# LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

11th Assembly

## Select Committee on Youth Suicides in the NT

**Public Hearing Transcript**

10.35 am, Tuesday, 31 January 2012

Nitmiluk Lounge, Parliament House

**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:**

NT DEPARTMENT OF JUSTICE
Mr Greg Shanahan, Chief Executive Officer
Mr Alastair Shields, Deputy Chief Executive Officer
Ms Pippa Rudd, Director Youth Justice
Mr David Ferguson, Manager Professional Standards Unit and Intelligence NT Corrections

DEPARTMENT OF HOUSING, LOCAL GOVERNMENT & REGIONAL SERVICES
Mr Ken Davies, Chief Executive Officer
Ms Giovina D'Alessandro, Director Local Government
Mr Phil Luck, Director Technical Support Remote Housing
Ms Trish Angus, Executive Director Strategic Policy Development and Coordination

WEST ARNHEM SHIRE COUNCIL
Mr Nathan McIvor, Regional Coordinator Community Safety/Shire Services Manager Warruwi

DEPARTMENT OF CHILDREN & FAMILIES
Ms Clare Gardiner-Barnes, Chief Executive Officer
Ms Joanne Townsend, Acting Executive Director Social Inclusion Policy & Program Division

SOUTHERN CROSS CLINICAL PSYCHOLOGY
Dr Ruth Rudge, Clinical Psychologist
Dr John Rudge, Clinical Psychologist

MENZIES SCHOOL OF HEALTH RESEARCH
Mr Gary Robinson, Associate Professor Indigenous Parenting and Family Research Unit
Mr Sven Silburn, Director Centre for Child Development and Education
Mr Bernard Lecking, Research Assistant Child Health Unit

**DEPARTMENT OF JUSTICE**
**Mr Greg Shanahan**
**Mr Alastair Shields**
**Ms Pippa Rudd**
**Mr David Ferguson**

**Madam CHAIR:** I have a short official statement to read. On behalf of the select committee I welcome everyone to this public hearing into the current and emerging issues of youth suicide in the Territory. I welcome to the table Mr Greg Shanahan, Chief Executive; Mr Alastair Shields, Pippa Rudd, and Dave Ferguson. Thank you for appearing 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 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 the committee to 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 ask – I am not sure who – if any of you would like to make an opening statement before proceeding to the committee's questions. Could you please state your name and the capacity in which you are appearing?

**Mr SHANAHAN:** Greg Shanahan, Chief Executive Officer, Department of Justice.

**Mr FERGUSON:** Dave Ferguson, Manager, Professional Standards and Intelligence for NT Correctional Services.

**Mr SHIELDS:** Alastair Shields, Deputy Chief Executive, Department of Justice.

**Ms RUDD:** Pippa Rudd, Director, Youth Justice Unit, Department of Justice.

**Madam CHAIR:** You know members of the committee obviously. I have apologies from Peter Styles, the member for Sanderson.

Would you like to make an opening statement?

**Mr SHANAHAN:** Yes, a brief one, if I can. By way of a general observation, the Department of Justice really does very little in the way of direct service delivery to the youth we are talking about except in the areas of Corrections and courts. They are the two areas we have focused on in our submissions.

I guess that does not recognise youth suicide is a significant issue for the Northern Territory and nationally. It is something we are very much focused on as a group of CEOs. Within our justice system the incidence of suicide is, thankfully, very low. In relation to deaths in custody in juvenile detention, there has only been one in 2000. In relation to the Correctional Services generally, there have been seven suicides since 1980 involving people between 18 and 25. There was one recently, but prior to that it was back in about 2000 so there has been quite a gap.

Thankfully, we have been able to keep those numbers very low, which is a credit to our staff in Correctional Services who look after people in custody. However, I did say that within the system from courts to Corrections there are points where we come into contact with youth within that age group and we have systematic responses to those youth at risk. We will probably explore that a bit later on as we answer questions.

That is all I really wanted to say as an opener.

**Madam CHAIR:** We might proceed to questions. Michael?

**Mr GUNNER:** One of the things we have been interested in with this committee is those points of intervention. We had Gary Barnes come before the committee earlier and education and schools are seen as a particular points of intervention. Here, obviously, we are talking to justice and the prison system. If you could take us through some of the intervention processes, or gate-keeper training, or things you might be doing in the Corrections system to improve prevention?

**Mr SHANAHAN:** Okay. I guess there is a crossover between education and our juvenile centres, because they provide education to our youth who are in custody. They provide quite a few programs in self-esteem and that sort of stuff in that process. Dave is probably best placed to elaborate on what actually goes on in training staff and the like.

**Mr FERGUSON:** With respect to training staff, we conduct, when we have new youth workers, prison officers, and community corrections staff coming in, they all undertake a thing called Mental First Aid which gives them an awareness of the issues that young people face; to recognise the signs. Then, they are bound to respond to that; once they have picked up they can refer them on.

In the case of Community Corrections, for example, where they are not actually working in a detention environment, if they suspect that someone is at risk they will actually pick up the phone and ring 000 and say: 'Come here and help". They will put it straightaway; that is their obligation.

A lot of the stuff, as Mr Shanahan was saying, is the stuff for the kids, the detainees themselves, are delivered through the education program. We also have outside agencies - NGOs like FORWAARD will come in and provide programs. Prison In Reach program will come on a referral basis. If the senior case workers in detention think there is an issue with a particular child they will actually source outside help. This is aside from our general health provider, SOS, and Forensic Mental Health.

**Madam CHAIR:** I am just following up on your question actually, Michael. Dave, if a young person has been sentenced to a custodial …

**Mr FERGUSON:** Term, yes.

**Madam CHAIR:** They have been sent in. Can you just walk through - they have gone through and assessments would have been done on this young person?

**Mr FERGUSON:** On reception.

**Madam CHAIR:** What is the process for Corrections when that young person is coming into their custody?

**Mr FERGUSON:** Are you actually talking about if a person comes in at risk already, which happens?

**Madam CHAIR:** Do you know that they are at risk?

**Mr FERGUSON:** Yes, if we are notified by the courts or police that they are at risk …

**Madam CHAIR:** All right. So, what is that process, then?

**Mr FERGUSON:** Once they are admitted - the standard filling out of forms etcetera, the details recorded - they will be placed at risk. Okay? Once they are placed at risk they are observed every 15 minutes at a minimum. If it is considered that they are in imminent danger of self-harming, they we will call the health provider, SOS. They will come in immediately and assess them.

When someone is placed at risk, they generally are put in a non-rip gown and that sort of thing, in a room that is camera observation, as well as face-to-face contact every 15 minutes. That will continue until they are assessed by a professional, who then will decide whether they stay at risk or are taken off.

Quite often, when young people come into detention the first time, it is distressing. If it is their first time they have ever been in, they are unsure of what is going on. The courts or the police will say: 'We think this child is at risk, therefore, we follow those procedures until they are assessed by a professional.'

Is that what you are after?

**Madam CHAIR:** At facilities like Don Dale, you have nursing staff and others who will ...

**Mr FERGUSON:** They are on call. They are there during the day, but they are on call 24 hours.

**Madam CHAIR:** Okay.

**Mr GUNNER:** We had Dr Bath present yesterday morning. He came with some Menzies research that showed that one of the risk points is the transition from school to the general community, which often can be as much drop-out as completion, if not more drop-out. So, that transition is in a defined grey area.

I know in your submission you talk to the transition from Corrections into the general community as a potential danger point after leaving your care and going into what care – that is the question mark. You mention community mental health providers and the dialogue needed between Corrections and them. Is it a fact that those community mental health providers are available and people are taking it up and therefore we need to work better on that, or is it that there are not enough community mental health providers to provide the service to possible at risk people leaving Corrections?

**Mr FERGUSON:** Where are we?

**Mr GUNNER:** That is towards the end of page 2. Specific gaps exist in ongoing treatment of (inaudible) being returned to the community (inaudible) at risk of self harm or suicide and in between services such as correctional facilities and community mental health providers need to be strengthened.

**Mr FERGUSON:** They do need to be strengthened because currently there is a gap. Once juveniles, or in fact anyone, is released from detention or imprisonment unless they are continuing on an order of the court – parole say - Corrections itself currently has no control over what happens. We can refer people when they leave to a residential program at FORWAARD or CAPS or something like that, particularly adult prisoners, but there is a gap for young offenders at this point in time.

**Mr GUNNER:** They are disassociated. Their personal choice to go is probably not going to be there.

**Mr FERGUSON:** I do not know if their personal choice is, but most of the young offenders especially who come from juvenile detention, will be released back to - depending on their age and their family circumstances - most of them will go back to their family. If they were a child in care, then perhaps they might go to a safe house that DCF maintains, but there is that gap of the consistent straight through services being provided all the way through. That is how we perceive it to be.

