definitely hoping that we can somehow get more services to the area with the data." (DPO)

"We knew our new our community had significant mental health issues and we were interested to find out more. When it comes to funding and when it comes to looking at programs that are going to suit the community, that was that was a drive behind the results of the survey in seeing what that was. And we are definitely, obviously, we definitely want to see that report so that we can then start making educated decisions around whether we need to be pushing for more of this or more of that, or whether we can start reaching out and running more support groups or all that kind of thing. So all of that data in itself is absolutely fundamental to our planning." (DPO)

During the Round Three Evaluation, we hope to discover more about how local level data was utilised.

Understanding the characteristics of the participating communities was central to the ACDC Project, and necessary.

4. THE ACDC SITES: WHICH COMMUNITIES ENGAGED AND WHY?

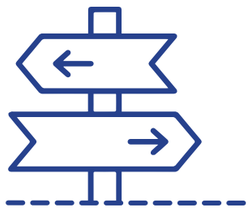
The contextual diversity across and also within sites was significant; with Round Two involving 17 metropolitan and regional sites across all Australian states and territories (with the exception of the ACT, which was visited in Round One), with often several suburbs visited within each site (see Table 7).

This section provides an overview of the ACDC Project communities – the social, cultural, economic, and environmental conditions – based on statistical data, DPO interviews and focus groups with People Connectors. A mix of data sources helped to explore the dimensions of diversity in various ways: statistical (demographics, remoteness, socioeconomic advantage or disadvantage); observed (physical terrain, streets that are welcoming); as well as felt (openness, friendliness, stigma, a sense of safety). Please note, in this section, sites will be identified.

Burnie (TAS)

TABLE 7 ACDC sites and suburbs

ACDC PROJECT SITE	SUBURBS VISITED (Postcodes)
New South Wales (NSW)	
Cabramatta	Cabramatta (2166)
Clarence Valley	Maclean (2463), Yamba (2464)
Greenacre	Greenacre (2190)
Hurstville	Hurstville (2220)
Wollondilly	Picton (2571), Tahmoor (2573)
Northern Territory (NT)	
Palmerston	Johnston (0832), Moulden (0830), Woodroffe (0830)
Queensland (QLD)	
Ipswich	Ipswich (4305), North Ipswich (4305), West Ipswich (4305)
Mareeba	Mareeba (4880)
Redcliffe	Margate (4019), Redcliffe (4020)
Toowoomba	Harristown (4350), Kearneys Spring (4350)
South Australia (SA)	
Port Adelaide	Alberton (5014), Rosewater (5013)
Tasmania (TAS)	
Burnie	Burnie (7320), Upper Burnie (7320)
George Town	George Town (7253)
Victoria (VIC)	
Macedon Ranges	Gisborne (3437), Riddells Creek (3431), Romsey (3434)
Bendigo	Bendigo (3550), Eaglehawk (3556), Golden Square (3555), Kangaroo Flat (3555), Long Gully (3550), North Bendigo (3550), White Hills (3550)
Fitzroy	Fitzroy (3065)
Western Australia (WA)	
City of Swan	Beechboro (6063), Ballajura (6066)



4.1 PHYSICAL CONDITIONS

The terrain and built environment of every community was different. Some were busy, metropolitan centres with towering public housing apartment buildings (Fitzroy, VIC), or high rise and high security apartment blocks (Hurstville, NSW). In other communities People Connectors contended with farm blocks with long (over 500 metre) driveways and no mailboxes due to the remoteness of the region (Mareeba, QLD). In Burnie (TAS), the terrain was hilly and required high levels of physical ability and fitness and similarly, in Maclean (NSW), the large hill and lack of footpaths made doorknocking tricky:

"Maclean is one massive, big mountain as well, so it's like one huge hill that we have just got to walk up and down. There are no footpaths, there's nothing like that." (People Connector, Clarence Valley)

Conditions at dwellings also posed some challenges. In Mareeba (QLD), People Connectors reported high instances of dog ownership and therefore locked gates on properties, and some houses could not be reached. Similarly, in Palmerston (NT) security gates and padlocked fences were a frequent access barrier. In Hurstville (NSW), many of the intercom systems attached to apartment buildings were old and broken and so People Connectors were also unable to get to the front doors.

Adverse events

Weather and climate

Weather conditions were variable across sites, and sometimes uncomfortable and challenging. Mareeba (QLD) was experiencing the wet season at the time of doorknocking; the mud on the dirt tracks meant a risk of being bogged. In Toowoomba (QLD), Householders were reluctant to stand at the door and talk because of the cold wind and rain. Heavy storms forced doorknocking activities in Greenacre (NSW) and Cabramatta (NSW) to a halt for a week.

In Palmerston (NT), People Connectors worked in heat and humidity, which meant trudging up and down asphalted streets under the searing sun in temperatures upwards of 35 degrees. Heat was mentioned as a challenge for People Connectors at several other sites, including Burnie (TAS), Mareeba (QLD), Bendigo (VIC), and Hurstville (NSW).

"We are getting 40-degree heat next week and it's like three or four days in a row and we didn't stop. We just keep going..." (People Connector, Bendigo)

Maclean (NSW)

Palmerston (NT)

Flooding

Flooding had devastated several communities in Northern New South Wales and south-east Queensland, interrupting doorknocking activities at five sites (Ipswich, QLD; Redcliffe, QLD; Clarence Valley, NSW; Toowoomba, QLD; and Wollondilly NSW). The Clarence Valley (NSW) People Connectors reported damaged roads due to recent flooding, and similarly, in Wollondilly (NSW), there was extensive damage to roads which restricted travel. The worry, stress and burdens associated with potentially being cut off or having one's home flooded, was an important contextual factor identified by the People Connectors who visited the communities affected by floods.

"[After the floods there was] so much mental health impact. People are probably still in shock, a lot of them... Still dealing with what they're dealing with and not realising the impact months, years in the future. Hearing the stories about people screaming inside their houses while people are trying to drive past with boats trying to rescue people... Then thinking about the PTSD that's going to come from this in the future." (People Connector)

COVID-19 pandemic

The effect of COVID-19 varied significantly depending on the timing of the implementation with current conditions such as lockdowns, border closures and/or levels of infection. The Fitzroy site (VIC) had experienced multiple and extended COVID-19 lockdowns before and during the People Connectors being active in the area, which they thought had impacts on wellbeing of the Householders they visited, especially young people and university students in the area.

"We are directly connecting with people. And even though the project wasn't born out of COVID, what an amazing time to be doing this, because that connection is what we have lost in the last few years." (ACDC Project Team member)

At seven sites, doorknocking activities were interrupted by COVID-19; by lockdowns, or in other sites People Connectors were unable to work due to contracting the virus or being a close contact of someone who had tested positive to the virus (Fitzroy, VIC; Clarence Valley, NSW; Wollondilly, NSW).

Multiple adverse events

Some sites had experienced multiple adverse events in the years preceding the ACDC Project. The people living in Wollondilly (NSW) for instance, had experienced flooding, drought, bushfires, and a lockdown (due to COVID-19) in the three years prior to door knocking.

"It's just one thing after another. In our area, we've had terrible bushfires...Then floods and COVID-19 on top of that ... obviously, we all have different levels of mental health [need], but it's just some are affected by it more than others. And if anything, [these events] are going to push you to the edge if you had anxiety, or depression... [it] just seems to be never ending... It's just, it's been a horrible two, three, four years for people really." (DPO, Wollondilly)

"It's just one thing after another. In our area we've had terrible bushfires...Then floods and COVID-19 on top of that...And if anything, [these events] are going to push you to the edge if you had anxiety, or depression..." (DPO, Wollondilly)

People Connectors noted that there was a strong sense of community and resilience at this site, despite the lack of services and history of natural disasters.

There was extensive damage to roads which restricted travel.

Geographical remoteness

Geographical remoteness was another variable that reflected the diversity across the sites. The ABS Accessibility and Remoteness Index of Australia[57] (ARIA) measures remoteness relative to a location's access to services[58] (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'. The 'remoteness' of each ACDC Project Round Two site was determined using the ARIA calculation and definition – see Table 8. There were no ACDC Project sites that met the classification for 'Remote' or 'Very Remote'.

TABLE 8 ARIA classification of sites

MAJOR CITY	INNER REGIONAL	OUTER REGIONAL
Cabramatta	Bendigo	Burnie
City of Swan	Clarence Valley	George Town
Fitzroy	Macedon Ranges	Mareeba
Greenacre	Toowoomba	Palmerston
Hurstville	Wollondilly	
Ipswich		
Port Adelaide		
Redcliffe		

Geographical location and availability/access to services

While many people who live in Australia's regional areas thrive, it is not always the case, and one of the defining features of geographic remoteness is that services are less accessible – for example, GPs, disability services, family assistance offices, employment services, Centrelink, financial institutions, and Medicare[59]. People Connectors described how living in a rural area can affect one's quality of life.

"Everyone loves kind of the 'rural-ness' of where we are. But then the flip side is that we don't have those services, there's very limited access, there's no access afterhours, we don't even have, say like a short stay facility for anyone with mental health problems that just needs to go somewhere for 24 hours. Like there is nothing in Macedon Ranges just for that. You either have to go Bendigo or Melbourne. Then obviously there is the financial aspect of it, a lot of people are supporting other young families or partners that aren't working... And then typically, with the males (or ones around here), they don't open up until something like that happens. So, a lot of them feeling uncomfortable with actually sharing what's happening." (DPO, Macedon Ranges)

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

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

[59] Australian Bureau of Statistics. (2006). General Social Survey 2006 (GSS 2006). https://www.abs.gov.au/

George Town (TAS) residents faced difficulties with the distances from basic services as well as health and welfare services, public transport was lacking, and there were limited employment opportunities.

"There isn't a lot of jobs. It's quite remote from the city; it feels quite rural and regional out here and that also comes across in the health services that are available here. Sometimes they might have businesses open for a little while and then they just close really quickly, so there's a high turnover in businesses and the main street as well." (People Connector, George Town)

There are also many barriers to overcome to access mental health care[60]. People in regional towns often need to travel for mental health support (especially specialised services), do not have as many options for mental health support (in comparison to those living in major cities), and, for any services that are provided locally, there are often incredibly long waitlists due to high demand.

"We are lacking lot of services here in Bendigo. It's really disappointing, but we have knocked on people's doors and they're on waiting lists for 12 months and their referrals are running out and they have to travel to Melbourne." (People Connector, Bendigo)

Limited availability of, and access to, services in these regions meant that People Connectors often provided information about other, non-mental health supports. For instance, it was hoped that community and social groups that could address co-occurring needs and reduce isolation could act as a 'buffer' while people awaited clinical mental health support.

For the ACDC Project sites, the percentage of culturally and linguistically diverse persons was highest in Hurstville (NSW) and Cabramatta (NSW) where most residents were born outside of Australia (70.8% and 69.6%, respectively.

4.2 KEY HOUSEHOLD CHARACTERISTICS

Demographics

Statistics relative to age, ethnicity, employment, disability, and public housing were diverse across sites at the State Suburb Classification (SSC)[61] level. In many instances, demographics were also considerably different from the national average. Appendix B presents key characteristics of households across the ACDC Project sites (SSC level), with some key points summarised here, alongside descriptive information from People Connectors.

Age

According to the latest Census (2021), the Australian median age was 38 years. Across the ACDC Project sites, Yamba (Clarence Valley, regional NSW) had the largest aging population of Round Two (median age 57), which was considerably higher than the lowest, 33 years (Greenacre, NSW; Hurstville, NSW; Moulden, Palmerston, NT; Woodroffe, Palmerston, NT). The coastal town of Yamba is known to attract retirees where Householders typically own their own homes.

Ethnicity

The highest proportion of Indigenous residents was in Moulden (Palmerston, NT), where Census data estimated 24.1% of people were Aboriginal and/or Torres Strait Islander. Conversely, only 0.2% and 0.3% of people living in Hurstville and Cabramatta were Indigenous (respectively). The Australian average was 3.2%.

[60] Australian Institute of Health and Welfare. (2022). *Rural and remote health*. https://www.aihw.gov.au/

[61] SSC approximate the officially recognised boundaries of suburbs (in cities and larger towns) and localities (outside of cities and larger towns).

In Maclean (Clarence Valley, NSW) and Ipswich (QLD), 14.8% of residents reported living with disability, which was disproportionately higher than the Australian average, 6.0%

People Connectors at Palmerston (NT) reported that completing the survey often took a lot longer for Indigenous Householders, because English was the third or fourth language for many and words like 'community' had different meanings. As a result, People Connectors had to paraphrase, tell stories, and/or translate the questions.

Nationally, 29.3% of people are born outside of Australia and 24.8% live in a household where a non-English language is used. For the ACDC Project sites, the percentage of culturally and linguistically diverse persons was highest in Hurstville (NSW) and Cabramatta (NSW) where most residents were born outside of Australia (70.8% and 69.6%, respectively) and lived in a household where a non-English language is used[62] (89.6% and 82.8% respectively). This was considerably different to the Eaglehawk and Golden Square suburbs (both Bendigo, VIC) where less than 11% of residents were born somewhere other than Australia. West Ipswich (Ipswich, QLD) and Eaglehawk (Bendigo, VIC) reported the lowest proportion (4.3%) of households where a non-English language was used. Interpreting services and/or bilingual and bicultural People Connectors were required for areas with higher levels of linguistically and culturally diverse populations (these included City of Swan, WA; Hurstville, NSW; Greenacre, NSW; Cabramatta, NSW).

Employment

Unemployment was highest in George Town (TAS) at 13.0% which was more than double the Australian average, 5.0%. All suburbs within the Macedon Ranges site (VIC) had the lowest unemployment rate (approximately 3.0%).

Disability

In Maclean (Clarence Valley, NSW) and Ipswich (QLD), 14.8% of residents reported living with disability[63], which was disproportionately higher than the Australian average, 6.0%, and also approximately 10% higher than what was reported in Johnston (Palmerston, NT) and Riddells Creek (Macedon Ranges, VIC).

Clarence Valley (NSW)

[62] ABS definition.

[63] People who have need for assistance with core activities.

Public housing

The proportion of the population in public housing ranged from 21.2% (Moulden, Palmerston, NT) to less than 1% (Yamba, Clarence Valley, NSW; all suburbs in Macedon Ranges, VIC), while the national average was 3.0%.

Relative socioeconomic advantage and disadvantage

The ABS Index of Relative Socioeconomic Advantage and Disadvantage[64] (IRSAD), which reflects the economic and social conditions of households within an area, was allocated to each site at the suburb level. Decile 1 refers to sites of greatest disadvantage (lowest 10%), whereas decile 10 (top 10%) refers to sites with greatest advantage. A low decile can indicate a postcode where many households were low income, and/or many people in low-income occupations, but also, where few households had high incomes, and/or few people in high-income occupations. A high decile indicates the contrary. As Table 9 shows, sites spanned multiple IRSAD categories reflecting differing socioeconomic statuses across the suburbs visited by People Connectors.

Wollondilly floods (NSW), pictured bottom and right

TABLE 9 IRSAD Deciles (SSC level) across states and territories, sites and suburbs

POSTCODES VISITED AND INDEX OF ADVANTAGE/DISADVANTAGE											
STATE/ TERRITORY	ACDC SITE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
New South Wales	Cabramatta	2166									
	Clarence Valley	2463		2464							
	Greenacre			2190							
	Hurstville							2220			
	Wollondilly			2573						2571	
Northern Territory	Palmerston	0830			0830						0832
Queensland	Ipswich	4305 Ipswich	4305 North 4305 West								
	Mareeba		4880								
	Redcliffe		4019								
	Toowoomba	4020									
South Australia	Port Adelaide		4350	4350							
Tasmania	Burnie		5013	5014							
	George Town	7320			7320						
Victoria	Macedon Ranges	7253									
	Bendigo							3434		3437	
	Fitzroy	3431									
Western Australia	City of Swan	3550	3556								
		3555									
		3550	3555								
		3550	3550								
								3065			
				6063		6066					

The majority (69.4%) of suburbs were categorised as decile 1 (7 suburbs; 19.4%), decile 2 (10 suburbs; 27.8%) or decile 3 (8 suburbs; 22.3%) which indicated, on average, a high incidence of disadvantage in the suburbs visited by the People Connectors. The lowest decile suburbs (deciles ranging between 1 to 3) were found in the Cabramatta (NSW), Greenacre (NSW), Clarence Valley (NSW), Ipswich (QLD), Mareeba (QLD), Redcliffe (QLD), Toowoomba (QLD), Port Adelaide (SA), and George Town (TAS) sites.

[64] Australian Bureau of Statistics. (2018). *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016.* https://www.abs.gov.au/ausstats/

People Connectors reflected how localised relative advantage/disadvantage could be, with noticeable wealth discrepancies between neighbouring suburbs, streets and even between houses on the same street.

"We saw areas of need, we have services in Ipswich, but we know that it's a very high needs area, predominantly, a lot of lower socio-economic areas, a lot of different pockets" (DPO, Ipswich)

Only 11.1% (4) of suburbs fell within deciles 4 to 6. These included suburbs from the Palmerston (NT), Burnie (TAS), Bendigo (VIC), and City of Swan (WA) sites. The remaining suburbs (7 suburbs; 19.4%) were categorised between decile 7 and 10. Fitzroy (VIC), Hurstville (NSW), and Macedon Ranges (VIC) sites had the highest decile suburbs which suggests the highest incidence of advantage among Householders visited by the People Connectors in these sites.

This analysis demonstrates the large variability that occurred within some sites. For example, Palmerston (NT) included suburbs in both decile 1 and decile 10. We know that even in areas with higher advantage, however, there are people living with significant disadvantage. This was observed for example in Fitzroy (VIC). The deciles are suburb-level indicators that do not necessarily reflect residents' experiences; in many suburbs there is no 'average' experience. People Connectors reflected how localised relative advantage/disadvantage could be, with noticeable wealth discrepancies between neighbouring suburbs, streets and even between houses on the same street.

Greenacre (NSW)

Implications / Disadvantage and co-occurring needs

The ABS data was indicative only, but helped to set the scene for who lived in each community and their possible struggles and challenges. Demographic factors can be associated with wellbeing, including quality of life and life satisfaction[65]. For example, Indigenous peoples and individuals from culturally and linguistically diverse backgrounds face greater challenges accessing health and welfare systems. Racism, language barriers, lower health literacy, and difficulties navigating an unfamiliar system put these groups at greater risk of poorer quality health care, service delivery and poorer health outcomes compared with other Australians.

Socioeconomic factors are key determinants of health. Generally, people in lower socioeconomic groups are at greater risk of poor health and wellbeing, disability and illness, unemployment, social exclusion, and homelessness/housing instability[66]. Experiences of these issues can be compounding, leading to co-occurring needs.

"They are socially isolated. They don't have social interactions, a lot of financial costs, and crime in the community. It's the stuff that we live in. It's that many issues." (People Connector, Palmerston)

Higher disadvantage is typically associated with shortage of income (and money), and this is often correlated with lower social participation, poorer wellbeing[67], and less opportunity to access support.

"In the higher socio-economic area, if people want to get support, they can pay and go and get support, whereas in Beechboro, there's a lot more poverty." (People Connector, City of Swan)

[65] Sirgy, M. J. (2021). Effects of Demographic Factors on Wellbeing. In: *The Psychology of Quality of Life. Social Indicators Research Series*, 83. Springer, Cham.

[66] Australian Institute of Health and Welfare. (2022). Health across socioeconomic groups. https://www.aihw.gov.au/

[67] Steen, A. & MacKenzie, D. (2013). Financial stress, financial literacy, counselling and the risk of homelessness. *Australasian Accounting. Business and Finance Journal*, 7, 31–48.

Given the negative life and mental health impacts associated with social disadvantage, it was expected that People Connectors in less advantaged communities would find that Householders had more needs.

4.3 COMMUNITY FACTORS AFFECTING MENTAL HEALTH AND WELLBEING

Social issues

Housing

The greatest community concern raised in the interviews and focus groups was the housing crisis (a shortage of housing and affordable housing) and the rental crisis (high cost of rentals, limited availability of rentals), and the rising cost of living was impacting peoples' ability to secure housing. This had dire consequences for Householders' and community wellbeing generally.

"Housing is a phenomenal issue. We have no housing, we don't have crisis housing, we don't have domestic violence housing, we have nothing... All our Department of Housing houses are full to capacity. And the waiting list is three years or more. And rentals right now through the roof... For the people that used to live in the caravan parks and could afford it now can't afford it and are now homeless... And we've got people coming, you know, buying houses sight unseen from all over Australia, who are moving, and so they're buying up the houses, which is fine, except they're taking the houses that could be rented, or that people would use as investment homes. So it's just been a domino effect. And we just now have a huge population of people who are homeless." (DPO, Mareeba)

The People Connectors in Palmerston (NT) reported a high incidence of homelessness and rough sleeping, or rental properties in such poor condition that they were essentially unliveable due to safety concerns.

Palmerston (NT), pictured above and below

"People... can't even secure their own houses. And you've got people wandering the streets all night every night. I talked to a lady this morning; she can't even lock her house up. And she's been asking for months for that to be fixed. She can't even have her kids stay at her house. They have to stay at her parents' house because she can't lock her house. And she can't not stay there because she's got all her property there." (People Connectors, Palmerston)

Housing was affected by local conditions. Specifically in Clarence Valley (NSW), housing issues were worsened by the Lismore floods.

"Since the flooding, I guess a lot of people from Lismore have been transferred more to these areas. Yeah, housing is a real issue at the moment." (DPO, Clarence Valley)

Transport

Transport was regularly discussed as a barrier for Householders accessing needing to access resources or services, especially in the context of limited options in regional towns.

Clarence Valley (NSW)

"There's minimal employment opportunities for people, there's no high school here, and doctors shuts at five o'clock... There's no afterhours care at all, for anyone... Everything is a drive to get any services or health care." (DPO, Macedon Ranges)

A lack of transport options and the cost associated with transport was a key challenge facing some community members, especially in the outer regional communities, such as George Town (TAS):

"There is a bus that comes from George Town into Launceston [but it is difficult for people] to be able to utilise the transport to get to their appointments in Launceston...some people might have barriers to taking buses or to access supports for themselves." (DPO, George Town)

Employment

Limited employment or employment options were often reported as issues across communities, sometimes co-occurring with substance use issues. DPOs described limited employment opportunities in Macedon Ranges (VIC) and People Connectors in George Town (TAS) spoke about the relationship between substance use and unemployment.

"I feel like that's why there's a lot of drug issues and addiction around this because – small town, not a lot to do, not a lot of jobs. It just. Yeah, people escape from reality, really." (People Connector, George Town)

Drug and alcohol issues and family and domestic violence

Drug and alcohol issues were also often observed to be concurrent with higher levels of family and domestic violence and crime in the community. This was noted by the DPOs in Ipswich (QLD), as well as People Connectors in Burnie (TAS).

"There's a lot of drug and alcohol, domestic violence, that sort of thing." (DPO, Ipswich)

...the rising cost of living was impacting people's ability to secure housing.

"... there was lots of domestic violence there and they're all like, 'Don't go there, don't go there.' And the day we were actually supposed to go there, the cops were there three times while we were in the street. There was lots of arguing, but we still put the pamphlets and stuff in the mailbox as we slipped past... And then when we were halfway up the road, the girl had opened the mailbox and was standing there looking at them." (People Connector, Burnie)

"They see a lot of drunk or drug-affected people sort of walking down the street, but ...they still felt safe in their area, it wasn't necessarily that they didn't feel safe." (DPO, Fitzroy)

Social isolation and loneliness

Social isolation was raised as a significant problem by DPOs and People Connectors, across several communities. Service providers recognised that social isolation had increased, often, as a consequence of the COVID-19 pandemic.

"COVID has obviously been the biggest impact for them in terms of their mental health and the isolation for a lot of people, whether it was them living by themselves, or them not being able to see family or like friends and work colleagues." (DPO, Macedon Ranges)

People Connectors in Hurstville (NSW) reflected on the loneliness and isolation of older people in their community. This suburb had a large Chinese community, and the People Connectors noted the cultural stigma around mental health. People Connectors also noted ongoing racial discrimination towards culturally and linguistically diverse households and Householders, which likely perpetuated the social isolation of this group.

Perceived mental health needs

The need for specific supports and services

DPOs in Bendigo (VIC) reported concern for young people and felt that youth-specific services and supports were not accessible or available. This gap in the service landscape was also noted by the Macedon Ranges People Connectors (VIC). Similarly, at the time of door knocking, People Connectors in Bendigo (VIC) reported a one-year waitlist for admission to the Child and Adolescent Mental Health Unit, the community was missing child psychologists, and were managing excessively long wait-times to access Headspace services.

"Mental health for youth in our area was a big one. We've got a Headspace but for a lot of them... if they're really unwell, they have to go to Melbourne. So that separates families, and if they're single parent families and with other kids, it's just really hard to have a sibling and the parent in Melbourne, or the parent won't want their child to go to Melbourne without them." (DPO, Bendigo)

Older people were also unable to access psychologists, outreach services, and home visitation services due to transportation barriers and costs. People Connectors stressed the need for additional funding to reach isolated, older people in their community.

"...the elderly [are a concern] mostly because they just seem to be really isolated" (DPO, Ipswich)

People Connectors reported other cohorts who were missing out on supports to address their mental health needs, including veterans (and youth veterans), people with disability who would benefit from the NDIS, and culturally and linguistically diverse persons.

