



LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY
11th Assembly
Select Committee on Youth Suicides in the NT

Public Hearing Transcript
10.30 am, Friday, 4 November 2011
Litchfield Room, Parliament House, Darwin

Members: Ms Marion Scrymgour, MLA Chair, Member for Arafura
Mr Michael Gunner, MLA, Member for Fannie Bay
Ms Lynne Walker, MLA, Member for Nhulunbuy
Ms Kezia Purick, MLA, Member for Goyder
Mr Peter Styles, MLA, Member for Sanderson

Witnesses: DEPARTMENT OF HEALTH
Dr Robert Parker, Associate Professor
Bronwyn Hendry, Director Mental Health

NT POLICE
Commissioner John McRoberts

DEPARTMENT OF EDUCATION
Paul Nyhuis, General Manager, Student Services
Eva Nicholls, Manager of Mental Health and Child Protection, Student Services

**Department of Health
Dr Robert Parker; and Ms Bronwyn Hendry**

Madam CHAIR: On behalf of the select committee, I welcome you to this public hearing into the current and emerging issues of youth suicide in the Northern Territory. I welcome to the table to give evidence to the committee Dr Rob Parker and Ms Bronwyn Hendry. Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee and look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligations not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearings you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private. I will ask each of you to state your name for the record and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding to the committee's questions. Can you please state your name and the capacity in which you are appearing?

Dr PARKER: I am Associate Professor Robert Parker. I am currently the Director of Psychiatry for Top End Mental Health Services. I am here, I suppose, in a bit of a mixed capacity. I was actually approached by the committee to put a submission in, which I did, I suspect, in a private capacity. However, I used my DOP, Director of Psychiatry, title in doing that. So it has been attached to the department submission as well. I am very much in agreement with the Director of Mental Health. I do not think anything I am going to say is going to conflict with anything she is going to say. I suppose I am here both in a private capacity and also as a member of the department.

Ms HENDRY: Bronwyn Hendry. I am the Director of Mental Health and I am here representing the Department of Health.

Madam CHAIR: Thank you. I will just get individual members of the committee to introduce themselves, then I will invite you to make an opening statement.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy.

Ms PURICK: Kezia Purick, member for Goyder.

Mr STYLES: Peter Styles, member for Sanderson.

Madam CHAIR: My name is Marion Scrymgour, member for Arafura. If you would like to make an opening statement.

Ms HENDRY: First of all I thank the committee for inviting us to appear at the hearings today. The Department of Health has provided a comprehensive submission to the committee, so I will make my opening statement brief.

Suicide is a tragedy that affects us all on a personal and a societal level. I would like to restate the Department of Health's absolute commitment to reducing the rate of suicide in the Northern Territory and to the provision of, and development of, appropriate programs and support for individuals, families, and communities at risk of suicide, and those bereaved by suicide across the Territory.

Second, I emphasise the efforts made by the NT and Commonwealth governments, non-government organisations, individuals, and communities over the last 10 years in seeking to address our high rate of suicide, and in creating and providing innovative programs to combat and reduce suicide attempts. Much of this work goes unseen, and I am sure many committed individuals and organisations will welcome the opportunity to show their work to the committee.

The amount of service provision in this area has grown exponentially over this time, and I am sure this has made a significant contribution to keeping the suicide rate in the NT from rising further. More recently, there seems to have been a slight drop in the suicide rate for the NT; however, it is still double the national average and, of most concern, is the very high rate of suicide in our young people.

Our submission includes current and potential suicide prevention strategies in the NT, funding sources, and the information and research needed to effectively target scarce resources to reduce youth suicide. I

have had an opportunity to quickly look at some of the other submissions to the committee and think there is a wealth of information in the combined submissions that can usefully inform further suicide prevention work in the NT. As many of the submissions have highlighted, suicide results from the interaction of a complex range of factors, including mental health problems, drug and alcohol misuse, family history, inadequate education, lack of meaningful or any employment, cultural and sexual identity issues, poverty, sexual and physical abuse, relationship issues and problems with family and the law. Factors such as the grief, loss and trauma experienced by many Aboriginal people and communities can also have a significant impact on an individual's vulnerability.

In Australia, those at the highest risk of suicide are young, male, Indigenous, and live in remote communities. The high suicide rate in the NT is significantly influenced by the fact a large proportion of the population in the NT are in this population subgroup. Conversely, most Territorians in the high risk category do not suicide. Consequently, interventions need to have widespread usefulness and appeal in order to reach the people who may be suicidal at any time. The majority of people who take their own lives in the Territory do not have a diagnosed mental illness and are not known to mental health services. This is particularly so for young people aged 15 to 24.

This means that in undertaking meaningful suicide prevention activities, the focus must be on promoting and maintaining wellbeing at an individual, family and community level. Research suggests effective suicide prevention needs to combine a range of strategies and approaches that are sustained over many years. These sustained approaches target the whole population, specific groups and individuals at risk, and require a whole-of-government and community partnership approach. Broad approaches become less effective when targeting particular communities and individuals at elevated risk.

At a local level, families, schools, work places and other organisations require knowledge and skill so they can make their communities safer, identify individuals and families in need of assistance, and provide support with ready access to specialist services if required.

Whilst most suicides may not be the result of mental illness, it is a significant risk factor and access to mental health treatment and support for individuals will help to reduce their risk of suicide. In the event of a completed suicide, sensitive support is required to assist those affected by the loss and protect others who are at increased risk as a consequence. The majority of youth suicides in common with all age groups in the NT are from hanging, around 80%. This is different from other jurisdictions and complicates prevention efforts. Removing means is considered an effective prevention technique, although it is not known how often other means are substituted. Unfortunately, restricting means for hanging is almost impossible.

Our submission makes frequent use of data based on confirmed and more recent unconfirmed suicides in the NT. This data supplied by the coroner's office should be interpreted with caution. Owing to the low numbers, significant fluctuations occur year-to-year obscuring meaningful trends and making comparisons with other states and territories difficult. However, regardless of minor differences in data collection techniques, the high rate of youth suicide in the NT is a tragedy.

Whilst children under 17 are outside the terms of reference of the current committee, it is clear that prevention activities targeting youth need to commence in younger age groups. There has been a high rate of suspected suicide of young people under the age of 18, including girls in remote communities in the NT over the last two years. Anecdotal reports also suggest self strangulation play is an issue for some remote communities as are threats to hang in order to manipulate others. Careful and targeted intervention is required to address the de-sensitivity of a hanging implicit in these behaviours.

The difficulty of defining exactly what is self-harm and attempted suicide makes rates of reported attempts very inaccurate. The variance of self-harm and threatening behaviours between communities and the relationship to completed suicide warrants further research. There is also a need for further research on protective factors.

There are some common themes in the submissions to the committee which we would support. These include:

- the need for communities to be engaged, to talk about the problems even though these may be painful and to take assertive action to make their communities safer. This includes action to address alcohol and other substance supply issues, and to communicate and reinforce what behaviours are acceptable and what behaviours are not.

- young people need to have the opportunity and be encouraged to engage in purposeful activity, for example, sporting, cultural and artistic group-based activities. Organised activities can be utilised as a basis for ongoing relationships with mentors, and provide opportunities for modelling team work and other adaptive responses to difficulties. New Northern Territory initiatives include targeting at-risk youths for inclusion in activity-based programs with the addition of problem-solving resilience enhancing and suicide prevention elements to these group activities.
- increased support for young people to remain in school and achieve better educational outcomes.
- support for families to improve their parenting skills so they can provide a supportive environment for each other.
- we also need frank discussions to inform people about the impact of exposing children and young people to suicidal behaviour.

The National Life framework and the NT Suicide Prevention framework and Action Plan 2009-2011 provide the overall guidance and direction for suicide prevention in the NT. The NT framework alliance works closely with the revised National Life framework but retains a specific focus on Indigenous suicide prevention. The action plan expires this year and is currently under review. The deliberations of the committee will inform the development of future action plans in the NT.

We have outlined the many suicide prevention and wellbeing programs currently operating in the NT and have provided recommendations of the areas in which we believe we might obtain the most benefit in reducing suicide in our submission.

Thank you.

Madam CHAIR: Thank you, Ms Hendry. I will open questions to the committee.

Ms PURICK: In your opening statement, you said some people who commit suicide do not have a mental illness, and then there are people who commit suicide who are not known to medical people because they do not seek help or whatever. Is that what you said?

Ms HENDRY: The majority of people don't have a diagnosed mental illness. Sometimes it is difficult to tell after the event, if there may have been signs of mental illness without doing quite in depth analysis. So the majority in the NT certainly don't have ...

Ms PURICK: They are not diagnosed?

Ms HENDRY: No, and they have no contact with mental health services, and there is no indication from the primary health service either that they have a mental illness.

Ms PURICK: But there is obviously something wrong because that is why they have taken their life. Am I looking at too simple?

Dr PARKER: A consistent factor from a number of studies that have coronial factors of suicide appears to indicate, in the Northern Territory that about 60% of people who commit suicide have no contact with health professionals before they actually commit suicide.

As the Director has pointed out, suicide is the end result of a number of quite complex factors. I did some of the research into suicide in the Territory in the 1990s and I came to the impression that suicide - I don't know if you know the concept of a berry aneurism which is like a little abnormality in the brain which can pop at any time. Fortunately, it does not happen to most of us. Suicide is almost like an emotional berry aneurism where someone can carry a number of vulnerabilities that may never be exposed but a particular thing may happen to them at a particular point in time, and they are dead usually within a day. It is that sustained vulnerabilities, some of which are many years duration, which can all impact quite often within a very short space of time to get someone to kill themselves.

Mr GUNNER: Just following up on that point, something I asked a lot of witnesses yesterday is around first contact. I am interested in that moment when someone goes from being in the general community to accessing services. We had quite a few service providers who came before us yesterday who presented well, and spoke well. I am really trying to come to grips with that threshold where you go from here to here and you are saying 60% of people don't actually get health help, or haven't been known to health

professionals beforehand. What I am trying to understand is how we can make that first point of contact (a) happen; or (b) happen earlier. I wonder if you have had any thoughts around that?

Ms HENDRY: There are some thoughts. What is known to be effective is educating health professionals and other frontline workers to better detect that people might be at risk of suicide. Also, things like universal screening programs, for instance, for people with chronic disease or other issues that come before health services may assist in detecting people who are depressed or anxious or exhibiting early signs of mental illness for example, so I think really it is about, in terms of detection, is making sure that everyone who comes into contact with vulnerable individuals has the knowledge and skills to actually assess whether somebody is at risk. Having said that, that will not catch everybody by any means because sometimes it does seem to be a very impulsive act with no identifiable, precipitating indications that you might be able to identify.

Dr PARKER: I might add that I have a slightly different take on this. I think education certainly is the key. I think self-education is very important and I mean one of the points I make on my report is about the MindMatters curriculum. Now I think it is a bit controversial whether it is still in existence, I am hearing it may be in existence, it may not be, but I think there was MindMatters for high school and KidsMatter for primary school, which I think was one of the most important curriculums to educate children about mental health issues.

Madam CHAIR: We had them yesterday, we spoke to them yesterday and it is still delivered in 65 schools in the Northern Territory.

Dr PARKER: It is really good to hear that it is still going, but my feeling is that it should be delivered to every child in every school in Australia, because it actually does educate kids about emotional issues, about the normal emotional responses, and it starts to tell them a bit about mental illness and it is self-education but also education of peers. So, the thing that Bronwyn is talking about where other people recognise that someone is not doing well and get them to attention. If more people know about those issues and I think we are talking about mental health literacy here, so the more people that have got mental health literacy, the more chance there is that an affected individual will be picked up and brought to help early rather than going and killing themselves, and quite often these issues are very subtle. It may be increasing social isolation, it may be failing school performance, it may be inappropriate anger at times, all of which when you look at it is fairly minor but in the end it is a sign towards a suicide happening and if people can pick that up and get people to help, that is a very good thing.

Mr STYLES: Anyone of you guys can answer this. I have been to way too many funerals of people who have suicided and there is a particular one that I would like to put to you and this seems to be evident across the board; there are so many that I have been to. You go to a funeral, you go through the ritual, at the end of it, everyone has a cup of tea, and then you start talking to people and they say: 'You know, I saw Billy the other day, he did something really strange', and they explain what it is. Then you go to the next person and they tell the story recently of something strange they did, and then you go through 10 to 12 people who have all observed strange behaviour.

When you actually stand them in a circle, it is glaringly obvious that a person who has not had any contact with the medical profession, with psychologists, psychiatrists, or anybody else that the alarm bells should be ringing. So, how is it that we get to the public and train people that when these small things happen, irrespective of how small they are, we should be talking to other people and how do we train people in the community to do that because I believe that if we can actually get people to understand those little small indicators of people in trouble, then we can actually start talking to each other and then once you start talking to one another, the big bell goes off and someone gets help before they go out and we have a tragedy on our hands.

Ms HENDRY: I mean there are a number of very well-regarded established programs to do that. One of them is the Applied Suicide Intervention Skills training and that is rolled out in the Territory, but we would really benefit from increasing the coverage of that. There are other less intense programs; Safe Talk, for example, which can be delivered to young people as well in schools; Suicide Awareness training; Mental Health Literacy; and Mental Health First Aid. There are a whole range of programs we can use to actually educate people better about signs and symptoms of mental illness, and there are also interventions we can make in workplaces. I sat on the plane yesterday next to a person who was from the department of construction and industry and they were telling me that everybody in that industry has to have a white card, which I had not heard about before, but that entails a half-day training session on various aspects of safety and, included in that, is one hour on suicide prevention - and that is fantastic.

They are the sorts of opportunities where we really need to educate everybody on how we can better look after ourselves, and each other, and how we can assist people when we think they may need some extra support.

Mr STYLES: Robert, when you were saying in MindMatters and KidsMatter - and I am familiar with the MindMatters program; I have actually worked with it and been trained in it; it is an excellent program. How do we actually get the community, through any means, to take onboard KidsMatter in schools and to look at that training, the early intervention, so that kids can identify other kids who are in trouble and we take the stigma out?

Dr PARKER: I was the chair of a school board for a number of years. It is probably an aspect for the school boards, or parents and citizens issues with school, to probably try to involve parents – and I am not quite sure of the technicalities of the curriculum, but I hope there might be some parental involvement sessions in the evening where the curriculum could be discussed with parents and kids to make people more aware of the curriculum and the issues about talking and being able to talk to people both ways. And, I suppose, the parents having some responsibility for knowing about some mental illness issues and being aware of emotional issues in their own children's lives.

It is probably best with increased community and parental involvement in the school process, as well as I still think it is a program that needs to be taught to every child in Australia, rather than just at a select number of schools.

Ms HENDRY: There are stages in the curriculum, and various schools have taken up various levels of things like the MindMatters program. Schools are very interested in this idea, but the curriculum is crowded and there are a whole lot of competing issues that people would like to see included in the curriculum. And if there are more assertive efforts to ensure that every child does receive information that will help protect them - more than is currently happening - and access to support in the schools when they need it. School counsellors tend to be overwhelmed at times by the scale of the problem they are facing, so we really do need to provide that extra support to the vulnerable kids who have been identified.

