Mental Health and Wellbeing in the Shire of Augusta Margaret River

Final Report

Commissioned and facilitated by the Lishman Health Foundation

Centre for Rural & Remote Mental Health

Lishman HEALTH FOUNDATION

Prepared by

Robyn Considine, Dr Hazel Dalton, Prof David Perkins, and Nicholas Powell

Commissioned by. Lishman Health Foundation, Bunbury Western Australia

Acknowledgements

The Centre for Rural and Remote Mental Health has undertaken this project in response to a request from the Lishman Health Foundation. The Project Advisory Committee established by the Lishman Health Foundation, with representatives from across the shire of Augusta Margaret River have guided and supported this project. The consultation process has only been possible because of the commitment of people of shire of Augusta Margaret River to address mental health and wellbeing in their community. Their willingness to provide their views openly and frankly has provided a solid foundation for moving forward to promote mental health and wellbeing across the community.

About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

Contents

List of figures

Abbreviations

ABS	Australian Bureau of Statistic
ACCHOs	Aboriginal Community Controlled Health Organisations
AIHW	Australian Institute for Health and Welfare
AMR	Augusta Margaret River
ANSMHWB	Australian National Survey of Mental Health and Wellbeing
AMRB	Augusta Margaret River Busselton
ATL	Above the Line
CRRMH	Centre for Rural and Remote Mental Health
ERP	Estimated resident population
FRRR	Foundation for Rural and Regional Renewal
HWSS	Health and Wellbeing Survey
MBS	Medicare Benefits Scheme
PBS	Pharmaceutical Benefits Scheme
SA3	Statistical Area 3
SEIFA	Socio-Economic Indexes for Areas
SPMR	Suicide Prevention Margaret River
URP	Usual Residential Population
WA	Western Australia
YLD	Years lived with disability

Executive Summary

This report describes the results of a project to explore options for addressing mental health and wellbeing in the Shire of Augusta Margaret River. The project was undertaken to identify the key issues and explore community views about mental health and wellbeing in the area. The project was commissioned by the Lishman Health foundation and represents a commitment to address mental health and wellbeing in the area.

The methods used included: reviews of the literature to explore frameworks and models for mental health promotion and suicide prevention; quantitative analysis of prevalence, morbidity and mortality data for the area where available; interviews with key stakeholders; data triangulation to identify priority mental health and suicide prevention and service needs; and feedback to the community to determine whether initial findings reflected community views.

Key Findings

The results demonstrated concordance between the quantitative data and the perceptions of community members. There was a commitment to addressing mental health and wellbeing in the Augusta Margaret River community with many initiatives already underway. There are many strengths in the community and existing strategies which can be consolidated to address community mental health and wellbeing.

The socio-economic divide between different groups was raised as the key concern, impacting on community mental health and wellbeing. Population level social and economic indicators may not reflect this perceived divide because extremes of data will counteract each other and result in the shire appearing as in the middle range. This perceived divide was characterised by unemployment or underemployment, mortgage and financial stress, and homelessness in some sectors compared to other groups in the community who were socially and economically advantaged. That this divide exists was in contrast to the perception of AMR as one of idyllic lifestyles. It was also suggested that this divide was rarely acknowledged by decision makers, and affected the ability of the region to attract resources and services.

While the levels of mental illness in the shire was perceived as similar to other towns there was a common perception that suicide levels were higher. This was reflected in data for the shire which indicated that the estimated rate of deaths from suicide and self-inflicted injuries, for people aged 0 to 74 years was 17.9 per 100,000 people, higher than that for Western Australia and for Australia.

There are a diverse range of clinical and support services in the shire to address mental health and wellbeing but access was less than optimal with many of these unknown to service providers and the community resulting in problems with referral, and service gaps and duplication.

There are many disparate mental health and support services in the shire but these need improvements in a number of ways. First was the need for strengthening of the capacity of the primary care and specialist mental health system to be responsive to the mental health needs of the local community by planning for and providing integrated and coordinated care. This required strengthening the capacity of primary care to provide evidence-based mental health treatment to the community and ensuring access to a range of treatment options. There was a strong perception that there was an over-reliance on medications for treatment of common mental illnesses which was substantiated by some of the data. It also required planning for mental health services for the shire across the service system. Second were

concerns about access to and quality of specialist mental health services in the shire. In particular, the quality of specialist mental health services provided at Bunbury was raised as a problem, with some voicing concerns that they would rather avoid treatment than present or be admitted to Bunbury specialist mental health inpatient services. Third, there were numerous barriers to accessing services including transport within the shire and to services in Bunbury and Busselton, and cost barriers with gap payments charged for many of the services.

There were a range of individual and family, community and structural factors related to mental health and wellbeing and suicide highlighted by key stakeholders, and reflected in the data including:

- the need to strengthen mental health literacy and address stigma across the community to support access and access to treatment
- alcohol use
- drug use, in particular marijuana use, which is perceived as normalised in the community and is often used across generations
- misinformation about the impact of drug and alcohol use on mental health and wellbeing
- domestic violence
- homelessness
- geographical and social isolation within the community
- persistent disadvantage often occurring over generations
- trauma in the community
- economic diversity, underemployment and employment opportunities for young people

It was acknowledged that it was essential to address these contributing factors to mental health and wellbeing in order to achieve longer terms gains.

The Shire of AMR is already addressing some of the factors associated with mental health and wellbeing and suicide. Their strategies for tackling disadvantage in the community as part of its economic strategy, housing affordability and their support for youth are examples identified as important for mental health and wellbeing.

The way forward in addressing mental health and wellbeing is ultimately the decision of the people of the Augusta Margaret River community. A community taskforce is needed to guide the next steps with a focus on developing a plan of action and strategically advocating for a broad based approach to support and promote mental health and wellbeing. The role of the community taskforce is strategic, leading and developing a community based plan for the whole of the shire. Having leadership from organisations such as primary and specialist health services and the Shire of AMR involved in this taskforce is important, but the involvement of other sectors and community members, who can operate strategically and are in a position to advocate locally and more broadly is key.

The findings of this project, complemented by many of the existing initiatives and informed by evidence provide a foundation for the development of a community mental health and wellbeing plan for the area. The effectiveness of this approach will be strengthened by building strategic alliances across the community and developing short and long term strategies to address the immediate needs of the community but also to address the underlying economic and social factors associated with mental health and wellbeing.

Developing a plan for the community provides the opportunity to coordinate programs, services and initiatives under one banner to promote mental health and wellbeing and advocate for the needs of the communities of Augusta Margaret River.

Introduction

This project was commissioned by the Lishman Health Foundation. The Lishman Health Foundation funds, facilitates and promotes health research that has significant health gain for individuals, families and communities living in south-west Western Australia and more broadly regional Australia. The project was undertaken in response to community concerns about mental health and wellbeing and suicides in the shire of Augusta Margaret River (AMR) and a commitment to explore approaches to promoting mental health and wellbeing in the area.

Burden of Illness

Mental and substance use disorders are significant contributors to the disease burden in Australia, being responsible for almost 12% of the total burden in 2011, third after cancer and cardiovascular diseases[1]. In addition, these disorders were the leading cause of non-fatal burden, accounting for almost one-quarter (24%) of all years lived with disability (YLD)[1]. The annual cost of mental illness In Australia has been estimated to be $20 billion,[2] including health costs and the losses incurred by reduced productivity and labour force participation.

Mental Illness

The most recent Australian National Survey of Mental Health and Wellbeing (ANSMHWB) reported that mental disorders are experienced by approximately 20% of the population at a clinically diagnosable level in any 12 month period[3]. The most common mental disorders in Australia are anxiety, mood (e.g. depression) and substance use disorders. Within any 12 month period, 14% of the general population have experienced an anxiety disorder, 6% have experienced a mood disorder and 5% have experienced a substance use disorder, with harmful alcohol use the most common[3]. These common disorders peak in both males and females who are of working age[3].

In Western Australia (WA), data from the WA Health and Wellbeing Surveillance System (HWSS), a continuous data collection system that was developed to monitor the health and wellbeing of residents of the state, provide recent data on mental health[4]. The prevalence of anxiety, depression and stress-related problems diagnosed within the last 12 months was higher for WA adults aged 16 to 44 years and 45 to 64 years, compared with older adults[4].

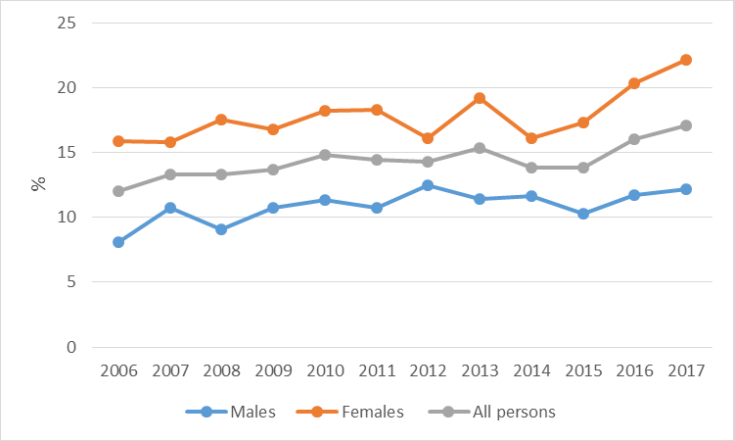


Figure 1: Prevalence of current mental health condition over time, WA residents 16 years & over

Of the 17.2% of WA adults diagnosed with a mental health condition in the previous 12 months, only one in ten (9.7%) were receiving treatment[4].

The prevalence of a current mental health condition for all persons, males and females in WA, has increased over the last decade (Figure 1)[4].

In Australia, the number of overnight mental health separations increased by an annual average of 5.1% in the 5 years to 2015–16[5]. In contrast, overnight separations for non-mental health conditions increased at a lower rate (annual average of 2.2%) over the same period[5]. Nationally, the two most common mental health conditions requiring hospitalisation

were drug and alcohol use, and schizophrenia and delusional disorders, together representing 36% of all mental health overnight hospitalisations and 37% of all mental health bed days[6].

The demographic, socioeconomic and environmental factors of rural and remote regions influence the burden of disease, with a higher incidence of chronic disease, risky health behaviours and difficulty accessing health services.

Suicide

Suicide is a complex issue, but mental health problems have been shown to increase a persons' risk of suicidal behaviour, especially when left untreated[7]. In Australia, suicide was the leading cause of premature death in 2016, accounting for 2,866 deaths[8]. Australia's suicide rate (approximately 11.7 per 100,000) has increased from 10.6/100,000 people in 2007 [8]. Suicide was the leading cause of death among all people 15-44 years of age and the second leading cause of death among those 45-54 years of age.

Deaths from intentional self-harm occur among males (17.8 deaths per 100,000 people) at a rate three times greater than that for females (5.8 deaths per 100,000 people). The highest proportion of suicide deaths of males occurs among those aged 30-34 years and for females, occurs in those aged 50-54 years[8].

Suicide rates are higher in those people experiencing socio-economic disadvantage. There is also an increased burden for suicide and self-inflicted injuries in rural and remote areas compared to metropolitan areas[9].

Nationally, in 2016, 162 Aboriginal and Torres Strait Islander persons died as a result of suicide[8]. The standardised death rate for Aboriginal and Torres Strait Islander persons was higher (23.8 deaths per 100,000 persons), compared to for non-Indigenous persons (11.4 deaths per 100,000)[8]. Between 2012 and 2016, intentional self-harm was the leading cause of death for Aboriginal and Torres Strait Islander persons between 15 and 34 years of age and was the second leading cause for those 35-44 years of age[8].

In WA, data from the HWSS indicate that adults (16 to 44 years and 45 to 64 years) were significantly more likely to report having thought about ending their own life in the last 12 months compared with those aged 65 years and over (8.1% and 5.3% compared with 2.2%)[4].

Factors associated with Mental Illness and Suicide

Factors that impact a person's mental health include: socio-demographic factors; their overall physical health status; and employment characteristics. Demographic factors such as age and gender are significantly associated with mental health problems with females more likely to report anxiety and/or mood disorders, and males more likely to report substance abuse problems[3]. Mental health and drug and alcohol problems are more common in younger ages and tend to decline with age[10].

Social factors include economic disadvantage and lack of social support. Having positive and numerous relationships with family and friends are considered to be a protective factor in promoting positive mental health[3]. Conversely, individuals living in communities with low levels of social cohesion often have higher rates of mental health problems[11]. Limited access to health services, especially in rural and remote areas may further adversely impact a person's mental health[3].

People with a mental illness have a shorter life expectancy than the general population with a gap of between 12 and 16 years, the majority (80%) of which is attributable to chronic

diseases[12]. Evidence also suggests that current chronic health conditions or behaviours that may impact on health (such as smoking) are associated with mental health problems[3, 12].

Employment in a supportive organisational culture is considered a protective factor, with people who are currently employed less likely to experience a mental illness than those who are unemployed.[3] These factors, as well as family roles and modelling, culture and norms of communities and families, and specific socio-economic indicators, are also associated with higher levels of substance use[13].

Despite evidence of the effectiveness of treatments, only 35% of Australians (aged 16 to 85 years) with a mental illness seek professional assistance from a health service[3]. With treatment, most people with a mental illness will recover and live productive lives but the success of treatment is greater if the problems are identified and treated early[14, 15].

Overcoming perceived barriers to help-seeking for mental health and substance abuse problems is one of the major challenges to increasing utilisation and effectiveness of treatments[16-18]. In the general population, barriers to treatment include stigmatising attitudes towards mental health problems[19], lack of confidence in seeking help or awareness of where to seek help, and the belief that help available would not be effective[20]. In rural areas, these barriers may occur at higher levels due to lower levels of mental health literacy, stoicism and the normalisation of symptoms associated with adverse life events, all of which prevent access to treatment and support[21].

Evidence base for addressing mental health and suicide in communities

There are a number of interrelated models and frameworks for addressing mental health and suicide prevention.

Mental health promotion and prevention

Addressing the factors that are associated with mental health is a key feature of many of the frameworks. These frameworks acknowledge the influence of individual characteristics or attributes, and also by the structural and community factors on the mental health of individuals and communities. Adapted from the World Health Organisation (WHO), Figure 2 describes the contribution of these factors[22].

Figure 2: Adapted WHO Conceptual Framework for factors associated with mental health and wellbeing

Individual and familial factors relate to a person's ability to deal with thoughts and feelings and to manage him/herself in daily life. It also relates to a person's capacity to deal with the world around by partaking in family and broader community relationships, social activities, taking responsibilities or respecting the views of others[22].

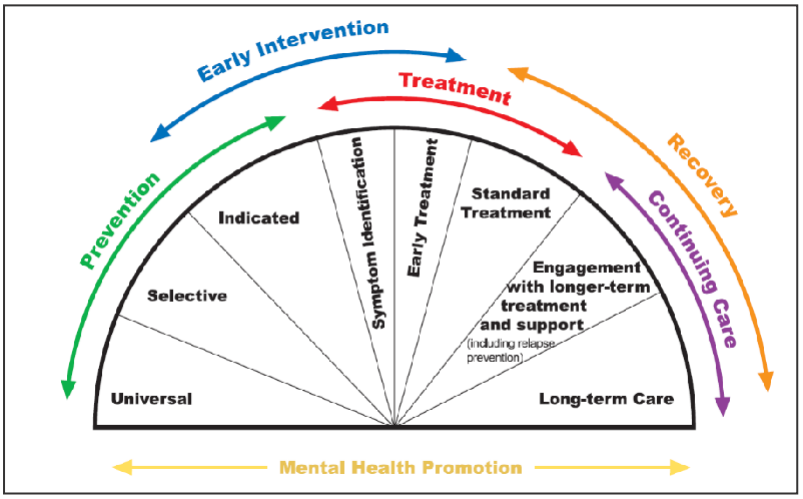
Community level factors cover the wider sociocultural environment in which people live and include levels of access to basic commodities and services, exposure to predominating cultural beliefs, attitudes or practices, discrimination, social or gender inequality and conflict[22].

Structural factors cover the opportunity to earn a living for themselves and their families and the socio-economic circumstances in which they find themselves. Restricted or lost opportunities to gain an education and income are especially pertinent socio-economic factors.

Prevention of mental ill-health focuses on reducing risk factors for mental ill-health and enhancing protective factors[23]. The promotion of mental health and wellbeing seeks to enhance social and emotional wellbeing and quality of life[23]. Initiatives can target entire populations, groups of people or individuals, and can occur in any setting[23].

Figure 3 describes a useful model outlining a broad spectrum of mental health promotion targeted at individuals and communities[24]. This model covers a range of activities from prevention to recovery and continuing care[23].

Figure 3: Spectrum of intervention model



Initiatives and strategies to prevent the onset or development of mental ill-health and to promote mental health and wellbeing can target: the whole community (universal); particular groups known to be at higher risk (selected); or individuals at very high risk who may be showing early signs of mental ill-health (indicated)[23].

