MENTAL HEALTH COUNCIL OF AUSTRALIA

Weaving the Net

Promoting Mental Health and Wellness Through Resilient Communities

November 2006

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QQSR
Qualitative & Quantitative Social Research

Building Resilience
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This report is an analysis of information gathered in the course of community consultations held across Australia. The Mental Health Council of Australia and the report authors would like to thank each participant in these consultations for their time and their frankness. We trust the main points made are properly represented in this report.

We would also like to thank all those who assisted us in arranging town meetings and making the most of this opportunity.

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The economics of well-being challenges the equation of economic growth with life satisfaction and reminds us of the cost of economic growth, notably the psychosocial impact of inequality and materialism … the structure and quality of social relations are fundamental to well-being and provides a context for analysing how the drivers of economic growth undermine individual and community efforts to remain or become connected.

Health assets … is an approach to public health that focuses on assets and resilience, rather than solely on deficit and vulnerability. It aims to maximise assets within a community, not just to reduce need. In mental health terms, it is the equivalent of measuring positive mental well-being, as opposed to surveys of psychiatric morbidity. This is important because strategies that focus on need may (inadvertently) reduce health assets, for example through fostering high levels of dependence on professional input; conversely, an intervention that enhances health assets, for example social networks, may have no impact on disease. In other words, interventions to improve health may be entirely independent of interventions to prevent disease.

Lynne Friedli

Promoting mental health in the United Kingdom: a case study in many parts Australian e-Journal for the Advancement of Mental Health, Volume 4, Issue 2, 2005

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Abbreviations

ACE	Adult and Community Education
AI	Appreciative inquiry
ATODS	Alcohol Tobacco and Other Drugs Service
CAT	Crisis Assessment Team
CBT	Cognitive Behavioural Therapy
COAG	Council Of Australian Governments
CWA	Country Women's Association
DADAC	NSW Department of Disability, Ageing and Home Care
GP	General Practitioner
HACC	Home and Community Care
IPMHS	Integrated Primary Mental Health Service
MHC	Mental Health Councils
MHCA	Mental Health Council of Australia
NGO	Non government organisation
RSL	Returned Serviceman's League

1. Foreword

> Recovery occurs when a person is an active and participating member of their community, fulfilling meaningful and socially valued roles of their choosing.
>
> *Counties Manukau, New Zealand*

This report focuses on providing a snapshot of community resilience and wellness within Australian communities. Resilience is typically understood to refer to the ability to bounce back from setbacks and, in relation to people, to readily recover from illness or trauma. However, for the purposes of this report resilience is defined as:

> The capacity of a system, community or society potentially exposed to hazards to adapt, by resisting or changing in order to reach and maintain an acceptable level of functioning and structure. This is determined by the degree to which the social system is capable of organising itself to increase its capacity for learning from past disasters for better future protection and to improve risk reduction measures, based upon and enhanced by various protective factors.

A healthy community is a vital part of good mental health. We all know this intuitively. You don't need to have a mental illness to appreciate support in the workplace, a network of friends or the local club. *Weaving the Net* does more than confirm this. It gives us an insight into how to create these supportive communities and improve people's mental health.

The Mental Health Council of Australia's 2005 *Not For Service* report laid bare the crisis facing Australia's mental health system. Many people are not getting the care they need, experiencing poor care or aren't able to get the right care at the right time. This is particularly the case away from the big cities of Australia where workforce shortages, changing demographics, prolonged drought and strong service demand are all critical issues.

Unsurprisingly perhaps, many of the best things happening to promote mental health in communities do not involve the health system, health service providers or governments. Instead, we see local people taking action to meet local needs. This could be a bus to get people together or the involvement of the local shop owner in some community project. These are the seeds of community resilience.

Weaving the Net gives a picture of how ten regional centres across Australia are trying to boost their mental health resilience and make their communities good places to live. We have not just collected their stories and their innovations in this report.

The Council is constructing an interactive feature on its website to allow this library to be shared with others keen to both learn and then hopefully contribute their own stories of resilience and success.

Building a strong and supportive community environment is a critical factor in achieving and maintaining good mental health. There is no one recipe for this to occur with local solutions needed to fix local problems. But common themes emerge and, particularly while mental health services are languishing, governments and communities need to focus their energies and investments into the things that really make a difference in people's lives.

The Hon Rob Knowles
Chair
Mental Health Council of Australia

2 Executive Summary

Weaving the Net: Promoting Mental Health and Wellness Through Resilient Communities is part of a series of papers prepared by the Mental Health Council of Australia to inform decision-makers about what they need to do to address Australia's mental health crisis. This crisis is now well-documented, particularly in the Council's own *Not For Service* report published in October 2005 and a similar damning report was prepared by a unanimous Senate Committee of Inquiry in early 2006.

In June 2006 the MHCA released a manifesto for change and innovative action in the mental health field called Time for Service (available at http://www.mhca.org.au/timeforservice/index.html), in which it was argued that:

> Mental illness is a key factor in social exclusion, leading to unemployment, poor housing, poor health and family breakdown. New investment in specific strategies designed to prevent this social exclusion is urgently required to re-integrate people with a mental illness who may otherwise fall through the net.

This theme was echoed and reinforced by a major report on Improving Mental Health Outcomes in Victoria: The Next Wave of Reforms, prepared by the Boston Consulting Group in July 2006 for the Victorian Government. The report concludes that there are clear economic reasons which spur investment in improved mental health services, improving economic productivity and social participation. The report argues that these results can be achieved by Victoria building on its last decade of reform and instituting a system characterised by four themes, all of which strongly accord with *Weaving the Net*:

- access to consumer focused services,
- connectedness between component parts of the mental health system,
- prevention and early intervention to reduce the severity of problems, and
- local partnerships and accountability to enhance the co-ordination of service delivery and ensure a more consumer-centric approach.

In July 2006, the Council of Australian Governments (COAG) published the National Action Plan on Mental Health 2006 – 2011 - available at http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf.

The COAG report was backed up by a 25% increase in Commonwealth spending on mental health but this was not genuinely matched by all State and Territory governments. It is estimated that the COAG process will move mental health's share of the overall Australian health budget from 7% to 8%. While any increase is welcome of course, the COAG process should represent the start of a longer and deeper strategic reform of mental health care in Australia, not a headline announcement.

> Reform of mental health services cannot be achieved through a quick fix – it will require a sustained contribution…from both the Commonwealth and the States and Territories to ensure long term fundamental improvements in services for the mentally ill. Together, our investment in mental health will support reform of the system and ensure that it remains sustainable into the future.
>
> *Prime Minister John Howard, 5 April 2006*

In October 2006, the Council released its *Smart Services* report (available at http://www.mhca.org.au/documents/MHCASSRlayout29-9.pdf) which clarified the key principles which need to underpin investment in effective community mental health services, covering both the clinical and non-clinical aspects of care. The Commonwealth's considerable investment in primary care and in non-government community services is acknowledged. But Australian governments generally seem much more reticent than counterparts overseas to systematically invest in community-based mental health services even despite a general acknowledgment that real reform depends on this.

One of the most fundamental questions to be answered in the aftermath of so many reports is not what is to be done or who by, but who is going to coordinate the interaction and integration necessary to produce the outcomes consistently identified as best practice by the National Mental Health plans. As previously stated, *Not for Service* draws attention to the flaws within the system; in other words what is NOT working. This begs the question: **so what is working?**

In 2006, the MHCA launched a mental health project within Australia designed to complement and extend the crucial work of the *Not for Service* study. This new project, entitled *Weaving the Net*: *Promoting Mental Health and Wellness Through Resilient Communities*, focuses on the ways in which communities find things that, at the local level, do work in providing support to people with a mental illness. In understanding this, the project explored how communities are resilient and how resilience can be further developed. The project focused on regional and rural communities as outlined in the following section.

Resilience has been defined as:

> **The capacity of a system, community or society potentially exposed to hazards to adapt, by resisting or changing in order to reach and maintain an acceptable level of functioning and structure. This is determined by the degree to which the social system is capable of organizing itself to increase its capacity for learning from past disasters for better future protection and to improve risk reduction measures. www.unisdr.org/eng/library/lib-terminology-eng%20home.htm**

And also as:

> **The ability to cope successfully in the face of significant adversity or risk. This capability develops and changes over time, is enhanced by protective factors, and contributes to the maintenance or enhancement of health. wind.uwyo.edu/sig/definition.asp**

For the purposes of this report, these definitions were combined so as to retain the community focus of the first and the protective factors for the second, arriving then at:

> **The capacity of a system, community or society potentially exposed to hazards to adapt, by resisting or changing in order to reach and maintain an acceptable level of functioning and structure. This is determined by the degree to which the social system is capable of organising itself to increase its capacity for learning from past disasters for better future protection and to improve risk reduction measures, based upon and enhanced by various protective factors.**

The paucity of mental health services facing consumers and carers makes investment in community-based services all the more critical. The work presented in this research report offers a strong guide to how to carry these broad ambitions forward in a practical and effective way.

The key findings confirm a central message that healthy communities don't rely on health services. In many regional areas, these services are so rare that they can't form an integral part of the fabric of regional communities. Instead, these communities are drawing inspiration from local leadership who seem to have a catalytic ability to draw together people and resources to make good things happen and, in the process, contribute to their community's mental health.

Overall, the report's key research findings are:

- a need for greater coordination between Federal, State, Local, non-government and volunteer initiatives underway in the communities and it was suggested that simply having a small number of coordinators in each State/ Territory whose job it was to organise meetings in communities in their jurisdiction would pay handsome dividends in catalysing community efforts.
- a clearer understanding of the impact of networking, with the more resilient communities benefiting from stronger networks, especially where various nodes in the network were key people or appointments within the community.
- that the 'tyranny of distance' exists at a local level. Many services are now centralised and often this proscribed the benefits for outlying regions ostensibly within the catchment area for these services, making it clear that a 'catalytic coordinator' would, by organising consultations and supporting networking, also play a role in mitigating this tyranny of distance.
- that the supply of volunteers is crucial—but varies locally and may be declining overall. Community resilience requires a degree of volunteering and so there is the possibility of less wellness at the local level if civil society and volunteering come under sustained threat from the concentration on economics as the language of social policy.
- an enduring focus on money as the great 'silver bullet'. In numerous consultations there was a tendency to respond automatically to the 'what if' question with relatively big ticket items. One of the roles that is envisaged for the coordinators recommended is to tweak the imagination of communities to take them beyond reliance on hand outs of money and goods.
- to highlight the significance of diversity, emergence and the 'panda's thumb'. All communities had things in common yet how they responded to needs varied across the different centres. Two key themes were:
  - First, this is an emergent process. That is, in the language of complex, self organising systems, something 'emerges', bottom up via the independent activities of many elements. Research has shown that such systems are far more robust and adaptable and 'alive' than systems designed 'top down'.
  - Second, what emerges is a 'panda's thumb'—that is, local adaptations have arisen which, while not perfect, do the job of delivering care, support and resiliency. The nature of the panda's thumb is explained in more detail at Section 6.7 below.

The idea of emergent, local adaptations is important since it reinforces the point about catalytic action. That is, the idea that things emerge from local action suggests that catalysing local action, rather than imposing a top down program upon it, is likely to be a far more powerful and effective process.

The research findings were linked with the overseas literature to generate ten principles which should underpin future investment in resilient communities:

1. Start with what is right, not with what is wrong—look at assets not deficits, wellness not illness—and trust local judgements about assets and needs;
2. In defining a community, use the boundaries that people 'know' and recognise—this maximises the chance of a shared sense of place, a shared vision and a commitment to neighbours;
3. Communities best understand their own needs and what is right and wrong for them;
4. Work out how best to use experts—in general, they are not best used in top-down design and didactic teaching which would tend to stifle local efforts and regiment models. Instead, use expertise in a catalytic fashion that promotes self organising and self sustaining efforts. Specifically, don't try to teach resilience—help people to create it;
5. Do not seek to develop in a community a neat, simple, rational system with clear and well defined boundaries between the groups and institutions that are providing local help, support and initiative and defined links to centralised, integrated projects at the next level 'up' (e.g. State). While such systems look good on paper they

are too rigid and not 'redundant' enough to allow for emergence and adaptation. Instead, redundancy, fuzziness, overlap and multiple feedback loops are optimal;

6. Nurture and build trust and try to catalyse engagement;
7. Where possible, have local volunteers helping and supporting other locals. Not only do they understand them better, this also builds trust and generates civic engagement;
8. Diversity in communities—diversity with regard to skill utilisation and option creation—is vital;
9. Help to create and sustain committed leadership in local communities; and
10. Take the time it needs to make things happen. There is no quick fix.

Particularly as the Commonwealth looks to roll out its community-based COAG initiatives, it is timely to consider these principles and also address some key challenges identified in the course of this project:

- How can we strengthen the connections between people's experiences of service and system priorities in order to drive greater adaptive capacity? What kinds of metrics are necessary? How can these metrics be built into existing patterns such as inspections, spending reviews, target setting and so on?
- How can the capacity of the system to continuously adapt to the dynamic, uncontrollable and unpredictable nature of human activity be put at the forefront of the debate, rather than managerial capability alone?
- How can the government invest in these 'in-between' spaces without legislating for everything that takes place within them? Beyond the straightforward deployment of existing innovation funds, what other kinds of business models and partnerships might help to grow these spaces to learn about what works?
- How can the lessons learnt from 'in-between' spaces be used to inform changes to institutional models and relationships? How bold are politicians willing to be in taking these lessons to focus future efforts on public service transformation rather than incremental improvements alone? (Parker & Heapy, DEMOS, 2006, available as a pdf file at http://www.demos.co.uk/publications/thejourneytotheinterface/, 2006, pp. 90-94)

Unprecedented attention by all Australian governments has opened the possibility of making progress in implementing ideas of the type advanced in this report, with the COAG initiatives offering wide scope for demonstration projects which can explore new ways of working. The time is ripe to apply these ideas, and in so doing create community resilience as a basis for promoting mental health and overall wellness. The core of the process is building the right networks. The central philosophy to be derived from this report's findings is that of teaching people to fish not giving them fish. It makes sense in light of this metaphor and the significance of building and activating networks to think of the task as '*weaving the net*'.

3 Key Study Findings: Weaving the Net Together

Seven themes have emerged from this study:

1. The Value of Coordination.
2. Networking.
3. Tyranny of distance.
4. Volunteering.
5. The men's shed.
6. The mighty dollar.
7. Diversity—the emergent 'panda's thumb'.

Of these seven themes, two (numbers 3 and 5) are specific to this study and do not have a direct link with the ten broad principles listed earlier. The other five, however, dovetail very clearly with those same ten principles. That is, there is a strong continuity between what this study has found and the principles that are advocated in leading studies of resilience and well being in a wide variety of comparable social contexts.

This alignment lends extra weight to the findings of the enquiry and sharpens the capacity of the study to make relevant, applied recommendations for action.

Noting this, the report now looks at a number of broad questions about what is best understood to characterise community resilience and well being and how best the mental health sector might act—and recommend governments to act—in order to promote these important features of community life.

3.1 What does Community Resilience look like?

The definition of resilience used in this study (see Executive Summary above) is a good general definition. It is however, possible to provide some more detail in relation to well being and mental health in Australian communities.

This report has found that resilience in communities is achieved when volunteers combine with services provided by Commonwealth, State and Local government and a wide range of NGOs and charitable bodies to:

- create a climate of support and general caring;
- treat anyone with actual or potential mental health challenges as a whole person not an illness;
- act preventively, especially with youth, to ensure that problems are less likely to arise and/or are mitigated and responded to constructively if they do;
- bring people into wider activities (sport, recreation, etc) than just those that are health related; and
- link together that which is provided by agencies and institutions and create workable solutions where gaps exist.

In terms of the government, NGO and charitable agencies, it is noted that:

- local councils are well placed to be a network node and to link a range of services with the NGO and voluntary sector, but this requires a view of local government that is more than the traditional 'three Rs'—rates, roads and rubbish;
- of the Commonwealth funded programs, Division of GPs are well placed to play a linking role as the example quoted with the Bright consultation makes clear;

- a number of other agencies such as State Government health departments have a great opportunity to contribute at this level; and
- numerous NGOs and charitable bodies, ranging from groups like the Richmond Fellowship to St Vincent de Paul's offer a great deal of help, although this is always locally patchy—i.e., some are active one place, others in another—and that with a minimum of cross connection and communication, this sector can offer very important contributions to resilience and well being.

3.2 What needs to be done to facilitate this support?

The view that emerges both from the research carried out and the literature reviewed, is that one of the key elements in facilitating support lies in using outside expertise, and a small amount of tangible support, in a catalytic role.

A major initiative that promises a large amount of gain would be to develop a small number of expert facilitators who were responsible for running a sequence of local consultations somewhat similar to those reported in this study, but with the goal of providing both a longer term connection (that is, the consultations would not simply be one off) and also able to link communities with one another either because they were geographically proximate or because they shared similar problems and hence would benefit from sharing ideas, possible solutions, etc. To use the examples in this report, while what works for Whyalla might not work for Port Douglas, what works in Whyalla *might* work in a more similar location like Burnie—and what works in Burnie might work in Whyalla. After all, both of these are locations where the major industrial base is in decline, unemployment is high, and so forth.

This links to another main recommendation, to be developed in the second phase of this study, about creating an on-line system where individuals, groups and communities can share ideas and success stories, where they can ask what others think and use the virtual community to their mutual benefit.

3.3 Who and why is the 'someone—the network star' in each area?

In the research section it was noted that in most locations there were one or more network stars who, when identified, were instrumental in helping get the consultation up and running. Further, it was noted that this was simply an extension of their crucial role in the local community. Who are these people and can one identify why they and not others are the stars?

