Attachment 1

Traumatic Loss

Text of a letter to Federal Minister for Health, The Hon. Tony Abbott*, in response to the announcement that the Community Mental Health Service covering Leeton and Narrandera would be without Mental Health Case Managers from 12th May 2005 due to a staff shortage. It was advised that the ACCESSLINE would continue to provide a 24-hour Mental Health Service for triage and risk assessment. It was suggested that if clients require frequent monitoring, such as risk assessments, that could be negotiated with the Accessline. Accessline would be responsible for monitoring and documentation, and responding to information requests. It was mentioned that relief staff were being sought for the CHS, and that details would be made available "when arrangements are finalised".*

Dear Minister,

I write to you concerning what I consider to be a serious concern with respect to an important mental health issue in our community. I consider that the care offered to those affected by traumatic loss in our community is inadequate and, as a result, may have lasting detrimental affects. I live in a country town, Wagga Wagga, and am employed as a Probation and Parole Officer by the Department of Corrective Services. However, the bulk of my caseload involves working with offenders from the Narrandera district. Consequently, my client base is of persons from a rural or a country environment. Two weeks ago, I received a faxed memorandum from the local Area Health Service (copy enclosed) notifying that there will be no Community Mental Health staff members available to cover Narrandera. No advertisements have yet been placed, and consequently no specific professional mental health expertise other than by means of telephoned or written referral to distant towns is available.

Researchers including Raphael & Wooding, 2004; Solomon, 1998; Strobe et al. 2001; Raphael, 1999; Robinson, 1999; Middleton, 1998: and Green, 2000; define traumatic loss as one that occurs as a result of a loss or death that was sudden, violent or unexpected. Traumatic loss is a common phenomenon in society today, and is frequently undiagnosed, until it manifests in what are later seen to be "problem behaviours". Some particular issues, which might bring it about in this 21st century, could be –

- The loss of a farm / business / home as a result of drought or downturn.
- The untimely death of a child.
- Terrorism – perhaps the 9/11 disaster.
- Mass violence – such as at Port Arthur.
- Homicide.
- The death of a loved one whose body is identified as disfigured or mutilated, e.g. post-Bali.
- A death resulting from extreme malevolence, e.g. rape.

- Death resultant from child abuse.
- Suicide.
- Joint murder-suicide or, correspondingly, an unsuccessful suicide pact.
- Death resultant from torture or from political imprisonment, e.g. war.
- Death as a result of a physical disturbance, e.g. the Boxing Day tsunami.
- Numerous scenarios within the Aboriginal and Torres Strait communities in which interrelated issues of historical violence have impacted on subsequent individual, family and community dysfunction.

Persons who suffer from traumatic loss, and those close to them, might not recognise this condition as such. One group whose symptoms might not be immediately recognised are those suffering from Post Traumatic Stress Disorder (PTSD). Matsakis (1994) details the "psychic numbing" of thoughts and feelings that are associated with the event. This self-protective measure is thereby a common coping strategy. Again, Matsakis (1994) cautions us that the symptoms may lie dormant until triggered, years – or even decades – later, resulting in "delayed onset PTSD".

Anecdotal evidence would suggest that the rural community in which I work is beset by another traumatic loss which goes unrecognised – that of the traumatic loss suffered by those in farming communities who, for the past five years, have been losing money because of the insidious drought bringing five years of lowered, then diminishing and, for many, now negative income. Five years of selling off stock, with no hope of re-stocking; of sowing with little hope of a crop; of paying for drenches, shearing, crutching and hand feeding of sheep whose starvation rations affect the ensuing staple of the wool so that the end return for the clip would be a loss. Finally, lower return for products means that rural people are not in a position to travel for health and mental health services. This lower use of services is nominated by Hickey (2004) to be a contributing factor to high suicide rates in rural and outback areas. Professor Raphael (2000) has outlined a population-based model for mental health, incorporating the comprehensive range of community treatment services extending beyond the public hospital model, which incorporates service integration that would be enhanced by intersectoral collaboration. The Groom et al. report (2002) also outlined a need for systematic reform of intersectoral collaboration.

