Submission on Renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS)

Name	Leanne Bird
Organisation	Royal Australian College of General Practitioners
Email	Leanne.bird@racgp.org.au
Phone	(03) 8699 0313

Step 1: Establishing Indigenous control, governance and coordination of national and jurisdictional level suicide prevention activity relevant to Indigenous communities.

If there is a national mechanism for the implementation of the renewed NATSISPS, which organisations should be a part of it?

The Royal Australian College of General Practitioners (RACGP) supports the recommendations outlined in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)[1] regarding essential Aboriginal and Torres Strait Islander leadership of suicide prevention activities. As such, the college supports the inclusion of both NACCHS and Gayaa Dhuwi (Proud Spirit) Australia (GDPSA) (particularly the Australian Indigenous Doctors Association (AIDA) and Dr Mark Wenitong, who can provide primary care perspectives), in any coordinating mechanisms that are established.

As outlined further below, well-trained and culturally safe General practitioners (GP) play a central role in the management of physical and mental health needs of Aboriginal and Torres Strait Islander people. General practice bodies such as the RACGP and Australian College of Rural and Remote Medicine (ACCRM) have both Aboriginal and Torres Strait Islander members and members who provide mental health services to Aboriginal and Torres Strait Islander people via Aboriginal Medical Services or in mainstream practices. A GP representative/s from these member-based organisations may also be an appropriate to provide a clinical and coordination-of-care perspective.

Additional organisations for consideration include: Australian Indigenous Psychologists Association (as well as mainstream psychologist organisations), the Royal Australian and New Zealand College of Psychiatrists, the National Aboriginal and Torres Strait Islander Health Workers Association and alcohol and other drug agencies (both Aboriginal and Torres Strait Islander-led and mainstream).

Resourcing is one of the key determinants of good governance. Involvement in governance activities must be appropriately resourced and supported to ensure identified organisations are able to participate fully.

What do you think about specific national initiatives that are proposed to be coordinated nationally under Indigenous governance? What/who is missing?

The RACGP is broadly supportive of the initiatives outlined in the discussion paper and reiterates its support for the recommendations outlined in the ATSISPEP report '*Solutions that work: What the evidence and our people tell us'.*[1]

National Indigenous-specific Tele-mental health Services
The current evidence base points to the same level of effectiveness of telehealth mental health services conducted between a patient and their usual GP and face-to-face consultations in achieving improved health outcomes.[2] However, the broad benefits identified here are not necessarily translatable to the Aboriginal and Torres Strait Islander population – further investigation of the enablers and barriers for telehealth utilisation for this population cohort may enhance implementation of this initiative.

More broadly, Medicare-subsidised mental health related services must reflect the complexity of the service provided and should be commensurate with those for the assessment and treatment of physical health issues. Current government incentives for the provision of telehealth services need to be strengthened and supported to enable patients to access mental healthcare. This would also apply to any services implemented specifically for Aboriginal and Torres Strait Islander people.

Consideration should be given to how existing Medicare supports, such as mental health care plans can be tailored and improved to meets the needs of Aboriginal and Torres Strait Islander people.

Broader upstream considerations, especially in the policy context
The RACGP acknowledges that clinical care is one aspect of a whole-of-system approach that is needed to address suicide prevention and other health issues. National initiatives must also consider the social determinants of health, education and awareness raising. Though there are established policy frameworks to address social and cultural determinants, for example the Closing the Gap National Agreement and the National Aboriginal and Torres Strait Islander Health Plan Implementation Plan, it is unclear how this Strategy will intersect and influence their development, representing a potential missed opportunity for an integrated response.

Step 2: Establishing Indigenous control and governance at the regional level

If there is to be Indigenous governance of suicide prevention at the regional level, how could it best be supported? Which organisations or groups should be involved?

As per our position outlined above, leadership from NACCHS Affiliates in states and territories and Aboriginal and Torres Strait Islander service provider agencies is essential, with participation from mainstream service providers and consumers.