"Access to health services that understand language and culture is limited and those that are good at working with people from different cultures are inundated and overwhelmed." (DPO, Toowoomba)

People Connectors discussed the lack of acute services for mental health related emergencies, especially where people needed crisis care. Others felt that more grief and trauma-informed support was required, particularly in one community where several school children had died in an accident and there were minimal support options for Householders needing to access trauma-processing therapies.

Need for more accessible and available support options

There were no services available in some areas. Often, this forced people to travel long distances to receive support, creating travel costs (including the loss of income from time required to leave work to arrive at an appointment during working ours). The Ipswich (QLD) DPOs suggested the use of outreach services in their area to address the transport barriers they faced:

"...the need for outreach services, because people, public transport is not great, you know, a lot of people can't access services. Or if they do they get that revolving door, you know, "Yep you're good off you go', and they're not necessarily good, they need some long term support." (DPO, Ipswich)

Some communities had a handful of existing mental health services; however, these were perceived as inaccessible.

"Yeah, there's, like long wait lists and stuff. And especially for down Maclean and Yamba like because they're sort of based in Grafton. So there are sort of only down that area one or two days a week. So I think it's hard for people down there to access mental health services." (DPO, Clarence Valley)

There were long waitlists and limited capacity for most services. People Connectors and DPOs reported high demand for mental health supports and services, and often, the Householders in these communities were also aware of these wait times. In these areas, the social, conversational aims of the project were more relevant than information sharing about mental health service providers.

"We know our community's got a large mental health problem. Our system to deal with that is at capacity and has been for many, many years." (DPO, Mareeba)

Need for more information about support options

Another concern raised by several People Connectors was a lack of education about the support services that were available and local to the community. In these areas, the information sharing aspect of the project was incredibly relevant and important. Some sites had one or more very active and accessible services that were assets for the community, but these were not often known to Householders. These communities found satisfaction and hope that the ACDC Project could easily address this need for more information, which could potentially have immediate benefits.

4.4 VALUE OF THE ACDC PROJECT FOR DELIVERY PARTNER ORGANISATIONS

"We service that area, and it allowed us to dig deeper... and see how all those support services can... assist residential people and the community, and help employers and community organisations to know more about their area and their community." (DPO, Fitzroy)

In Section 1 we noted how doorknocking is an underutilised and untested method within the social sector in Australia, so we were curious about why DPOs were keen to try it.

The DPOs discussed their experience of implementing the ACDC Project, and its perceived utility and relevance for their community context. Interviews were conducted towards the end of the doorknocking period, but before any data was available. These findings reflect only the DPOs who were engaged with the project. There were other communities who chose not to implement the ACDC Project, and representatives were not interviewed. Some evidence about hesitancy and concern relative to the project are noted, however, these conclusions are from the perspective of the ACDC Project Team.

Many DPOs were genuinely interested in the novel, proactive outreach model, and the ACDC Project provided a chance to try this in their community. Overall, DPOs saw potential benefits from the doorknocking activities, and anticipated several longer term benefits from engaging as well. Other DPOs had the appetite to try anything that might help with the mental health crisis in their local area:

"The biggest reason we want to do it and why we thought it was important is because we are paramedics and we're often there in times of crisis when people have either suicided or attempted to suicide... So it's been something that's been really quite hard, knowing that we've all grown up not having services." (People Connector, Macedon Ranges)

To reach people with less support options

The DPOs, especially in the regional communities, were aware of the need for more local mental health services and supports. In some communities, services existed but were at capacity; in others, there were no place-based, accessible supports at all.

"We're regional, so there's not a lot of services based in our area, so doing this project was another wonderful opportunity." (DPO, Wollondilly)

The DPOs' knowledge of missing services often influenced the suburb selection – it was hoped that People Connectors could visit areas where people were not getting the help they needed, due to socioeconomic disadvantage, and/or distance from services.

"We were quite aware of a) the demographic and b) the lack of services." (DPO, Redcliffe)

To collect evidence of service gaps and unmet mental health need

While many service sector organisations have a grounded awareness of the needs and unmet needs of their communities and clients, many do not have the substantiating evidence. DPOs were aware that this process could provide the evidence they needed, to confirm the service provision gaps and unmet mental health needs in their community.

"So this is why this project is really good for us because we have always been screaming out for help. You know? And a lot of services are funded for our area, but they concentrate on the areas that have larger population, that are more city-like. We're more rural, so we get left in the dark. And we've been screaming out for so long, 'We need it, we need it, we need it', and now we have the evidence to back what we're saying, which is really good for funding opportunities too." (People Connector)

Beechboro (WA)

The survey and research component of the Project was appealing, but likewise, the very direct experience of going door-to-door was seen as a way to gain new insights about the community or perhaps knowledge that could not be achieved through more conventional approaches. The DPO from Bendigo noted the importance of identifying gaps for knowing how to improve the service landscape in their area.

"I think the main reason would have been to discover the gaps – exactly what the ACDC Project was about – and to have those gaps identified and hopefully rectified in the future." (DPO, Bendigo)

The DPO from Toowoomba described the desire to gain insight about the households and Householders in their community and identify who was seeking help, and who was not and would benefit from doing so.

"[ACDC] gave us an opportunity to have a bit of insight into people in our community, and particularly those parts of our community, to give us a sense of who may not be accessing services" (DPO, Toowoomba)

To reach people who were hardly reached

The DPOs were conscious that certain groups of people in their communities were underrepresented in mental health supports, or other services, and were keen for this project to reach out to them.

"It is people's unwillingness or inability or mistrust for whatever reason, of accessing services and there are a variety of reasons why people don't or can't access services and I think the value of the project was looking at different ways to support people." (DPO, Port Adelaide)

DPOs felt confident that the doorknocking approach would help to reach Householders who would really benefit from a visit from People Connectors. One DPO spoke about their commitment to reach more people with psychosocial disability or mental health issues, more First Nations peoples, and culturally and linguistically diverse persons and felt that this could be achieved with the ACDC Project.

Interest in the doorknocking approach

Some DPOs were also just curious about doorknocking, and maybe did not have clear-cut expectations, but wanted to try something new.

"I thought it sounded really interesting. Like, going door to door. You know, talking to people about mental health and wellbeing was something I'd never heard of being done before...it was really quite intriguing." (DPO, Clarence Valley)

Several DPOs described their interest in the outreach side of the project; it was seen as an appealing method of investigating mental health need in the community, and a creative, direct means of gathering information about Householders' mental health and wellbeing.

"[We] definitely thought it was going to be a very beneficial program for the community and a very different way of collecting information, I think... sort of going straight to the people and finding out what they need" (DPO, George Town)

One DPO reported awareness of this approach in other places, and it appeared this sparked their interest in the project. They expressed wanting to be a part of the growing body of knowledge relative to doorknocking for mental health.

"We were intrigued by this concept of door knocking... what is it? 1980s maybe? And quite unique, and I love the fact that it was a project that was being piloted in lots of other places and could also build a body of evidence." (DPO, Toowoomba)

Some DPOs were also just curious about doorknocking, and maybe did not have clear-cut expectations, but wanted to try something new.

The Mareeba DPO had previous experience with a doorknocking approach and felt comfortable with the model, and also that they could do a great job for their community by delivering the project.

"What drew us to the program was the doorknocking method... we know how effective that is into getting people into services that they genuinely need. And so when we saw this, and we were like, we're going to be doorknocking, we're like, this is fantastic. You know, like this is the complete opposite of every model that is ever given out where clients have to come to you to ask for help. And so that was the biggest draw card and you know, in our souls we were like, 'we can smash this, this is going to be fantastic'. And so that's what made us put the tender in." (DPO, Mareeba)

Some sites, while initially hesitant, were agreeable to the door-knocking approach once the ACDC Project had been explained in detail and trusting relationships had been established.

"...You know, like this is the complete opposite of every model that is ever given out where clients have to come to you to ask for help..." (DPO, Mareeba)

Hesitancy or concerns

A large-scale door-knocking approach was a novel concept for many service organisations. As described above, most organisations 'leaned in' to the idea with curiosity and excitement, or a clear understanding of potential benefits. However, inevitably there was also some reluctance and hesitancy.

"Some sites refused to have the ACDC Project in their communities because it was such a bizarre concept for them... it is unique in its nature" (ACDC Project Team member)

There was apprehension or concern about doorknocking in particular areas, or approaching certain cohorts of people within regions and towns.

"The other time we found resistance was with [public housing area] – they are been severely impacted by COVID, they had been locked down and not been able to leave the flats. The person we spoke to was adamant that we could not at all engage with people in those flats, not even to put the brochure in the letterboxes and that was difficult because they were a huge section of the community that we were missing out on." (ACDC Project Team member)

Some sites chose not to go ahead with the ACDC Project, stating that recent natural disasters had overwhelmed the existing service infrastructure, and thus referring people to services would be ineffective and disheartening.

"They said you cannot do this project because people are traumatised from bushfires. When you knock on doors you give people hope, but the service infrastructure is exhausted." (ACDC Project Team member)

This raises questions about the benefits and risks of doorknocking in areas where people might be experiencing additional challenges or trauma; for some communities the risks were top of mind while in other communities the benefits were sought after and worth the risks. These questions will be further explored in Section 7.

4.5 CONTEXT IS EVERYTHING

Whether it was the physical and geographical landscapes, remoteness and distance to services, dwelling types, levels of advantage or social issues, there were multiple factors that influenced project implementation, relevance to need, as well as the very reasons that doorknocking for mental health was embraced as an idea. Even variations in the personal qualities of community leaders – their appetite to try new approaches or perhaps an adversity to risk – had an impact on which communities engaged and why.

While a comprehensive analysis of each context was not possible in this report, and communities cannot be compared as they are all affected by a unique, dynamic interplay of factors, the snapshot of information here does highlight the diversity of the communities. And that all of the Round Two findings presented in this report were, in some ways, mediated by these contexts.

5. OUTCOMES FOR HOUSEHOLDERS

In this section we summarise the measurable and potential impacts of the ACDC Project on Householders who engaged with the People Connectors. Over 6,000 Householders had a conversation with People Connectors at the door, and this analysis is based on the perspectives of a subset of these Householders; those who completed interviews[68] (N = 9) and those who completed the Wave 2 Evaluation Survey (N = 291). We categorised Householder feedback into:

- Immediate outcomes – relating to feelings or thoughts about the experience of the visit;
- Short-term outcomes (or short-to-medium term) – relating to any actions taken by the Householders in response to the visit; and
- Long-term outcomes – relating to any changes to the Householder's attitude, knowledge or awareness of mental health or available services; these were inferred as likely to be sustained changes and therefore represent longer lasting effects of the visit.

Table 10 overleaf presents a summary of key findings across these three categories.

[68] See Appendix C for the Householder Interview analysis coding framework.

TABLE 10 Summary of the immediate, short- and long-term outcomes of the ACDC Project for Householders

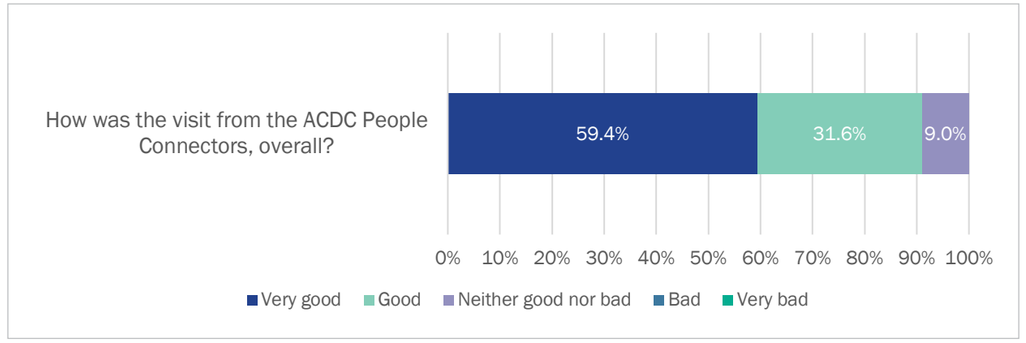
IMMEDIATE (experience of the People Connector visit)	SHORT-TERM (actions resulting from the visit)	LONG-TERM (changes in attitudes, knowledge or awareness)
Householders reported that the visit provided: – An enjoyable/safe interaction – Validation of personal experiences and challenges – Comfort in knowing that others in their community were receiving visits from the People Connectors – Comfort in knowing there are services in the community that they can go to – An opportunity to discuss concerns, issues or distress and reduce their sense of isolation – Increased motivation for change – Increased self-awareness of current mental health needs	**Householders reported that as a result of the visit they have:** – Increased their social interaction and openness to interactions – Helped others – family, friends, neighbours – through talking or sharing the ACDC Project resources – Made an initial contact with mental health supports – Utilised the resources provided by the People Connectors – Put the fridge magnet on their fridge	**Householders reported that as a result of the visit they have:** – Increased self-esteem – Increased understanding and knowledge about mental health and mental health concerns – Knowledge and information about services – where to go and what type of help is available – Normalised mental health as a need – Felt more confident or validated in helping others – Felt hope that more people in their community would get support
Supporting evidence: – Wave 2 Evaluation Survey delivered 1-2 months after visit – Householder interviews Both asked about the experience of the visit and different elements of the visit	**Supporting evidence:** – Wave 2 Evaluation Survey delivered 1-2 months after visit – Householder interviews Both asked about sharing of resources and planned use of resources, behaviour change or planned/intended behaviour change	**Supporting evidence:** Inferred from interviews and survey data Any evidence of attitude change or changes in knowledge regarding mental health, we assumed to have lasting impacts (but did not collect the evidence that this was the case)

5.1 IMMEDIATE OUTCOMES: THE HOUSEHOLDER EXPERIENCE OF THE VISIT

Feedback about the visit overall

Evidence collected from the Wave 2 Evaluation Survey and Householder interviews suggest that the ACDC Project left a positive, and often, lasting effect on those visited. When survey respondents were asked to consider the visit generally, the consensus was overwhelmingly positive – three out of five survey respondents rated their experience as very good, and a further one in three as good, meaning that over 90% thought of the visit overall as good or very good (see Figure 7). No Householders that were surveyed rated their overall experience as bad or very bad.

FIGURE 7 Overall rating by Householders of visit from the ACDC Project People Connectors



Householders were then asked about the specific components of the visit. All aspects of the project were rated positively by the Wave 2 Evaluation Survey respondents, including their experience of:

- talking to People Connectors;
- being asked about their mental health and wellbeing;
- completing the Householder Survey;
- receiving information about services; and/or
- being linked with services.

Typically, Householders rated their experiences of all the above as good, followed by very good – see Figure 8. When asked about various activities, a minority of Householders indicated it was a bad experience or very bad experience. For approximately 2% of Householders, being asked how they are, and about their mental health and wellbeing was, rated as a bad experience. Having People Connectors come to the door to talk was bad for 1.1% of Householders, and very bad for a further 0.4%. A very small percentage (0.4%) of respondents rated finding out about available services as a bad experience, and in 0.7% of instances, doing the survey was a bad experience.

FIGURE 8 Householder's experience of different aspects of their visit by a People Connector

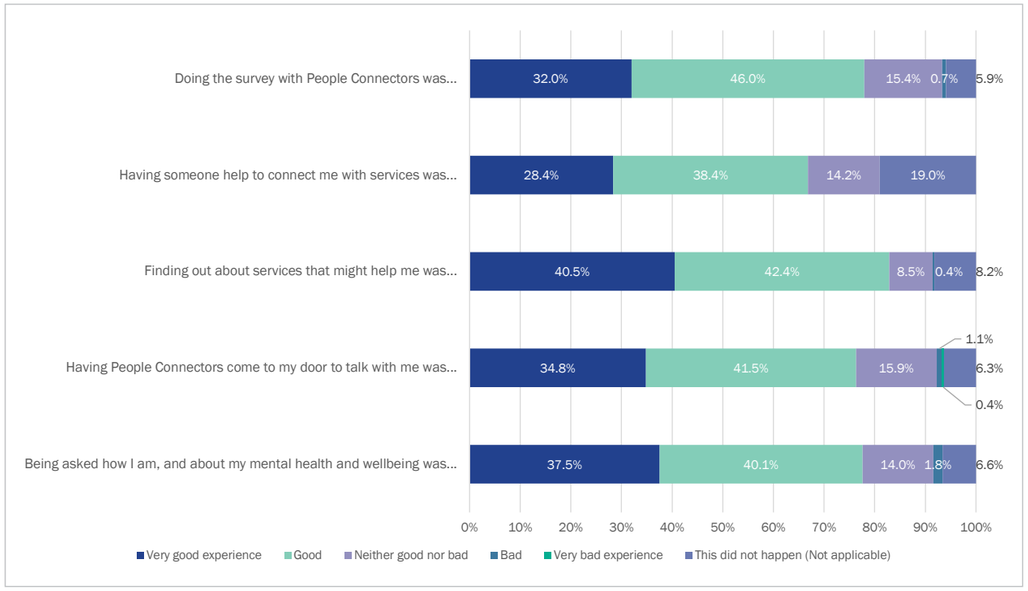


Figure 9 also indicates the proportion of Householders who did not receive certain resources or participate in specific activities with the People Connectors. In 19% of visits, People Connectors did not offer help to link into supports or services, and we are unable to know whether this was due to there not being a need, whether the Householder did not want to be linked to services, if there were no appropriate services to address the need, or another reason. Notably, the data indicate that 81% of survey respondents did receive help to link to supports or services.

Further, approximately 6% of respondents did not do the Householder Survey with the People Connectors, approximately 8% reported not finding out about services that might help them, and approximately 7% were not asked how they were regarding mental health and wellbeing. Additionally, 6.3% of respondents indicated that People Connectors did not come to their door to talk to them, potentially reflecting that they engaged with the People Connectors in other settings such as a community centre.

Although the sample of people completing the Wave 2 Evaluation Survey may be biased towards those who were more engaged and interested in the ACDC Project, these results suggest that most Householders were receptive to the method and welcomed the experience.

The Householder interviews provided additional evidence which reinforced this positive feedback:

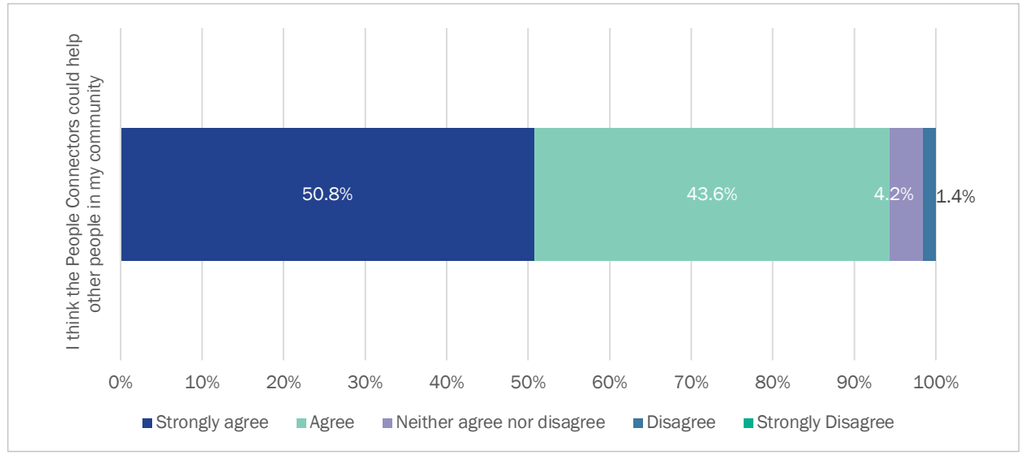
"[The visit was] a breath of fresh air." (Householder)

"I definitely felt a little bit better in myself, and it was that little bit of hope in a terrible time." (Householder)

> ***"It was not an officious visit. But it was a very powerful experience, just talking." (Householder)***

The Wave 2 Evaluation Survey asked Householders whether, based on their overall experience of the project, they believed that the People Connectors could help other people within their community. Results showed that the vast majority felt this project could be of benefit to others; nearly all (94.4%) respondents either agreed or strongly agreed (see Figure 9). We can only infer, but these data would suggest that there is always someone in the community who could use a knock on the door from someone who cares and wants to help, and perhaps Householders even held someone specific in mind when reflecting on this question.

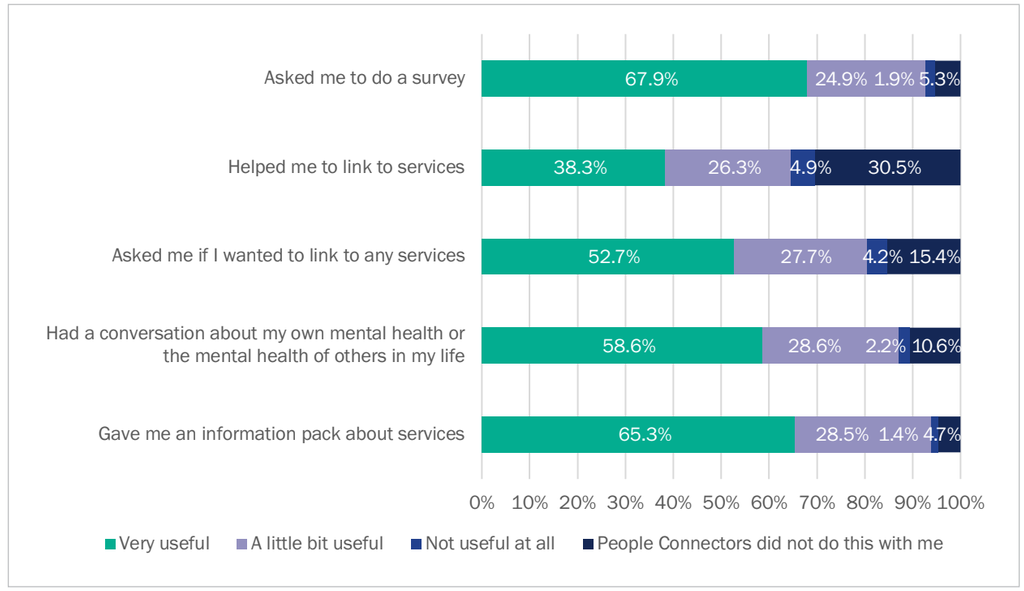
FIGURE 9 Benefit to the community



Utility of the components of the visit

The Wave 2 Evaluation Survey sought to identify the usefulness of the various activities or components of the visit, comprising the Householder Survey, linking to services, conversations about mental health, and the information pack. As Figure 10 shows, most Householders specified that all aspects of the project were 'very useful' to them.

FIGURE 10 Usefulness of components of the visit



Survey respondents were also given the option to explain why they found the activities useful or not by answering 'Can you tell us why you felt these things were useful or not useful?'. An overview of the results are presented in Table 11.

TABLE 11 What made the activities useful or not useful for you?

USEFUL	NOT USEFUL
– Opportunity to connect with others – Increased awareness about mental health generally – Increased self-awareness of own mental health (akin to a 'self check-in') – Useful especially if not needing urgent mental healthcare (i.e., not in a crisis) – Feeling heard and cared for	– Needed more help than People Connectors were able to provide in terms of mental health supports – People Connectors did not return with additional supports when they said they would – Felt uncomfortable talking or thinking about mental health

Experiences completing the Householder Survey

The Householder Survey was a key aspect of the visit. Although the survey had been refined and improved for delivery in Round Two of the project, continuing to collect feedback on the user experience of the survey was important. Feedback from the Wave 2 Evaluation Survey indicated mixed feedback – see Table 12.

TABLE 12 Feedback from Householders regarding the Householder Survey

POSITIVES	NEGATIVES
– Straightforward and easy to answer – Interesting – A good length and includes all the questions needed to grasp an understanding of mental health of Householders – Sense of satisfaction to contribute to data and potentially advocacy	– Confronting* – talking or thinking about mental health was difficult for some Householders – Ambiguous – some Householders needed clarification for several of the questions asked within the survey – Length – the survey was too long (time consuming) – Some questions felt repetitive – Not feeling that data will be used to make meaningful changes – related to not knowing h ow the survey will be used

Note. *More specifically, some people did not realise how unwell they were until they completed the survey, and this was distressing; others didn't want to talk about their mental health.

There was at least one known incident where a Householder felt upset after the survey, and, according to this Householder, their distress was made worse by the People Connectors leaving without being able to offer comfort or additional support.

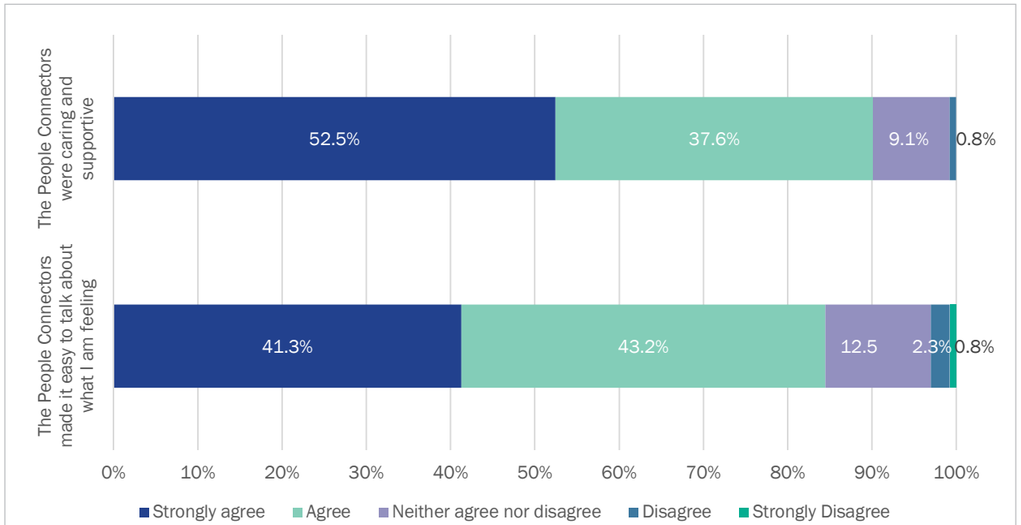
A few Householders described why the paper-based survey was preferred, and this method does seem to address some of the negative factors in the experience. This was not directly related to completing the survey on paper, but rather, doing the survey without the People Connectors waiting, which allowed Householders to take their time, more carefully consider their answers, and reflect on the themes raised throughout the survey and perhaps process the more difficult content in their own way (e.g., taking breaks if needed).

