Mental Health and Wellbeing in the Lithgow Community

Key Findings and Recommendations

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Prepared for Nepean Blue Mountains Local Health District

Centre for Rural & Remote Mental Health

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Commissioned by. Nepean Blue Mountains Local Health District, Mental Health Services

Acknowledgements

The Centre for Rural and Remote Mental Health has undertaken this project in response to a request from the General Manager of Nepean Blue Mountain Mental Health Services. The support of the Mayor's taskforce and the service providers involved is acknowledged. The consultation process has only been possible because of the commitment of people of Lithgow 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.

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Executive Summary

This report describes the results of a project to explore options for addressing mental health and wellbeing in the Lithgow City Council area. The project was undertaken to identify the key issues and explore community views about mental health and wellbeing in Lithgow, in response to a number of suicides in the area in the last few years.

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

Key Findings

The results demonstrated concordance between the quantitative data and the perceptions of community members. In particular the results indicated that:

- there was strong commitment to addressing mental health and wellbeing in the Lithgow community with many initiatives already underway
- the levels of mental illness, and suicide risks were higher than other communities and reflected the views of the key stakeholders
- there are a diverse range of programs and services in the area to address mental health and wellbeing but access to appropriate clinical and support services 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 were a range of individual and family, community and structural factors mental health and wellbeing and suicide highlighted by key stakeholders and reflected in the data including:
    - economic factors and in particular employment opportunities and economic diversity
    - socio-economic disadvantage
    - generational trauma in the Aboriginal and non-Aboriginal communities
    - mental health literacy in the community
    - stigma associated with mental illness acting as a barrier to help seeking
    - domestic violence and alcohol use
    - factors specific to young people including lower levels of educational attainment and sense of hopelessness for future employment opportunities
    - lack of awareness of health services, their roles and referral pathways
    - lack of integration of health services and support services
- it was acknowledged that it was essential to address the contributing factors to mental health and wellbeing in order to achieve longer terms gains
- the need for strengthening of the capacity of the primary care and specialist mental health system to respond to the mental health needs of the local community

The way forward in addressing mental health and wellbeing is ultimately the decision of the Lithgow community. The findings of this project, complemented by the many of the existing initiatives and

informed by evidence provide a foundation for the development of a community mental health and wellbeing plan for Lithgow. 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 Lithgow community.

Introduction

This report describes the results of a project to explore options for addressing mental health and wellbeing in the Lithgow City Council area (Lithgow). The project was undertaken at the request of the General Manager of Nepean Blue Mountain Mental Health Services in order to identify the key issues and explore community views about mental health and wellbeing in Lithgow and was in response to a number of suicides in the area in the last few years.

Burden of Illness

Mental and substance use disorders contribute significantly 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) illness[1].

Mental Illness

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. In 2011, in NSW, mental illness contributed to 11.6% of the total burden of disease and was the leading cause of YLD (23.9%)[1]. For males the greatest burden of disease resulting from mental illness was those aged 35-39 years (11.1%) and for females was those aged 25-29 years (10.7%). People living in outer regional areas and those who with greater levels of socio-economic disadvantage experience a higher total burden from mental illness[1].

Anxiety, mood (e.g. depression) and substance use disorders are the most common mental disorders in Australia. The most recent Australian National Survey of Mental Health and Wellbeing (ANSMHWB) reported that these disorders are experienced by approximately 20% of the population at a clinically diagnosable level in any 12 month period[3]. 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 Australia, the number of overnight mental health separations increased by an annual average of 5.1% in the 5 years to 2015–16. In contrast, overnight separations for non-mental health conditions increased at a lower rate (annual average of 2.2%) over the same period[4]. 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[5].

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

Suicide

In Australia, suicide was the leading cause of premature death in 2016, accounting for 2,866 deaths[6]. Australia's suicide rate (approximately 11.7 per 100,000) has increased from 10.6/100,000 people in 2007 [6]. 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[6]. Suicide rates are higher in those people experiencing socio-economic disadvantage. There is a clear trend of an increasing rate of burden with remoteness for suicide (and self-inflicted injuries)[7]. Suicide is a complex issue, but mental health problems have been shown to increase a persons' risk of suicidal behaviour, especially when left untreated.[8]

Nationally, in 2016, 162 Aboriginal and Torres Strait Islander persons died as a result of suicide[6]. 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)[6]. 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[6].

Factors associated with Mental Illness and Suicide

Factors that impact on 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.[9]

Social factors include economic disadvantage and lack of social support. Having positive and numerous relationships with family and friends is generally considered to be a protective factor promoting positive mental health.[3] Conversely, individuals living in communities with low levels of social cohesion often have higher rates of mental health problems.[10] 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 between 12 and 16 years, the majority (80%) of which of this attributable to chronic diseases.[11] 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, 11]

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 substance use[12]

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 that success of treatment is greater if the problems are identified and treated early[13, 14].

Overcoming perceived barriers to help-seeking for mental health and substance abuse problems is one of the major challenges to increasing utilisation of treatments.[15-17] In the general population, barriers to treatment include stigmatising attitudes towards mental health problems,[18] lack of

confidence in seeking help or awareness of where to seek help, and the belief that help available would not be effective.[19]

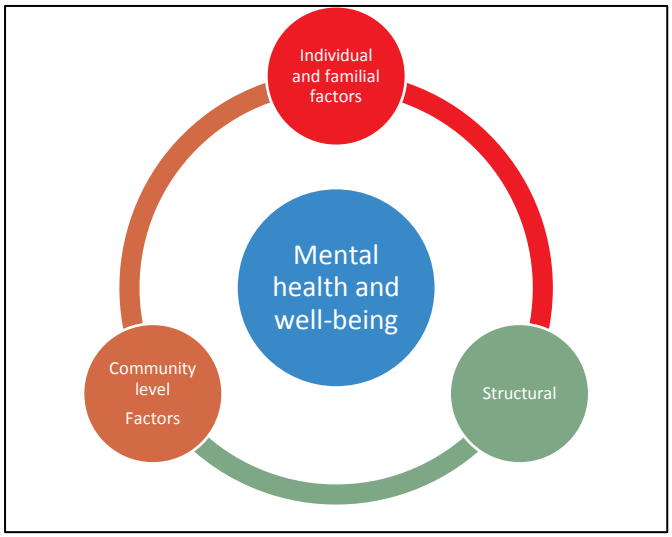
Evidence base for addressing mental health and suicide in communities

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

Mental health promotion and prevention

A focus on addressing the factors that are associated with mental health is a key feature of many of the frameworks, acknowledging the influence of individual characteristics or attributes, and also by the structural and community factors. Adapted from the World Health Organisation (WHO), Figure 1 describes the contribution of these factors.[20]

Figure 1: Adapted WHO Conceptual Framework for factors associated with mental health and wellbeing



Individual and familial factors relates 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.[20]

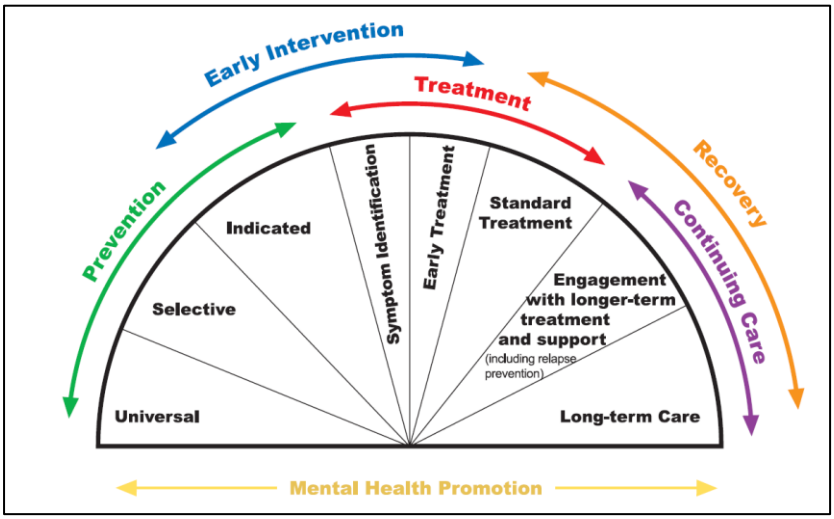
Community level factors cover the wider sociocultural environment in which people live and include levels of access to basic commodities and services, exposure to predominating cultural beliefs, attitudes or practices, discrimination, social or gender inequality and conflict.[20]

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.[21] The promotion of mental health and wellbeing seeks to enhance social and emotional wellbeing and quality of life.[21] Initiatives can target entire populations, groups of people or individuals, and can occur in any setting.[21]

Figure 2 describes a useful model outlining a broad spectrum of mental health promotion targeted at individuals and communities. [22] This model covers a range of activities from prevention to recovery and continuing care.[21]

Figure 2: 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).[21] Strategies may also aim to lower the severity and duration of an illness through early intervention, including early detection and early treatment.[21] They may also aim to reduce 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.[21]

Many communities in Australia and internationally have recognised the need to work together to improve mental health and wellbeing. There are a number of strategies which demonstrate evidence for positive impact on mental health and wellbeing in the community.[23-26] Common across these strategies is recognition of respectful partnerships across different sectors of the community.[27]

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 the Lithgow area. In partnership with community organisations across a town strategies were implemented under the common banner of ACT, BELONG, COMMIT to address mental health and wellbeing.[27]

Suicide Prevention

In their position paper on rural suicide and its prevention, and based on evidence, the Centre for Rural and Remote Mental Health (CRRMH) outlines five focus areas for action for preventing suicide in rural areas (Figure 3**Error! Reference source not found.**) [28]. The strategies in these areas are designed to save lives now and to lower the number of deaths and rates of suicide[28]. Strategies for immediate action to prevent suicide deaths include: preventing people who experience suicidality from taking their own loves; and helping those who are affected by suicide.

Figure 3: Rural Suicide prevention Focus areas

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

Importantly, this position paper recommends approaching suicide from a public health lens by addressing known risk and protective factors for good health and mental health [28]. 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, sexual preference etc., especially of 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[28].

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[28].

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, based on best available epidemiological evidence, along with the services required at each level[29]. 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 are able to progress through the mental health care system as symptoms escalate or diminish. 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.

In Australia GPs and other primary care services provide most mental health care [30] hence the role of the GP is central in the stepped care model[31]. As commonly the first point of contact for people experiencing mental illness and substance problems, the GP is key in ongoing management of their patient's mental and physical health acting as 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[31].

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[29, 32-34]. 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[35-38]

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[39]. 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[35, 40] 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[41, 42].

Our approach

This project was commissioned by General Manager Mental Health of Nepean Blue Mountains Local Health District in response to community concerns about mental health and wellbeing and suicides in the Lithgow area.

Aims

The project aimed to explore approaches to promoting mental health and wellbeing in the Lithgow area. 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.

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

Quantitative data from various publicly available sources was used to build a profile of the Lithgow area, 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 regional NSW, NSW and Australia where made where available.

Key Stakeholder Interviews

Interviews were conducted with key stakeholders within the Lithgow LGA. Stakeholders included: consumers, carers and interested community members; service providers from mental health, drug and alcohol and other community support services; and GPs and other medical specialists.

Interview Sample

The sample for the interviews was initially provided by the NBM LHD mental health team. Initial contact was made with those on this list. A snowballing technique was used to identify additional stakeholders who may be interested in contributing their views. Stakeholders were emailed to inform them of the dates and times for 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. Questions were open ended and included prompts for responses where necessary.