Strategies may also aim to lower the severity and duration of an illness through early intervention, including early detection and early treatment[23]. Reducing the impact of mental ill-health on a person's life through approaches such as rehabilitation, relapse prevention and access to supports within the community, such as housing, employment, physical health care and social engagement support care and recovery[23].

Many communities in Australia and internationally have recognised the need to work together to improve mental health and wellbeing. There is a growing body of evidence for models which are focused on the mental health and wellbeing of the community[25-28]. These models are built on respectful partnerships across different sectors of the community[29]. One such example of coordinated approaches to mental health promotion across a community aimed to:

- Involve community members in physical, mental, spiritual and social activity - **ACT**
- Ensure a sense of belonging by keeping connected to friends and family, involvement in groups, or joining in local community activities – **BELONG**
- Enable community members to be involved in activities that provide meaning and purpose in life, such as advocating for a cause, volunteering, learning a new skill, or setting challenging goals. - **COMMIT**

The ACT, BELONG, COMMIT initiative has the potential to inform a coordinated approach to mental health and wellbeing in communities with strategies implemented under the common banner of ACT, BELONG, COMMIT to address mental health and wellbeing[29].

Suicide Prevention

The Centre for Rural and Remote Mental Health (CRRMH) outlines five focus areas for preventing suicide in rural areas in their position paper on rural suicide and its prevention (Figure 4)[30]. The strategies in these focus areas are designed to save lives now and to lower the number of deaths and rates of suicide for the future[30].

Strategies for immediate action to prevent suicide deaths include: preventing people who experience suicidality from taking their own lives; and helping those who are affected by suicide.

Figure 4: Rural Suicide prevention Focus areas

Medium and longer-term strategies to reduce numbers and rates of death include: building healthy and resilient people and communities; building protectives factors in children and young people; and providing support to vulnerable groups.

In line with models for mental health promotion, this position paper recommends approaching suicide from a public health lens by addressing known risk and protective factors for good health and mental health[30]. In particular, it recommends that rural suicide prevention should include a focus on creating "suicide safe" communities by:

- Planning for the longer-term economic viability and prosperity of rural communities;
- Creating safe environments in the home, the school, the workplace and in the community;
- Creating socially inclusive rural communities that reject discrimination due to race, ethnicity, and sexual preference, especially for those who live alone or are in more remote geographic locations;
- Increasing the understanding of good mental health and how individuals and communities can increase their overall health and wellbeing; and
- Increasing the understanding of mental illness and suicide[30].

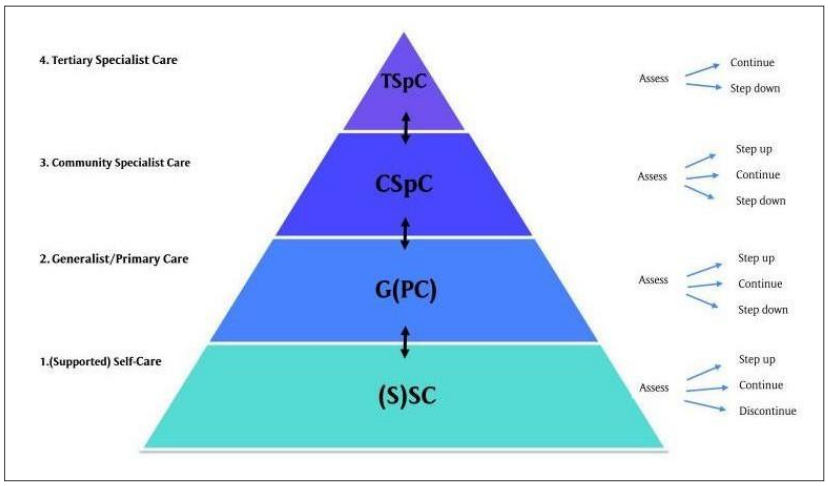
This can only be achieved by effective policies across health, social, economic, environmental areas and recognising groups specifically at risk such as males and Indigenous people. This requires multiple tiers of government to work cooperatively with communities to create and implement cohesive policies that support rather than compete or obstruct each other[30].

Stepped Care

Stepped care is a key feature of the Fifth National Mental Health and Suicide Prevention Plan, describing the various levels of mental health need, and the services required at each level[31]. Linkages between clinical and non-health supports are a key feature of the model.

A central tenet of the model is the provision of least intense services through a series of steps to the highest intensive treatment based on need. The model assumes that patients are routinely monitored, and assessed, and are able to progress through the mental health care system as symptoms escalate or diminish[32]. Ideally, this model supports continuity of care through shared information, and professional collaboration and respect across levels of mental health care services, and across other community services and disciplines.

Figure 5: Key Ingredient of Mental Health Stepped Care



In Australia, GPs and other primary care services provide most mental health care[33] hence the role of the GP is central in the stepped care model[34]. As commonly the first point of contact for people experiencing mental illness and substance problems, the GP is key in the ongoing management of their patient's mental and physical health. In this capacity, they are a key link between primary, secondary and tertiary care for people experiencing mild to moderate mental illness and substance abuse problems, especially as complexity increases[34].

Integrated and Coordinated Care

Empirical evidence and key policy documents emphasise the need for primary, secondary and tertiary mental health and drug and alcohol services to provide integrated and coordinated care[31, 35-37]. Collaborative care models for mental health care and drug and alcohol are evidence-based and have been shown to improve outcomes for common mental health disorders across populations[38-41].

Integrated care offers a number of advantages over traditional mental health care including: earlier identification of symptoms of mental illness and substance use; greater access to care; and improved targeting of symptoms[42]. Integrated models of care should include consultation and information sharing between specialist services and primary care providers supported by health information technology, as this has been shown to improve patient outcomes, treatment and costs[38, 43].

Despite this evidence, integrated models are lacking in the mental health and drug and alcohol service setting with the incorporation of a responsive integrated model in community-based settings proving a challenge[44, 45].

Project Aims

The project aimed to explore approaches to promoting mental health and wellbeing in the shire of AMR. In particular, it aimed to identify the mental health needs of the community, to determine the factors associated with mental health and wellbeing and suicide locally and to identify strategies and resources that can promote mental health and wellbeing across the community.

Our approach

In commissioning this project the Lishman Health Foundation has worked in conjunction with communities and with the support of the Shire of AMR, local health services, the South West Development Commission and local health practitioners.

Mixed methods were used to identify the key mental health needs, factors and potential solutions for the communities.

Literature review

Literature reviews were conducted to explore frameworks and models of care for mental health promotion and suicide prevention. National and international health organisation reports and policy documents were also sourced and contributed to the review.

Burden of illness data

Quantitative data from various publicly available sources were used to build a profile of the shire of AMR, including: socio-demographics; mental health, drug and alcohol and suicide status and contributing factors; and relevant service usage, access and availability. Comparisons with other communities including Western Australia and Australia were made where available. Data sources included those from local, state and national governments.

In some instances, the only available data was at statistical area 3 (SA3 level), which for this project is the Augusta Margaret River Busselton (AMRB) area. The SA3 level is a spatial unit used by the Australia Bureau of Statistics (ABS). For regional areas, they are often the functional areas of regional towns and cities with a population in excess of 20,000 people[46]. There are differences in population sizes and demographic profiles of the shire of AMR and the AMRB SA3 which need to be considered when interpreting these data. The AMRB SA3 area has over three times the population of the shire of AMR. In addition, the Busselton area has a different service mix to that of the shire of AMR, which also needs to be considered when interpreting the findings of the report.

Key Stakeholder Interviews

Interviews were conducted with key stakeholders from across the shire of AMR in late November and early December 2018. Stakeholders included: community members including consumers of mental health services and people experiencing mental health problems, carers, and those with an interest in mental health; service providers and managers from mental health, drug and alcohol and other community services; and GPs and other medical specialists.

Interview Sample

The sample for the interviews was initially provided by the members of the project advisory group. Initial contact was made with those on this list by the project team. A snowballing technique was used to identify additional stakeholders who may be interested in contributing their views.

Stakeholders were emailed or phoned to arrange dates and times for an interview. Interviews were face-to-face or by telephone if participants were unavailable on the day. One-on-one and group interviews were conducted depending on the preference of stakeholders.

Interview Questions

The interview questions were developed to reflect the project aims and the evidence base for mental health and suicide prevention and associated factors. Interview questions covered domains including: key mental health needs in the community; factors associated with

mental health and suicide; and solutions to improve mental health and to prevent suicide. Questions were open-ended and included prompts for responses where necessary.

Thematic Analysis

Interviews were recorded and information about the category of each stakeholder was collected. A modified thematic analysis was applied to identify common themes.

Interview Participants

There were 153 participants interviewed as part of the consultation. The categories of the participants are shown in Figure 6.

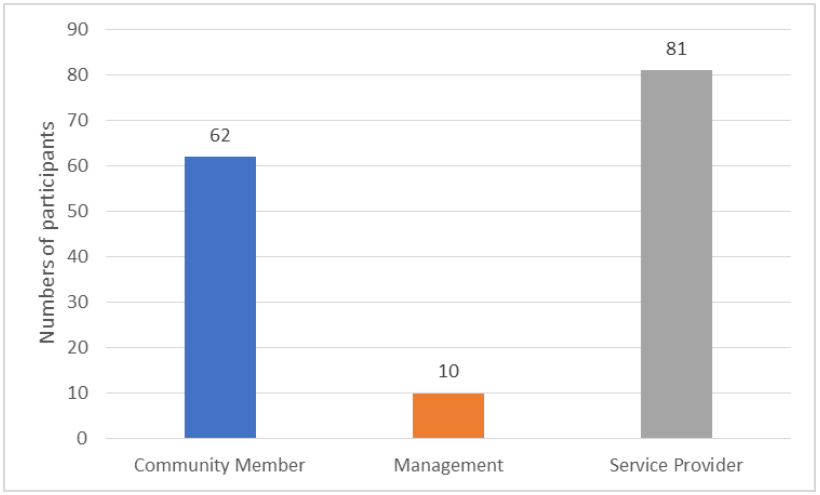


Figure 6: Overview of Participants by Category

The majority (n=91) of participants were service providers and service managers. The location where these service providers mainly provided services is described in Figure 7.**Error! Reference source not found.**

Of all service providers and managers, 42% provided services mainly in Margaret River. An additional 42% also provided services across all of the shire of AMR.

Figure 7: Overview of service providers by main location of service provision

The location of the 62 community members who participated in the interviews is described in Figure 8.

The majority of the 62 community members who participated in the interviews were from either Margaret River (n=27) or from Cowaramup (n=25) (Figure 8).

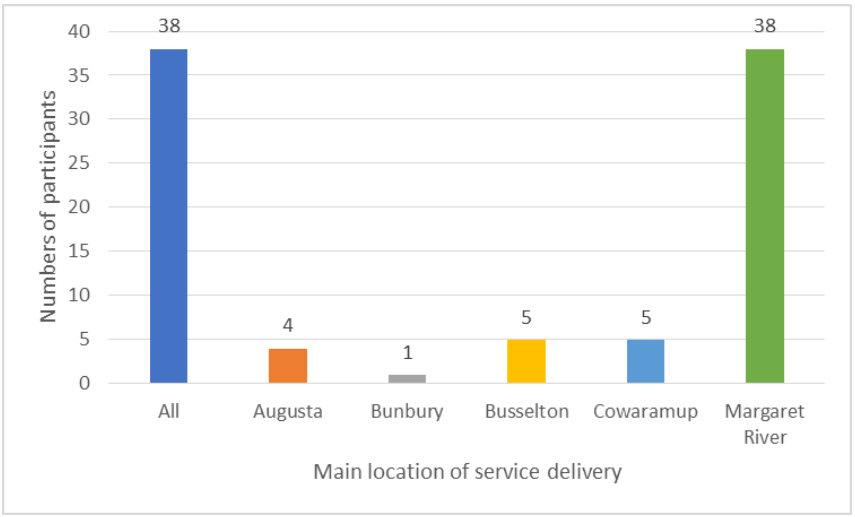
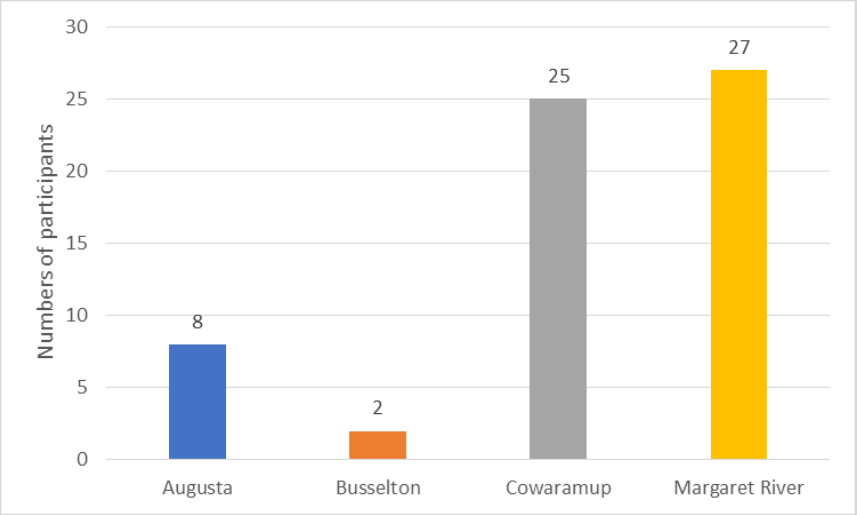


Figure 8: Overview of community members by location



Data Triangulation

The quantitative and qualitative results were triangulated to contribute to key findings and to test their consistency. The results of the data triangulation contributed to the identification of suggestions for the next steps for addressing community mental health and wellbeing in the shire.

Community Feedback

In order to identify if the initial findings reflected community views, a draft report was provided to the community for comments. Supported by promotion to the community, the draft report was provided on the Shire of AMR website for comments. In addition, a series of community meetings was held in Augusta, Cowaramup and Margaret River to present the findings outlined in the report and provide opportunity for feedback. The report was also circulated to participants who provided their email addresses in the initial stage of consultation.

Based on the data from the Shire of AMR website, there were 288 visits to 'Your Say' where the report was provided. The draft report was downloaded 165 times and there were three written responses. There was also written responses from three participants from the initial consultations.

Across the three towns, nineteen people attended the community meetings and separate meetings were held with 6 service providers who were unable to participate in the original consultations.

Augusta Margaret River Socio-Demographic Profile

Population, socio-demographic and economic indicators with relevance to mental health and suicide were identified to contribute to the understanding of the shire of AMR community.

Geography

The shire of AMR is located in the southwestern area of Western Australia (Figure 9) approximately 250 kilometres south of Perth[47]. The shire covers an area of approximately 2,240 square kilometres with 120 kilometres of coastline[47]. Margaret River, Augusta and Cowaramup are the main towns in the shire[47].

Figure 9: Shire of AMR in South Western Australia

The shire is a popular tourist destination with attractions including diverse landscapes, wineries and restaurants, and surfing beaches[47]. The shire combines tourism with farming activity, primarily beef and dairy farming, along with sheep farming, horticulture, viticulture and agro-forestry[47].

Since the 1970s the region has developed into an internationally renowned wine producing region which has changed the once primarily agricultural region into a tourism destination.

For local residents, this region holds a deeper meaning with each of the settlements in the shire possessing their own unique identity based on history, cultural heritage and a strong sense of shared community values.

Population

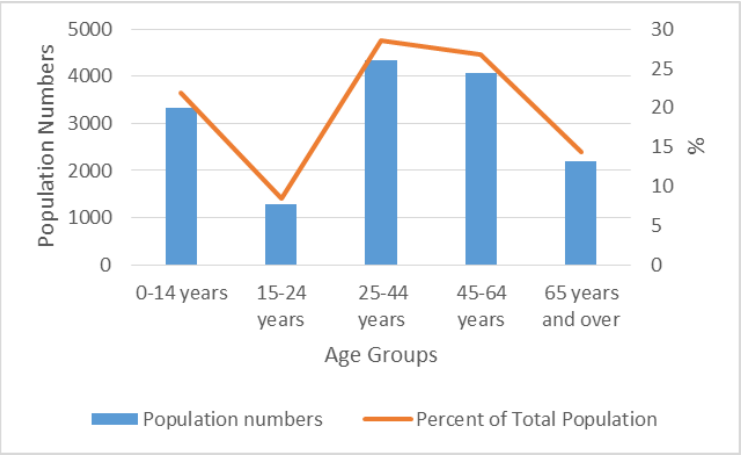
The estimated resident population (ERP) in the shire of AMR in 2017 was 15,212 people[48]. The shire has experienced an average annual population growth rate between 2011 and 2016 of 3.7%, the highest rate in all of South Western Australia[47]. The population estimate, which is based on Census counts by place of usual residence, may be affected by the count of 'fly-in, fly-out' (FIFO) workers who live in the shire but may spend more than six months in any one year working away[47].