Some Householders who had completed the survey at the front door reported that they would have preferred to be sent an electronic survey and described a discomfort answering the Householder Survey questions with the People Connectors present.

Experiences of interacting with the People Connectors

The People Connectors' approach, personality, and communication styles had an influence on how the Householders appraised the visit. Typically, Householders found the People Connectors to be caring and supportive, and they felt that the People Connectors' ability to create a sense of ease at the front door allowed them to talk freely about what they were feeling or experiencing (see Figure 11).

FIGURE 11 Householders' experience of the People Connectors



Consistent with the survey feedback, interviews with Householders indicated that the People Connectors were a good fit for their role. Further analysis of these interviews suggests that quality of engagement with the People Connectors was contingent on several, specific aspects, including:

- The People Connectors' authenticity;
- The People Connectors' ability to create a connection;
- The information People Connectors provided to Householders (e.g., quality or relevance);
- The People Connectors' personality and relatability (e.g., being friendly and caring);
- The People Connectors' work/life experiences (e.g., having lived experience was favourable for some); and
- The gender of the People Connectors (e.g., male Householders connected better with male People Connectors; whereas some Householders did not feel safe with male People Connectors approaching their homes).

Above everything else, the connection developed between the People Connectors and the Householder, often in a such a small space of time, was what Householders emphasised most regarding the ACDC Project. It was through meaningful conversation that this connection was built and ultimately, this sparked something for Householders. It is a credit to the skill of the People Connectors and the training provided to them that they were, on the whole, able to engage and connect so well, win trust, and rapidly overcome any hesitancy in a cold calling situation.

Factors influencing how Householders appraised the doorknocking approach

Householders, especially in the interviews, were asked to explore why they think their experience was positive/not positive. Transcript analysis of the discussions with Householders revealed that there were several conditions of the ACDC Project's doorknocking approach that accounted for the immediate impact on the Householder's experience (both positively and negatively). Six key themes were identified (and are discussed further below) see Table 13.

TABLE 13 Experience of the doorknocking approach

What Householders found positive and effective about the doorknocking experience	What Householders found uncomfortable and ineffective about the doorknocking experience
– The People Connectors not having an agenda, other than listening and caring – Feeling valued by someone taking an interest in their situation – The unexpected nature and novelty of the experience – Comfort in speaking to a stranger – Reassurance from People Connectors	– Reluctance/not feeling safe enough to discuss mental health at the front door – Feeling triggered – Feeling that the People Connectors could not resolve issues and provide more practical support

Factors leading to a positive experience

People Connectors having no agenda other than listening and caring

Householders described the People Connectors as respectful and authentic. If Householders did not want to participate in an aspect of the engagement, they felt the People Connectors were receptive and accepting of their preferences and boundaries. From the perspective of the Householders, the visit felt fluid, personalised and for their benefit; they felt that People Connectors were 'checking in' in a natural way without any hidden agenda other than looking out for the interests of the Householder. This positive feedback speaks to the skills and training of People Connectors, and indicates that any inherent pressures of the role (e.g., challenges of being in the field, pressure to boost survey numbers, hand out resources, engage with a certain number of Householders, etc.) did not impact on the quality of the connection with the Householder.

Feeling valued by someone taking an interest

Householders also noted feeling valued in their conversations with People Connectors; there was a sense of respect in being asked how they were faring, particularly whilst managing the repercussions of COVID-19, natural disasters, and severe weather conditions. Householders felt seen – feeling that the People Connectors were 'looking out for them' in a time of need.

"I'm 76, my wife's about three years younger than me. And I think it's the first time anyone's ever asked us [about our mental health]... At long last, you know, someone can have a say. And we felt a bit privileged actually, to be asked." (Householder)

"It was nice to know that someone was looking out for [people's mental health] during such a terrible time." (Householder)

Novelty of the approach

The novelty of the doorknocking approach was viewed favourably. One Householder described it as 'special' how the interaction was unexpected but still completely welcomed. Others reported that being visited by People Connectors was so positive because they had never had people approach their doors with good intentions; people usually sought to sell them a product or religion. In contrast, the People Connectors' visit was described as a pleasant surprise.

"Putting information in the letterbox is one thing, but for people to actually come to your door, and want to engage with you; rather than just run off; it was quite different." (Householder)

Comfort in speaking with a stranger

Most Householders interviewed had comments related to the fact that being able to speak to a stranger about their concerns or distress was an important part of the experience – they described a sense of safety, freedom and comfort that they do not experience when speaking to people who are more deeply embedded in their lives:

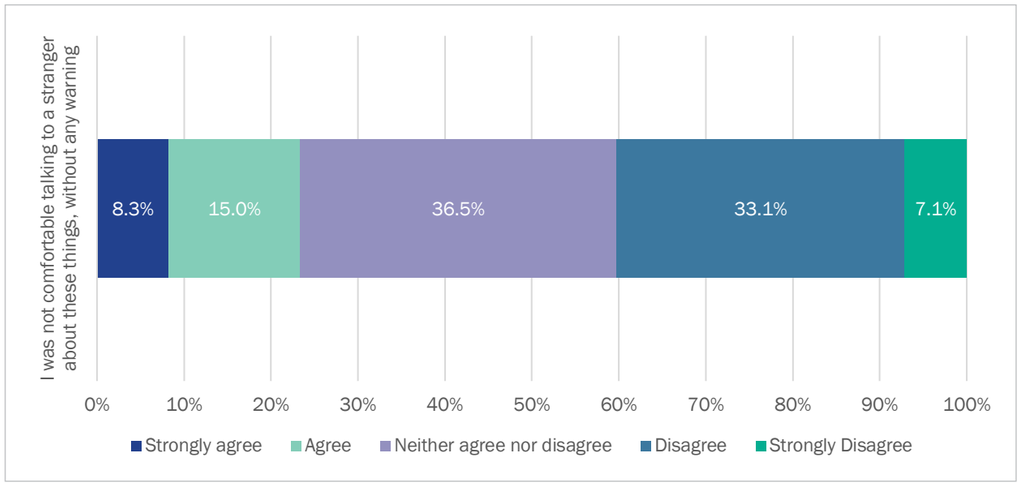
"It's just different... There were some things I could just say [to the People Connectors] without having to worry about what they [were] going to think about me. So talking to strangers is good in that instance. It was cathartic. I mean, I have a wonderful husband, but for some things, you just need to talk to someone else." (Householder)

"I haven't really spoken about my mental health with anyone, or anything like that. But talking to a stranger sometimes does seem a little bit easier. [It] takes away that element of shame and you can be a bit more open with people." (Householder)

From the perspective of the Householders, the visit felt fluid, personalised and for their benefit; they felt that People Connectors were 'checking in' in a natural way without any hidden agenda other than looking out for the interests of the Householder.

On the other hand, findings from the Wave 2 Evaluation Survey suggests a significant proportion of Householders (23.3%) were not comfortable speaking with a stranger about their mental health and wellbeing (see Figure 12). This could also be contingent on various factors including perceptions of mental health (e.g., stigma and discrimination and cultural understandings of mental ill-health), prior experiences of people approaching their door, distrust of others, people in the household, or neighbours within earshot.

FIGURE 12 Comfort in talking to a stranger about mental health



Initially being unsure but reassured by the People Connectors

Although the doorknocking approach was repeatedly welcomed by Householders, some others reported initial hesitancy relating to the visit.

"I think that it's always hard at the door, because you're thinking, 'what do these people want?'; you have your guard up for a little bit. Especially if you've had a lot of other types of people at the door." (Householder)

For the Householders who were unsure but did engage with the People Connectors, they were able to overcome the initial hesitancy, most likely as a result of the People Connectors' ability to create a connection and effectively describe the intention of their visit.

Factors making the visit an unwelcome experience

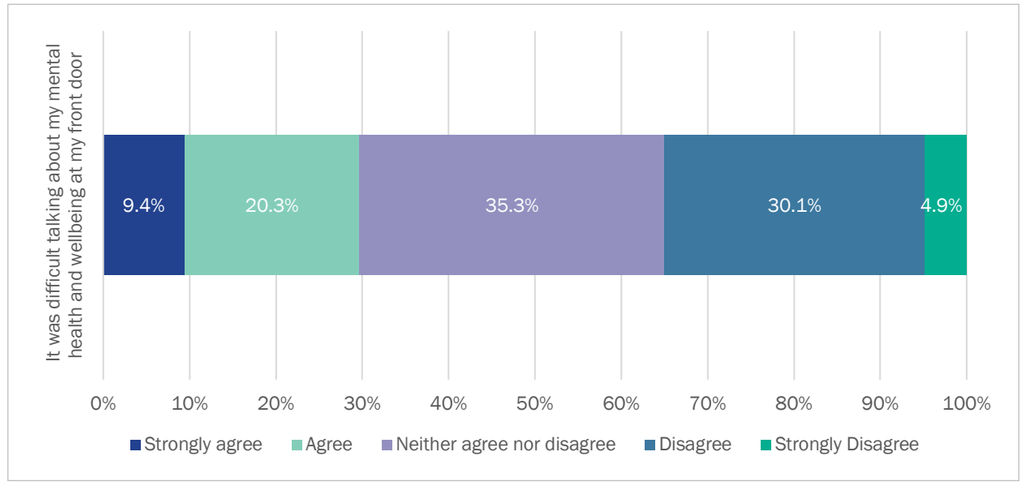
The ACDC Project approach was not viewed favourably by all Householders. Reasons for this varied, including feeling that discussions around mental health and wellbeing felt taboo, shameful or anxiety provoking, and perhaps that a conversation at the front door, without warning, was not ideal in such circumstances. One Householder described the project as 'intrusive' and described discomfort about being approached at their home.

One Householder described the project as 'intrusive' and described discomfort about being approached at their home.

Lack of privacy when discussing mental health at the front door

Reservations about discussing mental health at the front door was raised several times, and the survey was able to test the extent to which these reservations were felt. As Figure 13 shows, approximately 30% of Householders found it difficult to talk about their mental health and wellbeing at the front door (agreed or strongly agreed). However, slightly more Householders (35%) did not agree and therefore did not find the conversation at the front door difficult.

FIGURE 13 Speaking about mental health at the front door



These data highlight the variability of preferences around talking about mental health and wellbeing on the doorstep, which might reflect the variation in people's comfort in talking about mental health generally. However, qualitative data revealed that physical conditions impacted the experience of the visit. Was there a lack of shade on a hot day, noise from traffic, no privacy from close neighbours who might overhear, unsettled dogs, leaf blowers, or other interruptions?

One Householder noted that they feared their neighbours overhearing discussions about their mental and physical health challenges as they believed this was a threat to their safety.

"I don't want them to know about my physical and mental health challenges. It is not safe. I have already had threats of violence against me from my neighbours... It's not safe [to talk on my doorstep]." (Householder)

"People aren't going to stand at their door and talk about [mental health] – especially if they [have] mental health problems – and to tell two strangers... it's still taboo." (Householder)

Physical conditions impacted the experience of the visit. Was there a lack of shade on a hot day, noise from traffic, no privacy from close neighbours who might overhear, unsettled dogs, leaf blowers, or other interruptions?

Of those who did not feel comfortable discussing their mental health and wellbeing at the front door, the majority lived in complexes or apartments in very close proximity to their neighbours. At times, if the Householder felt unsafe at the door but still wanted to engage, the People Connectors went into their home to remove this barrier in order to meet the Householder's needs. Householders reported that inviting People Connectors into their homes felt very safe and a 'natural' engagement for them. Other Householders reported sitting in chairs in their front garden with the People Connectors, which would be the best case scenario, but of course many of these conditions remain outside of the project's control.

Triggering for some Householders

For other Householders, the ACDC Project triggered some distress and feelings of hopelessness. One Householder reported that People Connectors were not able to help them due to their high level of mental health need, and this left them feeling 'more depressed than when [the People Connectors] first came'. Similarly, another person noted serious mental health concerns and the need for an affordable, appropriate psychologist – and unfortunately, the People Connectors were unable to help in this case.

"This is probably more useful for the average person (not people with specific needs)." (Householder)

Additionally, as noted in 'Experiences completing the Householder Survey' one Householder described feeling unaware of just how poor their current wellbeing was until they completed the survey. This left the Householder with very negative thoughts following the People Connectors' departure.

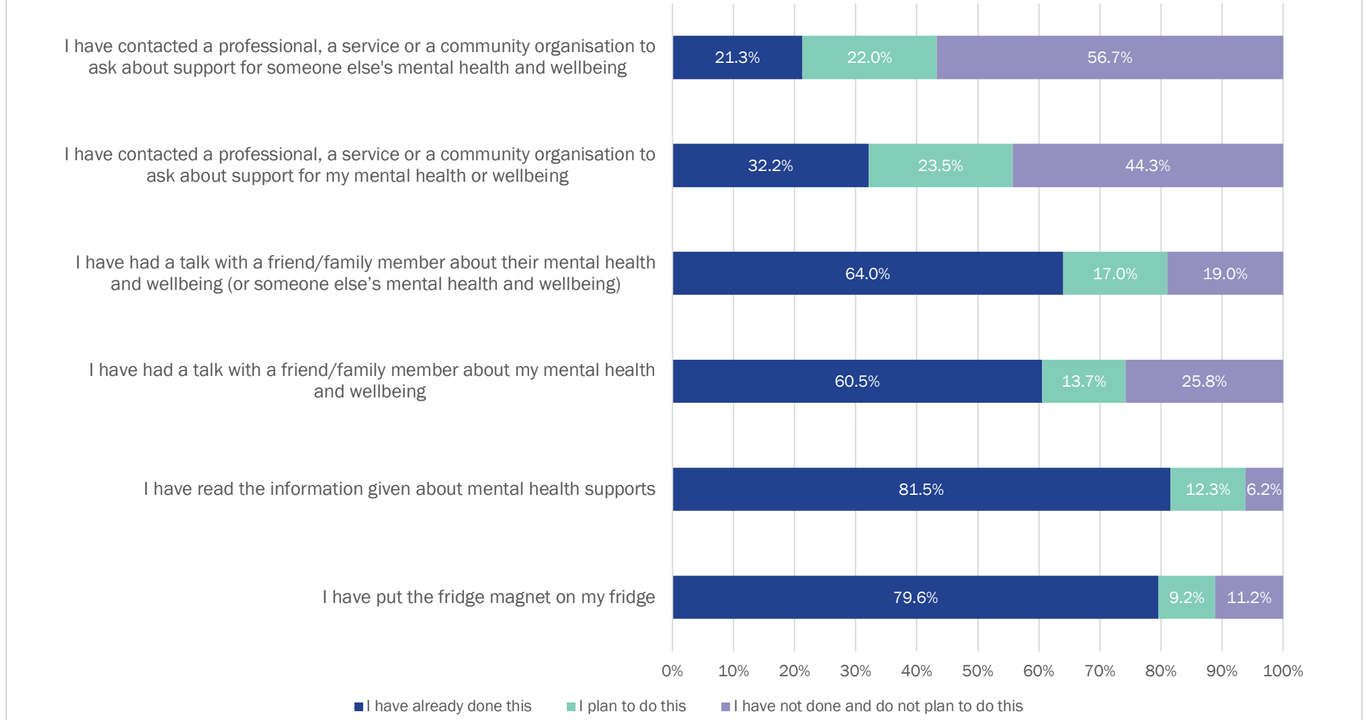
While on balance experiences of the ACDC Project were very positive, it is cautionary to note the instances where the experience was not good, even if they only represented a small number of people. All connection involves risk, and talking about difficult topics can risk discomfort and even harm. Findings indicate that the interpersonal qualities of People Connectors, their skills and training do set them up for providing safe and positive experiences generally, although remaining mindful of the potential to cause harm (which is covered in the training) remains crucial.

5.2 SHORT-TERM OUTCOMES: ACTIONS RESULTING FROM THE VISIT

Support-seeking behaviours

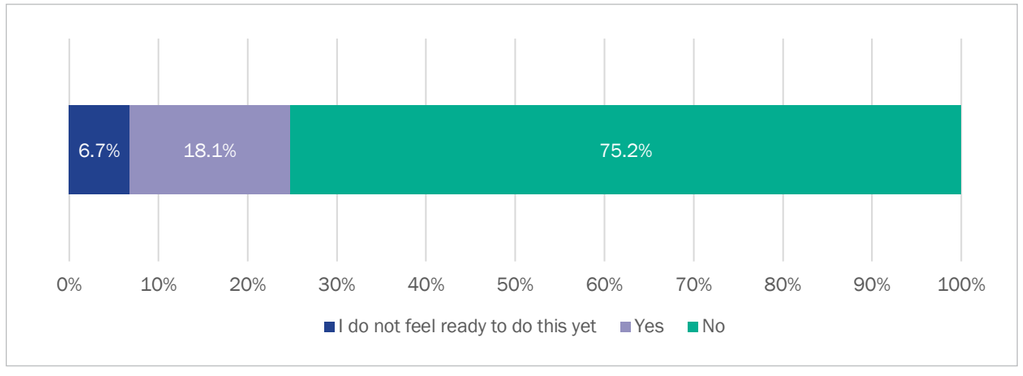
Both the Wave 2 Evaluation Survey results and Householder interviews suggest that, as a direct result of the ACDC Project, Householders were encouraged to act following their discussion with People Connectors. Figure 14 presents findings from the Wave 2 Evaluation Survey indicating that most Householders utilised the fridge magnet, read the information provided by the People Connectors, talked with someone about their mental health/wellbeing and spoke to a friend/family member about mental health/wellbeing as a result of the visit. Notably, over half of all survey respondents reported that the ACDC Project had prompted them to either seek supports, or plan to seek supports. And 43.3% of Householders indicated that they had, or planned to, contact support for someone else in their lives.

FIGURE 14 What did Householders do as a result of the visit?



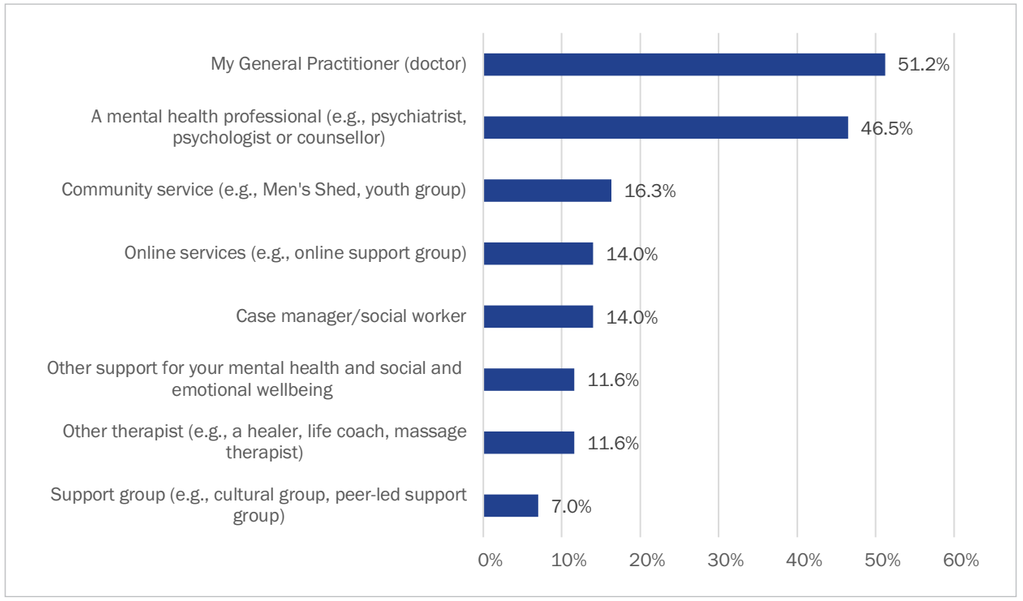
We also wanted to know whether Householders were prompted by the visit from the ACDC Project to seek supports for the first time. The Wave 2 Evaluation Survey asked, "Since the People Connectors visited, have you contacted any professionals or services to get support for your mental health and wellbeing for the first time?". Findings are presented below in Figure 15.

FIGURE 15 Support seeking for the first time



Close to one in five Householders who completed the Wave 2 Evaluation Survey indicated that they sought mental health support for the first time since receiving a visit from the People Connectors. We also asked where these Householders went for supports, and findings are presented in Figure 16.

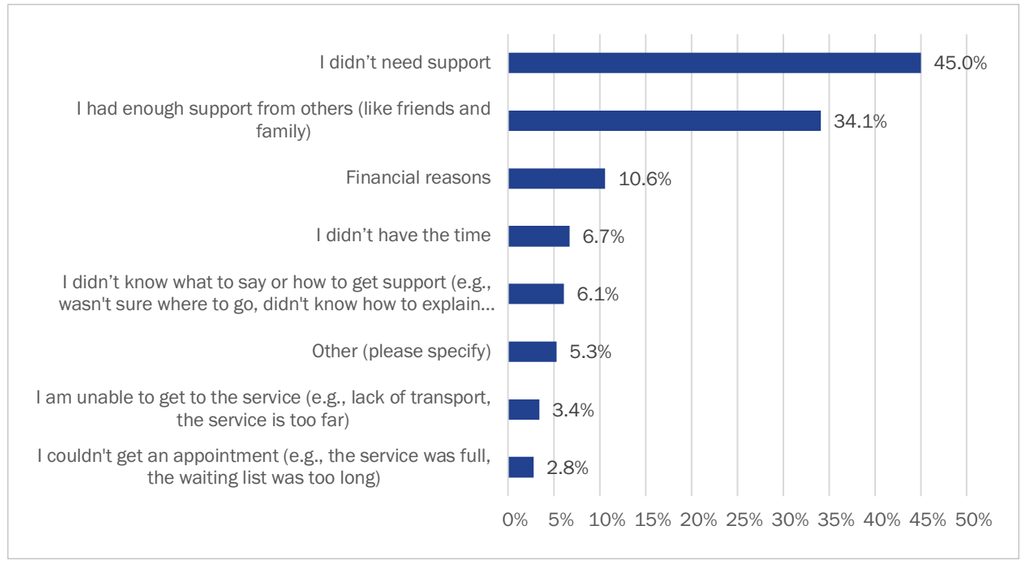
FIGURE 16 Where respondents sought help for the first time after visit from People Connectors



Note. Multiple responses permitted.

Most Householders sought initial support from their GP (51.2%), followed by a mental health professional (46.5%) which could suggest a preference for clinical supports for many Householders seeking mental health supports for the first time. Of those who did not seek supports (75.2%), reasons for this are presented in Figure 17.

FIGURE 17 Why respondents did not seek help



Note. Multiple responses permitted.

Most Householders said they did not access supports because they did not need them. Others indicated that they currently had enough supports from the people in their lives (34.1%), and 10.6% reported that financial reasons were a barrier that prevented them from seeking help. We analysed the responses provided as 'other' (5.3%) and found the following reasons for not seeking supports:

- Anxiety about seeking help;
- Anxiety about filling out forms;
- Distrust in professionals/services;
- Poor, prior experiences of seeking mental health supports;
- Unable to prioritise mental health;
- Overwhelm about the process;
- The effects of isolation; and
- The effects of poverty.

Clearly there are limits to this project's ability to address all barriers to help-seeking for everyone. However, overall survey results indicate that one in three people contacted a service about their own mental health, and one in five contacted a service about someone else's mental health, both relatively high rates of behaviour change as a result of the visit.

Householder interviews also confirmed that the visit inspired action in terms of accessing specific mental health supports.

[Did it prompt you to go and seek any help or at least enquire?] "Yes, it actually did! I went, actually got a mental health plan. I haven't done anything yet. But I got one, so that's good." (Householder)

5.3 LONG-TERM OUTCOMES

Improved wellbeing

When we defined this outcome category, we anticipated long term outcomes to be about attitudes, knowledge and awareness. What we did not anticipate were any longer-term wellbeing outcomes from one doorknocking visit. Although we do not know the true extent to which this happened, several Householder interviews – which were usually conducted between two and four months after their initial engagement with the ACDC Project – indicated that fairly significant increases in wellbeing from the visit were still being felt or at least appreciated.

"I just felt better about myself – I just felt really good. It was a really positive experience and just out of the blue. It is definitely an ongoing thing. It did really affect me in a good way. A really good way." (Householder)

Even though months had passed, some Householders still reported that they were 'on a high' from their experience (in their words). It is difficult to pinpoint how to describe why this was the case, and the researcher asked Householders to help. People described it as a 'spark' or a 'boost', and one Householder offered a metaphor that 'someone has lit a match in the dark' for them and that now it was a candle (indicating lasting light). This 'candle' translated into a new approach to their life:

"Since they have been... it has made me think about saying yes to more things and really stepping out a bit more and having more engagement with others... whereas in the past I would have just said 'hmm' and just shut myself in more. I've noticed that my social engagement has increased. And I don't know whether it is a result of [the People Connectors' visit] or whether that has been a part of a progression... Maybe it was a baby step that made me think, 'Oh, not everybody out there is scary. Maybe I can trust a little and maybe I can stretch myself to take a little step. And then another little step.'" (Householder)

As this Householder indicates, the visit represented a chance to reduce isolation, and this was mentioned by several Householders. Potentially some had not spoken to others for a long time, and this was a rare opportunity to connect, which had a lasting impact.