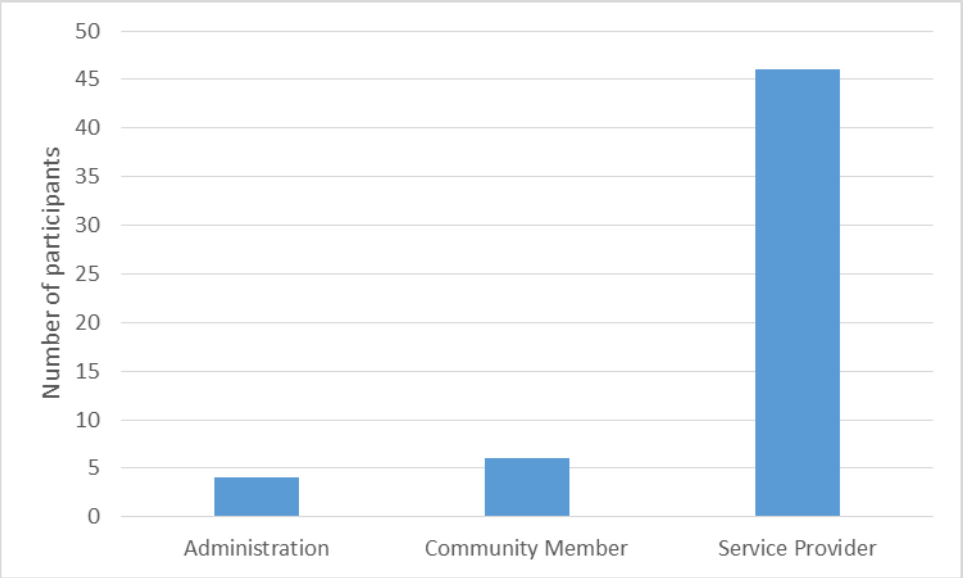
Thematic Analysis

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

Interview Participants

There were 55 participants interviewed for as part of the consultation. The categories of the participants are shown in Figure 4.

Figure 4: Categories of Participants by category



The majority (n=46) of participants were service providers. It is noted that of the participants, 63% (n=35) lived in the Lithgow City Council area.

Data Triangulation

The quantitative and qualitative results were triangulated to contribute to key themes and to test the consistency of findings. The results of the data triangulation contributed to the identification of recommendations.

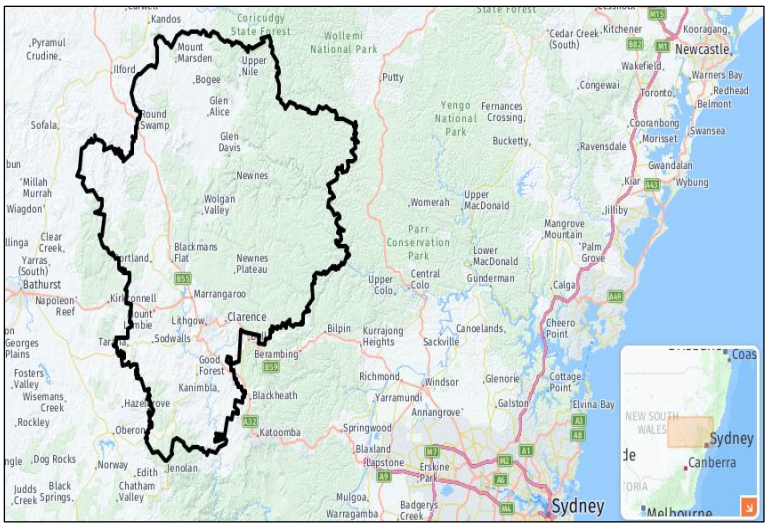
Lithgow Socio-Demographic Profile

Population, demographic and social indicators with relevance to mental health and suicide were identified to contribute to the understanding of the Lithgow community.

Geography

Lithgow City is located in the Central Tablelands of New South Wales, about 140 kilometres west of the Sydney CBD. It covers an area of 4,567 Km^2 with a population density of .05 persons per hectare[43].

Figure 5: Map of Lithgow LGA



Lithgow City is a predominantly rural area, with rural-residential and residential areas in several townships including Lithgow, the smaller townships of Portland and Wallerawang, and with some industrial land use[43].

Rural land is used mainly for farming, grazing and mining, in particular coal mining. National parks or state forest take up nearly two-thirds of the area[43].

Population

The Estimated Resident Population (ERP) in 2016 was 21,524 an increase of 674 people since 2011.[43] Selected subpopulation categories for Lithgow City 2016 and 2011 are provided in Table 1 with comparison with regional NSW populations. The Aboriginal and Torres Strait Islander Census population of Lithgow City was 1,208 in in 2016.

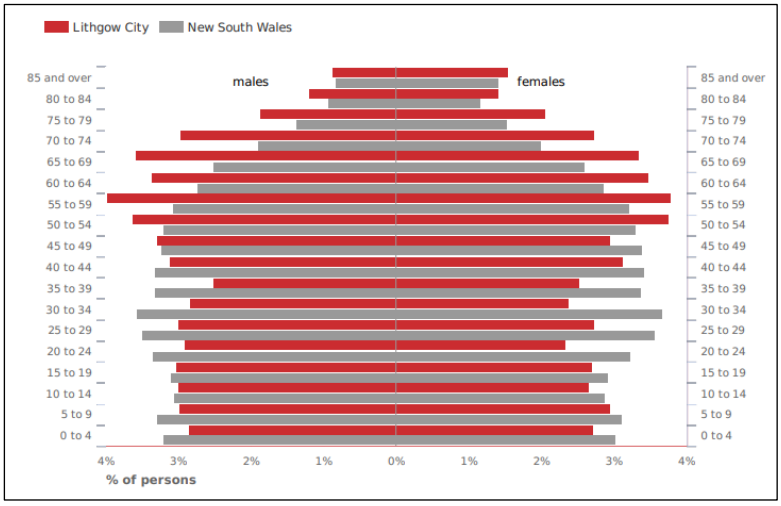
Table 1: Selected population categories

	2016			2011			Change
Population group	**Number**	**%**	**Regional NSW %**	**Number**	**%**	**Regional NSW %**	**2011 to 2016**
Males	10,689	50.7	49.2	10,291	51.0	49.3	+398
Females	10,401	49.4	50.8	9,870	49.0	50.7	+531
Aboriginal and Torres Strait Islander population	1,208	5.7	5.5	900	4.5	4.7	+308
Australian citizens	18,018	85.5	88.7	18,040	89.5	90.8	-22
Population over 15	17,494	83.0	81.6	16,386	81.3	80.6	+1,108

Employed Population	7,796	92.2	93.4	8,063	92.8	93.9	-267

The age and gender profile of the Lithgow population is shown in Figure 6. The largest age group for both genders was 55 to 59 year olds and there were 516 people over the age of 85 years[43].

Figure 6: Age Sex Pyramid Lithgow City 2016

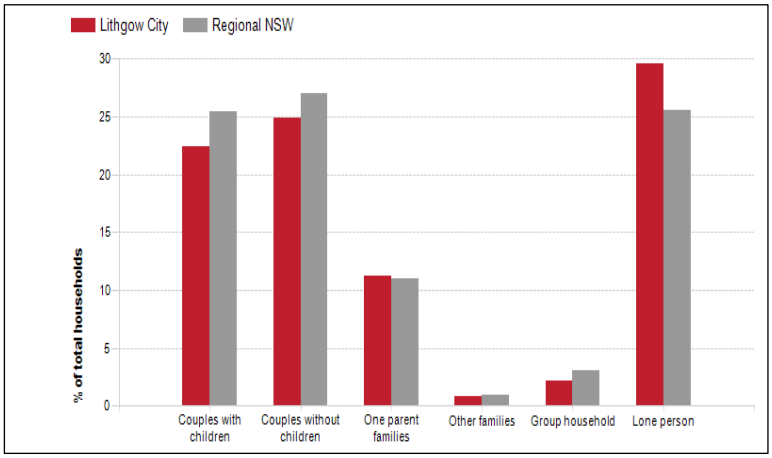


There was a smaller proportion of people born overseas in Lithgow (9.2%) compared with regional NSW 11.2%, as well as a smaller proportion of people from a non-English speaking background (4.4%, 5.8%)[43].

Source: Australian Bureau of Statistics, Census of Population and Housing, selected years between 1991-2016 (Enumerated data). Compiled and presented in profile.id by .id

Household type

Figure 7: Household Type, Lithgow in comparison with regional NSW, 2016

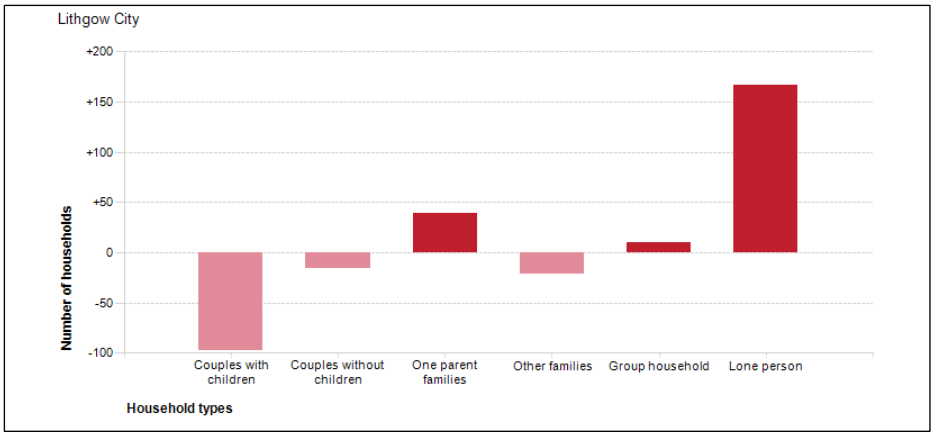


Source: Australian Bureau of Statistics, Census of Population and Housing, 2016 (Enumerated data)

In Lithgow City, in 2016 there were 8,639 households. Analysis of the household/family types in Lithgow in 2016 compared to regional NSW shows that there was a lower proportion of couple with child(ren) as well as a higher proportion of one-parent families (Figure 7). Overall, 22.4% of all families were couple families with child(ren), and 11.2% were one-parent families, compared with 25.4% and 11% respectively for regional NSW[43]. Nearly 25% of families were couples without children, lower than the proportion for regional NSW. There was also a higher proportion of lone person households (29.6%) compared to 25.5% in regional New South Wales[43].

Figure 8 shows changes in household type in Lithgow between 2011 and 2016. The total number of households in Lithgow City increased by 523 between 2011 and 2016.

Figure 8: Change in Household Type in Lithgow 2011 - 2016



Source: Australian Bureau of Statistics, Census of Population and Housing, 2016 (Enumerated data)

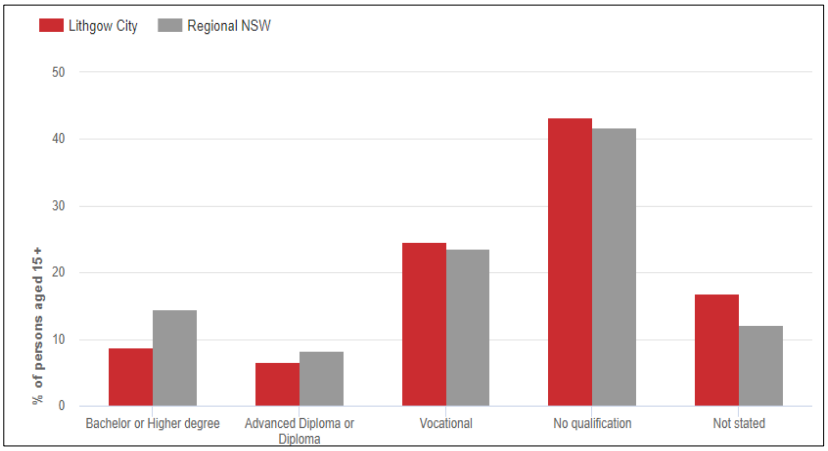
The largest changes in family/household types in Lithgow City between 2011 and 2016 were:

- Lone person (increase of 167 households)
- Couples with children (decrease of 97 households)

Education

The highest level of qualifications achieved by people living in the Lithgow LGA is described in Figure 9. There was a lower proportion of people holding Bachelor or higher degree or Advanced Diploma or Diploma, and a higher proportion of people with vocational qualifications or no formal qualifications in Lithgow compared to the population in regional NSW[43].

