Mentoring as an effective intervention for trauma, grief and loss in regional Australia

Carol Yates

Keywords: *Mentoring, Regional, Christian interventions, Trauma, Grief and Loss.*

Abstract

This paper addresses the unique mental health challenges that regional and rural Australia face, particularly in relation to trauma, grief, and loss. Although evidence-based interventions are available to families and communities, they are not yielding outcomes comparable to those in urban areas. The central discussion posits that regional disparities arise from specific barriers and distinct needs, necessitating tailored interventions. This paper makes several unique contributions: it provides a comparative analysis of urban and regional mental health outcomes, examines the specific impact of location on conditions like depression, anxiety, and suicidality, and highlights the importance of tailored interventions for individuals and families. By evaluating current interventions, the research identifies gaps in effectiveness. Newer approaches, like mentoring and group work, have the potential of text analysis for early detection of mental health issues with effective interventions. This paper will explore a Christian mentoring and strengths-based group work program that I have been involved in, that could enhance outcomes in regional settings.

Introduction

This report identifies what current research reveals about mental well-being in regional Australia and reviews therapeutic interventions targeting trauma, grief, and loss. It narrows the scope from national and state statistics to focus on support mechanisms and interventions experienced by regional and rural Australians (Australian Bureau of Statistics, 2024). By connecting these statistics to specific policy needs, the report highlights critical areas that lack adequate intervention strategies. It offers policymakers actionable insights to improve mental health outcomes in these communities.

Trauma in these regions comes from disasters or personal events, often resulting in overlooked grief and loss. This research will examine direct links between mental health and trauma, grief, and loss in these areas. Exploring systemic barriers described in recent literature, such as those by Kavanagh et al. (2023a), align with therapy challenges in rural settings. Addressing this could bridge the gap between anecdotal evidence and research, enhancing the credibility of the findings.

Corresponding Author: Carol Yates

Email: firmfoundation21@gmail.com

Australian Counselling Research Journal ISSN: 1832-1135

To further explore these issues, the data will be examined from a broader perspective, drawing on the Australian Bureau of Statistics (2024). The ongoing discussion focuses on mental health in rural areas. It leverages the State of Mental Health Report: Bundaberg & Fraser Coast (2024) to examine the current mental health status in those regions. This enables comparison of the differences cited by the ABS with those observed in regional settings.

This paper examines issues facing rural Australian families, focusing on trauma unique to rural areas, such as natural disasters and farming hardships (Campbell et al., 2006). The report addresses grief, loss, and the high suicide rate in rural areas (Johns, 2015). It argues that barriers in remote areas worsen mental health and that these barriers are unique to rural settings (Kavanagh et al., 2023a). The research focuses on underrepresented groups, including youth (Klinner et al., 2023). It argues that interventions must be directly relevant and tailored to the needs of these areas.

Current interventions used in urban environments may not meet the needs of rural Australians. Academic literature will support the presentation of a Christian worldview and highlight evidence-based interventions in both urban and rural communities. It is also worth noting at this point that there are some groups in the community who may be of different faiths or perhaps individuals dealing with incidences of religious abuse, for whom a Christian based intervention is not suitable.

The approaches address the “missing middle” (Brown, 2025), a term used to describe gaps in community mental health care. Studies indicate mentoring and group interventions improve participant engagement and quality of life without replacing traditional therapies. (Collins, 2021). Christian mentoring and group interventions, such as Empowered Faith Communities and the COACH mentoring program, can enhance clinical care (COACH network, 2025).

My experience as a counsellor in the regional Widebay community of Hervey Bay in northern Queensland, highlights distinct therapy issues. The paper will introduce a successful Christian therapeutic intervention I am involved in, recently used in some rural settings, drawing on the work of Mark Matthews and Toby Baxter, as well as programs such as Empowered Faith Communities and the COACH mentoring program (COACH Network, 2025).

