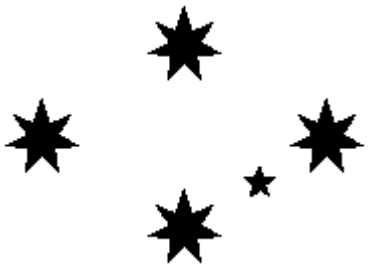
SOUTHERN CROSS CLINICAL PSYCHOLOGY SERVICES



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Presentation to Select Committee of Inquiry into Youth Suicides in the NT 31 JANUARY 2012

NEW INFORMATION – You will have heard a great deal about the issue of youth suicide. We hope to present new information that may provide useful directions for interventions with youth suicide that can result in real change. We will focus on our work in remote communities where we provide an on the ground, at the coal face service. Our presentation is drawn from this work. We also work with youth in Darwin in our private practice. Please feel free to stop us and ask questions at any time.

- BACKGROUND – Our training is in Clinical Psychology. We have Doctor of Psychology Degrees. We worked in Katherine in 2003/04 Ruth at Wurli Wirlinjang in community focused suicide prevention and John as a youth and Men's counsellor at Sunrise Health. We have worked extensively in these areas in Perth since the early 90's,

specifically, John in the Justice service with youth, and Ruth with youth suicide prevention and sexual assault and abuse. We started offering private clinical psychology services to Tiwi in 2008 with the support of Remote Health doctors. With this support and some interim Red Cross support we were able to expand from Milikapiti to include Nguiu, and now our colleague Fiona Leibrick, who is trialling visits to Pirlangimpi using bulk billing. Private psychology bulk billing services are not viable longterm. We are using bulk billing as it is an initial service trial. We are now funded through Specialist Outreach NT or SONT through NT Remote Health and are working towards getting psychology services to more communities. This is not permanent funding. We have requests for psychological services from many remote communities. We soon hope to commence offering services to Daly River and are exploring funding options. Fiona is also trialling visits to Goulburn Island and we hope to bring her under the SONT funding as soon as possible to provide a viable and ongoing service for this community. We have during 2011 also worked at Maningrida specifically with youth and families. There are few if any other clinical psychology services available to Top End communities on a regular fortnightly basis, as we are. Psychology services being provided to remote communities means people have access to mental helath services that are taken for granted in metropolitan areas. Having a psychology service in communities means medical staff can direct their attention to medical concerns and therefore it is a more efficient use of precious medical time. We believe a psychology service can be directly preventative when it comes to suicides of both youth and adult clients.

- OUR OWN EXPERIENCE – SOME ASPECTS OF SUICIDAL BEHAVIOUR in communities we have worked in –
    1. **FUNCTIONAL** - young people using threats of suicide to get what they want e.g. money for ganga, money, cigarettes, and to avoid doing things they do not want to do such as going to school. We do see young people threatening suicide in this way, with no intention to complete but because of the risk taking such as climbing electrical poles they may in fact die.

    2. **IMPULSIVE THREATS AND ATTEMPTS** - in response to stressors such as family conflict, jealousy, relationship break up, relationship difficulties. These attempts are without a doubt exacerbated by Ganga and alcohol use, by the use of internet social networking sites and texting, and by 'humbug'. Often these attempts indicate a severe lack of skills to deal with day to day difficulties in a way that is in line with the actual difficulty. We find such skill deficits also present in the adult population thus youth have few role models who are able to teach them how to deal with life stressors. What we commonly see is that responses to life stressors include such things as substance abuse, self harm and violence, which are all dysfunctional coping strategies. Youth see adults behaving in these ways and these are their role models and so we see youth behaving in these ways.
    3. **People who do not disclose** suicidality more publicly, (they will often disclose in a counselling session). These cases have long term issues e.g. abuse, trauma, domestic violence, previous exposure to suicide of people close to them. Some of the people who are suicidal that we see in this category have good coping skills and have simply become overwhelmed by life events in their community.

4. There are in every community we work in **several people who regularly threaten suicide** who take up a lot of clinic time particularly AHW/MHW time. These people are almost always substance abusers, often have a long-term history of trauma and abuse and have no professional support or coping strategies to deal with this. These people are difficult to treat in any setting. We do have success working with some of these people.

- **HOW RISK IS DEALT WITH**: We have found threats of suicide are often dealt with in a very casual way, this makes us very concerned; there is often a lack of appropriate follow-up available. There is a lack of services to deliver the follow-up that may be needed to ensure safety and decrease risk. We often find out about attempts sometimes weeks or months later. We are not seeking to blame anyone, services are simply overstretched, and staff are often moving from one crisis to the next.