Ms PURICK: A couple of questions. I guess it is a professional-type question. I was speaking to a lady yesterday who knows about this committee's work. She lost her son, and she said right from the word go, even as a little tacker, he had black thoughts, drawings - all that sort of thing. Are some people just born that way where, even if there was intervention and medical help and all that sort of stuff, it is just a question of time? That is that kind of question, then I have another one.

Dr PARKER: I do not think anyone is inevitably bound for suicide. Certainly, temperament is an issue that is part of human behaviour. They have shown that the hard wiring of the brain certainly can be a factor and it probably does make people more prone to suicide than other people. But, I do not think it is an inevitable process. There is a range of social factors and things that can intervene. Quite often - it can literally be an hour - something happens to someone and, if that had not happened, that person would still be alive. So, it is not just inevitability, it is a range of vulnerability factors ...

Ms PURICK: Other things that contribute.

Dr PARKER: ... and it may just be a particular set of circumstances - unfortunate circumstances - that leads someone to commit suicide. In our clinical work, we are seeing people with personality vulnerabilities who are, potentially, suicidal most of the time. These are people who have often had pretty awful early childhoods, experienced a lot of trauma, exposed to trauma, and they seem to cope. Despite the fact they are having recurrent suicidal ideation - and it is often for decades - they seem still to be alive and they seem to keep coping - and they probably do - but every now and then one of them may just get overwhelmed and, by intent or by accident in some cases, they end up killing themselves. So it is ...

Ms PURICK: Yes, because they also - from what I have heard from this lady who relayed the story, and I know it from another friend of mine who lost her husband; these are older or more mature people – seem to be very orderly much of the time. They get everything organised before they depart. Part of them is, obviously, not rational, but another part of them is very rational and clear on what they intend to do.

Dr PARKER: There are two different aspects to it. First, there are people with certain personality types. Certainly, in the study I did of the coroner's data in the 1990s appears to indicate that particular personality type, who is a very obsessive or orderly type of person, tends to be more prone to suicide than other personality types for some reason. It is probably a level of significant loss - they take loss very badly and are also very well organised in what they do, so it is an unfortunate combination. However, it is well

recognised that, on occasion, when people decide to kill themselves there can often be almost an elation that goes with that and for a couple of days people see everyone and say goodbye in a way that is not construed as - and often give materials away. That is reasonably rare, but is well recognised as a precursor to suicide.

Ms WALKER: Bronwyn, we had our first day of hearings yesterday and a number of service providers gave evidence. We have also received many submissions. Given that you have said in your opening statement that resources are scarce, we had a sense yesterday there are many service providers out there. How do you monitor the effectiveness to minimise duplication of services? There seem to be quite a few out there.

Ms HENDRY: It is a problem, in terms of potential duplication of services and also inequitable distribution in some communities being engaged with a range of service providers and others have very little access. We are making a consistent effort with the Commonwealth to ensure the initiatives they fund are complementary to the initiatives we are undertaking and that there is not that level of duplication. Some of it has been historical. There are multiple funding sources though, apart from the NT government and the Commonwealth government, and there are various departments in the Commonwealth government as well that engage in that. It is very difficult to control, even if you wanted to, who would be funded, whether the programs they are funded for are likely to be effective and, if they turn out to be effective, because of the multiplicity of funding sources.

We suggested in the submission some place-based mapping to get a very good handle on who is providing interventions in this area, which will help inform us how we can potentially rationalise some work, how we can educate funders to be a little more cognisant of what is going on in this space, and how we can better coordinate the activities people are undertaking.

Ms WALKER: One of the witnesses we heard from yesterday, who is here again this morning, said there are so many services out there that another volunteer organisation as a network to facilitate and direct people has been created in Darwin. This will help manage the traffic of information and direct people into the right service, which is helpful, but there are an awful lot out there.

Ms HENDRY: You need a range of approaches. It is a very complex question because you need a range of approaches to target various population groups at various levels, but also people respond to different types of interventions - people within the same age group or across different age groups. Whilst we need to strive for as much coordination as possible, we are never going to make this a simple approach. We will still need quite a wide range of strategies.

Ms WALKER: Thank you.

Mr GUNNER: There was also some talk yesterday about how to measure a program's success and the importance of shifting from an output-based measurement to an outcome-based measurement, which is something the Northern Territory Government has done over the last number of years. An example given yesterday was you give 300 breakfast to 80 kids, tick; you have done a good job. That is an output as opposed to an outcome. Does that need to happen more when we look at service providers and what services they provide?

Ms HENDRY: I think so, but it is a difficult area because sometimes the outcomes are achieved over many years. It is a complex task to determine what inputs achieved what outcomes. It is slightly easier if you take the example of a remote community like Tiwi where there are at least some locational boundaries. I know Rob was very involved in a response in Tiwi some years ago and there has been some pretty good outcomes and ability to maybe ascertain what contributed to those. But in an urban area, for example, it becomes much more difficult and you do have to sustain your approaches over time and the evaluations over time.

Madam CHAIR: If I could just ask a couple of questions, Bronwyn. Following the development of the NT Suicide Prevention Action Plan, the primary focus of the prevention coordinating committee in 2009 and onwards was the provisional training and professional development activities. Given the high turnover of staff in the more remote locations of the Territory, how often is the training in suicide prevention, intervention and postvention offered?

Ms HENDRY: I cannot answer that question off the top of my head. I know that we fund Anglicare and also Lifeline in Central Australia; Anglicare in the Top End to deliver ASIST training, Applied Suicide Intervention Skills Training, and suicide awareness training. There is not enough of it, so who gets it

depends quite often on how motivated the organisation or the community is to seek it. It is not just universally provided because it does not have the capacity to provide that coverage. So some communities will receive it more frequently and be much more engaged in that process, and some organisations and workplaces and others may not have received any training.

Madam CHAIR: In your opening statement you say 60% of fatalities, and if we look at that 60% there is a high number of those incidences in remote locations; does it relate to that? Because we have a high turnover of frontline staff we do not have the constant training and development so that people can identify or be able to see this issue?

Ms HENDRY: It is repeated in communities and organisations so there is an opportunity to try to cater for that turnover of staff and to train new staff as they come on board. But there just is not the capacity to provide the level of training that is required to ensure that everybody receives it. So it is patchy. That is really the issue. Some people might be really catering well to that turnover of staff and other people there may be no staff in that organisation for example who have received the training.

Madam CHAIR: The majority of clinics in remote communities are Northern Territory Government run. Does not the Northern Territory Government have an obligation to make sure that this training is consistent and ongoing even though despite the turnover of staff? Are you able to take that question? I am certainly interested in the number of staff and the turnover, and what is happening. You would be able to provide the committee with the information?

Ms HENDRY: We can provide the committee with the information we have access to, for example, where mental health first aid may have been delivered, and where things like ASIST may have been delivered, that we actually fund. I will make some inquiries also with primary health to see what information they have. But there needs to be more of it. That really is the bottom line.

Dr PARKER: Can we just make a point, though, that a lot of the issues are related to trying to build up the resource within the remote community. That was the issue with Tiwi where it was not just Glen Norris going over and doing it but also building up a core of health workers within that community who became like the experts and leaders within the community for suicides. So it was actually Tiwi people doing it rather than a bunch of visiting whitefellas. So it is trying to build up a resource and skill and in the end the people who stay in Aboriginal communities are Aboriginal people themselves. The whitefellas will come and go. It is trying to build up a skill base and a resource within the Aboriginal communities themselves, which I think in the end should be the point, so you have a range of skilled workers who are well resourced, well paid and also supported, and given opportunities, given them a sense of governance so they can have an opportunity for regular education and support so they feel supported in often very tough environments.

Madam CHAIR: I am not arguing with that. I think that Tiwi for Life program, Dr Parker, which I am most familiar with, was a fantastic program. The funding for that came to an end too. What we have is trained Tiwi people working in this area who were able to reduce suicides and they are not employed. So, that is the problem that we see across the board in our remote communities; it is building the capacity of our people, I agree, you know people come and go but we have got to get consistency in terms of the funding and I think governments have an obligation to make sure that they put that funding on the table.

Dr PARKER: I totally agree.

Mr GUNNER: I just want to touch upon first contact again for a while. Obviously, the preference would be that it happens at school or amongst family and friends, but sometimes it can happen in the workplace and the Salvo's mentioned yesterday mentioned their homeless shelters as a possible area where they identify people at risk. We had the Aboriginal peak organisations come before us yesterday - they were our last witness - and they spoke a lot about the youth justice system and police but they saw it as a risk factor, not necessarily as a first point of contact. Now, it is not the first point of contact you would want to have but sometimes that might be the first time someone comes across a trained person who might be able recognise a symptom so ...

Ms HENDRY: There has been training provided to Correctional officers and there has also been a significant increase in the mental health training provided to police recruits, so that has increased from approximately half-a-day's training over the past 12 months to four days training for police recruits and we also assisted the police to develop an online training module for serving officers. But, you are right, they are often the first point of contact I think and sometimes being in that situation may actually be the tipping point that Rob was describing in terms of people becoming suicidal. Obviously, being incarcerated can be very stressful, as well as being engaged with the police even for other matters, so having better trained

frontline providers really, in any area where people come in contact with vulnerable groups, is definitely the aim.

Mr STYLES: Rob, just going back to something you said in relation to people experiencing areas of life that makes them more vulnerable to leading down that path of suicide. When we talk about early intervention, what are your views and thoughts on where we need to start that early intervention and how we might go about that?

Dr PARKER: I think it relates again to health literacy, understanding about emotional response, and recognising that you are having an emotional issue. Part of our issue is that men particularly appear more prone to suicide because they are less verbal than women and they tend to be less social in many ways, so they do not talk about issues; what they do if they have got an emotional problem is go and get drunk, rather than actually talking about issues, which then makes them more prone to things, because as a result of being inebriated they are actually more impulsive and they are more likely to act on immediate impulse in the context of inebriation.

So, I suppose the issue is again – really, the first help is having a knowledge that maybe about grief and emotional issues yourself so that there is a desire to go and get further help if you are having that, rather than going getting drunk and getting angry as a result of the alcohol.

Mr STYLES: So, what I am thinking about is going to a primary school, *KidsMatter* and things like that, and starting right down in transition as we do, or used to do, with drug education. We have a very simplistic message that starts off in transition and goes all the way through and, in my former life as a school-based police officer, I used to tell stories to kids about vulnerabilities of adults and things like that so they understand and you try to get kids. Do you see any value in that, of actually starting the process of understanding the emotional journey in life? I am not necessarily going to say we should be talking about suicide in schools, however, there is obviously a starting point and I am interested to know how you guys would see where we could actually start with this training.

Because, obviously prevention is far better than cure, or frontline people who can identify it at the end.

Dr PARKER: Look, I totally agree. I think it has to suit the child's cognitive - kids actually have to have enough intelligence to actually understand about the issues, so probably late primary would be important, or even - I am not quite about it - might be mid- to late-primary, certainly in high school, would be a very important point for understanding those sort of issues.

So, I am very much in favour of, as soon as a child has got some of that level of understanding, then certainly doing that as an education.

I actually like the idea of stories, I think it is a really good idea about people's rights and your ability as a person to have rights. One of the issues I bring up in my report is Professor George Patton in Melbourne, who is doing some work with adolescent girls apparently, on ethics in high schools, and he is actually getting very good - he has not published on it yet - but he is getting very good responses on, basically, your rights as a person to say "no" and to have rights so you cannot be influenced too much by other people.

I think that sort of education is often best done in a story form, with an ethical slant about you have got a right as a person not to be abused, you have got a right to speak out if something is happening to you. It is unfortunate, in many ways, it has to be done through schools.

I go back to one of the key points in my report is that, marriage between them, when talking about a home and I think we have lost homes in many ways and, unfortunately, the schools have had to take the home environment to nurture children emotionally and intellectually. But really, I think stories are a very important part of that and giving people a bit of a – I think it used to happen.

One of the things I remember about Tiwi in the old days before television arrived, was everyone sitting around the campfire at night telling stories. With a lot of the old stories, there was often a lot of laughter and remembering. There was a lot of knowledge learned in that exchange, though, in the home environment. We have lost that to a degree. So, I am very much in favour of what you are describing: maybe a story-based ethics-type approach that suits young children, to give them an idea they have a right and they have an identity and it is important to maintain that.

Mr STYLES: You may agree that empowering young people earlier in life along those lines would be beneficial for their emotional intelligence development?

Dr PARKER: Yes, I certainly do.

Ms HENDRY: We need to focus on parents as well, and parenting styles, and educate parents about what the most constructive parenting styles are. Unfortunately, there is significant evidence that vulnerable parents will have vulnerable children, so a history of suicidal behaviour in the family seems to translate to intergenerational risk. So, whilst we need to focus our efforts on kids at schools, we really do need to focus our efforts in supporting families to create a more emotionally stable environment for their kids.

Madam CHAIR: We heard yesterday - Bronwyn or Robert can answer this - from the Aboriginal Peak Organisation - I think it was the justice representative – about the issue of foetal alcohol, and alcohol being a huge issue amongst Aboriginal people, the under-detection of that and, then, not seeing that until some of these young people come into the criminal justice system. In your experience throughout the Northern Territory with the mental health services, is that a critical emerging issue in the Northern Territory that we have not seen previously because it has been undiagnosed?

Ms HENDRY: I think all sorts of cognitive disabilities are an emerging issue in the Territory for a whole range of factors; including alcohol abuse, other substance abuse, and things that happen in pregnancy etcetera. I think Rob can probably elaborate, but there is full-blown foetal alcohol syndrome which is relatively recognisable but there is a whole lot of subclinical conditions, including foetal alcohol syndrome, which might not have really marked or gross symptoms along with it, but increase a person's vulnerability to a whole range of things, and impact on their development. That is where it is quite difficult, I think, to actually - we need to probably better recognise those individuals and to intervene earlier.

Dr PARKER: I totally agree about recognising early. I am not quite sure about the interventions. I know it is certainly a concern at the moment in northwest Western Australia around Halls Creek and Fitzroy Crossing. There is a major concern about an epidemic of foetal alcohol syndrome. There is some evidence that it is on the increase in the Northern Territory. I think Sue Sayers has been doing some work on foetal alcohol syndrome. There has been some work on it, but I am not quite sure ...

Madam CHAIR: Who is that?

Dr PARKER: Dr Sue Sayers, who is a paediatrician - I think. There is an increasing interest in it.

Unfortunately, I tend to totally agree with Bronwyn, that you get full-blown foetal alcohol syndrome which should be well recognised by the paediatrician when a child is born. Unfortunately, I get the impression - I may be wrong here - that it is almost like a permanent brain injury; once you actually have it, it is permanent, there is not an awful much you can do. It is more the issues Bronwyn is talking about. So, you are looking at someone who is like a child with an intellectual disability whose low level intelligence, and all the add-on factors that go with that, in terms of poor performance at school, limited emotional responses and whatever, which then make them more at risk for crime and potential suicide. So, all the issues that lead to a dysfunctional life and possibly suicide.

It is probably the more subtle factors Bronwyn was talking about that potentially get picked up by school psychologists - school performance issues - leading on to identification of what causes those and then looking at potential solutions. It is the more subtle issues rather than a full blown foetal alcohol syndrome where, unfortunately, there is nothing you can do.