Significant residential development has occurred over the past ten years and this is expected to continue, influencing the demographic and cultural profile of the shire's population[47]. The Shire of AMR projects that by 2031, the population will grow to approximately 19,000 people[47].

The Margaret River area is within the traditional lands of the Wadandi Nyungars. The Wadandi are the traditional custodians of the area and have a strong connection to the sea[47]. In 2016 there were 195 Aboriginal and Torres Strait Islander people representing 1.4% of the usual residential population (URP), lower than that for Australia (2.8%) and Western Australia (3.1%)[48].

The age profile of the shire of AMR is displayed in Figure 10. The highest proportion of the estimated ERP is in the 25-44 years age group (28.5%), similar to the proportions for Australia (28.2%) and Western Australia (29.3%)[48]. There was a higher proportion of young people under 14 years (22%) in the shire compared to the proportions for Australia (18.8%) and Western Australia (19.5%)[48].

Figure 10: Shire of AMR Population by Age Groups (Numbers and %)



In the shire, the age profiles differ across towns. While the median age for residents in the shire overall is 39 years, the median age for Augusta is 59 years, with almost two-thirds of Augusta residents aged over 50 years[47].

In 2016, 30.3% of the shire population was born overseas, a lower proportion compared with Australia (33.3%) and Western Australia (39.7%)[48]. The proportion of people born in predominantly non-English speaking countries was lower in the shire (6.9%) compared with Australia (17.9%) and Western Australia (16.6%)[48].

Families

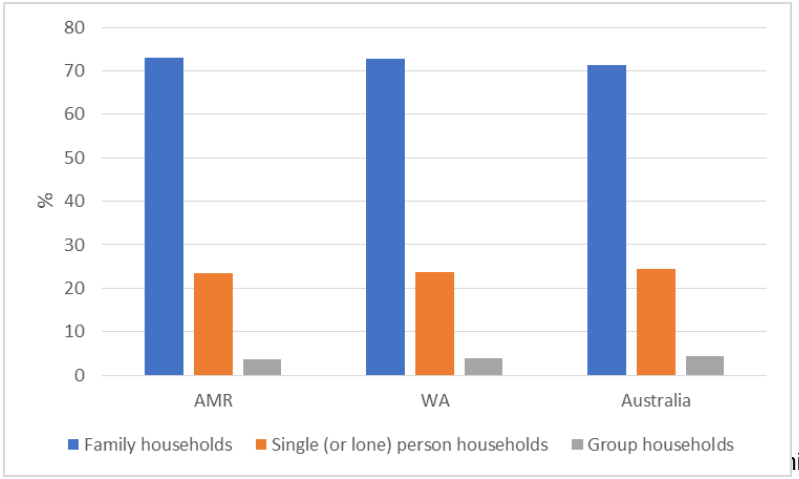
In the shire, 20% of families with children aged less than 15 years were single-parent families, a rate lower than for Australia (20.4%) and slightly higher than for Western Australia (19.1%)[48]. In the shire, of families with children under 15 years, 7.2% do not have a job, a rate lower compared to Australia (11.2%) and Western Australia (10.8%)[48]. Of all families, 9.2% are low income, welfare-dependent families (with children), a rate similar to Australia (9%) and higher than the rate for Western Australia (8.5%)[48].

Households and dwellings

The proportion of households in each household type for the shire, compared to WA and Australia is shown in Figure 11. In the shire, of all households, 72.9% were family households, 23.4% were single person households and 3.7% were group households. The composition of households in the shire is similar to that at state and national level[46].

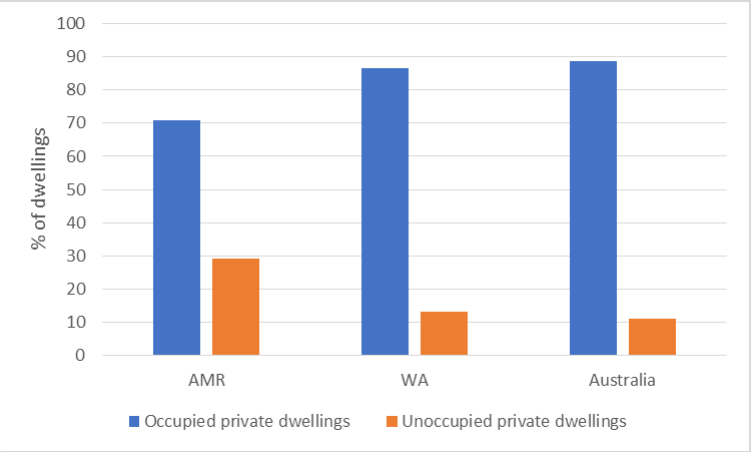
The proportion of private dwellings by occupancy for the shire is shown in Figure 11, with comparisons to WA and Australia. In the shire, 70.8% of private dwellings were occupied and 29.2% were unoccupied.

Figure 11: Proportion of households by household type



The proportion of occupied dwellings (71%) in the shire of AMR is much lower than the proportions at state and national level. In addition, the shire has a much higher rate of unoccupied dwellings (29%) compared to state and national levels[46].

Figure 12: Proportion of private dwellings by occupancy



Education

It is estimated that 27.2% of people in the shire left school at Year 10 or below, or did not go to school, a rate lower than Australia (30.4%) and lower than Western Australia (29.7%)[48]. There is a higher level of school leaver participation in higher education in the shire of AMR (36.6%) compared to Australia (33.6%) and Western Australia (33.9%). Of young people aged 15-24 years, it is estimated that 84.3% are either participating in education or in employment[48]. This rate is similar to that for Australia and Western Australia.

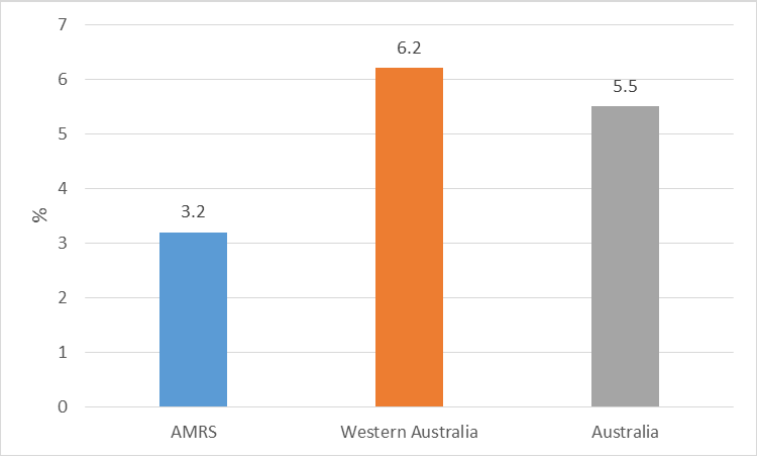
Early childhood development

The proportion of children who are developmentally vulnerable on two or more domains is 7.2% in the shire of AMR, lower than the proportions for Australia (11.1%) and Western Australia (10.5%)[48]. There is variation in the proportion of children who are developmentally vulnerable on two or more domains across the shire with the highest proportion in Augusta Karridale (13.6%) with Margaret River/Gnarabup (6.1%) and Cowaramup/Gracetown (7.3%) having lower rates[48].

Employment

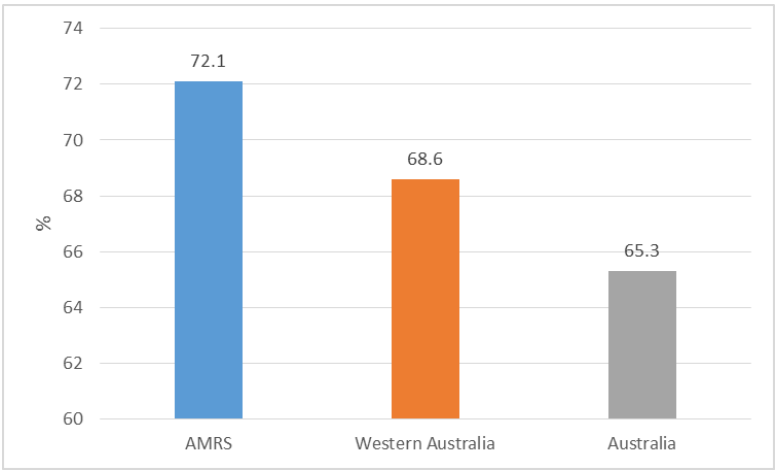
The unemployment rate for the shire compared to Australia and Western Australia in March 2018 is described in Figure 13[49]. The proportion of the labour force that is unemployed in the shire of AMR is 3.2% compared to 5.5% for Australia and 6.2% for Western Australia. For this time period, the shire of AMR had one of the lowest unemployment rates of any of the local government areas in Western Australia[49].

Figure 13: Unemployment rate –Shire of AMR, Western Australia and Australia in March 2018



The labour force participation rate of the shire of AMR in 2016 is shown in Figure 14, compared to the rates in Western Australia and Australia[48]. This is a measure the labour force (aged 15 years and over) expressed as a proportion of the civilian population for the same age group[48].

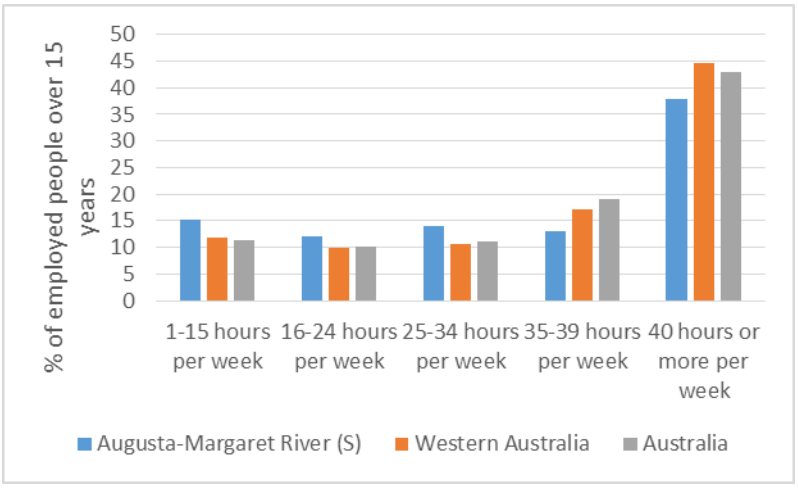
Figure 14: Labour Force Participation rate Shire of AMR, Western Australia and Australia in March 2018



These data indicate the labour force participation rate is higher in the shire of AMR (72.1%) than the rates in Western Australia (68.6%) and Australia(65.3%)[48].

The proportion of people working by hours per week for 2016 is described in Figure 15. These data indicate that higher proportions of people in the shire work fewer hours per week compared to people in Western Australia and Australia. In contrast, smaller proportions of people in the shire of AMR work 35 plus hours per week compared to those in Western Australia and Australia[50].

Figure 15: Employment and hours worked in Shire of AMR, Western Australia and Australia



Between 2013 and 2017, the majority of businesses in the shire of AMR were small businesses employing 20 people or less (Figure 16)[46].

Figure 16: Number of Business in Shire of AMR by employees

The top five industries with the most number of businesses in the shire of AMR between 2013 and 2017 are shown in Figure 17[46].

The construction and agriculture, forestry and fishing industries had the most number of business in the shire of AMR in 2017[46].

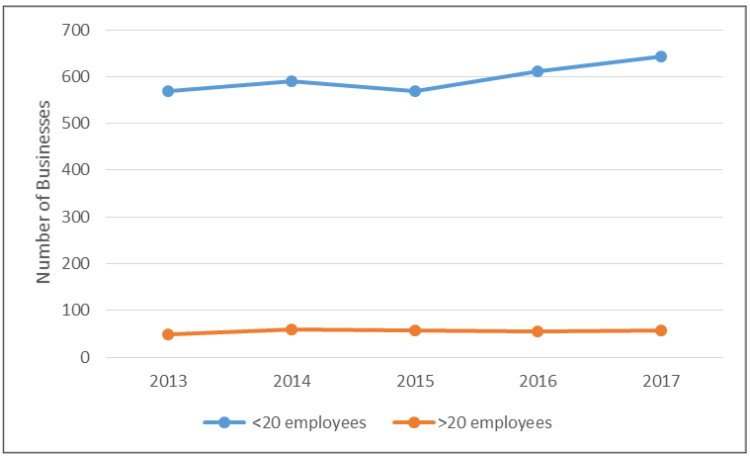
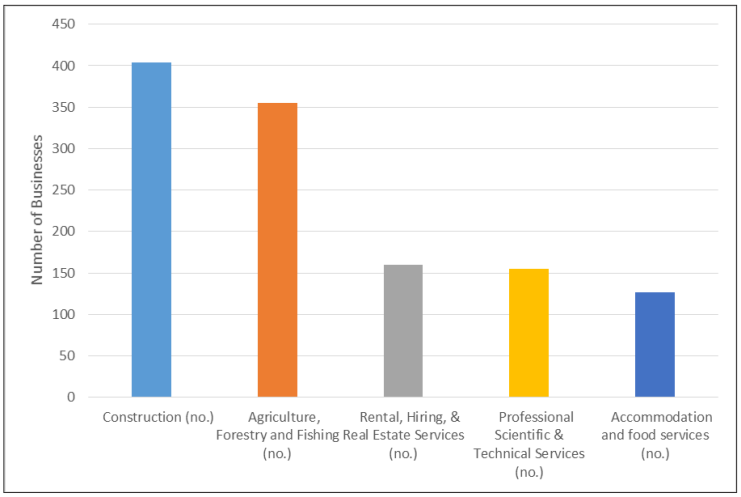


Figure 17: Industries in the AMRs with the most number of businesses in 2017



Industry of Employment

The top 5 industries that employ the highest proportion of people in the shire of AMR are shown in Figure 18.

Figure 18: Proportion of employed person by top 5 employing industries 2011-2017 in the shire of AMR

In 2017, the industries of accommodation and food services employed the majority of employees (11.4%), followed by construction 10.6% and manufacturing 18.5%[46].

The industries where there had been increases in the proportion of persons employed in this time period were:

- Administrative and support services (3.7%-4.5%)
- Education and training (7%-8.5%)
- Health care and social assistance (7.1%-7.7%%)[46]

The numbers of people employed by industry between 2006 and 2016 in the shire of AMR for the top five employing industries is shown in Figure 19.

Figure 19: Numbers employed by top 5 employing industries between 2006 and 2016 for the shire of AMR

The accommodation and food services industry employs the most number of people in 2016 and this has increased since 2006 in the shire. The numbers employed in the construction, manufacturing and retail industries have also

increased between 2006 and 2016[46].

Occupation

The occupations which employed the most number of people between 2006 and 2016 are described in Figure 20[46]. Technicians and trade workers comprise the most number of employed persons for 2016 (n=1185) followed by managers (n=1162) and professionals (n=1095)[46]. The numbers in all employment categories have increased between these time periods. The employment category with the biggest increase in employees is in professionals (n=414) and community and personal service workers (n=361)[46].

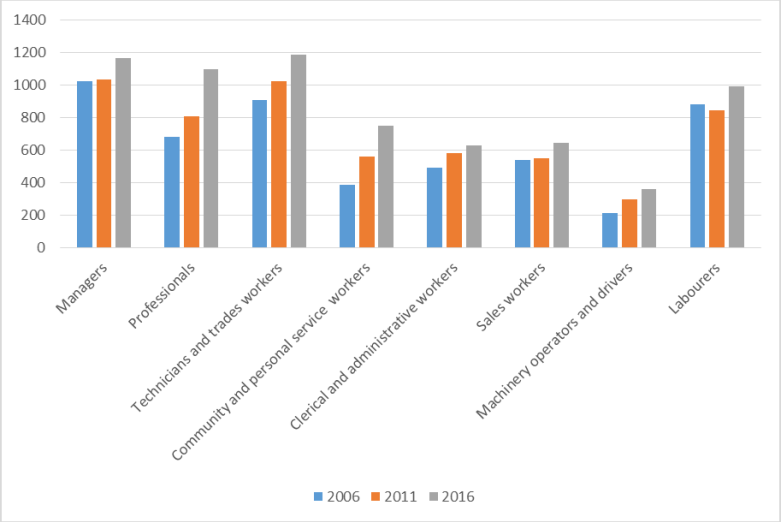


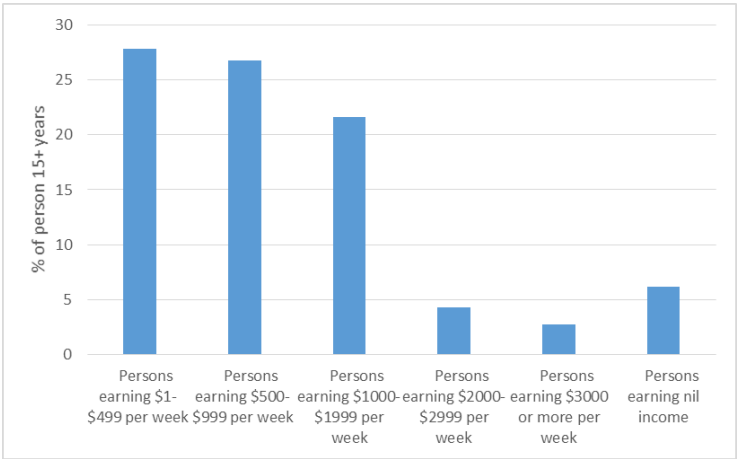
Figure 20: Numbers of people employed by employment category 2006-2016 for the shire of AMR

Household Income

The median total weekly household income for the shire of AMR was $1,285[46]. The proportion of persons in each total weekly income category for the shire is shown in Figure 21.