Current interventions in rural areas

Many regional families experience trauma, grief and loss that can often lead to depression, anxiety and in some cases suicidality. To provide context for this study, it is important to look at broader statistics on Australian mental health. The Australian Bureau of Statistics reports: “42.9 per cent of people aged 16–85

have had a mental disorder at some time. 21.5 per cent have a 12-month mental disorder, with anxiety being the most common (17.2 per cent of people aged 16–85). 38.8 per cent of people aged 16–24 years had a 12-month mental disorder" (Australian Bureau of Statistics, 2024). While these numbers reflect the nation as a whole, it is vital to understand the differences in rural areas. According to a report from the Hervey Bay Neighbourhood Centre *State of Mental Health Report* (2023), a significant number of Fraser Coast residents have a long-term mental health condition. This raises the question of whether similar figures are observed in other regions. Ayton notes that in health and social care, it is important to:

"Innovate, implement and evaluate programs and practices to identify an evidence base for care. We need to measure what we previously thought was not measurable. We need a way to explore and understand experience – this is qualitative research." (2023).

As a counsellor in a community employment provider, I have seen hopelessness caused by clients feeling unsupported and uncared for. To broaden the discussion, the National Rural Health Alliance says:

"The prevalence of people experiencing mental illness is similar across the nation: around 20 per cent" (Australian Bureau of Statistics, 2024).

Comparing the rates of mental illness in rural areas and major cities may have masked a high rate of psychological distress and untreated or undiagnosed mental illness. Self-harm and suicide have also been found to increase with remoteness. The research has found that people who experience suicidality are more likely than the general population to have a mental health disorder or condition.

There is also a consideration of the comorbidity of substance use. Rates of lifetime risky drinking (more than two standard drinks per day on average) show strong regional dependence, along with illicit drug use, which is higher in remote and very remote areas compared to all other regions (National Rural Health Alliance 2021).

Once again, drawing from my hands-on experience, I have worked with clients who have found that using alcohol and drugs has been their only way of coping with more deep-seated trauma, grief and loss. In the case of the cohort I have worked with, this, in turn, leaves them unable to maintain employment. The spiral continues downwards without sufficient interventions, leaving entire families at risk.

A 2024 ABS report on mental health on the Fraser Coast and Bundaberg regions of Queensland is particularly sobering. A staggering 13 per cent of Fraser Coast residents and 12 per cent Bundaberg's population live with a long-term mental health condition. 14 per cent of women and 11 per cent of men reported long-term mental health concerns, and nearly a fifth of First Nations people affirmed long-term mental health issues (18 per cent). This culminated in 35 per cent of the community having a core need for mental health assistance. Another notable fact is over a fifth (22 per cent) of unemployed people reported a long-term mental health diagnosis.

Based on my observations of these clients in my counselling, this figure suggests that individuals are underreporting. According to research published by McLachlan(2023) and colleagues, 31 per cent of people in rural Australian communities reported experiencing psychological distress, with the majority facing moderate distress and about a third experiencing high levels.

Past interventions that have missed the mark

Drawing on current research, several factors have been identified as potential mental health concerns when considering interventions and their effectiveness in regional areas of Australia. Kavanagh et al. (2023) developed a scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia to conduct a thorough review of the available interventions.

From my own practice experience, I was able to identify with the findings by Kavanagh (2023) that there are limited resources available to clients who are also trying to navigate complex systems. In addition other barriers such as societal attitudes, technology, geographical distances and cultural differences present ongoing difficulties for many clients.

Identifying attitudes towards social issues was one of the factors I observed while travelling to more remote areas. Often, the number of participants who engaged with the programs was much less than anticipated. Based on conversations with attendees, there was an overall sense that seeking support was pointless, accompanied by helplessness and hopelessness, and reports of not being understood culturally. Although high-quality programs were provided, uptake in the community was significantly lower than that of their urban counterparts. Furst (2021) adds to the finding by reporting disproportionate investment in services in regional areas relative to other areas. This study also identified confusion and a lack of clarity regarding who is responsible for care in these regions.

As Campbell et al. (2006) reveal in their study "Rurality and mental health: A primary care study", the gaps and barriers identified in these areas are as varied and distinct as the regions' demographics. They consider demographic factors such as Indigenous/First Nations status and whether the towns are mining sites, coastal tourist destinations, or small inland settlements. Each of these demographics has distinct needs, which makes narrowing solutions to mental health issues for each location more than a "one size fits all" scenario.