**Mr GUNNER:** I guess what I meant by disassociated is what we are seeing is often the kids at risk of committing suicide are the ones who are disassociated with their family, have dropped out of school and not in a care group so are withdrawing and do not present to any health service prior to completing suicide. They are not going into the system. Unless there is a formal direction they are not going to make that personal choice of getting help, which is why they are completing suicide.

**Mr FERGUSON:** That is correct. That would be correct.

**Mr SHANAHAN:** No mandated requirement.

**Mr FERGUSON:** There is no mandated program.

**Mr GUNNER:** You cannot formally direct so it goes back to the original incident and whether the court has the ability at that point to direct or not direct depending on what crime has occurred.

**Mr FERGUSON:** One of the things you need to consider if, as we say, these young people are at risk - one of the ways you are going to be able to determine that would be if they were medically or forensically assessed as being at risk at the time they were to leave, then that is something that needs to be handled by the health providers. They would be aware of it.

**Madam CHAIR:** What happens? That is an interesting point.

**Mr GUNNER:** (inaudible) on the exit so there is no reason the court would assume in the original sentence that they are going to be at risk because they are not necessarily at risk until they go into the correctional system. I imagine it to be quite depressing being thrown into gaol.

**Mr FERGUSON:** My understanding of this is going back to the pre-court process. If they appear in court and the magistrate considers them at risk the magistrate will have been told that by either the prosecution or the defence saying they are concerned about that. That automatically flows to Corrections if they are under an order and we look after that. However, you are correct in what you are saying. Once they have served that order there is nothing; there is no transition after that.

As well, the period of at risk might only be that initial shock of going into - for want of a better word - that environment and, depending on the length of their sentence etcetera. Generally, they do not stay at risk very long. They realise that it is not quite as frightening as they thought it would be, etcetera, and they will come off it. If there is an ongoing psychological, or there are family or community, issues they are going back to that is causing the at risk thing, then that is an issue where there is a gap.

**Mr GUNNER:** Within the prison environment, you are, to some extent, in control and monitoring. It is that transition from that - which is the same problem with transition from school. In the school environment, you are surrounded by peers and teachers. Once you transition from it and you go out on your own, if you are at risk, people are finding when you are at risk you are not associating with anybody. That is the …

**Madam CHAIR:** That is what I just wanted to follow. If you had a prisoner, say a young person who was sentenced to a custodial period of, say, 12 months - they got 12 months. But, they had, say, eight months to serve and then they would be released after eight months. I am not a lawyer, but we certainly have lawyers sitting at this table.

What happens when that young person – does Corrections have a responsibility? I know you do this for adult prisoners, right? People who are released from gaol are then monitored by Corrections. Do you see where we are coming?

**Mr SHANAHAN:** Only if there is an order which goes beyond that.

**Mr FERGUSON:** An order.

**Madam CHAIR:** Yes.

**Madam CHAIR:** But, a lot of these kids – don't a lot of these young people still have that standing order in that period of time? So, what happens? That is what we are just trying to ascertain – what happens? Does Corrections follow them up, do they monitor?

**Mr FERGUSON:** Depending on the order itself.

**Madam CHAIR:** Right.

**Mr FERGUSON:** To use your example, they have 12 months and serve eight. There is four months outstanding on that. During that time, they would be, most of the time, under supervision. Sometimes, they are not ordered to be under supervision by the courts but, generally, for that last four months they would be under supervision, in which case they would be under the care of Community Corrections.

There are various orders associated with that: the directions they may have to report weekly, they may have to report fortnightly, different things the court may have ordered, 'Upon release you will attend CAAPS and complete this program'. The court can order that and Community Corrections will then ensure they do that.

**Ms PURICK:** But what if the young person goes home to their community which is way out Lake Nash way? That could be the issue because they might not have any police station, health clinic, or whatever to report to. And they are still under an order?

**Mr FERGUSON:** Community Corrections does do remote and regional work.

**Ms PURICK:** Okay.

**Mr FERGUSON:** If they come from a particular area where there is not a Community Corrections officer in that area - they might only go there once or twice a month - during that time they would contact the youth while they were there.

**Ms PURICK:** Okay.

**Mr FERGUSON:** Okay, so we …

**Mr SHANAHAN:** They would be made to phone in using a phone or something.

**Mr FERGUSON:** Or what they will be able to do in the future is to actually – the offender who is out will be able to call up the Community Corrections office and talk to their parole officer, or at least notify where they are, what is happening with them. That is how it is followed up.

Community Corrections staff generally are very good at engaging with their clients, especially young clients. They have concern for their welfare and they will talk to them and ask them how they going and try to help them, and do all that sort of stuff. However, once the order is finished, they effectively are returned to their family and then it is up to them.

**Ms WALKER:** Regarding supporting those young people when they are brought into the likes of the Don Dale Centre. You said they might be unsure of what is happening – understandably, it would be very distressing for many. How are those kids supported where they are - Indigenous from very remote areas who may not have a relative available and language barriers?

**Mr FERGUSON:** This was very prevalent in years gone by. There is a trend, at the moment, where most of the juveniles in detention are not from remote communities. There are actually a lot of urban kids.

If they are there by themselves and there is language barriers, the staff try to help them as much as they can. We will, and have done in the past, had relatives from the adult system, if necessary, talk to them and explain to them what is going on.

When a juvenile comes into detention it is actually explained what is expected of them, the rules are told to them, they are told who they can talk to if they are worried or need some help with something, or they do not understand. When they first come in, they are generally treated fairly gently.

We have interpreter services available if it is really needed, but most of the time, most of the kids who come in these days do not have all that much of a language barrier. We give them as much support as we possibly can and they are monitored closely.

As Mr Shanahan said, we have had one death in custody in the whole recorded history of juvenile detention. We are very particular about what we do. The staff in juvenile detention does their best.

**Ms WALKER:** Any incidents of self-harm? Do you have a statistic around that?

**Mr FERGUSON:** I would treat that basically the same. There are minimal incidents of self-harm. We could possibly get that at some time but I do not have that handy at the moment.

**Ms WALKER:** Can we put that question on notice?

**Madam CHAIR:** Yes, that would be good. I would like to congratulate the Corrections system. I remember that death at the prison. I went to Don Dale and walked through and spoke to some of the staff. They do a fantastic job out there under difficult circumstances.

**Mr SHANAHAN:** In relation to the gap that has been identified, one of the recommendations of the Youth Justice Review was there be a through-care model which that unit will be responsible for coordinating. That is an area Pippa is going to be working on.

**Ms WALKER:** You describe that as a through-care model?

**Mr SHANAHAN:** Yes.

**Ms WALKER:** This is beginning to end - return to community?

**Mr SHANAHAN:** And engaging the community health services - across government.

**Madam CHAIR:** That is both in and when they go out - that transition? Do you want to go through some of that?

**Ms RUDD:** It is very early stages; however, what we are looking at is having a system that works with a young person from their first point of contact - potentially the first time they are picked up by the police and not necessarily arrested and charged - to the time when the young person, if they are unfortunate enough to engage in criminal behaviour and are charged, convicted and sentenced, through to a period when they exit detention and go back into a community or go back into their families.

The through-care model we are looking at as well is not just based on the intervention with that young person, but based on working with their family. As Dave was saying, when young people leave detention, they are not generally independently living; they are living with families, so it is about working with that family to be ready for their return as well.

**Madam CHAIR:** In many cases these young people at risk end up as a completed suicide. I am not saying all of them have come out of the corrections system, but when they have come from dysfunctional families how do we get that mandate where they have to continue that treatment and support? Often many of these young people do not have functional families to help them through that. Has that been looked at, Pippa?

**Ms RUDD:** It is very early days so I do not want to say we have decided this or that. It is only three months since the recommendations were handed down and we have been focusing on setting up the unit and doing the administrative work around it. However, we are looking at the model around the family responsibility program and, in my mind, calling it the Family Responsibility Program Plus.

The approach of working with families to get them back on track - evidence-based it is essential, but we need to think about the criteria; we need to think about the intersection with the education system and the intersection with the child protection system. The youth justice system has a very important role to play and there are things we need to do to improve it; however, we get children for a particular period of time who are often also involved in the child protection system and should be going to school. There are those crucial linkages that need to be made, but we are certainly looking at that family responsibility program approach and there is a capacity to mandate that.

There have been issues with that, but it is what we are looking at improving.

**Madam CHAIR:** You are right. There is a responsibility along the way; however, someone needs to be the champion for these kids to go through and, unfortunately, it is going to be justice because that is where those kids end up. Those young people, ultimately, end up in your system.

You have health as part of it, community services, the family responsibility stuff. Will you, at some stage, look at something that we have all talked about - the Cape York, the Family Responsibility Commission - and look at the legislative reform? Would that be something that would be considered at some stage through that, Pippa?