In 2017, the majority (55%) of persons in the shire of AMR earned less than $1000 per week[46]. Over a quarter (28%) earned less than $500 per week.

Figure 21: Proportion of persons (15+years) by income category for the shire of AMR in 2017



Financial Stress

Mortgage stress is an indicator which describes the proportion of families in a low-income bracket and pay more than 30% of their income on mortgage repayments[48]. For families that rent, rental stress is described as the proportion of households in the bottom 40% of the income distribution that spend more than 30% of their income on rent, as a proportion of rented private dwellings[48].

In the shire of AMR, 14.7% of low-income families are under mortgage stress and 30.5% of families in the bottom 40% of the income distribution experience rental stress[48]. These levels are higher than for families in Australia (9.3% and 27.3%) and Western Australia (10.1% and 27.8%)[48].

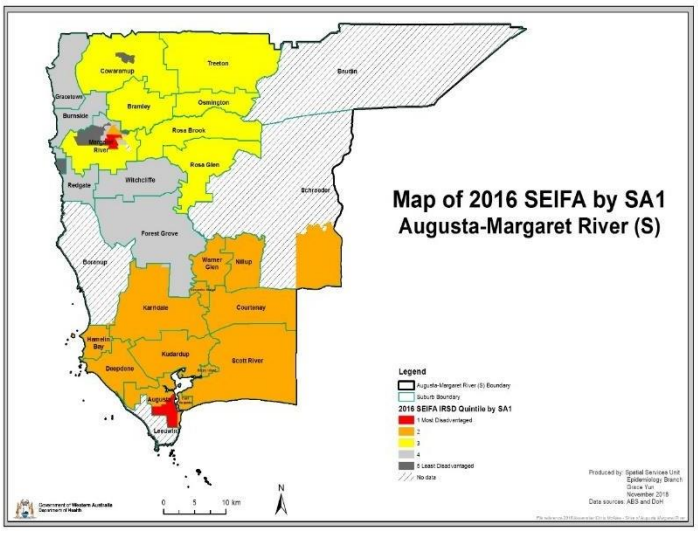
The ability to access money if needed quickly is another indicator of financial stress. In the shire of AMR, the estimated proportion of people (18 years and over) whose household

could raise $2,000 within a week was 89%, a level the same as Western Australia. The rate for Australia was lower at 84% of households[48].

Socio-economic Disadvantage

Socio-Economic Indexes for Areas (SEIFA) measures the relative level of socio-economic disadvantage based on a range of census characteristics including low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations[46]. It provides the relative level of disadvantage in one area compared to others.

Figure 22: Map of SEIFA Scores for the shire of Augusta Margaret River - 2016



The SEIFA score for the shire of AMR in 2016 was 1025 placing it in 9th decile within Australia and indicating a relative lack of disadvantage in general[48].

There was variation in levels of disadvantage across the shire in 2016. In general, areas of less disadvantage were in the northern parts of the shire with more disadvantage in the southern parts of the shire (Figure 22).

Internet Connection

An internet connection is now an important utility for most households in Australia, required for accessing essential information and taking part in the digital economy[46]. Importantly, the internet enables access to information and support for mental health. In 2016, 83% of all Australian households had internet access, decreasing with age, with seniors less likely to have internet at home[46]. In the shire of AMR 85% of households had internet access which is similar to the level of internet access for Western Australia.

Community Strengths

There are a number of indicators of strengths in the shire including: volunteering; a sense of community safety; community acceptance and discrimination[48].

Volunteering

In the shire of AMR, 28% of the population reported doing some form of voluntary work in 2016, higher than for Western Australia (19%) and Australia (19%)[48].

Community Support

The ABS collects a number of indicators of community support in its national General Social Survey conducted with Australians aged 15 years and over. Access to support in times of crisis is one indicator of community support. In the shire of AMR, it is estimated that 96% of the community could access some sort of support in a time of crisis, rates comparable to Western Australia (95%) and Australia (94%)[48]. The estimated rates of people who provide support for family members outside the household are similar for the shire of AMR (33%), Western Australia (33%) and Australia (31%)[48].

Safety

In 2016, the estimated proportion of people (18 years and over) feeling very safe/safe walking alone in the local area after dark was 64% in the shire of AMR. This proportion was higher compared with rates for people in Western Australia (49%) and Australia (52%)[48].

Acceptance and Discrimination

The estimated proportion of people (18 years and over) who disagree/strongly disagree with acceptance of other cultures in the shire of AMR was 5%, the same proportion as for Western Australia and Australia. The proportion of people who experience discrimination was the same for the people in the shire (21%) as in Western Australia and slightly higher than Australia (19%)[48].

Mental Health

There is a range of data available to describe the mental health of the residents of the shire of AMR. These data are measures of mental health problems and other related health indicators.

Burden of Illness

Psychological Distress

The Kessler Psychological Distress Scale (K10) is a 10-item instrument designed to measure participants' current level of psychological distress. The K10 is one of the most widely used screening tools for detecting psychological distress as an indicator of mental health problems at both individual and population levels[51]. The K10 results are grouped into four levels of psychological distress: 'low' (scores of 10-15, indicating little or no psychological distress); 'moderate' (scores of 16-21); 'high' (scores of 22-29); and 'very high' (scores of 30-50 and likely to have a severe mental disorder)[52].

For the shire of AMR, in 2014-15, the estimated proportion of people aged 18 years and over with high or very high psychological distress (K10) was lower at 8.1 per 100 people[48]. In 2014-15, the rate at which the population aged 18 years and over experienced high or very high psychological distress at state and national levels was higher (9.8 per 100 for Western Australia and 11.7 per 100 for Australia)[48].

Mental and behavioural problems

The estimated proportion of people with mental and behavioural problems in the shire of AMR in 2011-12 was 14.%, the same rate as Western Australia and Australia[48]. These estimates were based on data from the Australian National Health survey where people 15 years and over, reported whether they had a current mental health and behavioural problem which had lasted or was expected to last for six months or more.

Alcohol

The estimated proportion of people aged 15 years and over in the shire, who consumed more than two standard alcoholic drinks per day on average was 28%, higher than the Western Australian rate (20%) and Australia (17%)[48].

Alcohol-attributable hospitalisations, in in the shire between 2011 and 2015 was 854.4/100,000 population. The hospitalisation rate was significantly higher for males (854.4/100,000) than for females (730.7/100,000)[53]. These rates are similar to those for other local government areas in Western Australia[53].

Between 2006 and 2015, there were an estimated 31 alcohol-attributable deaths in the shire of AMR with the majority (71%) of these occurring in males. In this time period, there were 24.5 deaths per 100,000 residents, a rate similar to that of Western Australia[53].

Other Drugs

Between 2011 and 2015, there were an estimated 156 drug-attributable hospitalisations in the shire of AMR. A drug-attributable hospitalisation is one where substance misuse disorder or harm is the principal diagnosis. It is estimated that 48% of the hospitalisations were for males and 52% of the hospitalisations were for females[53] but this difference was not statistically significant. In the same time period, there were 287.2 hospitalisations per 100,000 for the shire of AMR residents. This rate is similar to other local government areas in Western Australia[53].

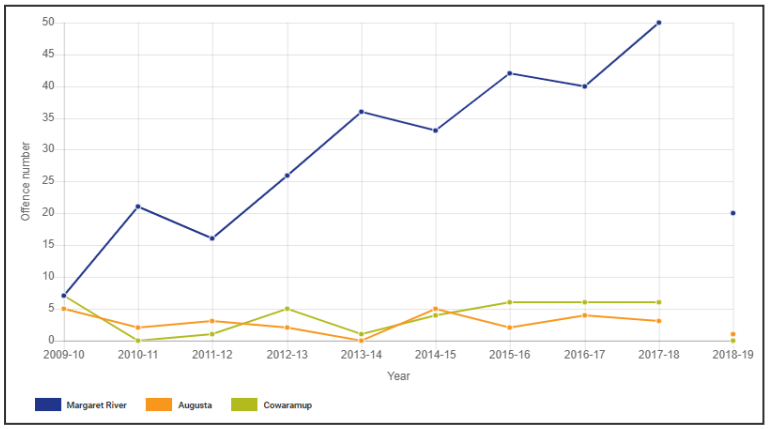
Domestic Violence

Domestic violence is a significant issue in Australian communities, contributing significantly to injury, death and disability and with women at most risk[54]. Domestic violence also has long term consequences for the physical and mental health of those experiencing this crime[54].

Evidence suggests that some women at greater risk of experiencing domestic violence are those where: there is significant alcohol and drug use by perpetrators; they have experience of violence as a child and subsequent victimisation as an adult; the women are pregnant or are separated, younger, Indigenous, living in rural and remote areas and experiencing financial stress[55].

Figure 23 shows the numbers of family assaults and family-related threatening behaviour for the towns of Margaret River, Augusta, and Cowaramup between 2009-10 and 2018-2019[56].

Figure 23: Numbers of family assaults and threatening behaviour – Margaret River, Augusta, Cowaramup

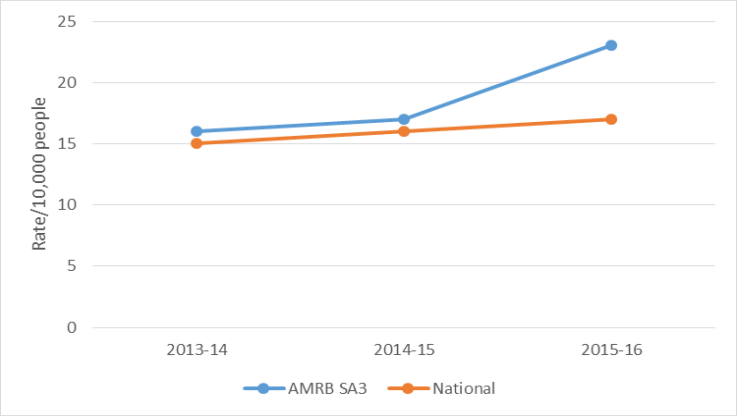


While the numbers of family assaults and family-related threatening behaviour have remained steady for Augusta and Cowaramup, the numbers for Margaret River have increased every year for the last decade. It is noted that these data are for numbers rather than rates of family assaults and threatening behaviours. The population of Margaret River is larger than that of Augusta and of Cowaramup, and as such the numbers of offences greater. However, the increases in offences in the town of Margaret River is not explained by increases in population.

Suicide and Self-harm

The age-standardised rates of admission to hospital for intentional self-harm for residents of the AMRB SA3 area compared to the national rate is shown in Figure 24. The rate for the AMRB SA3 was higher than the national rate for each of these years. The rate has increased to 23/10,000 people in 2015-16, higher than the national rate of 17/10,000 people in that year[57].

Figure 24: Age-standardised rates of admission to hospital for intentional self-harm AMRB SA3 and national rates – 2013-14 – 2015 -16



Between 2011 and 2015, in the shire of AMR, the estimated rate of deaths from suicide and self-inflicted injuries, for people aged 0 to 74 years was 17.9 per 100,000 people. This estimated rate was higher than that for Western Australia (14/100,000people) and for Australia (11.5/100,000 people)[48].

Mental Health Services

There is a range of clinical and community services providing care and support for people with a mental illness and at risk of suicide. In the shire, public health services are located in Margaret River and Augusta with public hospitals and community health centres in these towns. Inpatient mental health services are provided in Bunbury. There are a range of private community-based psychologists, counsellors and social workers as well as support services providing care and support across the shire.

Primary Care

Primary care including general practice, Aboriginal Community Controlled Health Organisations (ACCHOs) and community health services provide mental health clinical care to the majority of the population, and have a key role in early intervention. Primary mental healthcare involves: diagnosis and treatment for people with common mental disorders; preventing mental disorders; and applying key psychosocial and behavioural treatments[58].

Primary mental health services complement tertiary and secondary level mental health services and support coordination and integration of care. Indeed the effectiveness of primary mental health care is dependent on integration with more specialist mental health services.

The Medicare Benefits Scheme (MBS) provides subsidised mental health-related services provided by GPs, psychiatrists, psychologists and other allied health professionals (including some social workers, mental health nurses, occupational therapists and Aboriginal health workers)[59]. Services provided under the MBS by GPs can include preparation or review of a mental health treatment plan, supported by referral to mental health clinicians, ongoing management of a patient's mental health condition and focused psychological strategies.

Data to understand services delivered in primary care are available at the AMRB SA3 area only. The most recent data available MBS and Pharmaceutical Benefits Scheme (PBS) are for the 2013-2014 time period[60].

Figure 25 shows the rate of mental health treatment plans provided by general practitioners (GPs) for the AMRB SA3.

Figure 25: Rate of General Practitioner Mental Health Treatment Plans, AMRB SA3, WA and Australia in 2013-14 (rate per 100,000 population)

For the AMRB SA3 the rate at which GPs provide mental health treatment plans is higher (4550/100,000) than the rates for Western Australia (3,208/100,000) and at the national level (4,260/100,000 people)[60].

The reasons for these higher levels can relate to better access to GPs, and other mental health professionals such as psychologists. The variation could also be explained by the knowledge and attitude of GPs to mental health and the use of mental health plans[60].

Specialist Mental Health Care

These more specialist mental health services manage acute episodes of mental illness and provide follow-up care for people in the community. However, these services do not provide a solution for people with chronic mental illness who end up in the admission–discharge–admission (revolving door syndrome) unless backed up by comprehensive primary healthcare and community services[58].

In 2016/17, the rate of admissions for mental health-related conditions to public hospitals for residents of the shire of AMR was 1014.9/100,000 population. This is higher than the rate for Western Australia (945/100,000 population) and for Australia (996.3/100,000 population)in the same time period[48].

However, in these years, the rate of admissions for mental health-related conditions to all hospitals, including private hospitals for residents of the shire of AMR (1,128.8/100,000 population) was lower than the rate for Western Australia (1197.5/100,000 population) and for Australia (1884.1/100,000 population)[48].

For residents of the shire of AMR, in 2016/17, the rates of admissions to public hospital for mood affective disorders (such as depression) was 240.2/100,000 population and for all hospitals was 314.1/100,000 population. These admission rates were higher than those for Western Australia and Australia for public hospitals only. For residents of Western Australia, the rates of admissions to public hospital for mood affective disorders (such as depression) was 195.9/100,000 population and for all hospitals was 320.7/100,000 population. For residents of Australia, the rates of admissions to public hospital for mood affective disorders (such as depression) was 216.4/100,000 population and for all hospitals was 625.4/100,000 population[48].

In 2015–16, the rate of mental health overnight hospitalisations was 97/10,000 people for the AMRB SA3 area slightly lower than the national rate of 102/10,000[57]. While the age-standardised rates for overnight hospitalisations for depressive disorders, and bipolar and mood disorders were similar to the national levels, the rate for anxiety and stress disorders for the AMRB SA3 (21/10,000) was higher than the national level (14/10,000). This rate was higher than the national level for each of the three years between 2013-14 and 2015-16[57].

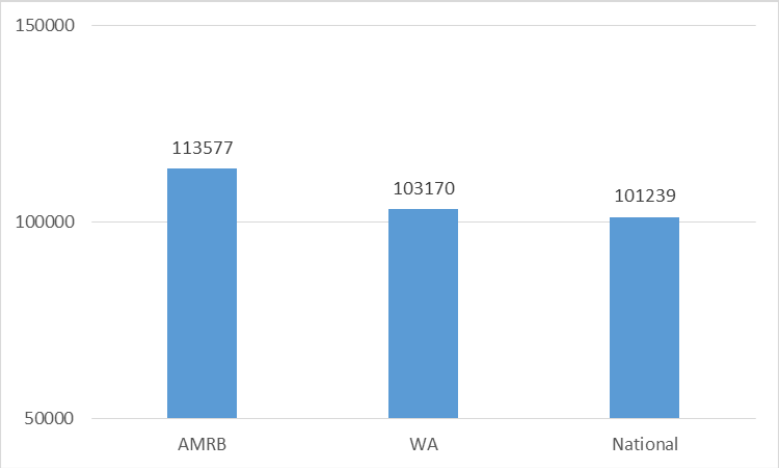
Prescription of Medications for Mental Illness

For individuals, treatment options for mental illness include pharmacological (medications) and non-pharmacological types such as cognitive and behavioural therapies, as well as psychosocial support. Both of these options have a role to play in managing mental illness.