This same report goes on to posit that mental health disadvantage in rural areas is due to service accessibility. Not only are there greater distances to travel, but there are also fewer specialist services and general practitioners. This research also suggests that community relationships should be considered and that community size and growth should be assessed. (Campbell et al. 2006). This, in turn, feeds into the differing rates of unemployment and poverty. Kavanagh's more recent report "A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia" (2023), indicates that these same barriers have remained problematic in rural areas in more recent years.

A study by Dashputre et al (2023) found that a range of lifestyle factors are associated with psychological distress and depression in a rural Victorian community. These lifestyle factors play a significant role in reports of stress and depression. It was found that individuals who were smokers and obese were 3-4 times more likely to indicate that they were dealing with psychological distress and depression. Lifestyle factors, including overall health, diet and attitudes towards health, have also been identified as possible areas of concern.

With these lifestyle factors in mind, research into more specific data that speaks to suicidality (Dashputre et al., 2023; Kõlves, 2012) reveals that factors such as cultural influences and appropriate treatment services contribute to the discussion around addressing specific factors leading to suicide in rural settings. These include the specific agricultural industry for each individual rural setting, Relationship conflict and breakdown, income and work problems, as well as alcohol use, also rated as a significant factor towards suicide rates in these areas (Kõlves, 2012).

Interventions currently used in regional and rural areas

While this paper to date has highlighted areas of concern in assessing mental health interventions in regional Australia, it is important to note that, despite these gaps, many attempts have been made to address them. A snapshot of the types of interventions offered in communities is provided in publications such as the Rural Wellbeing Toolkit (University of Southern Queensland, 2025). This toolkit is a resource provided to rural communities and follows three streams of support. The first is provided for the general community and supports interested community members in recognising signs of mental health concerns by listening, understanding, and identifying a person's needs. Once they have connected, they can help individuals identify qualified, appropriate support, and participants in this program are encouraged to maintain connections as friends and community peers.

It has been my privilege to coordinate a Christian mentoring program, COACH (Creating Opportunities and Casting Hope) (COACH Network, 2025), for two years. I will return to this reference when I address possible Christian interventions. This successful initiative, conceived by the New Peninsula Church through Toby Baxter and Mark Matthews in 2003 (Baxter & Matthews, 2022), exemplifies such mentoring.

The other two support streams are for professional facilitators to train and develop these programs, and there is also an online stream for interested stakeholders to engage and increase their awareness and competence regarding mental well-being. Other initiatives developed to support this cohort include interventions for farmer health (The National Centre for Farmer Health, 2025) and Rural Minds workshops (Lindley, 2025).

Many online supports are available to people in remote areas, including national services such as:

- Lifeline – https://www.lifeline.org.au/
- Beyond Blue – https://www.beyondblue.org.au/
- Black Dog – https://www.blackdoginstitute.org.au/
- Eheadspace– https://headspace.org.au/
- SANE Australia – https://saneforums.org/
- My Age Care – https://www.myagedcare.gov.au/

These online options also facilitate access to psychologists and counsellors.

Given the accessibility of technology, Antoniou (2022) argues that technology and text-based interventions can also serve as predictive tools (University of Southern Queensland, 2025). The aim is to identify possible indicators of depression, anxiety and even suicidal tendencies, by analysing the words that a client is using. Overall, these services provide contemporary solutions that were not previously available. In addition to emerging digital interventions, it is worth highlighting current group interventions that have been well utilised in regional and rural areas.

Cohorts identified as 'at risk'

At this point, the research has identified specific "at-risk" cohorts in regional areas that require attention before implementing best-practice mental health interventions. There has been mention of the prevalence of women reporting depression and psychological stress (Dashputre et al., 2023). This report aims to uncover the cohorts that are possibly under-reporting their mental health status.