- **LACK OF SUPPORT AND SUPERVISION FOR REMOTE STAFF**: From what we see, all remote staff, including aboriginal health workers/mental health workers deal with complex clinical cases without sufficient ongoing training or supervision. This is of great concern to us. We see staff dealing with completed and attempted suicides with very limited ongoing support and supervision. We constantly see cases where in other settings there would be a multi-disciplinary team response providing better treatment for patients and support for staff. In the end this puts pressure on the workers and can even result in them becoming suicidal themselves. Unlike other service providers in communities the aboriginal workers are usually related to families involved which results in a complex, stressful and often traumatic situation. Workers are often burnt out from previous experiences. We are aware of workers in the NT who have taken their lives due to such pressure.

- **RESPONSE:** There is a need for a prompt response if there is suicide risk– full investigation if a young person is suicidal to make sure that all the factors that have led to suicidality are known and so that the risk is effectively managed. We have many cases where this does not occur, and where families and communities live with young people at ongoing risk who do not get supported or are monitored. It is very common that we see people who report in session that either they are actively suicidal or that one of their family is currently or has been very recently. Every fortnightly visit this is the case.

- **HIGH RATES:** The high rates of people we see that are either currently suicidal and/or have made serious attempts on their life in the past, makes our work and everyone else's work in this area very difficult. One is forced to consider who to target when there is so much need, so many at risk, and ongoing triggers for suicidal ideation and acts.

- **SERVICES:** There is a need for quality clinical services that are focussed on the whole family/community rather than just at-risk youth. There are in fact many services that visit some communities, many government and NGO workers visit communities, but they are generally infrequent, short term, have high staff rotations, and there is little communication between service providers. We believe this is resulting in a great deal of wasted time and money and is not meeting the needs of the communities. Clearly with the rates of suicide we are seeing the current system even though there may be lots of services visiting it is not effective. We feel a review of the whole service model is required. Longer term coordinated intervention is required. – our focus is on creating a meaningful life – Lack of connection to positive

culture, substance use, lack of school attendance and lack of employment impact on having a meaningful life.

INTERVENTION: We work with young people who want to be back at school, who want to be in employment but there is from our experience no coherent over-arching system that facilitates school attendance or employment. There are many services, communicating with each other very poorly. This is not the fault of services themselves but rather the government funding models. For example we have young people who for over a year have wanted to get back to secondary school, there are multiple services funded to facilitate this and it does not happen in an effective or efficient way.

Many of these young people wander the community, engage in substance use, underage and unprotected sex, and crime and suffer all the associated consequences. These circumstances lead to situations of hopelessness and suicide can then become an option. There are no shortcuts to building meaningful lives for young people. However the factors that give young people meaning in their lives in communities are well known.

These factors are positive connection to culture, health, education employment, and community policing. Working with families and communities to facilitate these changes in a long term meaningful way is essential. We do see young people who with the right support make positive changes and create meaningful successful lives. E.g. one young person we worked with moved from lack of school attendance, crime and gambling to school attendance and developing a positive vision of her future, cessation of gambling and crime. When this happens others see this and are motivated to do the same.

ENGAGING: Most young people and families engage well with us, exceptions being significant intoxication at the time of session or ongoing substance abuse. In order to bring about change in young people's lives it has been essential for us to develop long term trusting relationships with young people and their families. Very little change can occur from short term contact or interventions.

MENTAL ILLNESS: There are suggestions that many youth who commit suicide have an undiagnosed mental illness. This is the case for some. However we feel it is far more useful to consider children and youth in the total context of their lives, we see that it is this context that pushes children and youth to suicide, not simply a mental illness that is within the child and separate from the environment where they live. The context of these children's lives may often includes family conflict, abuse, neglect, substance use and gambling by parents or carers, family trauma associated with others suiciding or loss of family through early death from violence or ill health.

In the face of these factors we have children who are often using substances themselves, are traumatised, not attending school. To refer to all this as mental illness undiagnosed misses the bigger picture, has the danger of over simplifying the situation and suggests there are easy solutions.

- **PSYCHOLOGY SERVICES**: The wider community has access to psychology through Medicare mental health care plans and a whole range of free services. In the mainstream, Psychologists are seen as part of the core services along with doctors and psychiatrists when dealing with suicidal youth. In Indigenous communities where there is a much higher suicide rate there are no similar psychology services. It has been very hard to get funding to provide psychology services, no programs to get psychologists into remote communities exist.

Combined with the lack of remote psychology services are the same issues that apply to doctors, nurses and any other professionals working in remote communities, sub standard accommodation, and so on.

- Thank you for the opportunity to speak and if it is useful we would be engage in further conversations at a later date.