It seems as if there is no one answer to this question. Networks of people are, by their nature not 'centred' in any given way. Who turns out to be the star is a matter of many different features. For example, the latest research out of the University of Virginia (R Cross and A Parker, 2004, *The Hidden Power of Social Networks*, H.B.S. Press) indicates that within organisations, the extent to which a person tends to become a star, and hence highly influential, is a function of four factors:

- **Knowledge**: that is, does the person have ideas, information, etc, that one would wish to have access to?
- **Accessibility**: that is, when one attempts to contact that person, is it possible to get access, time to be heard, etc?
- **Safety**: that is, to what extent is one confident to talk with this person, knowing that the person will not bite your head off, make you feel a fool, etc, but will instead treat you with patience, respect etc?
- **Engagement**: that is, if one has a problem or an issue and one contacts this person, will the person listen, take time, be helpful and facilitate you moving forward, or will they fob you off quickly, or give you an answer that does not really help you grow?

It is likely that these dimensions operate in a very similar way in community networks. It is also likely that other dimensions are also relevant. The research here is underdeveloped, but some obvious possible dimensions are:

- **A good sense of reciprocity**: that is, if one works with this person does the person both give and take? (Note that simply taking quickly leads to relations deteriorating, but that simply giving also has limitations in the long run);

- **Energy and tenacity**: that is, is this person willing to launch initiatives and then stick with them over time; and
- **Social skills**: that is, is this person reasonably likeable and good to work with, does the person appreciate other points of view, etc.

It might be thought that network stardom is a function of role. However, there is no evidence of this in the literature or in this research. In organisations, for example, the work from the University of Virginia points to companies where 'key roles' (which might a *priori* seem like network nodes) are occupied by people who score low to moderate on one or all of the four features described above—in these situations the incumbent shows up on the edge of and not in the centre of the network.

Similarly, in this research some of the stars occupied potentially pivotal roles in organisations (e.g. the Shire offices, the Division of GP, etc) but at the same time:

- others in these same roles were not network stars elsewhere, and
- other stars did not occupy these apparently pivotal roles.

Overall, it seems likely the features identified above—that is, for those who would want to make a contribution, knowledge, accessibility, safety, engagement, a good sense of reciprocity, energy/tenacity and social skills are much more likely to account for network stardom than social role.

The positive side of this finding is that it is likely that potential stars exist in all communities—the trick is to provide the support and knowledge that will catalyse their actions.

3.4 How is community resilience and wellness produced?

As indicated in various points in this report, resilience arise from a number of sources and underpins wellness. As Friedli argues in the quote that heads this report, the right approach lies in focusing:

> **" … on assets and resilience, rather than solely on deficit and vulnerability. It aims to maximise assets within a community, not just to reduce need … This is important because strategies that focus on need may (inadvertently) reduce health assets, for example through fostering high levels of dependence on professional input; conversely, an intervention that enhances health assets, for example social networks, may have no impact on disease. In other words, interventions to improve health may be entirely independent of interventions to prevent disease". [Friedli, 2005]**

In turn, resilience depends on social capital (see Section 3.5 below) and hence the central, linked questions are often:

- What is the level of social capital in this community?
- Can the level be sustained and/or raised?

This is the next topic explored.

3.5 Building social capital

Social capital refers to bonds of trust and mutual concern that arise through volunteering, socialising, and taking part in organisations such as church and civic groups, sporting leagues, Parents & Citizens groups, and professional associations.

Research suggests that social capital pays off in numerous ways—promoting the transmission of new ideas, improving children's education, enhancing the efficiency of labour and capital markets.

Robert Putnam (most famously in *Bowling Alone: The Collapse and Revival of American Community*, New York: Simon & Schuster, 2000) has argued that many activities that build social capital have been declining in the U.S. for several decades. For example, in a recent interview he states:

"… the soul-nourishing activities that build neighborhoods and bond community members one to another have been dwindling. Americans' civic involvement is in steep decline across the board -- voting, volunteering and showing up for civic meetings are all in decline. Student activities -- playing left tackle, playing King Lear, playing trombone -- are all in decline.

When I wrote about this decline in a new book, Bowling Alone: The Collapse and Revival of American Community, I found overwhelming statistical evidence of things like falling membership in the PTA and civic organizations. Participation in most team sports has fallen in recent decades, and bowling in leagues is down 60%.

People aren't just bowling alone. They are walling themselves off. Americans spend one-third less time socializing with friends and neighbours than they did two decades ago. Married people eat dinner with the whole family one-third less often than 25 years ago. Church attendance has drifted down by 25% in 35 years.

When I look at these statistics, I don't see just numbers. I see the fabric of our communities fraying. Civic disengagement threatens the things we cherish: safe streets, good schools and healthy families".

Crucially, Putnam suggests that there is a long term trend in the US towards replacing volunteer activity with cash donations. So far as this is true and could be extended to other countries, it would raise serious challenges for long term resilience.

While Putnam blames TV and the ageing of the civic-minded generations born before World War II for the loss of social capital, a different study by Dora L. Costa of Massachusetts Institute of Technology and Matthew E. Kahn of Tufts University focuses on such trends as the huge rise in working women and the growing racial, ethnic, and income diversity in communities.

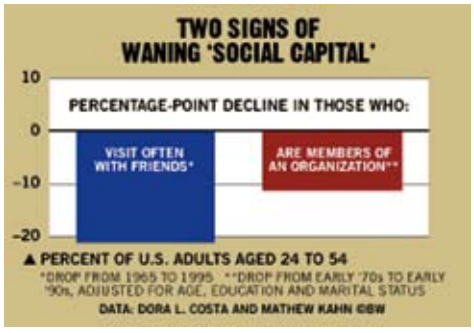
They report that rising income inequality has played a big part in eroding America's social capital outside the home, whereas the advent of the working woman has eroded social capital in the home. And despite the vaunted benefits of rising immigration and ethnic diversity, such changes (rather than racial diversity) also appear to weaken the ties that bind communities together.

Analysing copious survey data, the two economists first focus on a five- percentage-point drop since the early 1970s in the share of prime-age adults doing volunteer work. The main culprit, Costa and Kahn find, is growing income inequality in communities—suggesting that:

" … people are more likely to volunteer if they can identify with the economic status of those they're helping."

As an example of this decline, these authors produce these data on changes in social capital.

Income inequality was the largest contributor to an 11-percentage-point decline in organisational membership from the early 1970s to the early 1990s, with the impact especially apparent in youth, sports, church, literary, and hobby clubs. Increased ethnic diversity and the rising number of women in the workforce played smaller roles.



The study also looked at a drop in home-based social capital as reflected in declines in the frequency with which people entertain at home or visit friends and neighbours—behaviours that enhance the socialisation of children. Of the possible explanations here, the rising labour-force participation of women turns out to be by far the most compelling. [see Dora L. Costa & Matthew E. Kahn "Understanding the Decline in Social Capital, 1952-1998" *NBER Working Paper No. W8295*, May 2001].

Whatever the cause in the apparent decline of this important social attribute, the creation and maintenance of social capital is clearly vital to the on-going well-being of communities in the model which this report suggests as appropriate.

One key feature that varies with the level of social capital seems to be volunteering. As noted earlier, there is a suggestion (no more) that there may be a pattern of volunteering being higher in the communities that were identified as being in the vulnerable clusters compared with those in the opportunity clusters (see Section 4.2). On the face to it, this may seem to be less worrying than the other way round. Surely if volunteering is at its highest in the more vulnerable communities it may 'off set' their disadvantage?

In a limited sense, this may be true, but the implicit corollary—that in the opportunity clusters resilience will be promoted and people with problems will be looked after—does not follow. Indeed, this links again to the point made by Friedli when she:

> **" …reminds us of the cost of economic growth, notably the psychosocial impact of inequality and materialism … the structure and quality of social relations are fundamental to well-being and provides a context for analysing how the drivers of economic growth undermine individual and community efforts to remain or become connected." (Friedli, 2005, emphasis added.)**

That is, if social capital declines in wealthier 'opportunity clusters' it will be harder to sustain resilience and hence well being of the less advantaged in those communities.

Clearly, this is not yet the state of play in Australia. Port Douglas and Bright were good examples of opportunity cluster localities with vibrant local involvement, despite the manifest differences (the former relatively isolated from Cairns, the latter well integrated with Wangaratta and other centres).

The main point here, however, is that social capital—especially as expressed in volunteering—is a key feature to which attention must be paid and towards which efforts must be directed.

3.6 Produce the right environment

Producing the right environment for resilience to grow and flourish requires the confluence and operation of a wide variety of factors. Without doubt the communities with resilience displayed a number of these factors:

- **Empathy not sympathy.** In line with the wellness versus illness thought process, communities such as Port Douglas, Castlemaine and even successful services such as Swanport House in Murray Bridge employed empathy in dealing with those people with a mental illness. The model in these areas seemed to very much recognise the value in a human centred approach as opposed to merely looking at the illness. Developing empathy, of course, requires considerable commitment and training and a level of self-awareness. Empathy requires people, as Stephen Covey might say, "to seek first to understand" and in this process produce support and guidance to those in need. Again, the use of experts to identify and facilitate training in this area will likely go someway to expanding empathy within a given community.
- **Support Services.** Support services within the community must be diverse. The accessibility and availability of a range of options for treatment provide people with a mental health problem the ability, in conjunction with both professional and community advice and support, to address the person's needs be they housing, employment, social isolation rather than simply look at the illness.
- **Unique approach.** Recognising that any community solution is likely to be unique and individual to its area ensures that other communities seek not to replicate something that may not apply to their area but adapt aspects that will apply. This should also account for any factors that make the environment unique.
- **Leadership.** All resilient organisations or communities require some type of leadership. Increasingly, this type of leadership is based on influence not appointment, guidance not orders, inclusion not hierarchy. Developing the necessary leadership requires identification and fostering of existing leaders within communities. These people

may also be the network stars and so an early development of their skills; through increasing their understanding in what they do and how they do it may pay handsome dividends as these leaders are taught the skills that they can then develop within their community. In this way, not only are people taught 'how to fish' but at the same time the set of 'elders' in each community (those that can pass the knowledge onto succeeding generations) are restored, developed and grown – a key process in healthy communities that industrial society has neglected, leaving reducing social capital in its wake.

3.7 Locals need materials time/labour

In creating a way forward for communities, many of the initiatives that can be taken—and there are examples in the consultations—centre around concrete activities, especially activities that set out to build (in the literal sense) a facility.

As a specific instance, in the lead up to the Burnie consultation, an early arrival told the researchers about the creation of a drop-in centre with which she had been involved in a nearby community. To create this centre, the following things occurred:

- land was made available free of cost;
- local merchants donated materials;
- local trades people provided expert support where this was essential. They also provided supervision of and training for voluntary labour; and
- the voluntary labour was provided by the people who would use the centre and their families.

As a result of this initiative a number of clear cut advantages—some tangible, others intangible—flowed into the community. These included:

- at the tangible level, the drop-in facility was created; and
- intangibly but importantly:
  - those who made donations of materials, time and expertise experienced pride in their role in supporting a valuable venture;
  - those who worked on the project gained valuable skills and, above all else, raised self esteem and pride in their achievement; and
  - good social relations were created between many of the people who would later 'drop in', providing a web of empathetic connections and support.

That is, the process of creating the centre was almost as important as the centre itself. (Indeed, it could well be argued that this process both drew upon *and the same time* built social capital.)

This example is emblematic of the type of activity that many communities could undertake given a little help with organisation and a gentle 'tweak' of their imagination. It also links to the point made about the 'men's shed' (see Section 6.5). In many cases, the most successful of these work around projects (such as building a boat) in which the process is as important as the outcome and which offer a focus for activity which also unobtrusively offers emotional support.

3.8 Help people help themselves ('teaching people to fish')

In a familiar metaphor it is said that when one gives a person a fish one feeds them for a day but when one teaches them to fish one feeds them for a lifetime. The central thrust of the recommendations in this report is very much about 'teaching people to fish'. As in the previous sub-section with the example about the drop-in centre, the theme is about catalysing community efforts, with four linked goals in mind:

- to enable communities to create facilities and functions which are valuable in the own right;
- for those involved gain the benefit of involvement, be it pride, self esteem, skills or whatever;
- to enhance and maintain social capital; and
- to enhance the capacity to innovate, create and cope—that is, to be resilient.

In short, this report makes no recommendations about providing services but does make recommendations about facilitation.

3.9 Use of catalytic grants: funding 'holistic localism'

From the points that have preceded, it follows logically that were resources to be made available the sensible form in which to do this would be by providing what might be called 'catalytic grants'.

That is, providing modest sums of money, or equipment that had been specifically requested by a community for which a clear need had been identified and from which benefits would flow. For example, several communities spoke about the pressing need for transport. Making transport available in a form that was useable for the community—which might mean different things in different places, not a blanket provision of buses of some such—would be a constructive response.

This process should be guided by a central principle that might be termed holistic localism. This is holistic in the sense that it looks at what, overall would make a contribution to resilience, social capital and well being and localistic in the sense that the holistic answer would vary from community to community.

It would be especially attractive to provide grants for the missing piece of what otherwise is a completed jig-saw puzzle. For example a community that wanted a residential facility to provide respite care might have access to a piece of land, merchants willing to provide much of the raw material base and trades people to guide construction, but might lack a few key raw materials and some specialised equipment with which to kit out the finished facility. In such a case, a limited grant to cover the missing pieces of the puzzle would catalyse the production of something worth far more than the grant alone.

3.10 Role of MHCA in providing such coordination.

The report outlines the role that the MHCA could play in carrying forward these ideas. The ideas here are tentative at this point, but it is important to begin with a key observation. This is that, with the exception of Tasmania, the State bodies were willing to help with this research but appeared to have little leverage or influence in many areas that were selected for study. Requests for contacts, etc were met with two broad responses:

- We are not sure why you want to go there—we don't think anything interesting is happening there; and
- Why don't you go to these other places where interesting things are happening?

To some extent, these reactions were probably motivated in part by a different logic to the one employed in the research. In the research, the idea was to ensure a cross section of community types were included, whether the locations were 'interesting' or not whereas many people, thinking about good ideas and best practice naturally would tend to recommend places that were known to have interesting and innovative programs going ahead.

Notwithstanding this difference of focus, however, the research in fact found across all States some very vibrant communities with really interesting things happening in locations where it was implied that nothing much was known and/or that it was unsure whether anything was happening.

To what extent this is a simple issue of time and resources (which are often limited in this sector) is not known, so there is no implication here that the State bodies ought to have known these things and hence were in some way deficient in not knowing more about what was going on. Whatever the case may be, this observation suggests that more needs to be done to get the state and territory Mental Health Councils across what is happening in their jurisdictions.

As noted, the exception to this statement was Tasmania, where the Executive Officer was clearly 'across the issues', was fully informed about the communities we had chosen and provided excellent support to us in organising the consultations.

Looking forward, however, it is clear that the MHCA and the State MHCs potentially can play a pivotal role in the type of resilience enhancement activity that has been discussed in this report. Indeed, there would very likely be an argument that the MHCA is one of the national organisations which would naturally lend itself to being the base for the catalytic coordinators recommended as a major initiative to build resilience and hence well being.

Whether through this or other steps, however, the MHCA will continue to provide advice to governments about how to spend resources most wisely and in the catalytic fashion recommended here.

4 Study Method

4.1 The Research Approach

The research approach underpinning *Weaving the Net*: *Promoting Mental Health and Wellness Through Resilient Communities*, was carefully chosen to fit with the nature of the inquiry. That is, to consider what works rather than what is failing. This led to using the logic of appreciative inquiry or AI, (see http://appreciativeinquiry.case.edu/). AI was developed principally by David Cooperrider. In conjunction with Diana Whitney, he describes the approach as follows:

> **Appreciative Inquiry is about the co-evolutionary search for the best in people, their organizations, and the relevant world around them. In its broadest focus, it involves systematic discovery of what gives 'life' to a living system when it is most alive, most effective, and most constructively capable in economic, ecological, and human terms. AI involves, in a central way, the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. It centrally involves the mobilization of inquiry through the crafting of the 'unconditional positive question' often involving hundreds or sometimes thousands of people. In AI the arduous task of intervention gives way to the speed of imagination and innovation; instead of negation, criticism, and spiralling diagnosis, there is discovery, dream, and design. AI seeks, fundamentally, to build a constructive union between a whole people and the massive entirety of what people talk about as past and present capacities: achievements, assets, unexplored potentials, innovations, strengths, elevated thoughts, opportunities, benchmarks, high point moments, lived values, traditions, strategic competencies, stories, expressions of wisdom, insights into the deeper corporate spirit or soul--and visions of valued and possible futures. Taking all of these together as a gestalt, AI deliberately, in everything it does, seeks to work from accounts of this 'positive change core'—and it assumes that every living system has many untapped and rich and inspiring accounts of the positive. Link the energy of this core directly to any change agenda and changes never thought possible are suddenly and democratically mobilized. (http://appreciativeinquiry.case.edu/uploads/whatisai.pdf)**

The approach that was developed, of asking community groups what was working was a first step in understanding how, irrespective of whether central funding was fully adequate, local successes could occur. So far as such successes could be documented they would suggest how to build a framework of a decentralised approach to implementation and funding from national and state level.

Furthermore, it was seen as important to explore how these first steps might also initiate some processes of networking between communities, so that ideas could be shared and discourses developed. This is very much in line with an AI methodology, and material contained in Appendix 1 offers links to this type of community development and community capacity building in North America and the United Kingdom (UK).

As Section 8 below highlights, there has been some recognition of the need to coordinate the delivery of services to communities. Additionally, a British based study by Parker & Heapy (http://www.demos.co.uk/publications/thejourneytotheinterface/) notes the need to better link and coordinate the provision of government or institutional services. An Australian report by the Boston Consulting Group (*Improving Mental Health Outcomes in Victoria: The Next Wave of Reforms*) for the Victorian Government went further and outlined the need for connectedness between different parts of the mental health system and the creation of local partnerships and accountability to enhance the coordination of services. Essentially, *Weaving the Net* explores how to teach people to fish. In other words, how to promote mental health and wellness through the development of resilient communities. The report examines the *how* resilience is created and identifies that the building of such resilience requires the construction or weaving of a network that includes services, governments, consumers, carers and people from within the local community.