At the regional level, Aboriginal Community Controlled Health Services (ACCHs) and Primary Health networks (PHNs) have an important role in improving local planning and coordination and reducing fragmentation. As key funders of Aboriginal and Torres Strait Islander Health initiatives especially in mental health PHNs must foster inclusivity and undertake meaningful action to ensure Aboriginal and Torres Strait Islander leadership, to respond to community-identified need and gaps in service delivery. All PHNs must consistently apply the PHN and ACCHO Guiding Principles[3] to meet the commitment to work together to improve access to health services and improve health outcomes for Aboriginal and Torres Strait Islander people.

PHNs also have an important role in facilitating partnerships between the ACCHS sector and mainstream organisations. Although it is not directly addressed in the discussion paper, the RACGP is cautious about the competitive tendering approach to commissioning health services adopted by PHNs. It has been shown to favour tender allocation to organisations that are not Aboriginal and Torres Strait Islander-led. Stronger alignment of mainstream organisations with ACCHSs or other Aboriginal service providers must be supported to ensure culturally safe healthcare, accessibility and organisational capacity building.

Step 3: Establishing Indigenous control and governance at the community level

How can Indigenous governance of suicide prevention activity be best supported at the community level?

The ATSISPEP report identified community-wide suicide prevention strategies that are effective in Aboriginal and Torres Strait Islander communities. Crucial for success is that programs are led by those communities and consumers affected and address the problems they identify. Community empowerment, including local Elders and a cultural framework, are also components of successful programs. Health professionals are also often influential locally in the development of programs and policies, and so have an opportunity to advocate effectively that local Aboriginal and Torres Strait Islander community leadership is crucial for success in any suicide prevention program. Local service delivery must be available; but again, this must be led by the community.[4]

Step 4: Identifying program elements to be considered for integrated approaches to Indigenous suicide prevention at the community level.

Referring to the potential program elements mentioned in the Discussion Paper. What else is important in suicide prevention?

Overall the paper presents a comprehensive approach to suicide prevention. However, it could be strengthened though greater emphasis of the role of primary care in mental healthcare and suicide prevention. As GPs and practice teams are often the first point of contact for patients experiencing a mental illness, they are the most common providers of mental health services. They provide expert mental health care, and help patients manage any co-existing physical health problems. Existing relationships between patients and practice staff can facilitate early intervention for emerging symptoms, assessment of suicide risk, and effective monitoring of chronic mental illness. Patients with mental health related issues often experience multi-morbidity that generalists are best suited to

address effectively and sustainably. Therefore, it is essential that they have the necessary skills and knowledge to address patients' mental health needs.

There is a growing awareness of the value of trauma-informed care and services.[5] [6] Promoting a culturally competent primary care workforce with training in trauma-informed care, risk identification and which is supported to holistically meet their needs is important. This can include preventive and treatment programs and urgent access programs for suicidality; and trauma and alcohol and other programs. Some of the most effective interventions at reducing suicide death include GP capacity building, psychosocial support, and gatekeeper training of specific key people in a community, including GPs, nurses and Aboriginal and Torres Strait Islander health practitioners.[1, 7] The NACCHS/RACGP National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people outlines evidence-based clinical advice regarding the efficacy of interventions and population-level activities in relation to suicide prevention in primary care settings.[8]

There are significant gaps in training, access and funding that must be addressed. Workforce growth is a critical issue with additional need for Aboriginal and Torres Strait Islander psychiatrists and GPs, psychologists, mental health nurses and alcohol and other drug workers. The development of the National Aboriginal and Torres Strait Islander Health Workforce Plan may be an opportunity to explore how these shortages can be addressed.

Adequate funding for services is a critical component of effective program delivery. As outlined in the RACGP's position statement, 'Support for increased investment in Aboriginal Community Controlled Health Organisations' funding for the ACCHS sector is required to ensure the consistent delivery of high quality clinical and cultural health services. It isn't entirely clear how this Strategy will ensure long-term, sufficient funding for service deliver.

Step 5: Identifying vulnerable groups within the Indigenous population challenged by suicide for selective prevention activity within an integrated approach.

Referring to the groups mentioned in the Discussion Paper: Is there any other groups that should be included?