**Ms RUDD:** It would be actually be too early for us to say.

**Madam CHAIR:** Okay. But you would not discount it?

**Ms RUDD:** We would not discount anything.

**Madam CHAIR:** Okay. Just asking.

**Mr SHANAHAN:** Well, we have been asked to come back with various models for government to consider in funding. That is where we are at the moment.

**Madam CHAIR:** It should be looked at.

**Ms WALKER:** So, does that mean that you are looking at like jurisdictions - WA and Queensland - as to what they are doing with youth and ...

**Ms RUDD:** Yes, it is. I have been on a jurisdictional visit to Western Australia. I have looked at the urban and remote programs in that regard. I have to say that the Youth Justice Review is very thorough. We have a significant amount of information there. We are not trying to reinvent the wheel, but there are a couple of things we went to have a look at in more detail. Certainly, the community-based responses in WA was one of those things we looked at in more detail. We went and had a look at the urban court support and bail programs in Western Australia. A colleague is going to Queensland to look at their intensive case management program which is a Police, Department of Education, Department of Justice response in Queensland. We have also looked at juvenile detention facilities in South Australia just for some specific programs we have there. Someone else is travelling to New South Wales where they have just established a standalone Department of Juvenile Justice. We are looking at a lot of interstate models as well.

Interestingly, one of the jurisdictions is very interested in our family responsibility program and our youth camps. So, there is information exchange around those things. Every jurisdiction acknowledges that they do not have every element perfected. There are very good parts of our system and very good parts of theirs.

**Ms WALKER:** This, perhaps, is more a question for Department of Education given that they run the education program within the Correctional system. I note that elements of suicide awareness are taught as part of general health studies. There is a program that has been raised, probably in just for every public hearing we have held, called MindMatters, which is about emotional wellbeing and resilience.

I do not know if it is run in our Corrections centres, but with the success we have heard about where it has operated with great success, it would be something worthwhile doing.

**Madam CHAIR:** It has had really good results by the sound of it, where it has been implemented. It might be worthwhile to look at it with the school there.

**Ms WALKER:** You get KidsMatter in primary school-aged children and, then, MindMatters for high school-aged children.

**Ms PURICK:** You mentioned in the beginning that there were very low suicide rates in gaol, which is excellent - great news. Is it a combination of factors - not just good luck but good management, such as staff are well prepared, well managed, good programs, good observation, (inaudible) people who are in custody are not necessarily at high risk? Is it a combination of everything rather than good luck (inaudible) done this to themselves.

**Mr SHANAHAN:** It is certainly not good luck. They put a lot of emphasis on it …

**Ms PURICK:** It is a whole of management program?

**Mr SHANAHAN:** Yes, they manage the various family groups for a while, and they take notice of who is from communities, and which groups get on with each other. There is a lot of peer support in prison which does contribute with reducing that risk.

**Ms PURICK:** And you said the staff did that Mental First Aid or call professional staff?

**Mr FERGUSON:** They do. It is one of the things that is core to their training; the awareness of the issues being faced by people in detention and in prison. They are very vigilant on those things. We also try to house family groups together when possible, so there is always some sort of connection, whenever possible, to provide support.

Informally, it is quite common that if someone in a particular area – the other people have noticed they are feeling a bit down or depressed or whatever, they will inform the staff even if the person does not.

**Ms PURICK:** Okay, that is good.

**Mr FERGUSON:** So, from our point of view, it is a good system. It always can be improved, but it is working well for us, and has done for some time.

**Ms PURICK:** The majority of the people in our goals are men. What about the programs for women who might be at risk in goal, are they the same?

**Mr FERGUSON:** Similar thing, yes.

**Ms PURICK:** When a young person is released and is still under your orders - say three months, five months - do they become involved in youth diversion programs in that period, either managed, supervised or coordinated, and does that include things like Wongabilla? I understand every person who goes through youth diversion programs at Wongabilla is not a repeat offender? In that three or four months whilst still under your order, do they do youth diversion program activities?

**Mr FERGUSON:** It is not a diversion as such because the reason they have come in – generally, diversion happens before?

**Mr SHANAHAN:** To get us away from the courts.

**Mr FERGUSON:** To take them out of the system. Once they are in the system and have that period of probation or parole, depending on the court order afterwards, then they may do various things. There may be some stuff similar to diversionary programs, or they may have community work orders as part of that. They exist, and that is a court ordered option.

**Ms PURICK:** They could be put into that kind of educational type program?

**Mr FERGUSON:** Yes.

**Ms WALKER:** Can I ask, under one of the headings in your submission: access to Commonwealth funding programs – nil; no money. Given the fact we will be seeing implementation recommendations from the Youth Justice Review, and given the fact Aboriginal adults are over-represented in the correctional system, is there no access to federal government money under *Closing the Gap*, through COAG?

**Mr SHANAHAN:** It is certainly an area of frustration for me. As a CEO I have been trying to engage those programs; however, there seems to be a constitutional issue between the feds and states about who is responsible for prisons which permeates through all the dealings we have with them. When it comes to people in custody and all those types of things, they say it is a state responsibility. That is a fair summary of it.

**Mr FERGUSON:** The courts are similar.

**Mr SHANAHAN:** Courts - we cannot gain access to many things. It is different when it comes to community corrections and programs outside, but diversion stuff ...

**Madam CHAIR:** They will fund that outside?

**Mr SHANAHAN:** They will fund, but they will not do it within the confines of Corrections.

**Ms WALKER:** Yes, that is interesting.

**Ms RUDD:** I might add that the Commonwealth funds the Aboriginal legal services for those through-care services and prisoner reintegration services.

**Mr SHANAHAN:** They do some, yes.

**Ms RUDD:** As Greg said, it is things on the periphery of the system.

**Mr SHANAHAN:** The system itself.

**Madam CHAIR:** We received information yesterday on - I want to go to young women. What are your numbers in the juvenile justice system? We heard in the New South Wales system - I am talking about suicide and assaults against young women - one per 100 000 in New South Wales, in Queensland three per 100 000, and in the Northern Territory it was around 30 per 100 000. This is quite staggering in what we have and what we are confronting with young women in the Northern Territory. How many young women – what are the numbers in the correction system?

**Mr FERGUSON:** Are you talking about in juvenile?

**Madam CHAIR:** Yes in juvenile, not the adult prison.

**Mr FERGUSON:** I could not give you an exact number; it is only about half a dozen at the moment.

**Madam CHAIR:** Are you able to take that on notice and give us the exact numbers? Further, if there have been issues amongst that cohort, what sort of work has been done with those young women in their exiting the system.

**Mr SHANAHAN:** With those assault figures, one assault would drag it right up. All you need is one a year and when you multiply that by the proportion of - so statistics ...

**Madam CHAIR:** Yes, I realise that. One of the areas I will get to after this, Greg, is the reporting and statistical data, the compilation of that data, and what happens. That came out of the Institute of Health and Welfare looking at the Northern Territory.

**Me SHANAHAN:** As at Saturday there were eight.

**Madam CHAIR:** Is it urban? Are you able to give us the demographics, sorry?

**Mr SHANAHAN:** We will take that on notice.

**Madam CHAIR:** Yes, if you could just take that on notice and just give us that demographic just to help us. If you want that confidential, just for committee information, we will just have it for deliberations of the committee and we will not put that out. But, if you could just give us the demographics on that, thank you.

**Mr SHANAHAN:** In fact that number has grown, hasn't it?

**Mr FERGUSON:** Yes.

**Mr SHANAHAN:** In recent time, considerably over the years.

**Mr FERGUSON:** Yes. When it was first built, we had no females, and that number is growing.

**Madam CHAIR:** And amongst young women, it is growing?

**Mr FERGUSON:** When Don Dale was first built we very rarely had a female detainee. Now, they are a significant portion. It makes management issues within the centre hard, because you have to …

**Madam CHAIR:** Separate them.

**Mr FERGUSON:** It was not specifically designed for young women, and to keep them separate from the boys is a challenge at times.

**Mr SHANAHAN:** It becomes very costly, too, with staff and …

**Mr FERGUSON:** Yes, very costly.

**Mr SHANAHAN:** … to establish that division. But, it is definitely over the last five years it has been an increasing trend …

**Madam CHAIR:** Of young women increasing in the …

**Mr SHANAHAN:** … to have young women coming into detention, yes.

**Madam CHAIR:** We will not go any further; we will wait for that. Thank you, Greg, for your appearance, and the department's appearance.

When we get that information we will make sure it is used just for the committee and not outside.

**Mr SHANAHAN:** Yes. The problem is because we have small numbers you can actually identify people from regions, so we …

**Madam CHAIR:** And we said that to Dr Bath as well yesterday; that in getting access to some of the statistical data. It is clear that everybody is collecting and getting some data, but none are talking to each other. It is all over the place and it is hard to get the actual trends and what is happening, if everyone is doing their own research rather than getting some consistency across all the agencies.

We will certainly bear that in mind and make sure that does not get misused.

