Wellbeing Gap Analysis

Legatus Group Northern Councils Report

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LEGATUS GROUP

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Contents

Executive Summary

Wellbeing as an issue has been identified throughout Regional South Australia. The Legatus Group raised this as a matter as one of high significance in 2019 because relevant communities continued to be affected by the Drought.

In 2021, a Wellbeing Analysis, including where the gaps in knowledge lie, was undertaken across the Legatus Group Northern Councils to better understand what the future and current wellbeing needs and issues are.

A mixed methods approach was used and it included interviews, and three surveys to identify the key issues.

Our key findings were:

1. Mental health in the regions is a very complex issue and accessing support services is difficult and overall fragmented.
2. Current Mental Health Services in the Legatus Group Northern Councils are very differentiated.
3. There ARE long-term impacts of drought and COVID-19 on the wellbeing of people in the Northern Communities.

Building on this, and acknowledging the hard work that already goes into management of this issue, the key gaps identified in the mental health services for these communities are as follows:

- Service inappropriateness: it is hard to reach local and especially farming communities.
- Lack of outreach efforts.
- Requirement for more face-to-face vs on-line/ telephone counselling services.
- Existence of pride or a sense of shame that stops people seeking help.
- Increasing use of on-line/ telephone counselling services is occurring due to practitioners being unable to provide face-to-face help in rural areas.
- Referral paths are hard to navigate.
- There are long waiting times.
- The funding system means the services are not reliable in terms of being able to operate.
- Drought-affected communities are not prioritised in the current mental health system.

Moving Forward

The study indicates there is an urgent need for the introduction of region-specific, culturally appropriate mental health services with more outreach efforts, face-to-face as well as culturally safe services to improve the effectiveness of services provided by the Legatus Group Northern Councils. Furthermore, the findings show there is an imperative need for better regional coordination to 1) assist the local communities to access mental health services; 2)

support service providers align their services with the local needs, as well as; 3) collaborate with local councils to get more resources so that there is proper investment in local wellbeing.

The recommendations below summarise / set out what health authorities and stakeholders can actively do to improve the mental health services in the regions. These recommendations build on the work that current services already do well, but also pave the way for new and innovative opportunities that would strengthen the entire mental health service system in the regions more effectively and responsively. The objective is for the community to get the best return from services delivered.

- The Family and Business Support Program (FaBS Mentors) is a good program and a model that should continue and be strengthened.
- Build effective and meaningful communication links between local governments, regional agencies, service providers and local communities.
  i. Establish a Mental Health Coordinator who will be the central focal point of contact providing mental health service information in the region, facilitate meetings with various stakeholders, support local councils for local wellbeing plans, as well as collaborate with these councils on grant applications.
  ii. At the community level, establish a (virtual) hub as a central point so that people can have better access to the resources relating to mental health, share their experiences, and receive practical advice as to how to access the services.
- More investment in early intervention and appropriately equipped clinical services.
  i. Support more basic and well-located mental wellbeing staff who can do mental health training in terms of first aid, basic understanding of the suicide risks, and who are already involved in the industry and farmer community (prior to escalation)
  ii. Place-based psychologists.
- Focus on community awareness and capacity building

Specific to the issue of wellbeing and drought, recommendations include the following:

- Invest in an education and awareness campaign so that communities know where to go to access services.
- Councils, PIRSA and RDAs to work with farming communities to invest in the creation of value adding economic alternatives (e.g. tourism) to provide buffers against climate-related problems like drought.
- Invest in more mental health and wellbeing services in the regions including more rural counsellors and wellbeing hubs in each community.
- Prioritise resilience initiatives that focus on specific wellbeing issues created by or related to climate change, e.g., men's and women's support groups.
- Prioritise the mental health support services for farming communities and differentiate them where it is important to do so.
- Build several demonstration sites and training packages that support farmers' ability to respond to drought and in turn build wellbeing by enhancing economic resilienc. Some

examples from other regions include: (i) perennial pastures; and (ii) weed and feral animal control in times of drought.

- Invest in initiatives that create opportunities for farming and regional communities to 'value add' in different ways to their economic activities. This will build economic resilience and people's overall wellbeing.
- Build networks within communities in effective ways – find community champions who can help build networks – the more networked a community, the better that people will be in coping with adversity. An example is to set up a community centre that brings together affected people to share ideas, resources, hold events, etc.
- Undertake targeted research that addresses these recommendations.
- Work with the resources and networks provided by the Drought Resilience Fund.

Introduction

Wellbeing is an issue across Regional South Australia and this is no different within the Legatus Group Region.

This report presents findings of a project that undertook a gap analysis to identify what the wellbeing needs are for the region moving forward.

The Terms of Reference were as follows (Box 1)

To develop a Community Wellbeing Awareness and Gap Analysis report to gain greater clarity on the current situation and needs in the Legatus Group region.

This will provide clearer data to support lobbying for mental health support and contribute to Future Drought Fund or other applications.

- Development Community Wellbeing Awareness and Gap Analysis report to gain greater clarity wellbeing programs available to people in the Legatus region impacted by the Drought / COVID-19 / Bushfires.
- This project will involve desktop analysis of qualitative and quantitative data, survey design and implementation, case studies, one on one interviews and direct interaction with the reference group.
- Interviews with key stakeholders to understand what services are available in person locally, via Telehealth and what services require travel.
- Identification of what gaps to services there are in remote sections of the Legatus Group region.
- Options for an awareness campaign to increase the use and understanding of telehealth options.
- Research different options for a rural counsellor models that could be resourced in the region.

The report was led by Professor Melissa Nursey-Bray and members of her research group ACE (Adaptation, Community Environment), within the School of Social Sciences, University of Adelaide, specifically Dr Christie Lam. The project is part of the MOU between the University of Adelaide and Legatus Group.

Context

Wellbeing is a complex idea with multiple dimensions (Kim and Lindeman 2020) - and in the literature – various definitions (Martela and Sheldon 2019, Breslow et al. 2016, Dodge et al. 2012), originating with Aristotle's idea of *eudaimonia* (perfect wellbeing, Ransome 2010). As a scholarly term it first came into practice when T.H Marshall (1950) argued it was a process of social citizenship, where people are equal members of society and are assured their basic access to and are holders of social, economic and political rights (Marshall 1950). Today, it is gaining increasing attention as it is recognised that affluence alone is not sufficient for people, and that "there are many nonmarket aspects of life that people seek which the state needs to recognise more explicitly in policy" (Morrison 2021, 781).

Keyes and Lopez (2002) for example, construct wellbeing within five dimensions: (i) social acceptance, (ii) social actualisation, (iii) social contribution, (iv) social coherence and (v) social integration. The OECD measures wellbeing via eight dimensions which include health, education and learning, physical environment, time and leisure, control over goods and services social environment and one's personal safety. These elements, or the extent to which people access and can constitute these dimensions reflect a continuum of positive or negative wellbeing. Wellbeing can also be individual or societal, with literature around community resilience, overlapping with that of how wellbeing can create resilience to change (McCrea et al. 2016).

> "Mental health and well-being relate to emotions, thoughts and behaviours. A person with good mental health is generally able to handle day-to-day events and obstacles, work towards important goals, and function effectively in society. However, even minor mental health problems may affect everyday activities to the extent that individuals cannot function as they would wish, or are expected to, within their family and community. Consultation with a health professional may lead to the diagnosis of a mental disorder.
>
> Mental health and wellbeing relates to emotions, thoughts and behaviours and is an integral component of a person's overall health. A person with good mental health is generally able to handle day-to-day events and obstacles, work towards important goals, and function effectively in society. Conversely, poor mental health may affect a person's ability to participate in and contribute to many aspects of life within their family, community, and society more broadly" (ABS 2019)

Wellbeing itself though is not an independent factor but also about a range of other factors and indicators (Weeranakin and Promphakping 2018). Teghe and Rendell ((2005) note that these factors include the following: -

- Self-esteem
- Control over one's own life
- Good health
- Economic security
- Access to community resources (both physical and social)
- Meaningful participation in community and family life
- Meaningful participation in political life
- Absence of stressors
- Pleasant and secure physical environments
- Access to education
- Capacity to engage in lifelong learning
- Recognition and respect within and by community
- Sense of freedom,
- Sense of love for others
- Spiritual fulfilment.

Wellbeing theory identifies five domains as part of wellbeing including positive emotion, engagement, relationships, meaning and accomplishment and that measuring these domains will enable policy makers to assess levels of wellbeing – or levels of wellbeing they aspire to create/achieve via indicators (Forgeard et al. 2011, Cox et al. 2010). Loveridge et al. 2020) further suggest a Wellbeing Indicator Selection Protocol (WSP) as a means by which cost effective and flexible approaches to wellbeing can be implemented and measured in different policy contexts. Indigenous wellbeing is another aspect in Australia that needs careful consideration and incorporation into any wellbeing planning. The Aboriginal concept of health for example is holistic, with self-determination and cultural acknowledgement of the history of loss and dispossession being important. Wellbeing policy in this area must also respect the strength and centrality of Indigenous family and kinship (Dudgeon et al. 2014). The relationship between indigenous land, language and culture is also central to ongoing Indigenous wellbeing (Biddle and Swee 2012, Haswell et al. 2013). Cultural identity is also core to and promotes wellbeing and socio-economic outcomes for Indigenous peoples (Dockery 2020).

Wellbeing practices can enhance regional development as they situate human values and care into policy domains (Wallace et al. 2020). In regions, strong wellbeing is also associated with high social capital (Ning et al. 2015), where community members feel high levels of social support, shared values and trust in each other (Ward and Meyer 2009). Community wellbeing can also build social capital via the creation of opportunities for lifelong learning and sustainable wellbeing models (Manzini 2003) This is important as regional communities age (Merriam and Kee 2014) or can be built via economic initiatives such as sustainable tourism (Pope 2018). Unsurprisingly, as in urban areas, wellbeing in regions is multidimensional (Nanor et al. 2021). Further, increasingly wellbeing has become important as regional communities struggle with ageing populations, outmigration and issues caused by driving factors like climate change (Fudge et al. 2021). These challenges are amplified by the dominance of development paradigms for regional areas (Fudge et al. 2021) or as Wiseman and Brasher note engaging with "community wellbeing in an unwell world" (Wiseman and Brasher 2008, 353).

Climate related drought and other climate impacts (fire, flood) are now recognised as playing an influential role in the wellbeing (or not) of regional communities, and research is increasingly examining how to address this increasingly prevalent issue (Stanley et al. 2021). For example, one study of Australia farmers shows that as climate changes so too does the viability of agricultural and other livelihood practices; that there is a direct correlation between (negative) farmer wellbeing and intention to exit the business (Peel, Berry and Schirmer 2016). Another case study, this time in the Western Australian Wheatbelt, shows that the changing sense of place caused by climate change threats, is affecting farmer wellbeing by undermining notions of self-identity and leads to "cumulative and chronic place-based stress, culminating in heightened risk of depression and suicide" (Ellis and Albrecht 2017, 162). In this case, climate change exists as a serious threat to mental health and wellbeing requiring the development of climate adaptation options (Tonmoy et al. 2020). There are also significant gendered impacts of climate change. As Alston found in studies of rural and regional farming communities in Australia, climate change is causing higher levels of social isolation, causing decreases in socio-economic capacities which combined with ready access to firearms increases the risk of rural male suicide (Alston 2012). Women by contrast are more likely to experience having to work more to compensate for the family loss of income - while trying to maintain family wellbeing (Alston 2011). Thus, the wellbeing of both rural men and women are affected negatively by climate change impacts such as drought, but in differentiated ways. The implications of this are that policy needs to be more sensitive and rights based in order to address people who experience extraordinary stress in times of unprecedented change (Alston 2009). Some suggest one way forward is to better understand the "protective factors for mental and psychological wellbeing beyond the absence of disease" (Heinsch et al. in press). Others suggest the use of the arts to promote rural and regional revitalisation and social wellbeing (McHenry 2009).

In summary the literature highlights the following: -

- Wellbeing has multiple definitions
- Wellbeing is an issue overall in regions, and specifically, also a matter of concern in relation to climate related factors such as drought.
- Lack of wellbeing affects community resilience.
- Wellbeing affects economic, social, cultural and environmental domains.
- Indigenous wellbeing is connected to and/or enhanced by country.
- Wellbeing is a very complex issue, with no easy solutions or answers.
- Young people are facing particular wellbeing issues.
- Drought, fire and flood, related to climate change are having wellbeing impacts, specifically increases in depression, suicide, domestic violence, and relationship breakdown.
- These impacts affect men and women equally but in different ways.

The Wellbeing of Legatus Group Northern Region

According to the SA Population Health Survey (SAPHS) (2019), 1 out of 4 South Australians reported their health status as 'not good' and less than half (38.6%) of adults have reported having good overall wellbeing. Although the survey data shows rural populations report better wellbeing compared to metropolitan populations, it is clearly evident that their health and wellbeing status is different from place to place and tends to deteriorate where the SEIFA index (Socio-Economic Indexes for Areas) is lower. The lower the SEIFA, the more communities face disadvantages such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. The survey also indicates that rural populations have lower confidence in the public health system. The more disadvantaged they are and the greater the distance they must travel to get mental health services the more they experience more suffering as well as a greater, more chronic disease burden. In addition, rural populations have higher health risk behaviours such as drinking and smoking.

A recent national study shows clear health and wellbeing disparities between metropolitan and rural populations (Australian Institute of Health and Welfare, 2018). Statistics also find that there is a gap between suicide rates in the metropolitan area compared to country SA (ABS, 2012). Although since then this gap has been reduced, men in both urban and rural areas are more than 3 times more likely to take their lives than women. According to a report conducted by Country SA Primary Health Network (2019), males in country SA accounted for 79% of all deaths by suicide. Females are more likely to be hospitalized than males for intentional self-harm. The most common mechanism used for suicide was asphyxiation (hanging) compared to poisoning in most cases. While the details of local data in the Northern region are limited, the Northern regions of SA are identified as one of the highest vulnerable areas for mental health and wellbeing (Health Performance Council, 2013; Public Health Information Development Unit, 2016). The latest SAPHS data provided by Wellbeing SA shows that in the past three years (2018 to December 2020), some Northern councils areas especially Flinders Ranges and Peterborough have recorded very high incidences of mental health conditions as well as psychological stress (Table 1 and 2). Table 3 and 4 below present summaries of the mental health, wellbeing and socioeconomic indicators in the Northern region.

Table 1: Proportion of adults (18 years and over) reporting having a mental health condition (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	6068/21197	28.6 (28.0-29.2)
Metropolitan SA	4458/15228	29.3 (28.6-30.0)
LGA		
Flinders Ranges	8/24	34.1 (17.2-53.2)
Goyder	14/62	23.2 (13.6-34.1)
Mount Remarkable	14/66	21.9 (12.7-32.2)
Northern Areas	13/80	16.5 (9.4-25.5)
Orroroo/Carrieton	-	-
Peterborough	30/66	45.7 (33.9-57.4)
Port Pirie Regional	52/205	25.3 (19.8-31.6)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.
^Mental health condition includes anxiety, depression, stress related problem, and other mental health condition.Data not shown for LGAs ≤ 5 counts.

Table 2: Proportion of adults (18 years and over) reporting high or very high psychological distress, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	4138/20776	19.9 (19.4-20.5)
Metropolitan SA	3125/14915	21.0 (20.3-21.6)
LGA		
Flinders Ranges	8/24	35.0 (17.2-53.2)
Goyder	7/60	11.6 (5.4-21.5)
Mount Remarkable	9/65	14.3 (7.1-23.7)
Northern Areas	7/78	9.5 (4.1-16.8)
Orroroo/Carrieton	-	-
Peterborough	20/62	31.9 (21.6-44.5)
Port Pirie Regional Council	37/204	18.2 (13.3-23.9)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.Data not shown for LGAs ≤ 5 counts.
*The detailed SAPHS statistics can be found in Appendix.

Furthermore, recent literature (as outlined above) also indicates that existing socio-economic disadvantages and increases in climate-related disasters have negatively impacted the mental health of rural population especially for farmers. This issue has been widely addressed by researchers and clinicians (see the Orange Declaration, 2018) and at the policy level. Reports also show that there is a gap in terms of the provision of mental health services between metropolitan and rural areas. Rural residents with mental health problems are less likely to seek help. It is impossible to ignore the recent cumulative impacts from the experience of consecutive years of drought for many communities in the Northern region. Furthermore, the

COVID pandemic has compounded these cumulative stresses and contributed to even higher levels of trauma, mental ill-health and in some cases, suicidal behaviour in the region.

Table 3: Mental Health and Wellbeing Performance in Northern region

Higher proportions of diagnosed mental health conditions in Mid North regions (27.9%)/ Northern region 28.3% (17.1% of South Australian; 17.6% of greater Adelaide region; SA region SA 15.7%) (data source: SAMSS 2011)
Higher proportion s of residents experiencing psychological distress in Northern region 10.5% (data source: SAMSS 2011)
Northern region residents are more likely to report living with 2 or more chronic conditions 24%, the top among all country regions. (data source: SAMSS 2011)
Northern regions reported the lowest rates of good or better health in the country regions 76.3%. (SAMSS 2011).
Mid-North region has second highest rate (8.2%) among the country regions for drinking at level putting them at long-term risk from alcohol
Mid-North had the highest rate of mental health related hospital admission in 2015-2016 (data source: CSAPHN 2019)
Mid-North had the highest rate for anxiety and stress disorders, second highest Schizophrenia, depressive episodes for hospital admission (data source: CSAPHN 2019)
Lower North (26.4%) and mid North (22.2%) have highest rate for self-reported psychological distress (data source: CSAPHN 2019)
Lower SEIFA index than metropolitan areas (especially Peterborough and Port Pirie have high unemployment rate and low household income)
High percentage of population involves in agriculture (34.1% in Orroroo Carrieton; 34.1% in Goyder; 24.6% in Northern Areas)
High lone person households
Low volunteer participation in some council areas (especially Peterborough and post Pirie)
Access to services, cost of services and service waiting periods were believed to increase mental health problems and burden in the region (data source: CSAPHN 2019)

Table 4: Comparison of 7 Mid Northern Councils and SA Wellbeing

	Population	Lone person household	Median Weekly Household Income	Household have mortgage	University Qualification	Trade Qualification	Unemployment rate	Participation rate(population in the labour force)	SEIFA index of disadvantage 2016	Volunteers	Internet connection	Mental and behavioural Problems		Fair and poor health
												M	F	
Mount Remarkable (2019)	2,918	26%	927	24%	9%	21%	5.6% (1.2% increase)	54%	978	38%	69.8%	11.2	11.3	15.4
Peterborough	1700 (Aboriginal 6.6%)	39%	704	24%	6%	18%	13.5% (3.9 increase)	39%	792	26.6%	57.5%	15.2	15.4	21.6
Orroroo Carrieton	854	29%	1042	22%	10%	20%	4.8%	57%	991	43.5%	63.6%	--	--	--
Northern Areas	4608	29%	1,053	27%	10%	22%	4.7%	56%	981	40.2%	71.5%	10.7	11.8	15.8
Port Pirie	17630 (3.6% aboriginal)	31%	901	30%	7%	23%	10.8% (3.3% increase)	51%	886	22.5%	66%	13	14.1	19.3
Goyder	4,206	30%	889	27%	8%	21%	6.2%	53%	946		68.9%	11.5	12.4	18
Flinders Ranges * (2016 Australia bureau of statistics)	1643		951		10.2 % (Bachelor degree or higher)		6.5%	--	--	--	68.9%	12	12.3	16.2
RDA York and Mid Northern Areas		30%	925	27%	8%	22%	7.3% (increase)	50 (drop)	934	34.3%	----	--	---	---
Region SA		28%	1029	29%	9%	23%	6.6%(increase)	54 (drop)	944	27.8%	70.9 %	---	----	----
SA		27%	1203	34%	19%	20%	7.5% (increase)	58 (drop)	979	----	----	---	---	----

Sources: Mid Northern Councils Profile

Methodology

This project is based on a documentary review, semi-structured interviews of key stakeholders and three regional surveys. The study focuses on the 7 Legatus Group Northern Councils including the Flinders Ranges, Goyder, Mount Remarkable, Northern Areas, Orroroo/ Carrieton, Peterborough and Port Pirie.