Although we cannot know just how long-lasting these effects may be, and among how many Householders they were felt, there are potentially some learnings related to the power of people showing genuine care and validation, without agenda.

"I was down in the dumps. And then the fact that someone's just come in and, you know, just asked how you are going; that's enough to spark that little bit of happiness back, you know?" (Householder)

"I think it was a lovely validation and it was just like a friendly visit." (Householder)

Householders also reported feeling better, due to the opportunity to discuss concerns, issues, or distress. Increased motivation for change was also an impact that affected Householder's wellbeing in a sustained way.

"I felt more proactive. I guess that's probably a good way to think about it. I did feel really proactive after seeing those guys." (Householder)

Even though months had passed, some Householders still reported that they were 'on a high' from their experience (in their words).

Knowledge of support and keeping information for future use

Hearing from Householders that they have kept the resources in safe places, where they can find them if they need them, or that the fridge magnet has been moved to the new fridge, is evidence that the service information provided by People Connectors was more than just a brochure to be skim-read and be thrown away. It also signals longer term intentions to potentially utilise information or supports if needed, or inform others about them.

[Have you kept the resources?] "Yep! I've got them where I keep my mail – I can get to it quickly if I need it. [And so they gave you info about things you hadn't heard of before?] Yeah, because we had just moved to the area." (Householder)

"I moved house and [the fridge magnet] is still on there. I have the pamphlet too with all my notes in it. I keep it under my keyboard so I can access it when I need it." (Householder)

Householders also reported feeling comforted that they did have more knowledge and information about where to go for help and what types of help are available, often referring to hypothetical future use.

"[The] general thrust of what they were saying was very comforting. You know, if something happened to me, I know... that it'd be quite easy to get someone to come around and support my wife. Not that she needs it, but you know, if that was the case... the mechanisms are there." (Householder)

"Well, I think I started to realise that there's a lot of support services for us. When you don't need them, you know, you don't go looking for them or you're not aware of them, but I know that the support system's amazing in our little area here." (Householder)

Intention to help others – family, friends, community

Not only did Householders express comfort in knowing that people in their community are receiving visits from People Connectors, but their care for others extended to their own intentions, as a result of the visit.

"I actually gave [the fridge magnet] to a friend of mine who I felt needed it more than me. And I also gave her one of the surveys to fill out as well. She's in strife... Things were just not going well for her at all. She's actually reached out and got mental health help." (Householder)

Better understanding of mental health and wellbeing

One Householder reported that this conversation really changed the way they thought about mental health. It was eye opening with a de-stigmatising effect.

"When I think of mental health, I think of someone in a lunatic asylum, you know, rather than that guy that I talked about that started crying because he lost his wife. And I don't sort of, like my mind doesn't put them in the same bracket as mental health people or the asylum people. And so that was, that's kind of... getting a new awakening about that." (Householder)

"And I'm like, oh, I'm just going to go back to my old job after this. Maybe I don't wanna!" (People Connector)

6. EXPERIENCES AND VIEWS OF PEOPLE CONNECTORS

"We've said it a few times, but there's definitely a need for someone to go knock on doors and connect with people. Because a lot of those people wouldn't go out to seek support themselves." (People Connector)

The personal attributes and skills of the People Connectors were fundamental to the success of the ACDC Project; in some ways, People Connectors embodied everything meaningful about the project. After knocking on hundreds of doors, People Connectors were also well positioned to comment on the value and limits of the proactive outreach approach.

Teams of People Connectors from every site were invited to attend a focus group[69,70], with 38 People Connectors consulted in total. Their qualitative data was analysed using Nvivo software to code and uncover common themes. At times, the identity of the site was important to note in the analysis, but mostly, findings were drawn at a cohort level to ensure confidentiality.

People Connectors were asked about their experiences delivering the project. Feedback from the focus groups about project implementation (e.g., the magnets, uniform, information products, survey, optimal times to doorknock) was provided to the ACDC Project Team to inform changes between Round One and Round Two, as well as redesigns for Round Three.

While the People Connector perspective informed many aspects of the project and evaluation, this section is dedicated to broadly presenting their experience of the role: their personal growth, skills and capacity building[71]; their views on outcomes achieved for Householders; and if, overall, they thought the proactive outreach approach was of value to the communities they worked in.

6.1 EXPERIENCES OF DELIVERING THE PROJECT

Intrinsic rewards of reaching out directly

The satisfaction of connecting and being appreciated

People Connectors often found that doorknocking for the ACDC Project provided an experience of connecting with people that was highly satisfying. The opportunity to go door-to-door, with permission to be caring and curious, and have authentic conversations about anything and everything, was novel and rewarding in unexpected ways.

"We just feel privileged. We feel really privileged to be able to do this job in our community and for people to be engaging in conversations with us and sharing some of the most personal, intimate details. Like who does that?" (People Connector)

[69] For Round One, People Connectors attended two focus groups to facilitate implementation learnings and support adaptions as necessary.

[70] A total of 28 People Connector focus groups were held. One site declined as they completed the project early.

[71] For more information see Millard, J. (2023). ACDC Project People Connector Capacity Building Report. Community Mental Health Australia at: https://acdc.org.au/people-connector-capacity-building-project/

"I was seconded to the role, kicking and screaming a little bit, but I ended up accepting and it's been quite an amazing experience." (People Connector)

People Connectors spoke of appreciating the regular, positive interactions with Householders, Often, the Householder was not expecting to be assisted and the support People Connectors could provide was immediate, which was gratifying for both for the Householder and the People Connector.

"This one guy hadn't spoken to anyone for like nearly five months, not a single human being was in his home for five months, because of COVID. And then, he was stoked to just have a chat, have a general chat with me at the front door, which was kind of cool." (People Connector)

"We've had a lot of people thank us and like even if we just have a short conversation they'll be like, 'This is great. We love what you're doing. Keep up the good work or something'. So it's really nice, to feel appreciated." (People Connector)

The intensity of the role

Most People Connectors framed their experience of the ACDC Project in terms of both physical and emotional intensity. The demands of walking all day in the sun or rain, carrying Information Packs, and not being able to rest or sit down, were significant, especially in sites or seasons that were very hot, very cold, or very wet. There was also the emotionally demanding work of listening without any of the typical boundaries that the helping professionals have (such as time limits, appointment protocols, or comfortable settings), or the tiring work of always being an unscheduled and potentially unwelcome visitor.

"You do have to prepare for every door that you go to, regardless of whether it's answered or not. You have to be ready to receive negative feedback immediately..." (People Connector)

"Even just the rejection of no-one answering the door...if we have like five in a row, and no-one answers you, like the next one you sort of just expect them not to answer. Like, it sort of puts you down." (People Connector)

People Connectors reported speaking to people often for over an hour, and sometimes, two hours. In addition, the content shared by the Householders could be upsetting or difficult to hear. These tough conversations, as well as the deep empathy needed to engage with Householders who were potentially struggling, also carried an energy cost.

"You do have to prepare for every door that you go to, regardless of whether it's answered or not. You have to be ready to receive negative feedback immediately. And to be able to do that... you do need to be up there all the time, and ready to be rejected. And that is quite tiresome, I found it to be quite draining on myself, personally. Now that we've been doing it for eight weeks, the two of us pretty well all the time I'd probably think about a rotation. For 13 weeks I think it's quite a lot to ask for two people to continue to knock on doors for that length of time." (People Connector)

Not all teams found the role difficult all the time, however the demanding nature of the work was something that all People Connectors acknowledged. Some suggestions to lessen the emotional and physical demands were having larger teams and rotating the work in the field between a larger group of people, or doing doorknocking part-time and expanding the role to include non-field tasks, so individuals could recuperate energy and motivation.

It should also be said that the intensity of the role, the 'adventure' of doing fieldwork, and all the unexpected encounters that come with outreach work also added to job satisfaction in a positive way and some noted how hard it will be to go back to an ordinary desk job after engaging with the project in this capacity. Nonetheless, supporting People Connectors was critical to sustaining their energy levels, wellbeing and motivation to continue in their role.

Experiences of support

People Connectors received support from the ACDC Project Trainer during their initial training week and regularly throughout the fieldwork component. In addition, they received support from their Line Manager (an assigned supervisor based at the DPO), their teammate/s and from interacting with other People Connectors at online, fortnightly Community of Practice meetings.

Support from the teammate/s

The most significant support for People Connectors seemed to be their teammate/s. Most teams – often a male and a female, or less common, two females or two males – were very compatible and provided continuous informal support as they navigated their role. Many People Connectors mentioned the connection with their partner as a key driver of their management and enjoyment of participating in the ACDC Project. One team even specified that they would only do it again if paired together. Informal partner support was especially useful in managing any emotional burdens that were taken on, on a daily basis, which helped People Connectors continue to have potentially confronting conversations with Householders day after day.

Many People Connectors mentioned the connection with their partner as a key driver of their enjoyment of participating in the ACDC Project

"It's riding home in the vehicle [together with the teammate] and then debriefing when we get home in front of the river or something like that." (People Connector)

People Connectors seemed to look out for one another and step in with support if needed.

"We get in a car to drive to our location. She'll be like, 'You all right today?' And we have a brief talk and she'll take the reins for the first bit until I'm ready. And yeah. It's been very helpful to have someone like [my teammate] to do this project with." (People Connector)

The psychology-based 'test' that was done beforehand to match People Connectors together was mentioned as important by one People Connector. In the People Connector focus groups, friendly banter was often observed between the team members, and their rapport and respect for one another was apparent. A very small number of teams did not find themselves as compatible partners and in these cases the experience of the project appeared to be less enjoyable. Any interpersonal tensions could easily be amplified with the challenges faced and without that effortless, relational support of good comradery.

Supervision through the line manager, ACDC Project Trainer, and Community of Practice

Developing a good relationship with their supervisor was an important part of feeling supported for many People Connectors, and wherever line managers were engaged and keen to keep communication open with the People Connector teams, this was appreciated:

"I think it's been great, especially when it's face-to-face and there's that potential to be able to develop rapport... [being] able to spend time, not just in training, [but also] outside of training, having a meal, having a conversation. It wasn't just a task, I suppose. You get to learn that little bit more. Then that potentially enables better communication down the line." (People Connector)

The Community of Practice meetings were useful check-in points in which to share and debrief with other People Connectors across different sites, all with different levels of experience in the project.

Some people felt that the Community of Practice meetings (which were fortnightly) were sometimes too long or draining at the end of a long day. Occasionally, the subjects covered in these meetings were not applicable to all People Connectors, and one People Connector suggested splitting the group into a city verses regional focus to save time. However, generally People Connectors found the meetings facilitated deeper learning because discussions were grounded in diverse experiences, and the supportive conversations offered confidence-building opportunities through sharing challenges and problem solving together.

"... being able to hear what People Connectors in other areas are experiencing, especially if they've experienced the same struggle... [thinking] okay, it's not just us. That's been really good, I think." (People Connector)

"I think [the Community of Practice] had more real-life examples from other door knockers about what they've experienced and how they've approached it. And so, the conversations that happened in our Community of Practice versus the conversations that happened in our training were very different." (People Connector)

The fortnightly check-ins also enabled the ACDC Project Trainer to identify any teams that were facing challenges or needing more support. The trainer would then respond by offering further out-of-session support for that team, including visiting the sites.

"Through everything that we went through, I definitely felt supported enough. We had [the ACDC Project trainer] come back up last week to kind of just refresh a few things, which was really fantastic... Just kind of like, 'Okay, all right, help us focus again, help us get back on track,' and stuff like that, which was really great. I think they are going to come back up again in July just to call in and see how we're going... But that was really helpful to do." (People Connector)

Preparation for the role through training

Feedback on the training support was largely positive, and, despite People Connectors often coming to the role with prior experience in mental health or community settings, the one week of intensive training by a dedicated ACDC Project Trainer was considered critical to prepare for the complexity of the role and novelty of doorknocking.

The content of the training was highly structured, with scripts for what (exactly) to say to Householders at the door, scenarios and role plays to practice, and detailed walk throughs of the doorknocking process (e.g., what to do if...). The detail was not always considered necessary by some more experienced People Connectors, but for others it was reassuring. Many reported that it was useful to begin doorknocking with these very clear guidelines, but as their confidence, skills and knowledge of what worked in their communities grew, People Connectors were able to be more flexible and go 'off script'.

As their confidence, skills and knowledge of what worked in their communities grew, People Connectors were able to be more flexible and 'go off script'

"...in the training, I felt it was very regimented in terms of, this is what you have to do. But then I think as people get into the project, they start to understand that, no, no, hang on, I can get away from that a little bit more. I can twist that a little bit and do that a bit differently to make it work." (People Connector)

"...in the training, I felt it was very regimented in terms of, this is what you have to do. But then I think as people get into the project, they start to understand that, no, no, hang on, I can get away from that a little bit more. I can twist that a little bit and do that a bit differently to make it work." (People Connector)

Based on feedback from all People Connectors, it seems that the transitional support approach worked well – one that began with clearly structured rules and guidelines, but became more empowering, giving People Connectors the agency to adapt the approach as they gained greater confidence and knowledge of their local settings.

"I think there's a strong framework that's applied up front, which I think is, well, certainly got us into it and gave us a bit of material to get started... Now, we are a long way from a scripted approach." (People Connector)

Having the confidence and permission to go 'off script' was necessary in a pragmatic sense, as doorknocking necessarily meant interacting with diverse people and circumstances. People Connectors learnt to be intuitive and respectful about what was most appropriate at every door:

"The scripting probably says that we have to ask every householder, will they do a survey? But there are just some households that you knock that you just know you're not going to get a favourable response. So you just don't bother asking... It's just... You can't do it." (People Connector)

Overall, People Connectors felt the support provided was critical for their role. Whether it was having someone to sympathise with about discomforts such as the heat, or support to navigate risk in a potential domestic violence situation, the project provided various outlets for appropriate debriefing and supervision – including daily, weekly, fortnightly contact points, through a combination of internal and external roles, as well as multiple options for both peer and management support.

6.2 HELPING HOUSEHOLDERS

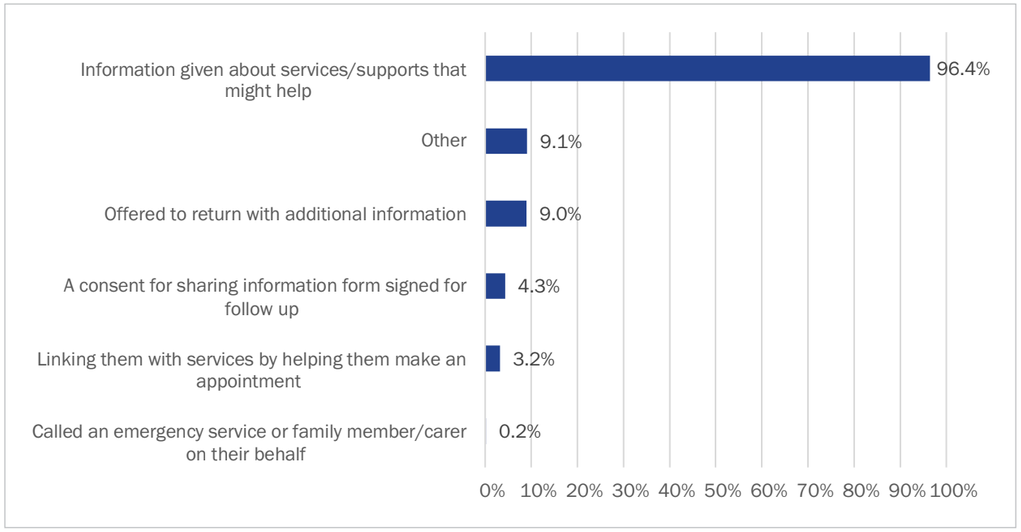
Extent and type of help provided to Householders

When completing the Field Survey (i.e., inputting data for each household visited), People Connectors were asked whether they were able to provide any assistance to Householders that they had engaged in conversation. Often, People Connectors felt they were able to help those they had spoken to (35.9%), or that perhaps they had helped, but they were unsure (39.4%). Without feedback directly from the Householders, it was difficult to know whether the help offered by the People Connector teams was useful, applicable, or welcomed. In about a quarter of cases (24.7%), the People Connectors felt they were not able to help (and it is unclear whether help was needed or not in these cases).

Often, People Connectors felt they were able to help those they had spoken to (35.9%)

The Field Survey was completed quickly while in the street in between visiting households, so to find out how People Connectors might have helped those they had a conversation with, a dropdown list of options was provided (see Figure 18 for full list of options). Mostly, People Connectors felt they were helpful to Householders by providing information regarding services and supports that could address their needs (96.4%).

FIGURE 18 How People Connectors felt they might have helped Householders



Note. Multiple responses permitted.

We examined the 'other' category (9.1%), where People Connectors were invited to describe other ways they believed they helped. Mostly, People Connectors felt that providing a safe, judgement-free space for Householders to share their story, concerns, or reflections was the most important help they could offer during their visit. This allowed Householders to feel validated and heard.

Another common way that People Connectors helped was by providing general information about resources (e.g., local police contacts, how to access MyGov, etc.), or making phone calls to services and organisations on behalf of the Householders.

The focus groups provided more of an open space for People Connectors to describe how they helped Householders, and these discussions often focused on psychosocial benefits of empathetic listening and proactive conversations about supporting mental health. People Connectors said they thought Householders often gained a sense of relief, hope, and unburdening through the conversations had at the front door. Examples of this are explored in Section 7.

Some people need more than one contact and greater familiarity – with the information or the People Connectors – before they can even consider engaging.

Experiences of powerlessness and limitation

People Connectors demonstrated a commitment to the core aims of the project and the wellbeing of people they connected with, to such an extent that they often held hopes of helping people beyond what was perhaps realistic. This was very clear in conversations with People Connectors who spoke of how some Householders' hardships 'weighed heavily' on them, and also how they were genuinely elated when they had success in lending support that was needed. However, despite many instances of apparent success, feelings of powerlessness were a common experience among People Connectors. This section explores these perceptions and the limits of the support that People Connectors could offer to Householders through the ACDC Project.

"But of course, you're set up to fail in lots of ways. There are lots of ways, reasons why you can't [help]." (People Connector)

Only one chance to build a connection

At every doorstep, People Connectors were acutely aware of the pressure on them to engage people's interest and gain trust very rapidly. The visit was not usually scheduled and may have been happening at an inconvenient time for the household, and although there was scope to arrange with the Householder to come back at a better time, convincing the Householder this was worthwhile was still required. Some People Connectors expressed that some people need more than one contact and greater familiarity – with the project materials, the mental health content, the individual people – before they can even consider engaging.

"It's emotional for me because you pick up on the sensitivity, the need, the vibe of the environment, the home, what it looks like, the condition that it's in... [And they do not want your help]. But maybe if you ask the second time or maybe it's the third time, maybe it's the fourth time, maybe it's the fifth time of somebody coming back, that they're actually prepared to accept that help." (People Connector)

People Connectors describe the feeling of walking away from a Householder who they believed would need additional support, but who was not ready to have that conversation, or receive information.

"Well, would it have been okay for me to call the police and get a wellbeing check done? And just those little simple things that you walk away and go, 'God, maybe I should have done that. Maybe I should have done that better'." (People Connector)

"There was an elderly woman. I knocked on the door and was told to go away, and you know, I just felt like, oh gosh... I heard a need." (People Connector)

Frustration at not being able to follow up

People Connectors were overall very successful in making authentic connections with Householders. Householders shared their troubles with People Connectors sometimes through very personal disclosures. The project design however generally limited the interaction to a one-off visit. There was scope for the Householder to sign a consent form for a second visit, however a specific support need was required for follow-up consent, and this was not utilised often (as indicated in Figure X above, this applied in only 4.3% of engagements). While these limits were clear for both People Connectors and Householders from the outset, they did inhibit People Connectors' abilities to meet those needs that could be better resolved with one more contact.

"There were a lot of times where I would think of something later or I might find out about a resource or something later, and I'll be like 'Oh wish I knew that at the time, and I could have passed that on to a person.'" (People Connector)

"The Householder is like, 'I'll take a paper survey, you know, I'm at work right now. I'll leave it out for you tomorrow.' And then we pick it up and take it back to the office and read it and it's like, damn, this person is really struggling, but we have no permission to go back to them. We don't even know who they are anyway because we don't have their address." (People Connector)

The ability to check in on Householders after the initial engagement, particularly Householders that People Connectors had concern about, seemed to be a missing piece in the role that People Connectors could play in the community. Many People Connectors believed that a second visit could be utilised to provide new information about support options, to see if the Householder had made contact with a service, or if they needed help or reassurance with this, and to have a renewed conversation about support options after the Householder has had the time to read the Information Pack and have time to think about what supports would best suit them.

"With the Information Pack that we give out, Householders might go, 'Yeah, okay, I'll contact the service'. We can be like, 'Do you want us to call on your behalf like now and help you engage with that service?' And then they decline... It's like you don't get that follow up to know whether or not they engaged... I wish there was a way that we could go back and revisit and check in [and ask]'Have you had contact?'" (People Connector)

"I think that the second house visit would be good because then they have that time to process the information that you've originally told them, look at the magnet, think about what support they might need even if they did decline initially." (People Connector)

Inability to know the outcome of support given

The one-off nature of the visit also prevented People Connectors from knowing the outcomes for Householders and the community beyond the doorknocking engagement. This was also frustrating for many People Connectors who clearly came to care for people after hearing their personal stories.

"One of the questions on the fortnightly report is, do you know the outcome for this family? And we've never been able to put an answer to that, because we don't know." (People Connector)

The People Connectors indicated that this made their role less fulfilling than it could have been and that more opportunities for 'completing the loop' by reconnecting with the Householder (when warranted) may be beneficial for both data gathering for the project and its potential for positive social impact.

"We don't really have a provision for follow up stuff to find out how they went with the information we accessed for them, because we are not there as support workers. So we can't go and make the phone calls with them and we can't go and take them to the appointments and follow up and make sure that they do these things... So it's just leaving the information with the hope that [by] 'leading the horse to water' [it] will actually drink from it." (People Connector)

Not enough services to refer to

Despite identifying need through the doorknocking approach, many of the People Connector teams reported feeling stuck that there were not enough local services or capacity within services to take referrals, particularly for specialist supports such as youth services, aged care, and inpatient services.

Even Householders regularly reported to People Connectors that they did not expect to be able to access services.

This awareness was not only among People Connectors, who often worked in the service sector; even Householders regularly reported to People Connectors that they did not expect to be able to access services:

"A lot of people we have spoken to have acknowledged that, yeah, they've really struggled. But they haven't really done anything about it other than talk to family and friends, because they're already making the assumption that there's not enough services. And they're pretty right about that." (People Connector)

On this issue, People Connectors often felt quite powerless. To problem-solve this they focused on making a difference at the door through empathy and brainstorming with the Householder any practical ways they could reduce their burdens. Sometimes this included referring Householders into local community-based supports, which often Householders were not aware of and were usually lower threshold and easier to access.

Providing information without adequate practical support to navigate or link into services, could be ineffective at best, or overwhelming at worst.

"There [are] no bulk-billing services. Let's be honest. There [are] very few. Or if they are, they're at capacity and nobody can access them any further. So really what we're trying to do is put low cost services in front of people and yeah, try and give them that belief that there's hope. And one day at a time. Here are some services that you can access immediately that will help support you to get up and going again." (People Connector)

People Connectors also became creative with options by suggesting that Householders find social connection at local craft, recreation or hobby groups. The ACDC Project Team ensured that information products included online and national telephone support options which did not have the capacity limits or wait times of local services.

Support needs that are beyond project scope

Some People Connectors commented on the frustration and concern of not being able to provide Householders with the level of mental health support that they need – particularly for Householders who were in significant distress at the time of engagement and were not already connected to supports.

Part of this limitation was the feeling that providing information without adequate practical support to navigate or link into services, could be ineffective at best, or overwhelming at worst.

"Sometimes when people are overwhelmed... adding all that extra information to them might even be more overwhelming, and they still won't access any of the information, which is probably a concern I would have if somebody was in a very bad way, and you only provide information to them. They're looking at that point for somebody to do things for them." (People Connector)

Although the People Connectors could provide a certain level of support, for example by connecting Householders to supports and starting the process of contacting the services with them, the limitations of the one-off contact prevented ongoing support, or a quick follow-up check in from being possible.

"We probably don't get enough time within our little scope to be able to get in there and attack [the issues in the community]. It's probably not our roles either. We just do the whole, 'Well, I'll provide you with some information, and maybe you can follow up on this'." (People Connector)

The limitations described by People Connectors – the inability to follow up, to understand outcomes, and limits to service options available – are not necessarily a flaw in the project design, since no program can be all-encompassing. However, there may have been opportunities lost, as People Connectors could not always act on their intuitions about who needs support, or an extra visit. As People Connectors also genuinely connected and cared, they also wanted to be there to follow through on conversations when it felt natural to do so.

