

Addressing Aboriginal mental health issues on the Tiwi Islands

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Objective: *This paper provides an overview of the services developed in response to the unique mental health needs of a remote Aboriginal community. We describe an evolving service on the Tiwi Islands in the Northern Territory and the challenges that need to be addressed if the community is to continue to take a leading role in dealing with mental health issues.*

Conclusions: *The Tiwi Mental Health Service demonstrates that community members are able to identify needs and respond accordingly if they are provided with the relevant information and supported in their decision-making process. The establishment of social governance mechanisms and the long-term commitment by a change agent to facilitate the empowerment process are important keys to success. The main challenge in establishing services in rural Aboriginal communities is to identify and support community strengths, including leaders and cultural practices.*

Key words: *Aboriginal mental health, empowerment, rural and remote psychiatry, Tiwi Islands.*

Mental illness in Aboriginal communities in Australia was thought to be relatively infrequent and similar to other Indigenous communities prior to contact with European culture.¹ However, in recent years, there appears to have been a significant increase in serious mental illness with hospital admissions rates for Aboriginal and Torres Strait Islander people double the Australian average.² A significant proportion of mental illness appears to be related to substance abuse and rates of admission to hospital of Aboriginal and Torres Strait Islander people for this problem are now over four times the Australian average.² The severity of Aboriginal mental illness is also demonstrated by the increasing suicide rates among Aboriginal people in the Northern Territory.³

The way in which these issues have been addressed is reflected in the way mental health services for Aboriginal people in the Northern Territory have evolved. In the early 1980s, mental health services were provided at the Royal Darwin Hospital with inpatient care and ongoing outpatient care. A psychiatric nurse was appointed to the Darwin-based rural health service to provide psychiatric care to communities in the Darwin rural area when the Northern Territory Mental Health Service was established in 1986. One such community was the Tiwi Islands.

With the commencement of the Coordinated Care Trial in 1998,⁴ responsibility for managing mental health services was transferred from the Darwin-based rural health team that visited the island communities to the Tiwi Health Board. A major reason for the establishment of the Board was to empower the community to manage health services on the islands. However, the Board was disbanded in 2003 due to financial pressures and the management of services reverted to the government health service. As of December 2005, the Tiwi Island Mental Health Service has comprised one psychiatric nurse and five Aboriginal mental health workers (AMHWs).

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THE TIWI MENTAL HEALTH SERVICE

The Tiwi Islands, with a population of 2400, are located 80 kilometres north of Darwin. The two islands, Bathurst and Melville, cover an area of 8400 square kilometres. Bathurst Island is 2600 square kilometres in area and Melville Island is Australia's second largest island with an area of 5800 square kilometres. The islands are the traditional home of the Australian Indigenous people, the Tiwi.⁵

In March 2002, the first author reviewed the caseload for one community on the Tiwi islands to establish baseline data about the nature of mental health problems on the islands. At that time, there were 91 active cases in a population of 1400 (6.5%). Of these, 17 had a recorded psychiatric diagnosis and 53 had a recorded psycho-social problem. In the 91 cases, 63 persons (69.2%) had a recorded episode of serious self-harm and 77 (84.6%) had a history of at least high levels of alcohol or marijuana use or both. In 2002, a review of mental health needs and services, involving key community members and health service providers, was undertaken to inform strategic planning by the Tiwi Health Board.

The 2002 review led to the establishment of core objectives for the Tiwi Mental Health Service that remain in place today. The objectives of the team are to respond to the mental health needs of the populace, to demystify mental disorder, to promote Aboriginal responses to mental ill health, to improve psychological and social wellbeing, to utilize community resources, to change attitudes and behaviors so risk factors are minimized and incidence and prevalence of disease and injury are reduced, and to create a mental health care network.

The mental health team provides basic assessment and support services for persons with a mental health problem. The AMHWs act as case managers. A system has been developed whereby family members can act as joint case managers. The AMHWs consult with, and take the advice from the family. The family member(s) also provide support to the individual in care. The involvement of local workers and family members providing care significantly improves the targeting and use of interactive intervention programs.

Mental health workers facilitate the active participation of individuals, families and the community in mental health and related issues, with an emphasis on the improvement of psychosocial wellbeing. As an example, AMHWs play a leading role in facilitating the monthly meetings of the Strong Men's and Strong Women's groups that act as social governance mechanisms. These meetings provide an opportunity for senior men and women to discuss key issues of concern, such as groups and individuals at risk of suicide, self harm, substance abuse and domestic violence, and explore ways in which community

members can intervene. Younger members of the community are encouraged to attend.