Data Collection:

Date was gathered in three ways: (i) documentary analysis including policy documents about rural mental health services and the latest regional health statistics, and analysis of the issue via literature particularly climate change and mental health, (ii) the conduct of 23 semi-structured interviews across key service providers, health agencies, charity organisations, government departments, council officials as well as local residents in the Northern region, and (iii) analysis of three regional wellbeing surveys.

The semi-structured interviews were conducted from April to May 2021 via Zoom/ phone interviews. The interview questions were based on three themes:

1) The mental health situation and public awareness in the area;
2) The availability of mental health services in the area;
3) The challenges and recommendations of delivering mental health services in the area

Thematic analysis was used to code and categorise the key results from the interviews. Thematic analysis is a flexible method that can be used across methodologies to assist in understanding people's perceptions, feelings, values and experiences. An inductive approach to the analysis was used allowing the coding and theme development be indicated by the data, rather than assuming anything.

In this report, results from the three community wellbeing surveys are presented. We developed an online wellbeing survey to understand how the local residents in the Northern region think of their current wellbeing and mental health situation, their accessibility to the services, service preferences and their voices for future service. The survey was distributed through the local community groups and local councils during May 2021. By early June, we received a total of 30 replies.

A community group from Caltowie in Northern Areas Council also launched an online mental health survey in late May. A total of 29 replies were received. In September 2020, three councils including the Clare and Gilbert Valleys Council, Northern Areas Council and Regional Council of Goyder also conducted an online community health and wellbeing survey to identify their key priorities for building a health and wellbeing community. Although all these surveys have relatively small sample sizes, the results offered us some invaluable information in relation to what local residents think of their wellbeing, their experience of mental health services and their recommendations.

Overall, the advantage of using multiple techniques (semi-structured interviews, surveys and document reviews) meant that we documented multiple perspectives about the development and perspectives around mental health services need and gaps analysis in the region.

Constraints

The project was constrained by two factors: time and confusion over what was meant by 'wellbeing'. Time was a factor because the project, originally meant to be a student internship project did not attract enough interest through the APR Intern Program. Consequently, by the time it was contracted, the time available to undertake the work was very limited.

Second, within the community itself, there was a lot of confusion around the project as there were or had been a number of other wellbeing initiatives implemented, so there was some community fatigue in terms of responding.

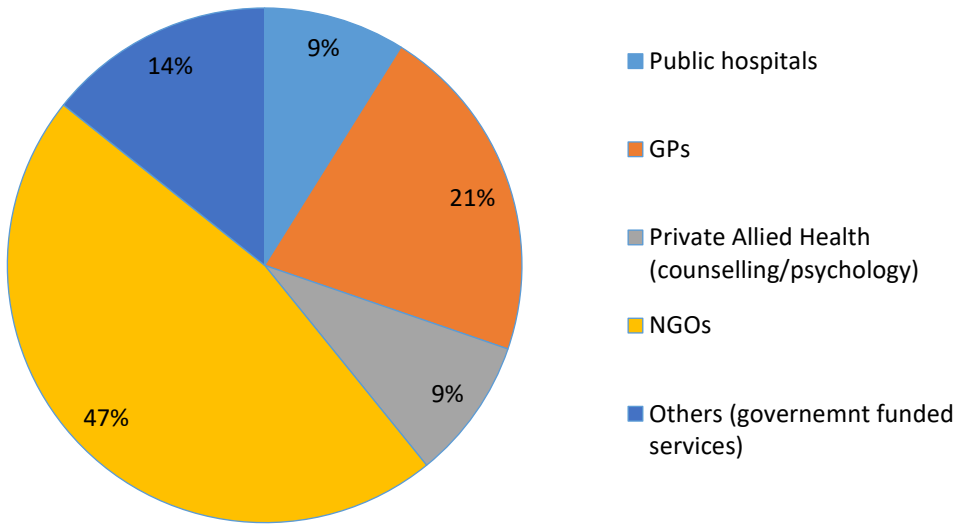
Results: Interview Analysis

1. Mental health in the regions is very complex and accessing support services is difficult and overall fragmented

One of the biggest challenges affecting wellbeing in the regions relates to the complex nature of mental health issues per se. Mental health not only involves different levels and types of psychological conditions, but it often interlocks with many other social issues especially poverty, unemployment, domestic violence, social isolation, drug abuse and alcoholism. Therefore, dealing with mental health issues relies not only on clinical treatments but also requires a great deal of social-psychological support as well. Most interviewees [2][3][4][5][[7][8][10][11][15][16][17][22]pointed out the current mental health service system is fragmented, it is difficult to find what services are available, and accessing services, particularly for those who suffer anxiety and depression is very challenging for people who often lack the means and motivation to find the right service for them.

In the region there are at least 58 service units which we have then classified into different service groups as shown in Figure 1.

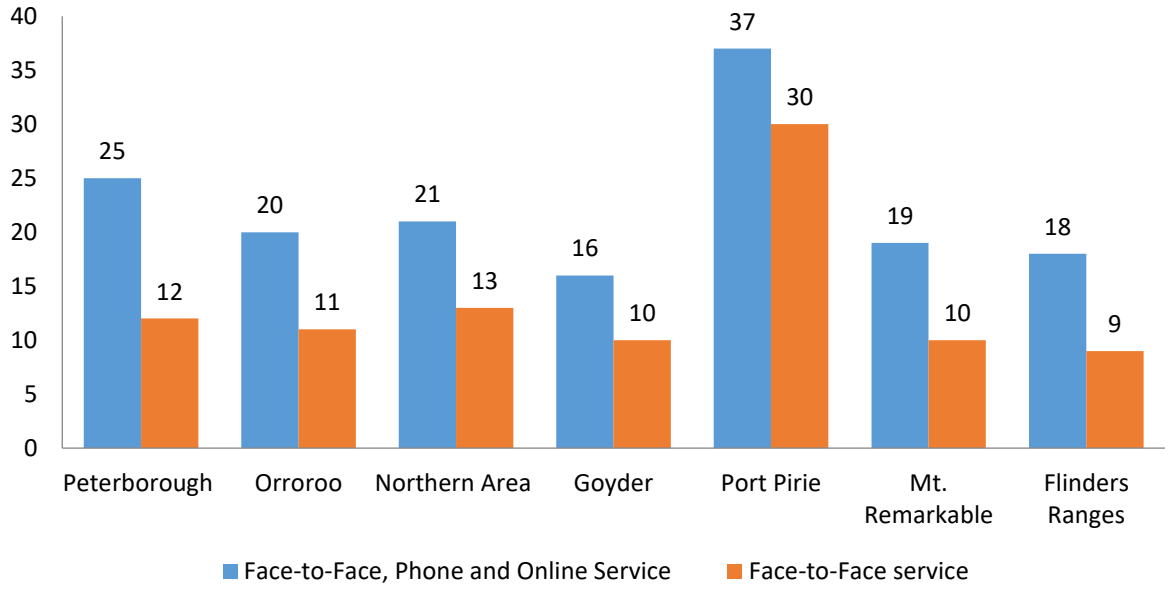
Figure 1: Overview of Mental Health Service in Northern Region



The results in Figure 1 indicate there are many different mental health services available. The largest service providers are from NGOs (47%), follows by GPs (21%), public hospitals (9%), private allied health specially counselling/ psychology (9%) and other government funded services (14%). The largest NGO service providers are the national *Country and Outback Health* (COBH) which offered 8 mental health service projects commissioned by Country SA Primary Health Network (CSAPHN). Another regional-based NGO *Uniting Country SA* (UCSA) runs two CSAPHN funded mental health projects. Other active service providers in the project area include the national-based *Life without Barriers* and regional-based *Centacare Catholic Country SA*. A national-wide NGO known as *On the Line* has provided a 24/7 counselling hot line service (Regional Access) funded by CSAPHN.

Despite the availability of various mental health services in the region, accessing these services is significantly different regarding geographical location and the mode of services. Depending on the levels of mental health illness, services can be delivered by face-to-face, phone, online or outreach visit. Figure 2 shows that Port Pirie has the most services available while Goyder and Flinders Ranges have the least. As most private and public health facilities and NGO branch offices are located in Port Pirie, it is unsurprising it has higher mental health services coverage especially face-to-face services. For the other council areas, residents have significantly less opportunity to access face-to-face counselling services. The results in Figure 2 also strongly suggest that telephone and on-line communications are trending upward and increasingly used for providing mental health services. Taking Peterborough as an example, there are nearly 25 service units but only less than half of them offer face-to-face service. A similar situation is found in the Flinders Ranges and Mt. Remarkable areas. Most face-to-face counselling services are only offered based on need and request.

Figure 2: Available Mental Health Services in 7 Northern Council Regions



2. Current Mental Health Services in the Northern Council Regions are very differentiated

Findings show that services in the region are not equal with differences in waiting times, types of services and the capacity of people to access them. Further many of them are time bounded and funding dependent. These realities weaken the overall strength and delivery of these services. The Country SA Primary Health Network (CSAPHN) and Country Health SA Local Health Network (SA LHN) are the two agencies responsible for the design and implementation of mental health services in regional SA. SA LHN focuses on clinical treatment services for acute mental illness clients including hospital admission, emergency services and community mental health centre. Meanwhile, CSAPHN concentrates on primary mental health care and has a wider service range from at-risk groups showing early symptoms through to individuals with severe mental illness and complex needs. CSAPHN does not delivery any services itself, but it provides funding to different mental health service providers.

2.1 Regional Stepped Care Approach

Due to the complexity of mental health illness, the intensity of services for clients can vary. In order to ensure the appropriate services provision to the needs of different groups, CSAPHN adopts the stepped care approach. That is, the person presenting to the mental health system is matched to the intervention level that most suits their current need. Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs (Table 5). The mental illness population is divided into 4 groups. These are briefly described below.

At- Risk groups: Self-help resources, low intensity intervention including digital mental health strategies

Mild Mental Illness: Mix of self-help resources, and low intensity face-to-face services with Psychological Services to those who require them

Moderate Mental Illness: Face-to-face clinical services through PHC and psychiatrists where required. Clinical-based self-help resources and other low intensity intervention services

Severe Mental Illness: Clinical care using a combination of GP care, Psychiatrics, mental health nurses and allied health. In-patient services and psychological support services, coordinated multiagency services for complex and severe illness.

To better understand current mental health services in the Northern region, we updated the stepped care table with the latest service programs provided by service providers and our key informants. Meanwhile, we note that outside of the services offered in the mainstream mental health system, there are several parties also playing important roles in supporting mental health wellbeing in the Northern region. The funding sources, project duration and service waiting times are documented in Table 5.

As Table 5 has shown: -

- Most mental health services are commissioned by CSAPHN except Telehealth which is funded by SA Health.
- Most commissioned mental health services focus on early intervention and socio-psychological support for mild to severe mental health illness populations.
- The biggest service provider in the region is COBH. It runs 8 different mental health programs from at-risk groups to the individuals who require services dealing with severe mental health issues.
- All commissioned programs have a timespan of only 2-3 years. For example, most COBH programs will end on 30 June 2021. These programs may be renewed or moved to other new programs. However, no confirmation is available yet.
- Telephone and online counselling services are used for early intervention. For example, CSAPHN funded the *Regional Access* service that provides 24/7 phone and online counselling services. *Telehealth* for mental health funded by SA Health provides support for people who suffer mental health issues.
- Face-to-face clinic services are often used for moderate to severe mental health illness cases. Most mental health services require clinical referral except *Regional Access* and *SMART Recovery*.
- The waiting time for face-to-face psychological service is 3 to 4 months. The Telehealth service also has a 3-4 week waiting time.
- Since 2020, and in response to the impact of the on-going drought on local communities in SA country regions and especially their mental health situations, a variety of wellbeing programs have been supported by the Federal and State governments, non-profit organisations. However, most of these support programs will end in June 2021.

Table 5: Stepped Care Mental Health Services in 7 Northern Council region

23.1% of Population (17,710 Persons)	**9.1% of Population** (6,900 Persons)	**4.6% of Population** (3,526 Persons)	3.1% of Population (2,376 Persons)
At Risk Group Self-help resources low intensity intervention including digital mental health	**Mild Mental Illness** Mix of self-help resources and low intensity face to face services with Psychological Services to those who require them	**Moderate Mental Illness** Face to Face clinical services through PHC and psychiatrists where required. Clinical based self-help resources and other low intensity intervention services	**Serve Mental Illness** Clinic care using a combination of GP care, Psychiatrics, mental health nurses and allied health. In patient services and psychological support services. Coordinated multiagency services for complex and severe illness
Low intensity Mental Health Service **Regional access (On the Line)** ○ Low intensity psychological service via telephone and online		Country and Outback Health **Understanding me** (until June 2021) ○ Therapeutic support for people (12+) experiencing symptoms of mental illness (12 weeks waiting time) **Discovery Me** (until June 2021) ○ Therapeutic support for children (under 12) to help them better understand and manage their feelings	Mid North Community Mental Health **Child and Adolescent Mental Health Services (CAMHS)** ○ CAMHS provides services to mothers in the perinatal period, infants, children and young people and their families, with moderate to severe and complex emotional, behavioural or mental health difficulties
Telehealth for Mental Health (SA Health) ○ People who suffer mental Health related issues (3 to 4 weeks waiting time			
Country and Outback Health (COBH) **SMART Recovery** (until June 2021) ○ Group support for people with problematic behaviours including addiction to drugs, alcohol, cigarettes, gambling, food, shopping, internet or others			
Headspace (COBH) (until June 2021) ○ Outreach two days in Port Pirie. Mental Health, physical health (including sexual health) alcohol and other drugs or work and study support for young people (12-25)			**Adult Clinic Care and Coordination (Sondar)** (start from July 2021)
National Suicide Prevention Trial (2017- 2021) (until June 2021) ○ The trial is placed at a regional level to better respond to local needs, and identify new learnings in relation to suicide prevention strategies. Whyalla, Port Augusta, Port Pirie, Port Lincoln and the Yorke Peninsula.			Country and Outback Health **My Wellbeing** (until June 2021) ○ Therapeutic support and help to connect with social mental health supports for people (16+) with severe mental illness (4 months waiting list)
Coaching 4 Life (COBH) (until June 2021) ○ Social Support for young people (12-25) to strengthen their mental health and maintain their wellbeing			
My Resilience (COBH) (until June 2021) ○ Guided therapeutic self-help for people (16+) who need support to manage their mental health during stressful and challenging periods (6 structured sessions)			
My Steps (COBH) (until June 2021) Therapeutic and social support for people who are misusing alcohol of other drugs and their families/ support people			
Commissioned Service Legends: Country SA PHN commissioned mental health Services		**Uniting Country SA** **Country Wellness Connections** (until June 2022) ○ Non-clinical psychosocial support service, focussing on the individualised needs of each consumer, to people with severe mental health conditions that result in reduced functional capacity.	
Country Health SA Local Health Network and commissioned mental health service		**Accommodation Support Program** (until June 2021) ○ ASP is an individual psychosocial rehabilitation and support service that assists individuals to achieve an optimum level of functioning and independence in self-care, health care, household management, behaviour management, and other activities that facilitate community living skills. Coffee and Chat group	
Others ○ GPs/ Private Allied Health ○ Community Connections program (Funded by DHS) (Start from July 2021) ○ Drought Resilience program (Australia Red Cross) (until June 2021, may renew 6- 9 months) ○ Family and Business Support (PIRSA) (until June 2021)		○ National mental health hotlines (Lifeline, Suicide Calling Back, Mensline) ○ Clare Lifeline Connect Centre (start from May 2021) ○ ifarmwell farmer self-help on-line tool ○ Country SA PHN funded the projects relating to drought and mental health (until 2020) ○ Connecting Drought Communities- Events Grant (PIRSA) (until 2020)	

3. Service Needs and Gaps Analysis

3.1 Long-Term Impacts of Drought and COVID-19 on the Wellbeing of Northern Communities

Ongoing drought extends throughout much of the North-Eastern half of South Australia from Jamestown northward and eastward and has caused significant economic and social dislocation to the Northern communities. The reality for many farmers in north-eastern SA is a 3rd or 4th year of having no crops to sell or having a crop yield that is well below the average. Feed on pastoral properties is at unprecedented low levels because of a lack of soil moisture and associated erosion; residual feed seed banks are not enough to achieve good coverage. The drought has drained the farmers and entire rural communities of their physical, financial and mental resources. According to statistics from the Yorke and Northern Local Health Network (YNLHN), since 2017 the number of mental health presentations to YNLHN hospitals' emergence departments has doubled, with 1194 cases in 2018-2019 compared to 731 cases in 2017-2018. This number remains the highest of latest statistics, with an average of 117 cases per month in April 2021.

This trend is corroborated by our interviews [2][3][3][8][10][11][17][19] which show that farmers are at high risk of mental illness and experience doubts about their self-worth due to the uncertainties caused by the on-going drought. As one interviewee [8] pointed out, the farming communities are becoming less optimistic than ever before because another dry year simply puts more pressure on them, accompanied by feelings of anxiety, nervousness, having to deal with family responsibilities, trying to be custodians of the land and needing to care for their livestock. Farmers feel increasing worry that they will lose their land at some point in the future. The psychological impact of drought not only affects farmers but also their families, traders working in the agricultural industry and the entire community. A resident from Jamestown [4] explains that farming is integral to the rural economy, and once farmers experience financial difficulties, they withdraw from participation in social activities. This tendency in turn affects local businesses such as retail shops, pubs, and consequently, "everyone in the town are suffering".

Another impact of drought is relationship breakdown [19]. One charity organisation's employee points out that drought not only affects farmers' income, children suffer because their parents have financial issues and sometimes suffer from substance abuse, so consequently, the wellbeing and mental health support for drought-affected communities is urgently required. Many charity organisations, federal and state government-funded community wellbeing events were planned in the region to provide mental health support services to the communities. However, many such activities were cancelled due to the COVID-19 pandemic. COVID-19 has thus further aggravated the sense of isolation by restricting the opportunities for people to socialise, travel, and get away from the farm.