4.2 Choosing Communities for Inclusion in the Study

Stimson et al (2000) research into community types provided the basis for the process of selecting the communities for inclusion in the consultation.

Stimson et al (2000) categorises large regional centres and towns into seven 'clusters'—social and economic groupings characterised by varying levels of advantage and disadvantage. The use of the Stimson model led to the identification of a cross sectional group of 10 communities in 5 States representing all 7 clusters. In the event, one community was substituted for practical reasons (Castlemaine for Mildura after a local tragedy in Mildura) while in another (Singleton) the consultation was abandoned. Important lessons, from which later consultations benefited, were learned in this case.

If the results gathered are to be of value, it is obvious that they should come from a range of communities. But what does 'range' mean in this context? Is this simply a question of population, of major industry type, of State or something else? To manage the problem of selecting a sensible cross section of communities, a two tier strategy was employed.

First, a typology of large regional cities and towns (populations greater than 10,000 at the 1996 Census) developed by Baum et al (1999) was utilised. This was based on a multi-variate analysis of census data for 122 Statistical Local Areas located outside the mega metropolitan regions and excluding Canberra and Hobart. The analysis offered by Baum et al showed these large regional cities and towns may be categorised into seven clusters or social and economic groupings characterised by varying levels of advantage (opportunity) and disadvantage (vulnerability). This typology identified four 'opportunity clusters' and three 'vulnerable clusters'.

4.2.1 Opportunity Clusters

Four categories of large regional cities and towns were labelled as places of 'communities of opportunity'. The first category of opportunity communities was a mining-based opportunity cluster (7 centres). This category is located in regional Western Australia, New South Wales and Queensland. The five places that made up this cluster were characterised by employment in extractive industries and persons employed in routine production worker occupations.

The second group of five opportunity communities were characterised as a tourism-based opportunity cluster (3). This group of communities had significant employment in personal service jobs—often associated with tourism—and had over the decade 1986 to 1996 recorded significant increases in employment and commensurate declines in unemployment.

A third large opportunity cluster comprised a large group of cities and towns, many of which have important regional and rural service functions, which are defined as a service-based opportunity cluster (1). These 36 localities account for about one in three of the regional cities and towns in Australia, and are found in all states except Western Australia. Some of these localities have regional universities. Together many of these cities and towns make up a group of large regional centres or non-metropolitan cities. Their economies are dependent to a considerable degree on government funded service functions, including administration, health and education.

A smaller group of 16 large regional cities and towns are distributed across New South Wales, Western Australia and Queensland and have been identified as an extractive/transformative-based opportunity cluster (4). These regional cities and towns are based mainly on serving agricultural/pastoral regions, but some also are involved in the processing of rural products.

4.2.2 Vulnerable Clusters

In contrast to the above sub-set of opportunity clusters in Australia's regional cities and towns, the three remaining clusters can be considered as representing the group of vulnerable regional localities.

A cluster of 24 regional cities and regions located in New South Wales, South Australia, Western Australia, Tasmania, Victoria and Queensland, was identified as a manufacturing-based vulnerable cluster (2). Many of these localities were developed during early periods of industrial growth in the era of protectionism, and have since seen a reduction in manufacturing fortunes.

The second vulnerable cluster was identified as an extractive-based vulnerable cluster (5), consisting of 24 cities and towns found in all states except Western Australia and the Northern Territory. These places are mainly agricultural/pastoral-based towns that have either become stagnant or are in decline. Often they used to have important rural product processing functions, a fact reflected in the above average proportions employed in extractive industries.

Finally, a cluster of 13 large regional cities and towns was identified as a welfare/retirement-migration vulnerable clusters (6). They are located in coastal New South Wales and Queensland. Specific localities—a number of which are often referred to in discussions of 'sun-belt migration' growth—included Coffs Harbour and Byron Bay in New South Wales and Hervey Bay in Queensland.

The second tier of our selection was to ensure a reasonable spread across jurisdictions. From within the clusters 10 communities were selected, 2 each from NSW, Victoria, SA, Queensland and Tasmania (WA and the NT were excluded on the grounds of distance, time and cost).

Of the originally selected 10, one (Mildura) was changed to a nearby, similar community (Castlemaine) after an extremely high profile traffic accident involving the death of a number of young people. It was clear that this event was of such local significance that it was likely to influence any responses gathered about community well being.

Once the 10 communities were selected a process of contacting groups and individuals was commenced within that community in order to create a collective consultation.

4.3 Stages in Data Collection

The project consisted of the conduct of ten community consultations using the WorldCafé technique within towns/areas within the clusters described in the above section. Further details on the WorldCafé method are available at www.theworldcafe.com.

The project was conducted in four discrete stages:

4.3.1 Stage One - Scoping

In the opening phase the communities for study were identified. Broadly, the following criteria were used to select the communities; access (travel), coverage of Australia (rural, remote, industrial, farming), assistance and support from local area (enthusiastic points of contact), availability of stories and practices that are required for the project.

Each of the communities, when identified, was then scanned to identify a variety of factors supportive of a successful project. These included local health services, local council representatives, venues, and advertising options.

4.3.2 Stage Two – Project Promotion

During this stage adequate lead time, up to eight weeks in some cases, was used to ensure information regarding the project filtered to professionals, family/friends, support groups; essentially anyone who had an interest in attending the WorldCafé.

4.3.3 Stage Three – Community Consultation

It was important to explore a variety of issues in the various communities. Had this been a survey based approach it would have been likely that questions would have been asked such as:

- What health services are providing the best outcomes for {*insert illness*}?
- What is working well in interaction with emergency services such as Police and Ambulance?
- Identify good solutions that have lead to positive outcomes for someone seeking health treatment.
- Demonstrate an example where NGOs have interfaced with the health system to deliver positive outcomes.
- Describe what situations the following service {*example of a service*} provides good outcomes for {*community*}.

In every group, organisation or community something 'works well'. No matter how low the level of resources nor how many problems, there are always some ways to manage and get good outcomes, at least some of the time.

However, community consultations do not permit collection on such a wide variety of questions. Moreover, to pose them explicitly in this way is to pre-set the discussion agenda and research in AI and in the use of 'natural conversation' in techniques like the WorldCafé shows that simple, open ended questions are more than adequate at generating wide ranging and informative discussions. Previous research projects by QQSR confirmed this in applied research in Australia.

Knowing this, a single basic question was asked:

- **We are interested in 'what works' in your community in the area of support for mental health.** We would like you have a conversation about this, making notes on the 'table cloth' as you go along about ideas, examples, success stories, clever 'tricks' people have used to gain support, helpful people and groups, etc. What is working in your community?

This general question was backed up by a second question used (from the third group onwards) in the wrap up phase. This was:

- **If only we could…then we would be able to…** ..As a final 'wrap' up, could you have a brief discussion—and prepare a few notes—on what simple things would make a big difference for your community. We are not after 'big ticket' items here. Rather we want to know about practical possibilities where access to a small amount of funds or some kind of practical support would really make a difference, acting as a 'booster' to the things that are already happening.

4.3.4 Stage Four – Analysis and Report Completion

In this stage the information gathered from the community consultations is analysed and collated into logical groupings for two purposes:

- information needed to provide this report which outlines a list of the solutions that have been identified and working in communities; and
- the basis for the construction of a suitable web based solution to facilitate further developments. The web based solution is to be located on the MHCA website.

5 Study Findings by Community

5.1 The Communities

The communities were approached in two groups of five. The first group, undertaken by QQSR, with the classification of vulnerable or opportunity cluster in brackets, were:

- Huonville, TAS (classed as vulnerable),
- Burnie, TAS (classed as vulnerable),
- Eurobodalla Shire, NSW (classed as vulnerable),
- Singleton, NSW (classed as opportunity), and
- Bright, VIC (classed as opportunity).

Of these, four consultations were carried out successfully while the fifth—Singleton —was abandoned for reasons described below.

As each consultation was carried out, the process was reflected upon and improved and the lessons learned about both the methodology and the topic were recorded.

After this group was completed, the second group was undertaken by O2C. This consisted of:

- Castlemaine, VIC (not classified—replaced an opportunity selection),
- Port Douglas, QLD (classed as opportunity),
- Gladstone, QLD (classed as opportunity),
- Whyalla, SA (classed as vulnerable), and
- Murray Bridge, SA (classed as vulnerable).

In the following parts the results from each of the consultations are outlined.

5.2 Huonville, Tasmania, 4 April

Huonville is a town on the Huon River, in the south-east of Tasmania, Australia. It lies 40km south of Hobart on the Huon Highway and has a population of about 1700. This population has been stable for some years (2001 census). The town lies within the Municipality of Huon Valley.

Today the Huon Valley is best known as one of Tasmania's primary apple growing areas. Once enormous in its extent, the significance of the industry has declined steadily since the 1950s and today fish farming is the rising commercial star of the district. The Huon River and the nearby d'Entrecasteaux Channel are popular fishing and boating areas. The Channel is sheltered from the wrath of the Southern Ocean by the bulk of Bruny Island to the east. Tourism is important: the area is renowned for its scenic beauty.

The municipality of the Huon Valley is the most southerly Council area in Australia. There have been several recent controversies over development in the region; particularly over logging at Recherche Bay and the development of a tourist resort inside the National Park at Cockle Creek.

Attendance at this consultation: 15, including professionals, family members, consumers.

Background and observations (derived in part from discussions with local MHCA staff before the full consultation commenced) were:

- good access to care when needed – very responsive and mobile;
- improved relationships between government/NGO sector;
- strong sense of community in Huonville, weakened by commuting;
- strong council, good community development;
- tensions between greens and loggers;
- the bottom had dropped out of economy. Tourism now strong, lifting economy. Long term decline of things like fruit, so need to 'diversify or die'. Apples now going into Asia and growing for that market, e.g. Fuji apples. Fisheries; and
- no sense of rural youth depopulation though not a lot of school completion. People not keen to go to Hobart for services, especially people born and bred in the area.

View of river and Huonville, 4/4/06

Huonville Consultation, 4/4/06

The two most important positive things from each table were:

Table 1:

- The health centre is important. It is well designed and it is trusted by the community.
- There is a reduction in mental health stigma. One can now discuss it openly, access services, support each other.

Table 2:

- The services that are needed are all here – the council, the centre, the internet. Professionals are here too. General practice is better equipped, makes correct identification and prescribes correct medication.
- Community awareness and acceptance is vastly improved.

Table 3:

- Mental health comes across in a whole range of agencies, it is more in the forefront.
- Organisations recently got together to put on a mental health forum (Mental Health First Aid, through ACE community education grant). Another example is that there are walks that link with sporting groups, run by volunteers.

Table 4:

- The community health centre. However transport would make a difference. Lots of things are on offer but if only we could access it and link up existing things better.
- Better linkages, use of volunteer work.

Post-group discussions were held with the full group. Themes that emerged were:

- **Linkages.** They have access to buses that people would give them to use and they have volunteers who are prepared to drive them, but it takes so long to get the volunteers through the police checks that they can't use the buses. They need support for things like more timely police checks so that use can be made of the volunteer labour.
- **Lack of services when mental health and drugs and alcohol intersect.** It is true that the stigma of mental health issues is reducing, and so people do not hesitate to go to the health centre and there is support for them there. However, it is not the same when drug and alcohol issues arise in combination with mental health issues. There is both a lack of education and stigma about this type of dual diagnosis. Even when services did become available people would not come forward to use them. So now all there is in this area are services based in Hobart and when that is added to people's reluctance to come forward, there are a lot of untreated issues.

Useful quotes from Huonville, extracted from the tablecloths:

Al Anon is OK in Sydney, Hollyoak is available here and even better. It helps provide support for family impacted by drug and alcohol abuse.

Taste of the Huon – a sense of identity, community pride.

GPs who have had mental health training and who are empathetic.

Volunteering in places where people are valued and recognised for their skills and contribution, leads to a building of confidence and social networks.

Only the squeaky wheel gets attention.

When will the Catholic Church get real about mental health?

We need more things that bring communities together. There is not enough cross-over. Geographical division adds – Cygnet and Franklin are on opposite sides of the river so people aren't aware of what's happening on the other side.

Need a drop-in centre [for men] – a men's shed!!

Involvement in sport is a healthy environment – less likely to smoke, take drugs, and good coaches are mentors, help kids to know about smoking etc. Kids will often listen to them when they won't listen to parents.

We need complementary therapies e.g. masseurs and prevention activities e.g. drug prevention, greater awareness of associated problems etc.

Support structure is now in place. Mental health in the Huon is becoming mainstreamed.

Geeveston seniors' community meet at a café in town and if someone is missing others will go check up on them.

Reporting on mental health keeps it in the public arena and has helped reduce the stigma often associated with it.

Good local newspaper for advertising events and reporting – good circulation throughout the region.

Services are now here and will hopefully stay! Professionals are here, are better equipped, and community awareness and acceptance is better.

Availability of on-line centres and moderately good phone and internet services are available. It is less isolating.

The council's proactive involvement in providing activities and services is good.

Locally the visitation of the nuns in the parish may seem quaint but is very effective in some circumstances.

It seems to be a myth that people will come to the aid of someone with a mental illness – but in a small community people are more likely to notice and help.

Perhaps more concern should be placed on people who are only mildly affected by mental illness – to ensure they do not slip right off into the deep end.

A small community where networking and support are easier. It works if you are trusting of the community.

Build on already existing community groups e.g. Lions, parishes.

Exceptional help from mental health people in the Huon in [my son's] case. Trust is important and he feels they are able to be trusted. But under-staffed. My son has not been contacted by them in a few weeks. The client won't initiate contact with them.

Taking people with mental problems on nature walks etc to help them deal with their issues in a positive way. Helps them with motivation to take a positive path in life.

Volunteers work well, in all areas.

Active community health is more available now. Publicity is available and is working – the local newspaper is an advantage. People can get medication locally and prescriptions. However there is a reluctance to go to community services due to being known by locals.

5.3 Burnie, Tasmania, 5 April

Burnie is a port city on the north-west coast of Tasmania, originally settled in 1827 as Emu Bay. Burnie port is the fifth largest container port in Australia.

Three main phases characterise Burnie's economic growth. With the late-nineteenth century mineral boom on the west coast, Burnie became the major port for the shipping of silver from Tasmania. This saw record growth in Burnie's business district and the further development of outlying farms. Banks, churches and schools were established, and by 1901, when the railway arrived from Launceston, the town's population had grown to over 1500.

Just before World War II, Associated Pulp and Paper Mills Limited (APPM) established a pulp mill in the town and while this was not the sole industry responsible for Burnie's post-war development and others have since established and contributed substantially to the town's economy and growth, there is no doubt APPM was the industry that prompted industrial development.

Downsizing at APPM began in the 1980s with Burnie entering a third era in its development history: the post-APPM years. The paper mills have scaled back in both production and workforce, and Burnie is no longer able to depend on one key industry to provide employment and economic growth. Nonetheless, Burnie remains the major deepwater port for the north of Tasmania, with two permanent container ships making daily crossings between it and Melbourne.

Although Burnie was declared a city in 1988, with a population exceeding 23,000, that figure has since decreased, and today the Burnie City Council has a population of 19,030 (2004). Burnie is now a city in transition. Driven by the need to renew its economic base, it is actively campaigning to bolster tourism, attract new investment and build the capacity of residents to develop businesses of their own.

Burnie has a wide range of shops and services including a multi-function civic centre and art gallery, post office, police station, Supreme Court, public and private hospital, as well as numerous sporting and social organisations. Burnie is also home to the north west campus of the University of Tasmania, and Hellyer College.

Attendance at this consultation: 7

At this session, only two tables operated, so rotations were reduced, to get maximum value from the group, the idea was introduced of asking them to consider a 'what if…' question. That is, to explore practical, low cost, possibilities such as, "…what if we had a bus we could use…then we could…."

Location for Burnie Consultation

Burnie foreshore

The most important positive things from each table were:

Table 1:

- The core positive points in relation to what is working are:
  - availability of mental health services,
  - the Education Department,
  - a wellness and wellbeing focus,
  - Red Cross and the mental health first aid workshops,
  - focusing on consumer strengths, and
  - various activities leading to the expansion of social support – not mental health as such but generally in the community.
- The 'what if' issues are:
  - a lack of access to transport,
  - marketing the product – rename it to take away the term 'mental health', and
  - better community education.

Table 2:

- The core positive points in relation to what is working are:
  - empathy for mental health issues by service providers;
  - permission to have mental health problems and to express inner thoughts about it;
  - meetings with people with common experience;
  - mates program – a befriending program;
  - Club Haven (Devonport) – a drop-in centre and client driven service with an art room, cooking, computer room, activities – friendships are established in this environment, builds self-esteem, implied responsibility to 'family group';
  - Child and Adolescent Mental Health Service (CAMHS) – an early intervention program for schools, staff very supportive to clients, a central location;
  - resilience building for young people and adolescents; and
  - greater advertising of programs.
- The 'what if' issues are:
  - a drop-in centre;
  - better transport – e.g. mates coordinator has no transport for his own use or to enable social outings;
  - improved public awareness;
  - breaking down the barriers, ceasing isolation. It is important to support the carers, look at the whole situation (family etc), take the time to build rapport, allow people (consumers and carers) to be heard, build trust and respect;
  - a focus on well-being and wellness; and
  - an older persons' mental health unit.