Anti-depressants are used to treat **mood disorders** such as depression. Evidence indicates that non-pharmacological interventions are the optimal treatment for milder forms of depression with the preferred treatment for moderate to severe depression being a combination of social and psychological interventions and antidepressant medicines[61]. Some antidepressant medicines can also be used to treat neuropathic pain and some anxiety disorders. They are also used to treat a number of other conditions prevalent in adults aged 65 and over, including some anxiety disorders, chronic pain and some types of urinary incontinence[61].

Figure 26 and Figure 27 show the rate of antidepressant prescribing for 18-64-year-old residents of AMRB SA3 and for those 65 years and over. For both these age categories, the rates of prescribing are higher compared to WA and to Australia.

Figure 26: Antidepressant medicines dispensing 18-64 Years, AMRB SA3 compared with WA and Australia (rate per 100,000 population)



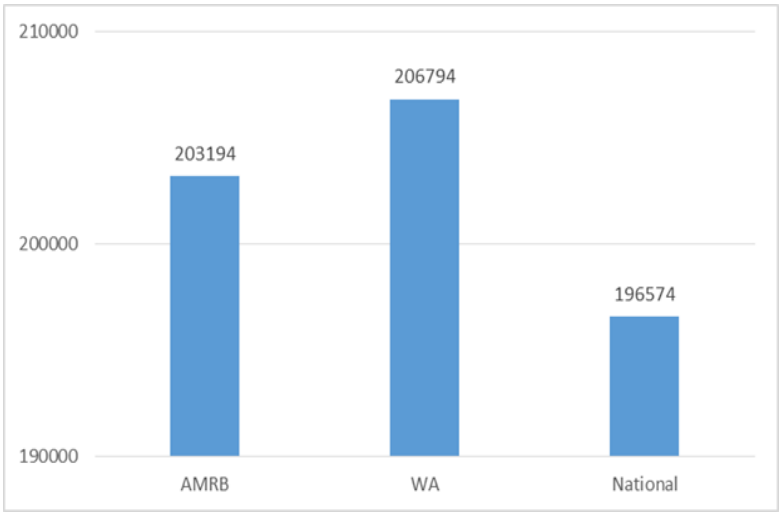
For those residents of AMRB, 18-64 years, the prescribing rate for anti-depressant medications was 113,577/100,000 people[61]. This rate of prescribing was higher than both state and national levels for this age group.

Reasons for this variation can relate to socio-economic and mental health-related factors and access to services. It can also relate to prescribing practices, training, knowledge and attitudes of clinicians and their assumptions that individuals want medication[60].

For older residents of AMRB SA365 years and older, the rate of antidepressant prescribing was 203,194/100,000 people, higher than the national level but lower than the state level.

At a national level, the rate of antidepressant prescribing is almost double those for adults aged less than 64 years[60]. In addition to reasons for higher rates in other age groups, these higher rates for older people can relate to reduced access to social and psychological interventions, the prevalence of chronic and other illnesses and use of these medications in other illnesses[60].

Figure 27: Antidepressant medicines dispensing 65 years and over, AMRB SA3 compared with WA and Australia (rate per 100,000 population)



Anti-depressants are also prescribed for young people under 17 years experiencing mood disorders, but more commonly for those in this age group experiencing anxiety[60]. The rates of anti-depressant medications in young people aged 17 years and under are described in Figure 28.

For young people aged 17 years and under, the rates for AMRB SA3 area are lower when compared to state and national levels[60].

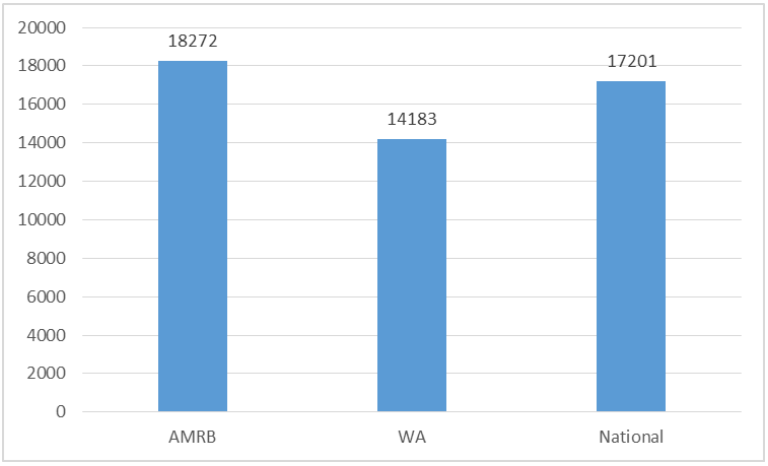
Figure 28: Antidepressant medicines dispensing 17 years and under, AMRB SA3 compared with WA and Australia (rate per 100,000 population)

Anxiety disorders are the most common mental health problem in Australia, affecting 14 per cent of people[3]. Anxiolytics are used to treat the symptoms of anxiety, insomnia and substance withdrawal over short periods. While there is evidence to support their effectiveness in the short term, they are not recommended for long-term use as they can be addictive and have a number of side effects[61].

For anxiety, these medications are often used in combination with antidepressants. A combination of antidepressant medicines and psychological interventions is more suitable and effective at maximising positive treatment outcomes for anxiety in the longer term. The rates of prescribing for anxiolytics are shown in Figure 29 (18-64 years) and Figure 30 (65+ years).

The rate of anxiolytic medicines for residents of the AMRB SA3 area aged 18-64 years is 18,272/100,000 (Figure 29) higher than the rate for the state and Australia[60].

Figure 29: Anxiolytic medicines dispensing 18–64 years, AMRB SA3 compared with WA and Australia (rate per 100,000 population)

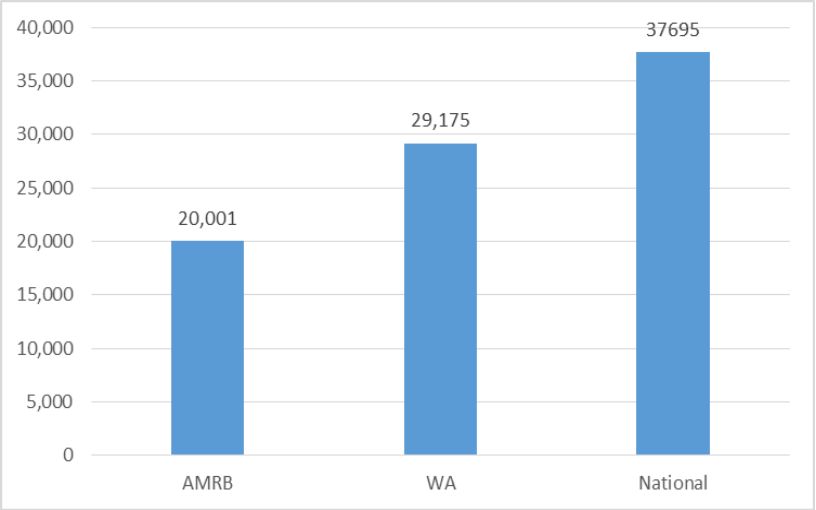


Reasons for variation in prescribing rates at the national level include: different levels of risk factors for anxiety; access to non-pharmacological treatment options; and prescribing practices, including short courses of treatment which aim to prevent dependence[60].

Rates of anxiety disorders are lower among older Australians[60]. Despite the lower rate, anxiety in older people can be associated with increased disability, mortality and the use of health services and may be harder to recognise because the symptoms of anxiety overlap with the symptoms of depression and dementia[60].

The rate of anxiolytic medicines for residents of the AMRB SA3 aged 65 years and over is 20,001/100,000 considerably lower than the rate for WA and the national rate (Figure 30)[60].

Figure 30: Anxiolytic medicines dispensing 65 years and over for AMRB SA3 compared with WA and Australia (rate per 100,000 population)



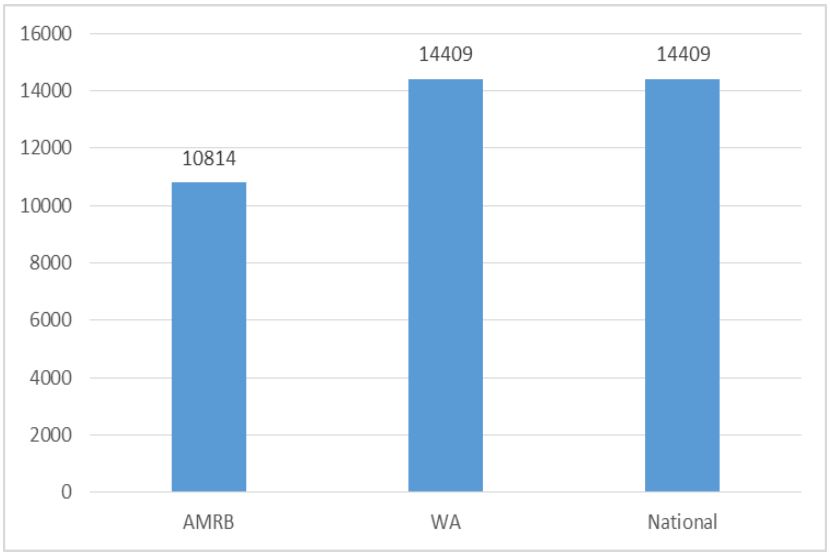
Reasons for variation in rates of prescribing anxiolytic medications in older people can include: reduced access to psychological treatment; clinician prescribing practices; and community awareness regarding prevention, self-management and non-medication treatments for anxiety[60].

Antipsychotic medicines are primarily used to treat psychotic disorders, including schizophrenia, and the psychotic symptoms of mood disorders such as paranoia, confused thinking, delusions and hallucinations[61].

In addition to antipsychotic medications, effective treatment for these disorders usually includes ongoing clinical support in the community; psychological therapies; education about symptoms and how to deal with them; psychosocial rehabilitation; accommodation, employment; and educational support[60].

The rates for prescribing antipsychotic medications for those 18-64 years in the AMRB SA3 are shown in Figure 31. For the population of AMRB SA3 aged 18-64 years, the prescribing rate for antipsychotic medications is 10,814/100,000, lower than the rate for Western Australia and the national rate[60].

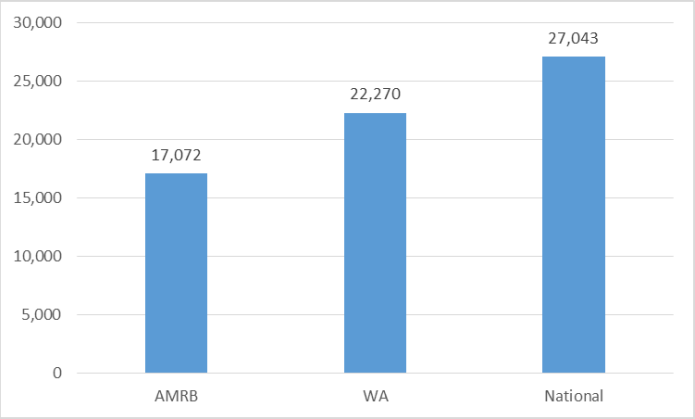
Figure 31: Antipsychotic Medicines dispensing 18-64 Years AMRB SA3 compared with WA and Australia (rate per 100,000 population)



There are a number of reasons for variation in rates for antipsychotic medications. These can include: prescribing practices; drug use and levels of disadvantage[60].

For the older population of AMRB SA3, the prescribing rate for antipsychotic medications is 17,072/100,000, lower than the rate for Western Australia and the national rate (Figure 32)[60].

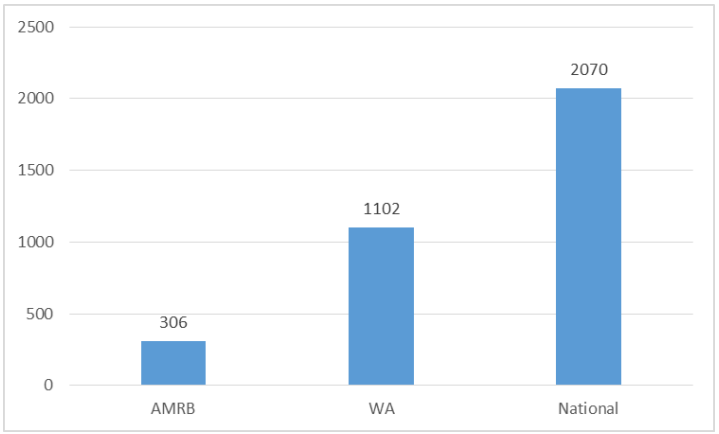
Figure 32: Antipsychotic Medicines Dispensing 65 Years and over AMRB SA3 compared with WA and Australia (rate per 100,000 population)



At a national level, there are concerns that prescribing rates for antipsychotic medication are high and these medications are used inappropriately especially in older people. In particular, and related to prescribing practices, for this older age group there are concerns that these medications are used for behavioural disturbances related to dementia or delirium before secondary causes have been excluded and non-pharmacological measures have been tried[60].

For younger people (17 years and younger), prescribing antipsychotic medication is used to treat a range of behavioural disturbances related to developmental and behavioural conditions, including autism spectrum disorder, attention deficit hyperactivity disorder and conduct disorder[60].

Figure 33: Antipsychotic Medicines Dispensing for young people 17 years and under AMRB SA3 compared with WA and Australia (rate per 100,000 population)



The rates for prescribing antipsychotic medications for those under 17 years in the AMRB SA3 are shown in (Figure 33). The rates (306/100,000) are considerably lower than state and national rates.

In addition to prescribing practices, variation can occur because of access to psychosocial interventions and incidence and prevalence of psychosis related to illicit drug use[60]. The willingness of clinicians, consumer and family to accept medication assistance can also be a factor explaining variation[60].

Community views

The participants in this project provided a range of views regarding needs in relation to mental health and suicide, factors associated with mental health and suicide, mental health and support services and potential solutions that would address the key issues in this community.

Community Strengths

There were key themes identified relating to community strengths that can support mental health and wellbeing in the community. Many of these of these are directly related to promoting mental health and wellbeing or are focused on connecting people across the community.

Sporting Clubs

The Margaret River Hockey Club has developed and implemented an Award Winning (2018 Smarter than Smoking Club of the Year) project called Above the Line (ATL), directly in response to promoting the mental health and wellbeing of its members. Above the Line is designed to promote healthy mindsets and culture within the club through positive actions and language in all on- and off-field activities of this sporting club. The project is being implemented in this club with a potential roll out to other sporting clubs, and indeed other community groups.

This Above the Line initiative is a project supported by Suicide Prevention Margaret River (SPMR), a group of community members formed in 2016 that aim to prevent suicide in the Margaret River community through sport, training, education and fun. Supported through funding by the Shire of AMR, SPMR has provided training in prevention programs “safeTALK” and “ASIST”. Another initiative of ATL is the sponsorship of a child to attend the Zero2Hero youth mental health leadership camp, “Camp Hero”.

There was recognition of the potential for sporting clubs in the shire to take a strong role in mental health promotion, prevention, early intervention and in suicide prevention through implementation of programs such as Above the Line or other programs which aims to enhance the capacity of players, coaches and administrators to address mental health and wellbeing.

Initiatives in Education

The schools in the area have a range of initiatives to support the mental health and wellbeing of students and staff. The Cowaramup Primary School has been implementing Positive Behaviour Support for over five years. In addition to improving academic performance, this evidence-based initiative aims to improve safety, decrease problem behaviour, and establish a positive school culture. It is an early intervention program, elements of which include:

- Clearly defined and taught behaviour expectations
- Consistent and frequent acknowledgement of appropriate behaviour
- Constructively and specifically addressing problem behaviour
- Effective use of behaviour data to assess and inform decision-making

Staff at the school reported positive benefits in terms of student resilience and in teaching style and approaches. As in other schools, this and other programs are supported by a school psychologist (8 days per term) and a school chaplain (2 days per week).

The Margaret River Senior High School also has a range of initiatives to support the mental health and wellbeing of students and staff. They have staff to support students including a

school psychologist and nurse, a youth support officer and a mentoring coordinator. These staff also participate in case conferencing with other health and support services to meet the diverse needs of students. There is a strong focus on mentoring to support students in academic and vocational performance and social skills.