Figure 9: Highest qualification achieved – Lithgow with comparison to regional NSW



Source: Australian Bureau of Statistics, Census of Population and Housing, 2016 (Usual residence data). Compiled and presented in profile.id

Overall, 40% of the population aged 15 and over held educational qualifications, and 43% had no qualifications, compared with 46% and 42% respectively for regional NSW.

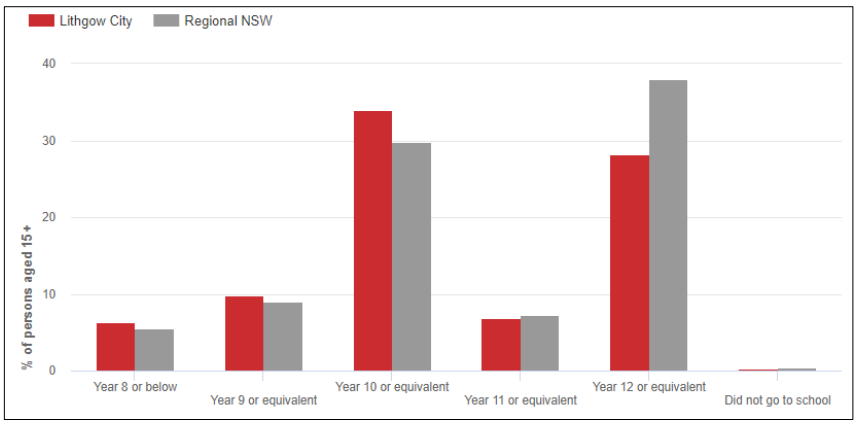
Between 2011 and 2016 there was changes in those with:

- No qualifications (decrease of 579 persons)

- Vocational qualifications (increase of 472 persons)
- Bachelor or Higher degrees (increase of 288 persons)
- Advanced Diploma or Diplomas (increase of 278 persons)[43]

The proportion of the Lithgow population in terms of highest level of secondary schooling completed is shown in Figure 10. There was a higher proportion of people who had left school at an early level (Year 10 or less) and a lower proportion of people who completed Year 12 or equivalent. Overall, 50% of the population left school at Year 10 or below, and 28 % went on to complete Year 12 or equivalent, compared with 44% and 38% respectively for regional NSW. For Aboriginal people in Lithgow City a smaller percentage completed year 12 or equivalent compared to Aboriginal people in the rest of NSW (22% compared to 28 %)

Figure 10: Highest level of secondary schooling completed – Lithgow with comparison to regional NSW



Source: Australian Bureau of Statistics, Census of Population and Housing, 2016 (Usual residence data). Compiled and presented in profile.id by .id, the population experts.

The largest changes in the level of schooling attained by the population in Lithgow City, between 2011 and 2016 were:

- Year 12 or equivalent (increase of 713 persons)
- Year 9 or equivalent (decrease of 220 persons)
- Year 8 or below (decrease of 194 persons)
- Year 11 or equivalent (increase of 50 persons)[43]

Between 2011 and 2016 there were increases in the numbers of Aboriginal and Torres Strait Islander population in Lithgow City, completing Years 10 (increase of 86 people) and Year 12 (increase of 70 people).[43]

Employment

Employment status

The size of Lithgow City's labour force in 2016 was 8,452, of which 3,002 were employed part-time and 4,627 were full time workers[43]. The employment status (as a percentage of the labour force) in Lithgow City in 2016 compared to regional NSW shows that there was a lower proportion in employment, and a higher proportion unemployed (Figure 11). Overall, 92.2% of the labour force was employed (48.3% of the population aged 15+), and 7.8% unemployed (3.7% of the population aged 15+), compared with 93.4% and 6.6% respectively for regional NSW (Figure 11).

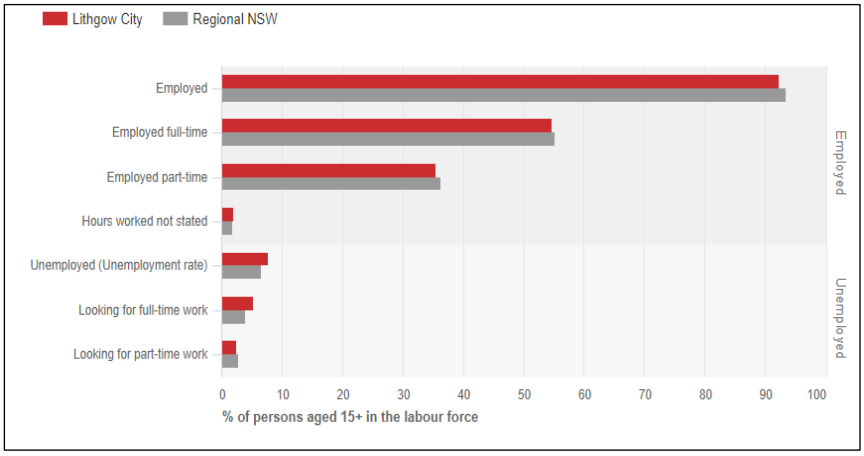


Figure 11: Employment Status 2016; Total Persons in Labour Force

Between 2011 and 2016, the number of people employed in Lithgow City decreased by 267, and the number unemployed increased by 31. In the same period, the number of people in the labour force showed a decrease of 236 or 2.7%.

Source: Australian Bureau of Statistics, Census of Population and Housing 2011 and 2016.

Table 2 shows the change in labour force status for Lithgow between 2011 and 2016 in comparison with regional NSW

Table 2: Change in Labour Force Status of Lithgow residents 2011 and 2016 compared to regional NSW

Lithgow City - Persons aged 15+ (Usual residence)	**2016**			**2011**			**Change**
Labour force status	**Number**	**%**	**Regional NSW %**	**Number**	**%**	**Regional NSW %**	**2011 to 2016**
Total labour force (Participation rate)	8,452	48.3	54.8	8,688	53.0	56.4	-236
Not in the labour force	7,359	42.1	37.9	6,799	41.5	38.5	+560
Labour force status not stated	1,689	9.7	7.3	899	5.5	5.2	+790
Total persons aged 15+	17,494	100.0	100.0	16,386	100.0	100.0	+1,108

Source: Australian Bureau of Statistics, Census of Population and Housing 2011 and 2016.

The labour force participation rate of the population in Lithgow City in 2016 shows that there was a lower proportion in the labour force (48.3%) compared with regional NSW (54.8%)[43].

The Aboriginal and Torres Strait Islander labour force in 2016 in Lithgow comprised of 394 people, of which 148 were employed part-time and 187 were full-time workers. There was a similar proportion of Aboriginal and Torres Strait Islander people in employment, as well as a similar proportion unemployed compared with those in NSW. The unemployed Aboriginal and Torres Strait Islander labour force was 15.0%, compared with 15.3% or the Aboriginal and Torres Strait Islander population in NSW[43].

There was a lower proportion of Aboriginal and Torres Strait Islander people in the labour force (48.3%) compared with the Aboriginal and Torres Strait Islander population in New South Wales - ATSI (54.4%)[43].

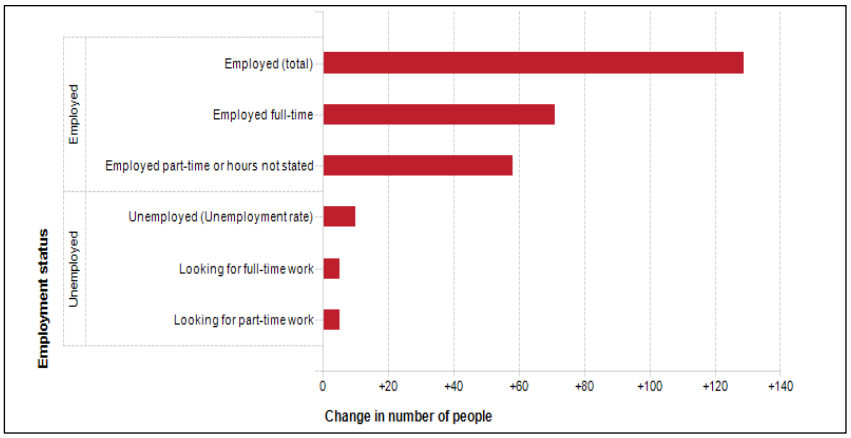


Figure 12: ***Change in employment status, 2011 to 2016 Aboriginal and Torres Strait Islander Peoples***

Between 2011 and 2016, the number of Aboriginal and Torres Strait Islander people employed in Lithgow City increased by 129 people and the number unemployed increased by 10 people (Figure 12). In the same time period, the number of Aboriginal and Torres Strait Islander people in the labour force showed an increase of 139 people, or 54.5% increase[43].

Table 3 shows the industry sector of employment for Lithgow in comparison to NSW with changes between 2011 and 2016. The industry sectors which employed most people in Lithgow were:

- Health Care and Social Assistance (906 people or 11.6%)
- Retail Trade (760 people or 9.7%)
- Public Administration and Safety (745 people or 9.6%)[43]

In combination, these three industries employed 2,411 people in total or 30.9% of the total employed resident population. In comparison, regional NSW employed 14.4% in Health Care and Social Assistance; 10.3% in Retail Trade; and 7.2% in Public Administration and Safety. In regional NSW there was a higher proportion of people employed in construction (8.7%) compared with Lithgow (6.7%)[43].

Industry of Employment

Lithgow City - Employed persons (Usual residence)	2016			2011			Change
Industry sector	**Number**	**%**	**Regional NSW %**	**Number**	**%**	**Regional NSW %**	**2011 to 2016**
Agriculture, Forestry and Fishing	218	2.8	5.7	216	2.7	5.8	+2
Mining	694	8.9	2.4	998	12.4	2.5	-304
Manufacturing	414	5.3	6.0	542	6.7	8.3	-128
Electricity, Gas, Water and Waste Services	283	3.6	1.3	350	4.3	1.5	-67
Construction	521	6.7	8.7	471	5.8	7.9	+50
Retail Trade	760	9.7	10.3	802	10.0	11.4	-42
Wholesale trade	174	2.2	2.0	156	1.9	2.8	+18
Accommodation and Food Services	701	9.0	7.9	671	8.3	7.7	+30
Transport, Postal and Warehousing	355	4.6	4.0	464	5.8	4.2	-109
Information Media and Telecommunications	62	0.8	0.9	52	0.6	1.0	+10
Financial and Insurance Services	158	2.0	2.0	133	1.7	2.2	+25
Rental, Hiring and Real Estate Services	104	1.3	1.4	77	1.0	1.4	+27
Professional, Scientific and Technical Services	229	2.9	4.5	247	3.1	4.6	-18
Administrative and Support Services	264	3.4	3.3	274	3.4	2.8	-10
Public Administration and Safety	745	9.6	7.2	681	8.5	7.2	+64
Education and Training	500	6.4	9.0	503	6.2	8.6	-3
Health Care and Social Assistance	906	11.6	14.4	885	11.0	13.0	+21
Arts and Recreation Services	89	1.1	1.2	81	1.0	1.2	+8
Other Services	302	3.9	3.9	288	3.6	3.9	+14
Inadequately described or not stated	319	4.1	3.8	167	2.1	2.1	+152
Total employed persons aged 15+	**7,798**	**100.0**	**100.0**	**8,058**	**100.0**	**100.0**	**-260**

Table 3: Industry Sector of Employment

Source: Australian Bureau of Statistics, Census of Population and Housing 2011 and 2016.