Preliminary and group discussions emphasised:

- There are quite a lot of things happening already, for example:
  - Commonwealth Care Link and Carer Respite for supporting families;
  - Mental health services, for example the Community Resilience and Mental Health Project;
  - Anglicare;
  - community psychiatric nurse; and
  - TASCAC (Tasmanian Consumer And Carer) group which advises State government.
- However linkages are critical – transport, community education, marketing etc.
- The consultation method was useful and helped to develop new connections and a cross-feeding of information.

Useful quotes from Burnie, extracted from the tablecloths:

Being able to feel connected with workers. Finding the right counsellor. There are some that have the compassion to listen to the consumer. Need to be in a safe environment to externalise thoughts.

Using service integration with clients is an important part of engaging clients. Clients are more inclined to use a service if they are familiar with the people within the service. A friendly/familiar face makes the service more approachable.

A good knowledge of services must be shared and kept current. This information is networked between services. It helps to ensure client referrals are appropriate.

Services don't have the time to give real care. There is a need for people to just listen, not to judge, be professional

Focus on wellness not illness.

In a club environment, those 'senior' members or those managing their illness could give support to those who need it.

Through 'Essential Learnings' schools can now implement more of a focus on health and wellbeing, personal futures.

Day activity centre give clients a reason to get up, motivation.

QQSR consultants noted that:

- People tend to see programs as something to be done (a magic bullet) not as a way of life (e.g., safety, diets – a new set of habits, mental health first aid, conflict coaching).
- The consultations used a method that promoted connection and learning for the mental health community.

5.3.1 Methodological lessons from the Tasmanian consultations

There were several methodological lessons from the Huonville/Burnie consultations:

- Getting the network/contacts to ensure that people turn up. In Tasmania the good offices of the MHC of Tasmania were relied on. This saved considerable time and effort and was greatly appreciated. However, this also meant that the 'usual suspects'—mental health professionals, carers and consumers, along with some local council employees with health related portfolios were likely to attend while a wider community (e.g., Police, CWA, etc) were less likely to be present.
- Nature/content of invitation – it became clear that it was important to discourage late attendance and to ensure that people understood they had an active role from the outset. Otherwise there is a tendency for some people to drop in part way through, which is workable for conventional public meetings with speakers but of little use for this method.
- It was worth asking each table to finish the evening by summarising their themes and then exploring the 'if only' question.

5.3.2 Substantive themes from the Tasmanian consultations

Substantive themes that seemed important for community activity and resilience were:

- good linkages between community services,
- transport to get to places,
- trust in the services,
- proactive intervention as people with mental health are reluctant to come to services,
- wellbeing and preventive approaches,
- linkages between 'ordinary' services (church, Lions, schools, newspapers, etc) as well as specialist mental health services,
- linkages between different types of services, and
- strong local councils.

5.4 Eurobodalla, New South Wales, 4 May

Eurobodalla Shire is a Local Government Area with an area of 3,422 square kilometres and a population of 33,167. It is located in a largely mountainous coastal region on the South Coast of New South Wales. The shire chambers are located in the town of Moruya in the central part of the Shire. Other major towns include Batemans Bay and Narooma with a number of other smaller towns and hamlets scattered through the area.

The Council administers only about 30% of the area of the Shire as the remaining 70% is non-rateable Crown Land held as national park and state forest: 40% of the shire is national park, 30% is state forest, 20% is productive farmland and 10% is urban settlement.

The Shire is unusual in that nearly half of ratepayers are non-residents. Just over 17% of ratepayers are residents of Canberra. Although the permanent population is around 34,100, the visiting population (who stay more than 3 nights) is 3.1 million per year. The age distribution is skewed towards the upper end, partly because of people retiring to live on the coast and partly because a significant proportion of young people leave the shire to continue to study or seek work.

The main growth industries in the area are construction, government services, real estate, retail, retirement, aged care, tourism; while dairy farming, forestry, sawmilling and commercial fishing are traditional industries in decline. Overall, the Shire has a high level of unemployment compared to the national average and is seen as economically disadvantaged.

Attendance at this consultation: 35 people attended a lively forum in the community centre with many opportunities for meeting new people and exchanging ideas and contact details.

Consultation in progress 4/5/06

Broulee,Mossy Point and Tomekin for the air

With such a large group—and hence many tables—it is not as valuable to try to present a table by table summary as with a smaller group. Instead, with this forum the write-up synthesises material across the full range presenting general themes first and detailed examples and illustrations second.

General themes

- There is a strong sense of community within the shire. This is especially true in places like Moruya, Central Tilba, Mossy Point and Tomakin where there is a good meeting place to bring people together.
- Awareness of mental health issues has been raised in recent times by dedicated people and good programs like Mental Health First Aid. Skilled volunteers work throughout the community in hospitals and through churches supporting people. Media awareness and support has been helpful and there have been a number of successful forums on various MH topics and these have been well attended and well received. As a result, mental health is being discussed more widely through the community and more people understand the real issues.

- Numerous support groups exist. They are effective and to some degree networked.
- There are many examples of good case management where community support and home support services have been integrated effectively.
- There are skilled and resourced volunteers who offer great value.
- Networking through a wide variety of events offers needed support to parents and relatives, although this is also an area where more growth is needed.
- Mental health help lines are good and have been of value.
- The local community has been strong and is genuinely interested in helping people, even though State and Federal help has not always been forthcoming or adequate.
- Early intervention skills training has been valuable.
- Youth cafes have been a success story.

Detailed illustrations/topics

- In Moruya, housing for people with mental illness has helped.
- In many cases, continuity of staff has occurred and been helpful.
- There are many cases where teams have worked well and created good family involvement.
- It is important to be able to share experiences and feelings with others. For example, Annie Florence organises an annual 'get together'—a dawn ceremony around bereavement [for those who have lost family members through suicide or drugs].
- The CWA Hall hosts a monthly support group for parents and carers of people with a mental illness or drug and alcohol problems.
- Could we please have a support group in Moruya for parents of bi-polar and schizophrenic children?
- St Vincent de Paul's is often a first point of call and plays an important role. It offers help with food and clothing, assistance with household bills, assistance with accessing services, helps people with budgeting skills and there is no stigma associated with 'Vinnies'. Similar comments were made about the Salvation Army.
- Self help support groups for cancer, dementia carers, grief and substance dependency are important promoters of wellness.
- Important work is being done with youth suffering from depression, helping them build defined routines, undertake physical activity and sharing meals and cooking.
- SPIRIT—the Suicide Prevention Intervention Referral Information Team—received a number of mentions as an important resource as was WORKABILITY, a committed group helping to get people into the workforce.
- It was suggested that Federal funds could always be pursued more successfully if one lived in a marginal seat.
- Numerous support groups were named including: Al-Anon, GROW, Salvation Army, South Coast Counselling Service; Eurocare, HACC senior day care, RSL Day Care in Bateman's Bay, church groups, Montague 50+, Women in Business, Quota, Apex, Rotary, CWA, Probus, Lions.
- The South East NSW Division of General Practice (GP) provides mental health education for GPs and free counselling for GP referrals.

- SAFE (Southern Area First Episode program) offers support to young people having a first psychotic episode. There is a structured program with a one on one meeting with as mental health worker, interviews and assessments at key points and the chance to meet others who have had similar problems and have recovered.
- There is active support for providing opportunities to succeed, such as a hospitality project by IMB designed to give young people vocational skills and hairdressers giving local kids training and jobs as well as things like helping young people (especially indigenous youngsters) to get a driving licence.
- Rural fire brigades were mentioned as groups that created a sense of community connection.
- Men's groups were seen to be helpful.
- Early intervention programs that were seen to be important were:
  - Families First—home visiting with new mothers,
  - Primary school programs identifying kids/families at risk, and
  - Mind Matters: high school mental wellness curriculum.
- Events in the community that gave people chances to connect were important and included fetes, music festivals, art exhibitions and performances.
- Volunteer work gives people a sense they are doing worthwhile work and there is a high volunteer ratio in this shire.
- The police are seen as very helpful and understanding.
- Respite care for people caring for others with a disability was seen as positive and DADAC was mentioned.
- The Division of General Practice was complimented for its program to up-skill GPs on mental health issues.

If only……

At the end of the session, each table group was asked to consider what modest initiative or help would make a big difference to the provision of support for mental health in their area. They were asked to consider completing a phrase of the form, "If only we had [x] we would be much better able to do [y]", where they chose what the x and y terms would be. It was stressed that what was sought was not a wish list of big ticket items but a sense of how limited funds might be spent in a targeted and effective way.

This activity was broadly successful in generating a final lively round of discussion. Some groups followed the ' if only …. we could' format closely, articulating both desires and outcomes, others focused more on desires only.

The requests were as follows:

Group 1:

- If only we could engage with Community Health Centres then we would be able to affect youth health outcomes,
- If only we could create more employment for the indigenous community then we would be able to increase self esteem and health,
- If only we could increase promotion of mental health issues and de-stigmatise mental illness then we would be able to increase the number of people with a mental illness accessing help,
- If only we could all see that each person with a mental illness is first and foremost a person then we would be able to watch them heal themselves,
- If only we could resource families early in life then we would be able to reduce the number of dysfunctional young people,

- If only we could get a few more community development officers then we would be able to broker more partnerships and have more great things going on in our community, and
- If only we could have the same funding for community housing as other areas then we would be able to make people feel more secure.

Group 2:

- If only we could keep doing what we are doing tonight [i.e. at the forum] on a regular basis then we would be able to understand how to build on our strengths.

Group 3:

- If only we could see or obtain feedback from this evening then we would be able to contribute more effectively, and
- If only we could get an acute mental health service in the shire then we would be able to care for our friends and relatives at home in our own community.

Group 4:

- If only we:
  - had cheap and reliable public transport,
  - had funding to maintain and boost food security (i.e., a food co-op),
  - could bring back local shops and services,
  - had increased funding for support services - especially companionship and community linking,
  - could boost employment, especially for indigenous people,
  - had supported employment and activities for people with a mental illness,
  - could continue to raise awareness to make community and services more inclusive, and
  - had HACC and DSP (Disability Support Pension) services that were held more accountable to ensure the eligibility of people with a mental illness.

Group 5:

- If only we could provide more coordinated community mental health education programs then we would be able to reduce stigma and have a more compassionate and informed community,
- If only we could provide more coordinated service delivery to clients and their families then we would be able to have a more holistic approach and help prevent people falling through the gaps or being over serviced, and
- If only we could run a series of information seminars on a range of mental health topics then we might be able to begin to address the previous two issues.

Group 6

- If only we:
  - could introduce clients to positive surroundings,
  - offer referral to dieticians to increase wellbeing,
  - give vouchers to fund local well being activities such as bushwalking,
  - had a small amount of funding to support local groups,
  - could more effectively network across local organisations and share ‘what works’ on a regular basis,
  - could form Association of Relatives and Friends of the Mentally Ill (ARAFMI) (carer support) groups,
  - had an overall coordinator for all mental health support services, and
  - could get more exposure for local support groups.

Group 7

- If only Bateman's Bay Community Mental Health had more space for interviewing clients and more comfortable facilities for staff then we would be able to overcome the current overcrowding which makes it hard to operate well,
- If only we could have more ancillary staff then we would be able to better integrate and support the services we have, and
- If only we could get better transport support then we would be able to free up ambulances and police vehicles.

Group 8

- If only we could get people who experience severe mental health issues together in their own communities then we would be able to find out what they need to assist them and improve their health, and
- If only we could get free support from counsellors and financial planners it would make a huge difference to people who are struggling.

A Eurobodalla initiative

Organising consultations often brought to light initiatives that people had made or were attempting to make. The following message from a person who attended the consultation and is trying to develop relevant ideas is worth quoting as an example of local efforts that might be supported by catalytic work of the type this report recommends.

I am currently seeking to establish a part-time counselling practice, with the emphasis on support. The central concept is to help people adjust to themselves and society and not wait until they are in difficulty. Basically, I have designed some support programmes which could be implemented to improve what is presently available to our community. So, if successful we will be proactive not reactive.

If implemented at the proactively, programmes do not have to be remedial, but rather concerned with facilitating an individual's optimum development and well-being. We do not have to wait until we have some form of crisis or problem before we learn problem solving and become consciously aware.

As these programmes would be anchored in the community, they would benefit us all and prove immensely valuable to the Eurobodalla shire. Together with a colleague, an adolescent and family counsellor/psychologist, we devised two programmes:

1. **Happy Families** which would assist new mums living in isolated rural communities to feel a sense of connection, thus improving the mental health for both mum and infant.
2. **Anger Management** which can be targeted at many sectors of the community, teaching them to identify anger and to deal appropriately with it.
3. **The High School Early Intervention programme** is a third initiative we would like to mount. This would assist 15/16 year olds in learning about themselves, their environment, and methods for handling their roles and relationships, greatly assisting them when major choices may have to be made, in terms of such things as career choices and family, social and sexual relationships.

This third programme was devised after consulting with a fellow counselling colleague, whose professional background is in secondary education.

We are very concerned with 'normalising' situations, and place the emphasis on support and situation. The aims of our programmes are to help individuals learn new ways of dealing with and adjusting to life situations. This is a process through which people are helped to develop sound decision-making processes, the individual's adjustment to himself and significant others in his life and the cultural environment in which he finds himself.

This type of SUPPORT programme seems to be a 'first' in our community, so hopefully it can make a difference and improve the way that we feel, interact and behave.

Lorraine Schmaman, Narooma.

5.5 Bright, Victoria, 5 May

Bright stands 304 metres above Sea Level. It has a population of 2000 and is part of the Alpine Shire, a Local Government Area located in the north-eastern part of Victoria. The Shire also includes the towns of Mt Beauty and Myrtleford and in total has an area of 4,885 square kilometres. In 2001 it had a population of 12,600.

After a colourful history which included persecution of Chinese miners in the gold rush, the main industry today is tourism, with much focus on the autumnal colours of the European trees planted in the area. A major cultural event is the Bright Autumn Festival and the town is the gateway to majestic Alpine.

It is also a popular family destination over summer and the population swells, particularly after Christmas. During the summer months Bright enjoys consistently warm, sunny days with comfortable overnight temperatures. There is a high proportion of retirees in the area, many of them from professional backgrounds with two branches of Probus operating in this one small area.

Attendance at this consultation: 16 people attended and worked in five groups, with rotations as per the normal format.

The material summarised from the five tables follows.

Table 1: The key theme to emerge from table 1 was that social connectedness is important and very helpful to the area.

The general tone was positive and noted that many things worked well in the Bright-Myrtleford area because of the high level of social connectedness in the area. Specific and positive mention was made of:

- GP support services, such as the medication program, are linked with Integrated Mental Heath Service in GP clinics;
- the school community; at all levels with specific mention made of decision makers at Bright PR College, student representative councils. Also note was made of a school welfare budget being spent on a youth worker thus creating continuity and partnership;
- Mental Health First Aid courses;
- co-location of important services;
- Ovens & King Friday lunch men's club;
- churches, including ACARS being run in Bright Uniting Church Hall;
- social groups such as book clubs, a wine group, a nursing mothers group, etc;
- the Bright Op Shop;
- Trinity: Cliff Bennett and the Myrtleford Art Group is a good support service. Access could be improved;

- Alpine Shire Youth Council/Alpine Youth Provider Network: the entire shire is provided with a Youth Service;
- community psychiatry—Dixon St;
- local service clubs (Apex, Rotary, Lions) and groups (e.g. SES, Fire Brigade);
- sports clubs—netball, soccer, football are all supportive;
- GP support services;
- festival and events, including music festival and showcasing our youth re school socials, the Autumn Festival Ball and Autumn Festival Queen;
- the high level of community generosity; community spirit, based on inclusion not exclusion, is alive and well and, "We do look after our own!" there is no separation of well and ill—everyone mixes in at our events;
- transport is not bad but could well be improved; and
- social services supporting community well being with regard to:
  - homelessness and transitional housing,
  - aged community health (Delaney Manor),
  - home care service, and
  - vacation and after school care.

Table 2: The key theme to emerge from table 2 very similar to Table 1—a connected community.

Positive details noted were:

- we look out and care for each other;
- education and training of community members who live in the local community is helpful and pays dividends;
- there are voluntary carers groups doing a good job;

Bright Memorial

- the men's group run by Ovens & King Health Services;
- in Mt Beauty the men's shed run by Alpine Health with its community garden;
- crisis intervention is positive—one gets to know the Police in a small community;
- Trinity Community—teaching work skills and life skills 9-5. Monday to Friday on a drop in basis with lunch twice a week. A great resource and more like this needed;
- monthly information nights at Wangaratta on various mental health topics;
- Wangaratta transitional housing—teaching social skills;
- Mental Health First Aid Courses—9 courses across 3 communities in the Shire since early 2004 have been complete by, in all over 100 participants. These were provided by Wangaratta Integrated Primary Mental Health Service and provided a great opportunity to help a range of people, including the Police, to increase their knowledge and understanding. At present, community groups are seeking money to support members attending; and
- Victoria Mental Health Branch Research Institute came to Bright earlier in the year (March) the community organised a trivia night and 250 people attended.

Two main areas where this table made constructive suggestions were:

- In the ACT, when Police are called to what seems to be a mental illness related incident, a case worker attends with them. How could we work towards implementing this in rural areas?
- There is a need for well informed 'intermediaries' for consumers. This would be a single person with whom one

would have a stable contact and who could direct consumers to different services/supports depending on the precise need at the time. Different people have different needs and the same person may have different needs at different times.

Tables 3-5: Again the positive theme of social connectedness in the community dominated at all tables.