Mr STYLES: Robert, I could not agree with you more. I have seen it; it is a huge problem out there and I think your assessment is on the money.

A couple of years ago I spoke to some people off the record from Menzies who were looking at research in relation to the vulnerability of Aboriginal people in relation to marijuana abuse. They said it is going to have dramatic and devastating effects and they were trying to figure out why it seemed to have a more pronounced affect on Aboriginal people than non-Aboriginal people. Are you aware of any studies that are going on in relation to that area, even though it may not have been reported?

Dr PARKER: I was part of a large study by Alan Clough in the late 2000s. I looked at the use of cannabis in East Arnhem. There is a range of factors impacted on that. As I pointed out in some of my writing, you have a range of individuals - quite a few people who smoke cannabis have previously sniffed petrol or a volatile substance and may already have acquired brain injuries which make them more prone to psychosis and other issues when they smoke cannabis. I believe we said 60% of adult males in east Arnhem were smoking cannabis which is a large number of - and it is published – large number of people smoking cannabis.

There are the issues of Aboriginal people, when the use substances, tend to use it in a binge fashion. When they smoke cannabis they do not just roll a joint and have a puff; they get a large amount of it, throw it into a bucket bong and sit around and really hit themselves time after time. You are looking at not just the substance itself, but patterns of use and the strength of the substances. I was not particularly persuaded about the skunk argument; however, I was at a conference recently where I heard the Dutch are now manufacturing cannabinoid with 22% THC rather than 16% THC.

There are efforts to increase the amount of active THC within cannabis which makes it much more potent. If you are using large amounts of the stuff in a bucket bong on a regular basis, and you probably already have an acquired brain injury, it is not surprising people are becoming psychotic. I feel cannabis is a predisposing factor. Psychosis, in itself, is a significant risk factor for suicide and is often well-identified by people.

George Patten, who has done work with adolescent girls and ethics, has also done some work on cannabis and depression in adolescent girls in Melbourne. He found regular cannabis use does lead people to become depressed. Even though it has an immediate euphoric effect, people become depressed and depression, in itself, is also a risk factor for suicide. Cannabis is a particularly dangerous substance for mental health issues.

Also of concern for us is amphetamine use and I think a lot of our current psychosis that we are seeing is due to amphetamines as much as cannabis, particularly Ice. At the moment it is not widespread in Aboriginal communities, although I understand well paid mine workers are taking it to some communities and some Aboriginal people are getting it. That is a significant concern.

One of the articles I have here is the Paparelli article on star gazing, which talks about the connection with cannabis and amphetamines and psychosis these days. A lot of our work these days relates to cannabis and amphetamines.

Ms HENDRY: I think you are right, Rob. The ability of people who have experienced various traumas in childhood, whether they be physical traumas, assaults on their brain or emotional assaults, means they will have continual problems with emotional regulation and that will increase impulsivity. So when you add a substance to that, you can get quite impulsive behaviour that can be really dangerous, suicide being one.

Mr STYLES: This all leads to situations where people find themselves in a whole range of situations where suicide may be an option. What about when we go back and we look at alcohol versus marijuana and amphetamines. If you are putting marijuana and amphetamines in a group, would you put alcohol in another group?

Dr PARKER: I think alcohol is by far the more dangerous substance. Alcohol governance issues are one of the key issues for suicide prevention in most communities. One of the things that I quote here, and unfortunately it has never been published, was the police review of issues on Tiwi after the introduction of mid-strength beer. It really led to a major reduction in social distress in Tiwi. The police note that before mid-strength beer was introduced whole suburbs would ignite with a fight one night; a couple would fight, everyone else would join in, the whole suburb would be involved and the police would be out and about all night just trying to sort out domestic issues. The more disturbing issue is that they would find these tribes of kids on the road at two o'clock in the morning who are just wandering because it was not safe to go home. Apart from the actual issues of safety, those kids would be school the next day and their ability to actually learn anything at school the next day would be reduced because they had been up half the night. After the introduction of mid-strength beer apparently very few callouts for domestic violence and all the kids were off the road and at home asleep. So that was fairly obvious material.

I am amazed at the way the government in the past, or communities, tolerated some of the patterns of alcohol use in some of the communities and just accepted it was okay for a whole community to be shut down for two days, be drunk and not function because that is what happens. The impact on children in that situation - it is not just abuse but is also emotional vulnerability. You do not feel safe if you do not feel nurtured, if everyone is drunk and you are looking at a situation of chaos it is not surprising these kids are very emotionally strung out. They are not developing as secure human beings, which is very much that situation of what Mary Victor O'Reeri was saying about the home. That is why she is very clear now that her home is for her children, her home is a safe environment for her children. She has had to make that; she has had to do it from a tremendous personal pain. She lost two brothers a year apart from the same ceiling fan in the same house in Beagle Bay, from what she experienced as a child in Beagle Bay, she does not want that to happen to her children and that was very much an alcohol-related issue.

I agree with you that alcohol is by far the most damaging substance for kids in terms of their emotional regularity and emotional development and physical safety.

Mr GUNNER: We heard evidence yesterday about how the tragedy of one suicide can be a precursor to a cluster, and the importance of postvention. We heard an interesting story from a lady from Darwin Community Arts Centre who had an experience in Wales where 25 young people had committed suicide and people were actively told not to talk about suicide; within the schools any talk about suicide was actively discouraged. I was wondering how formal our responses are postvention, and what your thoughts are on postvention?

Ms HENDRY: Postvention happens differently in different places but I guess the principles involved are really that the people on the ground, the local community, and the local service providers, are in the best position to determine what would be the most appropriate postvention support.

Mr GUNNER: But is there any formal driver? So if someone commits a suicide somewhere remotely and there may or may not be a service provider in there, is there any trigger to a formal postvention, or is it just purely up to the service provider locally about whether they get involved or not?

Ms HENDRY: The police always ask the family if they would like support. If it is in a remote community, the health service is always aware. So they will be involved in supporting that family in various ways coping with that event. We have specialist people who have training in that area who can either provide support directly to a community if that is required, or to support the local service providers to support those families. So you cannot just say we have a postvention program and as soon as someone suicides we will just trot out with that particular program. It really does need to be tailored to that community, that individual, and whether the family actually at that time are accepting of support, or whether they are seeking support from their informal network. Sometimes people really do not want somebody from outside coming in at that particular time; maybe later when they are ...

Mr GUNNER: My question is not so much, is there a set program, as so much, is there a formal trigger for someone to talk, if that makes sense?

Ms HENDRY: Well, we always get notified of suicides from the coroner's office and we are informed by the coroner's office, initially by the constables that are responding to that suicide, whether that person has requested immediate support. So, it is always available. People are not always ready to have it though.

Mr GUNNER: We also heard evidence yesterday that not every suicide is classified as a suicide by the coroner's office, if that makes sense, because there are difficulties knowing sometimes. So, an example that was used yesterday was, you have got a 300km drive, there is one tree between one community and the next, and you happen to hit it on the wrong side of the road, that is not necessarily going to be treated as a suicide. I guess this is going back to my original question in some respects around first contact and those efforts we can make to prevent. Suicide, unfortunately, seems to be that precursor to perhaps more happening whether it is copycat or cluster, and it seems again - and in some ways it is a reasonable proposition - someone asking for that help at that stage, we cannot do more than that.

Ms HENDRY: I know what you mean about contagion and there are different types of contagion effects I guess that people describe. One might be an immediate contagion effect within that social circle, within kids that age group, for example, or kids in that community, but there are more insidious contagion effects I think which are about constantly being exposed to suicidal behaviour and that type of behaviour being employed as a problem solving type of technique.

Dr PARKER: The two things that I mentioned in my article, *The Journal of Nervous and Mental Disease*, are the concepts that came out of North Queensland with the community at risk and individuals at risk where you have got a community where children are growing up and all they are seeing is drunken adults beating each other up and so what they do is they incorporate that behaviour as what you do. If you are living with it all the time, you just incorporate it. If you have an argument with someone you go and beat them up rather than talking and, of course, the issues I was talking about before where you are actually living in a constant situation of trauma, you do not develop a lot of emotional resilience with dealing with those issues. So that when you actually become an adult yourself, you tend to use alcohol to self-medicate that issue, and in the context of the alcohol, you are much more likely to impulsively hurt someone else or yourself as a result of those background factors, but also, the fact that you are drinking means you are far more likely to be impulsive in the context of alcohol. So, I think those factors - and they are from North

Queensland and it is a fairly classic study - are sort of constant and it is a thing that I refer to again and again in coronials when I give evidence and it just seems to be it is a constant factor.

Now the other factor that comes up is the factor that also is referred to in that article about the meaning of a dead body in a community. I don't think Professor Ernest Hunter who was the key author of that, has actually gone on further to talk about the meanings of hanging for Aboriginal people, but there is no doubt that when you get a small community - when I was doing the work with the coroner's files, the suicide in the suburb was an anonymous event. Someone would kill themselves in a house, the ambulance would turn up, the body would be taken away - no-one was really aware of the psychological meaning of what happened inside that particular house although it obviously had major impacts for the family of the deceased.

In a community, you have a body that is often in a public place, is often seen by lots of people, and there is a significant psychological impact of that sort of public suicide. It is not just the physical presence - an issue that happened a number of years ago, there was a number of suicides of young men all from Aboriginal families within the Darwin rural area. Now, although they were not physically linked there was a lot of information networks from all the families, they were terrified because obviously the kids all knew each other and so there was a widespread knowledge base among all the young kids in the Darwin rural about what was happening with these young boys and the families were justifiably very anxious because again, it was not an anonymous issue. It was a public issue and when you get a vulnerable population and you are getting this public sort of event, it has a lot more meaning and it can have a lot more effect than just a private suicide.

Ms HENDRY: There is evidence, as well, that if communities really do take assertive action, they can prevent the type of contagion effect that you are describing. I went out to Daly River recently. There was some really significant concern about young people and suicide 12 to 18 months ago. Much more recently when I went there, it is a rare occurrence at the moment. The community really was able - and had leadership - to provide some really assertive action to actually address that problem in the community. So, yes, you do need outside assistance, quite often, maybe to help you formulate how you might respond to this but, ultimately in the end, the community has to sustain that response beyond that initial postvention support that people need.

Mr GUNNER: I keep returning to that point of first contact; whether it is early or, in this instance, postvention, because from a policy development point of view, the first steps are the hardest. The second, third, and fourth steps are comparatively easy. Once someone is in the service provision, they are there. But, it is getting them from here to here; that threshold is the most difficult bit, so I am just trying to understand better how that first step is made or not made and that is what is really driving me, talking to witnesses at the moment?

Dr PARKER: I want to quickly add, in the intervention, often the Coroner's Constables are a good first point. It is a very difficult job being a Coroner's Constable, because you have to have contact with a very distressed group of people. You have to do an investigation, and you are doing an investigation on a very distressed group of people.

What we have done is have a series of cards - Bronwyn's right - we follow up, we are given knowledge about each particular suicide that happens in the Territory, so we can follow-up. The Coroner's Constables still give people cards. When they actually do the interviews, they give people cards for postvention support.

On the issue of the Coronial investigation itself, you mentioned the issue of the car and the tree. One of the issues is that the Coroner has a particular role to play. They have a job to do, which is a legal job. That does not necessarily intercept with research issues for suicide. They have to perform a legal function to determine if the person intentionally took their own life.

Mr GUNNER: I do not want to criticise the Coroner's decision, but ...

Dr PARKER: Yes, but the issue is if they were given six times the resources they probably could have a broader role. But, they do not. They have a particular role to play, and that is part of the problem. The National Coronial database has an awful lot of information that is a result of Coronial information, and that can be a good research tool. But, quite often, the Coroner only has to reach a certain point, and they say yes or no. Part of the problem is there is probably a lot more data they could get if they were well resourced, but they do not have the resources or the legal issue to do that.

Mr GUNNER: My concern is not so much the Coroners decision because, in some respects, they are required to X, and it is more the Y about knowing from a health point of view that this has happened, but we might need to do this postvention. It is not going to be triggered, in this instance, by the Coroner's decision because they will be required to make decisions they have made. How can we post possible suicide help? What would be the trigger in that instance when you cannot rely on the Coroner's decision to be the trigger?

Dr PARKER: The other issue, too, is the Coroner often takes months to determine a report. There are things that need to be done, often within days if you are going to do a postvention. The Coroner will reach a determination often about three or four months after the actual event.

Madam CHAIR: Rob, if I could just ask one question, and then I will go to Peter. When we look across - and I talked about foetal alcohol and the issue of alcohol - amongst many of our communities often you hear a lot of the Aboriginal peak organisations and Aboriginal people themselves say: 'We are in constant grief' - the grieving that is happening across communities. I often hear that when a suicide happens in a community – one, that it is impulsive and two, that it is alcohol and drug-related. But is it a case that besides foetal alcohol being one thing, when you look at many of our communities, the post-traumatic stress in a lot of these young people, we are not getting the resources mobilised or aimed at this group regarding post-traumatic stress? Do you ...

Dr PARKER: Madam Chair, I think post-traumatic stress is a real issue and I have looked after many of people with it. I like Judy Atkinson's concept and I have referenced her work on traumatic generational issues affecting communities. That is a really important concept where you get a range of disempowerment over traumatised generations. I really like the concept of Professor Helen Milroy's idea of traumatic grief where people never get over one thing before something else happens. I believe Madam Chair is aware that a number of years ago the deputy coroner shut the Nguuu Club down for a week and the consequences from that...

Madam CHAIR: Yes I know, I reported you Rob!

Dr PARKER: It was just allowing the community time to grieve. Part of the problem is you want people to develop a proper emotional response and they cannot do that drunk; they have to do that sober. If they can get through that grief they can move - the problem is when you get people who are drunk and grieving there is much more likelihood of a further traumatic event occurring so you are adding to the whole process of grief. People are going to get over one issue and then have to get over something else. Helen Milroy's concept of traumatic grief and Aboriginal communities never getting over stuff before something else happens and having to deal with that is a key concept. The way alcohol both contributes to that, because often it does lead to people dying from motor vehicle accidents or suicide or murders or whatever, but then also people not being able to grieve appropriately because they are drunk. And I think you need to be sober to grieve.

There may be a certain proportion of people who develop PTSD from that; however, Judy Atkinson's concept of disempowered communities - I have referenced her chapter in my report - is a really important chapter because it talks about how communities gradually become disempowered because of grief and trauma and have far less resilience, as a community, to deal with substantial problems.

Madam CHAIR: Bronwyn was talking about leadership in communities and communities taking control of this issue. Is it because we have layers upon layers of grief that people have not had a chance to peel back those layers and take time to dissect and come to terms with it?

Ms HENDRY: That is right; but I also think maybe communities are not aware of what they can do. Because when you are in that overwhelmed situation you may not necessarily know what has worked for other communities or the strengths you can employ to do something about that. It is really important to engage communities in that and give them the tool box to say if you can do these things in a way that suits your context, you can actually make your communities a lot safer.

Dr PARKER: That is what Glen Norris in the end - it was as much the communication group – to do with the men and women - as much as the developing of the health workers that was important. It was allowing Tiwi to say: 'We are a strong people; we can control this', and developing some leadership within Tiwi that was as much the solution as – we ramped up mental health assistance, we could have better case finding, we could have more support from the mental health workers; however, much of it was about community empowerment which, in the end, made a big difference in Tiwi.

