Tabled: 17 May 2010

General Practice Network NT

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To: Senate Community Affairs Reference Committee

Submission to the Inquiry into Suicide in Australia

General Practice Network NT is pleased to be given the opportunity to contribute to the Inquiry into Suicide in the Northern Territory of Australia. General Practice Network NT provides a range of services that directly and indirectly contribute to suicide prevention within the Northern Territory.

This presentation draws on knowledge gained through the following program activities;

- Aboriginal Mental Health Worker Program
- Access to Allied Psychological Services
- Mental Health in Rural and Remote Areas (Central Australia, Katherine Region and East Arnhem Region)
- National Perinatal Depression Initiative.
- Regional Primary Health Services (Aboriginal Mental Health Worker Program)

A summary of recommendations, for further consideration, to reduce the level of suicide in the Northern Territory are as follows. The rationale or justification is contained in the body of the submission.

PROGRAMS AND SERVICES

1. Program duration needs to be appropriate and adequate for development implementation and sustainability.
2. A more flexible approach to ATAPS Mental Health Treatment Plans in Remote communities.
3. Care Coordination funding to support low income people at risk of self harm or suicide
4. Strategies to support mainstream GP services need to become more accessible and culturally sensitive to Aboriginal people and their needs.
5. Increasing services to remote communities such as a 'positive behaviour specialist'
6. Extending the *Mental Health in Rural and Remote Areas Program* to the Yuendumu, North Stuart Highway and Barkly areas
7. Increasing Forensic Mental Health services to clients in the Barkly region.

TRAINING

1. Development and delivery of appropriate training resources, utilising local networks and learning styles.
2. Development of an appropriate Aboriginal Mental Health Worker qualification that recognises and validates Traditional Healer skills.

3. Regular and mandatory orientation, cultural awareness and mental health First Aid training for all staff working in remote communities
4. Roll out of the Narrative Therapy approach to other remote communities in the Northern Territory

RESEARCH

1. Research to validate the non-clinical contribution to health and well-being eg. reducing stress, mediating disputes, and practical assistance.

ADDRESSING THE TERMS OF REFERENCE

PERSONAL AND SOCIAL COST ASSOCIATED WITH SUICIDES

- Suicide is high in Aboriginal communities in the Northern Territory Aboriginal communities, especially among young males. The Department of Health and Ageing *Fact Sheet No 3 on Statistics on Suicide in Australia* revealed that the number of Suicides in the Northern Territory in 2006 has been reported as 26 males and 3 females.
- In terms of rates per 100,000 people, the Northern Territory has the second highest rate in Australia at 13.0 per 100,000 people, behind Tasmania with a rate of 14.7 per 100,000 people.

Contributing factors are multi-faceted including:

- Lack of education;
- Family dysfunction associated with high levels of drinking, gambling and violence;
- Reactionary if unable to get access to money, drugs, cigarettes;
- Feelings of disconnectedness when community members are forced to leave their community.

Methods of Suicide is often by 'hanging' or jumping off power poles.

Impact of Suicide

- Payback,
- loss of fathers, brothers, sons, uncles, grandfathers
- loss of mentors and knowledge
- family left bereft and grieving
- copy cat suicides (attention seeking)

ACCURACY OF REPORTING – IMPEDIMENTS

- As noted in the Department of Health and Ageing Fact Sheet – *Statistics on Suicide in Australia*, the number of deaths classified as suicides are determined by the Coroner who is able determine, based on evidence, that a person died as a result of a deliberate act to cause his or her own death. If there is contrary evidence or insufficient evidence the coroner may not be able to reach a decision as to the cause of death.
- It is felt that in the Northern Territory, there may be a level of unreported suicides, but it is difficult to quantify. This assumption is based upon anecdotal information contained in reports such as the Yuta-Walnga 2009 report commissioned by Anglicare and through the information provided by staff working in the field.
- Aboriginal Mental Health Workers in Yirrkala reported that 'threats of suicide' were frequently used to intimidate family members during arguments or in attempt to obtain things. Such threats are not

always reported but they place a major strain on Aboriginal Mental Health Workers and families in not knowing whether the threat is real or not.