Identifying those who are not reaching out for treatment – who could be spiralling into chronic mental health concerns and suicide – is crucial. For instance, a recent analysis (Dashputre, 2023) suggested in some rural communities, underreporting could be as high as 25 per cent among certain groups, based on comparisons with known metrics of diagnosed cases in similar demographic groups. Further investigation would help refine such estimates and offer more precise insights. Identifying individuals who are reluctant to seek help or unaware of available resources remains a significant challenge, underscoring the need for ongoing outreach and tailored interventions.

It has been identified by Kõlves (2012) that those most at risk of suicide in remote areas are male youth, farmers and individuals identifying as Indigenous. To address these individually, it is hoped that a more detailed understanding of the target concerns for each group and of best-practice interventions to support help-seeking (Kõlves, 2012) will be developed.

When considering regional male youth, Klinner (2023) offers valuable insights from a qualitative exploration of young people's mental health needs in rural and regional Australia; the study identifies engagement, empowerment, and integration as key findings. This report concludes that young people who experience geographic isolation, which can be exacerbated by natural disasters such as drought and fire, require effective mental health education and support that they want and find useful. This report also reveals that these young people are facing stigma and negative beliefs that prevent them from seeking help, which must be addressed. For example, certain beliefs generated through community and social media exacerbate distrust of help-seeking supports and services. These include supports that are consistent and well-coordinated, engaging and empowering, and cost-free.

It was also noted that support offered should include teachers, parents, and other primary caregivers in their lives (Klinner et al., 2023). Based on this research, Klinner (2023) posits that a multi-pronged community approach is needed to provide this education and support across the following arenas: community, family, school, peers, and individuals. It is when there has been little to no help from the first four areas that a young individual will show signs of major depression and psychological distress. These signs include attention-seeking behaviours, aggression directed at peers, teachers and parents and signs of self-harm and suicide. When these signs go unchecked, such behaviours are normalised and become the accepted norm within the community (Klinner et al., 2023).

One of the programs I have personally been involved in is a strength-based, person-centred format that includes a one-hour box-fit class followed by two hours of psychoeducation, supporting clients in developing positive coping strategies and identifying common distorted thinking patterns, as well as other helpful mental health aids (Populi Solutions, 2025).

I have been greatly disappointed to find that other young people in the community were dissuaded from attending because peers and other influences distracted them from the support they could receive. Those who attend always report that they are pleased they did so and surprised by how much it improved their sense of well-being. One example of a successful outcome occurred during a "Gloves" program in a rural location.

When working with a small group in the South Burnett region in Queensland, during one of the group discussions, a participant reported that finding work had been difficult because he had no means of transport. He stated that, since his bicycle had been stolen, he had lost hope and was just sitting around watching television. When asked whether he would be able to try again if he had a bike, another participant responded promptly, stating that he had a spare bike and was happy to give it to the other participant. The young man in need accepted this kind offer immediately, and an ongoing friendship began to emerge. Through this small gesture, signs of hope and positivity began to lift the group's mood from this time on. As the facilitator moves away from the group, it is hoped that these participants will

continue working together as a community.

The next cohort identified as at greatest risk comprises those working in the primary industry of farming. It has been identified that farmers come in as the highest at-risk occupation, and statistics tell us they are 40 per cent higher risk of suicide than their urban counterparts, and in more remote areas, they are a massive 100 per cent more at risk. Some of the reasons identified as contributing to this unfortunate fact include geographic isolation and seclusion, limited employment opportunities, and industry instability caused by natural disasters such as bushfires, floods, droughts, and cyclones (Antoniou et al., 2022). The most at risk of suicide and depression for this cohort could fit a similar profile to this: young male, separated or divorced, usually living alone. These young men are usually labourers on farms, not farm owners, and have a history of mental health concerns. (Antoniou et al., 2022).

As has already been mentioned, our Indigenous communities are another cohort that are most at risk of being exposed to significant mental health barriers, suicide and grief and loss. Part of the issue for Indigenous communities who are remotely located is that they are not easy to access, and as such, they are significantly under-reporting their need for mental health care. It is also very important that, whatever the interventions are, those reaching these communities be culturally aware of the mental health nuances that inform them. An example of this would be the cultural meaning behind self-harm. To understand the cultural meaning and identity behind the acts of "sorry cuts" and "anger cuts", it is important to examine the significance of using them to express a desire to cope with unbearable pain. It is this kind of cultural awareness that is needed to broaden the social and emotional context of these communities. (Kavanagh et al., 2023a).