Farmers have been unable to attend markets and sales, field days, workshops and training activities. People have also been unable to attend funerals – funerals in rural communities often attract hundreds of attendees, because of numerous family and community connections.

Restrictions on gatherings at hotels and clubrooms, and church have severely curtailed the opportunities for already-isolated people to socialise. According to an online survey conducted in September 2020 by the Clare & Gilbert Valleys, Regional Council of Goyder and Northern Areas Councils, 35% of the respondents reported that the long-lasting drought has put strains on their mental and emotional health, and this rose to 46% during the COVID-19 pandemic. This could be a result of all three Councils and local community groups and services in the region focussing heavily on community events to bring people together in response to the long-term drought, whilst COIVID-19 restrictions have prevented community events from taking place and reduced opportunities for social interaction. This is such an important part of regional community life and people's wellbeing. In the survey, respondents also identify supporting the social and mental health community events as one of the top three priorities to improve people's wellbeing.

Results from our interviews [2][3][4][8][17][19] also indicate that the impact of drought on local livelihood and community wellbeing is prolonged. A good year with some rain cannot resolve the problems especially the on-going mental health issues that are occurring in local communities. The drought-affected Northern region thus needs more long-term support once the drought breaks, so that people can bounce back to their normal life and feel that they are in a position to take on future challenges.

Impact of Drought, COVID-19 and the Wellbeing of Northern Communities: Voices from Locals

"I will say now the situation is less hope, optimism is a bit lower at the moment. Normally, when it comes to the seeding season, people are normally excited about what this year is going to bring and I think at that moment, there is a certain degree of nervousness, a certain of anxiety, what this year will be? Because we have four really dry years, people are aware this year may be another dry year. In the past, we think this year will be alright; we will get on it, we have that nature of resilience to continue on and do another year. This year, the hope is less, the people just feel more anxious. I don't know whether this will escalate to suicide or not, but people just carry this burden and feeling stress…….I think there is a certain increasing rate for anxiety."

"For a farmer, it is not only financial stress, but I work hard but my effort is failure. They also have this self-worth issue over time. Also being the custodian of the land, this land is for many generations of my family and I may be the one to lose it for financial reasons or I can't take care my stock, and can't do as good as my father's generation; it is a pressure to perform. People are trying to control somethings (e.g. rain) which is actually out of their control." **(Interview 8)**

"The Upper North comprises a significant population of farmers who have already struggled to overcome the economic, social and environmental burden of battling through multiple years of drought. Other businesses in the region, in retail, service provision, agricultural industries and professional services have also suffered the effect of drought experience, as all local economies in here

are interconnected to farming. The additional burden of COVID-19 has made people in the Upper North like us more vulnerable to mental health distress……. Poor internet access and mobile phone coverage in the Upper North have impacted on the inability of people to connect online. Zoom-style communications are virtually impossibly in many parts of the Upper North." **(Interview 4)**

Because of the on-going effect of drought, what people need is the relationship support. Relationship break down from the drought, children suffer because their parents have financial issues, drugs, substance use, so additional support needs to come from the drought. Drought is not only affecting farmers' income, it affects the local business but also has an impact on relationships which I think is not well addressed. Mental health support is not only for the farmers but also the whole families, their children and people in the community. I think we need to have more support in place to address the drought impact. It may be having a good year, some rain but still we have on-going mental health issues, children affected by, the relationship affected by. I think having the support in place after the drought has to be addressed……It is not a short-term, but it is long-term support." **(Interview 19)**

Building on this, the key failures/gaps we identified in the mental health services for the Northern communities are as follows:

Service inappropriateness: Hard to reach the locals and especially farmer communities

The availability of services does not necessarily mean the services can be reached by those who are in need for such services. This is particularly the case when delivering mental health services. Our study shows that lack of outreach efforts, help-seeking behaviours of local communities and the use of telehealth/ online counselling have widened the service gaps in the Northern region. Consequently, people with the deepest need may tend to receive the least care.

Lack of outreach efforts

Table 5 indicates that most current mental health services require their users to contact the providers when such services are required. Evidence from the literature clearly states that rural adversity (e.g. low socio-economic status, remoteness, lack of primary health care services, transportation, culture) often means that people living in farming regions do not have enough information and face many challenges trying to access mental health services (Lawrence-Bourne et al., 2020). For this reason, outreach is believed to be the tool to fill the gap so that those people who in need help get the service they want. When a severe drought does a lot of harm to the Northern communities' wellbeing and mental health, poor outreach capacity is evident in the current mental health service system.

During the interviews [12][13][18][19][21][22], service providers pointed out that their budgets and geographical barriers are two major factors for the lack of outreach services to remote communities. One service provider [13] explains their service coverage area is often

large, for example, they only have 5 staff for a program which services 140 mental health clients a year. Simply put, it is not cost-effective to send a staff member to travel 2 to 3 hours to a local town to see one client. Another service provider points out that although most of their services cover the entire Northern region, they only visit small towns when there is a need and request. She feels disappointed that 30% of clients do not show up at their scheduled

appointments given that there are many people on the waiting list. She stated, "People get two chances if they DNA the appointment two times; they need to start from the bottom of the waiting list again. People need to be committed and ready for services".

Pride or a sense of shame stops people seeking help

From a local perspective, our study finds that locals often prefer outreach visits because "services need to be in the region". Members of the local suicide prevention groups explain that although more locals are willing to talk about wellbeing publicly, this is not the case for everyone and especially the farming community. Male farmers are often very proud and still perceive that "seeking help" is the behaviour of a weak person. Mental illness remains a taboo topic to many as they are afraid of being known in the community as someone who has mental health issues. The social stigma attached to this is one of the major barriers for people who request mental health assistance. Furthermore, the isolated nature of their workplace environments and busy farm work make people within farming communities reluctant to seek help when they are struggling and in crisis. For example, one of the interviewees [8] shared the view that her husband has been struggling for the last four years because of drought. Nonetheless he never asks for help. Most interviewees believe a more active and culturally safe approach is needed to reach the isolated communities.

Increasing use of on-line/ telephone counselling services is occurring due to practitioners unable provide face to face help in rural areas

The literature clearly identifies remoteness as one of the biggest challenges for rural residents when trying to access on-time primary and specialised health services (Lawrence-Bourne et al., 2020). It is very difficult to recruit medical/healthcare professionals to work in rural areas. In order to reduce waiting lists and increase access to the areas of high disadvantage, telecommunications technology is increasingly used in delivery of medical services and especially for mental health issues. This is particularly the situation in the Northern Region. *Regional Access* and *Telehealth for Mental Health* have been introduced to improve rural residents' access to counselling and clinical services especially for those are at risk or in mild mental illness stages. During the COVID-19 pandemic, many face-to-face counselling services have to shift to phone or on-line only. One service provider commented that telecommunications-based counselling services help reduce travel cost for clients. On the other hand, most interviewees criticise phone/ on-line-based services because they do not build trust, and locals do not feel comfortable sharing their problems with someone they do not know. These services may only favour people who are resourced, resourceful, urban, and

have more easily treated conditions than those with complex or multiple chronic illness (Stone and Phillips, 2020). Studies show rural communities prefer face-to-face services close to home (Health Performance Council, 2013). The situation is even worse when farmers know the person is city-based or interstate-based; they feel their problems would never be understood by outsiders. Consequently, locals may even choose not to use the services that are available to them. Most interviewees [2] [[4][5][8][10][17][19][22] point out that telecommunications-

based services should not be the only option for rural residents to seek mental help. To them it is equally important to provide face-to-face counselling services so that people can choose what is best for them. Some also suggest blending services may be a good strategy and one which can balance local needs, the workforce and resource limits. One interviewee [19] suggested a process whereby face-to-face services occur first and then once the trust is built, shift to telecom-based counselling services would be appropriate.

Referral paths are hard to navigate

Most current mental health services require referral particularly for the psycho-therapy services provided by mental health clinicians. For example, except for the SMART Recovery program, all COBH programs only accept clinical referrals from the GPs. However, GP services are often in short supply in rural regions. During the time we conducted this study, we were told that GP clinics would be closed in Mt. Remarkable and Peterborough which would leave residents in these two areas without access any primary health care. If this happens, residents from Mt. Remarkable and Peterborough will have to travel over 30km and 55km respectively to just get the service of a GP.

The psycho-therapy referral process is also complicated. A service provider [21] explained that because they provided a clinical outcome-based service which was different from general counselling, they only accepted clients who meet the assessment criterion. If they found they were not the appropriate service providers, they refer the clients back to GPs. She also emphasised that psycho-therapy services targeted mild to moderate mental illness people who were not at immediate risk - for the severe cases, GPs should refer them to the hospitals. She pointed out that it was not unusual for GPs to make inappropriate referrals due to a lack of mental health training. This adds further pressure on service needs and constricts the workforce. Another service provider [13] shared that many locals did not know or felt confused about the referral system: when they visited the centre, they were told they needed to have GP referrals to access the mental health services.

Unlike metropolitan services, rural residents have to navigate many challenges to access mental health services; transportation is one of the top barriers. Most services are only available in the regional town centres like Port Pirie, Clare or Port Augusta and outreach

services are often limited and irregular, that means residents have to travel long distances and find transportation to get there. Some interviewees [12][13] pointed out some locals were in deep poverty and did not have own vehicles. These locals have to rely on very limited community bus services which is also costly. They also need to take time off, sometimes a whole day off from work just to attend a doctor's appointment. One interviewee [13] described the situation as extraordinarily difficult, "this is all what people (rural residents) need to navigate to just to get in the service." The survey results (details refer to next section

"Wellbeing Survey") show that most residents have to travel over 45km to get the medical services.

There are long waiting times

Another key gap in the mental health services offered within regions is the long waiting times, especially for face-to-face psychological therapies services for people suffering mild to moderate mental health illness. According to the stepped care approach, the mild and moderate mental illness are the critical stages where the client's situation may get well or worse, as well as when more intensive care is needed, especially the face to face psychological therapies and other social support services. In our consultation with different stakeholders, we found that access to the face-to-face psychological therapies has a 3 to 12 months waiting time. A shortage of people within the mental health workforce and increases in demand are two major factors that attribute to these long waiting times. One service provider [18] explained there are significant national-wide shortages of mental health nurses and clinic psychologists: it is therefore even more difficult to recruit people to work in the regions. He pointed out the mental health awareness programs may drive people to be more willing to seek help when they experience anxiety and depression.

The new tendency to online care, has further escalated inadequate medical services in rural regions. Different from metropolitan areas, medical services mostly rely on public rather than private sectors. For example, in our project areas, a private counselling service is only found in Port Pirie and Peterborough, and residents have no choice so must accept the long waiting times. Although a telecom-based mental health service has been introduced, according to our key informants, the waiting time for the telehealth service is also 3 to 4 weeks. As mentioned in the earlier sections, local residents are very reluctant to use phone/ on-line mental health services. In a recent survey conducted by the Caltowie community, some respondents criticised the reduction of face-to-face counselling services and expressed a strong opposition to the Toll-Free phone mental health services. The long waiting times have not only discouraged local residents to seek for help but have also built distrust between potential patients and the mental health service system. An interviewee [19] pointed out that "people just think there is nothing (services) there."

The funding system means the services are not reliable in terms of actually operating

Mainstream mental health services or post-disaster recovery programs are also highly affected by short funding timespans. As shown in Table 5, except for the hospital services, almost all the mental health services are commissioned with only 2-3 years contract times. Under the tender system, service providers (charity organisations) have to compete with each other. Further, urban, national, or interstate-based organisations tend to have a higher chance of getting the contracts than regional and local based service providers [12] [13]. During the interviews, a regional-based service provider [12] described the situation as very unhealthy.

This funding instability makes it difficult to retain a stable rural mental health workforce. It also causes negative impacts on clients especially due to the frequent change in service providers. She explained mental health recovery was a long journey which required a huge amount of time to build up the trust with clients, unfortunately, once this relationship was built, the project was over, and the clients had to transfer to other programs. She urged the government to consider how to ensure the best services are given to the people suffering mental illness. She strongly believed that local based organisations had better knowledge on how to deliver the regional services [12]. Another service provider [21] also admitted that short project timespans have had negative impacts on workforce training and consistent counselling services. In the worst case, clients face the frequent changes of mental health clinicians. Stone and Philips (2020) also point out there is clear evidence that relationship-based care is important, with health professionals who change frequently would increase distress for people.

As one of the severe drought-affected regions, a lot of post-disaster recovery programs focusing on community wellbeing funded by Federal and state governments, private corporations, have been introduced into the Northern areas. These programs have included community wellbeing events funded by Country SA PHN, National Drought and Flood Agency's regional recovery program, PIRSA's Family and Business Support program (FaBS), Australian Red Cross's drought resilience program and so on. Although these programs seek to address the mental health needs of the local communities after the disaster, they lack coordination and fail to build up local capacity in long-term. Some local communities felt they were "abandoned" once the funding dried up [4][5][[19][22].

During the study, we realised that regional recovery programs and the FaBS and Red Cross programs all ended in June 2021. Although these programs may be extended, the extension time is likely to be just another half to one year. These short timespans negatively impact on project outcomes. Australian Red Cross's drought resilience program is a good example: this program sought to build community resilience by getting local communities trained, involved and skilled up about mental health first aid. However, because of budget and time constraints, the Red Cross could only provide the training once to each participant community. As a result, without any further support, it could not build the local community capacity needed to cope with the increasing mental and emotion needs due to the climate-related disasters. As an

interviewee [19] pointed out, as many services and programs came and went, the locals became reluctant to attend and questioned the sustainability of these programs. Volunteer-based local network groups also found it difficult to organise community activities due to lack of funding [4][5]. The fragmentary and temporary nature of this funding means rural people may not know what services are available, and accessing services become confusing.

Drought-affected communities are not prioritised in the current mental health system

Our findings show there is a call to prioritise mental health support for drought-affected communities during and after disasters. As mental health is a highly complex issue, a specific strategy for high-risk population groups is often needed. For example, mental health needs for youth, aboriginal communities and regional/ rural men are addressed in the current

Country SA mental health system. In the past 5 years, CSAPHN had conducted substantial suicide prevention activities for working men in the Country North region of SA including Port Pirie. By contrast, the programs for mental health support for drought-affected communities in the region are often short term and band-aid disaster-response policies rather than comprehensive mental health policies. These programs highlight the immediate psychological needs for communities after disasters but fail to implement any enduring policy to address the mental health issues caused by long-term drought for rural population particularly farmer communities. When budgets to assist these communities becomes partially available, they do not always reach the people who need the help the most. Several interviewees [17] [18] [22] pointed out that there was no national-wide policy to address the issue of mental health problems for farmers communities who faced increasing climate-related disasters, Covid-19 and Australia's trade disagreements with China. They believed a nation-wide policy would help tackle the issue in more targeted, effective, holistic and sustainable way. One interviewee [19] explained it would allow more resources to identify the problems and implemented strategic interventions.

Service inappropriateness: Hard to reach local people and especially farmer communities
○ Limit Outreach Efforts "I am a farmer, I married a farmer. When I am talking to farmers, I can understand their situation, what they are dealing with, I understand their pressure point. I am walking to their place as much as I can, so I think it is building the trust. I continue turning up and continue be there so the people will realise I am still here, I am still listening; it is about building the network." **(Interview 8)** "We want to cover more areas, but we don't have capacity to travel 2-3 hrs to just see one person. Usually for each referring client, the hospital also tells us how many hours we need to give the service, but the hours are cutting down every year….I think many service programs are good, but we need to cover large areas and the situation just does not allow us to have really intensive care for our clients." **(Interview 14)**

"Yes, it may have many services but it seems people don't really know it. And these program officers are not always available for the rural communities. May be they reach out to the doctor and professionals, but they haven't gone to the people themselves…… We may be the first person to contact these people affected by drought. Be the person to reach out to, we could be important for them to help them to access other services. These people haven't been spoken to anybody else." **(Interview 19)**

- Reluctance to get help

"Getting people together is always a great thing. People get great benefit from it. Having dry time events …it is a pressure relief for us. …but some farmers are really struggling, they couldn't make themselves come out; are those farmers actually getting steps to get help? They are not getting steps to get this pressure relief or seek help from the professionals. Like my husband is struggling in the past 4 years. When I say to him to go and talk to someone to get help, he is absolutely resistant. I don't know how to get him to go." **(Interview 8)**

- On-line counselling

"One of the biggest confusions for people living in the regional areas is to put on Telehealth, and in my opinion it doesn't work. My husband is a farmer; if I say to him you can have a chat with a person with phone, he won't do it, it's just not happening. I am concerned that the service needs to be in the region, at the same time, I build the network, trust, people know I live here, I am from here, I am not going to anywhere, I think…having someone come in and change over like GPs, it is very hard to build up the relationship. It is hard to build up trust when every time you sit down and talk to somebody different. ……Also it is about the continuity, if you have face-to-face 1-2 sessions, after that using Zoom/phone is OK. If it is the same service providers, the person you have built up that relationship. It is important …not having to tell you the stories again …I think to have continuous care is the most important……Having someone who understand the industry, having someone who understands the region and the pressure, who is able to communicate in a non-threatening way approach this guy and ask, 'how's it going?'" **(Interview 8)**

Referral path - hard to navigate

"Some children have to wait a long time to get the service. Then they need to come to the major town, often we see the people don't have car or if they have, their car is not registered because they are not able to renew their licences. They will drive their unregistered cars and then the police charge them, then they can't drive." **(interview 12)**

"Some may have a community bus, but they need to get on the bus at 8am and only get back to home by 6pm…..whole day stuck on the bus for a doctor's appointment. And the transportation cost is not that cheap, this is all what people need to navigate to just to get in the service."
"Most services need to have GP referrals, so when people come to our centre, we tell them you need to get a GP referral to get other services. This is also what they need to navigate. It is not that easy you come in and get help." **(Interview 13)**

"I think there is a need for huge additional support. If you are young people, may be you are able to access the service through the school counsellor, but then reaching medical professional service is really difficult to get. And the people need to travel to Clare, to Pirie to get the service. It is very hard for some of them to get the transportation. It is very difficult to get the appointment because there is a long waiting list. We do have local doctors but they can't do so much. If they refer the people, again there is long waiting list. I feel it is quite difficult for people to know where to go,

people just feel that there is no service they can just reach out to. A lot of them have go through the long process and spend a lot of time. I think it is a big issue, at the end a lot of local people just don't get any support. They just think there is nothing there; this makes the situation worse because people don't talk to another body. So I feel there is a really limited service in our areas. And there is a big concern about mental health issues in the rural area." **(Interview 19)**

"All the evidence shows if someone has mild to moderate mental issues, people are actually not at risk. They don't need immediate service. If they need immediate service, they should not be

referred to us. They should go back to their GPs. I am not funded to serve them. The GPs have to find the appropriate services for them. "
"We are not a general-counsellor service; we are a clinical outcome-based service. We are not just talking to you, we will ask you to do something, and we will do the outcome measure. If we find we are not the appropriate service providers, we will refer the clients back to GPs.**" (Interview 21)**

Long waiting time

"I know someone gets to see the GP and the GP refers to someone else, but later he is told that he can have the telehealth appointment in 3 months!" **(Interview 8)**