- In the Northern Territory many Aboriginal people do not speak English well or because of the 'shame' associated with such an event, are not able to describe the situation correctly which results in the death being described as 'accidental death' rather than suicide.

APPROPRIATE ROLE AND EFFECTIVENESS OF AGENCIES SUCH AS POLICE, EMERGENCY DEPARTMENTS LAW ENFORCEMENT AND GENERAL HEALTH SERVICES

- There are a limited number of agencies with a permanent presence in communities eg. police, GPs not always in each community however, where they are, there are good working relationships and approaches and they are often first to respond to an event.
- Where there are no Police, GPNNT Mental Health Workers often have to be the front line response.
- It is important to recognise that not all communities in the NT have equal access to staff working in a Mental Health Worker capacity in remote communities – distribution of support is not consistent.
- GPNNT provides mental health services to the following communities: Hermannsberg, Areyonga, Wallace Rockhole, Papunya, Mt Liebig, Haasts Bluff, Kintore, Yulara, Docker River, Mutitjulu, Imampa, Yirrkala, Borroloola, Groote Eylandt, Umbakumba, Angurugu, Katherine, Ngukurr, Minyerri, Beswick, Yarralin, Timber Creek, Pine Creek, Adelaide River, Batchelor, and the RFDS is now starting to service communities such as Santa Teresa, Ali Curung, Epenarra and Lake Nash. These services are provided via teams of community based Aboriginal Mental Health Worker staff supported by designated Mental Health Professionals who visit each community on a regular basis. (weekly and fortnightly)
- Visiting mental health specialists (e.g. Psychologists and Psychiatrists (MSOAP) play a key role in support of the clinics and AMHWs, particularly when medication and admission to hospital are considered necessary for diagnosable mental illness.

EFFECTIVENESS OF PUBLIC AWARENESS PROGRAMS

- Beyond Blue and headspace campaigns have generated public awareness.
- Governments incentives for GPs and Allied Health Professionals through programs such as ATAPS, MAHS (now Regional Primary Health Services and the Drought Initiative etc have facilitated access to Allied Health Professionals to a large number of community members but the impact has largely been contained in the urban settings rather than remote.
- Lifeline have become prominent through further advertising and are a good source of counselling. (The uptake of this service in remote communities has been particularly good as the service is available after hours and is confidential)
- GPNNT Mental Health staff distributes relevant education /resources/ information to other agency and community based staff in remote communities across the hubs.

EFFICACY OF SUICIDE PREVENTION TRAINING AND SUPPORT FOR FRONT LINE HEALTH AND COMMUNITY WORKERS

- Suicide Awareness workshops have been developed for remote communities however, they are expensive. This could be enhanced through more culturally appropriate suicide awareness material.
- Mental Health Skills Training (MHST) programs for GPs and practice staff has been provided each year. (Note In remote communities GPs are often not resident and have to deal with very acute health problems so MHST not always applicable).
- Face-to-face youth and suicide focused programs provided by GPNNT.

- GPNNT provides training in Mental Health to Aboriginal Health Workers, Aboriginal Mental Health Workers, other service providers, community leaders and community members.

Support for the Workers

- For Aboriginal Mental Health Workers working in remote communities it is extremely difficult when a suicide occurs. The workers know everyone in their community and are related to many. A successful suicide has a deep impact on these close knit communities, and on the workers, who may have also been closely involved in supporting them through mental illness or a crisis. They experience personal grief and loss, while at the same time are required to support the wellbeing and mental health of families directly affected, and dealing with the tension arising from potential payback arising from the death. This has contributed to AMHWs leaving the workforce at Borroloola, Katherine, Galiwinku and Yirrkala.
- Support is provided on a consistent basis from the GPNNT Aboriginal Mental Health Worker Manager and/or the qualified Mental Health Staff to work with the Aboriginal Mental Health staff to develop their skills and resilience.
- GPNNT developed the Collaborations for Life Resources which were designed to be used during consultation and incorporate risk assessment tools. It contains a referral guide, listing community and mental health services and provides clinicians and their patients with a wide range of referral pathways.
- GPNNT also have developed a Directory to Psychological Services and maintain our website with up-to-date information.
- The use of Narrative ways of working has strengthened wellbeing, optimism, connectedness, resilience, health and capacity in some of the individuals/communities who have been exposed to Collective Narrative Practice
- The GPNNT Young Minds Training provided Doctors and other health professionals with advanced training in treating depression and anxiety in young people.
- ASIST suicide prevention training has been delivered at several communities, and Aboriginal Mental Health Workers have advised that it increased their awareness and confidence to deal with threats and attempts. The spot light on suicide in Yirrkala after several deaths in one year also increased communication and cooperation between organisations, and the development of a mitigation program to try and reduce further deaths (Yuta – Walnga 2009, Anglicare).

