

Legislative Assembly of the Northern Territory

SELECT COMMITTEE ON YOUTH SUICIDES IN THE NT CALL FOR SUBMISSIONS

30th September 2011

A recent report on Young Australians, Their Health and Wellbeing 2011, produced by the Australian Institute of Health and Welfare reported that, young people aged 12-24 years of age make up just over 18% of the total population of Australia. Indigenous young people make up 3.7% of this total Australian youth population and Indigenous young people aged 12-14, make up 27% of the total Australian Indigenous population.

Of these around 9% of young people aged 12-24 in the general population experience high or very high levels of psychological distress and one in four experience at least one mental health disorder. Given this, and that Indigenous young people make up only 3.7% of the Australian youth population, it is alarming then to consider that 31% of Indigenous young people 12-24 experience high or very high levels of psychological distress.

Predictors of mental health issues and psychological distress can include: prenatal brain damage, genetic factors, low intelligence, physical and intellectual disability, poor social skills, low self esteem, being bullied, physical and psychological trauma including abuse and neglect, family violence and loss of family, stress associated with poverty, social disadvantage, homelessness, racism, substance use disorders, and parental mental health issues.

It is important to note that of all the states and territories in Australia, the Northern Territory has the youngest population, with 20% of persons aged between 12-14; this is without including children under 12 years of age. According to the Australian Bureau of statistics, 40% of the Central Australian population is under the age of 25.

The Northern Territory is also unique from other states with a higher proportion of Aboriginal and Torres Strait Islander population and significant amount of people who reside in remote or very remote locations. In Central Australia, 74% of the population is classified as living in remote areas and 24% in very remote areas. Indigenous people are 11 times more likely to be living in very remote regions. Indigenous persons are also more likely to have physical, substance use and sexual health problems, as well as having child protection involvement, be involved in crime, be victims of violence and live in overcrowded housing. They are also less likely to access health services due distance, transport, and cost, lack of education and cultural appropriateness of service provision.

So what do we know?

There are significant predictors of psychological distress and mental health issues, these have been outlined above. Unfortunately, people in the Northern Territory and specifically, Central Australia, due to its high youth and indigenous population base, likelihood of living remotely, and significant alcohol and poverty issues, have a

higher chance of being exposed to or involved with these risk factors. These risk factors can lead to mental health issues and psychological distress, which in turn is often be a precursor to self harm and suicide.

The Northern territory has a suicide rate that has been increasing substantially since the mid 1990's against national data trends. Data suggests that the rate for the Northern Territory is more than double the national average with remote and young urban Indigenous males being at higher risk. It is also estimated that suicide rates among Indigenous people are at least 40% higher than the national average.

In addition to the suicide rates, there appears to be an increasing trend towards threats and attempted suicides, also usually as a result of relational difficulties and impulsivity. There however, is no accurate data on this phenomenon in Central Australia, and there is yet to be any discussion about how these data could be captured accurately.

So the odds appear to be stack against the Northern territory and specifically, Indigenous people living in remote regions.

Proposals to access commonwealth funding programs

It would be useful to note, that often staff who are working in this area of Mental Health or suicide response in Central Australia, are often employed in services with minimal staffing levels and where it is difficult to recruit experienced clinical staff. As a result, clinical staff are often overwhelmed with the level of clinical work that they are faced with and rarely have the time to explore opportunities for, let alone compose complex proposals to access commonwealth funding.

Services for high risk groups

When we talk about services for high risk groups in Central Australia, there is a need to distinguish between visiting and on the ground services, particularly in remote communities beyond Alice Springs. Response to acute situations in remote communities is provided by on the ground clinic staff. Clinic staff usually have limited professional education or training around mental health and/or suicide.

Ideally, there is a need for mental health trained staff to be on the ground in communities to provide therapeutic and crisis intervention services. This however, is not overly realistic. Barriers to this include the inability to recruit and retain adequately skilled staff and logistically a severe shortage of housing in remote areas, to the point that visiting services are difficult to accommodate make this an unrealistic option at this point in time.

The response and policies of agencies such as police and health services

In terms of health services, response to suicide, self harm or serious mental health concerns in remote communities is limited. There is no capacity to provide ongoing counselling or therapeutic intervention to people who reside in remote communities. There is just far to greater distance to cover, and far too many communities to service with the limited number of staff allocated.

In an acute instance mental health cannot respond to communities, but can provide assessment once a client is evacuated into the Alice Springs Hospital emergency department. Often however, by the time a person is evacuated in to Alice Springs, the event that initiated the suicide attempt (with attempts often being the result of

impulsivity in relation to drugs, alcohol or relational dysfunction) is less pertinent and the person is likely to present without suicidal ideation and in shame for having attempted suicide in the first instance. On these occasions a person may be transferred back to the community following minimal follow up intervention in town. There is also often a significant time lag between return to the community and mental health review visits, due to an approximate 6-8 week turn around between visits to any one community, and the person may not even be present in the community when mental health arrive.

The adequacy and appropriateness of youth suicide prevention programs, including in schools

I cannot comment on suicide prevention programs in schools, however, am not aware of any if there are. I do know that of the large suicide prevention programs in Central Australia, they are primarily targeted at adults, with a focus around suicide and suicide prevention. Prevention programs, however, I think, need to be broader than suicide prevention; they need to be about wellbeing. They need to look at addressing the underlying factors that influence a person's probability of developing mental health concerns. Specific areas of concern in Central Australia that need improvement are housing, alcohol and other drug problems and the safety of children, including adequate responses from the child protection system. If we cannot develop mechanisms for intervening at the source of these issues we will continue to be providing a bandaid solution.

The accuracy of suicide reporting

The solutions are not simple nor are they going to be cheap. We need to acknowledge that even one suicide is always too many. What we are lacking the most is not complex models of intervention or suicide prevention strategies or public media campaigns, it is people. You cannot provide any type of successful primary universal whole population based service (education or prevention) or any secondary or tertiary services for people with mental health issues without skilled personnel. Even more so in Central Australia given the amount of physical space that needs to be covered in order to provide services.

The first step in responding to this need and identifying required staffing levels needs to be accurate data collection, specifically around suicide, suicide attempts, suicide threats and the primary factors that influence these rates. Without a baseline you cannot define what response is required, or establish whether any response that is initiated is effective. I do not have the answers about how we start collecting this data, but do think with the combined knowledge and passion of professionals in the Northern Territory that this is achievable if we work together.

Please note that these views are written from a private capacity and not on behalf of the Northern Territory Department of Health.

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