"Workforce and demand issues cause this waiting list, if they (some service providers) are fully staffed, probably the waiting list will be reduced but the situation is different from place to place. In Clare you need to wait 14 weeks, but another place may be several weeks depending on demand. That's why we have this stepped care; if people experience high risk they should come to us, the GPs should refer to us."
"I know to wait 3 months to see a psychologist is not a good thing but I am not sure we can see the considerate changes in the areas. It is hard to recruit someone to work in regional areas. Mental health workforce is in shortage. We are also struggling to recruit the workforce." **(Interview 18)**

Funding system makes services unsustainable

"Both programs we work with our clients who requite amount of time for their recovery journey. We need to work with 140 clients in a year but we only have 5 staff. We need to do the service in Port Pirie, Peterborough and Clare, and that is quite a wide region. Really when the support linking is there then it is the time to transit to other services. But there are limited services in here, if possible we try to keep them, we create certain groups just give them psycho-social support." **(Interview 13)**

"We lose so many people who have many years' experience of mental health…..people have to look after themselves, if they know the program is going to finish, they go for other programs or organisations. We lose all this knowledge and we have to start all these things again for a new program." **(Interview 12)**

"The tender policy is certainly unhealthy especially in the country area. We are a local-based organisation, we employ the local people, we know our community, we know our people, we know what the issues are about, we know how to manage the regional services, often we see the tender process happens, the city-based organisations or inter-state-based organisations will be awarded the contracts. Then the department comes back to us to say this organisation can't manage the

contract, can you take over it to the end? ……The government should support the local-based organisations. It is not we want to build an empire here; it is just to make sure we can have the best services to the people in the country areas. Understanding the local communities is critical to provide the regional services." **[Interview 12]**

"That is very common. As I know even like us we got a bucket of money, but once the money is gone...I think the strategy is to try to get communities trained, get involved, get skilled, resilience training. The idea is to get the community top leaders to have resilience training and then they can assist the community. Try to give them the tools so that they can be on-going. Unfortunately, a lot of the programs are short-term which is disappointing because people get connected with something and then it stopped……. I feel the people in here are bit reluctant, because services/ program come and go, it is hard to find the trust. They feel it is not that sustainable." **(Interview 19)**

Drought-affected communities are not prioritised in the current mental health system

"May be farmers should be identified as a vulnerable group…..we have Aboriginal people identified as a vulnerable group and they have specific target services for that population. There is always no enough comprehensive service designed to support this population [farmers] who

have their uniqueness, although there are some services for them. But there is no coordinated approach, may be they need a state-wide coordination approach to address the needs of farmers…impact of export, drought issues, bush fire, COVID-19, of course they will be the group at the high risk for developing mental health issues and experiencing a lot of stress because their livelihood is regularly impacted and they get no sense of controlling their environment. We need to have a state or national plan to address their wellbeing and mental health needs." **(Interview 18)**

Moving forward

This gap analysis identifies a range of issues which are preventing efficient and much needed place based mental and wellbeing care and provision of services in the region. The next section identifies and presents a range of options that offer some opportunity to redress some of these gaps.

Firstly, the Family and Business Support Program (FaBS) emerged as a good and relevant program to role model (albeit with limitations).

- Very positive
- Local based / Service in the region– gain the local trust
- Early-stage intervention
- Provide locals on time mental and practical supports
- As the program sits under PIRSA, it helps reduce the negative image of "mental health", people are more willing to talk their difficulties

Limitations of this project:

- No clear job requirements like outreach efforts, follow-up the cases are not required. It is up to the individual mentors.
- No counselling backgrounds.
- Even they refer their client cases to the service providers- long waiting list. In fact, some service providers only accept the referrals from GPs, not FaB mentors.
- It may beyond the mentors' capacity to handle some very complex cases.
- Hard to quantify the outcomes of program.

How can we address the gaps?
"I think FaB mentors work well because they will actually when they hear someone struggling, they will go there. We have one Fab mentor here, he is a grain trader, he easily notices if farmers are struggling. He can pop in and start the conversation easily with farmers. He won't threaten the farmers, not like I am here as a mental health worker to come here to help you. I am here just talking about farming, in a non-threatening way. " "It is important to have a psychologist, so that people don't need to travel to Adelaide, but I do think it is important to have someone in the region who can provide the support before the situation gets to escalating." **(Interview 8)** "Yes, the majority of farmers won't come to our services or to the Country and Outback Health service, they may not often go to their GPs and their own culture may also prevent them to open their issues. I think the gap is that there is a need to have more people at the basic level for mental health training in terms of mental health first aid, basic understanding of the suicide risks, and who are already involved in the industry and the farmer community. These people will visit the farmers and farmer families on-site, they can listen and evaluate people. I think this can help address the particular gap. Putting the knowledge to the people who actually have contact with farmer communities." "The other thing is that I think council talks a lot of people feeling isolated and having trouble about loneliness, other types of psychosocial issues. In my opinion, I think council needs to put more investment into initiating the support for connectedness of community, do more to support employment, create more spaces for community members to come and connect with each other; they can play a more active role in addressing the social determination of health. We can't only focus on service response. The psychosocial issue is better to address the social determination of health and support the people connectedness. I think councils sometimes put the responsibility of service work, we need to have a compound response, we need to have services but also we need jobs, places and transport. It is not just so simple to get the service in." **(Interview 18)** "I think both federal and state governments need to look at this, and also not-profit charity organisations as they don't have secured funding anyway, they need more support. Also there are

many different sectors like drought, mental health different aspects but seems they are not connecting them together. Also there is lots of drought funding that councils received and used to stimulate the local economies, but it seems if we can better support the mental health of the community, it can help the local economies more. If people are suffering mental illness, there are still suicides, depression, so maybe we should be in touch with the core problems." **(Interview 19)**

Results: Wellbeing Survey

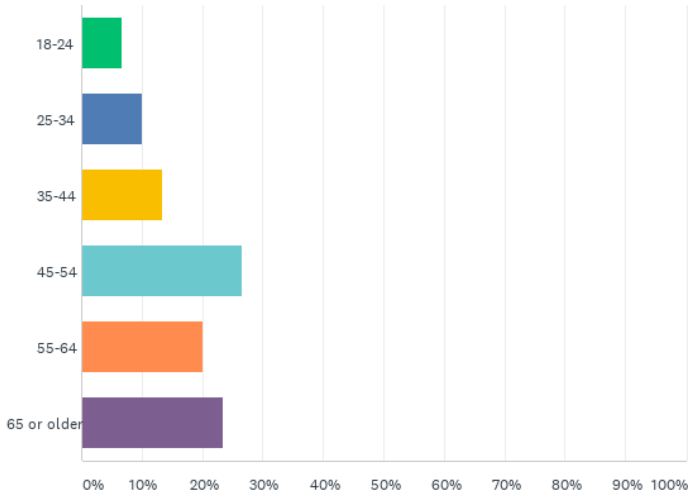
Survey 1

This section presents further information about how communities perceive the issue of wellbeing and service provision in the regions via analysis of the surveys that were conducted that relate to this project. Firstly, we conducted the broader survey via Survey Monkey. In this survey, more women (82%) as against men (16%) answered the survey and while respondents predominantly come from Flinders Ranges (53%) and followed by Northern Areas (20%), there were fewer respondents from Goyder, Port Pirie and Peterborough. No respondents are from Mt. Remarkable. In terms of age range, while there was a relative even spread in between 18 – 65+ year old, the majority of respondents identified over 45 years old.

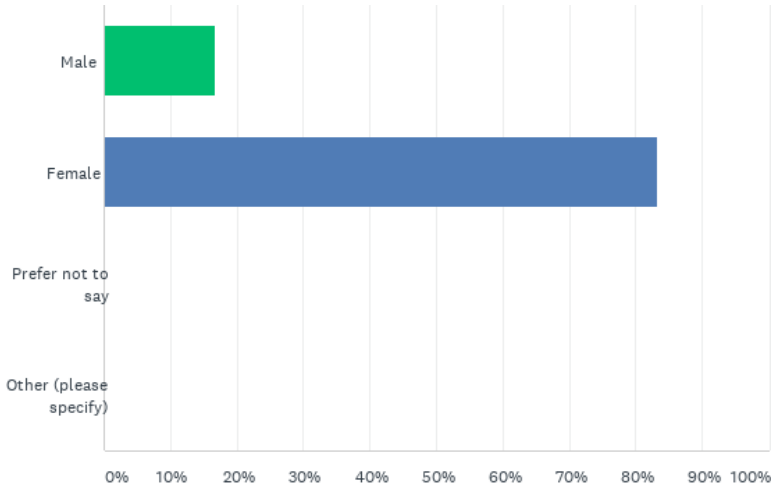
Key Summary points:

- Access to health service is one of key factors negatively affect people wellbeing, particularly mental health service
- Major issues include no transportation and long travelling times to get the medical service (half of the respondents mentioned a need to travel over 40km to get service)
- Nearly half of the respondents reported being negatively affected by COVID-19
- Respondents wanted more support for health service and education programs for mental health

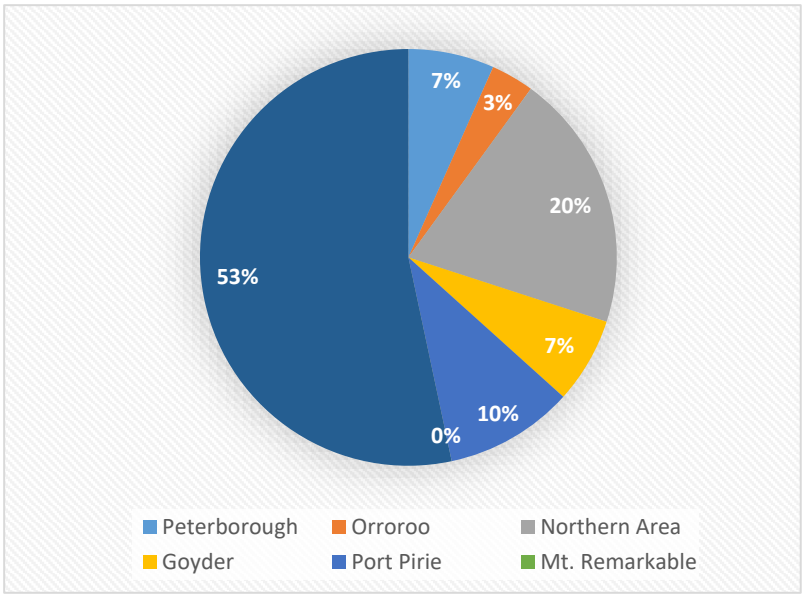
The following sections present the data from the survey.



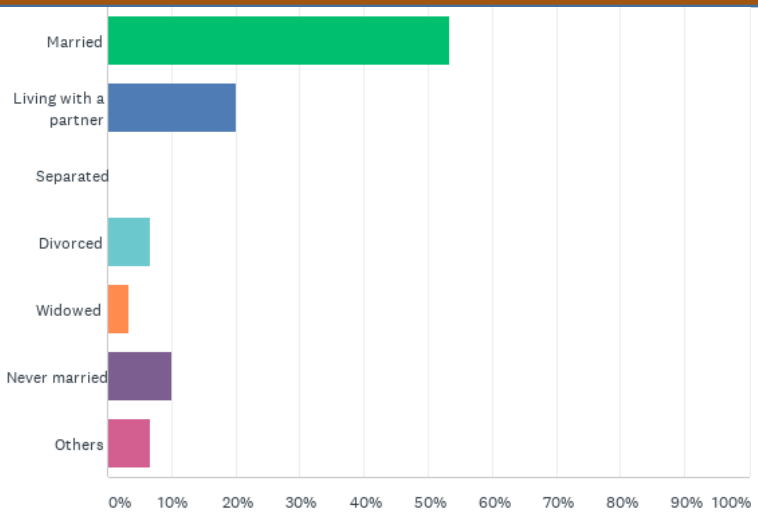
Age Groups



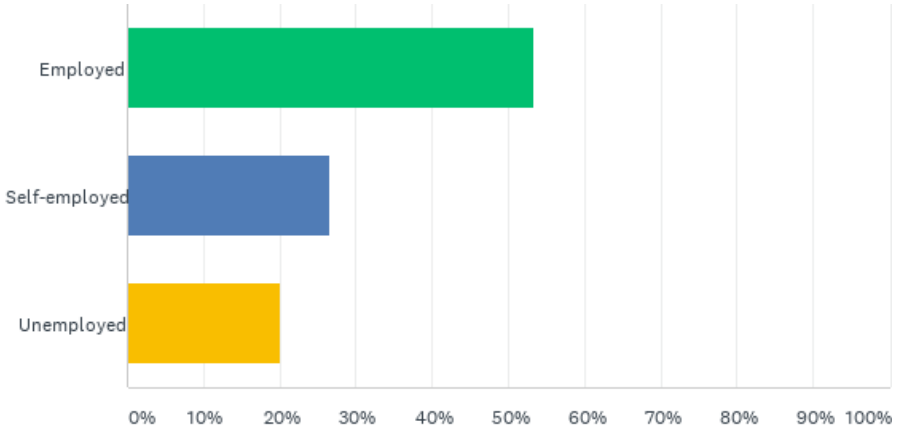
Gender



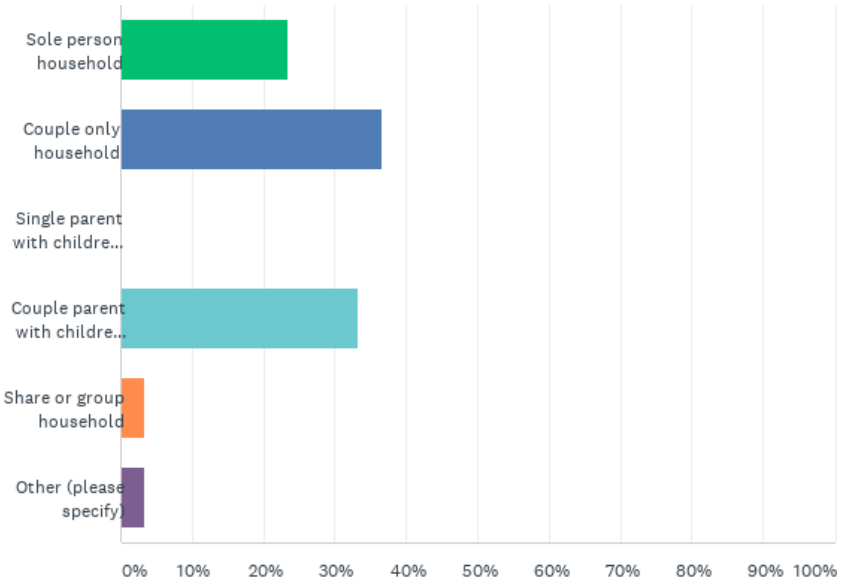
Location



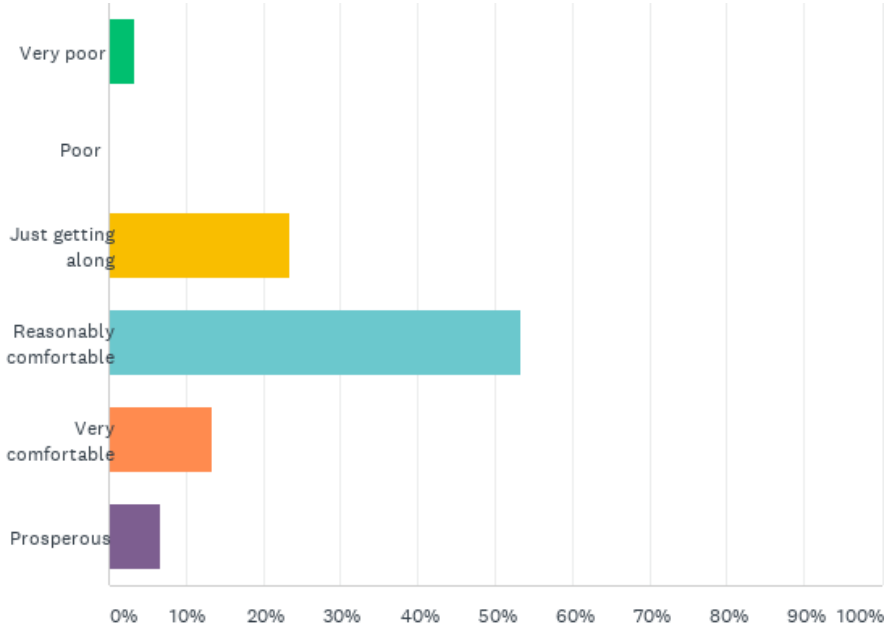
Relationship Status



Employment Status

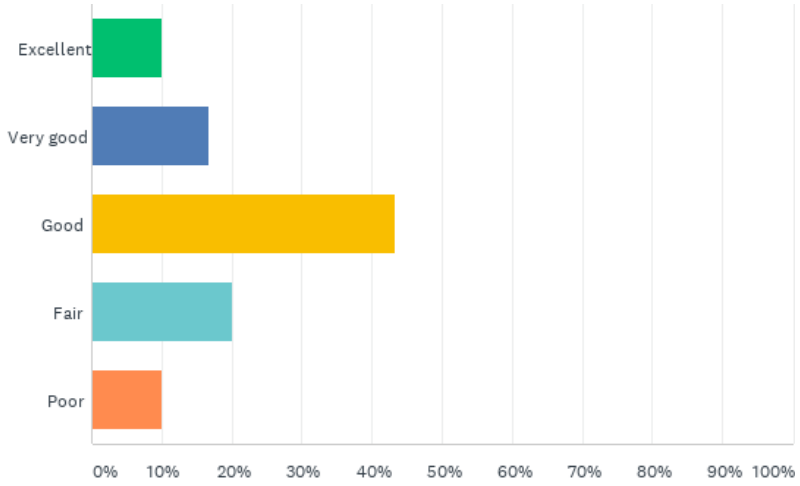


Household Types

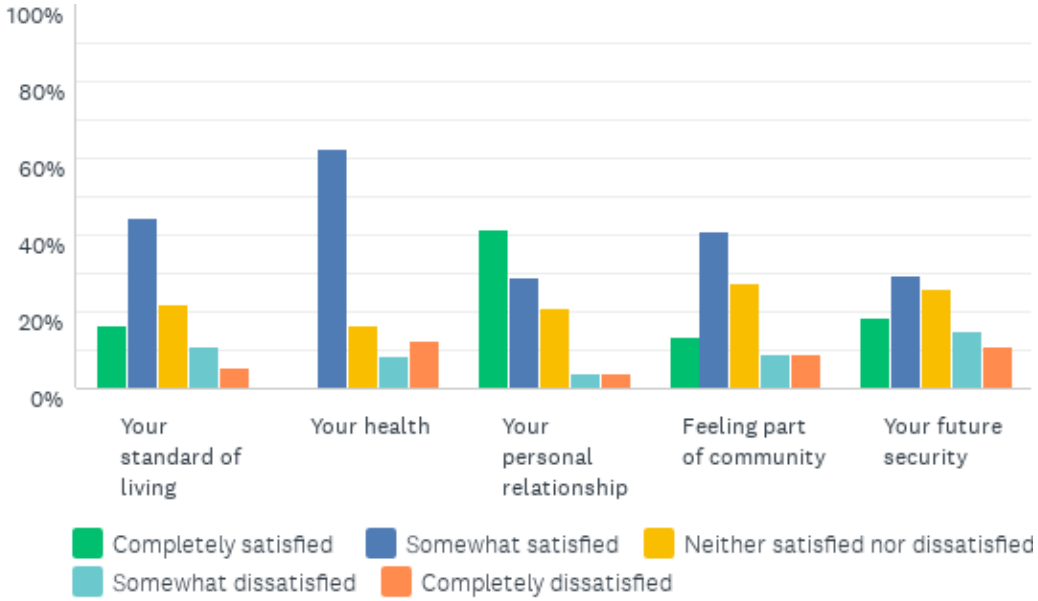


Financial Situation

Q 1: How would you rate your general health?