Initiatives that have been implemented to improve the mental health and psycho/social wellbeing of the Tiwi people include:

- case management for people with a mental health disorder;
- social care program for persons with a mental health problem who are assessed as at risk (e.g. buying clothes/food/chasing up pensions);
- prisoner support program, providing support to prisoners in prison and after release;
- court reports and support for those charged with an offence who have a mental health problem.

OUTCOMES

For the period 2002 to December 2005, the following outcomes have been achieved:

1. There had been an increasing trend in suicide numbers over time from two in 1999, and one in 2000 to six in 2001 and 10 in 2002. Following implementation of a suicide prevention program in 2002, the number of suicides on the Tiwi Islands fell to three in 2003.
2. Fifty-two people with a known psychiatric diagnosis were treated and supported in the community over the period – with support including case management, medication, counselling and support for basic services such as access to accommodation and meals (family assumes control of money which would otherwise be used for gambling, marijuana and alcohol).
3. Acute mental health problems were responded to by the community-based team 24 hours 7 days a week.
4. As a result of training programs, AMHWs workers are now able to deal with most problems in the community without the need to refer on to the psychiatric nurse or other healthcare professionals.
5. Mental health team clients are now supported in court with case histories and current mental health status assessment – a recommendation submitted by the mental health team resulted in the first home detention order in an Aboriginal community in the Northern Territory.
6. A mental health team workshop to improve inter-sectoral working relationships between different services increased collaboration between the Tiwi mental health team, Darwin inpatient psychiatric facility, police, health centre, correctional services, schools, youth group, aged care and Red Cross.

7. Tiwi Island police have attended training sessions on managing mental health clients who are at risk of offending.
8. Tiwi Island police refer families and domestic violence issues to the mental health team for counselling services.
9. Over a 12-month period in 2002/2003, 600 men, women and children (or 25% of the Tiwi Islands population) attended a Strong Men's or Strong Women's meeting in one the three population centres (Nguuu, Milikapiti and Pirlingimpi) on the Islands.

THE CHALLENGES

Psychosocial disruption

There are significant and long-standing mental health problems in Aboriginal communities around Australia. Recent literature addressing these issues highlights social issues and causes of psychological problems among Indigenous people.⁶⁻¹⁴ Prior to the arrival of Europeans, Tiwi society's rules and laws were clearly defined and understood. Elders played a key role in maintaining social harmony. After 1788, the establishment of a mission settlement and its subsequent demise, together with the increasing interface with Western society, with its different values and laws, has led to the disempowerment, social fragmentation and social disruption of the Tiwi people.

Addressing Indigenous mental health issues through empowerment

Since 1989, the impetus to develop a broad-based mental health service has come from the psychiatric nurse working with community elders and AMHWs. The Tiwi AMHWs are, in the main, senior community elders.

"In Western psychiatry credibility is demonstrated by 1) qualifications and 2) length of experience ... we need to recognize that such qualifications may be more likely to be meaningless signals in another culture ... especially Aboriginal culture, where elders have a high standing and they traditionally play a role in mental health, in working with distressed individuals in their communities. These people should be listened to."¹⁵

The objective has been to develop a service that meets the needs of the Tiwi population through the empowerment and support of the Tiwi AMHWs, to continue their interest and involvement in mental health service development and delivery. Empowering individuals provides them with the confidence to have input into the decision-making process. There were 25 applicants for the most recently advertised mental health worker position. Most were from senior community members who see working in the mental health service as enabling them to have some influence on the social and mental health wellbeing of their community. We suggest that employment as an AMHW is seen to give legitimacy, in terms of acceptance by Western

society, to senior members of the community to intervene in social issues – a role they say they had prior to Westernization.

The focus of the process has been to empower two key groups in the community. The first group is the senior community members, either those in formal positions such as council members or recognized traditional elders, who are kept up to date with mental health issues and corresponding service needs and development. The second group is the AMHWs. The AMHWs are provided with clinical support and supervision by the psychiatric nurse in the team, medical staff of the Tiwi Health Service and by visiting psychiatrists (the latter are accessible by telephone and occasionally visit the islands). AMHWs who live and work on the rural communities, need a support mechanism as the community consider that they are available on a '24/7' basis. In addition, their services often involve friends and relatives. Consequently, it was decided that no AMHW should be left to work alone. The AMHWs on Tiwi, together with the psychiatric nurses, have formed a strong supportive network. AMHWs also attend training courses provided by visiting health and social welfare professionals, in particular social welfare groups. A training program for AMHWs is provided by Batchelor College in the Northern Territory. This provides in-service training and support and AMHWs are encouraged and supported to present papers at conferences and workshops. Presenting papers on their own at such venues greatly enhances the confidence of AMHWs and further empowers them.