Recommendations to Improve

- Training and awareness raising is however limited in its effectiveness, when those who train, and the material they use, are not adapted to remote Aboriginal contexts. 70% of remote Aboriginal people speak English as a second or third language, and this is consistently underestimated when engaging with this group (sharing the true stories 2005).
- Written resources and internet sites have very limited uptake for people residing in remote communities, so programs need to utilise local networks and key individuals to convey messages that are constructed in accoddance with their learning styles and world view.
- Material suitable for Aboriginal audiences in some of the southern States is often not suitable as it can assume higher levels of literacy and understanding of the issues by remote Aboriginals in the Northern Territory.
- An appropriate Aboriginal Mental Health Worker Training program is required to compliment the skills of the individual who is often selected by the community to provide the mental health support.
- Recognition of the importance concerning the community selection of the individual to assume the role of Aboriginal Mental Health Worker needs to be incorporated into current and proposed mental health programs. This is because the individual is recognised and respected by the community and often already has an important role as an 'Ngunkari' or Traditional Healer.

Numeracy and Literacy requirements to attain a Mental Health Worker qualification often prevent these key people from achieving the qualification as required by the Program.

- Flexible funding, - to 'broker' Cultural Consultants, or community solutions that are aimed at protecting and building resilience.
- Regular and mandatory orientation, cultural awareness and mental health First Aid training for all staff working in remote communities (High turnover of staff and the common complaint of overload/burnout means that effective training opportunities need to be continued).
- Roll out of the Narrative therapy approach to other remote communities in the Northern Territory. - Communities have heard about this approach which has been developed in Central Australia (Yia Marra) to community capacity building and have requested that their communities also have an opportunity to experience Collective Narrative Practice.
- Collective Narrative practice has increased the communities sense of agency as they have become more knowledgeable about their own skills, knowledge and abilities, which they can put to use in addressing the difficulties that they (and others) are experiencing.

ROLE OF TARGETED PROGRAMS TO ADDRESS HIGH RISK GROUPS

The Mental Health in Rural and Remote Areas Program has been in place since 2006/2007 and this has demonstrated a number of strengths. – reduction in the number of suicides through early intervention and prevention, better clinical management of people with mental illness, reduction in risk factors and promotion of positive protective factors (eg narrative therapy) for suicide and self harm.

- In Central Australia (NT), there have been two suicides in the cluster of 11 communities in the three years. These suicides were drug and alcohol related. The value of the targeted (Mental Health in Rural and Remote Areas) meant that there were no 'copy cat' events as had been the case in previous years.
- It takes a long time to implement things in remote communities, get staff and the trust of community people before you can even start working effectively
- GPNNT support initiatives that reduce risk factors and promote positive protective factors for suicide and self harm. Many of the barriers to service provision have been reduced or eliminated in the following ways: -
  1. Improved access as ATAPS services are free and waiting time short.
  2. Waiting lists have virtually been eliminated in the GPNNT Mental Health in Rural and Remote areas hubs.
  3. General Practitioners are better supported to care for mental health clients.
  4. There is increased knowledge in communities about how to access services and the process to get assistance has been simplified. Clients and Carers can self refer or be referred through other community members/services as well as through the Medical Officers at the local Health Clinics
  5. GPNNT Mental Health Services is seen as an integral part of each of the communities. Attention to building strong, respectful relationships enables stigma to be broken down and assistance to be sought when needed.
  6. Group work i.e. Men's Anger Management has broken down some of the barriers to men talking to each other about the issues which concern them. The educational aspect of these meetings has assisted many men to understand and take responsibilities for violent behavior. (such as a group of Hermannsburg men (30-60) continue to meet regularly to address anger

issues. While there is still a significant amount of violence in the community there is a determination by this group that violence is unacceptable and should cease.)