The ACDC Project as a community development initiative

People Connectors were confident that their conversations made a difference for individual Householders. They also spoke extensively of community benefits that they either observed or hoped for as a result of the ACDC Project. Doorknocking was viewed by People Connectors as contributing to the community:

- as a public awareness raising initiative that supported community members' connections and care for one other;
- as a learning process for services to help identify needs and better understand gaps in support available locally (see Section 6.3); and
- as an effective way to connect with individuals or sections of the community that were higher need and/or not necessarily already connected to support (see Section 6.3).

People Connectors also identified the untapped potential for a greater wrap-around approach to localised data collection, where Householders' support needs could feed back directly into local community supports and service planning. In Round Two, survey results were presented in local agency meetings in some communities, although the evaluation evidence for this was limited and it is hoped these activities and collection of evidence will be more developed during Round Three.

Demonstrating concern and care for one another

While not every Householder discussed their own wellbeing, many were keen to talk about wellbeing issues in their community. Conversations covered social concerns like housing affordability and crime, and Householders also offered ideas about much needed infrastructure, specific supports that were lacking, or suggestions for which cohorts (e.g., young people or young parents) needed more targeted support.

"Even if they didn't need the help, they're always thinking about the next person who does." (People Connector)

"Some people would say, 'Oh, we are okay, my household is good, no problem.' And then that creates another conversation as well [about who is not ok]." (People Connector)

Many Householders who said they did not need support, were still very keen to receive the Information Pack, and indicated their intention to share information to help others in their community access support. Especially in cases where Householders had someone in mind who they were concerned about, the visit and Information Pack provided a good excuse to reach out, and also empowering in providing information needed.

"An individual person is not only going to think about themselves, but they're also going to think about the context of their community. And so, what we are doing at the moment [is] providing this information, engaging with Householders and empowering them with information. And it is information that is not only meant for them." (People Connector)

Householders offered ideas about much needed infrastructure, specific supports that were lacking, or suggestions for which cohorts (e.g., young people or young parents) needed more targeted support

People Connectors tapped into concerns that were there already – about vulnerability in the community.

"There is a genuine concern about the lack of support for the youth in the area. There's not much for them to do. There's a lady today who's got two daughters, they're in their teens, and she's really worried about the lack of services for her teens. She has heard that there's a lot of youth suicide and issues in the area.... So there appears to be maybe a lack of support or programs in the area for the prevention of teen suicides or suicide in general." (People Connector)

People Connectors also believed that having these conversations widely, alongside the community promotion work of talking about the ACDC Project on local radio and community newspapers, led to raising awareness about mental health and help seeking.

"I think it's amazing for creating awareness though, because not only is it going to the people who are in need, it's also going to their whole community. So that hopefully neighbours, friends, family, who are there for the long term and do have relationship and do have rapport are now aware of all of these services." (People Connector)

In these ways, People Connectors embraced community development principles: that is, empowering people in a community setting with the skills, knowledge and resources to connect and better support one another.

6.3 GROWTH IN SKILLS AND CAPACITY, AND UNDERSTANDINGS OF MENTAL HEALTH

Focus groups were conducted 10 weeks after People Connectors started in the role. The Evaluation Team observed how, at this point, teams generally presented as highly confident about doorknocking and attuned to helping people, but also exceptionally reflective about their own learning process which included gaining skills and knowledge, but also more broadly, personal growth and thinking differently mental health.

Emotional intelligence, and new skills and interest in the connecting role

After working in a role based around connecting to others, People Connectors reported sometimes profound changes in themselves. It appears that connecting with others – risking the potential of rejection, remaining physically and emotionally present, being authentic while maintaining personal boundaries – is something one can practice and get better at. It is not that these were new skills, as People Connectors were often recruited for their interpersonal and communication skills. It is that these skills were greatly enhanced by the role. Also, not all People Connectors felt they were naturals at first.

"Well, definitely the skills that I've learned from this job, they're worth their weight in gold. To be able to knock on someone's door and just talk to someone about anything and everything. Yeah. I would never have learned that skill anywhere else. And just by doing this role it's allowed me to have that confidence to be able to just to do that, I suppose." (People Connector)

"So for me, it has been really quite a gracious project in terms of how I've grown as a person and it's kind of influenced my view on our community and community work. So I think I'll carry that forward, regardless of whatever I end up doing... this will inform my choices and decisions going forward." (People Connector)

Carrying out this role often required strong emotional intelligence to quickly assess and navigate the complexities of each person, what they might need and if it is appropriate to help, and, if so, how.

"It's not like you're a psychologist in a clinical setting, but then you're not a friend either. You're in this sort of space in between, which is very boundaried but also needs to be natural." (People Connector)

"I've personally benefitted a lot. I've learned a lot because I'm quite new to the industry. So for me on a personal level, learning to compartmentalise work and hearing all of these people talking and opening up... and developing a bit of a thick skin if you're told to get lost. That's been really beneficial for me..." (People Connector)

The People Connector must constantly respond to the Householder and their immediate environment, while remaining sensitive to their social circumstances (which may also involve making assumptions and relying on intuitions). People Connectors reported that this role involved a steep learning curve and continual growth and self-reflection.

"I am a privileged white male, you know. Social services is new to me. Mental health is new to me. So I haven't had any exposure. And so then I'm knocking on doors and to do the job well, I've had to let go of prejudice. I've had to let go of biases. I've had to let go of my ego and any of that sort of stuff, so that I can engage well at the door and just meet the person really where they're at. And to be nonjudgmental, totally nonjudgmental in that approach and in doing so, that's allowed them to get to know me and me to get to know them and just to lower that guard down and to really be respectful and understand people's stories. If I didn't or wasn't able to lower that guard down I wouldn't have learned so much and I wouldn't have engaged as well as we have." (People Connector)

The People Connector experience largely involved listening; active, empathetic listening and putting the Householder at the centre of each interaction. For some, practicing the discipline of listening, and taking on board (taking to heart) the Householder stories was transformative.

"It's opened my eyes to the community, to what's needed out there and what potentially we can do moving forward to really make them know that they were heard from that project, that that project wasn't just a thing where it's going to float away, and nothing ever happens. That even while we're waiting for anything to come back from that we can start to work towards what the community asks for and what support they need." (People Connector)

One People Connector noted that this job required a high degree of authenticity as a person and as an employee, and a willingness to develop greater coherence between intention and action in their roles and, perhaps, in their lives more generally.

"They [the Householders] get a read on you really quickly. So if you are not true...if your intentions are a bit blur they will be put off by that." (People Connector)

Due to their satisfying experiences directly connecting with and assisting people, and the personal growth that arose from that, several People Connectors indicated that, moving forward, they did not want to have a desktop role, or to be so constrained by administrative processes, but they were keen to take their strengthened skills at connecting directly with people and apply it in new ways.

Being better informed about local support gaps and needs

In training for and undertaking this role, People Connectors gained comprehensive knowledge of the local service ecosystem, including informal knowledge about the quality of those supports.

"We've had to learn about other services that come out to this way or are around, and we've built some good connections to be able to refer on to, and then likely vice versa to refer to us, which again, I was, to an extent, I didn't have much knowledge of. I was always focused on my role I did here. And realising what other services can offer and how we can all work together, it's real beneficial." (People Connector)

People Connectors also came to understand who in their communities had support needs, who was missing out on accessible support options, and where the gaps in services were most acutely felt. Many People Connectors could describe in detail where they believed the gaps were; whether it be more mental health services for women with long term mental health issues; informal support groups for young people; or, social supports for older people who may be experiencing loneliness.

"There's also a lack of clinical and nonclinical support, especially for the younger people. I think a lot of people don't want to go to a psychologist, because it sometimes can be very clinical. So having those support groups that are less formal, I guess, is what those age groups really need. And the more preventative peer work stuff, without being focused on a hobby. I think a lot of the groups in the area are either for older people, or you've got your craft groups and things like that." (People Connector)

People Connectors uncovered more general concerns:

"There's a lot of unmet need in our community, a lot. Massive gaps across our community. We're finding a lot of people are isolated." (People Connector)

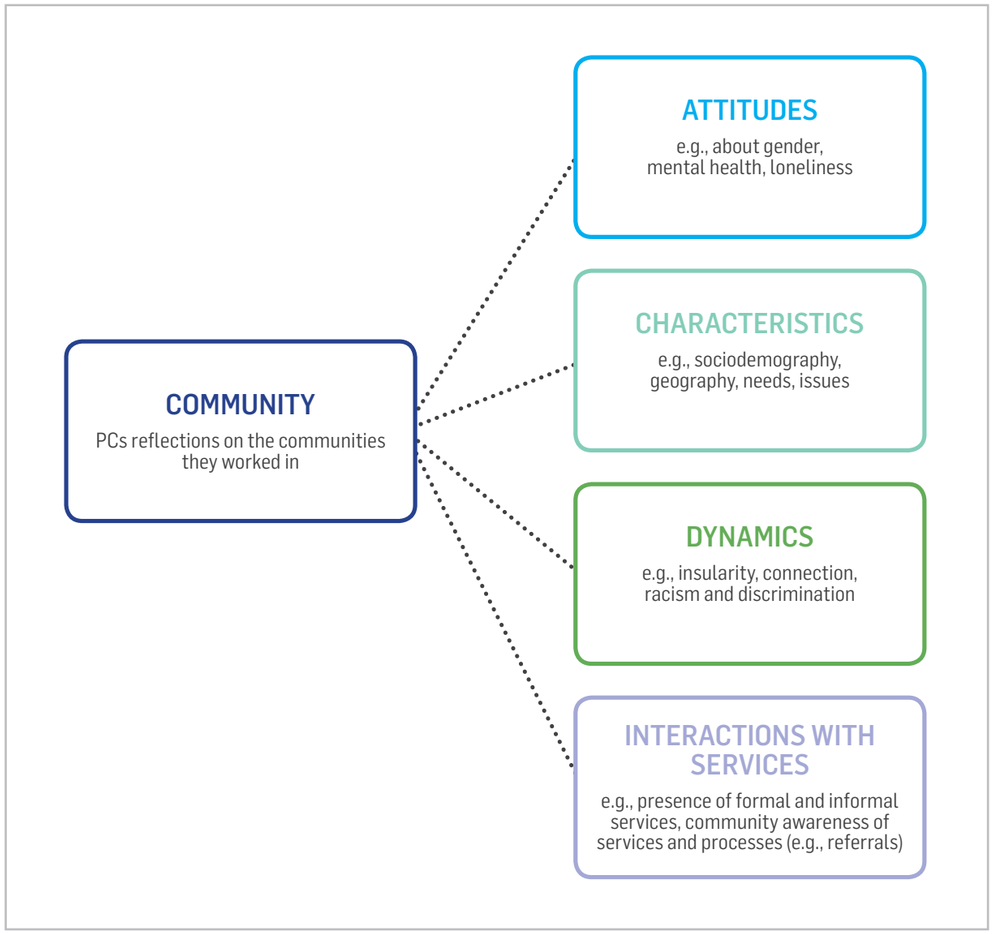
"There's not enough services for mental health, especially bulk billing." (People Connector)

Or they gained new understandings that challenged assumptions and stereotypes:

"I think we are seeing that there are vulnerable people in affluent places. I think we've had some amazing discussions with people who have opened up to being vulnerable, and shared their stories." (People Connector)

The following diagram (Figure 19) reflects the topics that focus groups uncovered, and how nuanced People Connectors understandings were about the communities they worked in.

FIGURE 19 People Connector focus group coding framework for reflections about communities



People Connectors discussed their communities in terms of general social attitudes, sociodemographic characteristics, dynamics and the interactions with services, revealing a strong knowledge base attuned to complexity and enriched through their doorknocking experiences.

New understandings of mental health

Many People Connectors recognised that the ACDC Project had increased their understanding of mental health needs in the community and the importance of connecting people to supports:

"[Doorknocking provided] a really grassroots understanding of what the needs are within communities. But through experience and actually seeing that and actually hearing that firsthand, it has really given a new sense of appreciation of the importance of the role [of doorknocking] within mental health." (People Connector)

People Connectors were often left with a much broader understanding of mental health problems. For example, rather than adopting a static illness model, mental health problems were understood in the context of Householders' circumstances (and their access to resources; the social determinants of health).

"So often we've got this complex situation where people are just already stretched... and it's that constant stretching... all the way across your lifespan. And then all of a sudden you reach your point... and then you get a crisis moment. Your partner is leaving you and all of a sudden, bang. You've got to find your own way in life. You're not a dual income anymore. You're a single income. Rental prices are ridiculous. You've got to shift and there are relocation expenses. You've got bond to pay and all those things, removal costs... And so then you're trying to pay $90 gap on a mental health service that you've accessed through your GP. And it's just, you can't even afford that. So what's next? Where do you go? What do you do?" (People Connector)

One People Connector described a complete about-turn in how they personally viewed people needing support. Whereas once they were less tolerant of some behaviours, they now have a more empathetic outlook as they are able to look deeper at the possibility of historical trauma that may be affecting people's behavior, or at least the lack of resources and opportunities having an impact.

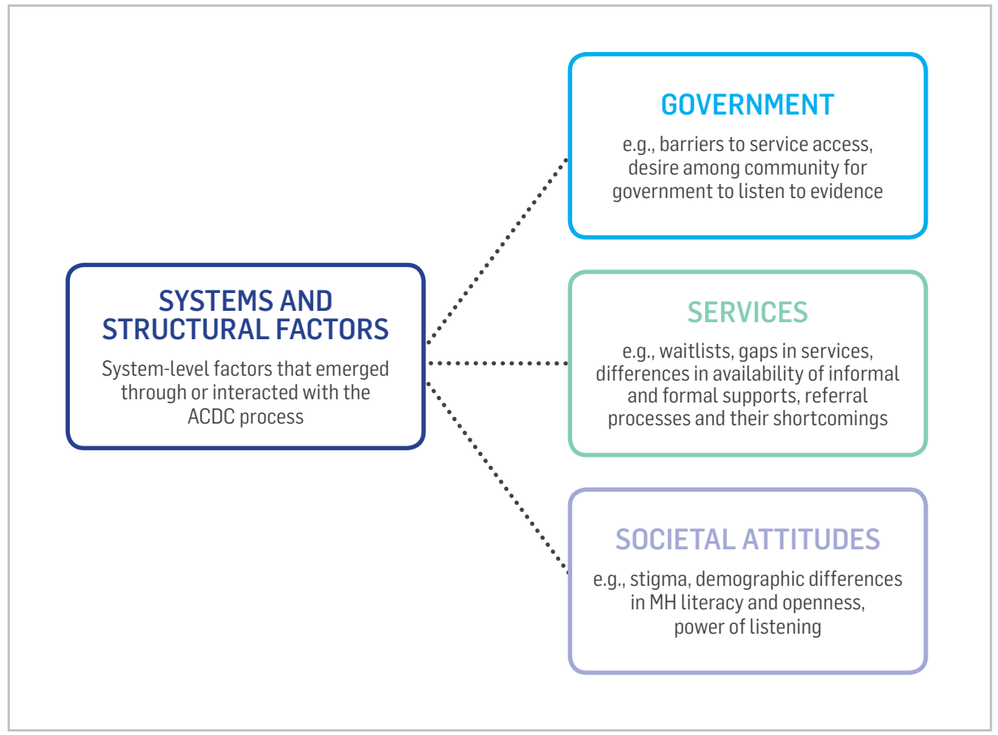
"In the neighbourhood we are knocking, they just want the kids locked up. You know, they just want the crime dealt with. And my thinking previously to doing this project would've been very similar, in terms of just those kids are being too softly dealt with, they need to be locked up and put away. But the real fix to this isn't locking kids up. The real fix to this is giving these kids better homes, better opportunities, giving them opportunity for employment and education, breaking the cycle of trauma – intergenerational trauma – that they've probably come from. And that doesn't happen by addressing mental health needs. It comes by addressing community needs." (People Connector)

These perspective shifts were based on grounded experiences of talking to diverse people, and People Connectors felt it would enable them to more effectively work in the mental health and community services sectors into the future.

People Connectors came to understand causes of mental health for individuals with more depth and breadth, but were also privileged to be able to see the service system from the standpoint of people, some of whom may not be able to access, or ever consider accessing, these supports. This informed People Connectors views of the service system and understanding structural and access barriers.

Their thoughtful reflections were also captured in focus groups, and the coding framework that presents relevant themes is provided in Figure 20.

FIGURE 20 People Connector focus group coding framework for reflections about systems and structural factors



As reflected in the ACDC Project training modules (see Section 3), the skill set required by People Connectors to undertake their role was extensive and included learning how to maintain psychological and physical safety for self and others, self-care, mental health literacy and supporting people effectively. These skills and understandings were further enhanced through the practical experience of doorknocking, and the evidence presented in this section indicates that People Connectors often gained a highly sophisticated understanding of their communities, considered diverse experiences of mental health, and were able to situate this within broader structural and political conditions.

6.4 A SENSE OF PURPOSE

People Connectors actively engaged with the objectives and purpose of the ACDC Project – either subtly or explicitly. They upheld the values of care and respect for others, wanted especially to connect with people in the greatest need, and help wherever possible.

"They can see our drive and our passion for our community that we live in. And we make that pretty clear to them that we are from the area, this is our community; that we're not from the city, we're not coming in and doing these projects and then going away and you'll never hear from us again; that we're actually going to try at least to make a difference." (People Connector)

At times teams of People Connectors indicated a wish to continue doorknocking: to expand who they were able to help with this method, or to doorknock in new locations to try to help specific communities they thought would especially benefit:

"For me, the job is good, and I'd love to continue. I wish it continued in another location, another site. I don't mind traveling." (People Connector)

"I would like to help more people... And all different people from different areas. So, you get different opinions everywhere. That's how I see it." (People Connector)

This sense of purpose also applied to the way People Connectors engaged with the survey and the data collection aspect of the project; they understood how the survey results could be used to make the case for change.

"I think we are getting that across to people now that these surveys aren't just surveys. It's actually an opportunity to make a difference to our community. And it's their say. It's what they say as issues. It's what they say we need help within our community. And I think they can get that from us." (People Connector)

Whether it was an intended or unintended outcome of the project, many People Connectors were personally aligned with the project objectives. This was not always the case at the start of their engagement, but after talking with a large number of Householders, People Connectors more richly understood the need for diverse support options, the need to help people link to that support, and the insufficiencies and injustices in the service systems. An interest in advocacy, or systems change, therefore seems reasonable, and after the hard work of going door-to-door for a few months, People Connectors perhaps felt they earned the right to comment on what they think needs to change, or even to pursue meaningful work in the future that allows them to build on these understandings.

"I would like to help more people..."

"All these [experiences of distress] have a bigger picture in rural areas, and no one looks at it. They're just like, 'That person's depressed.' No one goes, 'Hang on. He hasn't been able to find a job for the last seven years.'" (People Connector)

7. THE EFFECTIVENESS OF DOORKNOCKING

In previous sections we explored the impact of the ACDC Project on Householders, People Connectors and DPOs. This section takes a broader view, to look at the overall effectiveness of doorknocking as a proactive outreach method for mental health, as guided by the following evaluation questions:

1. Were people generally responsive to proactive outreach through doorknocking; were communities and individuals happy to engage?
2. Was doorknocking effective for linking people to supports, especially people who would otherwise not be supported?
3. Under what conditions, and for whom, did it provide the most benefit?
4. What were the mechanisms that made doorknocking an effective approach, and under what conditions was it less effective?

Several dimensions of effectiveness were considered (see Figure 21). We wanted to explore the ability of doorknocking for mental health to connect with diverse social groups, the receptiveness of individuals and communities to this approach and the responsiveness of the Householders in terms of the lasting impact of the experience. Our final analysis looked at the value of this method from a health equity standpoint, through answering the following:

1. Could 'hardly reached' people, and/or under-resourced communities, be effectively engaged?
2. Did this approach make a difference for people experiencing greater disadvantage by enhancing their access to care and support?

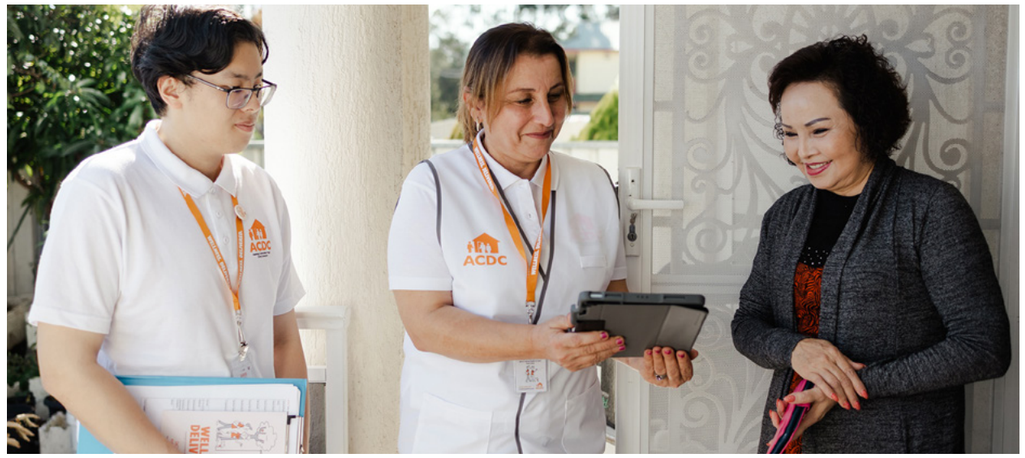
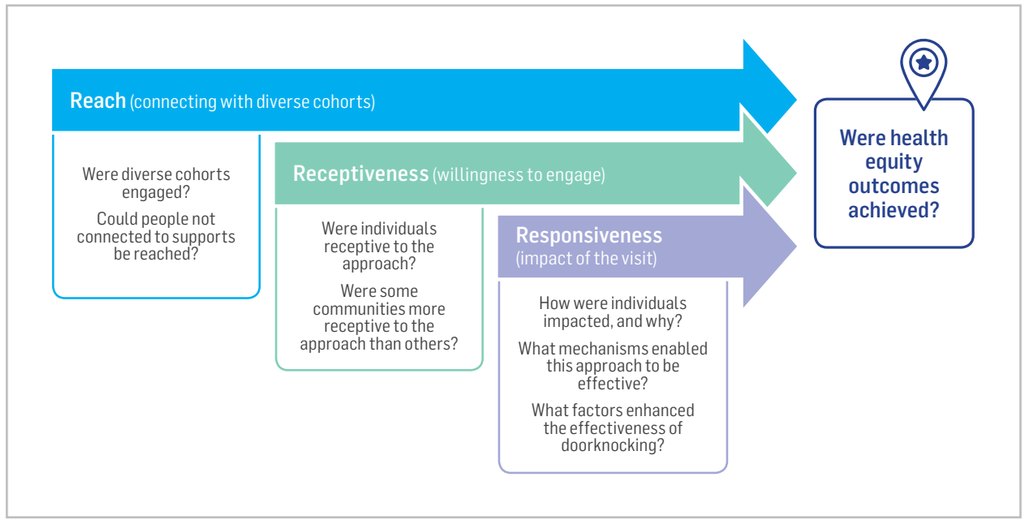


FIGURE 21 Dimensions of effectiveness



Evidence was sourced from the Field Survey (Conversation Report), nine Householder interviews and 20 People Connector focus groups (Round Two data), and written reflections from People Connectors (Impact Stories). Analysis involved a quantitative summary of engagement data, and for the qualitative data we adapted techniques from realist evaluation and the success case method, as well as presenting two brief community case studies.

7.1 REACH: CONNECTING WITH DIVERSE COHORTS

In research, hardly reached[72] refers to cohorts whose voices and experiences are often missing. This concept can be applied also to people who are hardly reached by mental health services.[73] As the literature review (Section 1) outlined, some populations typically underrepresented in mental health services include:

- people from culturally and linguistically diverse backgrounds;
- people living in regional and rural areas;
- people from lower socioeconomic backgrounds and areas; and
- men.

Not only are these populations underrepresented in services, they are also less likely to reach out to services as they are not seen as appropriate, safe, or accessible for them, or they have had poor experiences in the past and have chosen not to re-engage. This is also the case for many Aboriginal and Torres Strait Islander peoples, even more so for those who are living in regional and/or remote communities and are under-resourced.

Literature suggests that these groups may be more affected by stigma (perceived external discrimination and/or internalised stigma) which also prevents help-seeking. They are also more likely to have mental health challenges due to the impacts of the social determinants of mental health.

Overview of who engaged

The following statistics show the demographics of Householders who completed the survey across the 17 sites (see Table 14; data is only indicative of who engaged as we did not collect demographic details from everyone who spoke to a People Connector, only those who completed the survey.)

[72] Note: the term hardly reached is preferred over hard to reach because the latter suggests that qualities of the cohort are responsible for not being reached, rather than the characteristics of the initiatives hoping to reach these groups.

[73] Freimuth, V. S., & Mettger, W. (1990). Is there a hard-to-reach audience? *Public Health Rep, 105*(3), 232–238.