Following the suicide of a family member, the mental health of the surviving family, often when worn down by the strain of economic hardship, isolation, and possibly the stigma of the suicide (Groom et al. 2003), becomes exacerbated, adding to their own personal despair and hopelessness, so that the downward spiral of traumatic loss is intensified, as is outlined in the National Rural Health Alliance 2001 position paper. This also aligns with the concept that there are interactions between the diminishing social networks of a community (its social capital) and its declining mental health, Cullen and Whiteford (2002). In districts where the traditional family farms are being lost, the labouring jobs are disappearing, high levels of unemployment and/or low incomes and

limited education are present, so that the risk factors in the wider community for traumatic loss are escalating (Malone, 2005).

Another area of traumatic loss that appears to have been documented but largely ignored is that of indigenous traumatic loss. Numerous writers have alerted us to the increasing mental ill health of indigenous peoples whose acculturation stresses – brought about by the Eurocentric models of education, housing, employment, law and medical treatment (to name a few) are exacerbated by the "habituated practice" (James and Clarke, 1994) of the government policy of the day. Thus the hardiness and resilience as referred to by Masten, Best and Garmezy, (1990) of the individual clients – and, by inference, of their families and their communities – is compromised according to the well being/effective functioning of the communal environment.

Coralie Ober, et al. (2000) also reminds us that the collective traumatisation of Aboriginal communities today is reflected in spiraling social and emotional ill-health in Aboriginal or Torres Strait Islander communities which are in crisis, with poor mental health, high mortality and morbidity, suicide, substance abuse and disease, education with poor retention rates, with disproportionate incarceration and juvenile arrests, minimal employment, and limited housing ownership rates; each of which reflects the spiraling social and emotional ill-health and traumatic loss in Aboriginal and/or Torres Strait Island communities. She and her colleagues advise that unless an holistic framework is adopted – taking into account the aftermath of colonization and enduring disadvantage – government reluctance to accept responsibility for past iniquitous policies can only be addressed by interventions aimed at restoring an integrated sense of self, family and community. Another notable advocate, Atkinson (1997), in discussing an appropriate indigenous approach to transgenerational trauma, and resultant traumatic loss, explores the interrelated issues and advocates indigenous therapies, healing techniques and trauma recovery techniques as integral to indigenous mental health practice. At the 8th National Rural Health Conference in Alice Springs in March 2005, various papers were presented by indigenous health workers. Each outlined the need for indigenous mental health care to be culturally appropriate – Mulholland et al. 2005, Bartik and Dixon 2005, and Bailey, 2005, in particular. Another source concerning holistic indigenous mental health care of traumatic loss is that paper compiled by the Sheldon Remote Mental Health team entitled "Leave only Footprints", based on a philosophy committed to the sustainability of Aboriginal culture.

The present care of those affected by traumatic loss

In rural and remote Australia, the standard of care offered to communities and/or individuals who seek assistance in dealing with traumatic loss varies, but there is little doubt that it is generally difficult to access and most frequently inadequately resourced. In my own nominated district of work, the provision of a non-residential service for public mental health is now non-existent. For persons of independent income, there is always the option of accessing psychologists and psychiatrists and the staff of private hospitals in the capital cities, whose excellent care is available,

once the initial appointment has been made available. But, according to an "Analysis of Current Health Issues Paper for Rural and Remote Australia, 2000", it is documented that country Australians have poorer access to health services than their urban counterparts. This is despite having documented higher levels of exposure to health risk factors, as outlined in "Australia's Health 2004". Professor I. Hickie, (2004), suggests that the lesser access to services, rather than higher rates of mental disorder, are a contributing factor to the disproportionate rate of suicides in remote and rural Australia, once again attributed to traumatic loss.

Nevertheless, discussion with rural community health worker colleagues has raised the following points which detail some perspectives, not only of the present situation, in terms of dealing with traumatic loss and other mental health issues, but also of how it could be improved.