Ms HENDRY: That is what we mean by a multipronged approach. You need to attack the problem at all levels at the same time otherwise you are not going to be successful in any sustained way.

Madam CHAIR: One more before I go to Peter. Bronwyn, we have been talking about a number of completed suicides and the fatalities. The other unspoken area is the number of attempted suicides. Has there been any research or analysis done on the number of attempts, tracking those people through to - have they gone from attempting suicide to completed?

Ms HENDRY: An attempt is considered the biggest risk factor for a completed suicide in the future. People are much more likely to complete suicide if they have attempted suicide in the past. However, in relation to data and what is happening in particular communities and how that relates to completed suicide, I think we need more research on that and certainly we propose that as one of our recommendations. It is a very difficult area to get reliable statistics, a little easier in a small geographic location - it is a little easier to collate all the statistics that you have and you are able to avoid double counting because you can identify individuals that may be counted in various sources of information. Much more complex as you can imagine, in a larger area where you have multiple sources of information.

You really need to be able to identify the numbers of individuals that are being referred to, to achieve a meaningful analysis of whether self-harm is increasing, and what the impact that is having on completed suicides. We have talked about investing in some research that will actually give us much better information in that regard. But there are all sorts of privacy issues; there are all sorts of technological issues in terms of extracting information from different systems. So it is quite difficult and it is something that everybody has been grappling with throughout Australia, and throughout the world. No one has an easy solution to it.

Madam CHAIR: Yes. If you look at a hypothetical: Joe Bloggs in the northern suburbs of Darwin, attempts suicide. Now, who is the first point – it is the police, I suppose, the police are called, or ...

Ms HENDRY: No, not necessarily. It may be no one if no medical intervention is required. So it may be that the friends and family of that person or, in fact, it may be just that the person recovers themselves and never tells anybody about it. So it could actually stay a very private thing.

It could be that medical intervention is required. If it is urgent medical intervention most likely ambulance and the ED or the police, for example, might be involved. So you can get statistics from those particular places. GPs - it is very difficult to get statistics from in terms of that.

Madam CHAIR: Yes, and it is all that privacy stuff.

Ms HENDRY: It could be counsellors. It could be a whole range of service providers that somebody might actually access in response to that. And some suicide attempts that require medical intervention, there isn't the same level of intention, for example, to commit suicide as there might be for a suicide attempt where no medical intervention is required. So actually gauging the seriousness of the attempt isn't necessarily based on what intervention happens afterwards as well.

Dr PARKER: Yes, part of my clinical work is dealing with a lot of these patients in hospital and self-harm just covers a whole range of different issues. In a non-Indigenous population we get people who repeatedly self-harm. They often have severe emotional vulnerability often dating from this early life trauma and they are probably far less – on occasion they may commit suicide, but if they don't in the end, they repeatedly self-harm in response to life stresses and ...

Madam CHAIR: That's non-Indigenous, did you say?

Dr PARKER: Non-Indigenous.

Madam CHAIR: Yes.

Dr PARKER: The study that I did, and there has been further documentation that seems to show that self-harm in an Indigenous person is more a predictor to later suicide. That was one of the things that came out of my review of the coronial data in the 1990s, and I think it has been shown by further data that there seems to be; in the Measey article - there seems to be an association between self-harm and suicide.

But, again, I have interviewed individuals who have had a fight with the wife, got really drunk, been found hanging off a door, been resuscitated, come to ED and cannot remember what happened and have no emotional – you know, they had a fight with the wife and ...

Madam CHAIR: And not seen their actions or ...

Dr PARKER: Can't remember what happened, don't appear depressed. Yes, they are going to have some counselling with alcohol, but really that is it. There is no particular warning sign and they don't do it again. So this is a one-off event that occurs in a range of probably a number of fights with the wife over a six or seven year period. On one occasion they get drunk and hang themselves off a door and they probably can't remember doing it. What do you do? It is very difficult stuff. We do always organise ongoing reviews and support, but they often have one or two things, they are doing fine, their back with the wife, doing well.

Ms HENDRY: That is an issue, isn't it, as well though that we need to get better at ensuring people do get follow up? So beyond that initial assessment sometimes, which might occur anywhere, in the ED, in a GP surgery or whatever, we have to try to make sure that we follow up that person a bit further down the track to ensure that they have been able to access whatever service might be appropriate for them. Certainly some of the things we are doing in terms of increasing services for acute mental health assessment will help with that, but it does need to be a coordinated response across all services.

Madam CHAIR: So, in terms of a young person - if we look at Darwin, let alone our remote communities - but let's look at some of our urban centres and the access to inpatient services; where does that occur if a young person requires an inpatient service?

Dr PARKER: Again, it depends how young is young. We currently do not have an adolescent unit in the Northern Territory. We are hoping one will be developed ...

Madam CHAIR: We don't or ...

Dr PARKER: We don't, no. We are hoping that the new Palmerston Hospital will possibly have six to eight adolescent beds because the purpose of that is, it is close to headspace, and really to link in with headspace is probably one of the key issues so we are hoping that may be an issue with the new hospital. We do admit young people to the inpatient unit but it is done often with extreme reluctance and often people have to be extremely unwell, probably psychotic. It's usually for adults for safety to make sure that they are safe. We do not do an awful lot for young people on the inpatient unit. Things are far better done in the community with counselling and social support, emotional education and stuff, so it is usually only a couple of days.

Madam CHAIR: I suppose, Rob, I am talking about that age group that 13, 14 young group.

Dr PARKER: No, we haven't got it.

Madam CHAIR: So, if they do stay in the home - just say the family is distraught, they need - so what sort of follow up and support is given to that family to look after that young person in the home to make sure that they don't walk off? I know a number of people who lost their children because they have not been able to watch them 24/7, so what support is given to those families?

Ms HENDRY: It depends whose attention they come to. If those young people are referred to us, for example, we do have a child and adolescent specialist service, however, they are quite stretched, so there is a great need for mental health services for young people across the board really. So, support will be provided to the family and the young person. Obviously, they receive any treatment or intervention that was required and education to the family about how to support them better in the home, but if you mean are there people that can then go and spend considerable amounts of time in the home supporting people, we don't have that kind of capacity, like a hospital in the home type scenario. Headspace would also offer a similar service to young people and their families. But it is difficult.

If people really require a very high level of supervision and intervention then the new inpatient beds will at least create an area where they can be cared for separately outside of the main adult environment. The reluctance to admit at the moment sometimes is really about the suitability of the environment as much as whether the young person actually needs inpatient care. I think that will improve situations for young people who are really acutely at risk but, as Rob said, the majority of the work needs to happen in the community and needs to happen on more of an ongoing basis.

Madam CHAIR: I have seen in a remote community where someone will have quite chronic psychosis and - I shouldn't say going mad in the community - but you know what I mean. They are uncontrolled in their community and the community finds it hard to be able to respond, so it is an issue.

Ms HENDRY: It is really an issue and one of the things when talking to some of the people from communities in terms of young people and the risk of suicide - not if they are psychotic obviously; then we need to really intervene with specialist mental health services, but is having a safe place for that person to be. So, we discussed the possibility, or we would like to explore the possibility, of extending the remit of some of the safe houses in communities, so there is actually somewhere that you might be able to provide support in a contained way to that individual. It might be that they will sober up or they won't be feeling so bad after a short period of time anyway. In some communities, there isn't really anywhere to safely care for that person just over that critical period.

Ms WALKER: The Suicide Prevention Action Plan expires this year. What are the next steps around that? Obviously, an evaluation about the effectiveness of a whole-of-government approach, but what are the steps are in place as to where to next?

Ms HENDRY: We have been talking to the Commonwealth about having a forum early next year and inviting all the stakeholders. We did that prior to the development of this action plan as well, and we have done a number of forums which have been fantastic. People have engaged really well. They provided a lot of on-the-ground information that has been helpful to government and to other service providers about what is happening and what they think might work. We are intending on doing that again early next year. The outcomes of the committee, as well, will really inform us about where we want to go.

There was much commitment to the action plan, but the majority of the actions outlined in there by the various government departments were of existing activity because there was not any specific funding source. There were not a whole range of new activities. The process did not work that well in getting a more concerted whole-of-government approach. One of the recommendations we have is that, perhaps, it becomes a standing agenda item on a much higher level committee, so we really get the buy-in at the very senior level. Then, the emphasis by government that it is a priority may assist to actually achieve more over the next action plan, if that is the way we go.

Ms WALKER: I hope, as well, that as part of the review going back to grassroots level out there in regions and remote areas about the success they have had in the Tiwi's, and if their familiar with the success out at Ganyagala/Yirrkala in reduction of suicides. The effectiveness of that is because it has been driven at grassroots level with strong senior people standing up in that community and tackling head-on what their issues are. Recognising as well, when we talk about whole-of-government, we have a new layer of government in there with our shires, and they have a key role to play in youth programs, youth diversion programs, Youth, Sport and Recreation programs.

Ms HENDRY: You are absolutely right; we do need to look at all areas of government. We also need to partner with the community in that because government cannot do it by itself, and there is a lot of expertise in the community sector. However, we cannot underestimate the fact that young people need something to do with their time, and they need a sense of belonging that is provided through participating in sporting teams or in other ventures that will really help them in their development and protect them against suicide. That has come through in many of the submissions.

It is certainly what we are trying to do at the moment. We have had fantastic uptake on our, fledgling at the moment, boxing program which has a psychological intervention component to it. The hook for young people is the boxing component. It is so popular at the moment with schools and young people, and teachers who are wanting to train, it really has just taken off unbelievably – and we still do not have a permanent venue; we are still in the process of negotiating that.

Ms WALKER: Where does that operate? I have not heard of that program.

Ms HENDRY: It is called Counter Punch. It has only started this financial year, and it is operating out of borrowed premises in Tang Street in Coconut Grove. There are referrals from a whole range of agencies and a whole range of schools are actively involved already, including the teachers from those schools. But we also want to target young people who are not engaged in schools as well. So, people like Mission Australia are involved in that.

It is really what you hear across the whole of the NT in terms of; young people not having enough to do, not obviously staying engaged in school which is another protective factor and the difficulty in keeping them engaged and keeping them away from destructive behaviours. The shires have a big part to play in that.

Dr PARKER: The Clontarf Academy, obviously, too, which is in a number of Northern Territory schools now, appears to be having really good outcomes between the school retention and ongoing work after school. That seems to be a couple of issues. There is the stuff that Bronwyn was talking about where kids actually have a range of activities it is not just the football; it is X-boxes and having a room at school they can go to with a range of activities to do as long as they stay at school. It is also having a mentor; someone you can relate to emotionally. That is particularly important in the context of adolescents.

Ms HENDRY: Yes.

Dr PARKER: The federal government is expanding the funding to Clontarf and I am really hoping - one of the problems is it has been primarily targeted at boys rather than girls, although Clontarf is now looking at having academies for girls as well. It is having really good ongoing mental health benefits for that particularly vulnerable adolescent group.

Ms HENDRY: Yes, certainly with the boxing program and the mentors Rob describes, you need adult mentors but also identify leaders within the young people themselves. That is a really good combination of having young people who have a leadership role and other young people who might be more at risk. You are not singling out kids at risk and congregating them together, but having a much broader approach.

Mr STYLES: A couple of observations. One is the importance of the mental health of communities which in turn relates to the mental health of individuals who are part of those communities. IQ and education are very important; however, one thing I have picked up over the last 10 or 15 years is the importance of emotional intelligence. If you do not have that, IQ can be useless to all of us as a community.

The other thing is, 60% of people who complete suicides do not have medical intervention prior to. That is the figure, is it not?

Dr PARKER: The research appears to indicate 60% of the people who committed - this is through coroners files – did not appear to have any intervention of helping the person prior to the suicides.

Mr STYLES: They are the brain explosions we have that say; obviously the answer to this is to go and suicide. The job is right, send a note, send a text, get everything organised and go and do it.

Dr PARKER: Virtually none of them have - one or two would leave messages. Many people do not leave anything behind, and that is why the coroner's constables often have a difficult job to disentangle all the issues. There are a few who have a level of organisation; unfortunately, most do not. There is no precursor; you cannot just pick things up.

Mr STYLES: So as a community, if we want to try and cut the human and emotional cost to the community, we can look at 60% and ask how to reduce that? Obviously, there are other methods involved with people who display some predisposition or give a clue through medical interactions or family. We can identify some of those people and say: 'Gee, you need some help' and we put in resources to do that. However, there are many people out there who, for some reason or another, get to a point where they complete suicide without letting too many people know.

How is it, as a community, we can go through – there is home, there is school, or community events or something. There does not seem to be a great range of ways we can do that in a bulk way. I have looked and said especially young people - if there is physical, emotional or sexual abuse at home that writes home off. It is obviously why they have issues; home is not a safe place to be. That leaves school or community events. Schools would be the obvious choice and the greatest one because kids are there. Kids may not be at community events where you can have a stand or a stall or some education type of thing.

What are your views on how we deliver that? If we go to schools, who delivers it, what type of resources do we need, and what extra resources do we need? Is it school-based nurses, teachers, more counsellors, school-based police officers, parents or workers? What are your views on how we look after that 60% and get the message through to them there are alternatives?

Big question; however, it opens it up to a range of stuff.

Dr PARKER: School is a really important aspect; however, who does the education in school is important. A range of people can do it. MindMatters, or something like that, is a crucial issue; and whether you need extra teaching staff to actually do that. I suppose the issue is that suicide is one of the issues you don't want to make too much prominence for it. The accepted wisdom is if you keep talking about it, it is not a good thing and people may end up committing suicide as a result of all the actual focus on it. So what you need to do is to get people to recognise it but not actually tell them suicide as such, but it is more an emotional regulation thing you are talking about.

I suspect there is a range of resources you could enhance people for that. Every child in Australia should be doing MindMatters as a part of their essential curriculum. The involvement of parents in schools and having parents, particularly in Aboriginal communities, having Aboriginal leaders coming in and talking to the kids about the culture and about strength, and about how they cope as people, is really important. So may be more involvement of parents and community leaders in school. And the sort of stories you are talking about, where people do tell stories that try to enhance the concept of who you are as a person and empower themselves may be really useful as well. That could be a school-based police person; it could be a parent who comes in. Again, I think it is very much for the school to try to identify who they feel are the people who may adapt to the best interests of that particular school population.

Mr STYLES: When we say there are various things as a community we do in schools to try to drug-proof kids: we give them skills, we give them capacity in a whole range of different ways. What I am suggesting here and asking is: how do we actually build a capacity in young people and give them a suicide proofing environment? I actually think I have got some of the answers to that but I am interested to find out how you guys would go about that so, as a committee, we can say we can make recommendations that we need more resources and counsellors.

That is one thing that has come through very clear: we do not have anywhere near enough counsellors in our community to deal with the emotional intelligence issues that are confronting us. They are building daily, but we are not keeping up with the resources. That is one resource we can put in. What other resources do we need to recommend to government to say, for the health of our community - because if we do not have a healthy community, what are we working for? So it is really important that we actually elevate the importance of having the mental stability in our community, and the capacity in our community to resolve some of these issues, and the commitment to build into our young people so we don't get to that particular place in the future.