The largest changes in the jobs held by the resident population between 2011 and 2016 in Lithgow City were for those employed in:

- Mining (decrease of 304 persons)
- Manufacturing (decrease of 128 persons)
- Transport, Postal and Warehousing (decrease of 109 persons)
- Electricity, Gas, Water and Waste Services (decrease of 67 persons)[43]

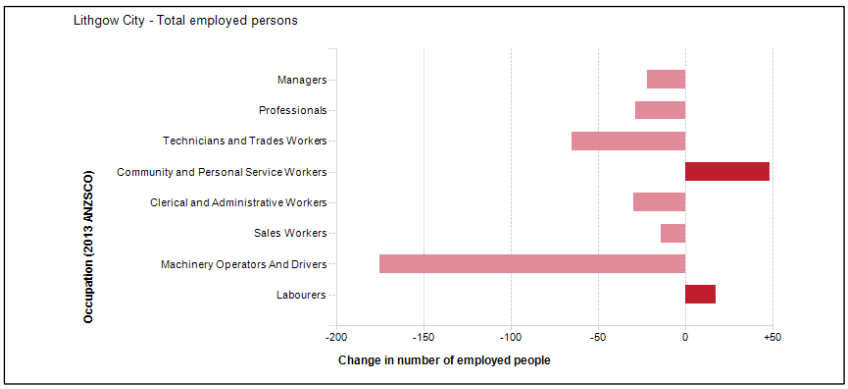
Occupation

The occupations which employed the most number of people in Lithgow in 2016 were:

- Technicians and Trades Workers (1,358 people or 17.4%)
- Clerical and Administrative Workers (1,035 people or 13.3%)
- Community and Personal Service Workers (1,003 people or 12.9%)

Figure 13 shows the change in employment by occupation between 2011 and 2016.

Figure 13: ***Change in occupation of employment, Lithgow City 2011 to 2016***



The number of employed people in Lithgow City decreased by 262 between 2011 and 2016. The largest changes in the occupations of residents between 2011 and 2016 in Lithgow City were for those employed as:

- Machinery Operators and Drivers (decrease of 175 persons)
- Technicians and Trades Workers (decrease of 65 persons)

In 2016 Aboriginal and Torres Strait Islander people in Lithgow were most commonly employed in occupations as:

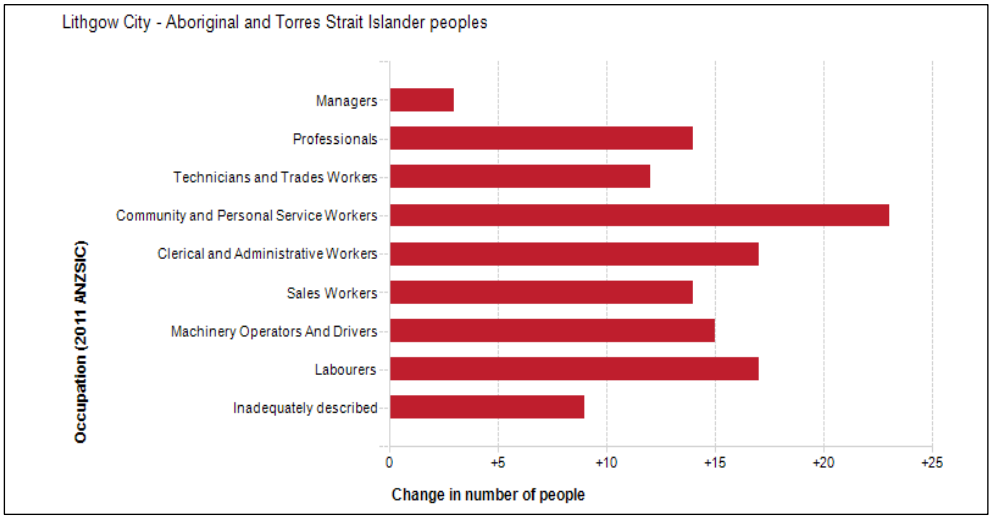
- Labourers (63 people or 18.9%)
- Community and Personal Service Workers (54 people or 16.2%)
- Technicians and Trades Workers (53 people or 15.9%)

In combination these three occupations accounted for 170 people or 50.9% of the employed Aboriginal and Torres Strait Islander population in Lithgow[43].

Figure 14 shows the change in occupation of employment for Aboriginal and Torres Strait Islander peoples between 2011 and 2016. The occupations in which the largest increases in employment has occurred were in:

- Community and personal services workers (increase of 23)
- Clerical and administrative workers (increase of 17)
- Labourers (increase of 23)

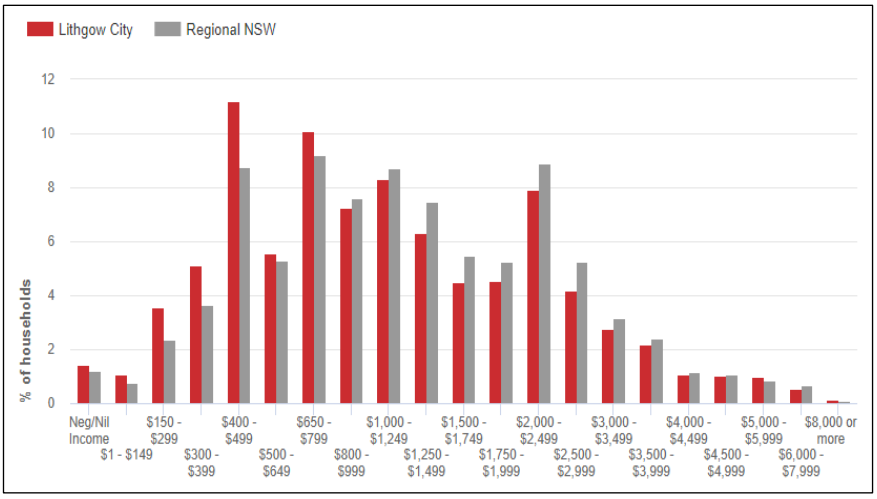
Figure 14: Change in occupation of employment for Aboriginal and Torres Strait Islander people-Lithgow, 2011-2016



Household Income

Figure 15 shows the weekly household income for Lithgow in 2016 in comparison with regional NSW. There was a smaller proportion of high income households (those earning $2,500 per week or more) and a higher proportion of low income households (those earning less than $650 per week).

Figure 15: Weekly household income 2016, Lithgow in comparison with regional NSW



Overall, 12.8% of the households earned a high income and 27.9% were low income households, compared with 14.6% and 22% respectively for regional NSW[43].

The weekly individual income for residents of Lithgow in comparison with regional NSW is shown in Figure 16.

The data on household incomes of Aboriginal and Torres Strait Islander levels in Lithgow City in 2016 compared to Aboriginal and Torres Strait Islander household income levels in NSW shows there was a smaller proportion of high income households (those earning $2,500 per week or more) and a higher proportion of low income households (those earning less than $650 per week)[43].

Data shows that there was a there was a similar proportion of people earning a high income (those earning $1,750 per week or more) and a higher proportion of low income people (those earning less

than $500 per week)[43]. Overall, 7.9% of the population earned a high income, and 42.2% earned a low income, compared with 8.3% and 40% respectively for New South Wales[43].

Figure 16: Weekly gross individual income, 2016 Lithgow and NSW

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[43]. It provides the relative level of disadvantage in one area compared to others.

In 2016, Lithgow City scored 923 on the SEIFA Index of Disadvantage. This places Lithgow in the second lowest quintile of disadvantage for LGAs in NSW.

Internet Connection

An internet connection is now an important utility for most households in Australia[43]. It is increasingly required for accessing essential information and taking part in the digital economy, and importantly now provides access to information and support for mental health. Nationally, in 2016, nearly 80% of all households had internet access, decreasing with age, with seniors less likely to have internet at home[43]. The lack of internet access is likely to indicate a level of disadvantage and could be related to socio-economic factors such as age, income and geographical isolation.

There was a lower proportion of households with an internet connection in Lithgow compared with NSW. Overall 66. % of households had an internet connection, compared with 73% in regional NSW. However, between 2011 and 2016 the number of households with an internet connection increased by 560[43].

Volunteering

In Lithgow City 18.4% of the population reported doing some form of voluntary work in 2016, slightly higher than for NSW (18.1%). The number of volunteers in Lithgow City increased by 353 people between 2011 and 2016.

Mental Health

There are a range of data available to describe the mental health of the residents of Lithgow. 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 mental health problems at both individual and population levels.[44] 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)[45].

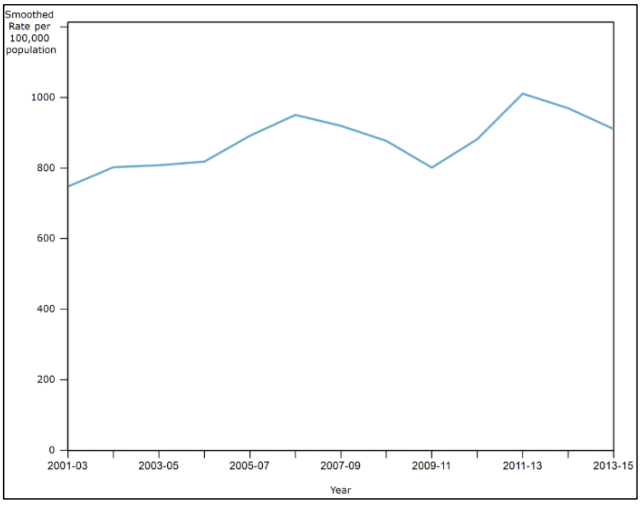
At national level in 2014-15, the rate at which the population aged 18 years and over experienced high or very high psychological distress was 11.7 per 100 for Australia and 11.0 per 100 for NSW[45]. For the Lithgow LGA, in 2014-15, the estimated proportion of people aged 18 years and over with high or very high psychological distress (K10) was 13.3%, higher than the NSW rate (11%) and higher than regional NSW (11.7%)[46].

Mental and behavioural problems

The estimated proportion of people with mental and behavioural problems in Lithgow in 2011-12 was 14.9%, higher than the proportion for NSW (13.1% and for regional NSW (14.5%)[46]. These estimates were based on data from the Australian Health survey where people self-reported mental health and behavioural problems.

Alcohol

Figure 17: Alcohol attributable hospitalisations, Lithgow LGA, 2001-03 to 2013-15



The estimated proportion of the Lithgow population aged 15 years and over who consumed more than two standard alcoholic drinks per day on average was 19.4%, higher than the NSW rate (16%) and slightly lower than the rate for regional NSW (20.2%)[46].

Alcohol attributable hospitalisations, in Lithgow LGA have increased over the last decade (Figure 17). In 2014-15 the rate for Lithgow was 910.6 per 100,000 people compared to the NSW rate of 670.4/100,000

people[47].

Alcohol attributable deaths for Lithgow LGA have increased slightly between 2001-2002 and 2012-2013. In contrast this rate has decreased in NSW in the same time period. 1n 2012-13 the alcohol attributable deaths were 19.2/100,000 population in Lithgow compared to the NSW rate of 15.4 /100,000 population[47].