7. Improved communication and collaboration with the Department of Health and Families Acute Mental Health Service has resulted in rapid response to critical events
8. AMHWs try and anticipate periods of high risk for individual clients, and take whatever measures they can to see them through these periods. The range of community supported options for referral available to them are limited in remote communities, so they often deliver the support themselves e.g. the senior AMHW at Galiwinku often has clients staying at her house until they are through a difficult period

What could be improved?

- Program duration needs to be increased in order to achieve sustainable improvements. The short term nature of funded programs is problematic – it takes time to develop relationships and trust within the communities. There needs to be consistency in terms of personnel, clinical treatment and capacity building.
- A more flexible approach to ATAPS Mental Health Treatment Plans in Remote settings as there is often no resident GP in the community.
- Care Coordination funding to support low income people at risk of self harm or suicide to access GP's (the requirement for GP involvement in MHTP is often a barrier or deterrent as there are very few GP's who will bulk bill).
- Many mainstream GP services need to be more accessible and culturally sensitive to Aboriginal people and their needs.
- Strategies to increase confidence of people living in remote communities that their health information will be confidentially maintained and secure.
- Increasing services to remote communities such as positive behaviour specialist
- Many of the children in remote communities have disabilities and qualify for extra support through the education system. Quite a few of these children are disturbed and need extra support in the form of behavior management. These children frequently get sent home from school, therefore falling further behind in their education. A highly skilled positive behavior specialist is needed to help these children, their teachers and families. Without such help early these children will probably go on to develop more severe behavior and mental health problems. As a result their teachers and other student's mental health are often negatively impacted by their challenging behavior.
- Extending the Mental Health in Rural and Remote Areas Program to the Yuendumu, North Stuart Highway and Barkly areas would benefit by access to a primary mental health team for both adult and child and youth clients
- Increase Forensic Mental Health services to clients in the Barkly region. Currently they have very little if any follow up once they are released from prison. A program which continues the group/individual work started by the Psychologist in the prison is likely to decrease the alarming rates of recidivism in the Barkly area.

ADEQUACY OF PROGRAM RESEARCH INTO SUICIDE AND SUICIDE PREVENTUON AND HOW THIS INFORMATION IS DISSEMNINATED TO PRACTITIONERS AND INCORPORATED INTO POLICY

- The high prevalence disorders effecting Aboriginal communities are depression, anxiety, and substance abuse disorders. The most frequent presentations are not 'severe' mental illnesses, but psychological distress. It is also reported that at least 30% of suicide deaths are associated with no known mental illness at all.

- Further research should therefore be undertaken to validate the non clinical contribution to health and wellbeing e.g. reducing stress, mediating disputes, and practical assistance. Aboriginal Mental Health Workers, and Mental Health professionals who are working in remote communities on a regular basis, are at the forefront of such service delivery, where as medication or hospitalisation play a relatively small part of a client's treatment.
- Non clinical skills in wellbeing work need further recognition and incorporation into the scope of programs - this would facilitate the entry of more Aboriginal workers, who are better placed to work in their own communities than highly qualified expensive non Indigenous professionals that are often brought in instead.

EFFECTIVENESS OF NATIONAL SUICIDE PREVENTION STRATEGY.

- The aims and objectives of the Strategy are considered to be valid and worthwhile. The issues that are emerging from this however, are the short term nature of the programs. It is difficult to sustain the programs.
  An example of this is as follows;

  GPNNT was successful in obtaining funding under this program to develop a program at Nauiyu (Daly River), where 4 young people were employed full time to run youth programs aimed at:
  - building resilience in youth of the community as a whole
  - connecting youth to culture, land, history and community Elders
  - providing support for 'at risk' youth by peers and through improved access to professional help via fortnightly visit to community by youth psychologist, and emergency phone support

  Training was provided for young leaders in the community around suicide prevention and awareness programs, enabling them to provide 'on the ground' support to their peers.

  Unfortunately this program was not sustained once the pilot was completed despite a commitment for this to occur. This leads to significant disillusionment with a particularly vulnerable target group, which will make it difficult to re-engage in the future.

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