TABLE 14 Indicative demographic data from the ACDC Project survey sample

Demographic characteristics	Representation through survey data
Gender	Females most frequently completed the survey; 58.4% of respondents identified as female, **41.1% male**, and 0.5% identified another way.
Age	There was a balanced representation across all age groups. Most survey respondents were aged between 25 and 64 years (64.2%). A further 16.6% were aged 65 to 74, 8.9% aged 75 to 85, 7.5% 18 to 24 years, and the remaining 1.8% were older than 85.
Aboriginal and/or Torres Strait Islander people	A considerable **proportion of survey respondents (9.3%) were Aboriginal and/or Torres Strait Islander** (the remainder did not indicate that they were either Aboriginal or Torres Strait Islander), which is significantly higher than whole-of-population representation (3.3%).
Culturally and linguistically diverse	Two variables collected – country of birth, and main language spoken at home – were indicative of culturally and linguistically diverse persons. Over a quarter **(26.3%) of survey respondents were born outside of Australia** – similar to the national average, 29.1%. Most survey respondents (91.2%) spoke English at home, however, **many survey respondents spoke different languages.** These included Arabic (3.5%), Mandarin (2.4%), Vietnamese (2.4%) and Cantonese (1.7%), among many others.

In terms of engaging communities with lower socioeconomic status (SES), the ACDC Project, by design (i.e., through suburb selection), spent more time doorknocking in disadvantaged suburbs compared to more advantaged suburbs. As described in Section 4, most communities were categorised as lower SES as indicated by decile 1 (7 suburbs), decile 2 (10 suburbs) or decile 3 (8 suburbs; using deciles one to 10 to classify the SES across suburbs[74]). Of the 36 suburbs visited by the People Connectors, nearly 70% (25 suburbs) were categorised in the lowest three deciles.

The ACDC Project did reach people living in regional or rural areas, although with organisations needing to submit a tender and successfully demonstrate they had capacity to undertake the project, this tended to favour organisations in larger towns. Eight sites were in metropolitan areas, five sites were classified as 'inner regional' and four as 'outer regional' (ABS ARIA[75]). There were no ACDC Project sites that met the classification for 'remote' or 'very remote'.

The survey data is indicative only; there were significant sample size variations across the different sites, and smaller samples are less representative of a population. However, the demographics represented in the total survey sample (Table 1), and the site characteristics (as indicated by IRSAD and ARIA data), does indicate that hardly reached groups were adequately reached, or at least not significantly underrepresented. This was not surprising given the behind-the-scenes effort that went into engaging certain social groups, and the characteristics of doorknocking that made it suitable for reaching diverse groups, as will be explored in this section.

The data does indicate that hardly reached groups were adequately reached, or at least not significantly underrepresented

[74] Based on the ABS Index of Relative Socioeconomic Advantage and Disadvantage categorisation – decile 1 reflects the most disadvantage and decile 10, the most advantage.

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

People Connectors with diverse cultural backgrounds could make connections with local cultural groups or leaders

Strategies to engage the hardly reached

In line with the literature review findings, recruiting People Connectors based on the known demographics of the area was a successful strategy for ensuring those who engaged were generally representative of the community.

For example, recruiting bilingual and bicultural People Connectors in regions known to have large culturally and linguistically diverse populations, or Aboriginal People Connectors in communities with high proportions of Indigenous peoples, seemed effective for engaging those cohorts, as evidenced in those sites' demographic survey data, and the reflections of the People Connector teams. It seems that the cultural background of People Connectors encouraged people with similar backgrounds to engage, or perhaps made it feel safer for them to do so.

Anecdotally, it was clear that bilingual or multilingual People Connectors who could speak languages commonly spoken in the local area were an asset to the project. People Connectors in all sites had the option of contacting interpreters through the Translating and Interpreting Service (TIS National), who could assist with interpreting the doorstep conversation while on the other end of the phone. However, where it was used, People Connectors reported limited success; the logistics of connecting over the phone and through an interpreter did not lend itself to the nuanced and personal nature of the conversations required for meaningful engagement.

"It's just, you're tackling really challenging conversation about that kind of trauma and they're frustrated because they don't think that the message is getting through the translator to us very well. It's really dependent on how effective the translator is with the dialect and also the content. And the nonverbals, like empathy, compassion, trust. Those are the things that are really challenged in those conversations as well. (People Connector)

In addition to language and cultural assets, People Connectors with diverse cultural backgrounds could also make connections with local cultural groups or leaders, such as Aboriginal Elders, and spread the word about the ACDC Project through their networks which perhaps helped give the doorknocking visit some legitimacy across diverse groups.

For Aboriginal communities, anecdotal data indicated that the potential of a truly effective cultural engagement strategy, guided by cultural protocols and with support from Aboriginal Elders, could not be achieved in Round Two, as there was not the adequate lead time before doorknocking commenced.

Engagement was also mediated by gender. Householders gave positive feedback about the opportunity to talk to male People Connectors. Some men who felt more comfortable talking to a male about their mental health, or having a male present to relate to, could have been the 'make or break' for engagement in these instances. Another Householder pointed out that they did not feel comfortable when the first person who came to their door (who knocked and led the chat) was a man and they would have felt safer if that person was female. Mixed teams – at least one male and one female – seemed to work to deliver a fairly balanced participation of males and females, and could also cater for preferences, if Householders preferred to engage with someone of a particular gender.

7.2 RECEPTIVENESS: WILLINGNESS TO ENGAGE

One learning from the project was that overall, Householders were more willing to participate than was anticipated.

"We expected a lot more rejection." (People Connector)

In the project's early stages, it was not uncommon for project staff or DPOs to have second thoughts about whether doorknocking for mental health would be well received. However both quantitative and qualitative engagement data show that People Connectors were often welcome visitors.

People Connectors inevitably knocked on many unanswered doors, and if the door opened, they needed to quickly and intuitively find the best way to connect with the Householder (see Section 6). Occasionally there was some hesitation, but the 'low stakes', informal nature of the interaction helped these people to feel at ease and able to engage.

"A lot of people don't want to talk to us, you can see it at the start, that fear of engagement or whatever. Then when we start talking to them, [and] halfway through it, they're like, 'Oh, no, this is a really good idea. I really like this. Keep it up.'" (People Connector)

"[They might say] 'I don't have time to do this.' And then 45 minutes later, you're still standing there on the doorstep." (People Connector)

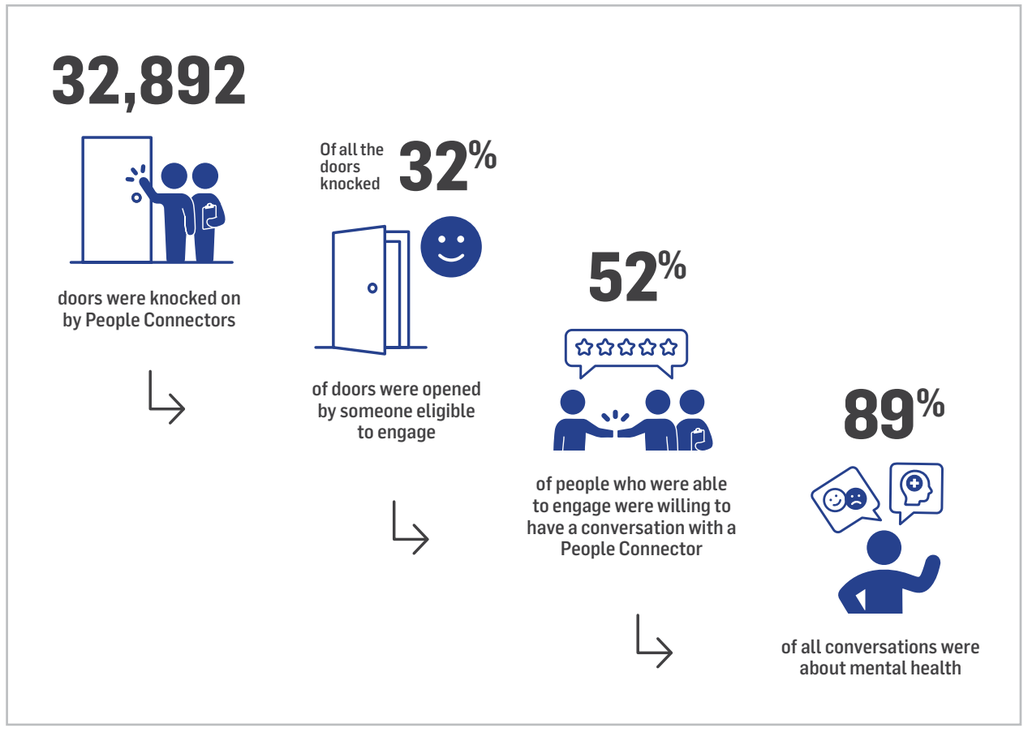
Where people were not willing to have a conversation, there was no pressure to do so. However, the interest was generally there among Householders, and engagement with willing Householders generally did not involve much friction or exertion on the part of the People Connectors.

Receptiveness of Householders

Many Householders were receptive to the People Connectors' visit, and also happy to talk about mental health and wellbeing. Of the Householders who were home to answer the door (and were eligible to engage), 52.4% had a conversation with a People Connector and the vast majority (89.4%) of these conversations included discussions about mental health (see Figure 22)[76].

Occasionally there was some hesitation, but the 'low stakes', informal nature of the interaction helped these people to feel at ease and able to engage

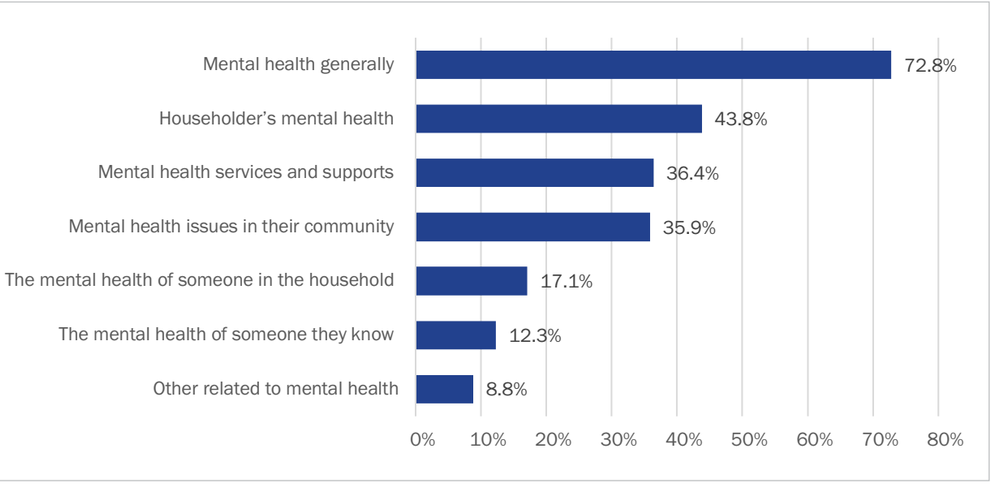
FIGURE 22 Key activity and engagement data



[76] These statistics are based on engagement data collected in the Conversation Report collected in the Field Survey.

Most of the discussions about mental health were general (72.8%), with quite a significant number of Householders willing to discuss personal experiences of mental health and wellbeing (43.8%). Other discussion topics included mental health services and supports (36.4%), and mental health issues in the Householders' community (35.9%; see Figure 23).

FIGURE 23 Types of discussion about mental health at the door (%)



Note. Multiple responses permitted.

Discussions categorised as 'other' (8.8%) comprised several more specific topics related to mental health such as Aboriginal and Torres Strait Islander social and emotional wellbeing, caring responsibilities and carer mental health, COVID-19, natural disasters and climate change, the NDIS, physical health, and housing concerns.

Receptiveness of communities

Strong engagement data and Householders' general comfort with the approach does indicate that generally communities responded well to the approach. However, anecdotal information, and engagement data that varied across sites, did indicate that some communities were more receptive than others. The ACDC Project Team, as well as DPOs and People Connectors, encountered some reticence about the idea of doorknocking for mental health. Early in the project there were instances where community leaders who were approached about supporting the project gave a firm 'no' to the idea (although some changed their minds at a later time). For those communities that did go ahead with the project, there were times that People Connectors felt resistance to the project, or the approach just did not 'land' well. Possible reasons for this are explored in Table 15.

> ***The experience of People Connectors, and especially the teams that worked across diverse areas, tells us that, as is the case with Householders, some communities are more receptive than others***

TABLE 15 Possible reasons communities were not receptive to the ACDC Project approach

Reasons communities were not receptive	Examples
Stigma about mental health	Anecdotal evidence indicated that there was a strong presence of stigma around mental health in one Chinese community, and therefore this group was less willing to engage directly. Other evidence suggested that a general community-level stigma may have been a problem across other sites.
Fear in the community	In one street, People Connectors found that the Householders would only open their doors a small crack, and in another community, there had been recent shootings, affecting the likelihood of Householders talking to strangers. A third community had a history of crime in the area and here, People Connectors found Householders less willing to engage.
Resistance and scepticism by community leaders	Community leaders occasionally did not allow People Connectors to access certain community groups who were perceived to be vulnerable, e.g., people living in public housing towers.
Perceived lack of service infrastructure to support the project	In some areas, there was also a perceived lack of existing, accessible services to support any need uncovered, or a lack of organisations that would be willing to promote the project locally.
Perceived lack of relevance in communities where practical supports were badly needed	At times, the project was not considered appropriate in the aftermath of natural disasters where the community priority was crisis management and practical help for people who had lost their homes to flooding, for example; or in suburbs facing a housing crisis where basic needs for food, shelter and sanitation were unmet.

These findings are not conclusive. Some are based on perceptions only, and some were provided as reasons for communities not to engage with the project and so remain untested. At other times, the hesitation and concern about the doorknocking approach (reasons presented in Table 2) were the key motivators for other communities to engage. Where communities were experiencing low levels of trust, high stigma and a lack of locally-available services and supports, to some local leaders, this was indicative of a need for the low-barrier, face-to-face contact which the doorknocking approach provides. There were also several anecdotes of certain sub-sections of a community that were found to be especially receptive, although they were not expected to be:

> ***Where communities were experiencing low levels of trust, high stigma and a lack of locally-available services and supports, to some local leaders, this was indicative of a need for the low-barrier, face-to-face contact which the doorknocking approach provides.***

> ***"One of the other places that we went was a men's boarding house. The team had popped in for a visit during the week and then we arranged to go back on a Saturday. There were 25 men in the house, and we put on a barbecue for them and just had a chat and whatnot, which was amazing. They all completed surveys, they were all more than happy... The guys all just really got a lot out of it. We provided tons of resources, referred a couple of people across to services" (DPO)***

Pre-judging the potential benefits of this approach for certain communities is complex and difficult to predict, as many factors and dynamics are at play, including how People Connectors adapt the approach to their community. However, the experience of People Connectors, and especially the teams that worked across diverse areas, tells us that, as is the case with Householders, some communities are more receptive than others. The following case studies unpack some of the possible mediating factors that influence the receptiveness of communities.

A TALE OF TWO COMMUNITIES: THE ROLE OF COMMUNITY CONTEXT ON PROJECT OUTCOMES

A comparison of two communities in NSW located near each other, but possessing different characteristics, illustrates how context influences project outcomes. These understandings were based on the views of a team of People Connectors who visited both communities.

Comparative overview

Yamba and Maclean are both regional towns located in the Northern Rivers region of NSW (about three hours south of Brisbane), and approximately 20 kilometres apart in the Clarence Valley. Yamba is located on the coast at the mouth of the Clarence River while Maclean is sited upriver and inland. In the most recent ABS census statistics (2021), Yamba had a population of 6,405 and a median age of 57, and Maclean had a population of 2,778 and a median age of 56. Aboriginal and Torres Strait Islander peoples made up 4.5% of the population in Yamba and 10.2% in Maclean. In 2021, the lowest-income quartile in North Maclean—South Maclean was the largest income group (30%).[77] This was also the case in Yamba, where the lowest income quartile accounted for 39% of the population.[78] However, statistics do not tell a full story. Income, for example, must be considered in the context of a population's other assets and life status. Based on the direct observations of People Connectors, in Yamba, there was large proportion of retirees who had no income but owned a house and were financially stable, particularly those who had moved from large cities.

The People Connectors who visited these two communities noted several key contextual factors:

- The higher SES and sense of financial stability apparent in Yamba compared to Maclean;
- Increased isolation, few job opportunities and a lack of supports and infrastructure in Maclean;
- That Yamba residents often had pre-existing and ongoing connections with high-quality specialist health support in larger cities where they retained access and/or could afford to pay privately;
- That Yamba residents were often working or busy with their day compared to Maclean residents who often had more time to speak with the People Connectors;
- A sense that the level of general health and wellbeing was worse in Maclean, including that People Connectors came across several incidences of people with cancer;
- That COVID-19 prevented natural community interactions and support from taking place, including whole-of-community supports in both towns;
- Rising house prices in both Yamba and Maclean, including rentals (to the point of unaffordability for many locals), although Householders in Yamba seemed more likely to own their own homes (inferred);
- A feeling of decreased social and relationship security impacting community connectedness and mental health generally among both communities; and
- Mental health distress and shock from the effects of recent flooding in the area, but a general sense that Yamba could 'absorb' shocks more.

[77] https://profile.id.com.au/logan/household-income?WebID=400

[78] https://profile.id.com.au/clarence-valley/household-income-quartiles?WebID=240

Reflections on the receptiveness of both communities

The People Connectors discovered a greater willingness of Householders to engage and have 'deeper' conversations in Maclean compared to Yamba. The relatively higher SES and potentially lower incidence of mental and physical health issues in Yamba was thought to contribute to more surface-level, and less productive, interactions between Householders and People Connectors. In comparison, in Maclean the People Connectors felt able to have generative conversations with Householders who seemed to be eager to connect, reflect on their needs, and welcome possibilities for accessing support.

This allowed the People Connectors to (generally) develop a better connection with the Householders in Maclean compared to Yamba, particularly because they had time on their side as many people were at home due to un/underemployment or financial constraints (i.e., there was more time to facilitate openness and rich discussion). Since this gave the People Connectors greater insight into the issues that individuals may be experiencing, and the types of support that might be helpful to them, they were able to suggest relevant support options and get ***"more engagement in the rescheduling, in the comeback and in the follow up"*** among Householders in Maclean, compared to Yamba where ***"it felt very closed"***. Because of this, the People Connectors reflected that it felt ***"more like a People Connector role [in Maclean] than what it did in Yamba... Yamba felt like we were gathering data."***

"In Yamba... were retirees who had no financial issues, who owned their own properties. [But in Maclean people say], 'We are isolated. We need supports. We don't have this, we don't have that. We're afraid that if we died in our house, no one would find us for a period of time,' even though they have things in place like aged care systems and that stuff. They're just identifying these things [whereas in Yamba] it's like, 'No, the weather's beautiful. Life's beautiful.'" (People Connector)

A TALE OF TWO MORE COMMUNITIES

Interestingly, a similar comparison of two communities located near each other in Western Australia, Ballajura and Beechboro in the City of Swan, was also provided in a separate People Connector focus group.

The People Connectors reflected on the fact that Beechboro had a lower SES than Ballajura which made their experiences "very different". However, in comparison to Maclean, where there was a higher receptivity to the People Connectors, the outcomes were more mixed in the lower SES community of Beechboro. Part of this was for practical reasons and the observed role of stigma:

"A lot of people we've noticed, especially in Beechboro, would shy away from [discussing] mental health. So we really had to keep it on the community level. There's just so much more stigma." (People Connector)

"I think in Ballajura, people just wanted to chat a lot more than in Beechboro. And I think part of that is people aren't having to work full-time jobs and then come home and look after kids. There's a bit more flexibility to work part-time or sometimes it's a single income house and another person is able to stay home and care for children and things. So it's just a bit more time to have conversations and things, which is good for our project." (People Connector)

There was also a sense that the level of receptiveness and the needs were different in the two communities. In the lower SES community of Beechboro, on the one hand, support and resources were considered important when compared to the higher SES community of Ballajura, where people had greater means to access support:

"[In Ballajura] it felt a bit defeating because I was handing out free resources and things...In the higher SES areas, if people want to get support, they can pay and go and get support... [Whereas] in Beechboro there's a lot more poverty. So there, the free resources are really useful and really great." (People Connector)

"We went to the Lakes in Ballajura, which is a private estate area and the houses... The wealth level between even that and other parts of Ballajura is immense. So, we got the most surveys that we had ever got from that place because people are wanting to chat and talk and like actually have time for it. But also in having conversations they're like, 'We already get support.' Like financial stuff isn't an issue at all." (People Connector)

On the other hand, in Beechboro there was a sense that the support offered by the People Connectors may be ineffective and was not welcome in some cases:

"When we knock on a door and we can definitely tell that they're struggling to get food, it's really difficult for us as People Connectors because we're giving out a fridge magnet. And they're like, 'We don't want your fridge magnet'... Especially in Beechboro we got a lot of hostility because they're like, 'Talking to you is not going to do anything for me.'" (People Connector)

This points to two 'extremes': one where Householders seem to have too many needs to find the support offered by the People Connectors helpful or meaningful, and another where Householders are financially and socially well-off enough that the support offered by the People Connectors is also not novel, nor particularly meaningful. The grey area in between is significant, but broadly, the pattern highlights the role of personal and community context in the efficacy of the doorknocking approach.

The two case studies suggest that in higher SES communities, there may be both an ability and willingness to engage with People Connectors, but less unmet mental health need (i.e., due to a greater ability to access and pay for supports). Comparatively, in lower SES communities, there may be greater unmet need around mental health and greater need to address the social determinants of mental health (including poverty and work/financial insecurity), and this may lead to an openness to have a doorstep conversation about mental health, or create more resistance to it.

The resistances may be because of stigma, a feeling that a conversation would be pointless or ineffective, or a feeling that they have other issues to worry about first and foremost. However, this is certainly not always the case – the example of Maclean (a low SES community) highlighted how many Householders were more willing to engage with People Connectors because they were struggling. Receiving face-to-face contact and an opportunity to discuss their experiences in these contexts was, in many cases, very appropriate and productive.

"There's a lot of units...where people are disadvantaged, they are on either like an NDIS, or My Aged Care or pension and they're the ones that we found had huge chats. So we'd be talking for an hour or two hours with one person, because there's so much going on, and they'd been so isolated. So that was really good, obviously for Gisborne." (DPO)

Taken together, this evidence suggests that the doorknocking approach may be most beneficial for people who are in the 'middle group', i.e., those who are open and receptive to talking about mental health and would consider seeking support (if needed and not already being accessed), have the time to engage, and have mild to moderate symptoms of distress or adverse life circumstances.

> ***Many Householders were more willing to engage with People Connectors because they were struggling.***

Many teams of People Connectors shared similar experiences of localised receptiveness to the ACDC Project, or even hyper-local experiences, where they felt that some streets were more receptive to opening their doors, talking to a stranger, and/or wanting support, than other streets. What was apparent was that every community was unique and that People Connectors came to know when things were working well in terms of their ability to engage a community, or when things were not working well. The People Connectors in Clarence Valley for example, felt that doorknocking in Maclean was a much better use of their time, and more meaningful work for them as well. A key learning could be that giving People Connectors the ability to adapt to these factors, to perhaps change the selection of doorknocking locations as they came to better understand community characteristics, might help to maximise the effectiveness of this approach.

For some Householders, the ACDC visit was experienced as a very significant event that created lasting change.

7.3 RESPONSIVENESS: WAYS THAT HOUSEHOLDERS WERE AFFECTED BY THE VISIT

The impact of the ACDC Project visit

In the ACDC Project context, the Householder on the other side of the door could be anyone, in any set of circumstances. The project needed to be highly responsive to the full range of human experiences, leading to wide ranging experiences for Householders, as well as how People Connectors engaged them.

We also know that for some Householders, the ACDC visit was experienced as a very significant event that created lasting change. Analysis of Householder interviews through a realist evaluation lens[79] revealed that three key 'mechanisms' help to explain why the doorknocking approach was so powerful in these instances, and how the visit led to positive experiences and outcomes among Householders. These mechanisms are:

- Providing a rare opportunity to reflect on needs and feeling supported to take action
- The reduction of stigma around mental health and normalisation of help-seeking
- Promoting general optimism by the focus on local mental health support

This is far from an exhaustive list of possible mechanisms, but exploring these three provides an insight into the very personalised nature of the project's theory of change.

Reflecting on needs and feeling supported to take action

The chance to pause and reflect on one's own wellbeing, through a warm, supportive conversation with People Connectors, and the Information Pack, was a rare opportunity for some Householders. A conversation about, for example, their lived experience of mental health distress, their role as a carer, or the mental health of their community generally, was very welcome and perhaps long overdue.

Providing this space for reflection led to shifts in perception for Householders – often a shift away from unawareness or overwhelm about mental health (either their own or others'), and towards recognition (if it was lacking) and feelings of support and encouragement, which promoted practical outcomes such as seeking further support.

The People Connectors in one focus group reflected on a young woman who initially said she did not have time to speak to them, but then opened up about her mental health condition once she felt at ease. Another woman who was interviewed, who had experienced mental health issues that prevented her from feeling connected to the outside world, commented that the sense of connection and confidence provided by the People Connectors' visit encouraged her to take her own independent steps to make more social connections herself.

This points to a possibility that existing opportunities to discuss mental health and feel supported were limited and/or of poor quality in many communities, or relied on people actively seeking them out. The ACDC Project afforded people the time and space to reflect on their own needs and to feel supported to take action – for example, by contacting services, seeking social supports or having conversations with loved ones – and was therefore often significant and welcomed.

[79] Realist evaluation maps how program inputs interact with a range of variables and contexts to promote certain outcomes. This method of analysis makes explicit 'for whom' and 'in which circumstances' programs work and how they achieve outcomes. A context-mechanism-outcome framework is used to show how different outcomes might be generated for different individuals. The 'mechanism' is the change in reasoning (e.g., attitudes, beliefs, or logic) that happened in individuals as a result of program inputs and resources (e.g., information or support), enabling them to make different choices (or not). Mechanisms thus explain 'how' a program leads to expected program outcomes. Mechanisms, however, are activated in different contexts. From a realist evaluation perspective, the same program can work in different ways for different participants depending on the context.

