Considine, Robyn 2020 Mental health and well-being in rural communities - factors associated with suicide, and integrated responses. *International Journal of Integrated Care, 21(S1)*:A75, pp. 1-8, DOI: doi.org/10.5334/ijic.ICIC20525

CONFERENCE ABSTRACT

Mental health and well-being in rural communities - factors associated with suicide, and integrated responses

ICIC20 Virtual Conference – September 2020

Robyn Considine[1,]

1: Centre For Rural And Remote Mental Health, Hamilton South, NSW Australia

Introduction

Despite similar prevalence of mental illness across Australia, suicide rates are 50% higher in rural and remote populations compared to capital cities. These data suggest the need for different strategies to prevent rural suicide.
In response to a geographic cluster of local suicides in three different communities in rural Australia, this paper examines the factors identified by community members as being associated with suicide. It also details the implementation of a wellbeing-focused collaborative response in one of these communities.

Theory/Methods

In each community, analysis of existing publicly-available health and social determinant data was analysed. In-depth interviews were conducted with key stakeholders and community members to identify their perceptions of factors in their communities (via thematic analysis). The combined objective and subjective data were fed back to each community via a report and community workshops wherein local responses were collaboratively developed.
In one community, a documentation review and follow-up interviews have been held to examine implementation of the local response two years in. A retrospective program logic model was developed to frame the implementation of the response.

Results

Existing community data demonstrated that socio-economic factors were relevant in each of the communities. In the initial stages of each response [n= 99 (Community 1), n=56 (Community 2), n=153 (Community 3)] stakeholders were interviewed. In community 1, 65 documents were reviewed and 36 stakeholders interviewed to examine the implementation of the response. Common across communities was acknowledgement of the contribution of socio-economic factors and lack of integration at service, organisation and system level in health services, across agencies and community groups. The implementation in Community 1 also suggested a community-led collaborative model, with multi-agency participation, for response in other rural areas.

Discussion

The findings highlight the need for locally relevant integrated responses to suicide in rural communities which address broad socio-economic factors. Building on local community assets is essential for community empowerment and for sustainability. This initiative could serve as a model for other communities to address suicide, self-harm and improve wellbeing on a whole-of-community and multi-agency scale.

Conclusions

Communities recognised that there are multiple factors associated with suicide, many of which are outside the remit of the health sector. They also demanded that responses are tailored, locally relevant and integrated across the community and across agencies.

Lessons learned

Data from communities at the local population level was necessary for action and planning in each of the communities. Supported and sustained by local leadership from community members and from agencies, this enabled the development of a shared vision in each community and provided a platform for targeted strategies.

Limitations

To date, implementation results are reliant on perceptions of stakeholders only in one community only. There is limited assessment of impact to date.

Suggestions for future research

More rigorous evaluations of community-based initiatives such as described have the potential to inform knowledge about suicide prevention. However, the tension between the needs of communities and the requirements of rigorous research design need to be considered.