In the same time period, alcohol attributable injury hospitalisations in Lithgow LGA peaked in 2006-2008 at 525.4 per 100,000 population and have since declined to 405.5/100,000 population in 2012-2014. In contrast alcohol attributable injury hospitalisations are lower in NSW but have increased over the last decade peaking at 329/100,000 population in 2012-14[47].

Domestic Violence

Domestic violence is a significant issue in Australian communities, contributing significantly to injury, death and disability and with women at most risk[48]. Domestic violence also has long term consequences for the physical and mental health of those experiencing this crime[48].

Figure 18 shows the rate of domestic violence related assault for the Lithgow City area between 2013 and 2017. These data indicate that the rate of domestic violence related assault for the Lithgow City area is higher than the NSW rate and since 2016 shows a spike in assaults[49].

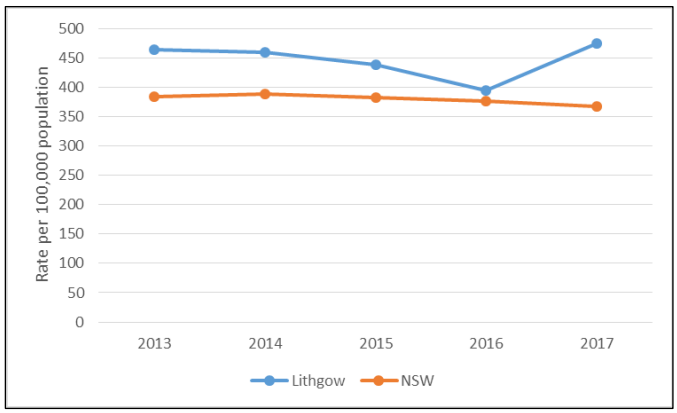
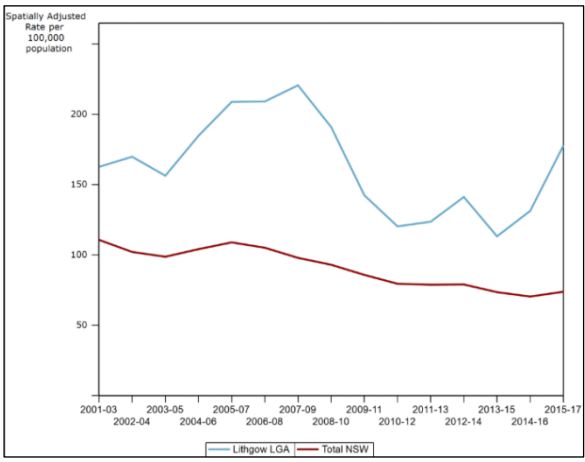


Figure 18: Rate per 100,000 population of domestic violence related assault – Lithgow and NSW 2013-2017

Another indicator of domestic violence is the rate of interpersonal violence-related hospitalisations for the area (Figure 19).

Figure 19: Interpersonal violence-related hospitalisations, Lithgow LGA, NSW 2001-03 to 2015-17



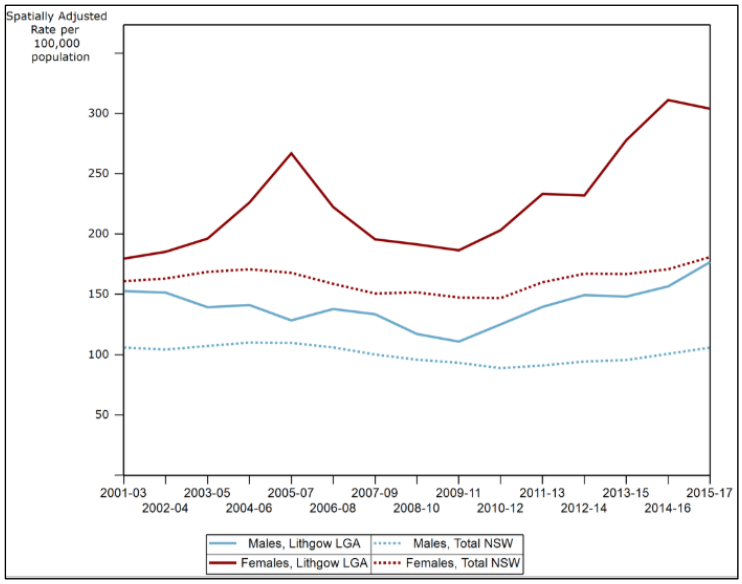
While men are more likely to be hospitalized due to interpersonal violence, women outnumber men by six to one in terms of sexual assault by bodily force. Women (40%) are also more likely compared to men (3%) to report spouse or domestic partner as the perpetrator[50]

Evidence suggests that some women are at greater risk of experiencing domestic violence including: alcohol and drug use by perpetrators; the experience of violence as a child and subsequent victimisation as an adult; women who are pregnant or are separated; younger women; Indigenous women; women living in rural and remote areas; and women experiencing financial stress[51].

Suicide and Self-harm

The rate of Intentional self-harm hospitalisations, for males and females in Lithgow LGA (Figure 20) has increased between 2001-03 to 2015-17[47].

Figure 20: Intentional self-harm hospitalisations, persons of all ages, Lithgow LGA, 2001-03 to 2015-17

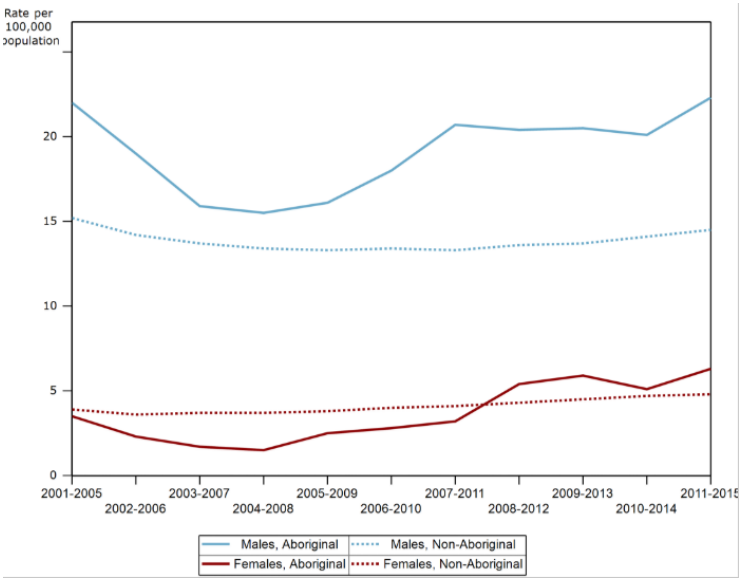


For males and females, the rate of intentional self-harm hospitalisations for Lithgow in this time period is higher than the NSW rates[47].

For Lithgow, between 2010 and 2014, the estimated rate of deaths from suicide and self-inflicted injuries for those 0 to 74 years was 11.4 per 100,000 population. This is higher than the rate for NSW (9.4/100,000 population) and lower than the rate for regional NSW (12/1000,000 population)[46].

Figure 21: Suicide by Aboriginality, NSW 2001-2005 to 2011-2015

Data on suicides for Aboriginal and Torres Strait Islander people is not available for Lithgow. However data for NSW shows that suicide rates for Aboriginal and Torres Strait Islander males and females are higher than for males and females for non-Aboriginal people (Figure 21). These rates have also increased over the since 2007-2011 (14/100,000 males and 3/100,000 females) peaking in 2015 (18/100,000 males and 6/100,000 females)[47].



Mental Health Services

There are a range of clinical and community services providing care and support for people with a mental illness and at risk of suicide.

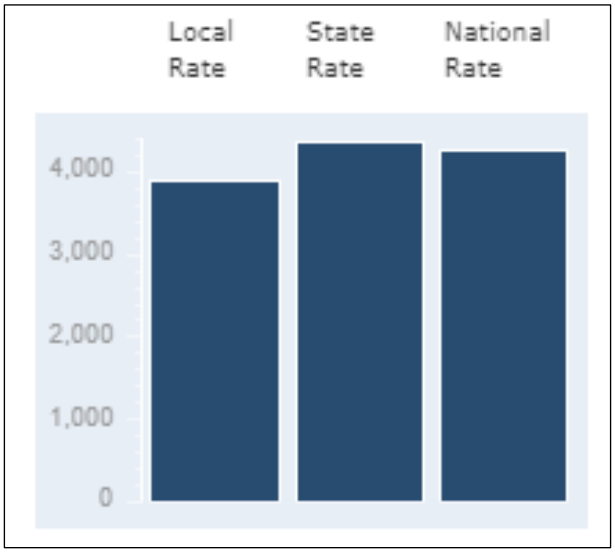
Primary Care

Primary care including general practice and community health are ideally place to provide mental health clinical care, and in particular early intervention. Primary mental healthcare involves: diagnosis and treatment for people with common mental disorders; preventing mental disorders; and applying key psychosocial and behavioural science skills[52]. Primary mental health services complement tertiary and secondary level mental health services.

The effectiveness of primary mental health care is dependent on integration with more specialist 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[53]). Services provided under the MBS by GPs can include preparation or review of a mental health treatment plan, management of a patient's mental health condition and focused psychological strategies.

Figure 22 shows the rate of mental health treatment plans provided by general practitioners (GPs) for the Lithgow-Mudgee statistical area level 3 (SA3).

Figure 22: Rate of General Practitioner Mental Health Treatment Plans, Lithgow,-Mudgee SA3 compared with NSW and Australia



For this SA3 the rate at which GPs provide mental health treatment plans is lower than the rates for NSW and at national level.

Specialist Mental Health Care

These more specialist mental health services manage acute episodes of mental illness. 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[52].

The rate of admissions for mental health related conditions to public hospitals for Lithgow residents was 1255/100,000 population. This is higher than the rate for NSW (906/100,000 population) and higher than for regional NSW (964/100,000 population)[46].

Similarly the rate of admissions for mental health related conditions to all hospitals for Lithgow residents (2404/100,000 population) was higher than for NSW (1894/100,000 population) and for regional NSW (1542/100,000 population)[46].

For Aboriginal people in the Lithgow-Oberon area admissions for mental health related conditions, was 1399/100,000 people, a rate lower for Aboriginal people in regional NSW (2273/100,000) and all of NSW (2,533/100,000)[54].

Prescription of Medications for Mental Illness

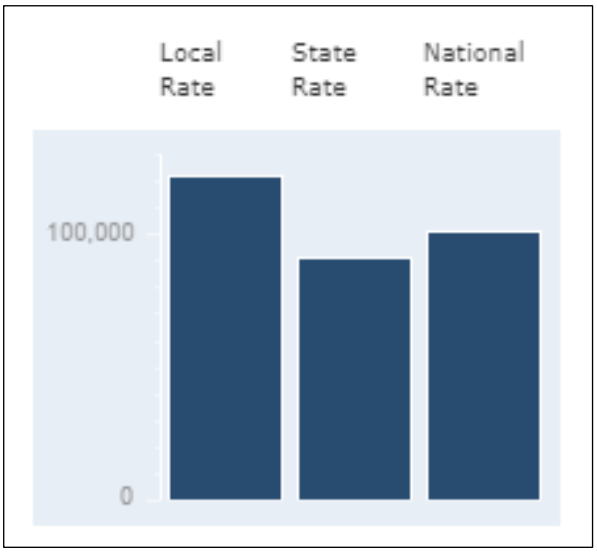
Mental health interventions include pharmacological and non-pharmacological types such as cognitive and behavioural therapies, as well as psychosocial support. Pharmacological and non-pharmacological interventions both have a role to play in managing mental illness.

The rates for describing a range of medications to treat mental illness is generally higher for this Lithgow-Mudgee SA3 compared with state and national rates.