Q 2: Thinking about your own life and personal circumstances, how satisfied are you with the following?

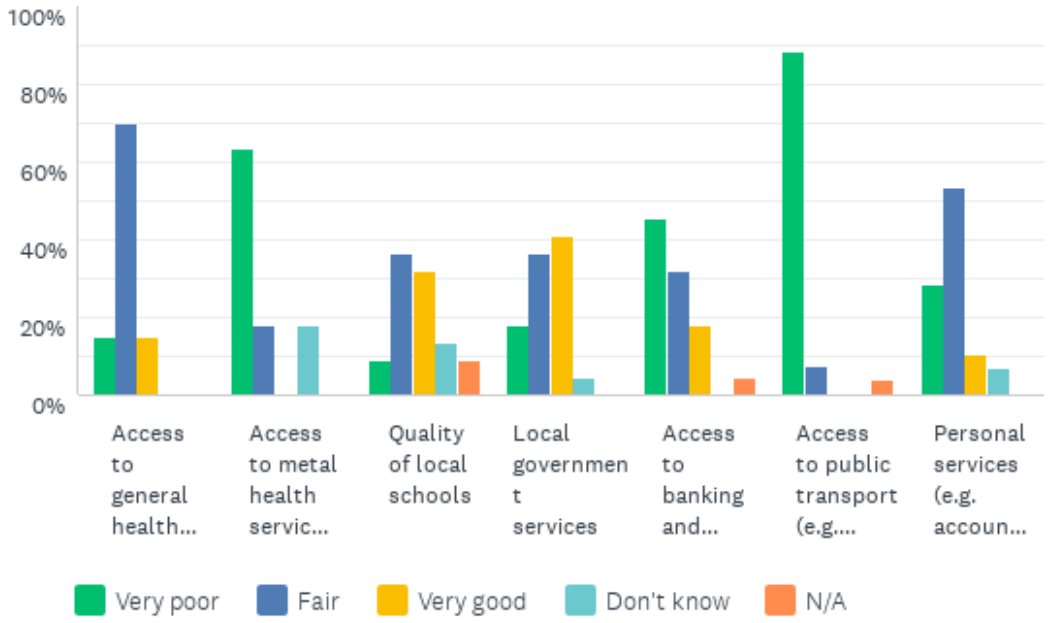


	COMPLETELY SATISFIED	SOMEWHAT SATISFIED	NEITHER SATISFIED NOR DISSATISFIED	SOMEWHAT DISSATISFIED	COMPLETELY DISSATISFIED	TOTAL	WEIGHTED AVERAGE
Your standard of living	16.67% 3	44.44% 8	22.22% 4	11.11% 2	5.56% 1	18	2.44
Your health	0.00% 0	62.50% 15	16.67% 4	8.33% 2	12.50% 3	24	2.71
Your personal relationship	41.67% 10	29.17% 7	20.83% 5	4.17% 1	4.17% 1	24	2.00
Feeling part of community	13.64% 3	40.91% 9	27.27% 6	9.09% 2	9.09% 2	22	2.59
Your future security	18.52% 5	29.63% 8	25.93% 7	14.81% 4	11.11% 3	27	2.70

Q 3: How do you define Wellbeing? What does it mean to you?

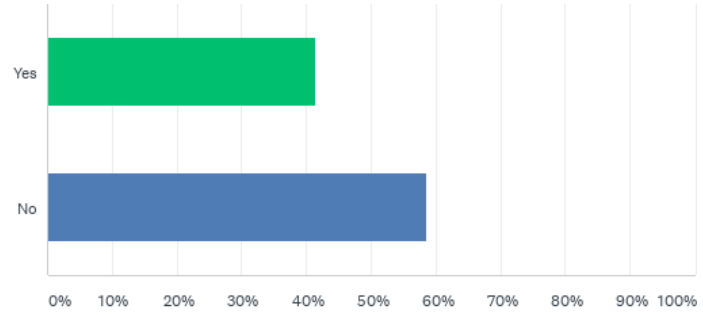
Responses
“fairly happy place most of the time”
“Being well in all aspects of life, including physical and mental health but also having a general feeling of happiness.”
“Live comfortably which means enough energy, money, fuel resources, food, time for the basic essentials plus a few wants”
“I am fine”
“Feeling like I have everything or most things in place in my life so I can be happy. My kids are happy and I love where I live.”
“Wellbeing is being happy and having the sense of belonging and support.”
“Having access to adequate services.”
“Feeling safe, relatively healthy, able to pay bills etc. have friends/ family I can rely on, hopefully at peace with myself, able to enjoy life.”
“Being happy with life”
“How I am doing physically and mentally”
“Physical, emotional, social status is positive and independently maintained”
“Happy, healthy in both body and mind.”
“How I am coping financially and emotionally.”
“Health and happiness”
“happy and safe”
“Feeling satisfied about life”
“Ability to cope with life’s pressures”
“Feeling comfortable with your physical and mental health. Being safe.”
“Being comfortable and able to love with minimal stress”
“It’s how comfortable I feel in my skin. Am I happy, contented, secure, healthy in body and mind.’
“Good physical health, good mental health, reasonable financial security, good friends.”
“State of health physically and mentally and how they interact.”
“Fulfilled life in a range of areas”

Q: How would you rate the following factors in your local region in relation to your well-being?



	VERY POOR	FAIR	VERY GOOD	DON'T KNOW	N/A	TOTAL	WEIGHTED AVERAGE
Access to general health services (e.g. GPs, drop-in centres)	15.00% 3	70.00% 14	15.00% 3	0.00% 0	0.00% 0	20	2.00
Access to metal health services (e.g psychologist, psychiatrist)	63.64% 14	18.18% 4	0.00% 0	18.18% 4	0.00% 0	22	1.73
Quality of local schools	9.09% 2	36.36% 8	31.82% 7	13.64% 3	9.09% 2	22	2.55
Local government services	18.18% 4	36.36% 8	40.91% 9	4.55% 1	0.00% 0	22	2.32
Access to banking and financial services	45.45% 10	31.82% 7	18.18% 4	0.00% 0	4.55% 1	22	1.71
Access to public transport (e.g. buses, taxis)	88.46% 23	7.69% 2	0.00% 0	0.00% 0	3.85% 1	26	1.08
Personal services (e.g. accountants, layers)	28.57% 8	53.57% 15	10.71% 3	7.14% 2	0.00% 0	28	1.96

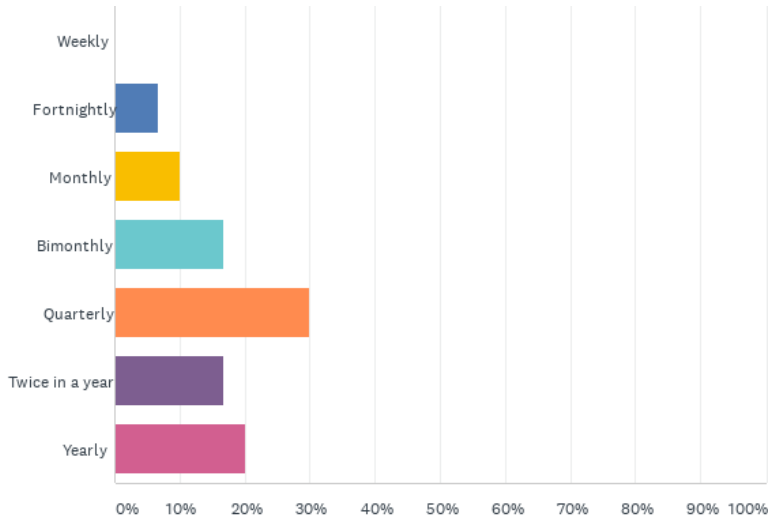
Q: Has COVID-19 affected your well-being?



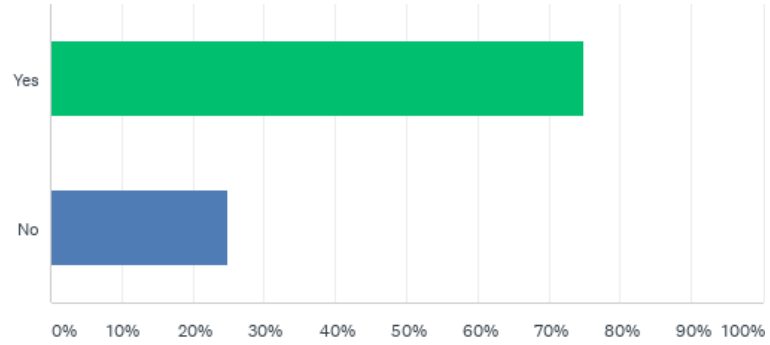
Q: If yes (COVID-19 affected your wellbeing), please explain in what way…..

Responses
"It did last year financially, due to a downturn in business, but this year things are going much better."
"More specifically Covid19 restrictions and changes have impacted me and I believe everyone else because of the additional stress our bodies are constantly dealing with."
"It has destroyed one family. It has also laid bear all the crackpot conspiracy theories I did know how deep it ran."
"Worrying about family members."
"Isolated from family with lots of extra work stress added."
"Impacting my mental health"
"It has increased my anxiety levels at times and also triggered my PTSD (from bank holdups) when people had to wear masks. Not willing to visit Adelaide in 2020."
"I am feeling more uncertain and stressed than ever before"
"It's added an Emory amount of compliance work"
"It's frustrated me in so many seemingly unnecessary restrictions."

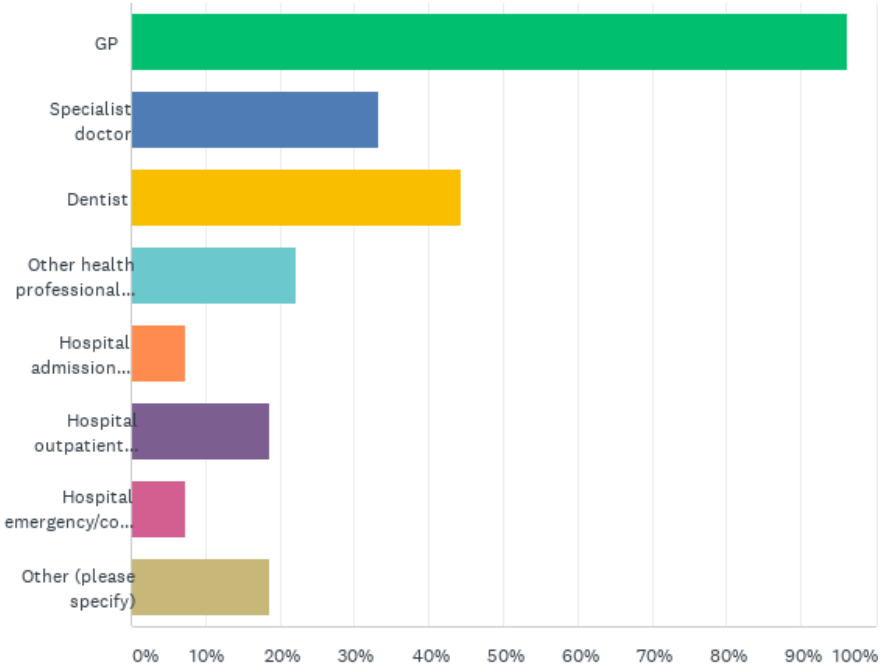
Q: How often do you visit your GP?



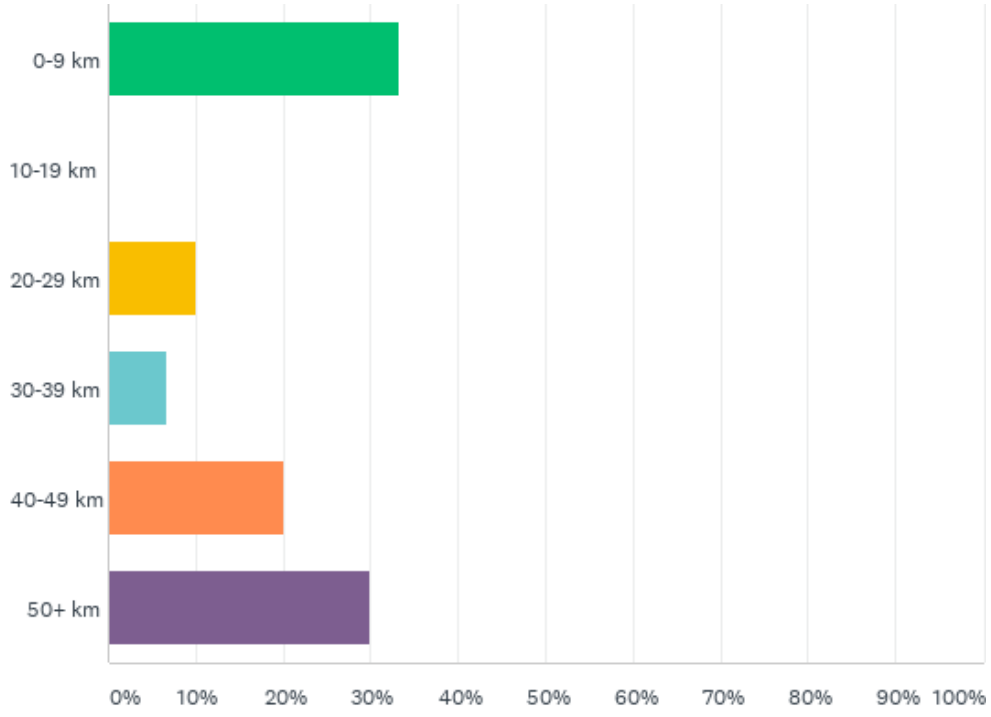
Q: Do you tend to go for regular check-ups or for emergencies?



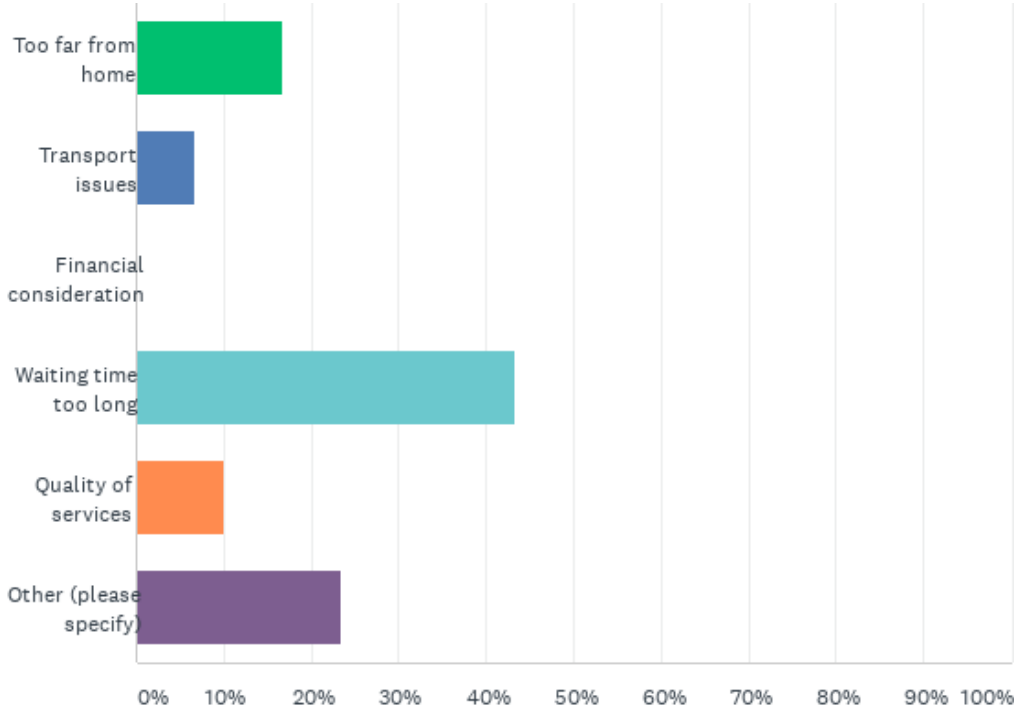
Q: If yes, which of the following services do you tend to go to?



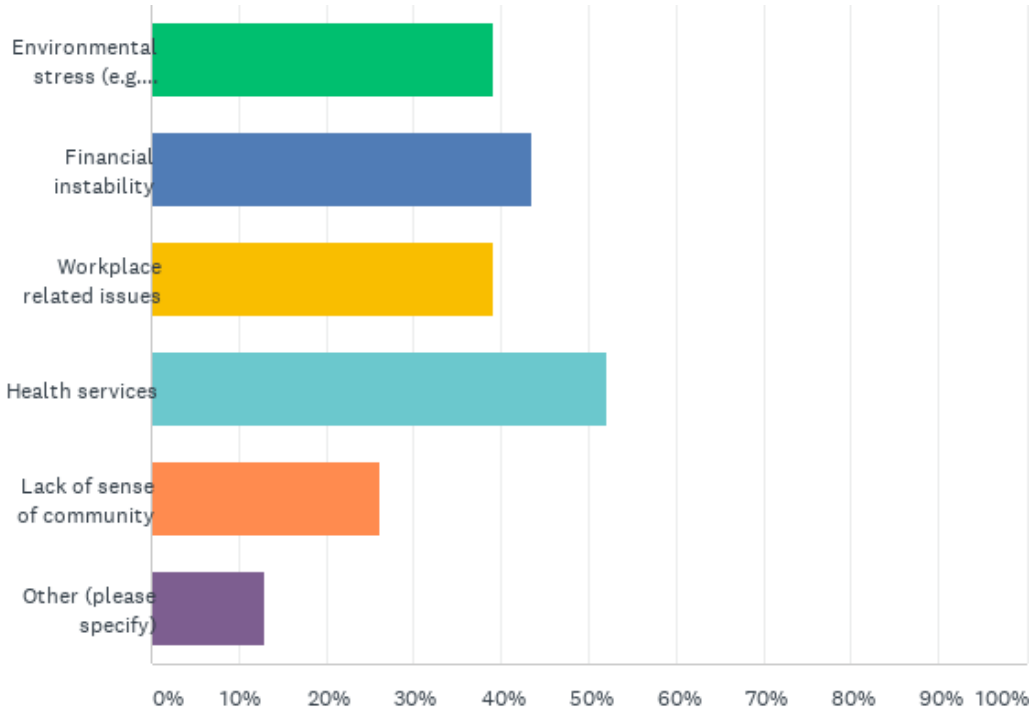
Q: How far do you have to travel to get to health and well-being services?