To avoid repetition of points above the following points are noted which add to elaborate the previous material:

- there is a Friends of Carers group which covers North Eastern Victoria and is very helpful;
- Alpine Health is very good with early intervention for child/adolescent mental health issues;
- there are good outreach series with friendly counselling;
- youth specific services are available out of school hours, e.g. Café Connect in Mansfield;
- there has been good continuity of service in many areas – same person providing service for some years;
- the regular monthly meetings in various locations are excellent points of contact;
- there is an awareness of the needs for rural areas, such as farmers suffering depression;
- local knowledge from staff in schools assists families to identify difficulties and support students and, in a similar way, the local school crossing supervisor or 'lollipop man' is a well known character who is a source of knowledge, connectedness and support;
- there is a good Rural Adolescent Program;
- there is an effective Falls Prevention Group;
- participation in sport is a great bonus, it reinforces 'mateship' and the local clubs are very encouraging about getting people to persist with their involvement;
- a number of depression awareness events have been held with excellent response;
- there is a good range of general health promoting activities like yoga, Tai Chi and strength training; and
- the local business community—especially show owners—is supportive and constructive.

If only……

At the end of the session, each table group was asked to consider what modest initiative or help would make a big difference to the provision of support for mental health in their area. They were asked to consider completing a phrase of the form, "If only we had [x] we would be much better able to do [y]", where they chose what the x and y terms would be. It was stressed that what was sought was not a wish list of big ticket items but a sense of how limited funds might be spent in a targeted and effective way.

This activity was broadly successful in generating a final lively round of discussion although, as will be seen below, there was a tendency for some tables to opt for the big ticket, wish list.

Five detailed sets of answer were received and the requests were as follows:

Group 1:

- a one stop shop handling all aspects of mental health and all aspects of the lives and needs of people with a mental illness;
- support for carers—similar to 'Gilchrist House', formerly in Beechworth; and
- follow ups so we don't get the revolving door syndrome.

Group 2:

- supported accommodation;
- public transport;
- employment training;
- more mental health professionals;
- greater emphasis on upstream health promotion; and
- greater collaboration between GP and other health and community services.

Group 3:

- community/neighbourhood centre;
- funding for mental health first aid courses;
- funding for mental health awareness courses;
- education/speakers at high schools—drug and alcohol workers, police, etc.;
- more awareness raising to de-stigmatise mental health issues;
- early intervention; and
- funding for mentoring with at risk kids.

Group 4:

- better public transport to regional centres;
- affordable local accommodation;
- increased 'hours' of service provision that come into the community;
- increased networking/linking between services and between services and community;
- increased funding so community members can participate in mental health first aid courses; and
- money to promote activities, services, programs to local communities to increase community awareness of mental illness, support and health promotion activities.

Group 5:

- more funds for youth camps;
- more information for community about what is happening with services and events;
- more GPs, psychiatrists and bulk billing;
- supported accommodation for those with a mental illness;
- more personal support for those with a mental illness so they do not remain isolated;
- government funding for more sporting activities for youth; and
- a neighbourhood centre, a meeting place for all ages that could be a disseminating point for all services to let community know what is happening.

An important initiative in the Bright area

As noted earlier in relation to Moruya, organising consultations often led to interesting programs coming to light. In the Bright area, a key network star, who helped greatly with setting up the consultation was Renee Williams, General Practice Mental Health Programs Manager of the North East Victorian Division of General Practice & Northeast Health in Wangaratta.

Renee also provided details of an innovative program which she instigated that combines Commonwealth and State programs in a positive and constructive way. This highly cooperative model—described below—has been important in creating bonds between groups and agencies in the area and seems to be a major reason why even small centres like Bright appear to be well supported and resilient.

The program figured as case study in a recent Commonwealth Report on the Better Outcomes in Mental Health Care Program, and the following description is excerpted from that report:

> The North East Victorian Division's Access to Allied Psychological Services project uses an employment model to support GPs and allied health professionals to work together to provide optimal mental health care in a rural setting. The key success of the project has been the partnership development between the Division and Northeast Health Wangaratta and the Area Mental Health Service, and the subsequent integration of primary mental health funding from Commonwealth and State bodies. The inception of the 'Integrated Primary Mental Health Service' has enabled six mental health clinicians to provide focused psychological strategies to 30 GP clinics across 33,000 square kilometres. The mental health clinicians deliver shared care within a co-location model.
>
> A key issue the rural project faces is the lack of alternative services to which GPs can refer patients. For example, there are limited counselling services in the rural townships of the Division's catchment, resulting in the integrated service being inundated with referrals by the GPs.
>
> Another issue is the tyranny of distance in the rural setting for both workers and clinicians delivering services, and patients accessing services. For workers and clinicians, extensive travel requirements create potential occupational health and safety issues. The project has put into place several strategies to address this. For example, the employment and integrated model, has enabled the Division to use pooled funds to lease vehicles for all its workers to deliver services. Recent recognition by the Commonwealth Department of Health and Ageing that vehicle leasing was part of direct clinical service delivery and not infrastructure, has further ensured the Division reaches its target populations. To minimise the effects of extensive workloads and distance travelled on all project mental health clinicians, staff are given a travel day per month to compensate for hours spent in the vehicle. This, in effect, provides staff with a nine day fortnight, once rostered days off are taken into account.
>
> Funding for mental health training for GPs is also an issue in rural areas. However, being a rural Division also enables GPs to access funds from Rural Workforce Agency for training. To address access to training opportunities, the Division has developed its own Level 1 training package which is accredited with the General Practice Mental Health Standards Collaboration.
>
> The lack of available psychiatrist in rural areas for patient assessment and secondary support is a considerable issue for GPs in the North East of Victoria.
>
> Overall, the level of funding provided for the project was not perceived to reflect the lack of alternative services and lack of available psychiatrists, the high demand for services, and the travel issues faced in rural areas.
>
> "*Rural and urban projects: Similarities and differences"* (Seventh Interim Evaluation Report of the program Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, March 2006), Belinda Morley, Fay Kohn, Lucio Naccarella, Jane Pirkis, Grant Blashki, Philip Burgess, Program Evaluation Unit, University of Melbourne.

This program has clearly had positive outcomes. For example, the most recent evaluation notes (among other things) these positive outcomes:

Health Outcomes:

- Clients of the IPMHS have had a significant decrease in their major symptoms and difficulties experienced as a result of their mental illness.

Client Satisfaction:

- There is a very high level of client satisfaction with the IPMHS.

GP Satisfaction:

- There is a very high level of GP satisfaction with the collocation model and services provided by the IPMHS.

General Practice Snapshot:

- 62% of North East Victorian Division of General Practice members are Level 1 accredited with 22% obtaining level 2 accreditation.
- Accredited GPs refer more clients to the service than non-accredited GPs.
- Accredited GPs billing percentages are marginally lower as compared to other Divisions.
- 31 Practices and 98 GPs or Practice staff were consulted regarding the uptake of the Better Outcomes In Mental Health Care Initiative package.
- Individual GP's with interest in mental health and who were level 1 accredited were most likely to understand the initiative.

Team Snapshot

- The IPMHS team has very high morale and relatively low levels of workplace distress.

How does this useful and innovative program work? The following excerpt, from the June 2006 evaluation gives an insight into this and into the unique structure that has been developed.

> The Integrated Primary Mental Health Service (IPMHS) has completed its third year of its successful service delivery partnership between the Northeast Health Wangaratta (NHW) and the North East Victorian Division of General Practice (NEVDGP). The original partnership has been further expanded in 2004 to include the Border Division of General Practice (BDGP). The IPMHS now represents a tripartite partnership model across North East Victoria, and the Albury/ Wodonga catchment area. This report represents the second year evaluation of the integrated model.
>
> The IPMHS continues to provide a range of services to both the general community and primary care providers.

The IPMHS has expanded its direct clinical services with the inclusion of the BOiMHC (Better Outcomes in Mental Health Care) Program funding from the Border Division of General Practice and the successful submission to the Commonwealth Department of Health & Aging for expansion funding. The IPMHS now co-locates six (6) mental health professionals within thirty-five (35) general practice clinics.

The IPMHS provides the opportunity for the people of North East Victoria to receive professional counselling within their choice of GP practice. Since the commencement of clinical counselling services in June 2003, over 1500 new mental health assessments being undertaken within GP Clinics. Additionally the local community throughout the region have benefited from over 5500 consultations with co-located mental health clinicians. The average number of new consultations has risen to over 25 new assessments per week.

People experiencing mild or moderate anxiety, depression and other high prevalence mental health disorders continue to be referred to the workers via their general practitioners for brief counselling. The IPMHS clinicians do not replace GP's as the main care providers. The referring GP remains the case coordinator and primary provider of health care to the patient. Instead the mental health professionals provide an additional, complementary service that enhances the range of care.

The counselling service aims to ameliorate the personal level of distress of clients and increase level of functioning and adaptive behaviour, through brief psychologically counselling interventions. Clients are referred to the service from General Practitioners after an initial assessment is completed. The IPMHS is a free and voluntary service

[…] The key educational and training focus has been on the delivery of Mental Health First Aid, ASIST Suicide Prevention, targeted education, training and secondary consultation to primary care providers, and TAFE Education. The principle aim of the IPMHS education and training program is designed to build whole-of system capacity across the primary care sector.

Furthermore our aim is to raise the level of mental health literacy and decrease stigma within the general community, in order to facilitate the early identification and earlier commencement of help seeking behaviour by individuals, families and group.

In additional to education and training, the IPMHS has increased its focus on secondary consultation to primary care providers, with the development of service partnerships with both Ovens & King Community Health and Upper Hume Community Health Services.

These partnerships have taken the form of conjoint education and training activities, the development of consumer and carer support projects, and visiting secondary consultation services

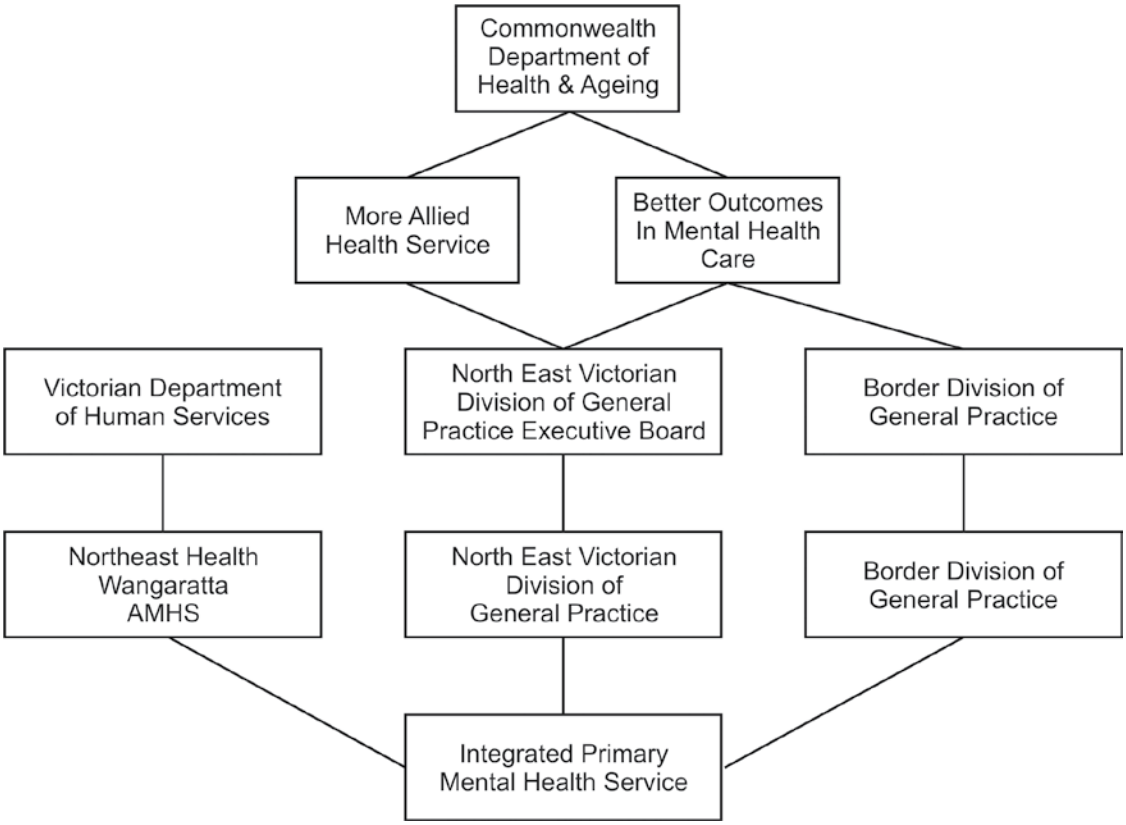


Diagram 1: Project management structure and reporting lines

The IPMHS continues to incorporate a number of program initiatives from within the Area Mental Health Service. These include the Eastern Hume Dual Diagnosis Service (EHDDS) and the Early Motherhood Service (EMS). These initiatives have been expanded to include the Angry Men's Anti-violence Project.

Since commencing its services, the IPMHS has sought to establish a positive, supportive learning environment work environment for its staff. This has been achieved through the provision of peer supervision and clinical governance processes. Additionally a strong emphasis is placed on ongoing education and research. All staff were engaged in postgraduate education or research activities, with three staff completing Master's degree.

With expansion of the IPMHS to incorporate the Border Division of General Practice, the organisational model and reporting lines have been adjusted to reflect this change. The diagram below provides an overview of the project management and reporting lines.

The IPMHS has expanded the geographical catchment of direct clinical and non-clinical services within North East Victoria and the Border towns of Wodonga and Albury. The area is approximately 40,000 square kilometres with a population of approximately 160,000 North East Victoria and 110,000 Albury/Wodonga. It encompasses the rural cities of Benalla, Wangaratta, Albury and Wodonga and the Shires of Alpine, Delatite, Indigo, Towong, Strathbogie, Moira, Murrindindi, Wangaratta; and Albury, Wodonga, Corowa, Culcairn, Holbrook, Hume Urana. (*Program Evaluation II of the Integrated Primary Mental Health Service NE Victoria*, June 2006 (Collaborative approach to Primary Mental Health Care), by Renee Williams and Gary Bourke.)

Overall, this project offers a number of interesting ideas about local adaptation of services and about what is possible when people take initiatives, join up the different streams of Federal and State funding and 'make things happen'.

5.6 Singleton, New South Wales

The Singleton consultation never happened. Once it appeared that the likely attendees were too few in number to make it worth holding a consultation (given the travel times and costs involved) it was decided jointly with MHCA to cancel the consultation.

However, while this may seem a negative result, two important lessons were learnt in attempting to organise this consultation. These lessons are explained below, in each case drawing on the detailed experiences of what did work in Moruya and Bright (and later was to work in the other 5 centres).

Lesson 1: in every community there seems to be one or two key people who are network 'stars'. In this context, the word star is used in the form of a geometric metaphor—a point form which many lines of connections radiate out to the people and other network clusters. (They are often stars in another sense of being really great performers in their local community).

If you can find the stars and work with them, the process of launching a consultation (etc) is made very simple.

In Moruya, which was the easiest consultation to organise and run, several stars were identified—at Eurobodalla Shire council, at the local paper (where one of the staff was interested in mental health, knew everyone and was a goldmine of contacts) as well as people working in mental health, volunteers and NGO people (e.g. the CWA).

In Bright, the local newspaper was little help and the Alpine Council was willing but had slightly less purchase than Eurobodalla. However, here the key player turned out to be someone in the Division of General Practice who was heavily involved in an innovative program of linking Commonwealth and State program and funds into an integrated and effective service. She was able to provide the relevant contacts, up to an including a contact for a venue and as a result a good turnout was achieved.

In Singleton, in contrast, the only 'star' that was identified was a senior nurse in the hospital based program who was just on the verge of leaving to go overseas on long service leave. She was unable to play the facilitation role that one or more people played in Moruya and Bright and this made it hard to energise a group for a consultation.

Contacts with the local newspaper were fruitless and the Council staff were willing but clearly did not have the strong involvement that, for example Eurobodalla Shire and to some extent Alpine Shire had.

Lesson 2: the second key lesson concerned the way that local geography and formal institutions interact, creating a version of 'the tyranny of distance'.

One of the problems with Singleton was that phone calls to potential players turned out to be met with one of two reactions (often both):

1. "Singleton, … hmmm, that's interesting, I don't think that there is anything happening here/there."; and
2. "I'd love to help, but I'm in Newcastle and it is a couple of hours drive away. I'm not really sure what is going up there and you'll understand it is too far to come for an evening meeting…."

The second reaction is certainly part of the explanation of the first. From the Division of GPs to NGOs, State government programs and back, head offices are in Newcastle the centre of 'the Hunter region'. While it would be unfair to characterise the conscious attitude of people in Newcastle towards Singleton as 'out of sight, out of mind', with regard to mental health where as is well known resources have been inadequate and stretched, more distant places like Singleton can fall off the radar.

The contrast with Moruya and Bright is quite stark. Eurobodalla Shire is relatively small, especially by Australian standards: North/South (or vice versa) is about an hour by road. Similarly, while Bright is tucked away at the edge of the Victorian Alps, the area is well connected with two main valleys connecting back towards the Hume Hwy and Wangaratta and distances involved are modest. In both cases, therefore, while local transport remains an issue for consumers or those on limited incomes, the majority of the population with easy access to car transport is well connected in a way that is not true for Singleton. It is also not true it seems (see further below) for Port

Douglas even though the trip from Cairns along the coast road is only about an hour.

In Port Douglas, we were able to create a consultation, and in part this worked because there had been time to absorb the lessons learned in Singleton. As the data below show, although initially informed (like Singleton) that "nothing was happening in Port Douglas" things were happening and, no doubt, things were happening in Singleton.

It seems likely, therefore, that when actual geographic distance, perceived distance ("it seems a long way away") and institutional form (e.g., all the head offices are in the regional centre) combine negatively then:

- a centre receives less attention and support than it deserves,
- local efforts are mounted, but they are limited, and
- those efforts are not 'on the radar' screen of the regional centre head offices.

This has clear implications—explored later—for determining concrete actions that might increase community resilience.