CASE STUDY: LISA (Table 16)

Lisa is a nurse who worked in a hospital Emergency Department (ED) during COVID-19 and experienced burnout, stress, anxiety and low mood during this time.

She was very positive about her experience with the People Connectors who visited her; their communication styles and personal qualities helped her feel comfortable, supported and heard. Lisa felt that their friendly but straightforward way of asking about her wellbeing helped establish openness and honesty, providing a much-needed opportunity to discuss the issues affecting her mental health – something she had not really spoken to anyone else about.

The factors promoting this positive experience with the People Connectors included feeling looked after, seen and supported, being offered a timely opportunity to share a personal story, the sense of anonymity created by talking to strangers, and a sense of renewed hope for the future. This led to tangible outcomes in Lisa's life. The interview with Lisa several months after the visit revealed that after her engagement with the People Connectors, she went on to utilise the information given to her, get a Mental Health Treatment Plan, have honest conversations with loved ones, and change jobs to support her mental health and wellbeing.

This "success story" case study corroborates other anecdotal evidence from Householders and People Connectors to suggest that providing an open, unhurried and personalised space to explore mental health, as a one-off experience, was powerful enough to affect change in a person's life. It is possible that a readiness for change already existed in the person in instances where this happened, i.e., when the mechanism was activated.

TABLE 16 Case study of outcomes realised by the opportunity to reflect on one's mental health

Before visit	During visit	Changes as a result of the visit
No longstanding mental health issues, but wellbeing impacted by being an ED nurse during COVID-19: **feeling burnt out, overworked, fatigued and anxious**, Lisa was unhappy and described herself as "down in the dumps"	Face-to-face contact, the caring qualities of the People Connectors, and the fact that they asked open and direct questions about how Lisa was going had a powerful effect on **helping her reflect on her circumstances and wellbeing**. The conversation was experienced as nurturing, which was greatly needed. It validated her need for more support and also encouraged her in practical ways to **seek more support** for herself	Lisa realised that working in the ED during COVID-19, where she experienced and witnessed extensive burnout and anxiety among staff and personally, was not healthy. She made the decision to **change jobs** after the PC visit and now works in a nursing home
Concern for others was Lisa's predominant way of being in the world – in her personal life as well as her workplace		Lisa is **more actively engaged in self-care** and now understands that she can make decisions for her own wellbeing
Lisa was resilient in the face of the challenging circumstances of responding the COVID-19 as a healthcare worker – however, this resilience and collective resilience in the ED environment meant **the hardships were unseen and unacknowledged**		Having felt valued, heard and understood, Lisa now **acknowledges difficulties** in a way that she did not before
In her role as a carer, especially in exceptional times, **it was rare to be shown concern** and have the space to talk about her own needs		Lisa **made space to have her own support needs met** by activating a Mental Health Treatment Plan so that she could continue to reflect on her own wellbeing and get the support she needed

Normalising mental health and reducing stigma among diverse groups

Another mechanism of the doorknocking approach that was effective for making a difference to Householders that we followed up with, was the sense of normalisation it created about talking about mental health, and the reduction of stigma, which often went hand in hand. This happened particularly in the context of communities where a high degree of stigma was evident. This was the case in some regional communities, culturally diverse communities and often among older people, although findings were also contradictory (it is difficult to generalise), and many People Connectors noticed 'pockets' of stigma in communities.

"[In inner-city locations] there is a lot more conversation [about mental health] and I was thinking like, 'Okay, cool. All done. The stigma is getting better!' But now I'm out here and it's... it's just like we don't have the resources and we don't have the information out there. Particularly for older generations and people that aren't just coming out of school and university." (People Connector)

The provision of information and resources to Householders, and the informal conversation brought literally to their home, were key aspects of the doorknocking approach that promoted normalisation and stigma reduction among some people.

Stigma could manifest as negative attitudes towards mental health in general or dismissing the mental health needs of others, and also internalised stigma which often led to not recognising one's own mental health condition or support needs. People Connectors encountered stigma through doorknocking; but this did not necessarily mean that people were resistant to a conversation – in fact it sometimes meant that talking about mental health was especially welcomed. If stigma had prevented people from seeking help or supporting others' mental health needs, the doorstep interactions sometimes appeared to spark a shift in awareness and perception among Householders. The provision of information and resources to Householders, and the informal conversation brought literally to their home, were key aspects of the doorknocking approach that promoted normalisation and stigma reduction among some people.

This mechanism was most evident among people who did not feel they had a need to discuss mental health (i.e., they felt they did not have problems with their mental health), people in households or social environments where mental health was stigmatised and difficult to talk about openly, and people who ignored or did not recognise the extent of their mental health difficulties. The case study below of Max highlights one way in which someone with a lack of awareness about mental health had their perceptions challenged and transformed by the visit.

CASE STUDY: MAX (Table 17)

Max was a man in his seventies who did not have urgent mental health needs, but had not really thought about mental health before.

Both he and others in his life were facing physical health issues, and he noted that the medical appointments they regularly attended did not provide the emotional support that people need but may not be actively seeking due to lack of knowledge and awareness, or the presence of stigma. Max found the People Connectors' visit to be a rare opportunity for connection and for his thoughts to be heard and valued, which was empowering and comforting. It also highlighted a gap in his own understanding of mental health. He reflected that, as he and his aging peers faced greater health needs, the human contact and engagement that the People Connectors demonstrated may be what many people are looking for from the health system.

Max was very satisfied with his experiences of the health care available to him, but the visit from the People Connectors made him reflect on his own and his small community's mental health needs (maybe for the first time). He reflected that people are often lonely and needing the comfort of human contact from the health system, which drives them to visit their medical professionals but at the same time can leave them unsatisfied by in-person clinical care. He came to realise that there were other options for social support, outside of the health system (see Figure 5).

TABLE 17 Case study of outcomes realised by the opportunity to challenge stigmatising attitudes to mental health

Before visit	During visit	Changes as a result of the visit
Max possessed a sense of **'mental health is for others, not me'** and limited understandings of mental health support being only about "lunatic asylums"	Max experienced **connection and mutual sharing with another man (male People Connector)** who facilitated a conversation about mental health, provided open space, authentic listening and resources including information	**Stigma-reduction** took place as Max was breaking through gender-related self-reliance and stigma to gain new insights that it is OK for men to have mental health needs
Max had a sound understanding of medical supports for physical health, however observed that the medical system does not meet relational needs well and **felt his community was under-supported emotionally**		There was a greater **normalisation of mental health** experiences and support-seeking as Max now understands that mental health is not sub-par to physical health, and this is empowering for him
No-one listened or asked his opinion about mental health or community health		Max felt **valued, heard and understood** and was therefore more engaged and open
Max had no urgent mental health support needs and therefore **did not know of services**, although had attended Men's Shed without recognising it as a support before		Max had a greater **knowledge of support options** beyond the medical system: although he does not need to connect with services, he is comforted to know "there is so much out there" for himself, his wife and neighbours if needed

Promoting a general optimism around local mental health support

Among most Householder interviewees, survey respondents and People Connector focus group members, there was a feeling of optimism about the ACDC Project potentially helping to support the mental health needs of the community, as part of a wider effort to address the mental health crisis at the local level. It was notable that so many Householders seemed to have pre-existing concerns about the mental health of their community.

"Sometimes people say, 'Look, I don't need [help] but…' And then they show so much care for the [neighbours'] wellbeing. Which I think has been a really surprising finding for me – how much people care about the wellbeing of their neighborhood." (People Connector)

This helps explain the sense of relief and hope with which Householders regarded People Connectors. This was particularly evident among people who felt that accessing the right mental health support was not a possibility, for themselves, loved ones, and for the wider community. This concern was also expressed for specific groups within the community such as young people, elderly people, or people who had lost jobs due to COVID-19.

Some people expressed the hope that the stories and perspectives of community members would be utilised in the design and funding of supports for the community.

People Connectors can respond directly and in real time to the most apparent need the Householder presents, and can take the time and the most appropriate course of action that acknowledges personal resistances, hopes or concerns

One Householder described the experience as "that little bit of hope in a terrible time" for a community experiencing a high degree of isolation and instability as a result of the pandemic and an ageing population lacking adequate social supports. Many people viewed the doorknocking approach as a feasible way to provide some sort of social connection to vulnerable community members, as well as practical support-seeking advice and encouragement. For Householders who were aware of what others in their community were going through, there seemed to be a greater concern for the wellbeing of community members outside their own household (and therefore belief in the potential of doorknocking to help them).

Among the most influential factors here were the face-to-face nature of doorknocking and its low-threshold, proactive approach. Householders had a real-time opportunity to discuss and reflect on mental health (either generally or personally) and to know that their neighbours and community members would also receive a visit. Some people expressed the hope that the stories and perspectives of community members would be utilised in the design and funding of supports for the community.

There were, however, people who did not express this optimism. In fact, some Householders felt that the project did not, and could not, help people at the practical level in any significant way. Without addressing the insufficiencies in the service system (e.g., high demand/low supply), they felt that doorknocking could not help people with accessing the timely and high-quality supports they needed.

CASE STUDY: KATE

Kate felt hopeful that, through the doorknocking approach and the understanding of community concerns and experiences around mental health, real change could happen.

For a woman living in a rural town with a family member who was experiencing mental health challenges, her hope was that the collection of data on people's lived experience of mental health challenges could feed back into service delivery for better mental health outcomes in the community.

Kate did not recall a tangible positive impact of her doorknocking experience personally (nor a negative one) but was nonetheless happy to engage in what she thought was a worthwhile program. She believed that the provision of information around mental health at a household level was important, and she retained the hardcopy information provided to her by the People Connectors who visited her and had shared it with her daughter.

To improve the engagement and efficacy of the program, Kate suggested holding pre-advertised public discussions (for example, in libraries or community centres) where people might feel more comfortable discussing community needs rather than personal experiences. She suggested this might be less confrontational and therefore more effective than a doorknocking approach. Nonetheless, she reiterated that, whatever the method, there was a need to initiate informal conversations across the community about mental health, for everyone's benefit.

The case studies of Lisa, Max and Kate illustrate how adaptive the doorknocking approach can be, which is perhaps the reason for its potential to create such a lasting impact for people. People Connectors can respond directly and in real time to the most apparent need the Householder presents, and can take the time and the most appropriate course of action that acknowledges personal resistances, hopes or concerns.

Table 18 summarises the mechanisms and outcomes presented in the case studies, starting from the universally-applied strategies that People Connectors use to engage all Householders, then the more targeted strategies that respond to individual Householders and lead to diverse outcomes. This analysis is rich, and acknowledges that with such a small sample of Householders we are only scratching the surface of the diverse experiences that doorknocking facilitated.

TABLE 18 Mechanisms and outcomes presented in the case studies

GENERAL PROGRAM STRATEGIES Strategies/protocols universally applied	RESPONSIVE STRATEGIES Examples of what People Connectors did to respond to individuals	MECHANISMS Examples of the ways that Householders responded that resulted in change	OUTCOMES Examples of the effects of the visit on Householders
– Bring face-to-face contact to the individual, direct and immediate (no appointments or waiting) – Explain aims clearly to establish comfort (and that there is 'no agenda') – Make discussing mental health accessible and friendly – Provide information on mental health and support options, in a format that is easy to share with others – Ask direct questions about things that are meaningful, provide an open space to talk	– Display care for the carer – Listen and value household's insights about community needs and opportunities to better meet needs – Show a willingness to talk about difficulties – no taboo subjects – Use the power of mutual sharing – disclosing and sharing relatable experiences as a man, as a nurse, as a carer etc. – Encourage help-seeking in targeted ways based on expressed need – Listen empathetically, sensitively and without judgement	– Feeling more empowered from being heard, seen and validated – Being supported and heard as a carer or an advocate for loved ones – Having information resources that are easy to share with others – A feeling that sharing experiences of not being able to access services could help make a difference – hope that service provision might improve – Relief in feeling able to be unburdened by talking to strangers – Feeling supported and encouraged to take action – Novel experience of feeling looked after, comforted and heard	– Boost in mood simply from being able to talk – Equipped individuals and families/carers with important information about mental health – Sense of hope for the future – Utilising information and support to get a Mental Health Treatment Plan and take further action – Breaking through self-reliance (e.g., gender-related, carer-related) – Comfort in knowing that there are other support options out there beyond medical support – Normalisation of mental health as an aspect of health needs – Motivated to seek support
People Connectors establish a safe conversation about mental health, with information provided	Through further open questioning and listening, People Connectors have deeper conversations that are responsive to individuals with an awareness of their potential barriers to help-seeking	Householders feel validated and heard which leads to a shift in perception, greater self-reflection and motivation to make changes	Householders are more comfortable thinking about their own mental health, better at help-seeking or feel solidarity about continuing to support others

7.4 WERE HEALTH EQUITY OUTCOMES ACHIEVED?

Seeing the ACDC Project through a health equity lens uncovered several key findings immediately. Firstly, the typical access barriers that vulnerable groups face when seeking help do not apply. One Householder said they were overcome by the fact that they were able to have an extended conversation with the People Connectors immediately, without wait times or administrative work or appointments to navigate. It was, simply, an unexpected experience of support. There were also no transport or cost barriers, or extensive eligibility criteria that often prevent people from getting support.

The power of the ACDC Project to connect with people who may be easily deterred by other barriers is notable. Perhaps once people have this experience of support and feel the benefits, they might be convinced to seek more sustained ways of being supported. The project also uncovered other learnings about what more equitable mental health care might look like.

Factors that enabled the hardly reached to engage

Through written reflections (Impact Stories) and focus groups, People Connectors documented examples of where the doorknocking approach could effectively link people to supports, and this most definitely included hardly reached people, who:

- were not already connected to supports;
- had unmet/unrecognised support needs;
- were reluctant to reengage with services after poor experiences; and/or
- had prior attempts to access help but had not been able to successfully get the help they needed.

This section reflects on the features of the ACDC Project that enabled effective connections with "hardly reached" people.

> ***"...They're comfortable where they are, they're comfortable at home, so they're happy to [disclose] everything to you." (People Connector)***

A safe space that comes to you

Many People Connectors reflected on how being at someone's home could help to support a connection, and also helped People Connectors better understand need.

"Because you're going to their safe place, because home is people's safe place where they're the most vulnerable, I think also contributes to the unloading... Of course. You know? They're comfortable where they are, they're comfortable at home, so they're happy to [disclose] everything to you." (People Connector)

A caring stranger taking an interest, as a one-off visit, also provides a fairly safe opportunity to speak freely.

"We are someone you can talk to... we don't know any of your friends, your family, and you can just unload everything off your chest, and then just wipe your hands clean of it and go back to your family afterwards. It's a rare thing that you get a chance to do." (People Connector)

First steps to break down isolation

"While door knocking, I spoke to an Aboriginal woman who had little kids and a partner at home – where I think it was a domestic violence situation – and she was really open and honest and told us that she was really isolated, she barely leaves the house, doesn't feel safe in the community so therefore didn't take the kids out of the house much either. What was great was that our People Connectors were able to link her up with an Indigenous Kindy which provided her with support." (DPO)

> ***One Householder said they were overcome by the fact that they were able to have an extended conversation with the People Connectors immediately, without wait times or administrative work or appointments to navigate. It was, simply, an unexpected experience of support.***

This example illustrates the potential of the ACDC Project model to gently intervene, without necessarily needing to have permission for a comprehensive assessment process, and without needing to intrude or draw conclusions about Householders' more acute needs. This approach might be highly beneficial and appropriate for some people living with complex health and other needs who are not already connected to services. People Connectors could sensitively provide some options to bring people out of isolation as a starting point, before their multiple coexisting needs can be addressed.

A holistic approach that is not service-centric

When prompted to think about how a doorstep interaction could help people to think more seriously about accessing supports for their mental health, one People Connector reflected:

"I think people realise that you're actually not there to judge them or to question them about [their mental health]. Just having that casual kind of conversation to start off with, a lot of people just start to open up about these things, and then you can kind of follow their lead and just ask them what services they've been getting for it. Then finding out that people aren't accessing services, and we can say, 'Well, have you heard of this place you can go? There's plenty of services out there.' Then they go, 'Oh, wow. Okay.' So then the more information we can give them, the more they open up to us and trust us, I guess." (People Connector)

The freedom that the People Connectors had to facilitate conversations without an 'agenda' and without representing a particular service meant that they could potentially broaden people's awareness about support options and mental health generally.

Some People Connectors attributed much of the success of their doorknocking interactions to its neutral, depoliticised nature:

"We're not coming in with this thing in the back of our minds going, 'Okay, we're going to identify these needs, and then we're going to refer them straight back to our organisation. We're going to profit from this'... it's a more holistic thing... We're not just focusing on fixing stuff and we're not focusing on getting you over to our service." (People Connector)

The lack of competition with other organisations potentially allowed for more natural doorstep conversations that were more empowering for Householders.

"It's that surprise and the genuine nature... I suppose it's that appreciation. When you do have that conversation with a stranger and you are potentially able to provide them with a little bit of information, a little bit of... not necessarily the pat on the shoulder, but the metaphorical pat on the shoulder that [says], 'Now we're going to go away, we're going to bring back some information, and then you can take that information and you can own that. You can be empowered by that. You can be empowered by throwing that in the bin or making that next step to make contact.'" (People Connector)

Problem-solving for access barriers

People Connectors found that some people who were not connected to supports were 'stuck' at various stages of the help-seeking process. This proactive approach was highly effective for discovering those who needed an additional nudge or practical help to connect with a service. For example help with contact the service and breaking down the various administrative tasks to make that happen. This was especially the case with those supports that are more complicated to access such as the Mental Health Care Plans, My Aged Care and the NDIS.

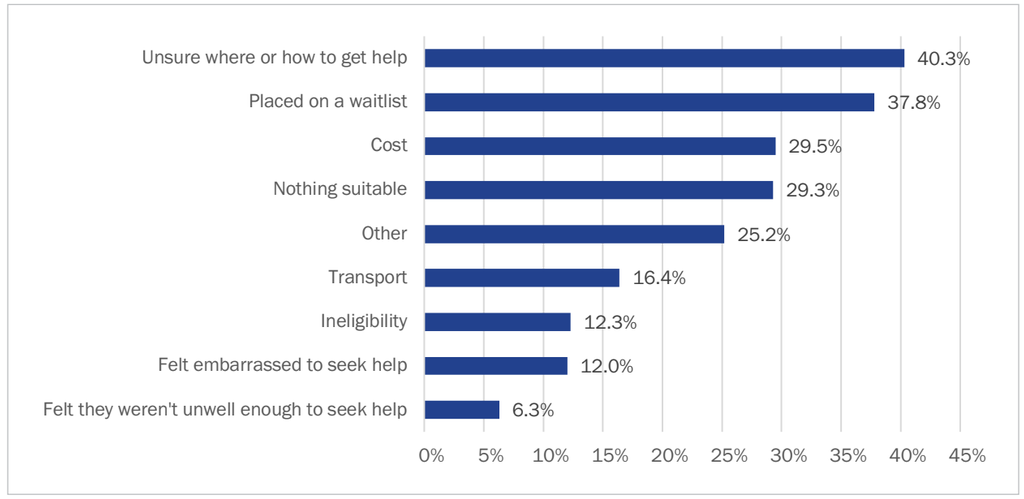
"...We're just standing on the doorstep. So, we can follow that conversation on all the leads...without going, 'Well, that's not my area of concern', or something like that. So, we can follow the conversation and we can pick up on all the things that the person is actually needing in their life, or information that will help them to make their own informed choices of what they need for themselves." (People Connector)

"We just got the bulk billed Mental Health Treatment Plan for the young lady who hasn't been able to access that for the last seven months, so hopefully on the twenty-first of this month, she will have a new active Mental Health Treatment Plan and will be able to access services again. The only reason she didn't have it in the first place is she couldn't get one bulk billed. It did take a few phone calls and a little bit of a conversation." (People Connector)

People needing mental health support, unfortunately, face many barriers when attempting to access the help they need. In the Field Survey, People Connectors were asked whether the Householder had indicated any troubles accessing mental health services, but most reported no concerns (84.3%). Of the remaining who had experienced difficulties getting the help they needed, reasons varied (see Figure 24). Notably, this project was able to directly address some of these barriers.

Some people who were not connected to supports were 'stuck' at various stages of the help-seeking process.

FIGURE 24 Reasons Householders had trouble accessing mental health services (%.



Note. Multiple responses permitted.

Based on the People Connectors' understandings of their conversations with Householders, the primary barriers to seeking mental health support were not knowing where to get help (40.3%), being placed on a waitlist (i.e., lack of availability of mental health services; 37.8%), the costs associated with supports (29.5%), and supports feeling unsuitable (29.3%).

While People Connectors could not address local service capacity issues, or the quality of services available, or the high cost of specialist care, they could help address many of the barriers, and especially, the most common barrier which was not knowing where to get help.

An extended conversation seemed to intervene effectively for many of these barriers. Where people were not clear about where to go, or not confident about seeking help, People Connectors could expand Householders' perspective on the types of supports that might be relevant and that are available (such as community-based supports) and also highlight options that are free or low cost which many Householders did not know about. Through conversations, they could also explore the resources and opportunities within the Householders' social network that could help to mitigate stress or create more positive connections.

While People Connectors could not address local service capacity issues, or the quality of services available, or the high cost of specialist care, they could help address many of the barriers, and especially, the most common barrier which was not knowing where to get help.

Limitations of doorknocking as an outreach method

The DPOs and People Connectors appeared committed to equity outcomes (inferred from their remarks during interviews and focus groups) and the limitations to the doorknocking method were something they were aware of – in particular, the fact that they were not able to help everyone who they felt needed support.

The doorknocking approach does not reach everyone, for multiple reasons. Reach is influenced as much by who is willing to engage as the contextual dynamics that exclude some people from answering the door in the first place or feeling receptive to the People Connectors (at that particular day/time of day/moment etc.).

> ***"If you walk past ten houses any day in any street and knock on them, maybe you do get one person that engages, maybe you get three depending on the community, depending on the way they see you, the way you present, the way you speak." (People Connector)***

Practically, doorknocking is also opportunistic and relies on people being home and available at the time. This leaves significant room for people with unmet mental health need to be 'missed'.

> ***"There was a particular lady... [who] basically said 'Oh no, no, I'm fine, but I am a bit concerned about my neighbour' and when we tried to knock on the neighbour's door, she wasn't home. So we did leave a little information and stuff for them and I don't know... if they got in touch or anything like that. I think that happened a couple of times." (DPO)***

The limitations of a one-off visit were also apparent to People Connectors. For example, some people might require prior warning, or more than one visit before they engage, which was outlined in subsection 6.2. While the doorknocking approach has great potential to connect with the hardly reached, and the ACDC Project has evidenced this potential, the reality of doorknocking and its practical limitations must be considered.

Was the ACDC Project effective for disadvantaged communities?

In subsection 7.2 we explored the ways that Householders' experiences of advantage or disadvantage could be a mediator for how receptive they might be to the ACDC Project, using Clarence Valley and City of Swan as case studies. This subsection looks more at how effective it was for people living in lower SES areas. Insights are drawn from other People Connector teams who worked across communities with differing levels of advantage. For instance, the Palmerston (NT) suburbs comprised: Johnston (decile 10), Woodroffe (decile 4) and Moulden (decile 1), involving large variance relative to advantage/disadvantage. Similarly, suburbs visited in the Wollondilly (NSW) site included Tahmoor (decile 3) and Picton (decile 9).

Observations of these People Connector teams indicated that characteristics of lower SES communities can influence how Householders engage and the extent to which their needs are met by this approach. Some characteristics observed in communities of lesser advantage are the increased presence of stigma, the sense that people either had more time or were too pressured to spend the time, that people had multiple co-occurring needs that existed alongside wellbeing issues and that these other stresses often felt more urgent than their mental health. Concerns about cost and affordability of services were also more apparent in communities of lower SES.

> ***The doorknocking approach does not reach everyone, for multiple reasons.***

Could people from disadvantaged communities be effectively reached and engaged?

Not only was it possible to reach and engage disadvantaged communities through the doorknocking approach, but there was anecdotal evidence to suggest that many people in disadvantaged communities who were not currently connected to supports were more inclined to engage. However, on reviewing evidence across many sites, the findings were also contradictory, as outlined in Table 19).

TABLE 19 Factors that influenced the appropriateness of the ACDC Project for lower SES area

Factors that influenced appropriateness of the ACDC Project for lower SES areas	Reasons doorknocking worked in lower SES groups	Reasons doorknocking was not suitable for lower SES groups
Presence of stigma	Informal, casual chats are productive and may indirectly lead to topics related to mental health and wellbeing In some cases, the presence of stigma meant people were especially interested in talking to People Connectors as it was a rare chance to discuss their wellbeing	Stigma prevented engagement with People Connectors or in-depth conversations about mental health, although other needs could be discussed
Time availability	People with caring responsibilities or were under/unemployed or socially isolated had time to engage and especially welcomed the chance to connect	The sense of stress from working and caring responsibilities led to people not being receptive to an unscheduled visit
Having multiple unmet needs	Multiple needs could be easily talked through with the holistic approach, and help linking to various supports including financial help (e.g., NDIS) was discussed	The sense that one had too many needs that were overwhelming and the impression that fridge magnet was not going to help or that mental health is a 'luxury'
More urgent needs than mental health	Those with mental health needs welcome the chance to have support to connect with various services, and also to have a caring conversation	Some people with mental health needs could be closed off to discussing mental health due to facing issues such as housing insecurity and financial stress: mental health is not a priority and not seen as relevant
Affordability concerns	Welcome chance to learn about free services that were not known about, and also the assistance to connect to NDIS or Centrelink supports	Services with a cost, or that involve travel expenses, are not seen as relevant so people can shut down the conversation

As this summary table indicates, it is difficult to make claims about the suitability of doorknocking for certain communities. For example, when trying to isolate factors such as 'stigma', the findings are contradictory across different contexts. Overall the receptiveness of communities will be influenced by an interplay of many factors together, as well as cultural characteristics of the community – such as the extent to which people are generally fearful and distrustful, or friendly, sociable and open.