Dr PARKER: Again, I think it is a school-based issue. I think alcohol governance - and I know the Territory is going towards a way with that with the new legislation, but I suppose just having a safe community where like Tiwi where kids could go home at night and feel safe and go to sleep, and that actually relates to a governance factor within a community. So communities having a measureable governance and they have to demonstrate alcohol being a privilege rather than a right. That is a key issue and you have to maintain a certain degree of community coherence and governance to continue your alcohol supply. It is a really important issue, so again, hopefully it will ensure that a lot of kids will go home and feel safe at home. If kids feel safe at home, can actually sleep well, and are not having to put up with drunken adults and potential abuse issues, they can actually go to school and learn and hopefully feel safe from that environment. And the things that Bronwyn is talking about, I think a lot of parents are really well intentioned but they often need help to be better parents and that is a good issue as well.

Mr STYLES: So would you agree that while working through it and going back, here we are, go back on the continuum to right back to where you saying we need to ensure that kids actually have that safe environment so that they grow up and don't put themselves in a position, or aren't exposed to particular human conditions, where they do think that suicide is an option. So do we need say more shelters? Do we need a particular place in communities where, for the sake of the exercise, we have a couple of houses with a big fence around it where women and children can go, if it is men, and get a safe night's sleep without people either bashing them, sexually harassing them, or whatever? Do we need to go back that far and say, for the sake of this particular group, for their mental stability and being able to get enough sleep, go to school, do all that sort of stuff, we need to do things as basic as that?

Ms HENDRY: People do need a safe place when they are at particular risk of suicide and that can be different for a variety of people but I think we did talk about maybe in communities the potential for using those safe houses for people who may be at risk but there are other ways of providing that safe environment which is identifying people in the community that will help to supervise that individual. So, there are a range of strategies that you can take and I really want to reinforce what Rob was saying: to provide suicide-proof individuals, you need suicide-proof families, and suicide-proof communities. It is very difficult to achieve one without the other and also in terms of imparting, giving people knowledge and power

about how they can be more resilient themselves - just talking at them in a formal sense. I mean that is one way of doing it and we should do that in schools and really create that mental health literacy, but also incorporating that into other activities I think is really important.

So, kids sometimes will turn off when they think someone is preaching at them but if you can introduce the message a little more subtly and have it in conjunction that something that they are actually enjoying to do, I think that can have a really positive impact. Especially when you are talking about adolescents who really sometimes don't think we know what we are talking about.

So, I think you have to take it a slightly more subtle approach in that regard.

Mr STYLES: Obviously, how you do these things - there are three categories: urban, rural, and remote and they could be as different as chalk and cheese as to how you go about achieving those things.

Ms HENDRY: The principles are the same though, really.

Mr STYLES: The principles - but how you get the message across can be totally different between say the northern suburbs, Nakara, than the Tiwis, or down in Central Australia. The delivery method in Central Australia would not be the same as what it is in Nakara.

But, the other thing that you mentioned there is like women look at safe houses and my experience in life has been that some people go through some horrific traumas at home just through – that is the only place you have, so obviously kids do not want to go there, parents do not want to go there sometimes. To have these safe houses around the place and the ability for people to have short-term interventions. I do not think we actually have - I think we have a couple of women shelters - I think we don't have anywhere near enough but I know the government is trying to take over a certain street out there, where as those houses become vacant, we keep adding on to. Which is a great thing because it actually gives people - but the problem is - two years ago they had to turn away 368 families because these are people who came there because of trauma and they have simply got nowhere for you to go.

Insufficient money to send them to a motel, they just could not look after them, so those people had to go back home to difficult situations. That is hard to track as to whether in a couple of years down the track, do we have any suicides coming out of that particular environment. So hard to try and get data on it, but as a community I think we need to look at that.

I used to run a safe house myself as a school-based police officer. I have had families turn up and live there for a couple of days as a break because there is nowhere else. So, there is obviously need in our community and I raise it here so that, hopefully, we get some interaction from you people who may be able to give us some answers or at least it is on the record.

Dr PARKER: I suppose part of the issue that Bronwyn referred to earlier too is sustainability of funding. If you are going to build safe houses, you need to have ongoing funding for people to actually look after them and be there and that is often the cost and the problem is with three-year cycles of government of course, government comes and goes, you build a house, funding falls off, somebody is not employed, and the house falls in disrepair. I think the issue is not just – if you are going to put them there, well and good, but to have an affective way of developing human support within those structures on an ongoing basis is really an essential part of it and so you are looking at that sustainable funding as well.

Madam CHAIR: And being creative in that – encouraging the private sector because I think that we don't get the corporates or anyone else involved in this because this is a community investment and I think we have got to get creative. I am just conscious of the time and I want to get a couple of things on the record. Bronwyn, can I say thank you for the comprehensive submission from the department which outlined all the funding and certainly some of the statistical information that is contained in your submission and also yours as well, Rob. We might come back again to both of you because it would be important for the committee to get the right interpretation of the statistical information as we are making our deliberations and recommendations to the parliament.

Just a quick one following on from what Lynne was saying, or questions she was asking, about the suicide prevention plan. There was a suicide prevention coordinator position. Is that currently filled?

Ms HENDRY: The person is on leave, so we have Monique, sitting behind me, who has been doing some work in suicide prevention whilst the person is on leave. That is Sarah O'Regan; many people would

have met. She is due back at Christmas time. It is uncertain at the moment whether she will be coming back. We will certainly be filling that position if Sarah did happen to resign.

Madam CHAIR: Does that position cover urban as well as remote? Regional and remote?

Ms HENDRY: It covers the whole of the NT. With the new funding we received this year, we will have two positions: one more focusing on some of the initiatives we are rolling out and working with some of the groups involved, and the suicide prevention position. As you can imagine, it has been quite a big task to actually get enough information, work with all the stakeholders, and really provide a high level of coordination with one person doing it.

Madam CHAIR: Are there any more questions? Any further questions? We will stop there. Thank you both for that and for the submission.

Ms HENDRY: Thank you.

Dr PARKER: Thank you.

NT Police
Commissioner John McRoberts

Madam CHAIR: On behalf of the select committee I welcome Commissioner McRoberts to this public hearing into current and emerging issues of youth suicide in the Northern Territory. Thank you for coming before the committee today. We appreciate you taking the time to talk to the committee and look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligations not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned what you will say should not be made public you may ask that the committee go into a closed session and take your evidence in private. I will ask you to state your name for the record. We know the capacity in which you appear and I will invite you to make a brief opening statement before proceeding to the committee's questions.

Commissioner McROBERTS: Thank you, Madam Chair, and good morning to panel members. My name is John McRoberts and I am the Commissioner of the Northern Territory Police. Thank you for the invitation to appear before this committee.

Suicide, particularly youth suicide, is a global problem that academics, health professionals and frontline emergency service personnel endeavour to understand, respond to and reduce each year. Sadly, the Northern Territory has more than its fair share of suicides and far too many Territory families suffer the consequences long after a person dies. In fact, due to our geography, the size of our towns or communities and the strong bonds that exist between community members, it is reasonable to believe that a suicide can potentially have a profound impact on every single resident.

Our national suicide figures paint a grim picture. Australian Bureau of Statistics data reveals there were 2132 deaths from intentional self-harm across Australia in 2009. On a per capita basis, the national rate of suicide is 9.6 per 100 000 population. Of particular interest, no doubt, to this committee is the fact that suicide accounted for 22% of all deaths amongst young men aged 15 to 24. In other words, one out of every five young men who died in Australia in 2009 intended to self-harm.

Closer to home, like road deaths, the Northern Territory has figures that are far from acceptable, in my opinion. 2005-06 data reveals a standardised death rate from suicide at 20.1 per 100 000, twice the national average. Perhaps of even greater concern is the fact that over the last five financial years, July 2006 to June 2011, our police officers responded to 419 attempted suicide attempts; 196 of these involved young men aged 18 to 25; 153 involved young women in the same age category; and of those 419 incidents, 189 involved Aboriginal youth. Thankfully, these incidents did not end tragically. I hope the people involved overcame their personal difficulties and are now leading healthy and rewarding lives. The Northern Territory police is committed to keeping people safe.

We will continue to work with other government agencies, the NGO sector, and the wider community on initiatives that will see a significant reduction in the number of people who take their own lives or attempt to do so. We stand ready to respond to reports of people contemplating suicide. Our officers will respond as

a matter of priority and deal with the incident in a professional manner as per the first-class training by our college. And, at this stage, Madam Chair, with your indulgence, I acknowledge and congratulate the fine work, not only of our police officers in proactively dealing with incidents where suicides have been prevented, but in the way that they have responded to the unfortunate cases where someone has died.

As articulated in our mental health and suicide intervention training material, suicide is not chosen. It happens when pain exceeds one's capacity to deal with it. The manual goes on to say, and I believe these are salient points, "Suicide is usually not about seeking death. For many, suicide is about escaping pain." However, out of all the statistics comes good news. According to a Better Health Victoria fact sheet titled *Youth Suicide, the Warning Signs*, about 80% of young people who complete suicide told someone they intended to kill themselves.

For me, that is an encouraging finding, for it means there is an opportunity through appropriate support and intervention to prevent a young person from taking his or her life. It is a well-documented fact that reports on the details of individual suicides increase the risk of copycat behaviour. It is therefore an embedded practice amongst agencies such as police and indeed the media themselves, that such deaths are not publicly reported. While I acknowledge the importance for this practice to continue unless emerging evidence suggests otherwise, I welcome this opportunity to address in broader terms, this tragic issue, and the loss to our community as a result of suicide which largely goes unspoken. Thank you, Madam Chair.

Madam CHAIR: Thank you, Commissioner, and I believe all members of the committee echo your sentiments and share your view about police being at the front line and their endeavours to deal with this. I extend also that the committee shares your view. I will now ask if members have questions.

Mr GUNNER: Just interested in that statistic at the end, 80% was it of people will say "help"?

Commissioner McROBERTS: Yes.

Mr GUNNER: Something that we have been talking about with witnesses yesterday and today is that first point of contact where someone goes from being in the general community to receiving the help they need and how the preference would probably be that happens at school or amongst family or friends but tragically often not. From the Department of Health, we heard earlier that 60% of people who complete suicide do not seek health help. We heard yesterday - the last witnesses were the Aboriginal Peak organisations and they talked a bit about police and youth justice - but they saw it in some respect as a risk factor whereas in many ways it could be the first contact or the first opportunity someone has to meet someone who is trained and can actually help guide them to someone who can help.

We heard earlier from the Department of Health how police have, and this is in your submission, received mental health first aid training. I am really interested in hearing more about that first point of contact, that conversation a police officer might have with someone to help them and how well your general duties police might actually do that when they talk to someone on the street having a chat, how that works in practice, and what else could be done that we could recommend to help you.

Commissioner McROBERTS: Well, ideally, police will play their part in any community, whether it be urban or rural, in taking a proactive approach to the communities they live in. Particularly in the Northern Territory, we are fortunate we have police in many small communities where, in other jurisdictions, we may not have a footprint. Hopefully, those police officers are able to have a very positive impact on the young people in those communities. Hopefully, they are able to influence them to grow up, particularly through adolescence, to live healthy and productive lifestyles. For most part, police do that very well in our communities.

Sadly, there are cases where police react to these incidents because it has been beyond their capacity to influence people positively in a proactive way. We stand by, as probably the only truly 24/7 emergency response agency with a huge footprint across the Northern Territory, to respond to people, no matter what their difficulty. That is a commitment we make, and a commitment we take seriously; that we will respond to provide people with support in whatever capacity it may be, particularly, however, those who are presenting with life-threatening choices.

Mr GUNNER: Another thing we have talked a lot about postvention, the importance of postvention, and that police probably play one of the largest roles in that. We heard a really positive story yesterday – well, I am not sure positive is the right way of saying it. There was a suicide completed two weeks ago in Alice Springs Town Camp which was, obviously, tragic. She spoke positively about the role police played the next day in coming in and just sitting around ...

Madam CHAIR: And talking to the family.

Mr GUNNER: ... and talking to the family in an informal way about what had happened. I was wondering what your thoughts are around postvention and the role of police, and how police can help.

Commissioner McROBERTS: Once again, I am grateful to hear the positive feedback on our officers in that particular incident, notwithstanding it is an incident I wish had not happened. Police play a critical role in sharing information with people. Particularly when family members, friends, loved ones are grieving, from my 30-odd years experience, the one thing they desperately want is information. No matter how the person came by his or her death, grieving friends and family want information.

As much as we possibly can, without breaching privacy or other aspects, particularly where a prosecution may be arising, we should share with people information about the incident so they fully understand. Particularly for small communities, it prevents rumours from escalating into more difficult challenges for us to deal with.

Ms PURICK: When police respond to a death in a home and it is suicide, is it treated as something else? We heard yesterday how - I am not sure if it was an urban setting or a remote setting - they went into a home and the person was dead, and the first thing the police did was tell everybody to get out of the house, which distressed them even further. In the police rules, is that what you have to do? You have to assume it was not suicide until you can show evidence that it was suicide?

Mr GUNNER: That was around the declaration of a crime scene. They said that it had to be declared as a crime scene.

Ms PURICK: Yes. Is it always declared a crime scene until known otherwise? That is what I was trying to say?

Commissioner McROBERTS: Generally speaking, that is the case. It is important to highlight that police do not make a declaration of suicide; that is a matter for the coroner based on the evidence we gather on the coroner's behalf and present for consideration.

I make no apologies for all deaths that police respond to being dealt with as a crime scene in the first instance. I think that is what the community expects; I think that is the appropriate way to deal with it on behalf of the family so we can make a thorough and objective assessment of the circumstances that led to that person's death. It would be a terrible circumstance to treat a matter informally as a suicide, not gather appropriate evidence, and later find there was some involvement by another party and, because it was not handled in an appropriate manner on first arrival, we have lost some evidence or an opportunity to pursue a prosecution.

Mr STYLES: Commissioner, we have had nearly a day and a half of evidence. We are talking about the mental health of communities, the mental health of individuals within those communities, capacity building and prevention. We have heard 60% of suicides are by people who have not had any interaction with medical interventions; they are people who, for some reason, have gone out and committed suicide. I thought your opening introduction was excellent, sad as it is, but an excellent presentation.

When you look at some of those figures, we are also looking at how to drug-proof young people. We are also looking at how we suicide-proof young people and build capacity in our community from all walks of life. In relation to police, they, until recent times, formed part of welfare teams in schools. We have looked at three areas where young people get their capacity building from - from the home, from school and from community events where there are information booths and all types of things mental health run and particular days where youth can engage with people they can get information from. They are the three areas.

When we take out the home through physical, sexual or mental abuse that takes that particular aspect out, if they are not at community events, that leaves schools. School appears to be a very big place for the community to give kids capacity to withstand the pressures that lead to some of them taking their own life. How do you currently see police being involved in schools and part of that capacity building, both in primary schools and high schools and, to a lesser degree, universities?