Antidepressants are used to treat depression. Evidence indicates that non-pharmacological interventions are the optimal treatment for milder forms of depression with moderate to severe depression best treated with a combination of social and psychological interventions and antidepressant medicines[46]. 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[46].

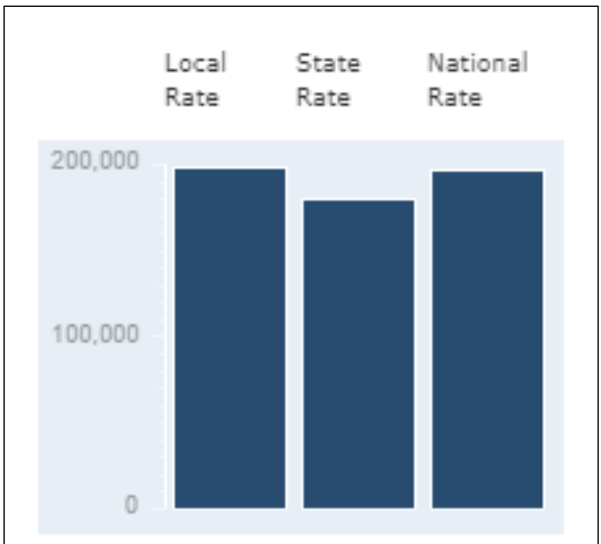
Figure 23 and Figure 24 show the rate of antidepressant prescribing for 18-64 year old residents of Lithgow-Mudgee and for those 65 years and over. On both these age categories the rate of prescribing are higher compared to NSW and to Australia.

Figure 23: Antidepressant Medicines Dispensing 18-64 Years Antidepressant Medicines Dispensing 18 64 Years, Lithgow,-Mudgee SA3 compared with NSW and Australia



For those residents 18-64 years the prescribing rate was 122,028/100,000 people and for those 65 years and older the rates was 198842/100,000 people[46].

Figure 24: Antidepressant medicines dispensing 65 years and over, Lithgow,-Mudgee SA3 compared with NSW and Australia

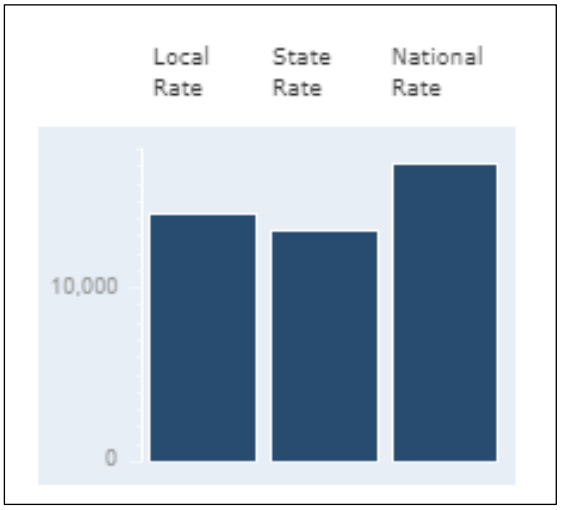


Anxiolytics are most appropriately used to treat the symptoms of anxiety, insomnia and substance withdrawal over short periods. While evidence support their effectiveness in the short term, they are recommended for long-term use as they can be addictive and have a number of side effects[46].

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 25 and Figure 26.

The rate of anxiolytic medicines for residents of the Lithgow-Mudgee SA3 aged 18-64 years is 14,267/100,000 slightly higher than the rate for NSW and lower than the national rate[46].

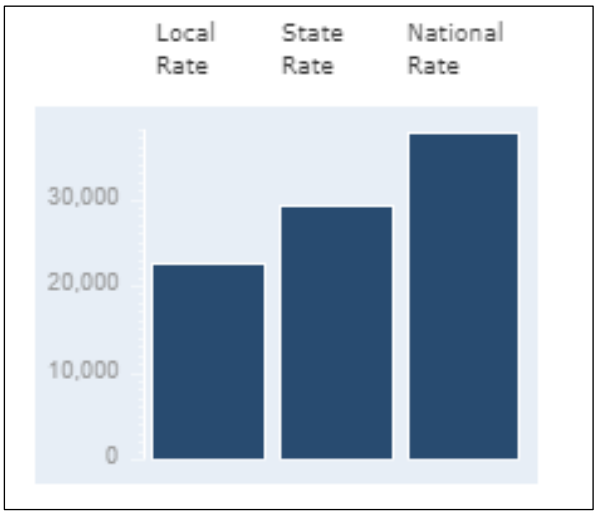
Figure 25: Anxiolytic medicines dispensing 18–64 years, Lithgow,-Mudgee SA3 compared with NSW and Australia



Rates of anxiety disorders are lower among older Australians[46]. 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[46].

The rate of anxiolytic medicines for residents of the Lithgow-Mudgee SA3 aged 65 years and over is 22,624/100,000 lower than the rate for NSW and lower than the national rate (Figure 26)[46].

Figure 26: Anxiolytic medicines dispensing 65 years and over for Lithgow Mudgee SA3 compared with NSW and Australia



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[46].

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[46].

The rates for prescribing antipsychotic medications for those 18-64 years in the Lithgow Mudgee SA3 are shown in Figure 27. For the population of Lithgow Mudgee SA3 aged 18-64 years, the prescribing rate for antipsychotic medications is 19,873/100,000, higher than the rate for NSW and the national rate[46].

Figure 27: Antipsychotic Medicines dispensing 18-64 Years Lithgow Mudgee SA3 compared with NSW and Australia

At a national level there are concerns that prescribing rates for antipsychotic medication are high and these medications are used inappropriately. In particular for this 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[46].

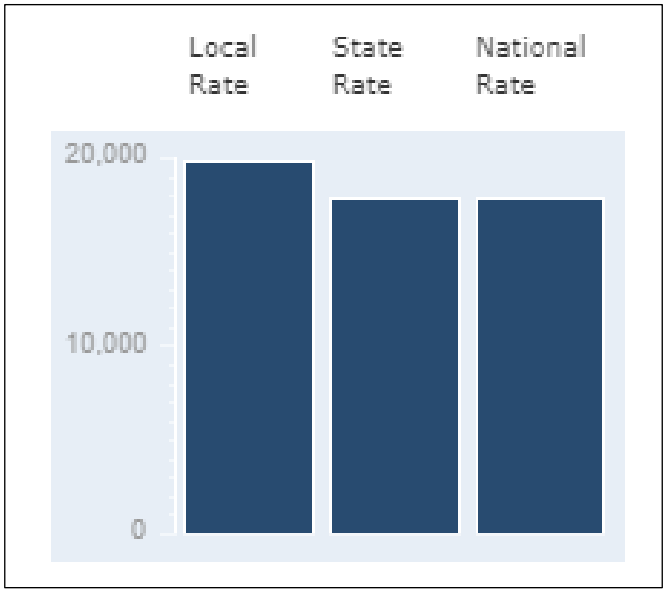
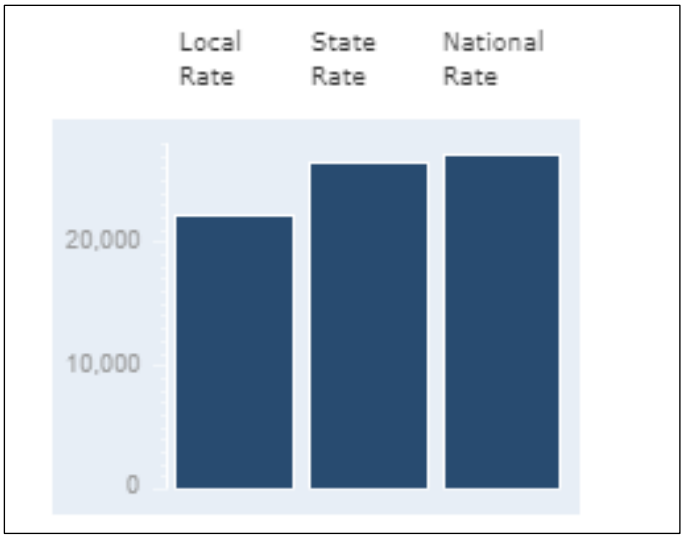


Figure 28: Antipsychotic Medicines Dispensing 65 Years and over Lithgow Mudgee SA3 compared with NSW and Australia



For the older population of Lithgow Mudgee SA3, the prescribing rate for antipsychotic medications is 22207 /100,000, lower than the rate for NSW and the national rate[46] (Figure 28).

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 are a range of community lead initiatives to support and raise awareness about mental health and for suicide prevention demonstrating the commitment of the community to address these issues. For example the "Walk and Talk" Lithgow was perceived as bringing the community together to support mental health and wellbeing and those affected by suicide. Similarly, the monthly barbecues held with the Aboriginal communities and a range of service providers, while not explicitly addressing mental health were perceived as important in bringing community together to support wellbeing.

Particular examples were provided where services had implemented initiatives to support mental health and wellbeing in the community. For example Lithgow high school has established a wellness hub attracting a range of services where students can go to speak with someone about mental and other health concerns. Indeed the Mayor's Mental Health Taskforce represents an important commitment to take leadership in the community about mental health and wellbeing.

Despite these initiatives it was perceived that these are 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 acknowledgement that the impact of the range of events could be strengthened. Further there was a common view that there was often reactive responses to particular events in the community which often dissipated over time.

> *Many of the kids, and younger people play sport. It's big here….The coaches and club members interact with them all the time. They often see when things are wrong but they are not sure how to handle it.*
> Community Member

It was also recognised that there was a strong sporting culture in Lithgow with many community members participating inn sport and associated activities. Some of the sporting clubs has supported specific events related to mental health and wellbeing in the community. There was recognition of the potential for sporting clubs to take an even stronger role in mental health promotion, prevention early intervention and in suicide prevention.

While sport was an important part of the cultural fabric of Lithgow, it was also acknowledged that there were limited options for those in the community for whom sport was not an interest. The need for enhancing options for the community and in particular for young people, outside of sport was supported.

There are many and diverse services in the Lithgow area which provide care and support for people with a mental illness through health care, employment, training, welfare and housing support. However these commonly operated independently and in some instances were not know by other service providers where partnerships could have supported people with a mental illness.

There are also a range of education options in Lithgow including tertiary options through TAFE and tow university campuses. However there was a common view that there had been significant reductions in TAFE courses and costs were barriers to participation in tertiary education. In addition there was a view that TAFE courses in particular did not support local employment pathways.

Mental Health and Suicide

There was a common and strong perception that levels of mental illness and suicide are higher in Lithgow compared to other communities. This a view held by the majority of stakeholders with a range of factors contributing to these levels. It was however recognised that the community could work together to address these problems with solutions not reliant on health care services alone.

It was perceived that levels of depression and anxiety in the community were high, and were associated with high levels of stress. In addition there was a perception that there were significant problems with substance abuse with alcohol being the most commonly cited problem. It was suggested that alcohol contributed to mental health problems as a depressant and also as inappropriate coping mechanisms to address underlying problems.

In relation to suicide there was a strong and common view of limited support strategies for people affected by the suicide of a loved one. This is not to say members of the community are not supportive. Rather there were concerns that the support was often reliant on individuals close to the affected family and friends. It was recognised that in some communities that there was an agreed systematic approach to supporting those affected by suicide which was not in place in Lithgow.

Factors Associated with Mental Illness and Suicide

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.

Mental Health Literacy

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. Mental health literacy refers to the knowledge and beliefs about mental disorders, and the skills which aid their recognition, management or prevention[55]. It was perceived that there was potential to improve the mental health literacy of the Lithgow community by action across settings. While it was acknowledged that some efforts has been made to address mental health literacy, the approaches

lacked a coordinated and strategic focus, with significant numbers of the community missing out on knowledge and skills.