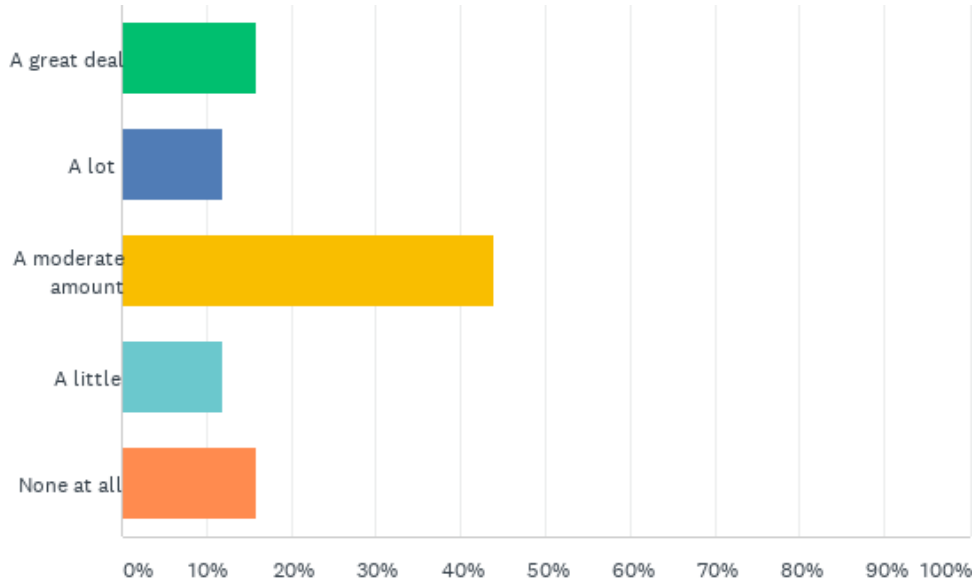
Q: What do you feel are the main challenges in accessing health services?



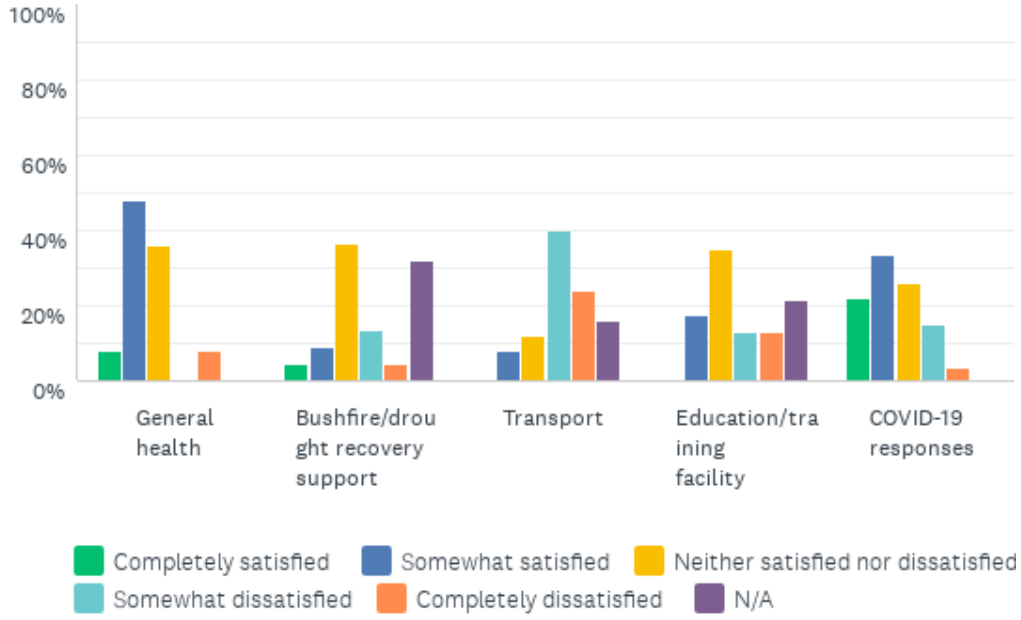
Q: Do any of the following factors negatively influence your general well-being?



Q: To what extent are you impacted by the factors you have identified?



Q: How satisfied are you with the following services?

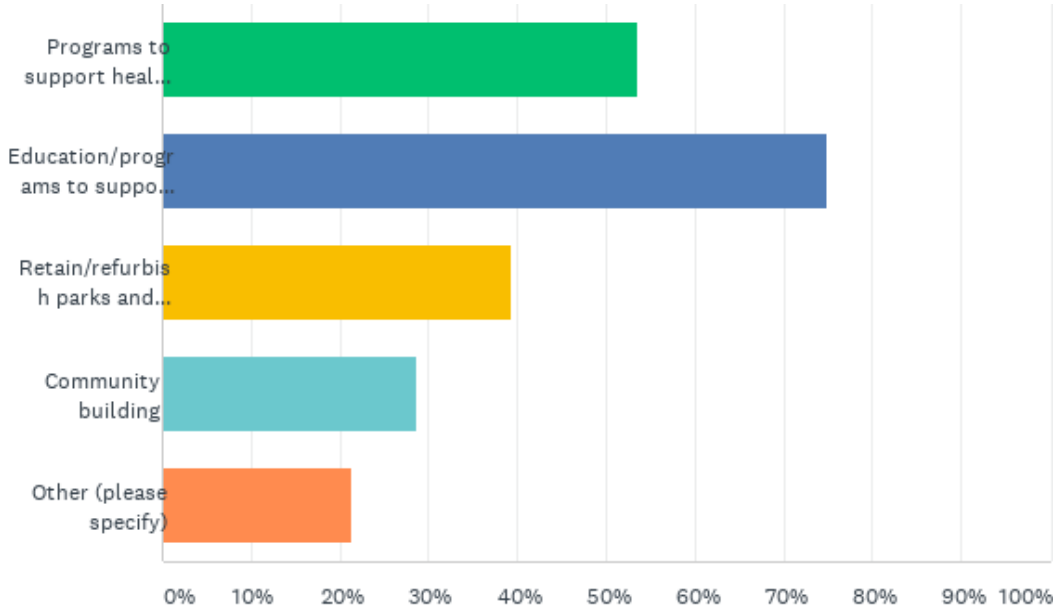


	COMPLETELY SATISFIED	SOMEWHAT SATISFIED	NEITHER SATISFIED NOR DISSATISFIED	SOMEWHAT DISSATISFIED	COMPLETELY DISSATISFIED	N/A	TOTAL	WEIGHTED AVERAGE
General health	8.00% 2	48.00% 12	36.00% 9	0.00% 0	8.00% 2	0.00% 0	25	2.52
Bushfire/drought recovery support	4.55% 1	9.09% 2	36.36% 8	13.64% 3	4.55% 1	31.82% 7	22	3.07
Transport	0.00% 0	8.00% 2	12.00% 3	40.00% 10	24.00% 6	16.00% 4	25	3.95
Education/training facility	0.00% 0	17.39% 4	34.78% 8	13.04% 3	13.04% 3	21.74% 5	23	3.28
COVID-19 responses	22.22% 6	33.33% 9	25.93% 7	14.81% 4	3.70% 1	0.00% 0	27	2.44

Q: What things are having a NEGATIVE effect on the wellbeing or quality of life of people in your community?

Responses
“people drug affected in supermarkets @STREETS SWEARING @Abusive”
“Access to services that metro people have every day and take for granted. I had to phone an ambulance recently and had to wait 30 minutes for one to come from Port Augusta. Not having phone coverage in areas just out of town. No ATMs when the IGA isn't open on a weekend. The positives outweigh the negatives, but there is a huge disconnect between what is available in the regions vs what is in the cities.”
“Level of health services available close to home”
“To many drug addicts walking around messing stuff up. One tried to car jack a friend”
“Lack of health services”
“Lack of Govt services... Private services must be in competition with private not taking over...Train transport is the best transport for people with disabilities, older people, people with children and tourists to bring life to communities... Provide Govt services and people will use them... ALL TAFES should be running community classes for art and craft, how to manage in times of stress and how to manage life generally life skills and these should be available in all regional centres and then classes” available in nearby country towns
“ No mental health support services of any use. No public transport. Long distances to access specialist treatment.”
“ Dry season distances to services and facilities our metropolitan counterparts can just take for granted”
“Rising costs of the weekly shopping for food etc. cost of fuel, Increases in council rates, private health, aged care facilities/ services.”
“No mental health recourses in the community. There is also nothing for the younger generation and they have to leave to find employment or study.”
“Ageing population, services available. Ability to get use of available services. “
“ No mental health service”
“lack of mental health assistance”
“ Lack of permanent doctors and health services”
“lack of public transport minimal mental health support although aware that it is being addressed”
“Finance and weather “
“Access to mental health services. I currently have to take my children to Adelaide, Port Pirie and Port Augusta to access appropriate services.”
“Bullying and sexual harassment in the workplace”
“Ongoing drought.”
“Drought Social isolation”
“Environmental factors, financial factors, social issues, lack of services.”
“Isolation”

Q: What is needed to improve health and well-being in your area?



Q: What more can be done to improve the quality and accessibility of health and well-being services?

Responses
"qualified people to do exercise classes, fix up local beach"
"Pay doctors more to work in the regions so they will move here! It needs to make financial sense to them. I worry that once our doctor retires, we will have very little healthcare available locally at all"
" Improve green areas including more street trees. Pressure government for more mental health services. Identify some drug mitigation strategies"
"Restore services removed. Bring people to country areas. Provide train services right around the state. Get people of the roads and into trains. Provide more services. NGOs are important as is not for profit organisations. There needs to be a massive Govt home building project in all areas including country towns... Why are we not providing housing at an affordable price for Australians? Importing people by the million and not providing enough housing, health, train and education and shopping services is disgusting for any Govt. Tired of the ideology of politicians and public servants who are self-serving. SA is not just Adelaide. It is the whole state so start by providing for the whole state."
"with regards to MHealth provide consistency in services, cut waiting times to access health services (general and MH), Help the town to find another GP so the current one can retire, properly fund health services, we used to have a pro-active approach to health and lifestyle which worked well. bring that back. Education wise.... from what I have heard.... get a decent principal who is more compassionate, and community minded to get our school back to a place where kids/parents want to go"
"More services "
"Families in regional areas are heavily burdened with difficulties of distance from specialist services. The cost and frequency of long-distance travel, the difficulties families face to meet the needs of the rest of the family when one member requires frequent or prolonged medical services 100- 300 km from home. There are so many examples of hardship that distance from the appropriate support

can impact individuals and families. Wellbeing is something that many individuals possess in spite

of the inadequacies of the health system or community services available."
"Regional areas need for funding for everything. Health, recourses, drought support. We are usually forgotten by the government."
"Encourage services to come to smaller communities."
"more money "
"Maintain and increase Health Services IN OUR Community - NOT in another community!!!"
"More GP services "
"Highly qualified practitioners."
"Tell Canberra to stop cutting services, it's appalling that we see services cut in a wealthy society. No doubt you need to pay for corporates welfare somehow. Nothing like taking money of poor people to give it to rich mates who don't need it."
" More GPS. More allied health professionals locally."

Survey 2

The second survey we analysed came from Caltowie (near Jamestown), which was undertaken by participants of the "Chilled out and fired up" music festival in between 25 May 2021: it had 29 respondents. This music festival was held to raise funds for mental health awareness and initiatives in rural communities and the following questions were asked: -

Question 1: In your opinion what is the current mental health/ suicide situation in regional South Australia? Is it getting worse, the same or better compared to a few years ago?

Question 2: Based on your answer above, what do you believe has contributed or the cause of mental health issues locally?

Question 3: Do you believe there is adequate access to mental health services in your local area? Please explain.

Question 4: In your opinion, what do you think would help improve mental health wellbeing in the region? Please be specific

Key Summary Points:

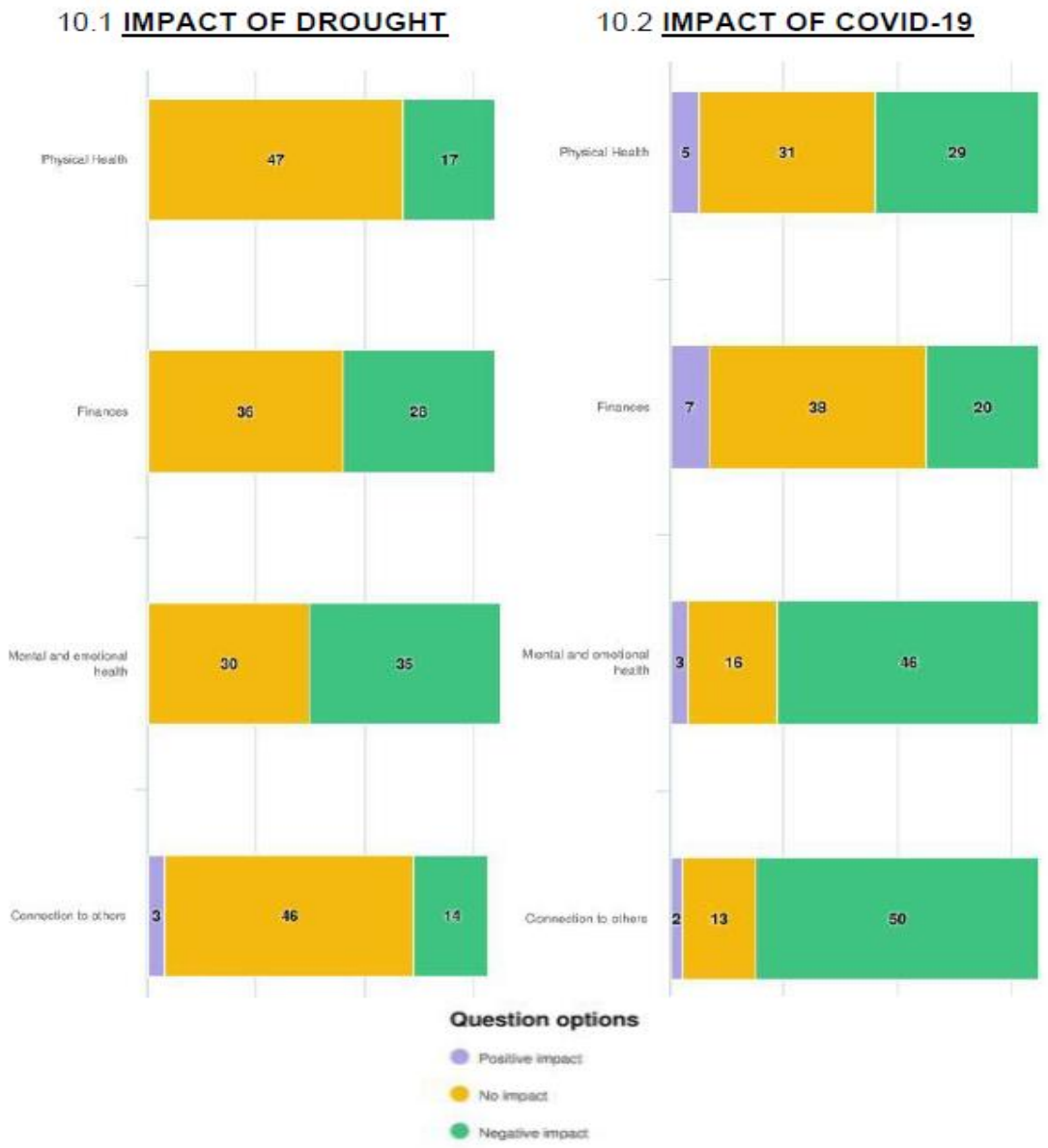
- 23 out 29 respondents said the mental health situation had become worse
- Many respondents complained about the reduction of face-to-face services and asked no toll-free Phone
- There was consensus that there was a lack of mental health services.
- Respondents called for greater community awareness and more mental health services

Survey 3

Finally, the Northern Councils (NGC) including Clare and Gilbert Valleys, Northern Areas and Regional Goyder delivered an online community health and wellbeing survey in September

2020, which sought to get community members to identify their key priorities for a healthy and well NGC community.

In response to recent adverse events which have impacted the region, such as long-term drought and the COVID-19 pandemic, the community was also asked what they thought had been the impact on their wellbeing and health - physical, finances, mental and emotional, and connection to others. The results shows that over one third of respondents mentioned the drought had impacted their mental health. COVID-19 had further deteriorated this situation with 46% respondents claiming their mental health was negatively affected.



Discussion

Overall, whether via interviews of the three surveys, a number of commonalities emerged. There is a clear message that currently there are major gaps in place based, face to face mental and wellbeing services in the region.

The lack of mental health services is often perceived as a major contributor to the deterioration of rural and regional people's wellbeing. In particular, substantial waiting times and long travelling distances to access professional services not only escalate the mental illness of people, but also create frustration for those who are struggling for help. However, the lack of services also serves as a warning sign of deeper issues that are hurting the affected communities including: band-aid approaches to mental health; a lack of support for primary health care; insufficient coordination between stakeholders; and a lack of long-term vision or viable strategy that helps people.

The findings of this study enable us to deeply reflect on what wellbeing means, and whether indeed, the support for more mental health services is available in the northern parts of the Legatus region.

Shifting from a service focus to social determinants of health

As discussed in the earlier section, wellbeing is a complex idea and consists of several aspects. Neither wellbeing nor mental health is an independent factor but they are closely associated with economic, social, cultural and environmental situations. There is convincing evidence in the literature that poverty and unemployment, loneliness, social exclusion, stigma or uncertainties caused by worsening climate change-related conditions will endanger people's wellbeing and mental health conditions (Lawrence-Bourn et al., 2020).

The results from our survey clearly show that when health services (51%) comprise one major factor influencing people's physical and emotional health, other issues such as financial instability (42%), environmental stress (39%), workplace-related issues (39%) and lack of sense of community (25%) are also key issues. The community survey conducted by the Chilled Out and Fired Up Music Festival working group strongly indicates that wellbeing and mental health are linked to many aspects as documented in the box below.

Survey Question: What do you believe has contributed to or the cause of mental health issues locally?

"Lots! Unemployment, anxiety over Covid, rapidly changing societal expectations, individual's fear of self-expression so as not to appear "weak"...plus no doubt many more stressors."

"Social media, lack of work in rural areas, a rise in domestic violence, bullying, anxiety in children. Family break ups."

"Redundancy in industries, uncertainty of future, Covid, struggle for income."

"Cost of living/quality of life. Poor educational and health spending."

"Possibly increased drug use."

"Lack of employment, affordable housing and social options...a side note to this is young ones moving away leaving those who stay feeling abandoned and isolated."

"Family circumstances/issues/stress."

"Drugs/alcohol/living in rural/isolated areas contributes to low interaction with friends and struggles having hobbies and interests."

"Rural areas have less job opportunities and can leave people unemployed and having money struggles."