Commissioner McROBERTS: Thank you for the question. I think police can play a very important part in schools in influencing young people and the decisions and choices they make, particularly through

adolescence, but into their adult life. As I travel around the Territory visiting our officers the length and breadth of this jurisdiction, I see outstanding examples of where our police officers engage with school-aged children not only in the school, but far beyond that. I am talking about sporting activities and Blue Light discos. Police play a very important part in their development and that is something we will pursue because anything we can do in a proactive sense, particularly if we are able to reduce the potential for a young person to even think about suicide, has to be a very good return on our investment.

Mr STYLES: Thanks, Commissioner. I agree. You are obviously aware of my previous life. The role police play in schools is as very positive role models so I am hoping out of this committee and the hearings the ability will be given to the Police department to strengthen that. In our deliberations I will strongly suggest you be able to carry out the things you are saying in a greater fashion.

One thing has come through, and from my own experience, is the anxiety levels of young people, even at primary schools and within their community, about lowering their anxiety levels and giving them some form of encouragement and protection from those in the community who will bully and pressure young people. We have heard about cyberbullying, we have heard about bullying in general around the place as being a cause, in a large degree, to someone perhaps taking their own life or at least attempting, and those cries for help.

Have you any comment on how the police might contribute to the overall reduction of anxiety levels of young people going through school, after school, and generally in the community?

Commissioner McROBERTS: I would hasten to say that it is not a matter that police alone are going to be able to deal with. It is important that we as a community, we as part of a collective of government agencies, we as part of a collective of non-government organisations which work in communities and larger towns, recognise that there needs to be appropriate interventions and support mechanisms for young people, particularly upon which they can obtain information. They can obtain information privately and without fear that accessing the services that are available are going to lead to additional bullying or that sort of behaviour. I think to some degree we have to place particularly young people's lives on a continuum where we intervene to prevent the blocks that probably lead to them choosing to consider self-harm.

If I can talk about this continuum, we as a community need to do better at ensuring that when children are born in Australia they are born free of some of the clinical conditions that they sometimes experience. I am talking foetal alcohol syndrome - and that is not something that the police will deal with. We as a community need to ensure that when young people are brought into this world they have safe and healthy lifestyles as infants. Once again, police do not play a direct role but we do play a role in identifying children who are not enjoying that sort of a lifestyle through our child abuse taskforce and the very good work they do in conjunction with their colleagues and the Department of Children and Families. That is a very important part to play to ensure that infants start to develop in an appropriate way.

For me, and once again as I travel around the Northern Territory, we have an appalling school attendance rate. I go to communities regularly and during school time, I see children who should be at school. You mention the fact that school is a place that can have a profound impact on the development of young people. It therefore suggests that what we ought to be doing is ensuring that these children are at school. Where, as I move around the Territory, I see schools not only as a place of education but a place of nutrition, a place of safe haven, a place of wise counsel, a place of mentoring and of support, a place that is free of some of the difficulties that young people experience in their home lives. So schooling to me is probably where we can make the greatest impact in the short term. If we were just to get all these youngsters to school, we can then start to assist them in developing a healthy and happy lifestyle.

Mr STYLES: I could not agree more with you, Commissioner.

Madam CHAIR: Commissioner, police do play a vital role in often being the first response to either attempted suicides or fatal suicides. What training and resources are provided to officers to help them deal with this role with a particular emphasis - if we look at the statistics and we have high Indigenous numbers in a lot of remote communities we have ACPOs or Aboriginal Community Police Officers, what training and support is provided to those officers to deal with this issue?

Commissioner McROBERTS: Madam Chair, we do have a very comprehensive training package for police officers. I stand to be corrected but I think it is delivered over four days and there is also an online training portal. We have our mental health and suicide intervention training. That is not specifically about suicide but it is this whole issue of how police officers best respond to people who in the first instance are believed to be demonstrating behaviour that may have, or is possibly the result of a mental illness. So

police officers are at the front line of this. Often family members, community members, and indeed in some cases, health practitioners call upon police to provide assistance in a variety of forms to deal with people who unfortunately are dealing with those challenges in their life.

Madam CHAIR: Commissioner, what systems for referral and support for family members are used – by police, if you are involved in a situation, what is their next step?

Commissioner McROBERTS: Police throughout the Territory are very well equipped with referral material. I am happy to share some of the material that we issue at police stations and to young people. It is timely that this committee is sitting now because only this week we released throughout the police force a new publication, not our own, but one which we are happy to endorse and distribute. It is called *A Mind Frame Resource for Police* and it is a ready reckoner for police who are responding to a person exhibiting signs of mental illness or a ready reckoner for police when called out to an incident involving a suspected suicide. This sort of material demonstrates the level of maturity that now exists in the Northern Territory police. We recognise this is a critical role for us to play. We take this very seriously because people's lives are at risk and we are absolutely committed to our mission of keeping people safe.

Madam CHAIR: So, every police officer and every unit has those packs with them. Is that what you are saying? They will carry those packs, Commissioner?

Commissioner McROBERTS: I cannot put my hand on my heart, Madam Chair, and say they have them as I sit before you, but we are in the process of distributing ...

Madam CHAIR: Of making sure those systems are ...

Commissioner McROBERTS: Yes and I am happy if it might assist the panel to distribute the internal - or to hand to you, table - the internal broadcast that we released only yesterday on this very issue.

Madam CHAIR: That would be good. Thank you, Commissioner.

Ms WALKER: Commissioner, Madam Chair just asked you about training that is provided to officers on-the-job, and I have absolutely no doubt that, on a daily basis, your officers are confronted with very confronting situations. Further to that training, how do you meet that need in recognising those responses are culturally appropriate and also recognising that around different locations in the Territory, it is not a one size fits all approach. So, how do you assist your officers in the cultural aspect?

Commissioner McROBERTS: Ongoing training, particularly when it comes to cultural issues, we have Aboriginal Community Police Officers who are very able to assist our officers understand the complexities of cultural issues in the communities in which they are posted. Through in-service training, through supervision by more senior officers who are more experienced police officers, so it is an ongoing arrangement. One that not necessarily occurs by way of formal training, but on-the-job training, life skills, understanding how to deal with people, understanding the interpersonal skills that are required to deal with all forms of people we come into contact with on a daily basis.

Mr GUNNER: Police are 24/7, that is what you touched upon in your opening comments. We heard yesterday from the Aboriginal peak organisations and this is a question I forgot to ask Ms Hendry who was before us as a witness. They commented that many suicide help services shut at 5 p.m. and you are obviously on the clock all day. Do you find that there are any particular times of day or night where there is a challenge for police in getting cooperation of other services?

Commissioner McROBERTS: I do not have any anecdotal evidence that that is the case, but can I say from my many years experience of policing, regardless of where you police, if services that police might seek to access or make available to somebody with whom they have contact are not available when we are working, then arguably there is a deficiency. We are a 24-hour response agency.

I can give you a completely different example to demonstrate it. If we respond to a violent family incident at 2 o'clock in the morning, we do so because we are a 24/7 response agency, a law enforcement agency expected to do that type of work. There will not be many places in Australia, including the major capital cities, where the level of support for victims will be available at 2 o'clock in the morning. It is just a fact of life that we cannot actually deliver the full suite of services in conjunction with our response.

I sit here before you and say it would be nice to have, but we have to be realistic and recognise that, particularly in a jurisdiction like the Northern Territory where police are operating in communities with as a

few as 40 residents, not all government services or non-government organisations that provide wonderful support for people on a day-to-day basis can always be available.

Ms WALKER: You mentioned in your submission - and I am familiar with it, being a representative of the East Arnhem area - in regard to the statistical data that has been collected from 2007 to 2008. It was done by the Officer-in-Charge at the time. I have obtained a copy of it because I was a member of the Harmony Group. It is a fairly extensive study in recording attempted and successful suicides breakdown in ages, sex, what the nature of the suicide was, attempted or otherwise. Is that a routine study that would be done across areas or was this something that was done in the East Arnhem region because of the particular OIC who saw it as a need to capture that data? And there is more than data; there was commentary that accompanied that.

Commissioner McROBERTS: No, it is something we do frequently to understand the nature of issues that confront police. We do not do it only for suicide; we do it for fatal road crashes, for serious injury crashes. We do it on a daily basis for the number of unlawful entries, for the number of assaults. We try to paint a picture of what the demand on our resources is across the Territory on any day.

Obviously, there are issues that are of greater concern for us. Only last year, I asked our Coronial Investigation Unit to prepare a report for me which painted a picture of suicide in the Northern Territory. Whilst those figures were preliminary, I recognised then we certainly have some challenges if we are to, I would like to think in the first instance, meet the national average but, ultimately, as a modern and sophisticated society, I would like to think across the Territory and, more generally in Australia, we stop seeing so many people take their own lives.

Mr STYLES: Commissioner, I have not had a chance to really read of this yet, but just a question that comes out of that. How many bodies do police have representation on in relation to mental health issues? Is there a particular area of the police force that says it needs to be in touch with mental health, the Health department, NGOs? There are obviously meetings occur on a quarterly basis; do police have representation on those bodies when they meet?

Commissioner McROBERTS: We do. We are represented on a wide spectrum of various committees and it starts at the top. I meet, from time to time, with the Chief Executive of the Health department and, only in the last couple of weeks, have we been negotiating a new memorandum of understanding for police officers dealing with mental health patients. That is an important piece of work to ensure police seamlessly integrate into the health system when we either deliver people to health facilities suspected of having a mental illness, or the mental health services or indeed the health services call upon us for assistance.

There are senior government agency meetings called the Coordination Committee where all chief executives talk about a variety of issues. There are inter-agency tasking and coordination groups in all the major towns and they cascade down into local tasking and coordination groups where the officer in charge of a police station would interact with colleagues from around the community, people of influence, elders and the like to address the issues unique to those communities.

It is fair to say when I heard somebody mention one size fits all, it would be a dangerous practice for me to instruct my officer in charge at Yuendumu how to police Yuendumu. Our sergeant there is doing a wonderful job in that community, but she understands what is going on at any point in time, she knows who the key players are, she interacts and her staff interact with people who are possibly more at risk than others.

The nature of policing in a modern and contemporary society is that we need to empower our people throughout the police force to tailor their services to best meet the needs of the community. Something we do well in the Northern Territory is initiatives that deliver tailor-made approaches for vulnerable groups. I am very proud of the work our people do in hoping to influence young people to grow up to be responsible citizens.

Mr STYLES: We have heard evidence that in a community welfare teams at schools put together - the whole range of people who form part of that welfare team - are youth engagement police officer still part of welfare teams in all high schools in the Territory?

Commissioner McROBERTS: I do not know the answer to that question; however, we continue to place a great emphasis on the role youth engagement police officers play. Last year, not only did we cement our commitment to that, what we endeavoured to do by having our youth engagement police officers effectively report through the police station, was to ensure the conduit of information between what

goes on in a school community links in to the information and the intelligence police officers who are working in the community have.

I would hate to think that a police officer working in a school is working in a degree of isolation where he or she does not understand what the patrol officers see going on and vice versa. When school finishes at three o'clock in the afternoon, I want to think that there is a continued level of service that our police officers are able to provide particularly to young people. Most importantly, if a school-based officer, or a youth engagement officer, knows of a young person who is presenting with risk behaviours then that information or intelligence needs to be passed onto the patrol that might be driving around in the early evening and see that individual walking out of the community, and it starts to put together what this behaviour or this activity may be leading to.

Mr STYLES: Madam Chair, I was wondering if we could perhaps ask the Commissioner if he could take that question on notice: if police are still involved in those welfare teams in schools. We have heard that it is a valuable resource and it would be good to see if you possibly could get back to us on that.

Commissioner McROBERTS: I am happy to take it on notice.

Madam CHAIR: The Commissioner is happy to take that on notice.

Mr STYLES: Just roughly, how much reactive and proactive work they do these days with young people. I think just a distinction between what you might classify as the proactive stuff and the reactive stuff that they might do. That would be very valuable information for the panel. Thanks, Commissioner.

Ms PURICK: Commissioner, in your submission you do reference about multimedia, Facebook, text messages, and whatever, and how it makes cyberbullying a reality. But your ACPOs liaise with schools and families, raise awareness, etcetera, but is there anything in the police establishment where you are addressing it as a work unit or program? In other words, you know it is out there and it is illegal, but do you have people within your set up who formally working with either schools or someone? How do we know how bad it is unless we have started to collect data, or have people revealing it or perhaps researching it? Is it just there or do you actually have something formalised within the police establishment to look at it and deal with it?

Commissioner McROBERTS: Social media is probably best described as the beast that never sleeps. Frankly, I do not think any of us really understand the extent of the problem that you refer to. There is no doubt that anecdotally we hear of what you would suggest is the misuse of various forms of social media. In answer to your question directly, no we do not have a team of people working on that exclusively but from time to time, when reports are made to us, we intervene as best we can.

Certainly, from an incident that occurred either last year or late last year, you may recall a young woman and her parents complaining about some lewd suggestions that had been made about her on one of these social networking sites. They are a particularly difficult challenge for us. These sites are generally hosted overseas. Accessing information from them is particularly difficult and consumes considerable resources to access. There is capacity for people to create accounts using a *nom de plume* and tracking it down through the Internet service provider is equally difficult especially when they are offshore, and do not, in the countries where those companies operate, have the same arrangements for sharing or providing information to law enforcement agencies.

The issue of cybercrime and the related aspects of the Internet-based technology is something that police commissioners around the country are addressing as a COAG directive, but I think it is probably too early to say exactly where this will lead us in the future.

Madam CHAIR: Commissioner, yesterday the committee took evidence about the negative impact of putting young people or a number of young people into the criminal justice system and particularly young people with both social and psychological problems. Those organisations felt that it was easy for the police, rather than trying to deal with those young people in a different way, that young people were being pushed into the criminal justice system. What options are there for police to divert young people to services if they feel that, rather than pushing them into the criminal justice system, that they go through a diversionary system?

Commissioner McROBERTS: Madam Chair, I certainly don't see any evidence in the Northern Territory that police officers push young people into the criminal justice system rather than diversion, but can I say from the outset the challenge for us is to hopefully get to a point where no young people enter the

criminal justice system in any way, shape, or form. Once you enter the criminal justice system, there is always a risk that you will go on to bigger and better things and that's why we are passionate about diversion. We hope that by diverting people at that point in time will hopefully be the end of their unlawful activity.

There is certainly capacity for diversion in the Northern Territory. We use it regularly. It is something that we train our staff in. Wherever possible, depending on the type of matter that our police officers are dealing with, diversion is always considered as a possible option, but clearly for some offences and based on the antecedents of the young person at the time, diversion may not be an option. So, there will always be, effectively, two pathways. And, indeed, there are probably three pathways, because I suspect that police officers wisely use their discretion on a number of occasions where they could arguably refer a young person to diversion or they could refer a person to the criminal justice system, but based on the circumstances, they exercise their discretion and hopefully through interaction with parents or responsible guardians that person changes his or her ways.

Madam CHAIR: Thank you, Commissioner. Like the Department of Health, which provided us with quite a comprehensive submission, I thank you for your submission, and I just ask before I hand over to any other members who may have questions - the attachment to your submission has a number of statistical information both by suburb, common place, race, and also age breakdowns - is that information public information, Commissioner?

Commissioner McROBERTS: It is not, Madam Chair, and I would ask that it not be made public.