External environment

This bottom-up approach to service delivery has often placed the team in conflict with the more accepted models of mental health service delivery. The government mental health service, in the years of early development of the Tiwi service, sought to have services restricted to persons with a known psychiatric disorder. This was strongly resisted by the Tiwi people. They wanted the service to focus on the mental health wellbeing of the community, while at the same time providing care for individuals in their community setting. In this regard, Tiwi beliefs about 'mental health' are very much in line with the definition of health elucidated in the *Ways Forward* blueprint for Aboriginal and Torres Strait Islander mental health in Australia,¹⁶ as well as the recent *Social and Emotional Wellbeing Framework*.¹⁷

The Tiwi people did not want to put the focus on care of persons with a psychiatric disorder and in the process isolate them from the rest of the community. Because of the significant stigma associated with mental illness in the Tiwi community, and a subsequent reluctance for people with an emerging mental illness to seek treatment, it is important that the Tiwi AMHWs be seen as generalist mental health workers supporting the entire community rather than as

therapists for those specifically suffering from mental illness.

There is a high turnover of staff of the general health service on the Tiwi Islands. New staff often bring with them their own set of beliefs about how a mental health service should be provided. This often leads to disagreement between health service staff and the mental health team members as to what they do and why. Much time is spent training new staff in the approach taken by the Tiwi Mental Health Team.

Short-term project funding

Successfully empowering community members to have some control over how services are developed requires access to funding. While there is core government funding for the psychiatric nurse position, from December 2005 all other positions have been funded from eight different external funding sources, including government and non-government agencies, each with their own set of objectives. As the team has had to source its own funding, service objectives identified by the team often have to be adapted to meet the objectives of funding bodies. Furthermore, funding from these sources is mostly for short-term projects lasting from 1 to 3 years. Funding agencies often agree to provide funds to establish a program, but then expect that ongoing funding will be sourced elsewhere. This means that the team is under continuous stress with regard to job security and considerable time and effort is allocated to obtaining funding. The Tiwi are not alone in this regard and other services have noted that money allocated on a short-term basis for pilot programs has made it difficult to sustain any gains made.¹⁸

CONCLUSION

The Tiwi AMHWs and the community in general see AMHWs as taking a leading role in enhancing psychosocial development of individuals and the community. The AMHWs have a number of limitations and strengths which affect their ability to meet the expectations of the community. Limitations include the fact that, as members of the community, there are restrictions on issues where they can become involved for privacy and cultural reasons (including issues to do with gender, other family groups and even dealing with their own family members). There is also a difficulty in maintaining a positive relationship with the community, which is demonstrated by discussions of payback for not preventing a suicide. Strengths include established relations with key resource persons, such as the police and community elders. AMHWs have a good knowledge of community issues, they know where people are likely to be found at different times in the year, they know the case and personal history of individuals in the community and they understand the local cultural issues.

For many years, Tiwi people have relied on others to provide them with the answer to life's problems in relation to the provision of community resources and community governance. However, experience with the Tiwi Mental Health Service demonstrates that involvement of key community members in the development of a health service that responds to community needs over time can be achieved in rural Aboriginal communities. The Tiwi Mental Health Service, with its broad-based approach to the mental health wellbeing of individuals and the community in general, demonstrates that community members are able to identify needs and respond accordingly, if they are provided with the relevant information and supported in their decision-making process. The success of the Tiwi community is strongly influenced by the establishment of a social governance mechanism (Strong Men's and Strong Women's groups) that enables AMHWs to work with community leaders to identify and address key mental health and social issues. To some extent, the development of such social governance mechanisms within the Tiwi population is akin to mechanisms of enhanced cultural continuity that have been found to be protective of suicide among First Nations peoples in British Columbia.¹⁹ The key challenge is to identify and support community strengths including leaders and cultural practices. Showing people what to do is disempowering. Supporting people to identify problems and ways to address their concerns is empowering.

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