Furthermore, taking Peterborough as an example, Wellbeing SA statistics from 2018 to 2020 (refer Table 1 &2) show that it manifests the most worrying mental health scenario (45.7%), compared to SA overall (28.6%) and metropolitan SA (29.3%). Similarly, respondents from Peterborough were more likely to report having high or very high psychological distress (34.5%), compared to SA overall (19.9%) and metropolitan SA (21%). Peterborough has the highest unemployment rate (13.5%) and also rates for current and daily smoking (34.5%) in the Northern region. Nearly a quarter (23.2%) of respondents from Peterborough reported they had run out of food and could not afford to buy more. It is clear that mental illness is a merely a symptom of deeper and serious social and economic problems. Clinical treatment and social support systems for people with mental illness are not a panacea to resolve the prevalence of mental illness. Wellbeing and mental health issues are very complex and there are no easy solutions.

Several interviewees [17][18][19] expressed their concern that discussions focus too much on "services" especially the need for psychologists or psychiatrists. One interviewee [18] who has worked extensively in the public mental health sector in regional area, commented: *"it is always welcome to have more psychologists working here but the reality is this would hardly happen.*" He pointed out that *"not all psychologists want to stay and work in Port Pirie or more*

remote areas" and most young professionals wanted a better lifestyle. As a result, it was extremely challenging to recruit and retain mental health professionals into the regions,

especially given the shortage of mental health clinicians which is a national-wide issue. *"I fully understand why locals want to have psychologists in their towns but I think, our focus should be on social determinations of health."* He explained that if the councils could improve the job market and support more facilities and activities so that people could have more opportunities for "connecting to others", this could to some extent alleviate the increasing mental health issues more effectively than costly clinical treatment for individuals.

Another interviewee [17] also questioned if people would really visit psychologists for help when the social stigma remains to do so is still very pervasive in rural areas. While she agreed that the presence of local-based psychologists would reduce the waiting times for those who were in the mental health care system, she worried the services would not reach the group who needed the most support but were still reluctant to seek help. During the interviews, some respondents [17][19] also suggested that more disaster-recovery funding should be allocated to community mental health programs because better community wellbeing not only can alleviate mental health problems; it can become a massive injection of capital into regional development. People would trust each other and solve the challenges (e.g. economic recession, disasters, etc.) together. In sum, our study indicates that provision of adequate mental health support services is important, but it is critical to think beyond treating illness. Economic, environmental, social and personal factors need to be urgently addressed.

Lack of appropriate mental health services is the problem

Our findings collectively suggest that the key problem may not lie in the lack of mental health services per se, as there are at least 58 services found in the region. Nonetheless the problem lies instead in the fact that these services are fragmented, differentiated from town to town, hard to navigate and fail to reach the people who are most need help. Indeed, service inappropriateness not only happens in the Northern Region but throughout Australia. Louise Stone and Christine Phillips, mental health scholars from Australian National University, criticise the current mental health policy for a situation that too often results in people who have the deepest need, receiving the least care (Stone and Phillips 2020). They point out that it is encouraging that the Federal government showed a commitment to mental health services, for example, in the 2020-2021 budget, where it announced A$7 million for mental health organisations Beyond Blue, Headspace, Kids Helpline and Lifeline. Furthermore, it has doubled Medicare-subsidised sessions (from 10 to 20 sessions/ per year) for seeing a psychologist or psychiatrist which will cost over A$100 million.

These policies are welcome; however, even so, the most vulnerable groups will benefit the least: organisations such as Beyond Blue, Headspace, Kids helpline and Lifeline only provide a narrow spectrum of care to those who tend to be resourceful, are literate in English, urban, and have more easily treated mental health conditions. The Medicare-subsidised programs

only favor those who can afford the co-payments and live in areas where psychologists are available. In fact, to restate the problem, people with the deepest need tend to receive the least care.

The findings of this study clearly show that difficult to navigate services and telecommunications-based services have discouraged local residents, particularly the farming communities from seeking help when they feel anxious and depressed.

Our study indicates the introduction of regional-specific, culturally appropriate mental health services with more outreach efforts, face-to-face as well as culturally safe services are urgently needed in order to improve the effectiveness of current mental health services in the region.

For example, such a service gap was found in mental health-related workshops. One interviewee [7] said he could not see any benefit arising from these activities: *"some organizations contacted our council to have a suicide prevention workshop. The workshop was held in the evening time and targeted for everyone. At the end there were only few participants"*. He made the criticism that service providers often offered the services without a good understanding of the local context. *"Social stigma is remaining prevalent in our community. Many farmers live far and are busy for farm work. How do we expect people will drop by and participate in the workshop in the town?"* In our interviews, many interviewees [[4][5][8][10][11][17][22] collectively urged us to document the fact that residents needed the service "in the region". That means, the person would understand their difficulties and provide the mental support in a safe and non-confronting way.

Similar findings were confirmed within the community survey done by the Chilled Out and Fired Up Music Festival working group. For the survey question, "What do you believe has contributed or the cause of mental health issues locally", besides the complex social and economic issues, some respondents believed *"the reduction in face-to-face services with funding being pushed into online or telephone support"* had worsened the situation. In another question, "Do you believe there is adequate access to mental health services in your local area", a majority of respondents answered "No". A respondent from Jamestown wrote that *"Toll-free numbers toll-free numbers/government-funded free help don't follow up like they say. Therapy options are extremely limited, long wait lists and often cost too much for average people."*

The comment was made that *"[we need] more options if travelling but not everyone can afford it."* Another resident from Jamestown felt that services were adequate *"but you need to ASK for it. I think that it is important for people to realise that help is there if they ask for it. However, with Peterborough closing its Medical Centre, it is going to be very hard for people from the area to see a GP and make the first move in getting help."* It appears both from the interviews,

survey results and other research work, additional support is not simply about adding more services but rather needs to be to ensure the current medical health services can be reached by the people who need help. The services' design and delivery should be more tailor-made.

In the case of the Northern region, it is more than just outreach efforts and face-to face services.

It is also vital to establish a hub so people can meet to support each other and get the services they need. The local councils and locally-based NGOs can play more active roles in filling current services gaps.

Improving the involvement of local councils and local-based NGOs in mental health issues

In our study, it is clear that local councils do not play any role in mental health services. All the Mayors and local government officers we interviewed pointed out that traditionally, health was a matter for the State and Federal governments. Consequently, they were not consulted and did not know the details about the services. When asked how the local residents could get the available mental health services information, a Mayor responded: *"probably people should go to GPs rather than council office as we don't have any information at all."* Another council officer admitted there were no regular meetings between funding agencies, mental health service providers and the council. Not until very recently did he try to arrange a stakeholder meeting and hoped the information sharing could help clarify the mental health services situation. One service provider [21] responded that they never did any consultation with the councils: *"Why do we need to talk to the councils? We only need to report to our funders. The services we need to provide are all detailed in the contract. We need to follow the contract."* Another service provider [12] explained that technically they only needed to report to the funding agencies. However, as a local-based charity organization, they had very close contacts with local councils and local communities, and therefore they knew how to approach the people who need support. To fill the gaps in the above-mentioned services, our findings suggest that it is important to get the councils and local-based NGOs involved in the current mental health system.

Primary health care and community connectedness as the foundation for Wellbeing

Local services, with connections to local GP services are seen as fundamental to and the foundation for achieving regional wellbeing. Again, there needs to be wider incentives to attract GPs to the region and explicit understanding of the specific community contexts in order to tailor and deliver appropriate community services. Further, the development of a specific marketing, education and awareness campaign that engages locals to understand and raise awareness not only about wellbeing but the services available is needed. This in turn builds community connectedness within the primary health care services. The recent closure of many place-based GP and medical centres significantly weakens the opportunities for proper mental health and wellbeing service delivery.

Conclusion and Recommendations

To fill the gaps in current services, our study shows that the project areas need more region-specific, long-term and culturally appropriate strategies and systems put in place. The Family and Business Support Program (FaBS) was cited as being a good program – this model should continue and be strengthened. Furthermore, the findings have clearly informed the imperative need for better regional coordination to: 1) assist the local communities to access mental health services; 2) support service providers align their services with the local needs, as well as; 3) collaborate with local councils to get more resources so that local wellbeing is properly invested in.

The recommendations below summarise / set out what health authorities and stakeholders can actively do to improve the mental health services in the regions. The objective is for the community to get the best return from the services.

- Build effective and meaningful communication links between the local governments, regional agencies, service providers and local communities.
  i. Establish a Mental Health Coordinator who will be the central focal point of contact providing mental health service information in the region, facilitating meetings with various stakeholders, supporting local councils for local wellbeing plans, as well as collaborating with these councils for grant applications.
  ii. At the community level, establish a (virtual) hub as a central point so that people can have better access to the resources relating to mental health, share their experiences, and receive practical advice on how to access the services.
- More investment in early intervention and appropriately equipped clinical services.
  i. Support more basic and well-located mental wellbeing staff who can do mental health training in terms of first aid, basic understanding of the suicide risks, and who are already involved in the industry and farmer community (prior to escalation)
  ii. Place-based psychologists.
- Focus on community awareness and capacity building

For the long-term, there is an urgent need to respond to the deterioration of mental health in the local communities due to the severe drought and other climate-related issues:

- Invest in an education and awareness campaign so that communities know where to go to access services.
- Councils, PIRSA and RDAs to work with farming communities to invest in the creation of value adding economic alternatives (e.g. tourism) to provide buffers against climate-related problems like drought.
- Invest in more mental health and wellbeing services in the regions including more rural counsellors and wellbeing hubs in each community.

- Prioritise resilience initiatives that focus on specific wellbeing issues created by or related to climate change, e.g., men's and women's support groups.

- Prioritise farming communities' mental health support services and differentiate them where it is important to do so.
- Build several demonstration sites and training packages that support farmers' ability to respond to drought and in turn build wellbeing by enhancing economic resilience – some examples from other regions include: (i) perennial pastures; and (ii) weed and feral animal control in times of drought.
- Invest in initiatives that create opportunities for farming and regional communities to 'value add' in different ways to their economic activities. This will build economic resilience and people's overall wellbeing.
- Build networks within communities in effective ways – find community champions who can help build networks – the more networked a community, the better people will cope with adversity. An example is to set up a community centre that brings together affected people to share ideas, resources, hold events, etc.
- Undertake targeted research that addresses these recommendations.
- Work with the resources and networks provided by the Drought Resilience Fund.

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Addendum 1: Extension of Family and Business Support Officers

The 15 member councils of the Legatus Group have extended their appreciation to the South Australian Government for the two expanded Family and Business Support (FaBS) Officer roles, occupied by Anthony North and Emma Scharkie, who have been employed in the region. Their contracting followed the November 2019 Legatus Group decision to support the proposal by the Councils of Orroroo Carrieton, Peterborough, Flinders Ranges, Northern Areas, Mount Remarkable, Port Pirie and Goyder to actively seek increased support for mental health due to the impacts of the drought.

Discussions were held in December 2019 with Premier Marshall, then Minister for Primary Industries the Hon. Tim Whetstone, the Minister for Health and local member the Hon. Dan Van Holst Pellekaan to propose a joint approach between Primary Industries and Regions SA (PIRSA), Health SA and Local Government to bring more services to the region.

The District Council of Orroroo Carrieton continued advocacy efforts on behalf of the Northern Council's (aforementioned) affected by drought. In May 2020, the advocacy efforts resulted in a collaborative approach with PIRSA to expand the existing FaBS program. The expanded roles included core objectives regarding face-to-face outreach for individuals in need. As well as collaboration with relevant agencies such as local government, health services and relevant NGOs to bring some additional coordination of existing drought response.

The March 2021 Legatus Group meeting endorsed a review of their November 2019 decision. Their June 2021 meeting was provided with the initial findings of the Wellbeing Gap Analysis, this cited these 2 FaBS positions as an effective program which should be strengthened. The meeting also heard from the District Council of Orroroo Carrieton Mayor Kathy Bowman that the 2 positions contracts are due to expire on 30 June 2021. The Legatus Group then approved a motion that as a matter of urgency it requests for the extension of the current 2 FaBS Officer positions beyond the 30 June 2021 by lobbying the South Australian Government.

At the time of the Wellbeing Gap Analysis report being completed the Legatus Group have delivered a letter to Hon. David Basham MP Minister for Primary Industries and Regional Development and Hon. Dan van Holst Pellekaan MP whilst also engaging with PIRSA to gain support for the extension of the 2 positions and to progress discussions to improve the effectiveness of current mental health services in the region.

The Legatus Group have been advised by Anthony North and Emma Scharkie that they have been invited to submit for consideration and extension of their contracts.

At the time of this report being finalised the Legatus Group have yet to hear from the Ministers.

Addendum 2: The South Australian Population Health Survey (SAPHS) (Wellbeing SA)

Background and Methodology

The South Australian Population Health Survey (SAPHS) is a state-wide population health survey managed by Wellbeing SA, which aims to monitor the health status of all South Australians. The SAPHShas been collecting information about the health of South Australians since July 2018.

Population health surveys play an important role in the development of health services by providing information to policy makers, providers and researchers about the health of the community, the
performance of the health care system, and its impact on people of varying social, economic, and illness levels.

This survey remains the principle source of information on population health and is used extensively by Wellbeing SA, SA Health and other non-Government organisations. Collectively the information from SAPHS is used to:

- provide high quality, representative data on the health of the South Australian population
- identify sub-groups of the community who experience less than satisfactory health outcomes
- identify emerging health issues
- measure trends over time for key health indicators
- monitor and evaluate population health policy, programs and initiatives
- share findings with relevant professionals, researchers and policy makers within SA Health, LocalHealth Networks and the wider community
- address State and Commonwealth indicators and targets
- be an ongoing source of data for key reports including the Chief Public Health Officer's Report and the South Australian Public Health Indicator Framework

The data presented in this report include a range of health and wellbeing outcomes by the following LocalGovernment Areas (LGA):

- Flinders Ranges
- Goyder
- Mount Remarkable
- Northern Areas
- Orroroo/Carrieton
- Peterborough
- Port Pirie City and Districts

Data for each indicator are also presented for overall South Australia, and metropolitan South Australia for comparison.

Data collection

The SAPHS is a cross-sectional population CATI (computer-assisted telephone interview) survey. To maximise participation, respondents are also offered the option of completing the survey on-line (CAWI, computer-assisted web interview) by receiving a unique hyperlink. A dual frame over-lapping sampling technique of mobile phone and landlines are used to collect information from a representative sample of South Australians, using random digit dialing (RDD). The majority of respondents are contacted via mobilephone.

Data are collected every month and anyone with access to a phone can participate in the survey. This survey has been reviewed and approved by the SA Health Human Research Ethics Committee. All answers are confidential, and results are presented in a form that does not allow any individual's answers to be identified. This report presents data for the period July 2018 to December 2020.

Weighting and presentation of data

The data presented in this report are weighted. Weighting is a technique for adjusting unit record survey data to enable population estimates to be made by statistically increasing or decreasing the numbers of cases with particular characteristics so that the proportion of cases in the sample are adjusted to the population proportion. A technique known as 'raking' was used to weight respondents incorporating various population characteristics (sex, age, area of residence, country of birth, dwelling status, marital status, education level, employment status, household size) designed to more closely reflect the South Australian population using benchmarks derived from the June 2016 ABS Census data.

The weighting of data can result in rounding discrepancies or totals not adding. Non-relevant responses such as 'don't know' and 'refused' have not been included in the analysis apart from when it is stated.

Data are not presented for counts ≤5.

Statistical analysis

Data preparation and analysis were completed using SPSS 24 software. Excel 2010 was used to collate tables. The weighted proportion of people who respond to each category of the attribute are presented in the tables along with the 95% confidence interval. Statistical significance is considered when the 95% confidence intervals for prevalence estimates do not overlap. A confidence interval is a range in which it is estimated that the true population lies.

Disclaimers

Data are not age-sex standardised. Different age and sex structures of the population over time may havean influence on prevalence rates. Non-relevant responses such as 'don't know', 'refused', or 'didn't apply' have not been included in the analysis unless stated.

Aboriginal is used in this document respectfully as an all-encompassing term for Aboriginal and TorresStrait Islander people, health and culture.

Demographics

The weighted sample of all SAPHS respondents aged 18 years and over from July 2018 to December2020 is presented in Table 1.

Table 1: Weighted sample, SAPHS July 2018 to December 2020 (n=21198)

		n	%	95% CI
All		**21198**	**100.0**	
Gender	Male	9902	46.7	46.0-47.4
	Female	11290	53.3	52.6-53.9
	Gender diverse	4	<0.1	
	Prefer not to say	1	<0.1	
Location	Metropolitan	15228	71.8	71.2-72.4
	Rural	5969	28.2	27.6-28.8
Age	18-29	4301	20.3	19.8-20.8
	30-49	6072	28.6	28.0-29.3
	50-69	7145	33.7	33.1-34.3
	70 and over	3679	17.4	16.9-17.9
Aboriginal and/or TorresStrait Islander Status	Yes	448	2.1	1.9-2.3
	No	20641	97.4	97.2-97.6
	Not stated	110	0.5	0.4-0.6
SEIFA*	Lowest	4261	20.1	19.6-20.7
	Low	4657	22.0	21.4-22.6
	Middle	4648	21.9	21.4-22.5
	High	3824	18.1	17.5-18.6
	Highest	3788	17.9	17.4-18.4
Highest Education Level**	No school to secondary	9520	44.9	44.2-45.6
	TAFE, trade, certificate	4495	21.2	20.7-21.8
	Diploma, advanced diploma	3380	15.9	15.5-16.4
	Degree or higher	3662	17.3	16.8-17.8
	Not stated	135	0.6	0.5-0.8
Household Income	Up to $20,000	2054	9.7	9.3-10.1
	$20,001 - $40,000	3099	14.6	14.1-15.1
	$40,001 - $60,000	2636	12.4	12.0-12.9
	$60,001 - $80,000	2247	10.6	10.2-11.0
	$80,001 - $100,000	1674	7.9	7.5-8.3
	$100,001 - $150,000	2457	11.6	11.2-12.0
	More than $150,000	1916	9.0	8.7-9.4
	Not stated	5115	24.1	23.6-24.7

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.

*SEIFA: Socio-Economic Index For Areas. **Education status 'other' (n =5) not shown

Table 1 – continued

		n	%	95% CI
Work Status	Full time employed	6880	32.5	31.8-33.1
	Part time employed	3237	15.3	14.8-15.8
	Casual	1531	7.2	6.9-7.6
	Unemployed	921	4.3	4.1-4.6
	Engaged in home duties	519	2.5	2.2-2.7
	Student	982	4.6	4.4-4.9
	Retired	5082	24.0	23.4-24.6
	Unable to work	1285	6.1	5.7-6.4
	Other	168	0.8	0.7-0.9
	Carer	243	1.1	1.0-1.3
	Volunteer work	243	1.1	1.0-1.3
	Not stated	106	0.5	0.4-0.6
Marital Status	Married/Living with partner	11193	52.8	52.1-53.5
	Separated / divorced	2947	13.9	13.4-14.4
	Widowed	1459	6.9	6.5-7.2
	Never married	5312	25.1	24.5-25.6
	Not stated	287	1.4	1.2-1.5
Children (including babies) under 16 years in the household	0	17687	83.4	82.9-83.9
	1	1658	7.8	7.5-8.2
	2	1106	5.2	4.9-5.5
	3	349	1.6	1.5-1.8
	4	89	0.4	0.3-0.5
	5+	43	0.2	0.1-0.3
	Not stated	267	1.3	1.1-1.4
Language spoken at home	English	19376	91.4	91.0-91.8
	Other	1758	8.3	7.9-8.7
	Not stated	64	0.3	0.2-0.4
Country of birth	Australia	15348	72.4	71.8-73.0
	UK / Ireland	1823	8.6	8.2-9.0
	Other	3930	18.5	18.0-19.1
	Not stated	97	0.5	0.4-0.6
Dwelling type	Owned or being purchased	14228	67.1	66.5-67.7
	Rented privately	1144	5.4	5.1-5.7
	Rented from the Housing Trust	4981	23.5	22.9-24.1
	Retirement village	359	1.7	1.5-1.9
	Other	228	1.1	0.9-1.2
	Not stated	258	1.2	1.1-1.4

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.