Madam CHAIR: Okay, that it is just used for the committee. That is why I wanted to just clarify that.

Commissioner McROBERTS: I fear, by way of explanation, that were it to become public it may create a stigma for a particular community or location, and my greatest fear is the young people, particularly in those places, may decide to self-harm.

Madam CHAIR: Okay, and that is why I thought I would clarify that. Most of the submissions will get uploaded onto the committee's website, but we will make sure that the statistical information with all of that data is not put up there.

In your submission, you refer to the Katherine Region Interagency Tasking Group as a model for improving cooperation between agencies, can you outline for the committee how the group works, are there similar groups in other regions, and what's being done to improve interagency cooperation across the Territory?

Commissioner McROBERTS: I am embarrassed to say I cannot tell you exactly how it works, because I have never been to see it, but I have only heard of its success and to the best of my knowledge I understand it is a group of senior people who come together to address the various issues that need to be addressed in a particular community.

The benefit of these groups is that they are flexible in their approach to issues, they deal with issues that are contemporary at the time. They are attended by people who have a capacity to make decisions on behalf of their agencies in towns. They are attended by people of influence in a community, such as elders and other respected individuals who do have a voice and will be listened to. But, once again, it is a case of what fits best for a particular place.

Certainly, in Alice Springs we now have a very effective group. We also now have a dedicated patrol coordinator in Alice Springs; a police officer whose task it is to coordinate the response of all the agencies, non-government organisations, and police on ensuring that, collectively, we deal with things in Alice Springs and the town camps rather than all going off and doing our own little thing, and others are unaware of what is going on.

Madam CHAIR: We will be travelling through the various regions, so we may write to get permission to have discussions or interaction with them. Say, for instance, in Katherine as well as Alice Springs.

Commissioner McROBERTS: Yes. I extend to you and your committee an invitation; if you are travelling, by all means I invite you to visit the Officer-in-Charge of police stations so you can hear a local perspective.

Madam CHAIR: Michael?

Mr GUNNER: I am good.

Madam CHAIR: Commissioner, in your submission, you outlined the issue of the accuracy of suicide reporting. It was also mentioned by the Department of Health. Is that a significant issue in how we report suicides in the Northern Territory? Would police rather it was not reported?

Commissioner McROBERTS: I am not sure I completely understand your question, Madam Chair. When you say reported, are you talking about it being made public, or are you talking about the reliable statistics?

Madam CHAIR: I suppose, published. No, maybe published reporting of suicide data.

Commissioner McROBERTS: I am always concerned that reporting a suicide may lead to another person taking their life. That would be a terribly tragic event, if someone chose to self-harm because of someone else or the reports in the media, or whatever other means it may be. That is a balance we have to strike because, clearly, there is a public interest. In fact, in many of the communities around the Northern Territory, the media does not particularly play a part. It is just a well-known fact that somebody has taken his or her own life.

As far as the reliability of the data goes, that is clearly a matter for the Coroner. From the small numbers - and I say this not to suggest we do not have a problem with suicides, but on a per capita basis we deal with, I think is something in the vicinity of 40 suicides per year. The figures are sufficiently small that the data is very accurate. But, there is always a possibility, for example, that a person could choose to commit suicide by driving a car into a tree. It, sometimes, is difficult, depending on the victimology, to fully establish whether the person had a road crash or it was deliberate self-harm.

Mr GUNNER: That was one of Professor Tatz's point; in fact, his argument around under-reporting which would, therefore, be uniform across the Territory versus national around how some of the reports ...

Commissioner McROBERTS: Yes, but from what I hear from our officers, the majority of suicides in the Northern Territory are clearly identified as a deliberate self-harm.

Madam CHAIR: I suppose this is more a comment rather than a question, Commissioner. Regarding your community engagement police officers, particularly the gentleman at Maningrida, I know in some of the communities where these positions are placed there is quite positive responses from the community in the engagement between the police officer and the community, which has been a long time in coming. That has been a good move by the Northern Territory Police.

Commissioner McROBERTS: Thank you, Madam Chair.

Madam CHAIR: Any other questions? Thank you for appearing before the committee, Commissioner.

The committee suspended.

**Department of Education and Training
Mr Paul Nyhuis; and Ms Eva Nicholls**

Madam CHAIR: On behalf of the Select Committee I welcome Mr Paul Nyhuis and Ms Eva Nicholls to this public hearing into current and emerging issues of youth suicide in the Northern Territory. Thank you for coming before the committee today. We appreciate you taking the time to talk to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private. I will ask you both to state your name for the record and the capacity in which you appear and I will then invite you to make a brief opening statement before proceeding to the committee's questions.

Mr NYHUIS: Good morning, thank you. Paul Nyhuis, General Manager for Student Services of the Department of Education.

Ms NICHOLLS: Good morning, everyone. I am Eva Nicholls, Manager of Mental Health and Child Protection for Student Services for the Education department.

Madam CHAIR: Would either of you like to make an opening statement?

Mr NYHUIS: I am happy to. Firstly, thank you for the opportunity. Student Services is probably the key agent or service provider for issues in the area of mental health and child protection. That portfolio encompasses a school counsellor program which sees a number of school counsellors primarily based in middle schools and senior schools. That school counselling program is right across the NT. We also have a school psychology service which involves a number of school psychs based centrally and regionally to provide psychology services. The majority of those services are in the assessment capacity which is about identifying students who have intellectual needs and disabilities, etcetera, so it is a stronger assessment role.

The other dimension of that is a very small team that we have really only just started to try to build and grow stronger which was on the back end of a Commonwealth project around a program called the Keeping Safe Child Protection Curriculum. We have just started to build a capacity around child protection as well which we have aligned with the mental health area for obvious reasons given the counselling agenda, the mental health agenda of school psychs and now the other child protection factor to that. Under the child protection area there is also some of the mandatory reporting which no doubt many of you are familiar with and that curriculum program which is about keeping young people safe.

That is a very broad and general scope of our work specific to this agenda. Student Services also deals with a lot of the disability services and behaviour and wellbeing, and all of those other agendas as well which often seem to interconnect. For the purposes of this committee, it is really that mental health and child protection agenda and our submission focused primarily on the school counselling services which is where we believe we have the opportunity to provide some support and intervention and prevention in this area.

Madam CHAIR: Thank you. Any questions?

Mr GUNNER: We have heard much about the importance of first contact, and schools have been specifically identified as perhaps the most important early intervention outside of the home or the family or friends. We also heard yesterday from MindMatters, they presented to us, which is targeted at senior schools. Now I am not sure the extent to which KidsMatters is in schools. I would be interested in hearing about KidsMatters. I am also interested in hearing about MindMatters where schools voluntarily ask them to come in. Does it work best when it is voluntary and they are asked to come in, or should we be looking at a more compulsory and earlier involvement?

Mr NYHUIS: I will start and then ask Eva to add comment. There are a number of issues. One is, to answer the last part of your question first, the whole notion of voluntary versus mandating something. As a former school principal, my response would probably be it is about wanting the community and the staff and the community wanting to engage with something as opposed to something being forced upon them. The MindMatters and KidsMatter staff actually sit within our area, which is a really nice complement as well, so we get to sort of look at some of those partnerships and strengths.

There are a number of those programs. We have seen KidsMatter and there are some schools that have had a take-up of KidsMatter and doing some really good things. Again, it is about a culture and climate within a school that provides a safe environment, building resilience, building social skills, and I guess an awareness of what to look for when young people are not doing so well.

We have also, though our Chief Executive and executive - and it is part of our strategic plan - implementing school-wide positive behaviour support which is another framework, philosophy, if you like, around building a positive school culture climate. So, I guess there are so many elements to this agenda, things like bullying, and where does that factor in. To answer your question, KidsMatter is out there and certainly some schools are taking it up. School-wide positive behaviour is also starting to get some leverage and really we have only been on that journey probably for about 18 months and there are schools that actually do not have either of those programs operating but still have some fantastic school codes of conduct, some really good values, and some great programs.

Another program that is quite popular is a program called You Can Do It which teaches values, behaviours, and resilience for young people. So, there are, like with anything, there are a suite of programs available. Certainly, school-wide positive behaviour support is a strategic focus for DET. KidsMatter has certainly got some traction and I know, working with Executive Directors of Schools and School Principals, that there is an expectation that schools are engaging in something that can foster a positive and safe environment.

Hopefully I have answered that question for you, Michael.

Mr GUNNER: The first part of the answer was important around voluntarily versus compulsory. Many of us can understand the value in someone saying come in, and therefore the way in which it is welcomed, as opposed to mandating.

Perhaps the other element I am interested is we heard from Dr Parker about kids have to be of an age where they are capable of learning properly about suicide prevention and all those things around mental health - at primary school they could potentially be too young, it is over their head, and so this is why I don't know very much about KidsMatter yet. Obviously, we have had MindMatters talked to us yesterday but is it best to have those programs targeted at the middle school on and primary schools use other things?

Mr NYHUIS: I would say that the development of that understanding, awareness, and those core values starts at infancy, it really does, and I think certainly in an early childhood agenda, in childcare centres, preschool etcetera, you start to embed a better culture around safety, wellness, wellbeing, and resilience. Eva is a strong advocate for social communication and emotional communication strategies and skills and there are some great – again, it is a culture that you develop - and I think the other challenge around that is the school is one place, it is all the other agendas and issues that are happening in communities, in families, and how do you try to foster that same sort of ethos if you like in those other critical areas of peoples lives, young peoples lives. Eva, I don't know if you want to add anything further.

Ms NICHOLLS: If I can, yes, I agree, and I think early intervention is what we need to be looking at and where we still do need programs that target that specific age level from middle school up and focus on specific youth suicide intervention programs. We need to be building those skills with the young people from very early and with our child protection curriculum we have, keeping safe child protection curriculum, we are taking that into daycare centres, so that we are actually developing the language, we are talking about the language and the ability to talk about those issues from that very early stage and so people are comfortable about. Because many people are very uncomfortable about talking, you know the Are You Okay program recently through the media. The response we got was interesting, because people are not used to doing that. So, we need to be building that language in but, then, also building the skills in as to how to manage that. So, the earlier the better.

Mr NYHUIS: And how to respond when someone says 'I am not okay' is critical.

Ms NICHOLLS: The earlier the better, and even outside the school so we have working with communities, families, and family groups to look at the language so there is a consistent language so everybody feels comfortable talking about issues and saying 'Are you okay?'

Mr GUNNER: We have talked a lot about postvention and the importance of postvention. In some ways, you are the first people we have talked to about a formal setting for that within a school environment. What policies do you have around postvention in a school setting?

Ms NICHOLLS: Are you talking about post-intervention?

Mr GUNNER: Yes, sorry. What we have heard about is the tragedy of one suicide leading to others ...

Mr NYHUIS: Okay, sure.

Ms NICHOLLS: Yes.

Mr GUNNER: ... and the importance after one suicide of actually talking to people.

Mr NYHUIS: Probably the critical policy we would have would be a critical incident response approach. Again, that would be deemed as a critical incident. Unfortunately, we have had a few of those where we have needed to provide that support. I guess from a central agency stand, it is really about value adding to the services already in a school, in a community, in a region. Typically - and, again, Eva has oversight of

that – it is using the resources on the ground where we have counsellors in place to actually provide those services and, where appropriate, sourcing additional services and also using some of our own central staff to actually be able to be on call, essentially, to provide emergency critical response.

Again, that is the sort of agenda, I guess, Eva is talking about - going in and actually having the skill sets to be able to talk with staff, young people, and the community about what has happened and how we manage and address this and prevent.

Ms WALKER: Can I just ask a question further to that? Schools are geared up to have a response in place for fire, for a bomb threat but, in postvention where we have the sudden death of a student, or a former student who may still have close links with the school - but especially with suicide, and I have seen it in one of the schools in my electorate twice in the last couple of years. We know we have to have counsellors there, but are there plans at schools to say these are the steps, this is what you do? Yes, basically, a procedure that says this is what you do first.

Mr NYHUIS: My response would be it is a school site specific response. To the best of my knowledge there is not a departmental response but, obviously, we have responses around communication and accessing the critical incident. There is certainly a process to that. I was just thinking, again, my response would probably be - and I am probably putting my principal hat on to some extent – around the notion that it is just so situational and context specific in what are the needs, what are the family connects, what is the extent of the relationships ...

Ms NICHOLLS: That policy, though, does allow – principals are encouraged. If you look at the policy, there is a page at the end that actually talks about engaging with people like school counsellors, school staff, to actually develop an intervention – your own plan ...

Mr NYHUIS: Again, a response, yes.

Ms NICHOLLS: ... as part of our critical incident response.

If we are called in to support a school around a critical incident, then I encourage the staff to actually sit with the principal if there has not been a plan, to actually then engage in the development of a plan. That would be an expectation of the school counsellors in the schools; to work with principals. Again, it is a requirement – a principal's decision.

Mr NYHUIS: Site specific.

Ms WALKER: I suggest, if I might be so bold, that rather than encourage the school leadership to have that, it is a must do.

Madam CHAIR: It should be.

Ms WALKER: If we can respond to a bomb threat, we can respond to a fire, we can respond to other disaster situations, then the sudden death of a student or former student by suicide has the potential to send a school into absolute meltdown.

Mr NYHUIS: Yes.

Ms NICHOLLS: Yes.

Mr NYHUIS: My response would be that certainly the procedures, the steps, and the personnel are in place to do that. The experiences that both Eva and I have been across, are very much an immediate and very timely response from the principal to the regional manager, director, etcetera, where whatever resources are needed and required to aid and assist that community are provided. It is an interesting point you raise.

Mr STYLES: My understanding is all schools have a critical incident plan in place. When you take branches of that off for fire, for flood, famine, suicide, there are various degrees of development of that plan. Every school has a critical incident plan on how to respond.

Mr NYHUIS: Yes.

Mr STYLES: I am unsure if that came through earlier, but they are in existence now.

We have had evidence about drug proofing and suicide proofing young people. Obviously, prevention is better than cure because, unfortunately, for suicide there is no cure, especially when it has been completed. We need to look at how, as a community - what recommendations the committee can make to prevent people in the age group we are looking at completing suicide. We have to go right back. My understanding is we need to build rock solid foundations in the education process of young people to give them capacity to withstand all sorts of things in life which lead to self harm.

When we talk about day care centres, what about family planning? What about going into high schools and getting to the people who are about to go out into the world shortly and have children of their own? How do we look at capacity building right back into prevention? Either of you might like to comment on that. Do you have any thoughts on how we might go about that?

Ms NICHOLLS: It is a hard one.

Mr NYHUIS: It is a hard one because it is such a complex issue.

Ms NICHOLLS: You did a big circle so we are going right back to the beginning. But then we are also moving into ...

Mr NYHUIS: Eva and I are here today speaking from purely an education perspective.

Mr STYLES: Can I ask: do you think it is a good idea, as opposed to asking for the answer. Would you agree it would be?

Ms NICHOLLS: I do not think one approach to this incredible problem is the answer. A one size fits all is not the answer either. We need to be looking at - there needs to be much more ongoing research around how we respond, particularly within Indigenous communities. We need to look at the preventative stuff; however, we also need to look at the programs targeted at the target group around suicide. We also need to look at a whole range of things. Once you start to look at why and get some understanding of the reasons suicides are occurring, you can put programs in to support - once you start to understand the reasons why.