**Mr SHIELDS:** Marion, just to clarify the two questions on notice …

**Madam CHAIR:** Yes.

**Mr SHIELDS:** …that I have noted down to see if they accord with your thinking. The first one I had was how many incidents of self-harm in juvenile detention. The second was this break-up of juvenile detainees by gender and demographic.

**Madam CHAIR:** Yes. I was really interested in the young women.

**Mr SHIELDS:** The women.

**Madam CHAIR:** Yes, Alastair.

**Mr SHANAHAN:** Will we get confirmation of that like we do with Estimates or …

**Madam CHAIR:** Yes, we will provide you with a transcript …

**Mr SHANAHAN:** Yes, so we can check.

**Madam CHAIR:** … a draft. If there are any corrections you want to make, or you think it has not been recorded properly, you get back through the Secretariat.

**Mr SHANAHAN:** Okay, thanks.

**Madam CHAIR:** Thanks very much.

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The committee suspended

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**DEPARTMENT OF HOUSING, LOCAL GOVERNMENT AND REGIONAL SERVICES**
**Mr Ken Davies, Chief Executive**
**Ms Trish Angus, Deputy Director Strategic Policy. Development and Coordination**
**Ms Giovina D'Alessandro, Director, Local Government**
**Mr Phillip Luck, Director, Technical Support Remote Housing**

**Madam CHAIR:** I have a quick official speech and then we will get started.

On behalf of the select committee, I welcome you to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome to the table Mr Ken Davies Chief Executive; Ms Trish Angus, Deputy Director Strategic Policy, Development and Coordination; Giovina D'Alessandro, Director, Local Government; and Phil Luck, Director, Technical Support Remote Housing. Thank you all 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 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 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.

**Mr DAVIES:** Thank you, Chair. Ken Davies, Chief Executive of the Department of Housing, Local Government and Regional Services in the Northern Territory.

**Mr LUCK:** Thank you, Chair. I am Phillip Luck, Director of Technical Support for the SIHIP and NPARIH Program.

**Ms ANGUS:** Thank you Chair and members. I am Trish Angus, Executive Director Strategic Policy and Development Coordination for the Department of Housing, Local Government and Regional Services.

**Ms D'ALESSANDRO:** Giovina D'Alessandro, Director of Local Government within the Department of Housing, Local Government and Regional Services.

**Madam CHAIR:** You know all the members at the table. I should also have introduced Julia Knight to the previous witnesses before the committee. Ken, would you like to make an opening statement?

**Mr DAVIES:** If I could Chair, thank you. I wanted to say to the committee, thank you very much for inviting myself and my colleagues to discuss such an important issue. Although youth suicide is a sobering issue, we are certainly pleased to offer the department's unwavering support. My staff have introduced themselves. Youth suicide is having a devastating effect on the Northern Territory. The department acknowledges it has a role to play in reducing current suicide rates through providing appropriate housing for people, improving living conditions, improving issues such as overcrowding in remote communities, providing employment opportunities in local governments, delivering meaningful services to youth through local government, and promoting effective delivery and coordination of remote services.

The department would like to offer its support to the committee in any way we can today, and well beyond this hearing. Thank you again.

Madam Chair, what we have done across our areas of responsibility in my agency is a submission that we wanted to leave for the select committee. It just covers issues of housing in remote areas, deals with things like overcrowding, improving living practices, and government employee housing. We have a section on homelessness, on local government reform, funding and support for shires, Grants Commission funding, and remote service delivery and coordination of services.

We have put in this submission some current up-to-date facts about where the department is up to in delivering government's priorities and some matrix that we thought the select committee might find useful in the consideration of the issues they get to work on through the process. I was hoping I could just table that with you today and leave it with you, provided it was appropriate.

**Madam CHAIR:** That would be good, Ken, if you could table that. Maybe we can get the committee to have a look at it. It would have been good to have had that before, then we could have framed some questions.

You talk about homelessness, Ken. Does that submission touch on youth homelessness in Darwin as well as the regions or remote communities?

**Mr DAVIES:** It deals specifically in the homelessness area. I will get Trish to refer further to that. Under homelessness, it actually talks about the sorts of programs that we are auspicing with the Department of Children and Families and so on in the homelessness agenda. Also, the extra infrastructure we have been able to deliver through the national partnership, Madam Chair.

We have just collated this information. We thought we would talk through some of this with you today, and we really wanted to leave it as background information. We did not see it necessarily as a formal submission to you today, but are very happy to leave it in that context.

**Madam CHAIR:** Yes, that would be good.

**Mr DAVIES:** Because we thought it was just a useful analysis of all of the areas we are responsible for at the moment, and the sorts of numbers we are delivering.

Just as one example, under the National Partnership Agreement on Remote Indigenous Housing we are going to be delivering substantial numbers of new houses in remote. To date, we have delivered 475 new houses. We have an implementation plan to deliver 934 new in remote. In totality, we will be delivering over 1400 new houses in remote by 2018. I just wanted to emphasise that in that context, in the gap around housing, with that injection, the current number of people per house is 10.3. That investment will take the numbers of people in houses to around nine people per house. So, even with the $1.7bn investment out to 2018, it just shows we still have a long way to go, even with the delivery of additional new housing. Bearing in …

**Madam CHAIR:** Much better than the 20 people in one house that they have had previously.

**Mr DAVIES:** That is right. And we have made some substantial improvements in places like Wadeye and Maningrida in particular, where we have added large numbers of additional houses. Just to emphasise we still have a long way to go in the housing area. Some of those facts are in this document here.

**Madam CHAIR:** Do any members of the committee have any questions?

**Mr GUNNER:** Something that came up in Tennant Creek when we had our hearings down there late last year. I cannot see it in here; I might be missing it. It was around funding of Youth, Sport and Rec officers. That is through Local Government funding?

**Mr DAVIES:** The Youth, Sport and Rec program is funded through NRETAS …

**Mr GUNNER:** Yes, okay.

**Mr DAVIES:** … Mr Gunner, but there are Australian government funds that are also funded directly to shires. On the ground, the youth programs are delivered by shires. We have attached some examples of where there are specific programs being delivered by local government. I thought today - to give you an example, this is the Roper Gulf annual report which shows very specific detail around the type of programs they are delivering in helping children get a good start in life and helping our people grow strong and proud. They have some numbers in their annual report that are detailed. Do you want to go to some of the detail around youth programs in shires?

**Ms D'ALESSANDRO:** It is important to note that, although it is not a distinct core service, the shires really do pick up youth services in the communities. They acknowledge that, generally, they are best placed to deliver programs whether it sport and rec or just providing activities after school. On the Tiwi's they take it very seriously. They have a sport and rec director there now who has a great background, is a very good sportsperson and is really driving setting up long-term consistent sporting programs over there.

The Roper Gulf one is excellent and has made it one of its pillars - one of the important - on page 15 of the written submission:

*The Tiwi Islands Shire Council has a successful youth diversion and development unit funded by the Northern Territory government and other partners*.

It is a recognition that they get not only Territory funding - whether it is through NRETAS or their own grant type funding from our department - they get it from the feds as well.

*The program delivers innovative mediation family conferencing for youth offenders working closely with the police and other service providers such as Red Cross and CatholicCare, and the program has recently been reviewed by the Australian Institute for Family Studies.*

*With regard to Roper Gulf, their youth services program has established a dedicated youth centre and space in three targeted communities. The program is also assisting young people to complete Certificate II in Community Services as a pathway to employment. It also has a youth voice committee to encourage a new generation of leaders*.

Following on:

*The East Arnhem Shire Council once again is drawing upon funds from both the Commonwealth and the Northern Territory government to deliver a range of youth focused sport and recreation facilities including the upgrading of ovals at Galiwinku, Umbakumba and Ramingining.*

*The upgrading of sport and recreation will also support youth programs, and upgrading the Milingimbi drop-in centre with improved IT facilities*.

As you are all aware, in addition to running youth services and programs - sport and rec programs - shire councils are responsible for putting on cultural events - that is part of their core services - and East Arnhem is definitely doing that and is linking in with other NGOs to do that.

Even though we have pulled out a couple of examples from the shire councils, you would find that is repeated across all shire councils.

**Mr DAVIES:** Madam Chair, I could work through the elements of this submission if you like, or if you had any specific questions we could ...

**Madam CHAIR:** We could either way. If you are going to work through the submission, Ken, then I need to ask you whether you give permission for us to put this on the website for publication. I just wanted to ...

**Mr DAVIES:** Absolutely. We are very happy with that.

**Ms PURICK:** There seems to be much information around homelessness in urban areas versus - I am not talking about remote communities. Has the department ever done any preliminary work, or tried to get a grasp on the amount of homelessness - not necessarily young people but they are included - in the greater rural area of Darwin? I know anecdotally – and anyone from the rural area would know as well - there are many people who live in cars, in dongas. They are not always young, but they are not always old. A fair chunk of them are at risk. Some of the data I collected for my talk in parliament was from the ABS. Call it Litchfield Shire area has an enormous rate that for suicides - for young suicides. I know there is not a lot of public housing in the rural area, for lots of reasons, historically as well as current.