Subjective Individual Wellbeing

Respondents were asked four questions relating to their wellbeing "Overall, how satisfied are you with your life nowadays?", "Overall, to what extent do you feel the things you do in your life are worthwhile?", "Overall, how happy did you feel yesterday?", and "Overall, how anxious did you feel yesterday?" For eachof these questions respondents gave a number between 0 and 10 where 0 meant not at all and 10 meant completely.
The four wellbeing questions were then used to categorise respondents into three groups; those with good wellbeing, those with poor wellbeing, and those who were neutral[1]. Respondents were considered to have good wellbeing if they scored well on all four questions:

- A score of 8-10 for life satisfaction, life being worthwhile, feeling happy yesterday and 0-2 for feeling anxious yesterday.

Respondents were considered to have poor wellbeing if they scored badly on at least one measure:

- A score of 0-4 for life satisfaction, life being worthwhile, feeling happy yesterday and 6-10 for feeling anxious yesterday.

All other respondents were considered to be neutral.

Table 2 presents the proportion of adults reporting individual subjective wellbeing measures by selectedSouth Australian LGAs. The proportion of adults reporting good wellbeing ranged from 44.8 to 56.6 percent across the LGAs. Respondents from Goyder (56.6%), Northern Areas (50.4%) and Port Pirie (45.7%) were more likely to report good wellbeing compared to SA overall (38.2%) and metropolitan SA (36.4%) respondents.

Table 2: Proportion of adults (18 years and over) by overall subjective wellbeing status (SAPHS† July 2018 to December 2020)

	Good wellbeing		Scoring neither well nor badly (neutral)		Poor wellbeing	
	n/N	% (95%CI)	n/N	% (95%CI)	n/N	% (95%CI)
SA Overall	**7900/20690**	**38.2 (37.5-38.8)**	**7474/20690**	**36.1 (35.5-36.8)**	**5315/20690**	**25.7 (25.1-26.3)**
Metropolitan SA	**5402/14841**	**36.4 (35.6-37.2)**	**5496/14841**	**37.0 (36.3-37.8)**	**3942/14841**	**26.6 (25.9-27.3)**
LGA						
Flinders Ranges	11/24	45.1 (27.3-65.3)	-	-	9/24	39.5 (20.4-57.4)
Goyder	35/62	56.6 (44.1-68.3)	18/62	29.2 (18.9-41.1)	9/62	14.2 (7.4-24.8)
Mount Remarkable	29/65	44.8 (33.0-56.7)	23/65	36.0 (24.6-47.4)	12/65	19.2 (10.5-29.1)
Northern Areas	39/77	50.4 (39.6-61.6)	29/77	37.0 (27.5-48.8)	10/77	12.6 (6.9-21.8)
Orroroo/Carrieton	12/26	46.8 (28.2-64.9)	10/26	36.7 (21.8-57.6)	-	-
Peterborough	30/66	45.3 (33.9-57.4)	18/66	27.0 (17.7-38.8)	18/66	27.8 (17.7-38.8)
Port Pirie Regional	90/196	45.7 (39.0-52.9)	67/196	33.9 (27.8-41.0)	40/196	20.4 (15.2-26.5)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.Data not shown for LGAs ≤ 5 counts.

[1] Abdallah, S. and S. Shah, Well-being patterns uncovered: an analysis of UK data. 2012, New Economics Foundation: London

Health care utilisation

Patterns of health service use can reflect on patterns of illness as well as the availability and accessibility of health services and the ways people choose to use them. Respondents were asked how many times in the last 12-months they had used a general practitioner (GP), dentist, specialist doctor, hospital admission(in-patient), hospital outpatient clinic, emergency department (ED), and other health service. Respondents who had used hospital in-patient, outpatient and ED services are grouped together and were considered as visiting hospital in the last 12 months.

Table 3 presents the proportion of adults using a general practitioner (GP) in the past 12-months. GP visitation ranged from 83.4% to 98.1% across the LGAs. Respondents from Peterborough (98.1%) were more likely to reporting visiting a GP compared to SA overall (91.3%) and metropolitan SA (91.0%) respondents, while respondents from Mount Remarkable (83.4%) were less likely compared to SA overall.

Table 4 presents the proportion of adults using a dentist in the past 12-months. Visitation ranged from 30.0% to 69.8% across the LGAs, and respondents from Goyder (30.0%), Peterborough (34.6%), and PortPirie (46.6%) were less likely to visit a dentist, compared to SA overall (54.7%) and metropolitan SA (56.2%) respondents.

Table 5 presents the proportion of adults using a specialist doctor in the past 12-months. Visitation rangedf rom 31.5% to 55.8% for the LGAs. Respondents from Peterborough (31.5%) were less likely to report using a specialist doctor than the SA overall (47.4%) and metropolitan SA (47.6%) respondents.

Table 6 presents the proportion of adults visiting a hospital (admission, outpatient clinic, and emergency/casualty department) in the past 12-months. Visitation ranged from 27.5% to 56.9% across the LGAs, and respondents from Goyder (56.9%) and Port Pirie (43.4%) were more likely to visit a hospital than SA overall (35.3%) and metropolitan SA (33.9%) respondents.

Table 7 presents the proportion of adults using any of the above-mentioned health services in the past 12-months. Visitation ranged from 93.1% to 100.0% for the LGAs. Respondents from Orroroo/Carrieton (100.0%) and Peterborough (99.8%) were more likely to report using any health service than SA overall (95.7%) and metropolitan SA (95.6%) respondents.

Table 3: Proportion of adults (18 years and over) reporting using a general practitioner (GP) in the past 12-months, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**19183/21007**	**91.3 (90.9-91.7)**
Metropolitan SA	**13714/15073**	**91.0 (90.5-91.4)**
LGA		
Flinders Ranges	23/24	96.2 (82.1-99.5)
Goyder	58/62	94.5 (85.4-97.8)
Mount Remarkable	55/66	83.4 (73.0-90.8)
Northern Areas	69/79	87.9 (78.7-93.3)
Orroroo/Carrieton	26/27	95.4 (84.0-99.6)
Peterborough	65/66	98.1 (93.1-99.8)
Port Pirie Regional	188/199	94.5 (90.6-97.0)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.

†Don't know/refused response excluded

Table 4: Proportion of adults (18 years and over) reporting using a dentist in the past 12-months, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**11500/21007**	**54.7 (54.1-55.4)**
Metropolitan SA	**8472/15073**	**56.2 (55.4-57.0)**
LGA		
Flinders Ranges	17/24	69.8 (51.1-85.9)
Goyder	19/62	30.0 (20.2-42.8)
Mount Remarkable	33/66	49.8 (38.2-61.8)
Northern Areas	42/79	53.5 (42.2-63.9)
Orroroo/Carrieton	17/27	64.1 (44.2-79.1)
Peterborough	23/66	34.6 (24.2-46.8)
Port Pirie Regional	93/199	46.6 (39.9-53.7)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.

Table 5: Proportion of adults (18 years and over) reporting using a specialist doctor in the past 12-months, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**9958/21007**	**47.4 (46.7-48.1)**
Metropolitan SA	**7177/15073**	**47.6 (46.8-48.4)**
LGA		
Flinders Ranges	11/24	44.9 (27.3-65.3)
Goyder	32/62	51.5 (39.3-63.7)
Mount Remarkable	25/66	38.6 (26.9-49.9)
Northern Areas	40/79	51.1 (39.8-61.5)
Orroroo/Carrieton	15/27	55.8 (37.1-72.9)
Peterborough	21/66	31.5 (21.5-43.6)
Port Pirie Regional	85/199	42.7 (36.0-49.7)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded

Table 6: Proportion of adults (18 years and over) reporting a hospital visit^ in the past 12-months, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**7406/21007**	**35.3 (34.6-35.9)**
Metropolitan SA	**5104/15073**	**33.9 (33.1-34.6)**
LGA		
Flinders Ranges	9/24	38.4 (20.4-57.4)
Goyder	35/62	56.9 (44.1-68.3)
Mount Remarkable	26/66	39.9 (28.3-51.4)
Northern Areas	35/79	44.9 (33.7-55.3)
Orroroo/Carrieton	14/27	53.7 (33.6-69.7)
Peterborough	18/66	27.5 (17.7-38.8)
Port Pirie Regional	86/199	43.4 (36.5-50.2)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.
^ includes hospital admission (in-patient), hospital outpatient clinic, and emergency/casualty department

Table 7: Proportion of adults (18 years and over) reporting using any health service^ in the past 12- months, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**20112/21007**	**95.7 (95.5-96.0)**
Metropolitan SA	**14413/15073**	**95.6 (95.3-95.9)**
LGA		
Flinders Ranges	24/24	99.4 (90.2-100.0)
Goyder	59/62	95.6 (87.6-98.6)
Mount Remarkable	63/66	96.8 (88.4-98.7)
Northern Areas	73/79	93.1 (85.0-96.8)
Orroroo/Carrieton	27/27	100.0
Peterborough	66/66	99.8 (96.3-100.0)
Port Pirie Regional	189/199	95.0 (91.3-97.4)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.
^includes use of GP, dentist, specialist doctor, other health professional, hospital admission, hospital outpatient clinic, and emergency/casualty department.

Mental Health Conditions

Respondents were asked if they had been told by a doctor or health professional if they had any of thefollowing mental health conditions; anxiety, depression, stress related problem, other mental health condition. If they responded yes to any of these, they were classified as having a mental health condition.

Table 8 presents the proportion of adults having a mental health condition. Reporting of a mental health condition ranged from 16.5% to 45.7%. Respondents from Northern Areas (16.5%) were less likely and Peterborough respondents (45.7%) were more likely to have a mental health condition, compared to SA overall (28.6%) and metropolitan SA (29.3%) respondents.

Table 8: Proportion of adults (18 years and over) reporting having a mental health condition^, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**6068/21197**	**28.6 (28.0-29.2)**
Metropolitan SA	**4458/15228**	**29.3 (28.6-30.0)**
LGA		
Flinders Ranges	8/24	34.1 (17.2-53.2)
Goyder	14/62	23.2 (13.6-34.1)
Mount Remarkable	14/66	21.9 (12.7-32.2)
Northern Areas	13/80	16.5 (9.4-25.5)
Orroroo/Carrieton	-	-
Peterborough	30/66	45.7 (33.9-57.4)
Port Pirie Regional	52/205	25.3 (19.8-31.6)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.
^Mental health condition includes anxiety, depression, stress related problem, and other mental hea lth condition.Data not shown for LGAs ≤ 5 counts.

Psychological distress

Psychological distress was measured using the Kessler-10 scale whereby 10 questions were asked about the feelings the respondent had in the past four weeks, and how often they had those feelings. The answers to the 10 questions were then given a score between one and five with higher score denoting higher f requency of the negative feeling. The question scores were then summed to give an overall score between 10 and 50 and those with a score above 22 were deemed to have high to very high levels of psychological distress[2] .

Respondents from Northern Areas (9.5%) were less likely and Peterborough respondents (31.9%) were more likely report having high or very high psychological distress, compared to SA overall (19.9%) and metropolitan SA (21.0%) respondents.

Table 9 presents the proportion of adults reporting high or very high psychological distress. Reporting of psychological distress ranged from 11.6% to 35.0%. Respondents from Northern Areas (9.5%) were lesslikely and Peterborough respondents (31.9%) were more likely report having high or very high psychological distress, compared to SA overall (19.9%) and metropolitan SA (21.0%) respondents.

Table 9: Proportion of adults (18 years and over) reporting high or very high psychological distress, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**4138/20776**	**19.9 (19.4-20.5)**
Metropolitan SA	**3125/14915**	**21.0 (20.3-21.6)**
LGA		
Flinders Ranges	8/24	35.0 (17.2-53.2)
Goyder	7/60	11.6 (5.4-21.5)
Mount Remarkable	9/65	14.3 (7.1-23.7)
Northern Areas	7/78	9.5 (4.1-16.8)
Orroroo/Carrieton	-	-
Peterborough	20/62	31.9 (21.6-44.5)
Port Pirie Regional	37/204	18.2 (13.3-23.9)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.Data not shown for LGAs ≤ 5 counts.

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[2] Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2001. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/4D5BD324FE8B415FCA2579D500161D57

Food Security

Respondents were asked if there had been any time in the past 12 months that they had run out of foodand couldn't afford to buy more.

Table 10 presents the proportion of adults reporting with food insecurity in the past 12 months. The majority of data are not presented due to small numbers. Respondents from Peterborough (23.2%) weremore likely to report having food insecurity than SA overall (9.7%) and metropolitan SA (9.6%) respondents.

Table 10: Proportion of adults (18 years and over) reporting with food insecurity in the past 12 months, (SAPHS† July 2018 to December 2020)

	n/N	**% (95%CI)**
SA Overall	**2050/21073**	**9.7 (9.3-10.1)**
Metropolitan SA	**1453/15120**	**9.6 (9.1-10.1)**
LGA		
Flinders Ranges	-	-
Goyder	-	-
Mount Remarkable	-	-
Northern Areas	-	-
Orroroo/Carrieton	-	-
Peterborough	15/66	23.2 (13.9-33.9)
Port Pirie Regional	24/204	11.7 (7.9-16.7)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.Data not shown for LGAs ≤ 5 counts.

Smoking

Respondents were asked if they were currently smoking cigarettes, cigars, pipes or any other tobacco products, and how often.

The proportion of adults reporting current smoking and daily smoking are shown in Table 11. The proportion of current smokers ranged from 13.8% to 34.5% and daily smokers ranged from 8.5% to 34.5%. Respondents from Peterborough were more likely to be daily and current smokers than SA overall and metropolitan SA respondents.

Table 11: Proportion of adults (18 years and over) reporting smoking, (SAPHS† July 2018 to December 2020)

	Current Smoking^		Daily smoking	
	n/N	**% (95%CI)**	**n/N**	**% (95%CI)**
SA Overall	**3604/21155**	**17.0 (16.5-17.5)**	**2940/21155**	**13.9 (13.4-14.4)**
Metropolitan SA	**2590/15192**	**17.0 (16.5-17.7)**	**2037/15192**	**13.4 (12.9-14.0)**
LGA				
Flinders Ranges	-	-	-	-
Goyder	9/62	13.8 (7.4-24.8)	8/62	12.9 (6.3-22.9)
Mount Remarkable	9/66	14.0 (7.0-23.4)	6/66	8.5 (3.9-17.8)
Northern Areas	15/80	19.5 (11.4-28.3)	15/80	19.5 (11.4-28.3)
Orroroo/Carrieton	-	-	-	-
Peterborough	23/66	34.5 (24.2-46.8)	23/66	34.5 (24.2-46.8)
Port Pirie Regional	44/205	21.7 (16.3-27.5)	37/205	18.0 (13.3-23.7)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded.
^Current smoking status includes those who report smoking daily, at least weekly, and less often th an weekly. Data not shown for LGAs ≤ 5 counts.

Alcohol Consumption

Respondents were asked in the previous 12 months how often they had an alcoholic drink of any kind, andthe number of standard drinks they usually consumed on a drinking day. Respondents were also asked a series of questions to determine the proportion that drank at levels that put them at lifetime risk of disease or injury and single occasion risk of injury.

Alcohol consumption measures used in this report are based on the 2009 National Health and Medical Research Council (NHMRC) guidelines regarding potential harms associated with alcohol consumption[3]. The NHMRC has two guidelines for health risks associated with alcohol consumption for healthy adults (both men and women) aged 18 years or over. It is recommended that:

- drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
- drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-relatedinjury arising from that occasion.

Table 12 presents the proportion of adults reporting consumption of alcohol that put them at risk of diseaseor injury over a lifetime. The proportion of adults reporting lifetime risky drinking ranged from 13.3 to 50.1 percent across the LGAs. Respondents from Flinders Ranges (50.1%) were more likely to drink alcohol at levels that put them at lifetime risk, compared to SA overall (16.4%) and metropolitan SA (15.9%) respondents.

Table 13 presents the proportion of adults reporting consumption of alcohol that put them at risk of injury from a single drinking occasion at least monthly. The proportion of adults reporting single occasion risky drinking ranged from 16.2 to 55.2 percent across the LGAs. Respondents from Flinders Ranges (55.2%) and Port Pirie (32.9%) were more likely to drink alcohol at levels that put them at risk of injury from a single drinking occasion, compared to SA overall (24.4%) and metropolitan SA (23.7%) respondents.

[3] National Health and Medical Research Council, *Australian guidelines to reduce health risks from drinking alcohol*. 2009, Australian Government: Canberra.

Table 12: Proportion of adults (18 years and over) reporting consumption of alcohol that put them at risk of disease or injury over a lifetime, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**3462/21118**	**16.4 (15.9-16.9)**
Metropolitan SA	**2411/15165**	**15.9 (15.3-16.5)**
LGA		
Flinders Ranges	12/24	50.1 (31.0-69.0)
Goyder	16/62	25.1 (16.2-37.6)
Mount Remarkable	9/66	14.3 (7.0-23.4)
Northern Areas	14/80	18.1 (10.4-26.9)
Orroroo/Carrieton	-	-
Peterborough	8/63	13.3 (6.2-22.5)
Port Pirie Regional	40/205	19.4 (14.5-25.3)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded. Data not shown for LGAs ≤ 5 counts.

Table 13: Proportion of adults (18 years and over) reporting consumption of alcohol that put them at risk of injury from a single drinking occasion at least monthly, (SAPHS† July 2018 to December 2020)

	n/N	% (95%CI)
SA Overall	**5101/20899**	**24.4 (23.8-25.0)**
Metropolitan SA	**3556/15010**	**23.7 (23.0-24.4)**
LGA		
Flinders Ranges	13/24	55.2 (34.7-72.7)
Goyder	18/61	30.2 (19.2-41.7)
Mount Remarkable	11/66	16.8 (9.2-27.0)
Northern Areas	15/80	18.3 (11.4-28.3)
Orroroo/Carrieton	6/27	20.6 (9.8-40.2)
Peterborough	10/63	16.2 (8.5-26.3)
Port Pirie Regional	65/196	32.9 (26.9-40.0)

Note: the weighting of the data can result in rounding discrepancies or totals not adding. CI: Confidence Interval.
†Don't know/refused response excluded