Initiatives of the Shire of AMR

The Shire of AMR has a *Strengthening Youth Plan*[62] which aims to provide youth with connections and opportunities into the future. Developed in consultation with youth, the plan has four goals focused around: leadership and engagement; community and recreational facilities/services; affordable all ages events; and education and employment.

The plan guides many initiatives for young people in the area and has supported the development of the Margaret River Youth Precinct consisting of a multi-faceted skate park, play area and youth Zone Room. The Shire of AMR also has an annual scholarship for a community development trainee to work in the organisation to support and guide youth initiatives, which has now been in place for 15 years.

The Shire of AMR also facilitates a Youth Advisory Council which aims to provide a space for young people to have a say on issues that impact them, as well as help coordinate activities and programs for young people.

The Shire of AMR has identified a number of key priorities for the next five years, which are relevant for community mental health and wellbeing including:

- Developing and implementing the Shire's Reconciliation Action Plan and supporting policies
- Developing a plan for community resilience and regeneration, to absorb the Community Safety Plan and include strategies for volunteerism, community capacity building and addressing disadvantage
- Developing and implementing the Public Health Plan to include the core principles of the Community Strategic Plan 2036
- Developing long term partnerships to provide youth mental health services across the shire[63]

The Shire of AMR has also recognised the issue of disadvantage in the community and is aiming to address this as part of its economic strategy[64]. The report which has guided this work, recommends a number of strategies which address some of the social and economic factors raised in this report. The focus of these recommendations is on:

- fostering a diverse and inclusive small business sector and promoting new social enterprises that support pro-place and pro-community initiatives
- supporting a variety of housing options for disadvantaged sectors
- activating youth through multiple actions and creating a centre of excellence in creative ageing
- partnering in the development of community focused training and engagement courses, especially agricultural training.

Community groups and events

There are many community groups in the shire of AMR area. Many of the participants indicated that they belonged to particular groups in the community.

There are **Men's Sheds** in Augusta, Margaret River and Cowaramup. Men's Sheds are community-based organisations that are accessible to all men providing a safe and friendly

environment for men to work on meaningful projects at their own pace in the company of other men. A key objective of Men's Sheds is to advance the wellbeing and health of their male members.

> *The Men's sheds are great, especially for older men … especially when you are new to the area …….lots of people move here from Perth and other places and don't have lots of friends*
> Community Member

In the shire, some of the Men's Sheds have women participating in some of the initiatives. There was a common and strong perception that these were important in providing opportunities for social connection for men in these communities. It was perceived that this was particularly important for older men who may have retired and are missing the connections through work. It was also perceived that it provided a contact point for men moving to the area.

Many of the participants identified as being members of small groups associated with arts and cultural activities such as book clubs and painting groups. There are also more formalised community groups such as those provided by Lions and Rotary and those supported by community resource or neighbourhood centres such as playgroups for young mothers and their families.

There are many community events which aim to bring people together in each of the communities. In Augusta, there is the annual river festival attracting large numbers from the community and other locations. Farmers and night markets are held in Margaret River and are seen as important opportunities for social connection.

Volunteering

Volunteering was perceived as being a feature of the shire of AMR. This was reflected in higher rates of volunteering compared to state and national levels. There are 229 community groups listed on the Shire of AMRs CommunityCONNECT portal which lists community groups in the shire and provides details of the types of services, locations and contact details.

Many of the services including ambulance and fire are dependent on volunteers to provide the first line of response. In contrast to eastern states, there are few employed people in these roles.

Mental Health and Suicide

There was a common and strong perception that overall levels of mental illness are similar to other communities in Western Australia. However, there was a perception that levels of anxiety in the community were high, as were the levels of substance abuse. Reasons given for the perceived higher levels of anxiety included: family stresses; financial stress; and some of the tragic events in the community.

In relation to substance abuse, there was a perception that there were high levels of risky alcohol use. This was attributed to increased stress levels in the community; the promotion of alcohol as a key feature of life in the shire of AMR; and availability of alcohol. It was recognised that alcohol, as a depressant, contributed to mental health problems and also was an inappropriate coping mechanism to address underlying problems.

Marijuana was seen as a commonly used drug, which in many parts of the community was seen as normalised. There was also a strong view that there was a lot of misinformation about marijuana use and lack of recognition of the impact on mental health.

There was also a common perception that the complexity of those with mental illness in the community was increasing, and that services to meet these needs were limited in the community.

In contrast to perceptions about the level of mental illness, the rates of suicide were perceived as higher in the shire of AMR compared to other communities. It was perceived that this has been a problem in the shire for many years, affecting all age groups across the community.

Factors Associated with Mental Illness and Suicide

From the analysis of the interviews the individual and family, community and structural factors are reported.

Individual and family factors

There were a number of key themes related to individual and family factors. It is acknowledged that these factors are inter-related with community and structural factors.

Mental Health Literacy

Mental health literacy refers to the knowledge and beliefs about mental disorders and the skills which aid their recognition, management or prevention[65]. While the levels of awareness of mental health, mental illness, suicide and contributing factors have increased it was perceived that there were still significant gaps in the community. In particular, there were concerns that there was a lack of understanding of early signs of mental illness, how to access support for mental health and pathways to care.

It was perceived that there was potential to improve the mental health literacy of the community of the shire by action across settings. This has occurred in some settings such as in sporting clubs and in some workplaces. However, the potential to increase mental health literacy and support understanding of pathways to care could be strengthened through a coordinated and strategic focus in settings across the community.

Stigma

People with mental illness can experience stigmatising attitudes in themselves and also from people around them and in the community[16]. Stigmatising attitudes can delay a person seeking help, can increase levels of psychological distress and contribute to difficulties with personal relationships and the ability to achieve educational and vocational goals[17]. Evidence suggests that people in rural and remote areas experience stigma at higher levels than those in metropolitan areas[66].

There was a common and strong view that stigma about mental illness was a significant barrier to acknowledging and seeking support for mental illness in the shire of AMR. It was perceived that this was across the community and was also reported as a barrier for seeking help, delaying opportunities for early intervention. This was viewed as being related to the culture in rural communities of self-reliance and reluctance to seek help.

Persistent Disadvantage

One of the key factors identified by participants was the disadvantage experienced by some families in the areas which occurred over multiple generations. There were two issues raised that were perceived as contributing to persistent disadvantage, which were seen as often interrelated. First, it was perceived that some families experienced poverty over multiple generations with these families requiring support with housing, income and education.

Second was the impact of generational drug use. This was perceived to be a factor with some families, relating in particular to marijuana use over generations. It was perceived, especially by people interacting in a professional or volunteer capacity that this impacted on family functioning, poverty and educational and vocational attainment by young people. It was also perceived that the drug use impacted on the mental health of family members including young people.

Isolation

There were a number of factors raised relating to people being isolated which contributed to mental health problems and suicide risks. The first was related to rural communities and the isolation that some people experience in these areas, especially when there are difficulties with transport within the family, and no availability to or costly public transport.

The second related to the experience of people moving to the shire of AMR from other areas, and apart from families and friends. This was said to often occur with young families and retirees looking for a better and more affordable lifestyle. In these circumstances, there was a perception that the attraction of the beauty and lifestyle of the shire attracted people to the area, but without family supports, the reality was often different to the perception.

Compounding this isolation were the difficulties in integrating into a new community. While it was recognised that there were lots of community groups which should support integration, there was a strong perception that these were often difficult to become part of for those new to the area.

The final factor related to the impact of the lack of transport within the area. This was relevant for the small towns and villages but also within Margaret River itself. Without access to private transport, there was a perception that many people were isolated across the area and found access to services and social activities difficult.

Community Factors

Factors associated with the community of the shire of AMR were also identified by participants as related to mental health and wellbeing.

Trauma

> *We have experienced some significant tragedies… but we pull together and get through it. But it takes a toll over time.*
> Community Member

At both a community and individual level, people living in rural areas may experience greater exposure to a range of potentially traumatic events[67]. In these rural communities, there is also a greater occurrence of adverse events, such as drought, floods and bushfires[67]. Social cohesion and support, characteristics of rural communities, contribute to mitigating the impact of traumatic events on individual and at population level[67].

The impact of trauma in the shire of AMR was raised consistently. In particular, the Gracetown cliff collapse (1996), the Margaret River bushfires (2011) and the most recent Osmington tragedy with the death of seven members of one family (2018) on a rural property outside Margaret River through an act of familicide, have impacted people across the community. In line with evidence, it was suggested that these events have a broad impact and contribute to mental health problems in individuals and in the community.

While recognising the significant and potentially cumulative impact of these events, it was also acknowledged that the resilience of the community assisted recovery. It was perceived

that the community worked together after each of the events to support each other. This was considered a strength in the community. It was however acknowledged that people experience these events differently and that the social support following these events may not help everyone.

A community-led response to the Osmington tragedy, facilitated by the Shire of AMR, Red Cross and local health providers resulted in the Health and Community Recovery Sub-committee being established. The purpose was to ensure that appropriate support was easily accessible for individuals and community groups affected by the tragedy in the region. The group is now known as the Response, Recovery, and Resiliency AMR working group. In 2019 the group will plan a series of Healing events after the Shire of AMR was successful with a grant from Foundation for Rural and Regional Renewal (FRRR) for a healing planting program and will continue to support community members access any counselling or support they may require.

The majority of participants perceived the level of support for people in the community following the Osmington tragedy and the support by the Shire of AMR as very positive. However, a number of participants identified challenges with or opportunities for improving the response. Participants identified that the response to this tragedy from state government could have been strengthened. While not a natural disaster, which normally warrants support, it was identified that communities need coordinated approaches across governments in these circumstances.

While the guidance provided by Red Cross immediately after the tragedy was acknowledged it was also perceived that they left suddenly with limited ongoing support. This was perceived as due to lack of funding for Red Cross to continue in their support role. In addition, it was suggested that the focus of the initial response may have led to more sustainable support if there had been more collaboration with local providers to embed support.

There was also a perception that some groups or individuals involved in the response and media covering the event were focused on escalating emotional responses rather than respecting community and individuals' grief and focusing on strategies for coping. In addition, it was suggested that a number of aspects of the response need examining and in particular: the most appropriate length of time for the Health and Community Recovery Sub-committee to continue working on the response; the evidence the response was based on; and the lessons learnt. It may be timely to examine and evaluate the response to the Osmington tragedy to reflect on the process and enable new knowledge of community responses to trauma to be shared.

Domestic Violence

The incidence of domestic violence was perceived as high in the shire of AMR and contributed to mental health problems. This was recognised as occurring across the shire but particularly in Margaret River. While recognition of domestic violence as an important social issue and crime had increased there was a perception that there was still a reluctance to talk about this in the community.

There was also a perception that alcohol and other drug use in this community were high and contributed to domestic violence in the community. In particular, alcohol was seen as a significant factor associated with domestic violence.

The lack of access to services to support victims of domestic violence, mostly for women was identified as a key service gap. In particular access to counselling and safe houses for women and children experiencing domestic violence were seen as needed services.

Homelessness

Homelessness was identified as an important concern for the community. However, there was a perception that this was often hidden with a reluctance to address the impact it has on individuals experiencing homelessness, and the community.

There were two aspects of homelessness that were mentioned. Couch surfing was perceived as common with limited long-term and affordable rental options which could provide access to housing for people who have to rely on sleeping in the homes of friends and family when they may prefer to access their own accommodation.

The second aspect of homelessness was rough sleeping. There was a perception that there was a lot of homeless people who slept in cars, on beaches or in the bush who may have moved to the area but are unable to access local affordable accommodation.

There was also a view that homelessness in the area was not readily acknowledged by decision makers. The reason for this was suggested that it was in conflict with the perception of the shire of AMR being one of an idyllic lifestyle.

> *If we want to go to uni we have to really leave Margs to study. I know there is a campus here but it doesn't cover a lot. And then once you leave it is hard to come back cos there are not the jobs here for young people unless you want to work in tourism or retail*
> Community member

Youth-specific factors

Bullying was raised as a significant contributor to mental health problems in young people. This occurred in person, and in particular through social media. It was acknowledged that the schools were committed to addressing bullying, but were limited in their capacity within social media contexts.

The other factor that was raised as a concern was educational and employment opportunities for young people. There is a TAFE campus in the shire based in Margaret River, with others located at Busselton and Bunbury. There are also two university campuses which provide some tertiary education options for young people.

However, there was a perception that for most people wanting to undertake tertiary education they had to travel either to Bunbury or Busselton or to Perth. This was accepted as the norm by most young people and was often seen as a positive experience.

The employment opportunities for young people who wanted to stay in the area or return after tertiary studies were considered limited. Indeed many considered that the most likely employment options for young people were in retail or tourism. These were considered to provide limited career pathways, low incomes and job insecurity. These contributed to a sense of lack of hope and affected the mental health of some young people in the area.

Impact of holiday homes

The numbers of unoccupied dwellings, most commonly holiday homes for people outside the shire of AMR was raised consistently by participants. There were a number of concerns about the numbers of holiday homes: empty houses meant reduced opportunities for social connection in neighbourhoods; access to affordable housing was more limited for residents;

and the contribution that residents make to the local community and economy was not realised.

While it was acknowledged that much of the local economy is based on tourism, and the area was a renowned holiday destination it was perceived that the ratio of holiday homes to residents' homes was out of balance and affecting the community.

Perception vs Reality

There was a common and strong view that the perception of the shire of AMR was often different to the reality of living in the area. The area was perceived and frequently promoted as the ideal lifestyle area offering idyllic coastlines and access to wonderful national parks and the experience of the wine region. The term *"idyllic Margaret River lifestyle"* is a common term used to promote the area as a great lifestyle destination for families and retirees.

While most people recognised the importance of beaches, national parks and vineyards to attracting people to the area, there was a perception that the reality of life was different to the promotion. Many of the factors identified above and in the following sections contributed to differences between reality and perception. Factors such as isolation, lack of transport and services, and employment and educational opportunities all were some of the realities faced by people living in and moving to the area.

Differences across Communities

It was recognised that the communities were very different across the Shire of AMR. In particular, the small villages and hamlets were perceived as different to the larger towns. In addition, Augusta was seen as very different to Margaret River and Cowaramup, with a much older population. Most participants identified the need to ensure approaches were tailored to local communities rather than applied for the whole shire.

> *There are a lot of wealthy people that live here or have holiday homes here. But the beautiful homes on acreage overlooking the sea and the vines is not the reality of everyone. In fact there are a lot of really poor people. In fact there are real strata or divides across the community which you don't see as much in other areas*
> Community Member

Structural Factors

There was a view that there were a number of structural factors which impacted on mental health and wellbeing in the community.

Economic Factors

There were a number of economic factors identified by participants as impacting on the mental health of residents. The first was a lack of **employment opportunities and underemployment**. It was perceived that employment opportunities were limited for many people in the area and there was significant underemployment. The underemployment related to working fewer hours than desired, or working in employment below qualifications. Compounding these issues were the lack of secure employment with many people on temporary contracts or working as casuals.

There were concerns consistently raised about the **socio-economic divide** between different groups in the community. There was a perception that the shire of AMR was often characterised by the beautiful homes in the area and the lifestyles afforded for people who are wealthy. The reality was perceived as very different. Indeed many participants mentioned that there were strata in the community based on an economic divide.

This divide impacted on the mental health of the community because of a lack of acknowledgement of these strata. It was perceived there was a reluctance to acknowledge this as it conflicted with the perception of the area. Further, it was perceived that this meant that the shire of AMR often missed out on services and resources because of the over-whelming perception that it was not an area of need. Traditional indicators of need were also identified as not providing a full picture of need in the area.

Impact of FIFO

Across the shire of AMR, it was perceived that there was a significant proportion of fly-in fly-out (FIFO) workers living in the area, mainly working in the mines of Western Australia. Many participants recognised that FIFO workers had been identified as having higher levels of mental health problems.

In addition, it was perceived there was significant impacts of FIFO on families. Relationship breakdown was identified as being more common with these families. The impact on children in school was considered significant with children experiencing disruption and related behaviours associated with the FIFO cycle.

It was also perceived that the impact of the downturn in the mining industry had an impact on these families contributed to economic hardship and distress in the families.

Over-emphasis on the wine industry

There was a common view that the importance of the wine industry was often over-stated in the area and dominated decisions about land and economic development, and promotion of the area. While the importance of the wine industry was recognised, especially in attracting visitors to the area, there was a perception that returns to the local community were much lower than the importance placed on this industry. It was acknowledged that elements of the wine industry contribute to local community building activity, and supported this project in recognition that mental health of the community impacts on the wine industry community.

A number of concerns were raised about the wine industry in the area that were perceived as not supporting the local community: much of the employment was perceived as seasonal, contractual and not undertaken by local residents but by people from other areas; income derived from work in the vineyards was low with limited career paths except for a few; and much of the return on investment was not available to the local community but was exported to other areas.