Stigma

There was a common and strong view that stigma about mental illness was a significant barrier to acknowledging and seeking support for mental illness. It was perceived that this was across the community and in particular for men. It was also reported as a barrier for seeking help in young people who could benefit from early intervention. This was viewed as being related to the macho culture common in mining communities where it was considered weak to discuss mental health problems.

Trauma

Intergenerational trauma was perceived to play an important role in the mental health of the community. This was acknowledged as an important factor in the Aboriginal community but also in other parts of the community. It was recognised that it was important for all sectors to acknowledge the contribution of such trauma in addressing mental health and other social issues.

The issue of intergenerational poverty in some members of the community was also raised as significant. This had a significant impact on some members of the Aboriginal and Torres Strait Islander community and also on other community members. While it contributed to mental health problems, it also impacted on associated factors such as educational attainment, employment and drug and alcohol use.

> *Lithgow is a mining town with a strong macho culture. In this town we have not been used to speaking about problems like this. I know it has to change but it has been like this for a long time….blokes don't speak about things like this or get help.*
> Community Member

Isolation

There were a number of factors raised relating to people being isolated which contributed to mental health problems and suicide risks. Relationship breakdown in families was perceived as being a major contributor to mental health problems and was cited as being a significant contributor to some suicides in this community. Many participants indicated that people and in particular men became isolated after relationship breakdowns, and often did not appear to have the coping mechanisms to work through the impact. While participants recognised that relationship breakdowns were a risk they also viewed that it was difficult to know what to do to support someone in this situation.

There was also a view that an increasing number of people in the Lithgow area lived alone, either through choice or circumstance following the death of a partner or a relationship breakdown. This contributed in some cases to social isolation and impacted on mental health and wellbeing. In

addition there was a view that some people were geographically isolated with limited means of transport to support social interaction and access to services.

Community Factors

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

Domestic Violence

Domestic violence was perceived as high in this community and contributed to mental health problems. While it was recognised that there were a number of initiatives to address domestic violence, there was a perception that for decades that there had been a culture of tolerance to this crime in the community which would take a long time to overcome. It was also perceived that this in some families was generational. In addition it was suggested that the macho culture of the area contributed to the rates of domestic violence.

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

Youth specific factors

There were a number of factors which were identified as factors associated with young people. First **bullying** was raised 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.

Second the level of **academic achievement** in the Lithgow area was perceived as being lower than other communities. It was acknowledged that the high school was seeing this as a priority and that there had been improvements in levels of academic achievement. However it was viewed that academic achievement was not a cultural norm in Lithgow previously, with a focus, especially for males, on completing school in Year 10 and working in the mines.

> *The downturn in mining has been happening for some time. We have all known about. But still some people, especially those supposedly representing us have failed to do anything. In fact, some of them have fought against it. There is so much potential here, but there are people with their heads in the sand about mining still being the saviour. But it's not and it's not going to be and they have failed young people here…*
> Service Provider

Third, there was a perception that for young people not involved in sport, there were limited opportunities for them to participate in **social and cultural activities**. These young people often felt marginalised because of lack of social interaction, and because they were outside the community norms. Associated with this was a perception that some groups

of young people also struggled for acceptance within their peer group and within the community. Members of the LGBTIQ community and those from other cultures were cited as sometimes being marginalised in the community. There was a view that events like the Resilience Festival, a charity music festival raising awareness for mental health and suicide prevention was attempting to address these marginalisation factors.

> *There used to a hundred or so apprenticeships given out in the mines every year. I think the last years there has been about six. It was tradition that you would just get a job in the mine….this doesn't happen now and there aren't many other jobs that these kids can apply for. This has had a huge impact*
> Service Provider

Last there was a concern about the lack of **hope** experienced by some people in the community. A number of reasons were identified as contributing to the lack of hope. The closure of mines and reduction in employment in coal mining meant that traditional employment pathways were no longer available for some young people, and in particular young males. These young people often were in families where multiple generations had worked in mining, with the expectation that this tradition continues. In particular this was experienced by young people who did not see tertiary education and in particular university as a pathway.

Opportunities for employment in other sectors were seen as limited for the young people who may have traditionally worked in mines. Despite the evidence about reduction in employment in mining, there was also a view that there was a culture in the community that mining should still be the main employer, with lack of support for other industries.

There was also a perception that there had been insufficient strategies and failure of leadership to support a more diversified economy at local, state and federal government levels. There was anger in the community about both the reduction in mining and also the failure of leadership to diversify the economy.

It was perceived that these issues in combination severely impacted on the hope of young people for future employment and opportunity for living in Lithgow and impacted on their mental health.

Structural Factors

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

Economy

Concerns were raised about the economic factors as key contributors to mental health and wellbeing in Lithgow. The impact of unemployment associated with mines closures and workforce reductions are perceived as significant. This was coupled with a lack of diversity in economic opportunities, and as stated about a lack of strategic planning and leadership to diversify the economy.

Despite the potential opportunities for diversifying the economy, which were identified as proximity to Sydney and the Blue Mountains, rail and road links, the natural beauty and environmental diversity and housing affordability, it was commonly perceived that there leaders in the community had failed to acknowledge and plan for the necessary changes in the economy.

Health Service

There were strong and common views that the many changes over the last decades in the **boundaries and structures** for state and federal health services meant that Lithgow commonly missed out on health service provision. This was viewed as relating to Lithgow being located at either the extreme western or eastern end of local health districts (state) or primary health networks (federal).

In addition there was a view that the way mental health services were delivered had changed, with **increasing specialisation of state mental health services** meaning they provided care for people with serious and acute mental illness. This meant people with less serious and acute illness had few services for care and support.

In addition, with changes in the way psychology services are provided, **gap payments** are required by many providers. These gaps payments were perceived as a barrier to accessing psychology services for many people in the area.

There are **many support and health services** in the community. 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 has become more fragmented. There are new services in towns, and some services in the community have been de-funded. Indeed many of the service providers were unaware of other services in the community resulting in lack of integration and opportunities for maximising client outcomes.

Many of the services are provided as **outreach** and are not based in the community. There was a common view that this was less than optimal and view as a symptom of Lithgow being forgotten by health service decision makers.

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 clinical and support services with services providers and community members which makes referral pathways problematic and results in duplication of some services.

Specialist Mental Health Services

Participants expressed concerns that access to specialist mental health services is poor in the Lithgow area and had reduced over the last five years. While people with mental illness can now present at emergency at Lithgow hospital, if needing admission they are transferred to Blue Mountains Hospital which has mental health beds. For community based specialist mental health services there is reliance on outreach services, with these being provided through community health for children and young people, adults and older people. There was also a view that these mental health services were not responsive to local community need.

> *I went to my GP a number of times with [condition]. He wanted to give me [medication]. I wanted to try other things but he was reluctant and just wanted to write a script. I persevered and eventually got a mental health plan and was able to see a psychologist after a while. But I had to persevere…*
> Community Member

Because of the specialist focus there was a perception that LHD specialist mental health are difficult to access. Their focus on severe mental illness meant they do not provide services for less serious patients. Associated with this was a view that these services are focused on excluding patients from their services rather than on assessing and referring to appropriate services. There was also a view that some staff in Emergency show stigmatising attitudes to people with mental illness. Many participants cited poor experiences when attending Emergency at Lithgow hospital and were reluctant to attend even if they were unwell. .

There was a perception that access to psychiatrists was poor with waiting lists, gap payments as barriers. Transport was also cited as a barrier for some people who sought specialist care in areas outside of Lithgow. There was also a view that access to clinical psychologists was poor in the community with waiting times and gap payments being a barrier to access.

General Practice

There is a concern expressed by participants that the capacity of GPs in relation to mental health needs to be strengthened. It was recognised that time pressures, knowledge, skill, interest and attitude were problematic for GPs, with people with mental health problems often requiring more time. Some participants also expressed a concern about the lack of use of mental health care plans by GPs. Instead there was a view of over-reliance on medication as the first treatment option.

There was also a view that some GPs and staff in general practice show stigmatising attitudes to people with mental illness. This was cited as a barrier to discussing mental health with their GP. Indeed some participants indicated they actively sought out GPs who were more willing to address the mental health of their patients in a supportive manner.

Support Services

There are many services in the Lithgow area 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. There is a silo mentality in some support services which is exacerbated by the competitive funding cycle.

There was also a concern that these service providers providing support for people with a mental illness were often working beyond their skills and capacity for this complex area. This was perceived

as occurring because of lack of access to more specialist mental health services in the areas. There was also a concern that there was no mechanisms for escalating those clients with deteriorating mental health because of difficulties in accessing more specialist clinical mental health care.

Solutions

Participants offered a number of solutions to addressing mental health and wellbeing which were tailored to the context of the Lithgow area.

Building on community strengths

It was recognised that there is a need to build on some of the community based commitment and events which are addressing mental health and wellbeing. Strategic alliances across the community were perceived as potentially more effective than the disparate nature of activities that are currently occurring. Strategic alliances had the potential to building awareness about mental health, mental illness and suicide prevention and increase the capacity of the community to address mental health and mental illness.

Using an evidence Based framework

There was a strong view that whichever strategies were adopted that they needed to be based on evidence. There were concerns that too often in the past that initiatives were implemented which were not based on evidence and indeed could potentially do harm.

> *This is not a recent problem. It has been a problem here for a long time. Lots of things have been done in the past nut they are one-offs or short term. Unless you address the underlying factors it is a waste of *%^$ time. And we will be back talking about it in 10 years.*
> Community Member

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. 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.

As a priority most participants identified the need to address the economic problems in the community. In particular there was a view that there was a need for leadership to build economic diversity in the community. It was perceived this required leadership from all levels of government in partnership with business and the community. There was a view that there were opportunities to build diversity in the economy by capitalizing on the natural environment and proximity to Sydney but that this need to be supported by local planning and regulations which supported the establishment of new businesses.

There was also a view that more could be done to ensure population growth in the city. Support for strategies to attract people to the area were supported and were seen as a way of also encouraging businesses to the area.

Supporting social and cultural diversity by strategic alliances which support multi-cultural communities, creative communities and LGBTI communities was also recommended as an important initiatives. It was viewed that strategies to support social and cultural diversity would help to address the marginalisation that some groups in the community experience.

Providing an integrated needs based service system

It was perceived that the current health system and associated services were not meeting the needs of the Lithgow community. There was a view that there needed to be planning for health services across the service system to meet local needs. 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 the mental health of wellbeing for young people was considered a priority. While the strategies to increase awareness about mental health and provide support for students and families currently being used in the high school were supported and encouraged it was recognised that these need to be embedded in the school system and applied across all levels of education. Schools were also recognised as being crucial in the strategic alliances necessary across the community. There was also recognition of the importance of schools focusing on achieving excellence in education was critical for long term sustainability.

The presence of tertiary education providers in the Lithgow areas was widely supported. However it was suggested that there needed to be much greater alignment between this sector and the economic and social diversity strategy needed for the community.

The Way Forward

There is significant commitment in the Lithgow area to improving mental health and wellbeing and on suicide prevention. The impact of mental health problems and suicide is significant for the community. Importantly there is acknowledgement that 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.[56] Understanding the level of community readiness supports a community in moving forward to take effective action. [56] There are nine stages in community readiness as described in Figure 29.

Figure 29: Stages of community readiness

This project did not aim to identify the stage of readiness for the Lithgow community to address mental health and wellbeing. However, the readiness of the community is demonstrated in the actions already being taken and their willingness to engage with the consultation process and offer potential solutions which could form the basis of a community plan.

Importantly key stakeholders recognise that a coordinated and multi-pronged approach, supported by communication and strong partnerships will be the foundation of positive mental health and wellbeing for the Lithgow community.