A Christian worldview intervention to support longitudinal change

To clearly assess the impact of Christian interventions on mental health outcomes, we need to define 'longitudinal change' operationally. For this purpose, we consider longitudinal change as sustained impact over at least three years. Indicators for this assessment will include reduced frequency and severity of mental health episodes, increased engagement in community activities, and reports of improved quality of life among participants. Establishing this time frame and these indicators will guide readers' expectations and facilitate evaluation of the intervention's effectiveness.

To address this question, I will refer to two interventions that are each stand-alone yet closely linked. One of these programs was mentioned earlier: the COACH mentoring program; the other is an initiative gaining momentum, "Empowered Faith Communities". One of the features of these programs is their ability to work alongside other evidence-based interventions, and, at the same time, their heart to introduce the Christian figure of Jesus into the lives of all involved, mentors and participants alike. As was quoted in "Mentoring for extra-ordinary transformation"

"Jesus was a mentor, and his life serves as a model for all mentors to follow." (Baxter, 2022).

To support the success of this program in communities, churches, and individuals' lives, a study was conducted (Ayton, 2012,) and subsequently endorsed by Monash University in Victoria. This study explored the impact of the COACH mentoring program on health and well-being, thereby demonstrating the effectiveness of this person-centred empowerment model of mentoring. Mark Matthews was reported to say about the study:

"One of the most powerful findings from the research was the concept of the 'missing middle" (Brown, 2025)

This term describes individuals who need more than one intervention and find themselves "falling through the cracks". Perhaps this is the very cohort that has been described thus far as under-reporting and sceptical about help provided by "one-off" mental health interventions. It was also reported that the aim of the COACH initiative has always been to adopt a long-term perspective on breaking generational poverty. Because the view has never been about brief intervention, the program offers a position by which longitudinal change can be observed.

COACH is an acronym for "Creating Opportunities and Casting Hope". It is framed on the website as being "Community impact through integrated, strength-based, best practice frameworks that equip partners with effective tools to provide support, create belonging and empower people in their local communities. (Coach, 2025). Mentors are thoroughly trained and screened. Only those who can walk alongside of their participants as a "friend with a purpose" (Coach, 2025), without judgement and able to with-hold their own religious or philosophical views, are released to mentor. Once they are matched there is ongoing supervision and training.

The following scenario illustrates the positive outcomes achieved through the COACH program.

Jan is a 25-year-old mother of five children. For as long as she can remember, she has never known a day of peace in her family home. She is the daughter of migrant parents who fled the terrors of war in Afghanistan. She knew her father loved her; however, he was so often absent due to alcohol after the untimely death of her mother when she was just 13 years of age.

By the time she was 15, she fell into the arms of her 18-year-old partner, David, who was also looking for a way to escape the family violence in his home. David thought he was in love with Jan and wanted to rescue her from her unstable father. Soon thereafter, Jan became pregnant and gave birth to their first son at age 16.

For two years they lived in a caravan on David's grandparents' property. David found it hard to find work and soon started taking drugs to cope with the uncertainty of life. Within three years, they had three children under the age of three, and in the fourth year, Jan fell pregnant with twins. David began to use the violence he learned from his family to cope, and after a very explosive episode, he was sentenced to a jail term because he was found with drugs and also assaulted an officer.

Jan cried out for help when she learned that her third child was diagnosed with autism. After the birth of her twins, her daily struggles were compounded by her own diagnosis of chronic fatigue.

Jan had been seeking support from a mental health service to try to help her deal with her depression and anxiety when she was referred to COACH.

Sandra became her "friend with a purpose", and together they are working towards her goals to build better relationships with her children, find order and peace in her home and establish new friendships in the community.

Progress is slow, but Jan finally feels that there is someone in her life who is willing to provide the guidance and support she was never given growing up.