5.7 Castlemaine, Victoria, 8 June

Castlemaine is a town, in the 'Midlands' region of Victoria about 120 kilometres northwest by road from Melbourne, and about 40 kilometres from the major provincial centre of Bendigo. It is part of the Mount Alexander Shire. In 2001 Castlemaine's population was 6,835 (2001 census data), of whom about 8% were born overseas (mostly in the United Kingdom) and 2% of whom speak a language other than English, a pattern typical of much of rural Australia.

Castlemaine was established during the gold rush of 1851 and originally named Forest Creek and later Mount Alexander, but the chief goldfield commissioner, Captain W. Wright, renamed the settlement to honour his uncle, Viscount Castlemaine.

After gold mining gradually ceased a number of other secondary industries sprang up. The largest was established in 1905 as the Castlemaine Bacon Company, producing smallgoods. The company is still the area's largest single employer with around 750 employees there. Tourism exploring the gold-rush era buildings, and other attractions including an art gallery featuring a number of fine Heidelberg School works, is also a major source of income for the town.

Typical 19th-century building in Castlemaine

Attendance at this consultation: 29 including local mental health workers, consumers and carers, local police, Bendigo Division of GPs, community health representatives, non-government sector also represented.

Background and observations:

- Castlemaine benefits from being part of two shires although predominantly covered by Mount Alexander Shire,
- strong sense of community and pride in location from Castlemaine populace,
- good volunteer sector, and
- depth and variety of mental health support available.

The most important positive items from each table were:

Table 1:

- strong range of players available, accessible such as The Maine Connection, St Luke's, Mental Health Carers Group, Gallay St Tin Shed;
- high level of tolerance within community for people with mental health issues as noted through GP influence, availability and acceptance of complementary treatments, vouchers from Churches and Salvation Army; and
- plenty of social connections with visits from friends, personalised care from case managers complemented by self help education, physical activity and gardening.

Table 2:

- largely a focus on what individuals do to make things work; bike riding, table tennis and other social activities; and
- local education programs increasing awareness of mental health also helped.

Table 3:

- a range of good meeting places are available for people to access assistance or just connect socially for a while; and
- a night like the community consultation provides all an opportunity for dialogue between all people involved with mental health.

Table 4:

- familiarity of small community and looking out for each other;
- the broad diversity of groups – carers, recovery programs, counselling services, psychiatrists, St Luke's, Castlemaine Community Health, various focus groups for depression, Psych triage, The Maine Connection; and
- sense of community.

Table 5:

- employment opportunities at the bacon factory and wool mill; and
- variety of support available and the 24 hour nature of police and emergency support.

Table 6:

- focus here on the range of creative options to build resilience such as listening to music, creative writing, Moon Rocket Band, bike rides, drama, painting, sculpting, theatre trips;
- Hands on Health provides a holistic option; and
- local PDRSS (Psychiatric Disability Rehabilitation and Support Service) also has good people.

Table 7:

- the value of social connections and networks;
- the Maine Connection provides a safe space; and
- the ability to participate fully in life through sport, pets, talking, reading, walking.

Additional Points (from Q2) and Themes

Utility of Consultation Nights. The ability to meet and network across services and with a wide variety of people was highly valued by the group.

Community spirit. The sense of community was palpable, within the group and in answers given, e.g. the personal connections and efforts many local mental health services made.

- an on-call CAT member for Castlemaine at night to relieve burden on police,
- improved public transport and accommodation,
- a better supply of community meals for people who are too tired or sick or lack the skills to self care,
- provision of on-going forum on mental health,
- map of existing mental health and allied services for newcomers to Castlemaine,
- van or bus connection to The Maine Connection, and
- someone to mind pets while people in hospital.

Useful quotes from Castlemaine, extracted from the tablecloths:

Great GPs a big influence

Tolerant community

Committed carers counsellors and workers

When our local taxi service went broke, heaps of people offered to drive me so I could shop, swim, go to the doctor etc

More nights like this – opportunity for dialogue, mixture of clients, carers, service providers – empowering for client groups

Understanding police force "clients have had a good run with the Castlemaine police"

At St Luke's we get to have our say about what we want to do

Having the chance to be a volunteer keeps me fulfilled, happy, joyful, purposeful

Local hospital provide place of safety that can't be provided at the closest psych ward

Forums like this where people get together and talk

Funding for consumers to do their own thing

The better we feel the easier it is to do things

More community forums to break down the barriers about mental health

Courses for employers and managers handling employees with mental illness

If only we had groups of people who want to accompany others to events such as the footy, theatre, pictures, jazz nights the pub or pictures

Local education to reduce mental health stigma including the use of local people as examples and role models

The need for business and service clubs to support nights like this (the consultation)

5.8 Whyalla, South Australia, 17 July

Whyalla is a city and port of just over 24,000 people located on the east coast of the Eyre Peninsula opposite Port Pirie in South Australia.

Founded by BHP in 1901 as the end of a tramway bringing iron ore from the Middleback Ranges to be used in the lead smelters at Port Pirie as flux. A jetty was built to transfer the ore. The settlement consisted of small cottages and tents clustered around the base of the hill. The arid environment and lack of natural fresh water resources made it necessary to import water in barges from Port Pirie.

From a peak population of 33,000 in 1976, the population dropped rapidly. Since then the city has gone through a slump. Whyalla has experienced a net migration loss since 1981, reflecting the continuing decline in the BHP iron and steel industry. The Whyalla steelworks is the sole producer of rail and steel sleepers in Australia.

HMAS Whyalla was landlocked as a tourist attraction in 1987. In the late 1990s the spectacular annual migration of the Australian Giant Cuttlefish to the reef areas north of Whyalla around Black Point and Point Lowly became recognised by international divers.

Attendance at this consultation: 17 including local council, mental health and community health services, Centacare, the general public and the Regional Mental Health Program Manager.

Background and observations:

The recent Whyalla social profile conducted in April 2006 highlights the town:

- may become more of a fly-in, fly-out location for operations in the northern parts of the State, such as the Gawler Craton, Roxby Downs and Olympic Dam. If this occurs, a very high standard of accommodation and hospitality services is expected by this segment of the market;
- the Indigenous population is younger (median age 16 years compared to 35 for non-Indigenous residents) and the population is expected to grow at a considerably faster rate than the non-Indigenous population This will clearly have an impact on health services, housing, education, recreational facilities, support services, culture and so on;
- a higher proportion of relatively young, skilled trades people and professionals from overseas are more likely to make Whyalla their home, rather than moving back to the City within a few years, as currently occurs with many of the graduates who come to Whyalla. This aspect will change the multicultural aspects of Whyalla to some extent, adding a new and young breed of migrants with different cultural needs; and
- if the strategy to attract 'sea change' retirees to Whyalla is successful, this will increase the over 65 population. This may have implications into the future for support services, health services, amenities, and home care services.

Table 1:

- new rooms at the hospital provide privacy and a positive environment;
- value of state and federal governments return to work programs;
- success and support from various non-government agencies, such as GROW and Centacare; and
- CAG (Consumer Advisory Group) mental health advisory group enable people to air their views and participate in a healthy and effective manner such as write to the minister.

Table 2:

- interagency relationships effective in providing psychosocial packages of care and accommodation;
- referral processes streamlined due to relationship between GPs and mental health teams;
- promotion of mental health issues via mental health week;
- wide range of non-government sources active such as United Care Wesley, church groups and GROW; and
- regional quarterly mental health meetings provide forum to improve consistency of care and service.

Table 3:

- raising awareness of mental illness issues through the media, at schools;
- range of services including hospital, support groups, counsellors, carer support, 'Our health in our hands'; and
- various hotline numbers such as 13 14 65, Lifeline, Child Youth Hotline as seen as effective.

Table 4:

- the interagency relationships effective such as the Consumer Advisory Group and Mental Health Advisory Group meetings;
- range of services: Anglicare, St Vincent's de Paul, Salvation Army and a variety of supporting activities such as tai chi, sport, hobbies, relaxation classes; and
- recognition of value of early intervention.

Additional Points (from Q2) and Themes

- get up to date directory of services,
- bus route needs to change to get to community centre – John Gibson's house,
- re-open the recently closed drop-in centre,
- a men's health shelter, and
- free bus service to Community house/GPs and Centrelink.

Useful quotes from Whyalla, extracted from the tablecloths:

Flexible funding not pilot projects

Cycle of funding needed to allow 5 year planning

Closure and threat to funding of community houses provides people with a mental health problem nowhere to go

People/professionals who are working in mental health in Whyalla are keen and enthusiastic

The Whyalla Guide has useful information but it is not presented in a user friendly way

The need for life skills to be taught such as how to maintain a home, cook

5.9 Murray Bridge, South Australia, 18 July

Murray Bridge is a city in South Australia about 80 km southeast of Adelaide and 1 hour drive north of Meningie. It is the service town for a farming area including dairy, pigs, chickens, cereal crops and vegetables (including 'stay crisp lettuces').

It is where the Princes Highway crosses the Murray River on the main road and rail routes from Adelaide to Melbourne.

The town provides a centre for much of the river Murray district of the area and plays host, for example, to the River Murray Football league and a premier junior golf competition.

Attendance at this consultation: 11 people - seven service users (plus one who was from another area who was accompanying one of the other attendees and did not participate) two workers (one government and one NGO) - and one church minister present at the consultation.

Background and observations:

- network stars identified yet administrative reasons prevented greater participation from Murray Bridge community,
- majority of participants linked to Swanport House, and
- Swanport House coordinates a recovery program run on an empowerment model where consumers lead the service.

The most important positive items from each table were:

Table 1:

- Swanport House plays a vital role in educating and supporting service users from gardening programs to advocacy to a place of refuge or safety, and
- Swanport House provides an opportunity for service users to form groups and gain confidence to do things such as go to the gym.

Table 2:

- Murray Mallee community health service provides great support to service users and works in partnership with a range of other organisations, and
- Professionals that combine lived experience, textbook knowledge and empathy are very effective.

Additional Points (from Q2) and Themes

Swanport House – the consumer led recovery program is viewed as a very effective empowering experience and an additional staff member would enable the community to assist a greater number of people than currently possible.

- a larger car park with better lighting (Swanport House),
- opportunities for consumers to interact with local government agencies,
- identification of opportunities for community to learn about mental health issues and see people with mental illness as part of society,
- allocation of grants to what actually works well, and
- the establishment of a co-operative community based on bartering i.e. someone might like ironing and barters the gardening to undertake this task.

Useful quotes from Murray Bridge, extracted from the tablecloths:

Dealing with the duty worker at Murray Mallee community health service was a positive experience

Very few hospitalisations when assisted by Swanport House

The value of depression net; the access to chat rooms, notice board, support services, newsletters and information

Swanport House staff assisted with police requirements and removal from town to a safe place. They understand, support and enable protection with a positive active hand

Outreach to smaller towns. Mannum has a small social group that help each other personally or as a group and meet regularly

Support in small things can change lives

Validation – being asked to chair a meeting then told I had done a good job.

Support workers follow up how you are going…if something has been mentioned in conversation…it's nice for them to call and see how we are going

Write on toilet paper what bugs you, use it and flush it!

A sense of belonging and ownership… accepted by peers and workers…being able to participate at own level ...there is no hierarchy stuff just mutual respect.

"It" doesn't have the power over me that "it" used to have.

Going to Swanport House gave me my life back. I became confident and could express myself.

Each service user needs assistance in goal setting for their own lives so that they can be empowered to live their own life in the community

Gladstone, Queensland, 24 July

Gladstone is an industrial port city located on the coast of Queensland. The city's population stands at 28,500 (2004 estimate), of whom 3.5 percent are of Aboriginal and Torres Strait Islander origin, with the remainder being of primarily European descent. An additional 15,800 (2003 estimate) persons live in the adjoining Calliope Shire. Being a port city, its local commerce is primarily industrial-based and include large-scale industrial plants include alumina refineries, aluminium smelting, heavy chemicals and shale oil.

In the past few years Gladstone has experienced major growth booms with industries setting up and expanding, new services have been provided to cope but are not doing quite well. The city centre is being re-developed (and currently open) to attract visitors back to the city instead of outer suburban malls.

Attendance at this consultation: 17 including Anglicare, local Mental Health services and consumers.

Background and observations:

- Gladstone operates in a boom bust mentality due to the mining. Both parts of the cycle provide different mental health challenges to deal with; and
- when in boom the population can be quite transient as younger people flock to the community to make their fortune in a Eureka gold rush outlook.

The most important positive items from each table were:

Table 1:

- strong interagency links 'Rumble in the Jungle' received a variety of grants and required work with the police, youth, health and welfare agencies to assist 12-17 year olds. Local Police have good links with mental health services and also well trained; and
- community works together – Rock and Roll day – churches provide hall for free, schools donate videos good attendance.

Table 2:

- vast array of support available ARAFMI, Lifeline training, men's resource centre, workshops on depression, Centacare, Anglicare, HACC, CBT programs; and
- a range of programs for all ages including school aged and older persons.

Table 3:

- setting the right environment where clients/consumers are respected and empowered in a non-threatening open way; and
- the variety of programs: Knight Eagle crime prevention program, the Redclaws Netball team for teenage girls play not drink, Blue Light Discos attract over 180 young people.

Table 4:

- recognition that clients may have a number of barriers to overcome; drugs, alcohol, domestic violence, homelessness, attitude, mental illness. Consequently, a holistic inter agency approach is likely to produce more appropriate and lasting arrangements; and
- staff at all locations make the difference in their attitude to clients and capacity to link across agencies because of their knowledge of what is available.

Additional Points (from Q2) and Themes

- free Bus and driver to connect clients to appointments, group programs, agencies, counselling sessions especially after hours;
- need for cheaper and more readily available accommodation;
- pooling of local resources may produce better access and utilisation;
- Callide Dawson needs greater support with their own worker and cheap transport to connect smaller towns to Rockhampton and Gladstone where the services are located;
- establish a men's shed – a program to build self-esteem – perhaps as part of current men's shelter;
- employ a permanent psychiatrist in Gladstone; and
- improve awareness of mental health issues within the area including workshops and promotion of programs in schools.

Useful quotes from Gladstone:

Just because you have a mental illness does not mean you are going to be dangerous

Less over-dramatisation of incidents from people with mental illness by the local press

We have a very close committed community

Community forums are a big hit! Lots of local support and outside visitors to share their expertise

Would like to have funding for a full time person in a large region rather than a half position to service Central Queensland

Our acute mental patients either miss out completely on appropriate care or have to be transported to Rockhampton

Don't promise what you can't deliver

There are professionals within our community who recognise individuals with mental health issues and act on it

Follow up calls are made by mental health workers in regard to clients from other services

5.11 Port Douglas, Queensland, 25 July

Port Douglas is a town in Far North Queensland, approximately 80km north of Cairns.

It has a population of approximately 3000 residents. The town's population can often quadruple, however, with the influx of tourists during the peak tourism season May-September. Port Douglas developed quickly based on the mining industry, other parts of the area were established with timber cutting occurring in the area surrounding the Daintree River and with settlement starting to occur on lots around the Mossman River by 1880.

An interesting point is that Port Douglas was the Presidential vacation stop during Bill Clinton's visit to Australia in 1996. On dining out at a local restaurant the Clinton's even witnessed a couple's wedding certificate. On a return visit on the 11th September 2001, the then ex-president was again dining in a local restaurant, at which he signed and dated a plate. Notable residents of Port Douglas have included former-Beatle George Harrison, actress Diane Cilento, John Farnham and Just Jeans founder Craig Kimberley.

Four-Mile Beach, Port Douglas.

Attendance at this consultation: 20 including consumers, social workers, local pharmacist, representatives from mental health services, Directors of Nursing, Area Coordinator Disability Services and the Human Resources manager from the Sheraton Hotel.

Background and observations:

- state and Cairns based groups and agencies outlined that nothing was worth doing at Port Douglas as nothing was happening there, and
- the network node at Port Douglas accessed a vibrant enthusiastic community keen to both participate and build on the success of the consultation.

The most important positive items from each table were:

Table 1:

- the environment assists with management and health including the weather, access to nature, the rainforest, the ability to exercise, the beach;
- sense of community and treatment as an individual not as an illness including people using a sense of humour, good listening skills, trust and confidentiality; and
- a holistic approach is used incorporating aspects of professional treatment, the location and nutrition and use of complementary therapies.

Table 2:

- individual skills emphasised including learning about mental illness and improving your own self awareness in relation to onset patterns;
- gathering information on availability and types of services, whether mainstream or complementary, that may be of assistance; and
- role of community in understanding the problem and enabling participation in sporting groups, in other words being inclusive not exclusive.

Table 3:

- inter agency meetings useful between social workers, ATODS, police, GPs, pharmacies; and
- range of supporting areas from sporting clubs to the environment, art classes.

Table 4:

- linkages and help available from within the community – local doctors, police, neighbourhood centre;
- a hallmark of the community is the flexibility of support provided to consumers – this includes local business policies and practices, the attitude of the community, assistance form professionals, and knowledge as to what is available within the area; and
- community takes 'social responsibility' to look after its own.

Additional Points (from Q2) and Themes

- community awareness – provide information sessions,
- transport support – maybe a bus pass for locals or a cycle way between Mossman and Port Douglas,
- proactive consultations – build on this activity,
- professional support - On-call support from local professional 24 hours,
- Crisis Accommodation,
- movie theatre – can be a shed in a backyard, and
- Carer/Consumer group – invite Cairns group to speak.

Useful quotes from Port Douglas, extracted from the tablecloths:

Being able to live in the bush

Small community – better connected

Knowing there are people to help you and back you up

Knowing the warning signs, knowing your own body, being responsible for your own health

Awareness of the processes and the types of people who can help

The diversity of the community is grounding

Value the person with a mental illness – the human approach

Employing people with special needs is part of the hotel's community support philosophy

People with mental health issues are loyal employees

Smaller community can weave safety net in a place that services are not always available

Knowing you have people to talk with and support you

Interdependency – when in need of help knowing what is available e.g. food vouchers, food bags, support for paying bills

5.12 Other comments from the O2C consultations:

Throughout these consultations the facilitator provided the following wrap up for the participants.