Is it perhaps something the department could look at trying to get a picture? Yes, we know our homelessness rate in urban areas is high - we know that because you can quantify it; you can see them there or you find them in the streets. I guess it would be a joint project. You would have to look at obviously, counsellors, churches, and all those kind of people. They are at risk and a lot of the time they might die or be found dead. Sometimes, it is never actually tabulated as from suicide; it is just that they just died. There actually could be more out there; that is what I am saying.

**Mr DAVIES:** To answer your question, we have not done that work, Ms Purick. But we have conducted a rough sleeper study, which was commissioned in late 2010, to better understand the motivations for patterns of rough sleeping in Darwin and Palmerston. We used CDU to do the work for us, along with some of our quite experienced officers who are connected with the community on the ground just through our delivery of housing services. If it was a recommendation of the committee that we proceed and do something that was more in those outer areas, we could certainly do that work. That study was very useful in assisting us to develop some programs.

**Ms PURICK:** Is that study a public document?

**Mr DAVIES:** Yes.

**Ms PURICK:** Can we get a copy?

**Mr DAVIES:** Yes.

**Madam CHAIR:** Following on from what Kezia was saying, something that was raised when we look at rural and regions, is the issue of youth accommodation in places like Mataranka, Elliott. Those regional towns feel like they are remote from Darwin.

I agree with what Kezia was saying. In Darwin, you can see the homelessness situation. However, as we go further around, it is unseen. Whether that is something that you would take on as part of the national partnership to look at or report.

**Mr DAVIES:** Madam Chair, it is certainly something we are looking at just in the context of a remote public housing system. A public housing system in urban and regional areas looks like some - not a lot – four-bedroom house, a big proportion of three-bedroom houses, duplexes, and then single units.

In remote, as you know, our public housing footprint is largely houses and duplexes. The same applies in those regional towns like Elliott. We have not constructed, as part of a public housing system, single accommodation people could access if they were a young person trying to get into their own space. Going forward into the future, particularly for our growth towns, that is something we are going to have to look at in our public housing model.

There are the support programs where you actually fund specific accommodation for youth, but in a broader public housing model, if you wanted something that was fairly consistent, then you would be expecting to see, in a place like Maningrida, some single accommodation that young people could access. It is not there now, but that is certainly something we will be wanting to talk to the Australian government about in the next phase of the National Partnership on Remote Indigenous Housing.

**Madam CHAIR:** How do we get this happening – the dialogue for Humpty Doo, Elliott, Mataranka, those places that have an issue? It is sometimes young Aboriginal people, it is young non-Indigenous youths who have become disengaged. An Aboriginal youth who has moved from their remote community into these areas, and not in any form of accommodation.

**Mr DAVIES:** No. It is an area where we have had some quite - like the Chief Executive of the Department of Children and Families has phoned me because there was a discussion in Tennant Creek, where this is an issue as well. We are going to have to look at that as part of the public housing model, but in relation to the National Affordable Housing Agreement and the funds we get from the Commonwealth. Those funds largely have been targeted on Darwin and Alice Springs.

We have had the remote focus through SIHIP. In relation to specific infrastructure being built in other locations dealing specifically with homelessness, that would be an expansion of the program. We certainly have it on the agenda to discuss with the Commonwealth. However, currently, the focus has been on Darwin and Alice Springs. We have been able to build Percy Court in Alice Springs, Crerar Road out near the airport, and six of those housing units there have been allocated to the Department of Children and Families for specific cases where youth need supported accommodation and are in care. We have a set of units in Alice Springs as well to provide the same for the Department of Children and Families.

We have a way to go there.

**Ms ANGUS:** Could I add, the homelessness national partnership agreement is due for review in the next 12 months. This is the time to raise that in our negotiations with the Commonwealth in respect to expanding the program from the current urban areas and move to the rural towns. We have recently introduced a component of the homelessness NPA into Borroloola for tenancy support. That was the first time we took out of the bitumen, so to speak, and got the program there. The Australian government was supportive of that. As we go into the review of the NPA we can raise that as a priority area for us.

**Ms WALKER:** Can I ask a question around visiting officer's quarters? If I am going out to visit remote parts of my electorate where there are VOQs, I phone up and book a room competing with many others through DC. Who is responsible for constructing these places and who owns them?

As you would be aware, Ken, there is a shortage of short-stay accommodation on communities for a whole host of government service delivery areas, but including where we might have mental health workers going out, where we have special youth workers going out, or we might have an artist in residence doing a program for a fortnight at a school. Is there anything happening around expanding that program in our growth towns specifically?

**Mr DAVIES:** In regard to our GEH footprint - our government employee housing footprint - we have about 1030 staff houses in remote. In regard to the VOQ program at the moment, it is not on the books to expand visiting quarters.

We are trying to facilitate the permanent placement of people in communities. The VOQ footprint, we think at the moment, is manageable. We are focusing on ensuring, particularly in our Territory growth towns, that we have the accommodation ready and available for the new child protection teams that are going in there. Our focus has been on building permanent accommodation so we can ramp up our services in those growth towns and hub communities. That has been the focus.

The VOQ arrangement is complemented by the GBM's footprint from the Australian government, where they have been able to share facilities and infrastructure. However, we do not have a specific program at the moment to upgrade the VOQ footprint because we are trying to focus on the more permanent placement of government employees to provide services and coordination.

**Ms WALKER:** I am very aware there are school teachers, nurses, and aged and disability coordinators who house visitors in their spare bedrooms for want of available accommodation.

**Mr DAVIES:** Yes, we understand that. Part of the GEH focus is to try to expand, get the leases in place, try to get a coordinated construction program - not agency by agency, but a coordinated construction program of GEH in communities so we can minimise the impact on permanent people who are boarding overnight, people who are coming in, but also to move away, as much as possible, from the fly-in/fly-out to more permanent service delivery where relationships are built and people stay on the ground.

**Ms WALKER:** So, is there a scoping study about exactly what the – well, maybe not exactly - needs are, say, in our growth towns for additional GEH?

**Mr DAVIES:** We do have work done on that, and we could provide that to you, in the agency priorities. The agencies ask us and give us their specific priorities. That has to be overlaid against the existing GEH infrastructure as well in each community, but we do have a needs analysis done that we could provide.

**Ms WALKER:** That would be helpful.

**Madam CHAIR:** Does much of that come from Department and Children and Families?

**Mr DAVIES:** We have been working …

**Madam CHAIR:** Because that is where a lot of these programs come out of.

**Mr DAVIES:** Yes. Thanks, Madam Chair, for the question. We have been working very closely with the Chief Executive of the Department of Children and Families, and with her officers, around making sure that the child protection teams have GEH available to them so, as they are recruited, they can be placed into remote communities.

We have been doing that by looking at existing stock and seeing where there are efficiencies there, but also putting into the program where we need to build new stock as well. The priority is to get the teams out there, and that is what we have been working with them on.

**Madam CHAIR:** I just want to go back to your Youth, Sport and Recreation programs with the shires, if I could. Thank you for, in your submission, where you outlined where some of these programs are happening. I suppose with some of the shires it is hit and miss. What is the department doing to bring together the shires to be able to deliver? It is not just shires - I qualify that it is not just shires' responsibility for that; there are other players who get funded for that. What are we doing with pulling together all of those players? We have West Arnhem Shire turning up after this. Maybe we could ask them some questions on some of the communities out in West Arnhem.

What is the department doing in facilitating both Commonwealth and Territory programs into these communities in relation to youth?

**Mr DAVIES:** Okay. Gio, perhaps if I have a go, then I will hand to you. What we have is a regular shires forum where we meet quarterly, Madam Chair. In those forums we are able to discuss both the shires, the annual reports of the shires, but also their regional plans. The CEOs have an opportunity to talk about what programs they are implementing - a specific focus around youth in those discussions. We have been coming at the discussions with the shires around their sustainability, the specific issues they are dealing with on the ground, including things like animal welfare and dog control and those sorts of things.

Regarding the shires and a coordinated approach around youth, the relationship that shires have is with the funders, so it is the Australian government and NRETAS around the programs. If that was something the committee would like us, as the Department of Housing and Local Government, to go in on a specific coordination process with the shires around youth, we could do that.

Gio, have you got anything you wanted to add?

**Ms D'ALESSANDRO:** I am just acutely aware that shire councils are best placed to tell you exactly what they are doing with regard to this service. It is pleasing to note that West Arnhem will be here and have the opportunity to tell you.

What I am happy to do - and Ken is quite right in saying they are funded by different bodies. But, at our regional shires forum, the federal FaHCSIA, Mr Chalmers, attends and he certainly takes on board any concerns that are raised by shire CEOs, or mayors and presidents at the time.