Health Services

There are **many health and support services** in the community. Many of the psychologists are sole operators and not working in centres. This was perceived as impacting on the potential for more integrated care. There was also a lack of understanding of referral pathways to psychologists, allied health and counselling services. It was reported that referrals commonly were related to personal relationships between professionals because of a lack of knowledge of the broader system and access and referral criteria.

Many services are provided as **outreach** and are not based in the community but are provided from Busselton or Bunbury. There was a common view that this was less than optimal and reflected a perception of lack of need by health service decision makers. There was also a view that outreach reduced services' hours because travel time was part of their working day.

With changes in the way health services are funded through commissioning, and with the advent of the NDIS there was a perception that the **service system is more fragmented**. Indeed many of the service providers were unaware of other services in the community resulting in a lack of integration and opportunities for maximising client outcomes.

In addition, **gap payments** are required by many professionals providing psychology and counselling services. These gap payments were perceived as a barrier to accessing psychology services for many people in the area. There are three services which provide counselling services and offer bulk-billing for clients. In addition, a number of psychologists indicated they would provide bulk-billing for clients in need in some circumstances.

A number of participants raised the need for a health hub in Margaret River to support more integrated and accessible care. It was perceived that this could provide one centre for people to access a range of mental health care and support services and overcome some of the access barriers resulting from dispersed services.

The **increasing specialisation of state mental health services,** providing care for people with serious and acute mental illness meant people with less serious and acute illness had few services for care and support. The open door policy that state mental health services apply in the shire of AMR meant that everyone that is referred or walks in the door is comprehensively assessed by the team including a doctor. While this was seen as providing a service to all it was also viewed as inefficient given the limited resources with the team.

Mental Health Services

There are many different organisations providing clinical services for clients with mental illness but these are not well integrated. Participants identified that there was a lack of understanding of the role of different mental health services and if and how these were integrated. There is also a lack of knowledge about the role of mental health clinics and support services with services providers and community members making referral pathways problematic which results in duplication of some services.

Specialist Mental Health Services

Participants expressed concerns that access to ongoing specialist mental health services is poor and had reduced over the last five years. People with acute or deteriorating mental illness can present at emergency departments in the AMR, but if needing admission they are transferred to Bunbury Hospital which has inpatient mental health beds.

> *My [relative] has been admitted to Bunbury but the whole experience was appalling. No matter what I will not allow [relative] to be admitted there again.*
> Community Member

There is a community-based specialist mental health team based in Margaret River for adults and outreach services for children and young people, and older people. There was a perception that state-based specialist mental health services in the shire of AMR are difficult to access, apart from initial assessment, because of their focus on severe mental illness and inability to provide care for less serious patients.

There were significant concerns raised about the quality of care and treatment of patients who are admitted to Bunbury Hospital for mental health treatment. This was a common and strong theme offered by consumers and carers.

It was acknowledged that the specialist mental health services in the shire of AMR, including access to inpatient services in Bunbury are commencing service redesign with the aims of improving mental health care and experience for patients and carers.

Transport was also cited as a barrier for some people who sought specialist care in areas outside of the shire. With many people having to travel to Busselton or Bunbury for appointments there were limited options for public or community transport.

> *There are a few GPs here that are really good with mental health patients. They take the time, have the skills and offer a range of options…but there are others that go straight for scripts regardless of whether you need them…*
> Community Member

Access to services for people with substance abuse problems was a common concern. It was perceived that services such as drug and alcohol detoxification or rehabilitation were non-existent or were provided at significant costs to the clients.

General Practice

Participants perceived that the capacity of GPs in relation to mental health needs to be strengthened. It was recognised that time pressures, knowledge, skill, interest and attitudes were problematic for GPs, with people with mental health problems often requiring more time. It was acknowledged there were a number of GPs in the area with strong knowledge and skills in mental health treatment, and with attitudes supporting patients. These GPs are well known and often difficult to get into.

There was a view of over-reliance on medication as the first treatment option. This was perceived as a regular occurrence despite the wishes of the patients to have other therapies first.

Support Services

There are many services in the shire of AMR providing a range of support options for people with a mental illness. These services provide employment access, training, welfare and housing support. However, awareness about these services is limited and access across the shire is difficult making referral pathways problematic.

Solutions

Participants offered a number of solutions to addressing mental health and wellbeing which were tailored to the context of the shire of AMR and its communities. Strategic alliances across the community were perceived as potentially more effective than the disparate nature of some of the activities that are currently occurring. Strategic alliances had the potential to build awareness about mental health, mental illness and suicide prevention and increase the capacity of the community to address mental health and mental illness.

Building on community strengths

It was recognised that there is a need to build on some of the community-based commitments which are addressing mental health and wellbeing. The work of SPMR was well regarded especially in the Margaret River area but it was acknowledged that the resources for them to expand were limited. Support for expanding and resourcing some of the initiatives already developed by SPMR was widespread.

Building on existing strategies

There were existing strategies, particularly developed by the Shire of AMR, which can contribute to mental health and wellbeing. Tackling disadvantage through an economic strategy was strongly supported as were the projects targeting youth currently being implemented by the Shire of AMR. The importance of these strategies for community mental health and wellbeing was recognised and explicit recognition of their impact on mental health could strengthen their impact.

It was suggested that some organisations apply frameworks to ensure their strategies and decisions align to overarching principles. Examples were provided where organisations have environmental frameworks to ensure all of their decisions and strategies do not have an adverse environmental impact. It was suggested there was potential for organisations and community groups in the shire to apply a similar framework for community mental health and wellbeing ensuring all decisions support rather than hinder good mental health.

Using an evidence-based framework

There was strong support for evidence to guide future approaches in the shire. There were concerns that too often in the past that initiatives were implemented which were not based on evidence and were often short term. The preference for the majority of participants was to ensure strategies are applied which could be embedded in a range of settings across the community.

Addressing factors associated with mental health and wellbeing

There was a strong and common view that any initiatives must address the contributing factors to mental health and wellbeing. It was recognised that without addressing these factors that most initiatives would be futile. The approach of the Shire of AMR to tackling disadvantage through an economic strategy was supported widely and was recognised as crucial in a sustainable future for the area.

Factors associated with mental health problems such as alcohol use and domestic violence were identified as prevalent in the shire. Participants stressed the importance of acknowledging these factors and implementing strategies and services to mitigate these risks. This was seen as a responsibility not just for health services but across the service and business sector and across the community.

There were concerns that many responses in the past were reactive, not embedded in the community and failed to address the underlying causes of mental health problems and suicide. Because of this many of the initiatives were seen as not sustainable and ineffective.

Providing an integrated needs-based service system

It was perceived that the current mental health system and associated services were not meeting the needs of the shire community. There was a view that there needed to be planning for mental health services across the service system to meet local needs regardless of the funding source (state or federal). This planning should focus on awareness of mental health services, their roles and should support referral pathways and integration between services.

Focus on young people

A focus on mental health and wellbeing for young people was considered a priority. There was recognition that the Shire of AMR were implementing a range of approaches to support young people. However, support for the mental health of young people was recognised as being broader than a schools-based approach. Strategies to support young people need to

be considered across all community settings with explicit recognition of their impact on mental health.

It was acknowledged also that most schools were proactive and responsive to supporting the mental health needs of young people. Schools were recognised as being crucial in the strategic alliances necessary across the community and could play a key role across the community.

Community Feedback

Based on the methods applied to obtain community feedback on the draft report, there was strong support for the project and its findings. In particular there was support for the focus on addressing factors associated with mental health to build community wellbeing. It was recognised that the community response needed to be holistic, across different sectors of the community and using multiple approaches.

The findings relating to the often concealed socio-economic divide in the community were strongly supported. Participants acknowledged the importance of recognising this divide and advocating to strengthen approaches to address inequities in the community.

Participants supported the need for a community response to mental health and wellbeing and recommended a community taskforce approach. Having representatives from organisations such as health services and the Shire of AMR involved in this taskforce was acknowledged as important, but the involvement of community members was considered as key.

There were concerns about the resources required to support a community response. It was suggested that the final report should support advocacy to ensure a community response.

The Way Forward

Like many other communities, the people in the shire of AMR area want to improve the mental health and wellbeing and on suicide prevention. The impact of mental health problems and suicide is significant for the community. Addressing these issues will take a coordinated approach across the community with collaboration across sectors.

Community Readiness

Community readiness is an important indicator in the degree to which a community is willing and prepared to take action on an issue.[68] Understanding the level of community readiness supports a community in moving forward to take effective action. [68] There are nine stages in community readiness as described in Figure 34.

Figure 34: Stages of community readiness

This project did not aim to identify the stage of readiness for the AMR community to address mental health and wellbeing. That actions are already being taken through activities such as ATL and the sheer number of participants in the consultation process demonstrate the willingness to identify potential solutions which could form the basis of a community plan for community mental health and wellbeing.

Building on the momentum provided by the actions taken to date and the findings of this project will be critical. Importantly there will be a need to tailor responses to the different communities and to the different sectors of the community.

Principles for promoting mental health and wellbeing

Based on evidence for mental health promotion and informed by effective public health approaches for a range of health issues the following principles are recommended for consideration by the residents of the shire of AMR that are committed to addressing these issues. These principles informed the analysis of the common themes and aim to guide the development of strategies for the community plan. The principles suggest that strategies selected should:

- Focus on **population health** approaches
- Be **evidence-based** or **theoretically informed**
- Apply **multiple and sustainable strategies**
- Focus on **risk and protective factors**
- Ensure options for **early intervention**
- Provide **clear pathways to appropriate and accessible services**
- Provide **support for families**
- Be **targeted and tailored** to specific groups include specific cultural and age groups
- Build **capacity of services** to promote mental health and wellbeing
- Adopt **effective governance and evaluation**

The application of these principles to suggested strategies within the community plan will ensure an effective approach to mental health and wellbeing.

Key Community Issues

The findings of this research indicate a number of inter-related issues which impact on the mental health and wellbeing of the community.

Community Strengths

The results indicate significant strengths in the community of the shire of AMR. Like many other communities, the residents of the shire of AMR have faced significant trauma. The community has also demonstrated considerable resilience in addressing this trauma and being able to move forward. Building on the resilience of the community through social cohesion and support can enhance community mental health and wellbeing.

The response to the most recent Osmington tragedy has been praised. There are learnings to be examined from the response which are potentially valuable to the community of the shire of AMR and indeed to other communities. The opportunity to examine and evaluate the response can provide new knowledge and understanding of how communities can respond to such traumatic events which are inevitably experienced by many communities over time.

The community strengths identified in this project such as ATL, and the strategies being applied by the Shire of AMR can be strengthened to more explicitly address mental health literacy and capacity of the community to respond. Building the capacity of the community in relation to mental health and wellbeing can be achieved through different settings such as the many community groups, workplaces and services.

Socio-economic Divide

The priority concern identified from the findings was the socio-economic divide between different groups in the shire of AMR. This divide was perceived to have a significant impact on community mental health and wellbeing but was largely unrecognised outside of the shire. This perceived divide was characterised by some sectors in the community experiencing unemployment or underemployment, mortgage and financial stress, and homelessness, compared to other groups in the community who were socially and economically advantaged.

Population level social and economic indicators commonly used to make decisions about resources and judgement as to need in a community do not always reflect this perceived divide. In the shire of AMR, extremes of data used to assess socio-economic status of a community will counteract each other and result in the shire appearing as in the middle range.

That this divide exists was in contrast to the perception of AMR as one of idyllic lifestyles. It was also suggested that this divide was rarely acknowledged by decision makers, and affected the ability of the region to attract resources and services.

Economy and Employment

Evidence demonstrates the economic performance of urban and regional communities is reliant on economic diversity and supports the attraction of business and people to work in these industries[72]. This in turn impacts on the social capital and mental health and wellbeing of communities[72].

Examples of thriving regional communities typically have strong local leadership teams from across the community, active economic development practitioners and an understanding of the changing requirements of economic and social development practice in the new economy[73]. Key to successful regional economies is the identification of a region's competitive advantages and the creation of an economic and social vision for the region[73].

These findings identify significant economic and employment issues in the community. Some of these issues are currently seen as a priority by Shire of AMR. Underemployment and lack of employment opportunities for young people locally are two of the key economic issues identified. Like many of the other solutions to mental health and wellbeing building economic diversity and addressing disadvantage requires strategic alliances across the community.

Need for a coordinated approach

Despite the initiatives being undertaken in the shire of AMR, some of which are specifically targeting mental health and wellbeing, it was perceived that these can be disparate and often one-off events, often undertaken in isolation and lacking a strategic view of the goals for improving mental health and wellbeing.

This was not a criticism of the community members who have shown such commitment to addressing mental health and wellbeing. Rather it was an acknowledgement that the impact of the range of events could be strengthened by applying a more coordinated approach across the community. Further, there was a common view that there were often reactive responses to particular events in the community which often dissipated over time. Having a planned and coordinated approach to community mental health and wellbeing would reduce the reactivity and increase the potential for sustained approaches.

Mental Illness and related health issues

There are significant concerns about mental health and wellbeing in the community. The indicators examined in this project demonstrate higher levels of mental health and substance abuse hospital admissions, suicide and self-harm rates and in medications prescribed for some mental illnesses. These levels support the need for coordinated action.

Data on alcohol for the shire of AMR community also indicate high levels of problems in this community. Similarly, community perceptions supported the need to address alcohol as a contributor to mental health problems.

The numbers of family violence assaults were high, especially in Margaret River, and supported community perceptions. The need to change community norms related to domestic violence and provide services to support women and children was identified as an important strategy to support mental health and wellbeing in the community.

The issue of homelessness was a key community concern. The need to acknowledge this as a problem and to strengthen the community response to people experiencing homelessness across the shire was important for community mental health and wellbeing.

Health Services

There are many and diverse services in the shire of AMR which provide care and support for people with a mental illness through health care and support services. However, these commonly operated independently and in some instances were not known by other services. One of the key findings in relation to health services for mental health was the lack of knowledge about the services and referral pathways in the community and by service providers. This combined with the need to strengthen mental health literacy create unnecessary barriers to care and treatment and ultimately to improved mental health and wellbeing.

There is increasing recognition of the importance of place-based planning and management for services to support community health and wellbeing[69, 70]. Place-based planning has a number of advantages which are relevant to mental health and wellbeing including: strengthening communities; developing new models of care that span organisational and service boundaries; building and supporting collaborations and partnerships; and accessing

resources to meet local needs[70, 71]. The need for a more systematic approach to planning of mental health services in the shire of AMR to meet community needs is essential to ensure integration, access and avoid duplication and gaps in the system.

Given its discrete location, there are opportunities to apply place-based planning approaches to the mental health services for the shire. These opportunities have the potential to be realised by the requirements for collaboration between primary health networks and state-based health services. However, this requires leadership, the vision and strategic collaborations and coalitions to see the opportunity to undertake place-based planning for the local community.

It is acknowledged that GPs provide most of the mental health services in communities. The GPs in the shire of AMR are using mental health treatment plans to support care for people with mental illness at rates higher than state and national levels. This is positive for the community. However, the perceptions of variation in skills and capacity of GPs to provide care and support for people with mental illness suggests the need for strengthening the capacity of GPs as the foundation of mental health care in the community.

That the quality of care for patients admitted to Bunbury hospital was questioned by many participants is concerning. Unless these concerns about the quality of care are acknowledged it is likely that people with acute or deteriorating mental illness will continue to avoid treatment, impacting on their own health and that of their families.

The recent announcement of a headspace satellite service in Margaret River will support teenagers and young adults in Margaret River with access to free or low-cost youth mental health services. Linking this service as part of an integrated system will be key to its success.

The next steps

The next steps should be decided by the residents of the AMR community in response to these findings. There is already commitment to addressing mental health and wellbeing in the community which provides momentum for future action.

The project advisory committee for this project was established by the Lishman Health Foundation to oversee this project, and does not have an ongoing role in planning the response to this report. The community recognises the importance of a community response to the findings outlined in this report. This will require a taskforce, formed by the community to guide the next steps with a focus on developing a plan of action and strategically advocating for a broad based approach to support and promote mental health and wellbeing. The current project advisory committee is in a position to facilitate the establishment of a taskforce as part of the finalisation of this project.

The role of the community taskforce is strategic, leading and developing a community based plan for the whole of the shire, incorporating a range of short and longer-term strategies which address the. Having leadership from organisations such as primary and specialist health services and the Shire of AMR involved in this taskforce is important, but the involvement of other sectors and community members, who can operate strategically and are in a position to advocate locally and more broadly is key.