1. Staff in country areas frequently feel under-valued, under-resourced and lacking in the intersectoral opportunities to learn from professional leaders, most of whom work in city environments. Attendance at seminars and conferences is personally more costly, and involves not only traveling, but leaving their workplace unattended (see Commonwealth Department of Health and Ageing, 2003, "Evaluation of Strategies to Support the Rural Specialist Workforce"). It is also unremarked that no practicing psychiatrist is resident in the south or west of NSW. Apart from the cities of Newcastle, Sydney and Wollongong, the needs of rural patients are largely unmet, unless by visiting psychiatrists who fly in monthly, and have little sense of community – which, in the bush, is crucial. It is also suggested that a multi-disciplinary workforce be recruited – both indigenous and non-indigenous nurses, generalist health workers, counselors, mental health workers, substance abuse counselors, and psychologists – with substantial taxation and other incentives to work and live in rural Australia. These recommendations were also part of the NRHA Inc recommendations in its submission to the Senate Select Committee on Mental Health in May 2005.

   Further, until initiatives to retain the existing community health and mental health workers are developed and maintained, natural attrition will see that the position which has developed in my workplace in Narrandera – with one worker deceased, one on a year's sabbatical and another transferred because of "burn-out" (Kahill, 1988) – will be repeated.

2. Frequently, the only delivery of service (*if* a patient is assessed as suitable) is available at the local hospital. This, in practice, equates with crisis care – short-term with little or no follow-up, or recovery-based rehabilitation. Thus the patient is discharged to his/her carer, with little or no prospect of rehabilitation, mutual support, employment assistance or other options.

3. The support offered by carers because it is in the main, voluntary, is underestimated. Explicit and practical properly funded support is required which involves individual stress management counseling, when appropriate for carers, with involvement in treatment plans, if appropriate, with routine use of family therapy as necessary. This can help all involved to deal with the burden of additional worry and if present, stigma and greater visibility in the community. The National Rural Health Alliance 2005 draws particular attention to the plight of carers, frequently undervalued and certainly under-resourced.

4. Further public education to strengthen the social capital of the community as a whole, (Cullen and Whiteford, 2002) will strengthen stress resistance, and improve the ability of that community to cope with traumatic losses when incidents occur. Financial assistance for self-help support groups and or volunteer organizations – whose worth was recognised by both Tully (2001) and Tedeschi and Calhoun (1993) – is also sought. These groups enhance sound mental health practice for all concerned. However, they require further commitment to funding from the Federal Government.

5. That the Australian Government aught to prioritise ongoing funding to support practical quantitative and qualitative research into population-based approaches, as nominated by Raphael (2000) for mental health in rural and remote Australian communities is promoted by the NRHA Inc 2005.

6. That culturally appropriate mental health programs be developed and devised, utilizing indigenous practitioners and practices. In order to do this, a national indigenous mental health policy needs to be implemented, as a matter of urgency.

Mr. Minister, the time is past for pilot schemes, inquiries, reports and reviews. The statistics are to hand. SANE (2002) reports that 62% of Australians with a diagnosed mental disorder are not receiving treatment. Too many of these are suffering traumatic loss, the basis of further problems. How many offenders are in gaol because of the interrelationship between earlier traumatic loss and subsequent dysfunctional behaviour? How many in refugee camps develop mental ill-health as a result of the traumatic losses associated first with the treatment in the homeland, but later exacerbated by the protocols and treatment authorised by the current Australian Government policies after they arrive in Australia? How many rural families are suffering disenfranchised traumatic loss and shame over the suicide of a member whose own traumatic loss of farm/income/financial security was too much to cope with? How many indigenous families are enmeshed in a cycle of depression and traumatic loss? The time to make change is now – change which will be positive, practical and permanent.

Mr. Minister, my colleagues and I are coalface workers. We are not specialists, not politicians, not particularly important people. But every

working day we are faced with the collective human misery resultant from traumatic loss. Every working day we must apologise to clients that we are not able to provide or even suggest a better service. We hope that by writing this letter, you might be moved to further consider our perspective. We are prepared to travel to Canberra at your convenience to discuss the details of this issue with you, at a time to suit your convenience. We hope to hear from you at the earliest.

Yours faithfully,

Margaret Garraway
(Probation and Parole Officer
Wagga Wagga District Office, NSW)

3.6.05