**Madam CHAIR:** I get that. But, ultimately, which department wears the responsibility for the financial stability or sustainability of the shires? We talk about youth programs and other programs, and we ask these questions at CTC as well. Ultimately, you provide some funding. Yes, we are talking about a program which is youth, sport and recreation. Yes, that is Commonwealth - or whether they receive funding from another agency; however, surely the Department of Housing, Local Government and Regional Services has a responsibility to ensure the shires are financially sustainable and are delivering their programs. That is what I am …

**Mr DAVIES:** Madam Chair, you are, of course, right. We have some work going on regarding the shire sustainability process at the moment which is featured in these notes we have tabled for you today. In regard to coordination around the work shires are doing, we have their regional management plans and we use their annual reports to scrutinise what is going on. At the end of the day - and there is the focus for us around the delivery of shire core services - they have many supplementary programs as the largest service provider in remote. They do much work for the Australian government and it is fair to say we have not had a specific process where we have asked: 'What are your youth services looking like across all the shires?' We have not done that work.

**Madam CHAIR:** Is that something that will …

**Mr DAVIES:** We could certainly do that. If that was something the select committee wanted to raise as a specific issue we could certainly take that on. However, given the focus around this broader issue of youth suicide, we can raise it at the next shire CEO forum. We can build for you a picture across the shires of what youth services are available and what, specifically, each shire is doing in the youth services area.

They will always come back saying they need additional support to do that. One of the particular issues goes to housing and managing their overheads in doing the youth programs they have on the ground. Our minister has funded an additional $8.9m to support jobs in shires, and some of the shires have directed those to youth services.

**Madam CHAIR:** Yes, if we can get that information, Ken.

A quick follow-up and I will hand to Lynne. Can you also take on notice and provide the committee information regarding whether any of the shires have a process which engages - we have a Youth Round Table - there is some forum in which youth in these communities speak through to the elected members.

**Mr DAVIES:** Sure.

**Ms D'ALESSANDRO:** A good example is the Roper Gulf Shire Council which has a Youth Round Table, essentially a committee …

**Madam CHAIR:** Yes.

**Ms D'ALESSANDRO:** … and very much the focus is engaging their youth with a view to building them as future leaders for their council. Now …

**Madam CHAIR:** That is one shire?

**Ms D'ALESSANDRO:** That is one shire, but I am happy to do a breakdown for you across all shires to see what they will be doing. I would be very surprised if they were not doing that.

**Madam CHAIR:** What work does the department do to help facilitate some of that, Giovina? I have heard good things about Roper Gulf and East Arnhem. It seems to be limited to one or two shires and we want to try to get it across ….

**Mr DAVIES:** Yes.

**Ms D'ALESSANDRO:** We have funding available through *Closing the Gap* and special purpose grants. What you do not see is the money we give shire councils to upgrade their drop-in centres, their sporting facilities and that type of thing. Those are the sorts of grants you do not see and are additional to their normal funding and funding they get from the Commonwealth.

**Madam CHAIR:** It would be good to get some of that information.

**Ms D'ALESSANDRO:** Yes.

**Madam CHAIR:** When we look across the breadth of these shires there is substantial funding when we talk about what funding goes in there for specific purposes. Lynne.

**Ms WALKER:** I want to go back to what Marion was talking about previously, Ken, across government coordination of youth service delivery …

**Mr DAVIES:** Yes.

**Ms WALKER:** … with one glaring example from East Arnhem Shire, which does a great job. I know from the Chief Executive and the councillors there that it is probably the most difficult area they have to operate, particularly when it comes to recruitment and retention of people in that area. They are operating very successful programs across the East Arnhem Shire.

In competition for Commonwealth dollars, with other agencies and NGOs, there was a recent situation - when I say recent this is in the last six to eight months - East Arnhem Shire at Elcho Island had tendered for a youth diversion program. By all accounts they were very well positioned to provide that service, had people on the ground, were able to resource it with people to run it on the ground. The decision was made through Children and Families to award that contract to an NGO which was able to deliver that service by flying in once a month for two days.

As local member, I was just lobbied by the shire about how this decision had come about. I can see by the look on your face how frustrating that must be. For lack of - I do not know how we do it - between the Australian government and our agencies, to make sensible decisions about who is best positioned.

**Mr DAVIES:** Based on the considerations of where you get to in this select committee, through the Chair, that sort of advice would be really useful. At the moment, the coordination in the youth area, my agency is responsible for housing, local government and regional development, and has a unit that is around remote service delivery coordination. We coordinate at a very high level.

It does not have a specific charter around youth. The youth space is really picked up by Department of Children and Families. NRETAS has a role to play in it. Clearly, we have a role to play with shires, but there is not a specific area that has responsibility for youth service delivery across government in remote.

Of course, the other overlay is that we have FaHCSIA, DoHA, DEEWR - so a range of other Australian government players are also funding programs into remote and regional communities to the extent that there is a plethora of programs. There are numbers of NGOs that very capably deliver programs, but the coordination is an issue across the Territory.

**Madam CHAIR:** We recognise there is a number of departments. When you say that you do not have a specific youth mandate but you do have a policy which is called *A Working Future*, as part of *A Working Future* and that policy, there is an element which targets young Indigenous people in communities and to look at their transition. Whether it is through the education system building the capacity of these young people.

I recognise your frustration, and I would hate to be in your shoes, Ken. I wish you luck in trying to get the Commonwealth to coordinate them with the yourselves. It is important ...

**Mr DAVIES:** It is.

**Madam CHAIR:** They talk about stronger futures, they need to be better coordinated.

**Mr DAVIES:** Through the Stronger Futures negotiations we are having at the moment, particularly around the delivery of the program funding that will support that, there are opportunities to start to drive that coordination. We are all learning in this space. It is fair to say there was no *A Working Future* policy a number of years ago. There was certainly no service delivery coordination unit. We are getting better at what we do across government as we go.

The most important thing, though, is to make sure that core service delivery - whether it is in education or in Department of Children and Families - is delivered in a way that is cooperative, and not just shifted to the agency that is doing the coordination.

It is how we wire this up to make it work for youth, that your committee can provide some very strong advice for us. That would be very helpful for agencies.

**Madam CHAIR:** On that note, we will say thank you - and thank you for the submission.

**Mr DAVIES:** Madam Chair, I just wanted to flag – it is called a submission but really what it is it is just a …

**Madam CHAIR:** A matrix.

**Mr DAVIES:** … a matrix of what services we deliver, and if that generates further questions from the committee we are happy to answer them. It is really a current status report on the type of things the Department of Housing, Local Government and Regional Services is responsible for.

**Madam CHAIR:** There were a couple of questions on notice taken during that process. Would you like us to send that through?

**Mr DAVIES:** That would be terrific, Chair. We have somebody taking notes so hopefully we will be able to respond very quickly.

**Ms KNIGHT:** I will e-mail you, Ken.

**Mr DAVIES:** Thanks very much, Julie.

**WEST ARNHEM SHIRE COUNCIL**
**Mr Nathan McIvor,**
**Regional Coordinator Community Safety/Shire Services Manager, Warruwi**

**Madam CHAIR:** Nathan, we might start. I have a short official statement to read for *Hansard* purposes. If you wanted to make an opening statement you can do so and then the committee will go into questions.

On behalf of the select committee, I welcome you to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome Nathan McIvor, Regional Coordinator Community Safety/Shire Services Manager in Warruwi. Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee and I 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 the committee to go into a closed session and we will take your evidence in private.

I will ask you to state your name for the record and the capacity in which you appear. You can then make a brief opening statement. Could you state your name and the capacity in which you are appearing?

**Mr McIVOR:** Nathan McIvor, Coordinator Community Safety, West Arnhem Shire and Shire Services Manager at Warruwi.

**Madam CHAIR:** Would you like to make an opening statement, Nathan?

**Mr McIVOR:** No, I am right to go.

**Madam CHAIR:** You are right to go? Okay, we will go straight into questions.

**Mr GUNNER:** Could you take us through what you see are your biggest challenges in the shire and advise some of the services you currently provide?

**Mr McIVOR:** The Regional Coordinator for Community Safety is, basically, taking into consideration Night Patrol for Croker Island, Gunbalanya and Warruwi. We subcontract out to BAC in Maningrida. We have had some issues with BAC signing contracts and have had a number of high-level discussions with the Attorney-General's Department around the signing of those contracts. The reasons why the contracts have not been signed is because there is not enough money for the Night Patrol to run in Maningrida as far as BAC is concerned. So, BAC has refused to sign those contracts. We have only just had the Attorneys-General, through discussions I have had with them, agree to fund us as zone coordinator in Gunbalanya, and as zone coordination in Maningrida, which means there will be extra funding that will come towards us.