Did this approach make a difference for people experiencing greater disadvantage?

Despite the different experiences that individuals in lower SES communities have with the doorknocking approach, there is evidence to suggest that higher levels of social disconnection, prevalence of physical and mental health issues, and lack of services in a community may help generate more productive doorknocking visits.

> ***In communities where residents are under-supported through a lack of available clinical services…the ACDC Project plays a valuable role in connecting individuals to local community supports or online supports that are free or low cost.***

People Connectors are potentially more able to fulfil the 'connection' function of the ACDC Project in these contexts, particularly where more residents are at home during the day (e.g., because of unemployment or underemployment) and therefore have more time available to engage in longer conversations. In communities where residents are also under-supported through a lack of available clinical services, or without the ability to easily travel to specialist appointments that are often in larger cities (or are prohibited from doing so by cost), the ACDC Project plays a valuable role in connecting individuals to local community supports or online supports that are free or low cost.

> ***"I think people realise that you're actually not there to judge them or to question them about [their mental health]. Just having that casual kind of conversation to start off with, a lot of people just start to open up about these things, and then you can kind of follow their lead and just ask them what services that they've been getting for it. Then finding out that people aren't accessing services, and we can say, 'Well, have you heard of this place you can go? There's plenty of services out there.' Then they go, 'Oh, wow. Okay.' So then the more information we can give them, the more they open up to us and trust us, I guess." (People Connector)***

Another finding from multiple teams was that Householders in lower SES communities were particularly responsive to conversations about what the community needs. For example, People Connectors came across quite a few people in Maclean who were living with cancer but did not feel connected to others or socially supported, and their mental health was understandably affected by this. Partly in response to this, the People Connectors for Maclean indicated that a community-minded doorknocking approach would be beneficial:

> ***"[We found that doorknocking] doesn't have to be a mental health focus or disability focus or whatever, it's about community focus… let's speak to each individual [about] how to improve the community… [and ask] What do you think as a community we need to offer or we need to resource, or we need to do?" (People Connector)***

> ***The 'hands-off' nature of doorknocking had limitations, and in contexts where the need was significant and urgent, this felt frustrating.***

The People Connectors working across lower SES communities also believed that questions about what the community is lacking/what the local area needs may be more of a priority, and more relevant than an approach that is individualistic. From this perspective various People Connectors teams felt some frustration with the nature of the ACDC Project as it was in terms of its ability to help those experiencing hardship. Witnessing a high degree of social isolation, disconnection, mental health distress and poor support options among community members, the People Connectors felt their role was ineffective for addressing the issues facing Householders at a deeper level. The 'hands-off' nature of doorknocking had limitations, and in contexts where the need was significant and urgent, this felt frustrating.

In many cases, the People Connectors gathered rich information on individual and community need, but with no opportunity to translate it into action. They hoped that the survey data from the project could be used for local advocacy one day. The DPOs also reflected this longer term view about helping their communities:

> ***"I believe it's given us a good opportunity and grounding to seek Government funding for outreach programs to support different communities. We now have data on where the gaps are to be able to say that more services need to be provided." (DPO)***

Other times, People Connectors turned their frustration with seeing so many people unsupported, into tenacity to meet Householders' needs head on, as the next case study demonstrates.

WHAT IT TAKES TO MAKE A DIFFERENCE

We have examined the ACDC Project in terms of two overlapping groups: the "hardly reached" and communities experiencing high levels of disadvantage. The following case study provides an example of a Householder who was "hardly reached" and living in a lower SES suburb. The Householder had significant unmet support needs, and was in circumstances that required urgent intervention to reduce his obvious distress[80]. The needs addressed in this case extended beyond the usual scope of the ACDC Project approach, and yet the People Connectors found a way to make a difference for this person.

SUPPORTING A HOUSEHOLDER WITH BARRIERS TO GETTING HELP: ERIC (Figure 25)

Situation

Eric had been living with severe social anxiety, depression, pain, and a family crisis that had impacted his mental health. This had created difficulty with responding to social situations, making and keeping friends, and talking to strangers or people in general due to fear and distrust of others. Eric only saw his GP and didn't know if there was any support out there until the People Connectors visited him and provided information about supports and services for mental health and wellbeing. Because of his anxiety, Eric was not feeling confident to talk with strangers on the phone.

People Connector response

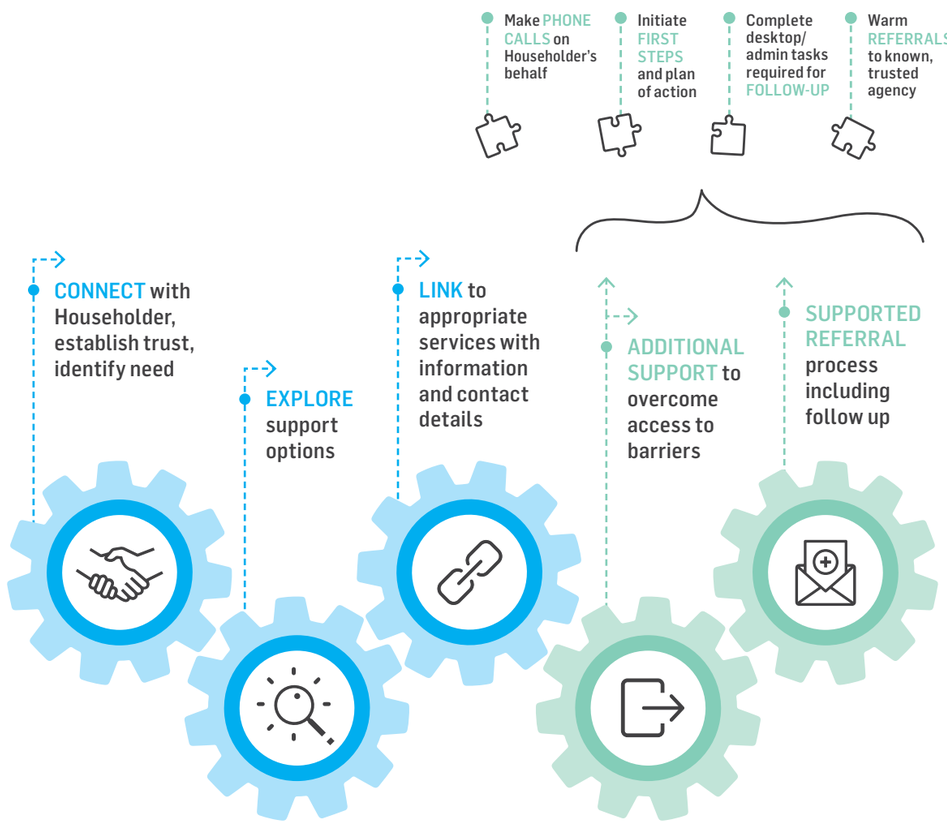
The People Connectors talked to Eric at the doorstep and listened empathetically, validated his concerns, and quickly identified some of his needs. They then supported Eric to make an initial phone call to the NDIS and Eric was provided with an NDIS Number. The People Connectors also referred Eric to Carers Queensland for ongoing support with the NDIS application process. Eric was given additional information by the People Connectors about services and supports that are available in his local area.

What happened next

Carers Queensland contacted the People Connectors to confirm that a case worker had been assigned to assist Eric with his ongoing application process. The People Connectors contacted Eric and informed him that he will be contacted by Carers Queensland to arrange a meeting for the purpose of the NDIS application process. Eric stated that "I'm really thankful for the support you guys provided, I couldn't have done this by myself."

[80] Several pieces of information have been changed to ensure the case study is not identifying.

FIGURE 25 The core functions of the People Connector role, plus additional functions in cases where further support is needed



Core function of the People Connector role

These functions were universally applied and for **most people were generally considered enough for the one-off visit** – it was then considered appropriate to give the Householder the time and space to reflect and decide on any actions

The expanded People Connector role

These functions were particularly **relevant for people living in lower SES suburbs** who perhaps had higher or multiple needs or experienced greater access barriers

The case study of Eric demonstrates how People Connectors were able to extend their role to better respond to someone with multiple, urgent needs to address. For this person, a conversation and leaving an Information Pack would not have been enough, and it was the extra time spent with Eric as well as time spent post-visit, that made this a success story.

The 'expanded role' of the People Connector that includes these additional functions was not utilised across all sites, and was not always how their role was conceptualised. People Connectors required the leadership support from their local organisation so they could spend the additional time helping individuals (e.g., desktop work, phone calls to agencies, following up with the Householder), and these tasks were not always interpreted by DPOs as a key part of the job design.

People Connectors also required a local service ecosystem with the capacity to take new clients, or, even better, informal relationships with trusted support organisations so that immediate follow-up could be offered to Householders. For instance, the People Connectors in Eric's case were able to connect him with Carers Queensland and this service put Eric in touch with a case worker almost straight away. When assisting people living in lower SES communities it would also be critical to have knowledge of support options that help people address the impacts of the social determinants of mental health (e.g., housing and homelessness services, financial counselling and employment services).

Strengthening the enabling conditions for People Connectors to work more deeply with the Householders who need it – especially if there were also local service options that could be called on to step in to support the Householder – could strengthen the ACDC Project doorknocking approach to make it even more impactful for vulnerable people and communities.

Discussion/reflections

This section aimed to assess the effectiveness of the doorknocking approach for reaching and supporting different communities, groups and individuals, in particular those experiencing disadvantage and unmet mental health need.

Our findings reflect the understanding that in the context of mental health, people cannot thrive if other, basic needs are unmet. This can be understood in the context of a needs pyramid hierarchy (see Maslow's Hierarchy of Needs[81]), which proposes that 'basic' needs must first be met to reach 'self-fulfilment' needs. Basic needs are physiological (food, clean water, housing, warmth, rest) and safety (security and safety). The next, psychological needs, include sense of belongingness, feeling loved, and esteem. When people are not able to fulfil the lower-level needs, it is much harder to reach a state of self-fulfilment, or elevated wellbeing.

People Connectors noted that long discussions about mental health were often less relevant for many Householders who were struggling with multiple needs relative to socioeconomic disadvantage, for example overcrowded living conditions and/or financial issues that were all-consuming. For those battling the negative consequences of disadvantage, it can be more difficult to directly address their mental health, and thus the ability of People Connectors to turn their focus to listening, validating, and providing a sense of connection is an essential part of a context-sensitive doorknocking approach.

It is this very feature of the ACDC Project that made it suitable for helping to address health equity, as a first step, and as a proactive outreach method. The emphasis on connection above all, the fact that there were no physical access barriers (People Connectors came to Eric's doorstep), and People Connectors' commitment to authentic, holistic and Householder-led interactions, created generally meaningful engagements for people experiencing disadvantage. While People Connectors perhaps needed more 'tools in the toolkit', or more strategies for helping to address some of the coexisting crises facing people in disadvantaged communities, they were able to be responsive and resourceful about how to help. At minimum, this method made a conversation about support needs possible, which was perhaps for some Householders, even life changing.

[81] Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. https://doi.org/10.1037/h0054346

"Someone cares about how they are feeling and how they are going and they are not forgotten." (ACDC Project Team member)

8. CONCLUSION

8.1 WHAT WE LEARNT ABOUT CONNECTING THROUGH DOORKNOCKING

One stand-out finding about this project was around the positive impact of the connections made through doorknocking. Efforts were made to ensure People Connectors engaged with Householders safety, meaningfully and purposefully (through careful recruitment, comprehensive training and ongoing peer support and supervision), and these efforts were reflected in the evaluation data from Householders; many described the connection as validating and comforting, while others described it as uplifting and even transformative.

The project also considered carefully how to connect with people who are hardly reached by mental health-related initiatives, and to explore doorknocking as an opportunity to connect with these people. We learnt that First Nations people, people from culturally and linguistically diverse communities and backgrounds, people living in disadvantaged communities and neighbourhoods, and people in outer regional towns, did effectively engage with the project, and their voices and experiences are well represented in the survey sample.

The risks were high, or at least felt that way initially. Proposing that strangers visit homes to talk about mental health – and also to seek out people who may be less 'mental health literate' or used to such conversations – brings up concerns about it being invasive and maybe even triggering.

However, evaluation data from Householders indicates that the experience of a doorknocking visit depends greatly on who comes knocking. The People Connectors were professionally, and also personally, invested in the project values, and wanted to help people and improve their community's wellbeing. They easily cultivated a personalised, safe, and genuine space to connect with Householders at their doorstep. What we learnt about doorknocking for mental health now seems obvious – people thrive on authentic connection, and care, and the risks of reaching out to ask someone how they are faring, are not as high as anticipated.

Of course, this is not to dismiss the fact that for a very small number of people, their experience of the ACDC Project was not good, and initiating conversations about difficult (or sensitive) topics without warning or control over where and when these conversations happen can provoke discomfort, and even distress. This was something that People Connectors covered in their training and the project's diligence around this remains crucial. It is not possible to ensure applicability to each person visited by the ACDC Project. All connection, however, involves risk. The opportunity to have these conversations anonymously in an informal 'no stakes' situation was, by and large, welcomed. The flip side about difficult conversations is that, when done skilfully, they can also produce a sense of relief, hope and motivation for change – which may account for the unexpected finding that a significant number of Householders went on to make changes and plans after the visit, and for some the one-off visit even had a lasting positive impact on their wellbeing.

Based on the evidence we have it does not appear that doorknocking helps connect with any particular cohort more than others, although there is some evidence that in Australia's most advantaged suburbs, people may not be as responsive to this method, or conversations may be less productive. In addition, for culturally and linguistically diverse communities, having teams with bicultural and bilingual People Connectors is recommended for meaningful connections to be established. To understand if there are particular groups or needs that are better suited to connecting via this method, more research and analysis is needed.

8.2 WHAT WE UNCOVERED ABOUT MENTAL HEALTH SUPPORT NEEDS

"The place a person lives in (however global, disembodied or transitory their existence) is, of course, central to how they experience their everyday life and doorknocking enabled me to remain aware of this" (Katherine Davies)[82]

People Connectors often reflected on the power of being at a Householder's home, in terms of the ability to more rapidly understand their circumstances and needs. The physical dwelling, the presence of partners, pets and children, sounds of cleaning, appliances and music, cooking smells... allowed People Connectors to quickly attain a fuller picture of the Householder, based on these impressions of the world they occupied. And while assumptions can be wrong, People Connectors felt they could at least intuit enough about the Householders' wellbeing to steer the conversation in the right direction.

While mental health services struggle to deliver holistic, person-centred care, this was much more effortless for People Connectors, where the whole-of-person was more evident, and even visceral. There were opportunities for People Connectors to comment, for instance, on a dilapidated shed (leading to links to financial assistance), flood damage to a house (leading to links to disaster relief support), a disability sticker on a car (leading to links to carer supports) – all issues that Householders might not have been forthcoming with in another context (and in these cases Householders did not know the relevant supports existed).

[82] Davies, K. (2011). Knocking on doors: recruitment and enrichment in a qualitative interview-based study. *International Journal of Social Research Methodology, 14*(4), 298.

Rather than learning about someone's needs through an intake form or diagnostic criteria, the informal conversation uncovered that support for mental health is much broader than diagnosing and managing a mental health condition. During conversations about struggles with mental health, Householders opened up about their neighbours, the issues in their communities, their loved ones and anxieties about coping with practical matters like child care, educational opportunities, or how to stretch the household budget. When you have conversations about mental health in the community, you realise that 'mental health isn't just about brain health' (People Connector).

We defined 'need' as the absence of support in instances where people were struggling with a mental health problem, but 'need' was much more diverse, even when people were asked directly. Some people had enduring, complex, and severe mental health conditions and hoped for more clinical mental health support options, others were lonely, isolated, and 'down in the dumps'. In both examples, People Connectors offered value; whether that be practical (a link to available clinical services in the area) or something more abstract – a sharing of a burden, or someone to respond with "that sounds really difficult, it seems like you're really struggling at the moment." For others, all-consuming concerns about financial or housing stress were the priority and the best thing People Connectors could offer to improve their wellbeing and reduce stress in these instances was to help them navigate the bureaucracies of support systems such as My Aged Care, the NDIS, getting a Mental Health Care Plan, Centrelink and housing services. It was concerning that many people did not even know these supports existed, let alone how to access them and successfully apply.

Often the mental health service system is based on narrowly defined concepts and criteria. However, conversations with diverse groups in the community about mental health has uncovered that people's language and understandings about mental health vary significantly depending on their experiences and circumstances and level of need.

As People Connectors discovered, an informal, 'no agenda', fluid and caring conversation outside a service setting, is a brilliant tool for assessing mental health need as well as a Householder's preferred options for support, as it can easily accommodate these diverse understandings through exploration.

8.3 WHAT WE DISCOVERED ABOUT HELP-SEEKING AND ACCESS BARRIERS

"We hear that a lot, like, 'just ask for help'.... but if the services aren't there and they're not accessible, I don't know how helpful telling people to ask for help is." (Orygen)[83]

As noted in the introduction, some people access services more easily than others. They have understandings of mental health – and consequently the language, awareness and help-seeking behaviours – that are compatible with current service designs. Their emotional, social and financial resources allow them the time and space to make efforts to get help, and for them, the barriers to seeking help – e.g., stigma, cost, transport – are more easily overcome[84].

The 'toughen up' culture in modern day Australia, general distrust of services among people who are hardly reached, and the traditional service delivery models (with heavy-handed with administrative processes) mean that, we suspect, a great many people are in need of extra support but are unable or unwilling to access it. People Connectors confirmed this was the case, based on their on-the-ground experiences of going door-to-door and speaking with people about their support needs. The stories of Householders who were greatly in need of support but were not aware of services or able to access help were aplenty, and gave People Connectors a sense of meaning from their work and the motivation to help more people, even after the ACDC Project finished in their community.

[83] Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation. Submission to the Productivity Commission's Inquiry into Mental Health. 2019.

[84] Of course, relative advantage is a mediating factor, but not completely. Anyone can experience mental health challenges, and facing the difficulties of accessing services while in elevated states of distress, overwhelm or not managing well with the symptoms of a mental health condition, makes overcoming access barriers even more effortful.

The fact that one third of people contacted a professional, a service or a community organisation to ask about support for their mental health and wellbeing, as a result of the visit, and another quarter planned to do this, speaks volumes about unmet need and how many people need help to overcome barriers in the initial stages of help-seeking, even if it is just a small amount of help. (And the personalised approach that a doorknocking conversation can offer might be what is so effective here.)

Mental health reforms are calling out the need for more prevention and early intervention, as waiting for people to be in crisis is not working (and is not cost effective). In this context, we cannot continue to put the onus on people to seek help, and also continue to design and deliver services that are difficult to find out about, access and navigate.

The data collected through 6000+ conversations in the community about mental health, and the 4000+ Householder Survey responses uncovers the extent of unmet mental health need and the barriers people face in seeking and getting help (see the ACDC Project's research report, Home truths about mental health in Australian communities[85]), and further data collection, analysis and exploration is planned in Round Three.

8.4 THE POTENTIAL FOR BUILDING ON THESE LEARNINGS

Our learnings about doorknocking conversations about mental health are based on analysis of multiple data sources, and overall they demonstrate that:

- Doorknocking is an effective means of discovering people with unmet mental health support needs;
- This approach can effectively link people into supports, and there is evidence it can do that for people who are otherwise not supported, by addressing the 'soft' barriers to help-seeking such as attitudes to mental health, rarely having the time or space to be able to reflect on their own needs, or not knowing that supports exist;
- Due to the flexibility and innate responsiveness of the method, it can be effective for addressing a very diverse range of needs and access barriers, including the needs and barriers of people who are hardly reached, and people living in lower SES communities.

The ACDC Project sought to deliver clear information and practical help to support people to link with local mental health services, but what People Connectors also delivered was validation and genuine kindness. Although this project was designed to be about mental health, it was essentially about human connection. We found that for a lot of people, including for people with unmet mental health needs, this matters a great deal, and this simple act of care and kindness may have been the missing piece for them in their ability to understand their own support needs, or reach out to get the help they need.

We hope the evaluation of this project can help bring about change and the findings presented in this report generate curiosity about the important work of proactive outreach for mental health. The ACDC Project's focus on, and investment in, the 'connector role' is notable, and a project such as this puts a spotlight on the power of connecting, and its possible significance in the mental health context.

Findings point to the need to dedicate more resources to purposeful, skilled connecting work, given its potential to contribute positively to the overall functioning of the mental health system. In Australia's crisis-driven and specialisation-focused mental health system, the dedicated resources for quality connecting work are not embedded, and the work and skills can be overlooked or undervalued. The ACDC Project has shown that outreach-focused connecting work is necessary if we want Australian healthcare to be inclusive, accessible, and equitable, and to adequately meet the mental health support needs of Australia's diverse population.

[85] 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.

APPENDIX A: LITERATURE REVIEW REFERENCE LIST

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APPENDIX B: ROUND TWO SITE DATA

Site / suburb	Median age	Indigenous status (%)	Born outside of Australia (%)	Households where a non-English language is used (%)	Disability* (%)	Unemployed (%)	Public housing households (%)
NSW							
Canberra							
Cabramatta	40	0.3	69.6	89.6	8.1	10.9	3.5
Clarence Valley							
Maclean	56	10.2	11.6	5.1	14.8	7.2	1.3
Yamba	57	4.5	13.2	4.3	8.7	3.7	0.6
Greenacre							
Greenacre	33	0.5	43.0	78.0	8.8	8.4	10.0
Hurstville							
Hurstville	33	0.2	70.8	82.8	4.8	6.9	1.5
Wollondilly							
Picton	38	3.9	12.4	7.2	4.8	3.4	1.7
Tahmoor	34	6.9	11.9	8.2	6.5	3.7	2.0
NT							
Palmerston							
Johnston	28	12.9	25.9	31.0	3.8	4.1	5.1
Moulden	33	24.1	15.8	16.5	6.4	8.2	21.1
Woodroffe	33	18.4	17.9	19.3	5.1	5.9	14.0
QLD							
Ipswich							
Ipswich	45	7.7	17.6	10.7	14.8	11.8	9.7
North Ipswich	38	6.9	10.7	6.2	10.9	8.0	1.7
West Ipswich	39	9.4	12.6	4.3	11.8	13	3.4
Mareeba							
Mareeba	40	15.4	19.0	19.7	7.0	7.2	4.3
Redcliffe							
Margate	46	4.4	22.9	8.8	8.5	7.0	8.3
Redcliffe	52	3.4	26.1	8.5	10.7	6.7	7.0
Toowoomba							
Harristown	38	6.2	17.3	10.7	10.5	7.1	3.3
Kearneys Spring	35	4.0	28.7	21.8	7.8	5.9	2.1
SA							
Port Adelaide							
Alberton	44	2.4	20.6	18.7	7.0	4.2	3.7
Rosewater	39	3.7	28.4	26.9	7.6	7.8	6.7
TAS							
Burnie							
Burnie	42	7.4	20.2	12.8	4.6	7.6	2.6
Upper Burnie	42	9.7	11.6	6.1	9.6	7.8	11.7

Site / suburb	Median age	Indigenous status (%)	Born outside of Australia (%)	Households where a non-English language is used (%)	Disability* (%)	Unemployed (%)	Public housing households (%)
TAS							
George Town							
George Town	45	6.1	12.1	4.8	10.9	13.0	9.1
VIC							
Macedon Ranges							
Gisborne	39	0.9	13.7	8.3	4.6	3.0	0.9
Riddells Creek	42	0.9	11.7	6.2	3.6	3.1	0.0
Romsey	38	1.4	10.5	5.6	5.3	3.2	0.3
Bendigo							
Bendigo	43	2.2	13.3	9.2	6.9	4.5	3.5
Eaglehawk	43	3.3	7.5	4.3	8.7	4.7	4.2
Golden Square	39	2.5	10.5	7.9	9.0	4.0	3.5
Kangaroo Flat	44	2.5	11.9	8.0	10.4	4.3	5.3
Long Gully	38	4.2	10.7	6.9	11.6	8.2	12.4
North Bendigo	37	3.0	14.8	9.9	10.7	4.9	4.8
White Hills	37	2.9	11.5	9.0	8.0	4.7	3.7
Fitzroy							
Fitzroy	35	0.6	34.2	28.0	4.3	4.5	14.4
WA							
City of Swan							
Ballajura	37	2.2	38.4	32.5	5.0	6.3	3.5
Beechboro	38	4.2	39.2	32.0	6.2	8.1	5.4
Australia							
Australia	38	3.2	29.3	24.8	6.1	5.1	3.0

Note: 2021 Census data; *disability was defined as a need for assistance with core activities; yellow = highest; grey = lowest.

APPENDIX C – CODING FRAMEWORK HOUSEHOLDER INTERVIEWS