Sandra enjoys her visits with her participant very much and leaves feeling that her life can be a small help to someone else.

Building on the foundational work offered through the COACH program, which is now operating Australia-wide, the "Empowered Faith Communities" have emerged. The vision of this program is to support many of the same individuals who are "doing life tough" by providing support in the community they are familiar with. These communities comprise individuals on the margins who are empowered and encouraged to grow in faith where they are. Having been a COACH coordinator, I have witnessed the depth of trauma and grief that has culminated in them living in less-than-ideal conditions. An Italian psychologist, Gianmarco Biancalani, suggests:

"Spirituality may be a key factor in reducing the negative psychological effects of traumatic events." (Biancalani et al., 2022).

Mark Matthew shares an encouraging story about a member of an "Empowered Faith Community":

"Rose is a regular member of the Forrest Hill Chase Empowered Faith Community, (EFC) in Victoria, Australia. Rose was in need of support from the Community Pantry at Crossway Lifecare. Life hasn't been easy for Rose and she was seeing a psychiatrist and on medication for anxiety…'Rose has been living with a significant anxiety disorder.Ordinary things that perhaps many people can do were not possible for Rose. And yet, in her EFC her growth and resilience has been quite remarkable…."

"Rose is learning to smile more and to focus on positive thoughts – and now she is actively participating in her community. Rose brings soup and cakes that she cooks to her EFC gathering as this is her strength…Rose also attends other community gatherings too and now, with her doctor's support, she has ceased taking medication and doing much better. She rarely misses her EFC gatherings and outings together…She is grateful for the life and friends she now has and loves sharing her resources with the group. She is a happy participant in the art activities and Bible reading….".

The COACH program, along with the "Empowered Faith Communities", is well placed to deliver good, evidence-based person-centred interventions, as well as the additional advantage of providing an opportunity to discover long-term transformation through a faith-based, group intervention.

Conclusion

If we were to implement the multi-pronged community approach suggested by Klinner (2023), we might not see as many rural people fall through the cracks across the community, family, school, and peer groups. There is no quick intervention that will support and empower this "missing middle" cohort into a place of flourishing. If this small town had a community of people whom Mark Matthews and Toby Baxter classify as "People of Peace" (Baxter & Matthews, 2022), there might be a referral to a well-trained mentor willing to accompany them on the long path.

The hope that can develop through a consistent and committed relationship may well offer a more positive future for individuals. It is also heartening to find, through the research, that substantial technological efforts are being made to support people in practical, user-friendly ways (Antoniou et al., 2022).

In summary, I would like to suggest that the preponderant interventions for trauma, grief and loss that have been explored and discussed in this paper leave many more questions than answers. Although the statistics presented support the need for greater investment in mental health interventions in regional and rural settings, research also indicates that these regions have not been completely overlooked but may have been mismanaged.

It is apparent that there remains room for development to ensure that current situations are addressed in proportion to each region's specific needs. Perhaps interventions in the form of programs, such as the Gloves program, are a step in the right direction towards long-term change. Could faith-based programs, such as the COACH mentoring program and the introduction of more "Empowered Faith Communities", be part of the solution to support the complex lives of individuals and their families?

References

Antoniou, M., Estival, D., Lam-Cassettari, C., Li, W., Dwyer, A., & Neto, A. de A. (2022). Predicting mental health status in remote and rural farming communities: Computational analysis of text-based counselling. *JMIR Formative Research*, 6(6), e33036. https://doi.org/10.2196/33036

Australian Bureau of Statistics (2024). *National Study of Mental Health and Wellbeing, 2020-2022.* https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

Ayton, D. (2012). The impact of the COACH community mentoring program on health and well-being evaluation report. *Monash University, School of Medicine, Nursing and Health Services.* See: https://coachnetwork.org/wp-content/uploads/2016/04/COACH-Monash-Evaluation-2012.pdf

Baxter, W. (2022). *Divine shepherd Christology in the Gospel of Matthew*. Lexington Books/Fortress Academic.