In Gunbalanya, we need that, definitely; Gunbalanya is getting worse. Maningrida definitely needs a zone coordinator. The issues around Night Patrol are retaining staff, basically finding staff who will do their job properly, and finding staff who are strong and will not back down or buckle under issues within the community. That has been a major issue and worry, for example, in Gunbalanya as well. …

There is not much the West Arnhem Shire can do in that perspective. We give BAC the money they should get, if they were going to be funded by the Attorneys-General direct - so much so to the point where I have just said - and I have taken advice from the Chief Executive Officer as well - that we no longer want to look after Maningrida Night Patrol. That will be BAC and they can work directly with the Attorneys-General.

**Mr GUNNER:** So, is BAC someone your shire has chosen to do the Maningrida ...

**Mr McIVOR:** No, BAC was running Night Patrol before the shires came.

**A witness:** They were doing it pre-[inaudible].

**Mr McIVOR:** That is true.

**Mr GUNNER:** So it is an historical thing that ...

**Mr McIVOR:** It is an historical thing. I can understand their misgivings and their concerns about the shire taking it ...

**Mr GUNNER:** But if they are not signing contracts would not their service provision come to an end?

**Mr McIVOR:** Well, we are in breach. West Arnhem is in breach of the Attorneys-General agreements because BAC is not signing those contracts.

**Mr GUNNER:** There is probably more complications here,

**Madam CHAIR:** It is complicated, let me tell you, and the shire has been in the meat in the sandwich with this. But, the federal government was told when discussions were happening with the Night Patrols to maybe separate Maningrida, because of the population, from the rest of the shires - to give the shires the rest of the boundary and just leave Maningrida separately. No one listened to that advice, hence, the problems you have now - which could have been avoided over two years ago. What is really disgraceful with all of that is that Maningrida was actually the model for that child safety program …

**Mr McIVOR:** That is correct.

**Madam CHAIR:** … that was being run there. It has just all fallen away. The shire is not to blame in any of this; it rests squarely with the federal government which would not listen to any advice.

**Mr GUNNER:** Well maybe on to an angle away from the BAC thing - in staff retention areas outside Maningrida they did not have any trouble with, does that mean you then have difficulty in getting and training people in gate-keeper training in mental health first aid so when they are on duty and they are seeing someone, they can identify they are at risk and get them the right sort of help?

**Mr McIVOR:** That is correct.

I will take Gunbalanya for example. I employ an ex-police officer from South Africa to come over to Gunbalanya. He was actually in New Zealand for five years. He was 27 years in the police force in South Africa, was Nelson Mandela's bodyguard. He was also working in maximum security in New Zealand. He came over to Australia to work as our team leader in Gunbalanya. He turned Gunbalanya Night Patrol around. Then, late last year, the clinic lost their AOD counsellor, and he applied for the job and he got it. He was getting paid a lot more than we could pay him. He had better housing, and it has left me basically in the lurch. We have had to put a temp in, a guy who used to be a police officer in Western Australia for 27 years or something like that. He has only just started in the last two weeks as a temp until we can sort out the zone coordinator position, but it is very difficult. Attorney-General's said to - the operational framework says they want Indigenous people to be employed within these communities. It is very difficult to find an Indigenous employee to be able to do the job required by the Attorney-General's Department.

It is very difficult to find somebody in the community who can understand the stats and all the rules and regulations behind what the whitefella government created. When I first started with West Arnhem Shire in December 2010, I put a submission through to them asking that they review the operational framework because, as far as I could see, it did not fit with community requirements. They said to me last time I saw them late last year that they were going to move towards giving that some credence.

**Madam CHAIR:** Good luck.

**Mr McIVOR:** Sorry?

**Madam CHAIR:** All I can say is good luck.

**Mr McIVOR:** Yes, exactly.

**Ms WALKER:** Nathan, is the West Arnhem Shire funded for any youth diversion activities or is an NGO providing that service for West Arnhem?

**Mr McIVOR:** There are NGOs in Gunbalanya. We are being funded for the VSA, the Volatile Substance Abuse program. We have Dallas Thompson from Ngukurr looking after that in Gunbalanya. One of the issues we have with that at the moment is the money was originally - there was $170 000 given in 2007 prior to the shires being amalgamated and we were then questioned last year about where that money had gone. No idea; do not know where that money has gone. All we have is a position that is funded, but there is no money in that position to run any programs or anything like that.

In Gunbalanya is it is coming out of the Night Patrol money. It is not coming out of shire money; it is coming out of Attorney-General's money and the Attorney-General's Department is not very happy about that. What I have tried to do is utilise the position and utilise Dallas Thompson as part of the Night Patrol team and be part of that referral service for young people.

**Madam CHAIR:** We have, Nathan, the Department of Children and Families, which was funding the VSA program, coming this afternoon. We can ask what happened with that funding.

**Mr McIVOR:** They reviewed it and one of my issues when I first started was the governance around many of these programs was not being done and certainly was not being checked up by the government. I could say much money was being spent, probably incorrectly. There certainly was not the governance behind - the government was not there to ensure the money was being spent correctly and there was no audit process in place to ensure what we were doing was correct.

Again, it comes back to who you employ within a community; the type of person you can employ in the community and the calibre of the person you employ in a community. One of those issues is you employ whoever has the best qualifications, but it does not necessarily mean they are the best person for the job. How they communicate with an Aboriginal person in a community that has been sniffing petrol, is drinking lots of alcohol, or is using ganja all the time is very difficult compared to working with somebody who works in mainstream society.

**Madam CHAIR:** Nathan with two communities in West Arnhem - I should declare my interest as the local member - you have Gunbalanya and Maningrida which, if you look at youth suicides in that region, they are probably two hot spots. What is the shire's capacity to fund positions - the funding you receive from governments? Do you know what that is?

**Mr McIVOR:** I do not know what the figure is, but it is very little.

**Madam CHAIR:** Are you able to see if you could take that on notice and see if that can be provided to the committee?

**Mr McIVOR:** Yes.

**Madam CHAIR:** Do not worry; we are always on the case about sustainability of funding for shires. It is a major issue, particularly with those two communities where they have had - and Gunbalanya recently last year. With the VSA position - was I right? - you were saying that the funding for that was removed?

**Mr McIVOR:** No, the funding is still there for the position – just the position.

**Madam CHAIR:** Just the position, but no operating costs?

**Mr McIVOR:** No operating costs. It is very difficult to do any governance around that. I will say that we have put through a submission to the Northern Territory police in regard to Gunbalanya and the issues that we are facing there at the moment. We have NGOs that are not wanting to go into Gunbalanya now. There

are people leaving Gunbalanya because of all the problems with the petrol sniffing. So, we have put through a submission to the police to ask what they are going to be doing about it, and what we are prepared to do to help - however, or whoever.

**Madam CHAIR:** Given Gunbalanya is a VSA - it has a management plan - does the shire have any intelligence on where the petrol is coming from? I spoke to the police over Christmas about it because incidents of petrol sniffing had reared its head up again in that community. Does the shire, or anyone in the shire, know where the fuel is coming from?

**Mr McIVOR:** The latest problems we have had in Gunbalanya are from the owner of the petrol station who, prior to the Wet Season, brought in a truck load of normal unleaded fuel.

**Madam CHAIR:** From the service station?

**Mr McIVOR:** For the service station, yes.

**Madam CHAIR:** He was in front of the media saying that he did not bring it in.

**Mr McIVOR:** Well, it is there.

**Ms WALKER:** And is VSA management plan.

**Mr McIVOR:** And it stopped**.**

**Madam CHAIR:** Yes, and it is a BSA management plan, but the *NT News* made him seem like he was a bloody angel.

**Mr McIVOR:** And the police have not done anything.

**Madam CHAIR:** Yes, because I …

**Mr McIVOR:** They have breached the VSA plan by bringing that in.

**Madam CHAIR:** You can rest assure the Commissioner of Police is looking at that issue.

**Mr McIVOR:** Good.

**Madam CHAIR:** It needed further investigation because there was, yes.

**Mr McIVOR:** We have young people now in Gunbalanya who are sniffing loads of petrol. They are up on the rock where no whitefella can go and get them, and they are hurling abuse at everybody in the community from the rock. They are waving flags, and they are ram-raiding houses now just to get the dogs out to go into the house and steal alcohol or whatever they can. There are only two police officers. Night Patrol is run off their feet. Night Patrol has two vehicles and, in the last six weeks, our windscreens have been smashed three times. Night Patrol is being attacked by people in Gunbalanya. I will not put up with that stuff. If anybody attacks us, they go to court, as far as I am concerned.

**Madam CHAIR:** And they should. I might get your details, Nathan, after this, and I will give you a ring. I have had a long discussion with the commissioner in relation to some investigation that needs to happen around Gunbalanya, and what has been happening with the illegal trafficking that has been coming in.