The RACGP agrees with the groups listed and suggests the below additions for consideration:

- Aboriginal and Torres Strait Islander peoples in the justice system and custodial settings
- Victims of online abuse and digital bullying
- People with chronic mental illness (schizophrenia) and who are experiencing housing vulnerability or homelessness.

Step 6: Developing and implementing integrated service models for mental health and those at risk of suicide / after a suicide attempt/ postvention within an overall integrated approach.

How can ACCHSs and other relevant services work together better? Who else needs to be considered?

The accessibility of general practice and its focus on comprehensive care that encompasses both mental and physical health means it is an ideal site for activities likely to be implemented through this Strategy. One way to keep the needs of patients central and facilitate an integrated approach is to keep GPs as the coordinators of care and stewards of any referral process. Patients must be supported to access a range of services from their practice or health service, reducing the need to visit multiple locations for the same issues and health concerns.

General practice also bridges the gap between the community and institutions such as hospitals, mental health outpatient services, drug and alcohol rehabilitation facilities, and prisons. Unlike many other public and private health care settings, general practice does not draw a distinction between mind and body systems. Assessment and treatment of mental illness is informed by a holistic, whole-of-person approach.[9,10]

Clear communication between government and services at all levels of mental healthcare is crucial. It is important that already-existing, effective networks are recognised and used. As outlined earlier, ACCHSs and mainstream/other service providers should seek partnerships to build reciprocal cultural and service capacity. Both sectors have important roles to play, however respect for Aboriginal and Torres Strait Islander leadership must be retained with mainstream services integrating with ACCHSs as the preferred providers.

Consideration for a 'no wrong door policy' across the healthcare system to support patients could support greater integration. The health system is already complex enough and patients must be supported to access appropriate care no matter what they enter the system.

Step 7: Ensuring the cultural safety of mainstream services.

How can we make mainstream services more culturally safe? How can we rapidly increase Indigenous employment across mainstream mental health and suicide prevention services?

It is crucial that all primary care services are accessible, affordable and are culturally safe to maximise the likelihood of attendance for those at risk. The issue of suicide in Aboriginal and Torres Strait Islander communities requires health services and health professionals to understand the ongoing effects of colonisation, exclusion and disadvantage, and their health consequences. This can be difficult for non-Indigenous health professionals to put into practice, which consequently may not meet community expectations.[11, 12] This underscores the importance of health practitioners working closely with ACCHSs and other Aboriginal and Torres Strait Islander service providers (eg. social and emotional wellbeing teams) and privileging their knowledge and experience.

The RACGP considers a broader range of skills and capabilities are needed to deliver culturally responsive healthcare, for example, engagement with local communities, employment of Aboriginal and Torres Strait Islander people and non-discriminatory governance structures. In the context of the GP-patient relationship, it relates to establishing relationships and building trust over time, so that during crisis patients will seek help from their GP. Strategies for the development of culturally informed services can include:

- specific investment in developing relationships between providers and patient/family/community to establish trust and engagement
- service design that combines cultural and community knowledge, values and practice with technical/clinical evidence-based components
- strong presence of Aboriginal and Torres Strait Islander peoples in design and, whenever possible, delivery of services
- family-centered, strengths-based, flexible approaches, including outreach and home-visiting models of service design
- services that take into account the complexity of social factors that impact on health and health service access, such as housing, legal issues, employment, income, health literacy and food security.

Having access to appropriate clinical and cultural training is important. With regards to cultural knowledge, practitioners should not be limited to training, as this has shown to be insufficient in ensuring a culturally safe environment. [13,14] The RACGP recommends that all practice staff attend at least cultural awareness training, preferably cultural safety training, and that this is done each triennium.[15] This will lead to benefits for all patients, as the overall quality of healthcare delivered is enhanced.

Two core RACGP objectives of the RACGP are to ensure that GPs and practice teams are equipped to deliver high quality, culturally responsive, patient-centred healthcare; and to support the growth of the Aboriginal and Torres Strait Islander GP workforce.