Building on the momentum provided by the actions taken place to date and the findings of this project will be critical. The people of the Lithgow area are ready to work together to address mental health and wellbeing through coordinated actions.

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 were recommended to the community committee. 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

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

Community Strengths

Community Commitment

The Lithgow community has demonstrated a strong commitment to mental health and wellbeing with a number of community lead initiatives to support mental health and for suicide prevention. Many of these have been based on individuals or groups within the community acting to address concerns. The difficulty with these approach is that they are reliant on individuals maintaining the commitment to sustain these initiatives. They are also operating as isolated and often one-off activities and miss opportunities for a coordinated and sustained approach to mental health and wellbeing.

Some sectors within the community have undertaken initiatives to provide services to address mental health and wellbeing. These also are often reliant on individuals within agencies with commitment to sustain the approaches and could be strengthened by being part of a community approach to mental health and wellbeing.

Geography

The Lithgow area is an area within approximately two hours by road or rail from Sydney. It is also on the main transport route from Sydney to western NSW. The area's proximity to the Blue Mountains and to Bathurst and Orange provide significant advantages for access. It is also surrounded by the national parks including Wollemi, Blue Mountains, Kananga Boyd and Gardens of Stone National Park and in close proximity to conservation areas, state forests and historical sites.

That participants reported that geography of the area is not sufficiently acknowledged in planning for the city and local economy with unrealized potential to support strategies to encourage business and visitors.

Mental Illness and related health issues

The findings suggest that levels of psychological distress, the number of people with people with mental and behavioural problems and the rate of hospitalisations for mental illness are higher in Lithgow when compared to NSW and regional NSW. Available data related to suicide for the Aboriginal and non-Aboriginal community also indicate the problems in Lithgow are greater than in other communities. These levels reflect community perceptions that levels of mental illness are higher in the community than compared to other places, and support the need for coordinated action.

Data on alcohol for the Lithgow 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.

Rates of domestic violence assaults were high and supported community perceptions. The need to change community norms related to domestic violence was identified as an important strategy to support mental health and wellbeing in the community

Health Services

There have been many changes over the last decades in the boundaries and structures for state and federal health services and the way health services are delivered. As a result there many problems have been cited about quality and access to health services in Lithgow. The lack of knowledge about the services relevant to mental health and wellbeing causes a number of problems for service providers and community members, making clear referral pathways problematic for services and for community.

There is increasing recognition of the importance of place based planning and management for services to support community health and wellbeing[57, 58]. 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[58, 59]. The need for a more systematic approach to planning of mental health services in Lithgow 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 approach to the mental health services for Lithgow. 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.

Economy and Employment

Evidence demonstrates 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[60]. This in turn impacts on the social capital of communities.[60] There is also evidence

that “one industry towns” can experience significant economic downturns and associated disparities within and between regions across a wide range of social and economic indicators[61].

These findings identify significant economic and employment issues in the community. The contribution of these to mental health and wellbeing cannot be under-estimated and have been raised as a significant concern by the community. While it may be require strategies in the longer term, these need to be addressed to sustain improvements to mental health and wellbeing in the community. Examples of successful regional communities typically have strong local leadership teams from all parts of the community, active economic development practitioners and an understanding of the changing requirements of economic development practice in the new economy[61].Key to successful regional economies are identification of a region’s competitive advantages and the creation of an economic and social vision for the region[61].

Like many of the other solutions to mental health and wellbeing building economic diversity requires strategic alliances across the community. However, building the economic diversity of the Lithgow community is critical to ensure opportunities for the future.

Social Issues

The findings raised a number of social issues which impact on mental health and wellbeing. Many of these are also inter-related with the economic issues raised in this report. The success of regional economies is related to technology, talent, tolerance, and good quality of place[62]. The tolerance of social and cultural diversity is fundamental to the future of regional communities [62]. The need for strengthening the social and cultural diversity is reflected in these findings. Support for strategies to support cultural activities, and particular communities such as the Aboriginal community, those who are LGBTI and from culturally and linguistically diverse can only enhance in Lithgow and its community. However strategies supporting this need to be explicit and reflected in planning and budgetary decisions.

There is also a need to build support for those at-risk individuals and groups in the community. Evidence indicates that community based initiatives which aim to increase the capacity of people to identify when someone is at risk and provide appropriate guidance and referral can be effective at a population level[63]. Supported by the findings there is opportunity to build the capacity of the local community to address mental health problems at the individual and community level. Indeed some of this is happening already with access provided to Mental Health First Aid training.

Cultural issues specific to the Lithgow community were commonly raised. Educational achievement is key to building strong futures for young people. That this has not been the norm in this area has been recognised with a strong focus on educational attainment at the local high school. This focus needs to be strengthened and supported in the community, including with explicit strategies to support aboriginal young people complete schooling.

Domestic violence and the macho culture was also raised as a significant social issue. There is overwhelming evidence of the impact of domestic violence on the long term mental health of those

experiencing domestic violence. Strategies to address domestic violence need to be strengthened in the community, beyond one-off events and embedded in sectors across the community.

The next steps

The next steps should be decided by the Lithgow community in response to these findings. There is already strong commitment to addressing mental health and wellbeing. In recognition of the commitment of the Lithgow to the community it is important that the findings are provided to them. As a result there are a number of recommendations about the next steps rather than specific strategies which should be decided by the community. These recommendations include:

1. Providing the findings of this project to the Lithgow community at a community forum which is focused on the way forward.
2. That at this forum a plan is developed, informed by evidence which addresses the findings with an emphasis on:
    a. Developing a unified and strategic community plan, incorporating a range of short and longer term strategies which address mental health promotion, prevention, early intervention, treatment, support and rehabilitation across sectors
    b. Using the plan as a voice and advocacy document for mental health and wellbeing in the community
    c. Building the capacity of the community to address mental health and wellbeing across all sectors
    d. Addressing the risk factors raised in this report
    e. Developing strategies to build the economic and social diversity of the Lithgow area
    f. Adopting a place based planning approach to support access to and integrated mental health services across the community
    g. Building the capacity of general practice and specialist mental health services to respond to community needs
    h. Strengthening community awareness of services and their roles
    i. Strategies to support a systematic approach for supporting those affected by suicide
3. Developing and implementing the plan will require financial and human resources
4. Oversight of the development of implementation of the plan should rest with the community with governance reflecting the diversity of the community and including key decision makers who can act to implement initiatives

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.

References

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

2. Australia's Social Trends: Mental Health. Canberra: Australian Bureau of Statistics, 2009.

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

4. Mental Health Services in Australia (2017, accessed November 2017).

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

6. Causes of Death, Australia 2016. Canberra: Australian Bureau of Statistics, 2017.

7. Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Canberra: ACT2016.

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

9. Slade T, Johnston A, Oakley Browne MA, Andrews G and Whiteford H. 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australian and New Zealand Journal of Psychiatry*. 2009; 43: 594-605.

10. Fone D, Dunstan F, Lloyd K, Williams G, Watkins J and Palmer S. Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis. *International Journal of Epidemiology*. 2007; 36: 338-45.

11. 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

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

13. Cuijpers P, Beekman AF and Reynolds CF. Preventing depression: A global priority. *JAMA*. 2012; 307: 1033-4.

14. 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.

15. Jorm AF, Barney LJ, Christensen H, Highet NJ, Kelly CM and Kitchener BA. 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.

16. 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: 1086-93.

17. 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: 947-56.

18. Brohan E, Slade M, Clement S and Thornicroft G. Experiences of mental illness stigma, prejudice and discrimination: a review of measures. *BMC Health Services Research*. 2010; 10: 80-90.

19. Bilsker D, Gilbert M, Larry Myetter T and Stewart-Patterson C. Depression and Work Function: Bridging the Gap between Mental Health Care and the Workplace. Vancouver: Health Care Benefit Trust, 2006.

20. 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. Geneva: World Health Organisation, 2012.

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

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

23. Donovan RJ, Henley N, Jalleh G, Silburn SR, Zubrick SR and Williams A. People's beliefs about factors contributing to mental health: implications for mental health promotion. *Health Promot J Austr*. 2007; 18: 50-6.

24. Donovan RJ, James R, Jalleh G and Sidebottom C. 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.

25. Donovan RJ, Watson N, Henley N, Williams A, Silburn S and Zubrick S. Mental Health Promotion Scoping Project: Report to Healthway. Centre for Behavioural Research in Cancer Control, Curtin University, 2003.

26. Jalleh G, Donovan RJ, James R and Ambridge J. Process evaluation of the Act-Belong-Commit Mentally Healthy WA campaign: first 12 months data. *Health Promot J Austr*. 2007; 18: 217-20.

27. Jalleh G, Anwar-Henry J, Donovan RJ and Laws A. Impact on community organisations that partnered with the Act-Belong-Commit mental health promotion campaign. *Health Promot J Austr*. 2013; 24: 44-8.

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

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

30. Australian Institute of Health and Welfare. Australia's Health 2016. Canberra: ACT2016.

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

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

33. Ho FY-Y, Yeung W-F, Ng TH-Y and Chan CS. 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.

34. Van Straten A, Seekles W, van 't Veer-Tazelaar NJ, Beekman A and Cuijpers P. Stepped care for depression in primary care: what should be offered and how. *Medical Journal of Australia*. 2010; 192: S36-S9.

35. Bauer AM, Thielke SM, Katon W, Unützer J and Areán P. Aligning health information technologies with effective service delivery models to improve chronic disease care. *Preventive Medicine*. 2014; 66: 167-72.

36. Cartier JM. A team-based approach to the care of depression in later life: where are we now? *Psychiatr Clin North Am*. 2013; 36: 651-60.

37. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*: (2012).

38. Reilly S, Planner C, Gask L, et al. Collaborative care approaches for people with severe mental illness. *Cochrane Database of Systematic Reviews*: (2013).

39. 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.

40. Vickers KS, Ridgeway JL, Hathaway JC, Egginton JS, Kaderlik AB and Katzelnick DJ. Integration of mental health resources in a primary care setting leads to increased provider satisfaction and patient access. *Gen Hosp Psychiatry*. 2013; 35: 461-7.

41. Cleary M, Dean S, Webster S, Walter G, Escott P and Lopez V. Primary health care in the mental health workplace: insights from the Australian experience. *Issues Ment Health Nurs*. 2014; 35: 437-43.

42. DeSilva M, Samele C, Saxena S, Patel V and Darzi A. Policy actions to achieve integrated community-based mental health services. *Health Aff (Millwood)*. 2014; 33: 1595-602.

43. Lithgow City Council: Community Profile. .idcommunity 2018.

44. 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: 308-16.

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

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

47. Centre for Epidemiology and Evidence. Sydney: HealthStats NSW, NSW Ministry of Health, accessed October 2017.

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

49. BOSCAR LGA crime tools. Sydney 2018.

50. Pointer S and Kreisfeld R. Hospitalised interpersonal violence and perpetrator coding, Australia 2002–05. Canberra: Australian Institute of Health and Welfare, 2012.

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

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

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

54. Aboriginal and Torres Strait Islander Social Health Atlas of Australia: Data by Indigenous Area. Adelaide: PHIDU, 2018.

55. Jorm A, Korten A, Jacomb PA, Christensen H, Rodgers B and Pollit P. 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.

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

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

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

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

60. Florida R. The economic geography of talent. *Annals of the American Association of Geographers*. 2002; 92: 743-55.

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

62. Florida R. *The rise of the creative class: And how it's transforming work, leisure, community and everyday life.* New York: Basic Books, 2002.

63. Jorm AF. Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*. 2012; 67: 231-43.