- Please raise your hand if you have learnt something new at this consultation.
- Please leave your hand in the air if you have met someone new tonight.

Both questions, regardless of the size of the group and the community, were answered with resounding unanimity. Of interest here is that this simple check reveals that the process of making connections and establishing a network is a simple as providing a forum for like minded and perhaps passionate or at least motivated individuals the opportunity to meet to discover others with a shared interest/vision/goal. From these first steps can spring further opportunities to build resilient communities.

All locations benefited from early contact with key people within the mental health networks of their community. This ensured a very good response at locations with the exception of Murray Bridge. Each location was also supported by the facilitator contacting 6-12 of the key contacts from the grid system. Only at Murray Bridge did the nodal system prove ineffective. This appears to be due some administrative difficulties that restricted the passage of information to a select group within the Murray Bridge community. The smaller attendance and service user focus was offset by the application and focus given to the task by the participants.

6 Common Themes Arising from Consultations

6.1 Value of Coordination

One of the major direct benefits of the consultation was the extent to which local people were brought into contact one with another. In some cases, this meant catching up with people they already knew, in others it meant meeting people they had not met before. Both were valuable and the combination (renewal and novelty) was especially powerful in generating a synergy within the group.

In the larger and more diverse consultations it was especially noticeable how many people stayed back after it had nominally finished, to continue conversations, swap ideas and exchange contact details.

Such meetings are not unique and in some locations other groups had succeeded in organising successful mental health days, workshops, etc before this consultation (this was very much the case in Eurobodalla, for example.) Nonetheless, even in those areas where other meetings had occurred, the consultation was seen a very valuable.

This suggests that simply organising a consultation/meeting of this type is a useful first step towards activating a community and hence building resilience.

Considered in terms of policy and programs, this suggests that *simply having a small number of coordinators in each State/Territory whose job it was to organise meetings in communities in their jurisdiction would pay handsome dividends in catalysing community efforts.*

6.2 Networking

The core of all successful community activities is informal networking based around some key 'stars'. This research illustrated this once again because the largest consultation groups which were most easily contacted for these consultations were also in the communities where activity levels were highest.

The two are not merely correlated—the well connected network with active stars both generates the activity and makes the consultations easy to organise.

It is likely that every community has potential stars—people with energy and commitment who, given the chance will keep in touch with and inform others and thus become catalysts for change in their community.

In this way, the previous point strongly links to this one—paid coordinators could and should, through their efforts:

- find existing stars and draw on their good will to organise consultations,
- offer support to those stars where possible, and
- identify other potential stars and see if it is possible to 'grow' them in that role.

6.3 Tyranny of distance

The tyranny of distance can be found in this data at two levels.

At the broader level, as identified earlier in relation to Singleton, there is evidence in this research to support the view that the tyranny of distance which has bedevilled Australia throughout its history can be found once more in relation to the way that communities respond to mental health issue.

It was noted above that it seems likely that when actual geographic distance, perceived distance ("it seems a long way away") and institutional form (e.g., all the head offices are in the regional centre) combine negatively then:

- a centre receives less attention and support than it deserves;
- local efforts are mounted but they are limited; and
- those efforts are not 'on the radar' screen of the regional centre head offices.

If this point is linked back to 6.1 and 6.2 above, it is clear that the 'catalytic coordinator' has been suggested would, by organising consultations and supporting networking, also play a role in mitigating this tyranny of distance.

Moreover, as the catalytic coordinator grew to know more and more people in various communities and in various local government and State/Territory offices, so this person would also become a network star in their own right—linking communities that might otherwise not be linked and linking communities to government and non-government agencies more strongly than otherwise would have been the case.

At a more grass roots level, another version of this tyranny came out in the repeated reference to the need for flexible local transport. In almost all locations, people mentioned that many of the simple transport needs of consumers and carers were unmet and pressing. For example, in Huonville, the view was strongly expressed that the local treatment options were pretty good but that getting people to them was a major difficulty and that having a bus would help a lot, a view echoed in various ways in other places.

Similarly, in several places people mentioned how helpful more bicycles would be, both for transport and also for healthy exercise. For example, in Port Douglas the view was expressed that some bikes and a cycle way to Mossman (a few kilometres north) would be invaluable.

6.4 Volunteering

The importance of volunteers, and the existence of a supply of willing people who were volunteering, came out in several consultations. For example:

- volunteers work well, in all areas—Huonville;
- there are skilled and resourced volunteers who offer great value—Burnie;
- volunteer work gives people a sense they are doing worthwhile work and there is a high volunteer ratio in this shire—Moruya; and
- good volunteer sector—Castlemaine.

These are encouraging comments and, with the exception of Burnie, emerged in relation to consultations which were well attended and, relatively speaking easy to organise. This suggests that there may be some link between the network and wider social characteristics.

At the same time, close inspection of this, however, reveals another interesting pattern. Leaving aside Castlemaine—which was substituted for Mildura (opportunity cluster) at a late stage and hence is unclassified—all three of the communities that strongly mentioned volunteering were from the five vulnerable cluster communities selected. On the other hand none of the three selected from the 'opportunity cluster' and where consultations took place (Port Douglas, Bright, Gladstone, Singleton being the fourth and with no consultation was) mentioned volunteers.

While numbers here are too small to being thinking about things like statistical significance, the pattern is suggestive. This will be explored further below.

6.5 The men's shed

In a number of locations it was specifically mentioned that groups for men were of special value. In some cases a program was desired:

- "We need a men's health shelter": Whyalla;
- "Need a drop-in centre [for men] – a men's shed!!": Huonville; and
- "We need to establish a men's shed – a program to build self-esteem – perhaps as part of current men's shelter": Port Douglas.

In others, it existed and was praised:

- "Men's groups were seen to be helpful": Moruya;
- "The men's group run by Ovens & King Health Services": Bright; and
- "Vast array of support available … men's resource centre": Gladstone.

It is likely that there are several inter-related reasons why men are seen to have special needs. These range from social change in family and gender roles (such as more middle aged to elderly men on their own after divorce and lacking simple skills like cooking) through culturally specific factors (the 'Aussie male' who finds it hard to confide about inner feelings) through to more general factors such as widespread differences in male and female support networks found in many cultures.

There is also a specific 'needs' issue here, since in rural areas in Australia and elsewhere stress in farming communities is associated with increased male suicide. Such stress arises from numerous sources, including changing agricultural practices and business arrangements (the rise of 'agribusiness' leading to rural depopulation), climate related issues (drought, global warming) and erratic economic changes to markets and prices in a globalised economy in which free trade and protection are intertwined in complex ways.

However, whatever the background to the issue, this seems to be something that many communities want or find valuable and, as such, might be an easy first step to suggest to communities looking to take steps to increase social involvement and resilience.

6.6 The mighty dollar

One of the things noted in numerous consultations was that, even when the 'if only...' question sought ideas for improvement that, if they came into effect, would be based on little, or at best modest funding, there was a tendency to respond automatically with relatively 'big ticket' items. It was as if the imagination space for many people, much of the time was filled with the simple assumption that a big program, a large item or a generous budget was the only type of help that could make a difference.

While persistence with the question usually led to a discussion in which a rich variety of ideas eventually emerged, the fact that the 'big ticket' was the first port of call was interesting.

There is not space here for an extended discussion of modern culture, the 'death of the welfare state' and a myriad of related ideas, but a few broad themes are likely linked:

- While Western governments of a variety of persuasions (from Keating to Howard, from Thatcher to Blair, etc) have argued that we have moved beyond the welfare state, that government funds are limited (especially in a world where voters expect tax cuts on a regular basis) and that people must take responsibility for themselves, it remains the case that the average person-in-the-street commonly expects that "they" should "do something about" social problems and that this something should involve government funds and government programs.

- Modernity is notoriously characterised by impatience and 'short termism'. This could be parodied as "what do we want?—a magic bullet, when do want it?—now". The idea that answers might take time and effort to be built up is not the first thing that comes to mind (though to be fair it did usually emerge in the discussions about the things that had been successfully developed in the area where a consultation was held).

6.7 Diversity—the emergent 'panda's thumb'

A key theme, which is implicit in a number of the previous themes, might be called diversity.

That is, all the communities had things in common (they were all part of a State, were all in a local Shire, were all in a Division of GP, all had local press and police, to name a few) yet how they responded to needs was varied across the different centres.

Here the Division of GP was influential, there it was not; here the local paper was important; there it was not; in one place the Shire council was very active and involved in mental health issues, in another it was not, and so on and so forth.

Yet every community was able to take some of the things provided from the Commonwealth government programs, something from the State, something from what was locally available, something from NGOs and, via cooperation, volunteering and goodwill, create a system that, while not perfect still delivered good things for the community, created resilience, provided help for carers and consumers and, in most cases, made efforts at mental health promotion and preventive efforts. Two things need to be discussed here.

First, this is an emergent process. That is, in the language of complex, self organising systems, something 'emerges', bottom up via the independent activities of many elements (people and groups) acting independently and following a few simple underlying 'rules'—such as helping one's neighbours, looking after people in need, contributing to one's community, etc. Research in the area of complex, self organising systems has shown that such systems are far more robust and adaptable and 'alive' than systems designed 'top down'.

Second, what emerges is—to use a metaphor from evolutionary biology—a 'panda's thumb'. The late Stephen J Gould in an essay of the same name points out that panda's do not have thumbs. Being bears, their thumb became part of their paw some millions of years ago. So when they changed to a diet of bamboo shoots, there was a problem—how to hold the bamboo shoots in one's paw? The evolutionary 'answer' was that an extension of the scafoid bone in the wrist developed into a 'sort of thumb'. It is not a very good thumb compared to the opposed primate thumb—*but it does the job*.

Gould uses this example to point out that the breathy commentaries on wildlife documentaries marvelling at the 'perfect design' that 'Nature' produces, overlook the fact that often what emerges in evolution is far from perfect—but it works.

This is true in the communities studied. Local adaptations have developed that work. They may not be perfect, but they do deliver care, support and resiliency. It may well be better to build on these emergent, less-than-perfect models than imagine that progress lies in replacing them with perfect, top down, solutions.

This is idea of emergent, local adaptations is important since it reinforces the point made earlier about catalytic action. That is, the idea that things emerge from local action suggests that *catalysing local action, rather than imposing a top down program upon it, is likely to be a far more powerful and effective process.*

7 Relevant Research from Overseas

Extensive searching was undertaken to find case studies that complemented this study.

Particular attention was paid to ensuring that a range of countries was covered, especially English speaking, affluent countries which might be usefully compared with Australia and where lessons learned would be applicable to this country.

In the USA, Canada, the UK and NZ it was possible to identify at least one major project which had published relevant material. There is also a key recent Australian report which contains relevant data.

In the sections that follow, the report first identifies the key project under consideration and then provides a brief excerpt from published (or one case unpublished) material which appears to contain important ideas, principles or lessons.

7.1 An important US initiative

A major study—the Resilience Solutions Network–is underway in Arizona at the Arizona State University (ASU), led by Professors Alex Zautra (psychology) and John Hall (public affairs).

This group is studying the factors that promote resilience at both the individual and community level, and then applying the results through a network of community-based 'resilience centres.'

The team is modelling its approach on the famous Framingham longitudinal study on cardiovascular disease. Unlike Framingham, however, which focused on risk factors within a fairly homogenous population over time, the ASU group will focus primarily on resilience factors within a diverse sample of approximately 5,000 persons in the Phoenix metro region.

A major report of research is *Resilience: Health In a New Key* (Arizona Health Futures, 2003) which, to be found at: http://www.slhi.org/publications/issue_briefs/pdfs/ib-03fall.pdf

The following passages are excerpted from the full report, with emphases added at a few key points.

Resilience, for social-ecological systems, is related to:

- The magnitude of shock a system can absorb and remain within a given state.
- The degree to which the system is capable of self-organization.
- The degree to which the system can build capacity for learning and adaptation.

It would be horribly ironic if we were to apply this concept of resilience in communities and move linearly from definition to assessment to intervention to evaluation, just like a risk based model. You know, march into communities and "teach" them how to be resilient. (emphasis added.).

What are some of the characteristics of resilient communities and individuals? We start with general components in the literature of biology and systems theory and gradually add insights from such fields as psychology and sociology. This is hardly an exhaustive account, but it's enough to connect us to where we want to end up, which is recommending strategies to promote more resilient, and hence more healthy, communities.

Social-Ecological Systems There are at least three central components of resilient social-ecological communities:

1. **Diversity** – diversity of species, functions, response, human opportunity and economic options, all of which maintain and encourage adaptation and learning.

   Key Point: "Resilience derives from things that can be restored only slowly, such as reservoirs of soil nutrients, heterogeneity of ecosystems on a landscape, or variety of genotypes and species." We can't quickly "manage"

change. **Promoting resilience by increasing diversity is a long-term, not a short-term, proposition. This remains a fundamental challenge in our postmodern culture of the "quick fix." (emphasis added.)**

2. **Redundancy** – redundancy in the sense of overlapping species, functions and institutions that diffuse disturbances and allow them to enter the system at a smaller scale instead of accumulating at a larger scale and precipitating system collapse.

   Key Point: Centralization and integration of functions and institutions do not necessarily increase resilience and may even decrease the ability of communities to respond to stress and adapt over time. How many times have we found ourselves saying, "there are too many of these small nonprofits out in the community, each doing essentially the same thing. This is inefficient. We need to encourage them to consolidate or go out of business." Again, what is efficient in the short term is not necessarily efficient in the long term. Resilient communities self-organize and adapt over time. (emphasis added.)

3. **Feedback Loops** – robust and stable feedback loops that underlie early warning systems and allow for quick response and adaptation to system stressors.

   Key Point: This is the critical component of connectivity, both in a biological and social sense. There is both a formal sense of connectivity – structured feedback loops that allow us to monitor and adapt to changes in the natural environment, social disasters, etc. – and an informal sense of connectivity in our everyday world of social relationships that often arises spontaneously and defines our communities and culture. These feedback loops are both positive and negative, and a resilient system needs both. **To the degree that we attempt to control feedback loops – connectivity – through rigid institutions, roles, regulations and relationships, we run the risk of depleting the "natural" reconstitutive capacity of communities to learn and adapt on their own (emphasis added).**

… How does resilience play out in actual communities, and what can we do to promote it? This isn't rocket science. Studies of resilient communities all over the world yield these common sense characteristics:

- **Boundaries.** Resilient communities have a shared sense of what their community is, and more importantly, what it is not. This requires a clear set of boundaries that demarcate the community from other communities and empower members with a true sense of place, a common vision and identity. Successful branding in the marketing world is based on this principle. So are resilient communities.
- **Time.** This is so obvious, it's invisible. Communities at risk are always on the verge of running out of time. Deficits and nasty trends are puffing at the door; a sense of urgency prevails. Resilient communities, on the other hand, know that the wolf is always at the door. If he weren't, they wouldn't be forced to prepare the house; they wouldn't be resilient. These communities take all the time they need – and it takes a lot of time — to develop the characteristics of resilience listed here. Time replenishes itself in resilient communities, because they have learned to adapt and change without losing their core identity. This is the "Zen" of resilience.
- **Committed leadership.** Not just the usual suspects – powerful CEOs and community leaders, people with 'clout' – but also an inclusive group of ordinary people in ordinary places with extraordinary energy and capacity for learning and inspiring others. For the long haul, communities that self-organize to adapt to changing conditions require informal as well as formal networks of committed leaders. If you think you aren't a leader because your name isn't in the paper, think again.
- **A high degree of civic engagement and associational life.** Simply holding a 'visioning' conference and flying in outside talent won't cut it. Residents of resilient communities are engaged with each other in a rich web of formal community organizations and informal associations. Nurtured over time, this develops trusting and caring relationships, a sense of social cohesion. Without social cohesion and connectedness, successful adaptation is impossible in both individuals and communities.

- **Diversity.** Not in the sense of pluralism, but diversity in economic base and environmental resources; diversity of skills, roles and relationships; diversity of perspectives and beliefs. Social cohesion through diversity is not easy to achieve, but in the long run harmonized diversity creates a more resilient web of community than social cohesion through monocultures.
- **A multi-functional approach to development.** Attractive as it is in the short term, a laser-beam focus on just one dimension of development, such as economic growth, won't build resilient communities over the long term. Communities that focus planning and development in the resilience zone – the place where social, environmental and economic issues overlap – have a better shot at building sustainable, vital communities over time.
- **Asset-based planning.** Resilient communities start the planning process with a focus on their assets and strengths, not their deficits and limitations. It is impossible to mobilize and energize communities without asset-based plans that set priorities and goals; merge social, environmental, political and economic resources; and build local capacity. But here's the catch: Elites and experts don't create a vision and strategic plan for the community and then 'present' it to them for their approval. The plan grows organically out of an inclusive community process. The *entire* community creates and 'owns' it. Experience confirms that this is a messy process, but there's no short cut. In a real sense, the asset-based planning *process* is the plan itself.
- **A culture of active learning.** Human communities are complex social systems. Complex social systems adapt and change through the spontaneous interplay of diversity and disturbance, which is part of the self-organizing process. Resilient communities learn to harness this process through monitoring feedback loops (social, environmental, economic) and adaptive management strategies that test knowledge through a self-organized process of trial and error.