Supporting practices in their employment and cultural safety requires a systems-based approach. In terms of training and education, the RACGP has mandated training modules and assessment on Aboriginal and Torres Strait Islander health as part of GP training programs. The RACGP has set standards for cultural awareness training to complement access to the Practice Incentive Program Indigenous Health Incentive access and delivery of the training module. The RACGP Standards for general practices mandate asking all patients the identification question. Although this in itself does not guarantee culturally safe care, it can change the conversation between patient and GP, which encourages patient-centred, culturally responsive care.

Increases in Aboriginal and Torres Strait Islander employment in mainstream settings is predicated upon a more culturally safe environment. Encouraging employment across all practice roles is a critical step to ensuring all aspects of service delivery at the practice are culturally safe.

Any other comments?

Currently, the issues outlined in the discussion paper are fairly high level, with many important concepts relatively undefined. Although it is important strategic documents are not proscriptive, this does need to be balanced with a risk that loosely defined (or undefined) concepts can result in a strategic document that is nominally well implemented, but not necessarily aligned with evidence.

The RACGP is a member of the General Practice Mental Health Standards Collaboration (GPMHSC), which is responsible for establishing standards of education and training to increase GPs' skills and knowledge in detecting, diagnosing and managing mental illnesses within the context of general practice. See for example: Mental health training standards 2020 – 22: A guide for general practitioners. The GPMHSC have developed a number of templates, resources and guides aimed to provide GPs with the tools and knowledge needed to assist in the management of mental health issues. Although these resources may not be well suited to the specific needs of Aboriginal and Torres Strait Islander communities, they provide a framework for educating and training primary care health professionals.

References

[1] Dudgeon P, Milroy J, Calma T, et al. Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. Canberra: Department of Prime Minister and Cabinet, 2016.
[2] Langarizadeh M, Tabatabaei MS, Tavakol K, Naghipour M, Rostami A, Moghbeli F. Telemental health care, an effective alternative to conventional mental care: A systematic review. Acta Inform Med 2017;25(4):240–46.
[3] PHN and Aboriginal Community Controlled Health Organisations (ACCHSs) - Guiding Principles. 2015. Available at: Australian Government Department of Health website to view the publication 'Primary Health Networks and ACCHS – Guiding Principles
4 Dudgeon P, Milroy J, Calma T, et al. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP): Suicide prevention in Indigenous communities. Literature review. Available at www.atsispep.sis.uwa.edu.au/resources
[5] Quadara A. Implementing trauma-informed systems of care in health settings: The WITH study. Sydney: Australia's National Research Organisation for Women's Safety, 2015.
[6] Wall L, Higgins DJ, Hunter C. Trauma-informed care in child/ family welfare services. Melbourne: Australian Institute of Family Studies, 2016.
[7] Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: A systematic review. JAMA 2005;294(16):2064–74
[8] National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners. National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people: Evidence base. 3rd edn. East Melbourne, Vic: RACGP, 2018.
[9] Lynch JM, Askew DA, Mitchell GK, Hegarty KL. Beyond symptoms: Defining primary care mental health clinical assessment priorities, content and process. Social Science & Medicine 2012;74(2):143-9.
[10] World Health Organization. Investing in mental health: Evidence for action. Geneva: WHO Press; 2013
[11] Isaacs AN, Pyett P, Oakley-Browne MA, Gruis H, Waples-Crowe P. Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: Seeking a way forward. Int J Ment Health Nurs 2010;19(2):75–82.
[12] Sveticic J, Milner A, De Leo D. Contacts with mental health services before suicide: A comparison of Indigenous with non-Indigenous Australians. Gen Hosp Psychiatry 2012;34(2):185–91.
[13] Durey A. 2010. Reducing racism in Aboriginal health care in Australia: where does cultural education fit? Australian and New Zealand Journal of Public Health. Jul;34 Suppl 1:S87-S92.
[14] McDermott, D. 2012. Can we educate out of racism? Med J Aust; 2012. 197(1):15. doi:10.5694/mja12.10936
[15] RACGP. 2010. Cultural awareness education and cultural safety training. Accessed 10 May 2019, from: https://www.racgp.org.au/download/Documents/AHU/NFATSIH-Cultural-awareness-and-safetytraining.PDF