The development of a plan in response to this report and to guide strategies will be one of the first responsibilities of the taskforce. This will require resources to support its development. Importantly the development of the plan should:

a. Be strategically focused and intersectoral, addressing the factors associated with mental health and wellbeing raised in this report
b. Develop strategies to address the socio-economic divide and build economic and employment opportunities
c. Build the capacity of the community to address mental health and wellbeing across all sectors
d. Build on community strengths and existing strategies with explicit articulation of their importance to community mental health and wellbeing
e. Advocate for improved health services by
    i. Adopting a place-based planning approach to support access to and integration of mental health services across the community
    ii. Adopting a focus on building the capacity of general practice and specialist mental health services to respond to community needs
    iii. Strengthening community awareness of services and their roles and referral criteria and pathways

The success of the plan will be reliant on the ability of community members, service providers and organisations to build strategic alliances across the community. Importantly it requires short and long term strategies to address the immediate needs of the community but also to address the underlying economic and social factors associated with mental health and wellbeing. Examining its success will also require a commitment to share data across sectors to monitor and evaluate the plan's implementation and impact.

References

1. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. 2016. Canberra: Australian Institute of Health and Welfare.

2. Australia's Social Trends: Mental Health, http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication25.03.094/$File/41020_Mentalhealth.pdf (2009).

3. National Survey of Mental Health and Wellbeing 2007: Summary of results. 2008. Canberra: Australian Bureau of Statistics.

4. Merema M and Radomiljac A. Health and Wellbeing of Adults in Western Australia, Overview and Trends. 2018. Perth Western Australia: Department of Health, Western Australia.

5. Mental Health Services in Australia https://mhsa.aihw.gov.au/services/admitted_overnight/ (2017, accessed November 2017).

6. Australian Institute of Health and Welfare. My Healthy Communities. 2017.

7. Australia's Health 2014 2014. Canberra: Australian Institute of Health and Welfare

8. Causes of Death, Australia 2016, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Intentional%20self-harm:%20key%20characteristics~7 (2017, accessed May 2018).

9. Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. 2016. Canberra: ACT.

10. Slade T, Johnston A, Oakley Browne MA, et al. 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Australian and New Zealand Journal of Psychiatry 2009; 43: 594-605. DOI: doi:10.1080/00048670902970882.

11. Fone D, Dunstan F, Lloyd K, et al. Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis. International Journal of Epidemiology 2007; 36: 338-345. DOI: 10.1093/ije/dym004.

12. Lawrence D, Hancock KJ and Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers British Medical Journal 2013 346 Journal Article. DOI: 10.1136/bmj.f2539.

13. Spooner C and Hetherington C. Social Determinants of Drug Use. 2004. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

14. Cuijpers P, Beekman AF and Reynolds CF. Preventing depression: A global priority. JAMA 2012; 307: 1033-1034. DOI: 10.1001/jama.2012.271.

15. Davidson L, Harding CM and Spaniol L. Recovery from severe mental illnesses: Research evidence and implications for practice. . Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2005.

16. Jorm AF, Barney LJ, Christensen H, et al. Research on Mental Health Literacy: What we know and what we Still Need to know. Australian and New Zealand Journal of Psychiatry 2006; 40: 3-5. DOI: 10.1080/j.1440-1614.2006.01734.x.

17. Reavley NJ and Jorm AF. Stigmatizing Attitudes towards People with Mental Disorders: Findings from an Australian National Survey of Mental Health Literacy and Stigma. Australian and New Zealand Journal of Psychiatry 2011; 45: 1086-1093. DOI: 10.3109/00048674.2011.621061.

18. Reavley NJ and Jorm AF. Recognition of Mental Disorders and Beliefs about Treatment and Outcome: Findings from an Australian National Survey of Mental Health Literacy and Stigma. Australian and New Zealand Journal of Psychiatry 2011; 45: 947-956. DOI: 10.3109/00048674.2011.621060.

19. Brohan E, Slade M, Clement S, et al. Experiences of mental illness stigma, prejudice and discrimination: a review of measures. BMC Health Services Research 2010; 10: 80-90. Article. DOI: 10.1186/1472-6963-10-80.

20. Bilsker D, Gilbert M, Larry Myetter T, et al. Depression and Work Function: Bridging the Gap between Mental Health Care and the Workplace. 2006. Vancouver: Health Care Benefit Trust.

21. Risks to mental health: an overview of vulnerabilities and risk factors: Background paper by WHO secretariat for the development of a comprehensive mental health action plan. 2012. Geneva: World Health Organisation.

22. Prevention First: A prevention and promotion framework for mental health 2015. Newcastle NSW: Hunter Institute of Mental Health.

23. Mrazek PJ and Haggarty RJ. Reducing risks for mental disorders: frontiers for preventative intervention research. Washington: National Academy Press, 1994.

24. Donovan RJ, Henley N, Jalleh G, et al. People's beliefs about factors contributing to mental health: implications for mental health promotion. Health Promot J Austr 2007; 18: 50-56. 2007/05/16.

25. Donovan RJ, James R, Jalleh G, et al. Implementing Mental Health Promotion: The Act–Belong–Commit Mentally Healthy WA Campaign in Western Australia. International Journal of Mental Health Promotion 2006; 8: 33-42. DOI: 10.1080/14623730.2006.9721899.

26. Donovan RJ, Watson N, Henley N, et al. Mental Health Promotion Scoping Project: Report to Healthway. 2003. Centre for Behavioural Research in Cancer Control, Curtin University.

27. Jalleh G, Donovan RJ, James R, et al. Process evaluation of the Act-Belong-Commit Mentally Healthy WA campaign: first 12 months data. Health Promot J Austr 2007; 18: 217-220. 2008/01/19.

28. Jalleh G, Anwar-Henry J, Donovan RJ, et al. Impact on community organisations that partnered with the Act-Belong-Commit mental health promotion campaign. Health Promot J Austr 2013; 24: 44-48.

29. Hazell T, Dalton H, Caton T, et al. Rural Suicide and its Prevention: a CRRMH position paper. 2017. Orange NSW: Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

30. The Fifth National Mental Health and Suicide Prevention Plan. 2017. Canberra: Department of Health.

31. Perkins D. Stepped Care, System Architecture and Mental Health Services in Australia. International journal of integrated care 2016; 16: 16-16. DOI: 10.5334/ijic.2505.

32. Australian Institute of Health and Welfare. Australia's Health 2016. 2016. Canberra: ACT.

33. Bywood PT, Brown L and M. R. Improving the integration of mental health services in primary health care at the macro level. 2015. Adelaide: Primary Health Care Research and Information Service.

34. The National Review of Mental Health Programmes and Services. 2014. Sydney: National Mental Health Commission.

35. Ho FY-Y, Yeung W-F, Ng TH-Y, et al. The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Scientific Reports 2016; 6: 29281. DOI: 10.1038/srep29281.

36. Van Straten A, Seekles W, van 't Veer-Tazelaar NJ, et al. Stepped care for depression in primary care: what should be offered and how. Medical Journal of Australia 2010; 192: S36-S39.

37. Bauer AM, Thielke SM, Katon W, et al. Aligning health information technologies with effective service delivery models to improve chronic disease care. Preventive Medicine 2014; 66: 167-172. DOI: https://doi.org/10.1016/j.ypmed.2014.06.017.

38. Cartier JM. A team-based approach to the care of depression in later life: where are we now? Psychiatr Clin North Am 2013; 36: 651-660. 2013/11/16. DOI: 10.1016/j.psc.2013.08.009.

39. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews(10), http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006525.pub2/abstract

http://onlinelibrary.wiley.com/store/10.1002/14651858.CD006525.pub2/asset/CD006525.pdf?v=1&t=j29smwky&s=3bbdc722a59ea2efc752c7f83b51215f1a2f71d8 (2012).

40. Reilly S, Planner C, Gask L, et al. Collaborative care approaches for people with severe mental illness. Cochrane Database of Systematic Reviews(11), http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009531.pub2/abstract (2013).

41. Bridges AJ, Gregus SJ, Rodriguez JH, et al. Diagnoses, intervention strategies, and rates of functional improvement in integrated behavioral health care patients. Journal of Consulting and Clinical Psychology 2015; 83: 590-601. Empirical Study; Quantitative Study. DOI: http://dx.doi.org/10.1037/a0038941.

42. Vickers KS, Ridgeway JL, Hathaway JC, et al. Integration of mental health resources in a primary care setting leads to increased provider satisfaction and patient access. Gen Hosp Psychiatry 2013; 35: 461-467. 2013/08/06. DOI: 10.1016/j.genhosppsych.2013.06.011.

43. Cleary M, Dean S, Webster S, et al. Primary health care in the mental health workplace: insights from the Australian experience. Issues Ment Health Nurs 2014; 35: 437-443. 2014/05/27. DOI: 10.3109/01612840.2013.855853.

44. DeSilva M, Samele C, Saxena S, et al. Policy actions to achieve integrated community-based mental health services. Health Aff (Millwood) 2014; 33: 1595-1602. 2014/09/10. DOI: 10.1377/hlthaff.2014.0365.

45. Regional Statistics by LGA 2017, http://stat.data.abs.gov.au/index.aspx?queryid=917 (2018).

46. Shire of Augusta Margaret River Local Profile. 2017. Margaret River: Shire of Augusta Margaret River.

47. Social Health Atlas of Australia: Western Australia - Data by Local Government Area http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas (November 2018, accessed January 2019).

48. LGA Data tables — Small Area Labour Markets — September quarter 2018, https://docs.jobs.gov.au/documents/lga-data-tables-small-area-labour-markets-september-quarter-2018 (2018, accessed January 2019).

49. 2016 Census QuickStats for Augusta Margaret River, http://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/LGA50280.

50. Slade T, Grove R and Burgess P. Kessler Psychological Distress Scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. Australian & New Zealand Journal of Psychiatry 2011; 45: 308-316.

51. Public Health Information Development Unit. Social Health Atlas of Australia Data by Primary Health Network (incl. Local Government Areas). 2017.

52. Alcohol and other drug data. 2018. Perth Western Australia: Department of Health Epidemilogy Branch.

53. Stavrou E, Poynton S and Weatherburn D. Intimate partner violence against women in Australia: related factors and help-seeking behaviours 2016. Sydney: Crime and Justice Bulletin (200), NSW Bureau of Crime Statistics and Research.

54. Phillips J and P. V. Domestic, family and sexual violence in Australia: an overview of the issues. 2014. Canberra: Department of Parliamentary Services.

55. Western Australia Police Crime Statistics, https://www.police.wa.gov.au/Crime/CrimeStatistics#/ (accessed January 2019).

56. My Healthy Communities. Canberra: Australian Institute of Health and Welfare, 2017.

57. Depression in residential aged care 2008–2012. . Canberra: Australian Institute of Health and Welfare.

58. Australian Bureau of Statistics. Characteristics of people using mental health services and prescription medication, 2011. 2016.

59. The First Australian Atlas of Healthcare Variation. Canberra: The Australian Commission on Safety and Quality in Health Care, 2015.

60. Social Health Atlases of Australia: Primary Health Networks. Adelaide: Public Health Information Development Unit, 2018.

61. Strengthening Youth Plan 2018-2022. 2017. Margaret River Western Australia: Shire of Augusta Margaret River.

62. Shire of Augusta Margaret River Priority Projects 2018-22, https://www.amrshire.wa.gov.au/council/organisation/priority-projects-201822 (2018, accessed January 2019).

63. Burke G and Stocker L. Tackling Disadvantage & Inequality through the Economic Development Strategy: A Report to the AMR Shire. 2018. Margaret River: Producton Functon.

64. Jorm A, Korten A, Jacomb PA, et al. Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia 1997; 166.

65. Fuller J, Edwards J, Procter N, et al. How definition of mental health problems can influence help seeking in rural and remote communities. Australian Journal of Rural Health 2000; 8: 148-153. DOI: doi:10.1046/j.1440-1584.2000.00303.x.

66. Handley TE, Kelly BJ, Lewin TJ, et al. Long-term effects of lifetime trauma exposure in a rural community sample. BMC public health 2015; 15: 1176-1176. DOI: 10.1186/s12889-015-2490-y.

67. Stanley LR. Community Readiness for Community Change: Tri-Ethnic Center Community Readiness Handbook: 2nd Edition. 2014. Fort Collins: Tri-Ethnic Center for Prevention Research.

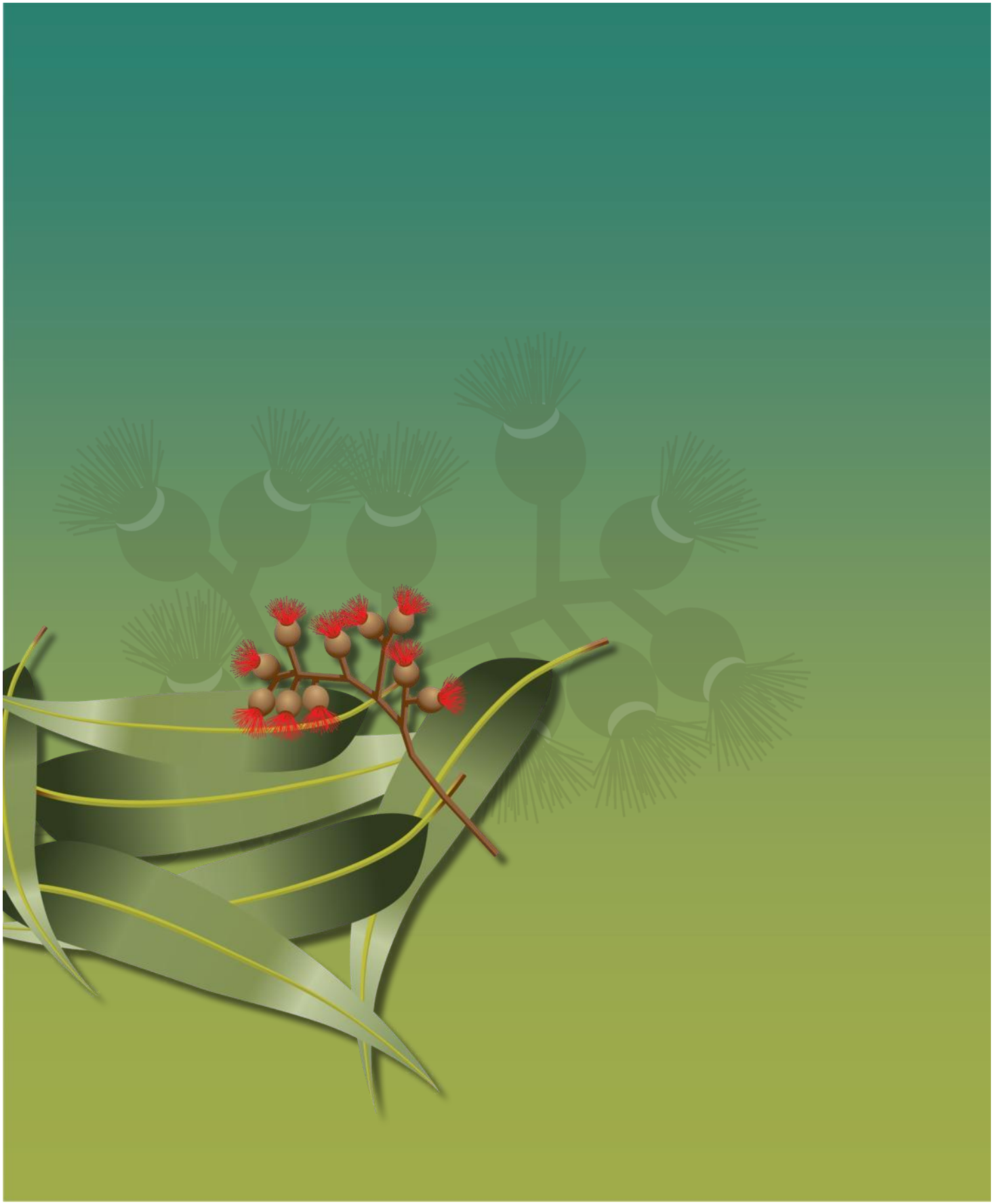
68. Bell J and Rubin V. Why Place Matters: Building a Movement for Healthy Communities. 2007. Oakland Ca: The California Endowment.

69. South J. A guide to community-centred approaches for health and wellbeing. 2015. London: Public Health England NHS

70. Ham C and Alderwick H. Place-based systems of care: A way forward for the NHS in England 2015. The King's Fund.

71. Florida R. The economic geography of talent. Annals of the American Association of Geographers 2002; 92: 743-755.

72. Collits P. Small Town Decline and Survival: Trends, Success Factors and Policy Issues. 2018. Sydney: NSW Department of State and Regional Development.



Centre for Rural and Remote Mental Health
T: +61 2 6363 8444 **E:**
crrmh@newcastle.edu.au
PO Box 8043 Orange East NSW 2800

Website Facebook Twitter YouTube

Centre for Rural & Remote Mental Health

THE UNIVERSITY OF NEWCASTLE AUSTRALIA