Some interesting stuff I have read - I will not bore you with it - is we should not put all youth suicide under the mental health umbrella. We are targeting youth suicide around mental health, but in fact Indigenous youth suicide has a number of different - if you look at the research - there are a number of different factors that have contributed to that. So we need to be looking at that and developing programs in response. It is a multifaceted approach and not just a one size fits all.

Mr STYLES: Great answer.

Mr NYHUIS: My response would be I agree with you, Peter. The notion of prevention is what we want to see happening. Whether we put our education hats on, our parent hats, or community conscious hats on, it is such a broad issue.

Eva and I have had several conversations about that whole notion of it being a school counsellor problem or a mental health issue; it is a much broader scope of social and community issues and a sense of purpose and engagement from these young people as to: what is there for me, what is my purpose, what is my function and where do I fit in society. You have to peel back many layers to understand the root causes.

Mr STYLES: We are seeking to get things onto the record here so that when we actually do our deliberations we can get - and I loved your answers. School counsellors; do we have enough of them?

Mr NYHUIS: I will try to make my answer short, too.

Madam CHAIR: Can I just expand his question. Across the Northern Territory, how many schools and then how many school counsellors are within those schools?

Ms WALKER: That might be a question on notice.

Mr NYHUIS: We have school counsellors ...

Madam CHAIR: You can take it on notice if you like, or you can attempt to answer it.

Mr NYHUIS: No, we should be okay. The current commitment is that we have school counsellors in every middle school and every senior school. That is the current commitment. The total number of counsellors in our current counsellor program is 27, and we have at least one, perhaps two more coming on under the Closing the Gap initiative which is at its conclusion. So we should be hovering around the 27, 28, 29 role. Again, that is with the understanding that recruitment is completed and we have all positions filled. A number of those school counsellors also operate in a group school capacity so they service a number of schools within a region. That is typically in some of the remote locations.

Madam CHAIR: So they have a cluster. So they if work within a school cluster, are you able to provide information to this committee as to what is the geographical coverage of those counsellors within that cluster?

Ms NICHOLLS: Yes.

Mr NYHUIS: Yes, absolutely.

Mr STYLES: And the ratio.

Madam CHAIR: Yes, that is what I am getting at.

Mr STYLES: And the ratio of students to counsellor. Some of the big schools have one. Some of the little schools have one and there is a massive overload on ...

Ms PURICK: That was one of my questions when you said there is a commitment to have a counsellor in each middle school and high school, and then when you get a big high school like Taminmin that has 1200 students and Darwin High that has about the same, they are not going to be able to deliver services where they are needed because it would just be one person. I do not know if it is a policy, or if it is commitment, but it really needs to be looked at as Peter and Marion are saying. One counsellor to a middle school that is only a baby middle school, like perhaps Nhulunbuy's middle school is considerably ...

Ms WALKER: Well, we are on the one campus, middle and senior.

Ms PURICK: ... considerably smaller than Taminmin's middle school.

Mr STYLES: So the recommendations from here are that if we figure out that we need more then we are going to have to recommend to government that the budget be increased to cover these particular people.

Mr NYHUIS: I will answer your question in a number of ways. No 1, the ratios that you have alluded to are fact. In terms of the service delivery and the capacity to offer the service, that is clearly still there. It is the level and type and degree of service, etcetera, and about prioritising your capacity to offer the service and what does that look like in a school. Is it intervention programs, or is it sort of the higher end, pointy end interventions, prevention, etcetera?

To answer your question, Peter, which was the notion of do we have enough. I will answer it in this context: there is certainly the opportunity and the capacity and I believe the value-add for having more counsellors would be a positive thing. That comes on the back end of your previous question which is around early intervention and prevention. So we have actually just negotiated one of our counsellors to begin work within the Palmerston/rural area in a primary school capacity, which is a really positive intervention. We are excited about that opportunity to be able to provide that resource.

Someone else made reference to the notion of the middle schools and the senior schools and what have you, but where there is opportunity and capacity those counsellors, where they are based in middle schools and senior schools, also provide a service where required to the feeder schools and the primary schools. Where there are critical issues and critical incidents then they are available to deliver that service to those schools as well.

Ms PURICK: A point of clarification: where a senior school and a middle school share the same campus, such as Nhulunbuy and Taminmin, do they get one or two counsellors?

Mr NYHUIS: Currently they get one.

Ms PURICK: Well, that is not fair because the commitment is one for middle school and one for senior school ...

Ms WALKER: And Taminmin is three times the size of Nhulunbuy.

Madam CHAIR: Well, maybe that is what we need to get, the information so that we can have a look at those ratio breakdowns. Will you take that question on notice and provide that information to the committee, thank you.

Mr NYHUIS: Absolutely. So just to confirm it is the number of counsellors, where they are located, and service region.

Madam CHAIR: And, if you have a number of counsellors that service a cluster, how many schools within that cluster, and the region in which they service that would be good.

Ms NICHOLLS: It is also important to add that we do have school psychologists that provide a service to the schools as well so they enhance ...

Madam CHAIR: How many do you have?

Ms NICHOLLS: We have 11 across the Territory.

Madam CHAIR: Eleven, and where are they based?

Ms NICHOLLS: In Alice, we have ...

Madam CHAIR: Can we get that on notice as well?

Ms WALKER: And the region they service. I know the one in northeast Arnhem Land has a huge area to patrol.

Madam CHAIR: Yes, and so the population, very important, because if you have one counsellor to 20 kids and then you have someone else that has 200 kids, there is an imbalance.

Mr STYLES: Where do school nurses sit in the equation of things at the moment? Do they sit with you or with Health?

Mr NYHUIS: They sit with us. They sit with Student Services and with the department of Education in schools. They are a bit of an interesting one because they are actually employed by Health, but sit within our schools.

Mr STYLES: A bit like youth engagement officers these days, paid by police, but sit sort of working wherever they do these days. Now, the welfare ...

Mr NYHUIS: They have essentially a dual line management, but predominantly through to Health for the health and the associated issues there with health but certainly, when it comes down to school operational matters, or their role and function in schools, we have a shared involvement there.

Mr STYLES: You people, I would assume and I just need clarification, you support school welfare teams and the principal of having that welfare team in place in schools? Do you see them as an important part of student welfare and obviously in capacity building?

Mr NYHUIS: Absolutely, and when you say we support them, just to clarify, we do not provide direct support but we support ...

Mr STYLES: No, the notion ...

Mr NYHUIS: ... the concept absolutely. Within student services, we have a service continuum that has been rolled out to every school in the Northern Territory and that continuum and the expectations of schools in that continuum are very much around schools having a school wellbeing team. Some people call it a guidance team, etcetera, but the concept is very much the same. That team is charged with the

responsibility of student wellbeing, whether it be for disability, for child protection, for all those health care, school nurses you referred to, etcetera, so absolutely.

Mr STYLES: And, if I was as part of this committee to argue and recommend that *MindMatters* ...

Madam CHAIR: You are not going to argue, Peter, you get bipartisan ...

Mr STYLES: Robust discussion, Madam Chair, over KidsMatter going into primary schools. Obviously, with all these things there are budgetary implications so we have to really work out what is important, what people need and all that sort of stuff, and that is obviously the idea of what we are doing. But, KidsMatter, we have heard it from other people who have presented evidence over the last day-and-a-half. It appears that most people who are presenting agree that KidsMatter is an excellent program and we probably should be implementing it into schools to try to build that capacity, so that we do not have the end result. Would you agree with the fact that KidsMatter would be a good thing to put into as many primary schools as we can?

Mr NYHUIS: I would actually go back to the earlier question and say that I believe *KidsMatter* is a quality program, but there are other quality programs out there as well, so my sense would be find what is right for your school, your community, so I guess, Peter, if you were asking to say we would like a recommendation along the lines of ensuring that schools have a targeted focus and program or policy around student wellbeing, then absolutely, and I would be confident in saying that schools have that. To hang it on one program - I would not be supportive of.

Mr STYLES: I would not disagree with you. That is an excellent answer. Thank you.

Mr GUNNER: The other thing was the barrier to accessing *MindMatters* did not seem to be budgetary; it seemed to be voluntary. So, when *MindMatters* presented the other day, they said they are happy to go to any school, any time. They were just waiting for the request to come in. They were not saying: 'We need resources'; they were saying: 'We need to be asked'.

Mr NYHUIS: Yes.

Madam CHAIR: We have *MindMatters* in middle and senior. We talk about Closing the Gap, about early childhood and that development. What are we doing in that early childhood area across the Northern Territory, with a particular emphasis in some of our remote communities in early childhood, to work with young people in protective behaviours and feeling good about themselves and 'Are You Okay', I suppose, for many of those young people in some of our remote schools?

Ms NICHOLLS: We do have the KidsMatter. As we said, it is a voluntary process. We also have the child protection training we do around the child protection curriculum. That, in itself, even though its focus is on child protection, it talks about resilience and being able to know how to recognise harm, risk of harm, and how to manage it. That is for both the staff and the students, and it is a very well-resourced program which is offered across the Territory. But, again, that is by request.

Mr NYHUIS: One of the things I would add, though, is we also have a curriculum that has a strong focus around health and wellbeing, and essential learnings contained in that curriculum. Again, I believe you would find the majority of schools, certainly in early childhood years and those developing years, do run lots of units and programs around health, wellbeing, safety, etcetera. There is a strong curriculum focus that is embedded in our curriculum that already addresses a lot of those issues. Some of the programs we are talking about are ...

Ms NICHOLLS: These are resources.

Mr NYHUIS: ... really resources, or a layer to resources, complements to the curriculum.

Ms WALKER: Can I ask a question around mobile phones which have come up in many submissions and the evidence that we have taken over yesterday and today, and about the role - the very negative role - they have in bullying and harassment in schools? This is mainly a legal question. What is the capacity of DET to implement and enforce a policy that says during school hours you cannot have a mobile phone at school?

I was a teacher in the days prior to mobile phones, and any parent who ever needed to make contact with the school in the event of an emergency, it was never an issue. That appears to be what parents are saying.

Ms NICHOLLS: Many individual schools do have a policy around mobile phones.

Mr NYHUIS: I guess the question was the ability to actually enforce, etcetera.

Ms WALKER: Implement and enforce a policy that says no mobile phones during school hours.

Mr NYHUIS: It is exactly that. It is currently a school site specific decision around appropriate mobile phone usage. Within the national Safe Schools framework and Safe Schools NT, the whole bullying agenda around cyberbullying is a very topical issue for the reasons you have alluded to.

Madam CHAIR: Why has the department not put a policy in place across the board?

Mr GUNNER: I have seen it consume debate at school council level. Parents actively want to be involved in the formation of that policy and come to an agreement on it.

Mr NYHUIS: Absolutely.

Ms WALKER: They still can be.

Madam CHAIR: They can be. If it is deemed school specific in discussion, I just cannot see why the department – and do not worry, I have had this discussion previously with the department – why the department should not ...

Mr GUNNER: If it is a departmental policy, then how can parents change it? At the moment it is a school set policy where parents have a say.

Madam CHAIR: We know the detrimental effect mobile phones and the use of social media ...

Ms PURICK: It is a safety issue.

Madam CHAIR: That is right; it is a major safety ...

Ms WALKER: And the fact they all have - nearly all of them – cameras on them, so the capacity to capture ...

Madam CHAIR: Yes, that is right.

Ms NICHOLLS: It is interesting in the child protection curriculum that we roll out, there is a significant section around mobile phones, and in our behaviour management programs that we do.

Mr NYHUIS: The only comment I make to that issue would be is it about putting policies in place that prevent access to that technology or it is about building and teaching appropriate use and how to manage it when it is not used appropriately. The challenge to that is the technologies being rolled out and used in schools right across Australia, the iPads which have recording cameras etcetera, mobile phones that are being used in classrooms for all types of learning - it is a big issue. That is why, at a national level, cyberbullying and the issues you are raising are being fiercely debated. How do you engage with technology as a learning medium but not have it be an antisocial or a negative one?

Ms NICHOLLS: In a school environment it is not only their capacity to wreak havoc with bullying and harassment, it is disruption to the teaching and learning environment where you have people utilising these devices.

Mr GUNNER: There needs to be a policy around it. I am not sure if it should be centrally set or not. Parents have argued they provide the phones for a safety reason; they want their child to be able to contact them so they provide the phone. It is not so much the denial of access we need to worry about, but making sure people are informed and aware of how to use and proper use.

Ms NICHOLLS: And the impact of misuse on other people is what we focus on in the work we do. We look at inappropriate use.

Mr GUNNER: An example, which may not be an appropriate example, is the way they advise parents that the home computer should be in a public environment, say in the kitchen. Things like that where you can make an environmental decision which will lead to better use or accidental supervision in a way. That is around using properly rather than denying use.

Madam CHAIR: As Kezia and Peter are going, and there were some remote area specific questions I wanted to get on the record, in the service Student Services provides to a number of our remote communities, we have a high turnover of staff in some of these schools and communities. What role does Student Services play in training and development of teaching staff, counsellors, and others going into communities in this area?

Mr NYHUIS: In this area. Well again ...

Madam CHAIR: Dealing with children with challenging behaviours. We probably have a number of challenging behaviours in some of our remote locations.

Mr NYHUIS: It is difficult to narrow it down. From a school counselling perspective, Eva and her team of professionals who supervise those counsellors in schools, have their own induction support and professional supervision process which works very effectively. In regard to new staff going into schools, the department has induction programs, mentoring programs and support programs for new staff to move into those schools.

You spoke about turnover, and the department is working very hard to address those issues and try to look at sustainability and continuity of service which, as we all know, is a really positive thing. From my perspective it is very much school specific. A staff member coming into a school understanding the roles and responsibilities, or the processes and procedures about how the school operates is probably more important. If we have a student who is not coping then the referral process to that student wellbeing team - some follow up actions from that capacity.

Where Student Services provides value-add, and we see our services as a specialist service provider, is where there are - there is a referral process for that - specific issues around disabilities, around behaviour, around mental health and wellbeing where a teacher, working with their school support team or their student wellbeing team, can refer a child - which is the process - to Student Services. We have regional intake meetings or case management meetings where a child is referred for any one of those reasons and support services are provided such as counselling, some psych support, behaviour support or disability support.

Ms NICHOLLS: Student Services has been involved in new teacher induction programs that DET has run. We have looked at specific disabilities, specific areas; for example, ASD and how you manage that, or different disabilities, behaviour, child protection. We also, on a regular basis based on information back from teachers as to what they want, actually roll out programs in a very similar manner across the Territory. We have just recently completed one. We are looking at - again, behaviour management always comes up, the child protection ...

Mr NYHUIS: Profiling our service.

Ms NICHOLLS: Yes. So, we provide ongoing training when it is required, and also we engage in the induction of new teachers.

Madam CHAIR: Thank you. There are some further questions, but we will get back to the department and maybe get you back before the committee again because we have probably just touched the surface in some of the areas we have talked about, because the schools are a pretty important in this area. So, thank you.

Ms NICHOLLS: Thank you.

Mr NYHUIS: Thank you.

The committee adjourned.