  "The adaptive management approach treats policies as hypotheses and management as experiments from which managers can learn, accepting uncertainty and expecting surprises." Resilient communities encourage a culture of learning in which people feel comfortable exploring new ideas in trial and error settings. They are willing to take risks. Easy to say, but hard to do, because much of what passes for management and education these days is primarily about control, not about active learning.
- **Access to skills and knowledge.** Resilient communities tap into the diversity of skills and knowledge that *all* members of the community possess, and not just the 'marketable' skills of experts and technicians. Community asset-mapping reveals skills that others in the community are often unaware of; attention to what people can bring to the table, as distinct from what they take away, is a tremendously powerful factor in motivation and involvement across traditional community economic, social and cultural fault lines. At the larger system level, resilient communities also tap into accurate information and knowledge about system components such as health, welfare, education, employment, the environment, transportation and arts and culture. Investing resources in the development and maintenance and connection of this knowledge is critical.

7.2 An important UK program

In the UK, and important initiative that brings mental health support to rural people and helps to create resiliency is the Shropshire Rural Stress Support Network. One of the primary researchers, Alison Monk of Harper Adams University College, England, sent an unpublished paper *Working Together to Promote Mental Health in Rural Areas* (Paper Presented at the Rural Communities and Identities in the Global Millennium Conference, Malaspina University College, Nanaimo, British Columbia. 1st – 5th May 2000.) The following key elements are excerpted from that paper. Again, emphases have been added where a point seems especially important.

> Probably the best developed and most successful group in England is the Shropshire Rural Stress Support Network (SRSSN) and its work demonstrates many of the ways in which County Rural Initiatives develop and grow. It has a full-time Project Manager and part-time Project Assistant working in a dedicated office, manning a phone line for a minimum of 5 hours a day. Beneficiaries are offered friendship and support through a large group

of volunteer workers, who receive ongoing training. The volunteers do not act as counsellors.

Their role is to provide guidance and support, helping raise the beneficiaries' self-esteem and confidence enabling them to regain control of their life and business. The volunteers are assigned to each beneficiary, pointing them in the right direction to access medical treatment, counselling, financial help etc.

There are a variety of individuals and organisations (voluntary and statutory) with which SRSSN networks to assist a beneficiary, e.g. Trading Standards, the police, land agents, banks, mental health services, social services, other specialist help-lines, lawyers, business advisors, feed companies etc. The networking works in both directions. Any one of these organisations may contact the SRSSN about a rural dweller who appears under pressure and for whom they are concerned. Equally the SRSSN may ask for any of these organisations co-operation to help a beneficiary. The SRSSN also tries to educate and inform these organisations on the facts about rural stress. Unlike many of the farmer support groups on the continent, the SRSSN accepts third party referrals. Since there is often a reluctance amongst farmers and other rural dwellers to seek help, this is a vital feature of the group's work.

[…] through raising the profile of rural stress, the SRSSN has helped reduce the stigma attached to asking for help. Through education it has helped other organisations understand the problems facing the rural sector and so appear more relevant and accessible to country people. Since farmers trust the opinion of other farmers, the volunteers are carefully chosen so they demonstrate an understanding of farming and the problems facing the rural sector. They can then act as an interface between rural dwellers and the services available, helping each contact the other. The SRSSN believes that it has developed a model that can be adapted by other counties, or countries, to suit local needs and promote rural mental health.

7.3 A Canadian Program

In Canada, a large university based study and action research program—the Resilient Communities Project—is underway at the University of British Columbia. A major focus of this program is combining insights from large scale network studies from leading analysts like Mark Granovetter and Ronald Burt with insights from social capital theorists like Robert Putnam.

A central question concerns the way that certain forms of networks and the right conditions for volunteering to arise (i.e. potential for high social capital) can combine to create the conditions for resiliency.

This work is of great relevance because there are complex relationships between the extent to which people are attached to a community, their willingness to volunteer in and commit to the future of that community and /or their preference to honour community 'obligations' through cash donations.

Putnam, for example, has laid strong stress on the growing tendency in the US for people who are wealthier and 'time poor' to prefer to donate money rather than time—a trend seen in a number of examples in Australia, such as the well known example of parents (especially mothers) to replace 'traditional' volunteer work such as serving in a school tuck shop with cash donations.

As the study cited below illustrates, the question of who is, and who is not, committed to staying in small, local communities can be very informative about some of these patterns.

In one study (http://www2.arts.ubc.ca/rcp/resources/PDFs/shouldIstayorshouldIgo.pdf) Page et al (2005) found in their study of small, rural communities in British Columbia, Canada, that people were less likely to consider leaving their community if:

- they are older;
- female;
- married;

- have high trust in institutions and community members;
- volunteer and are interested in local politics (i.e., have high levels of civic engagement);
- believed that local business leaders are creating economic opportunities in their community;
- evaluate their community as having good employment opportunities; and
- say that their communities are socially cohesive (as measured by sense of community and inclusiveness) and in control of their own future.

On the other hand:

- personal income and employment status shows no significant association with willingness to leave;
- ties to relatives *outside* the community is linked to a willingness to leave;
- people who say that their community's political leaders "generally represent the interests of a few powerful groups" are more willing to leave;
- evaluations of institutional functioning are not associated with willingness to leave, save for evaluations of safety.

Overall, their findings indicate that:

- At the individual level, social considerations may be more important than economic considerations with respect to decisions to leave a community.
- At the individual level, social capital that is directed toward the collectivity, but not to the individual, contributes to community resilience.
- Economic development should focus on diverse, bottom-up development (that is, driven by local business leaders) that creates many employment opportunities.
- Overall, the research supports a key argument in the social capital literature, namely that the social characteristics of communities influence whether or not their populace stays put in the face of an economic shock. They establish that the social character of communities is important in terms of whether or not people want to continue to live there.

7.4 New Zealand's new approach

In 2002, the NZ Ministry of Health launched a new approach to mental health: *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand*. Drawing inspiration from the Ottawa Charter, *Building on Strengths* is consistent with the five action streams based on the Ottawa Charter (WHO) and which are designed to enable people and empower communities. These actions are to:

- Build healthy public policy,
- Strengthen community action,
- Reorient health services and programmes,
- Create supportive environments, and
- Develop personal skills.

The key models use ideas congruent with this report and an excerpt of key themes is shown below.

- **Community development model.** This model is based on the premise that communities best understand their own needs and are best positioned to come together to resolve problems and promote healthy communities.

It is primarily about "building social cohesion, supportive environments, community ownership and control and unifying disadvantaged groups or those people excluded from participating in society" (Raeburn and Corbett 2001).

- **Primary mental health care model.** Activity under this approach recognises the services provided in settings currently covered under the scope of the Primary Health Care Strategy, with its emphasis on 'enrolled populations'. Besides general practice and primary health organisation services, mental health promotion interventions include those provided by school counsellors, nurse practitioners, midwives, voluntary groups, counselling agencies and self-support groups. It is important to note that families, communities and the voluntary efforts of community members, who mobilise around common problems, are often the first point of contact and provide the main source of help for many people with problems.
- **Strengths-building model.** The strengths model arose as an alternative to diagnostic-based social work approaches, which were often criticised as categorising people according to symptoms, ignoring critical environmental situations and ultimately blaming individuals for their disabilities. In contrast, the strengths perspective avoids blaming behaviour by focusing on identifying individual, family and community strengths (Russo 1998).

The philosophy behind this approach has three distinct elements.

First, rather than dwelling on what is wrong, on illness or deficit, it emphasises the resourcefulness and resilience that exists in everyone. The strengths approach recognises that all people have potential and capacity to grow, change and adapt. All people have capabilities, abilities, strengths, and the environments that act on these qualities include resources and opportunities that foster the development of those attributes and talents.

A second major philosophical emphasis of a strengths approach is that of the primacy of people and community. This includes a fundamental trust in people's own judgement about what is good for themselves, their families and their communities. The role of community (and community development) is especially emphasised here, because collective wisdom and collective support, and the building of group and community cohesion and strength, are believed to be optimal for improving overall health and wellbeing. At the heart of this is the belief that mental health is determined to a great extent by people's own sense of control over their lives.

The third element of a strength-building philosophy is the acknowledgement of the importance of both culture and society as determinants of our mental health and wellbeing.

In New Zealand in particular, culture has been recognised as being of huge importance in human affairs, and its influence permeates every aspect of the lives of all of us. A full recognition and honouring of this reality is essential for the good mental health of all people. In addition, in the past, mental health often has been regarded as an 'internal' matter, as something that is caused by some deficiency within the person.

7.5 The Action Plan for Northern Ireland

Finally, among the overseas literature, similar themes to those in NZ are echoed in this overview from Northern Ireland. *Promoting Mental Health: Strategy and Action Plan*, 2003-2008 (Department of Health, Social Services and Public Safety, Belfast, 2003)

Mental health promotion works at three levels: and at each level, is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems.

- **Strengthening individuals** – or increasing emotional resilience through interventions to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- **Strengthening communities** – this involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, childcare and self-help networks.
- **Reducing structural barriers to mental health** - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

7.6 A recent Australian report

A recent review of mental health service and delivery for rural and remote areas was prepared for Queensland Health. This review, *Unfenced road ahead: a review of rural and remote mental health service delivery and policy* (A report for the Mental Health Unit, Queensland Health, August, 2005) Ann Kreger and Ernest Hunter, can be found at:

http://www.aph.gov.au/SENATE/committee/mentalhealth_ctte/submissions/addinfo016.pdf

The excerpt below is a key section of the report in which the authors review the link between capacity building and partnerships, a literature that intersects closely with the goals of the research in this report.

Capacity Building & Partnerships

The majority of the literature focuses on health services and mental health professionals. Some efforts have been directed to other human services and workers but few publications detail efforts to optimise the capacity and resources for self care and informal mental health care within rural communities.

Partnership models recognise previously unskilled and unsupported human service and non-government organisation (NGO) workers at the point of first contact. This approach arose from identified problems with teamwork, service access and acceptability in rural South Australia. Recommendations included the appointment of a regional mental health coordinator to facilitate collaboration, peer support and other networking approaches, and the operationalisation of partnerships. A focus on boundaries was suggested in order to minimise inflexibility and gaps in service delivery (Fuller, Edwards, Martinez, Edwards, & Reid, 2004).

In New South Wales a rural-urban partnership enabled local intersectoral partnerships, clinical placements, telepsychiatry workforce development, consultative support, and community awareness in local media to achieve, in rural and remote areas, reorientation of services for children and young people towards early intervention (Kowalenko, Bartik, Whitefield, & Wignall, 2003).

Lessons from projects involving rural partnerships in the promotion of mental health and wellbeing identified:

- commonalities between mental health promotion activities and community capacity building;
- linkages between capacity building and sustainability;
- workforce development requirements for workers to implement mental health promotion;
- requirement for longer term projects in development of organisational capacity in addition to short term projects;
- emphasis on partnership development, with clear definition of purpose and planned and fostered projects;
- economic participation required knowledge of good practice in economic development, workforce development and cross sector partnerships, and;
- building on individual and community strengths from the outset strengthens mental health promotion projects (Victorian Health Promotion Foundation, 1999).

Partnerships with other agencies and the community are one predictor of sustainability in the reorientation of services to early intervention. Other predictors included workforce development, organisational development for management and policy support and targeted resource allocation. The barriers encountered were heavy workloads, high staff turnover and inadequate funding (O'Hanlon, Ratnaike, Parnham, Kosky, & Martin, 2002).

In rural Victoria, the Carers Education Exchange Programme provides education and facilitates development of support networks in a flexible manner to rural consumers and has been found to increase carer wellbeing and positive outlook (Hayman, 2005).

Embedded references:

Fuller, J., Edwards, J., Martinez, L., Edwards, B., & Reid, K. (2004). Collaboration and local networks for rural and remote primary mental healthcare in South Australia. *Health & Social Care in the Community*, 12(1), 75-84.

Hayman, F. (2005). Helping carers care: an education programme for rural carers of people with a mental illness. *Australasian Psychiatry* 13(2): 148-153.

Kowalenko, N., Bartik, W., Whitefield, K., & Wignall, A. (2003). Rural workforce development and staff support: Remodelling service provision for early intervention in child and adolescent mental health. *Australasian Psychiatry*, 11(Suppl1), S110-S116.

O'Hanlon, A., Ratnaike, D., Parnham, J., Kosky, R., & Martin, G. (2002). *Building Capacity for mental health: A two and a half year follow-up of the Auseinet reorientation of services project*. Adelaide: The Australian Network for Promotion, Prevention and Early Intervention for Mental Health.

Victorian Health Promotion Foundation. (1999). *Rural Partnerships in the Promotion of Mental Health and Wellbeing: Victorian Health Promotion Foundation Mental Health Promotion Plan 1999- 2002*. Melbourne: VicHealth.

7.7 Ten common principles from the overseas studies

Ten principles are common in these complementary studies from overseas and these are extracted below:

1. **start with what is right, not with what is wrong—look at assets not deficits, wellness not illness—and trust local judgements about assets and needs;**
2. **in defining a community, use the boundaries that people 'know' and recognise—this maximises the chance of a shred sense of place, a shared vision and a commitment to neighbours;**
3. **communities best understand their own needs and what is right and wrong for them;**
4. **work out how best to use experts—in general, they are not best used in top-down design and didactic teaching which would tend to stifle local efforts and regiment models. Instead, use expertise in a catalytic fashion that promotes self organising and self sustaining efforts. Specifically, don't try to 'teach' resilience—help people to create it;**
5. **do not seek to develop in a community a neat, simple, rational system with clear and well defined boundaries between the groups and institutions that are providing local help, support and initiative and defined links to centralised, integrated projects at the next level 'up' (e.g. State). While such systems look good on paper they are too rigid and not 'redundant' enough to allow for emergence and adaptation. Instead, redundancy, fuzziness, overlap and multiple feedback loops are optimal;**
6. **nurture and build trust and try to catalyse engagement;**
7. **where possible, have local volunteers helping and supporting other locals. Not only do they understand them better, this also builds trust and generates civic engagement;**
8. **diversity in communities—diversity with regard to skill utilisation and option creation—is vital;**
9. **help to create and sustain committed leadership in local communities; and**
10. **take the time it needs to make things happen. There is no quick fix.**

It is clear that the directions recommended in this report link in a very positive way with recent recommendations both overseas and in Australia about the ways in which services in this area need to be improved.

For example, a recent report in the UK—The Journey to the Interface: How public service design can connect users to reform (Parker & Heapy, DEMOS, 2006, available as a pdf file at http://www.demos.co.uk/publications/thejourneytotheinterface/) makes a strong case for reforming the way that all services are delivered to the public which fits well with this report.

While the Parker & Heapy focus is on the service delivery side rather than upon the way services are created and inter-linked, many of the principles they articulate are exactly congruent with the argument here. For example, they argue for:

1. Building adaptive capacity alongside managerial capability

   The challenge for policy-makers is to focus on building […] adaptive capacity, alongside the current goal of developing better managerial capabilities. [Managerially oriented reviews] … will not provide government with the tools it needs either to measure adaptive capacity, or to develop it.

2. Investing in 'in-between spaces' as well as existing institutions

   It is striking how many of the examples and case studies we found in the course of our research emerged out of […] 'in-between spaces' – partnerships and collaborations set up at arm's length from the major public service institutions that are in operation. This pattern is mirrored in innovation literature. Many markets are characterised by a handful of large stakeholders, and a larger number of small enterprises, whose innovations are tested and developed at a manageable scale, before the successful ones get incorporated and integrated into the larger organisations of that sector.

   In order to strengthen the system's ability to learn from itself, there is real merit in investing in these in-between spaces alongside strengthening the feedback loops between insights and organisational development. They are a means of experimenting, learning and innovating on behalf of the wider system. Much could be learnt from investigating and seeking to understand these collaborative models in more detail and government, both local and central, urgently needs to create opportunities for the development of these spaces.

   […] We also found that these collaborative 'in-between' partnerships enable new forms of incentives for user focus to be designed in to the ways in which services are shaped and offered. It is notable that many of the organisations that had successfully closed the gap between what they were offering and what people want and need had partnership, subscription or social enterprise business models […] looking at alternative business models for service organisations could provide a rich seam of insight about how public services can grow and form themselves around the needs of users and citizens.

Service design demands that the unit of service is the person, and that service is devised in collaboration with them in order to fit around their everyday lives. Too often, the power of institutional norms and practices stands in the way of this approach, regardless of sector. Therefore the most likely places to grow capacity for the kinds of user-centred approaches service design advocates appear to be those 'in-between' spaces. It is in these spaces that small organisations are really beginning to define very different notions of service and value. The challenge for policy-makers in these terms is two-fold: first, to find innovative ways of investing in these spaces without legislating for everything that takes place within them; and second, to learn more about how the lessons learnt in these spaces can be 'scaled up' to a system-wide approach.

8 Appreciative Inquiry and Community Development

Two major examples of using AI in relation to developing mental health resources are:

1. In Santa Cruz, California http://appreciativeinquiry.case.edu/practice/organizationDetail.cfm?coid=7475&sector=22
2. and in Hampshire, UK, http://appreciativeinquiry.case.edu/practice/organizationDetail.cfm?coid=6037&sector=21

A major resource for community development congruent with an AI approach is the Asset-Based Community Development Institute (ABCD), established in 1995 by the Community Development Program at Northwestern University's Institute for Policy Research. ABCD is built upon three decades of community development research by John Kretzmann and John L. McKnight and spreads its findings on capacity-building community development in two ways: (1) through extensive and substantial interactions with community builders, and (2) by producing practical resources and tools for community builders to identify, nurture, and mobilize neighbourhood assets. (http://www.northwestern.edu/ipr/abcd.html)

The Tamarack Institute Learning Centre, established in 2003, is designed to create a fluid, creative system of documenting community building activity and delivering this learning to organizations. The centre has a threefold purpose: to broadly disseminate knowledge gathered through research and practical experience; to help communities increase their power through learning; and to generate knowledge about community engagement so as to advance the field. (http://tamarackcommunity.ca/g31.html)

A related Canadian resource is the "Rural and Small Town Programme" (http://www.mta.ca/rstp/pubmain.html)

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