Biancalani, G., Azzola, C., Sassu, R., Marogna, C., & Testoni, I. (2022). Spirituality for coping with the trauma of a loved one's death during the COVID-19 Pandemic: An Italian qualitative study. *Pastoral Psychology,* 71(2), 173. https://doi.org/10.1007/s11089-021-00989-8

Brown, A. (2025). Bridging the Gap: An academic reflection on the impact of COACH Mentoring, 31 July, 2025. *COACH Network.* See: https://www.coachnetwork.org/bridging-the-gap-an-academic-reflection-on-the-impact-of-coach-mentoring/

Campbell, A., Manoff, T., & Caffery, J. (2006). Rurality and mental health: An Australian primary care study. *Rural and Remote Health*, 6(3). https://doi.org/10.22605/RRH595

COACH Network: Seeing people in tough places flourish. COACH Network. Retrieved October 12, 2025, from https://www.coachnetwork.org/

COACH Network (2025). *COACH community mentoring*. See: https://coachnetwork.org/coachmentoring/

Collins, J. (2021). Youth benefiting from rural mentoring program, Bush voices highlighting great rural projects. Country Education Project. See: https://cep.org.au/youth-benefiting-from-rural-mentoring-program/

Dashputre, A., Agho, K., Piya, M., Glenister, K., Bourke, L., Hannah, S., Bhat, R., Osuagwu, U., & Simmons, D. (2023). Prevalence and factors associated with mental health problems of psychological distress and depression among rural Victorians – analysis of cross-sectional data (Crossroads II). *BMC Psychiatry*, 23. https://doi.org/10.1186/s12888-023-04931-5

Empowered Faith Communities (2025). *Our vision is to catalyse the church to develop Empowered Faith Communities with people doing life tough*. Retrieved October 12, 2025, from https://www.efc.org.au/

Hervey Bay Neighbourhood Centre (2023), *State of mental health report.* Retrieved October 5, 2025, from https://www.hbnc.com.au/Handlers/Download.ashx?IDMF=4094df22-d4dd-47d4-8a7f-605c18dceb17

Johns, D. L. (2015). Bereavement care in rural and remote communities of Australia. *Austral-Asian Journal of Cancer.* 14(1). See: https://research-repository.griffith.edu.au/server/api/core/bitstreams/459b1e65-4782-43fe-a7c3-313356e38ad6/content

Kavanagh, B. E., Corney, K. B., Beks, H., Williams, L. J., Quirk,

S. E., & Versace, V. L. (2023a). A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. *BMC Health Services Research,* 23(1), 1060. https://doi.org/10.1186/s12913-023-10034-4

Kavanagh, B. E., Corney, K. B., Beks, H., Williams, L. J., Quirk, S. E., & Versace, V. L. (2023b). A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. *BMC Health Services Research,* 23(1), 1060. https://doi.org/10.1186/s12913-023-10034-4

Klinner, C., Glozier, N., Yeung, M., Conn, K., & Milton, A. (2023). A qualitative exploration of young people's mental health needs in rural and regional Australia: Engagement, empowerment and integration. *BMC Psychiatry,* 23(1), 745. https://doi.org/10.1186/s12888-023-05209-6

Kõlves, K. (2012). Suicide in rural and remote areas of Australia. Australian Institute for Suicide Research and Prevention.

Lindley, T. (2025). *Rural minds: Rural and remote mental health.* Retrieved October 11, 2025, from https://rrmh.com.au/our-programs/rural-minds/

National Rural Health Alliance (2021), *Mental health factsheet*, July2021. Retrieved August 11, 2025, from https://www.ruralhealth.org.au/wp-content/uploads/2024/05/nrha-mental-health-factsheet-july2021.pdf

Populi Solutions. (2025). Populi Solutions. Retrieved October 12, 2025, from https://www.populi.com.au

The National Centre for Farmer Health. (2025). *Health, wellbeing and safety factsheets*. Retrieved October 11, 2025, from https://farmerhealth.org.au/page/health-wellbeing-safety-fact-sheets

University of Queensland. (2025). *Rural wellbeing toolkit. Retrieved* August 13, 2025, from https://www.unisq.edu.au/research/sqnnsw-hub/resources/wellbeing-toolkit