**Ms WALKER:** Is kava an issue in that community?

**Madam CHAIR:** No.

**Mr McIVOR:** No.

**Madam CHAIR:** They used to sell kava. Before the intervention, kava used to be sold in Warruwi and Minjilang ...

**Mr McIVOR:** A lot.

**Madam CHAIR:** It was actually – yes, but it went okay. But, it was ...

**Ms WALKER:** Does it bring about behaviours that alcohol ...

**Madam CHAIR:** No, with alcohol. But, with the intervention, their licence was removed.

**Mr McIVOR:** Well, it was actually economically viable for the community to sell kava. There were not too many issues around the kava use. I grew up in Warruwi, and kava use when I was a kid was not that bad.

**Madam CHAIR:** Well, they were a lot calmer than what you see when grog and ganga goes in there.

**Mr McIVOR:** That is right.

**Madam CHAIR:** The council at that time; the kava sales - and I do not want to advocate this - got the council out of debt …

**Mr McIVOR:** Yes, that is right.

**Ms WALKER:** A lot of money.

**Mr McIVOR:** There are some TOs and there some elders in Warruwi who still try to put forward submissions to say we should be able to legalise sale of kava within our communities. The TOs in Warruwi, for example, are really staunch about bringing alcohol into the community; they are completely against it and that has been the case for 30 or 40 years. They are really strongly against it. In fact, when we had ceremony there late last year it was unprecedented, the police were working very closely, through me, through the TOs and the djungai there, to stop alcohol coming into the ceremonies. Police were there at the boats when they were bringing their ceremony stuff onto the island. It was a pretty touchy situation, but the police did a really good job working within the local people. The local people did not want alcohol to be there at ceremony so they were ensuring it was not being brought in.

Talking about youth suicide, we had a youth suicide in Warruwi last year, and there have been a number of attempted youth suicides in Gunbalanya. There have been a few at Maningrida, and in 2009-10 there were a couple in Maningrida as well. I do not have all the stats or evidence of those, but I know from what community people have said to me that it was ganja, petrol sniffing or alcohol.

Obviously, there are many underlying reasons, but they were intoxicated at the time of committing suicide.

**Mr GUNNER:** Do you know much about what happens postvention - after a suicide or suicide attempt?

**Mr McIVOR:** Not much. There is no debriefing. If Night Patrol finds somebody hanging from the ceiling there is no debriefing with those guys. In Maningrida, when they found a number of suicides, the lady who was working with child protection debriefed them, but nothing came in from Darwin - nothing.

**Mr GUNNER:** There are two things: a debrief social counselling process for the people who might find the person - in that instance Night Patrol - and second, say your officers are the ones who find somebody who has completed suicide, do they have anything they can do to pass on to family members present or who might be ...

**Mr McIVOR:** What I have offered before - the last one we had in Gunbalanya, I offered the team leaders to debrief with me and also through EAS. As far as debriefing with family, they rely on the local clinic. You do not have any psychological services going out there or anything like that. It is, basically, if somebody dies, somebody dies, and you get on with life. It is pretty hard but that is what they have to do because they do not get support services.

**Mr GUNNER:** You have a relationship with police as you mentioned earlier. They have some information they have recently redeveloped. They used to have some stuff but they have better stuff now and when they report to a scene where it might be a suicide, rather than prejudging it - it could be other things - when that occurs they have some information they can pass on to family and friends present for them and, if they choose to in the future, they know what to do or to look out for or something like that. It might be worth seeing if you can get a copy of that material.

**Mr McIVOR:** Do they know whether it works?

**Mr GUNNER:** It is interesting; we were talking to Dr Bath yesterday morning in his role as convenor of the child deaths review. There is no real good data around suicide or suicide prevention, and the data around that is purely around whether it makes the policeman's job easier. There is no way of measuring whether it has helped the family because of privacy and other issues. They cannot do a three month later questionnaire with the family about it so they cannot measure how well it is helping the family. However, they can measure how well it is helping the police, the people that do their job and at this stage - it is early - but at this stage it is successful.

**Mr McIVOR:** It is just a numbers game, surely. They should be able to work out if it has helped a family. They can say it has helped at least five families or whatever.

**Mr GUNNER:** At the moment they cannot go in as researchers and ask the family about how they find the kit working. In relation to clusters, there are no clusters occurring. In regard to the next suicide, that is not on the data. However, at the same time we do not necessarily have any information on suicide attempts because, often, some of the attempts and those that do not complete is not necessarily recorded anywhere or known anywhere. It is really difficult to measure how effect it is. However, it is an improvement in the sense that, if you report to a scene where someone has attempted or completed, at least you have something you can say the people were impacted by that. This is something …

**Madam CHAIR:** This is where you can go and what …

**Mr GUNNER:** Yes.

**Madam CHAIR:** It is basic information, and they have just only started. When the committee was provided with that, we did not ask the commissioner the follow-up: has this been rolled out in remote communities? I know they are using it in and around Darwin and some of our other places.

**Mr GUNNER:** There is always the assumption, and then you …

**Madam CHAIR:** I was not sure, but we could ask that question …

**Mr GUNNER:** I made the assumption that it was being rolled out everywhere.

**Madam CHAIR:** … and just see if it has been rolled out in our bush communities.

**Mr GUNNER:** It is not perfect, do not get me wrong, I am not trying to say this is a …

**Madam CHAIR:** No, it is not the panacea, but it is a start.

**Mr GUNNER:** No, it is not, no.

**Madam CHAIR:** When you look at the actual form, it just provides communities and people with 'these are other sources of assistance and where you can go'. We all know that when families are – and I only look at Gunbalanya and Maningrida. In the recent one in Gunbalanya, families do not want to know about that stuff yet because they just grieving and they are trying to deal with …

**Mr GUNNER:** That is the difficult part around all the postvention stuff.

**Madam CHAIR:** Yes.

**Mr GUNNER:** We did not get intervention stuff, but postvention definitely worked. You cannot mandate that people get care or go talk to someone or get counselling or any of that sort of stuff. They can only either be strongly encouraged - police officers can only strongly encourage that someone talk to somebody. You cannot …

**Mr McIVOR:** One of the biggest difficulties - and I am talking about a school here - about that is that you have a law system that is a western system coming to an Aboriginal system. You have these whitefellas who come up and say: 'You have to do this, this, this, this and this'. People have been killing themselves for a long time, and they have been killing themselves for a long time in Aboriginal communities, and they have been dealing with this stuff on their own. From what I am getting from people who are in Aboriginal communities, they are like: 'Well, why can we not just deal with this our way and, if we need some more

help, we will come and see you?' It is not like we need to be forced in this way. We do not need to be forced in this direction.'

**Mr GUNNER:** That is different to some of the witnesses we have heard from traditional healers …

**Mr McIVOR:** Yes.

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**Mr GUNNER:** … in Central Australia where they said: 'This is a new thing. We did not have suicide until the 1980s. We do not have advice. We feel we do not have advice or traditional culture we can give around dealing with substance abuse'. I am not paraphrasing wrongly, I hope.

**Madam CHAIR:** No, but that is what those old guys were saying, yes.

**Mr GUNNER:** They are saying: 'We feel like we need to know better how to provide advice around alcohol abuse, drug abuse and suicide'.

**Madam CHAIR:** Then translate that in the context of Binninj …

**Mr McIVOR:** Cultural.

**Madam CHAIR:** Yes, and how it is to a Binninj person.

**Mr McIVOR:** That is my concern. You are going from ...

**Madam CHAIR:** Yes.

**Mr McIVOR:** What you are saying sounds to me it is coming from a western perspective trying to put it into an Aboriginal perspective. It is very difficult to do that in some cases. I can understand them crying out and saying: 'We need some assistance with this stuff because we did not have this stuff prior to …' - whenever, the 1980s, 1970s, whenever.

My concern is if we keep on trying to put these western ideals into these communities, particularly communities that are cultural - for example Warruwi - you come up against this 'them and us' all the time.

Even though I grew up in Warruwi, I am still a whitefella. There is still this 'them and us'. I have offered to give some assistance and debriefing to these people before in the past, and it is only because of that connection that they will talk to me. But, if I did not have that connection they would not bother, they would go somewhere else ...

**Mr GUNNER:** But I guess …

**Mr McIVOR:** … to somebody they would trust, and it might be …

**Mr GUNNER:** I guess what we are saying is the information that police have been passing on is not just call a 1800 number in Darwin. It should be about saying you might want to talk to the Ski Beach group or a local community or groups. It is not necessarily about providing a western solution, it is about trying to make sure people – the stats show that if someone completes suicide, then the people around that person are at greater risk.

**Mr McIVOR:** Correct.

**Mr GUNNER:** The important thing is what you can do postvention. The question we are asking is not what we can do, but what can be done. Everything we have been shown is a community response or a peer level response is the best response. It is more about ensuring that point of intervention, which does not come up very often, but when it does you have to try to take advantage of it because someone tries to point someone in the right direction. The biggest issue we are finding is those points of intervention are few and far between and, tragically, one of the few you can see is a postvention point. People are dropping out of school or are not necessarily close to their family etcetera, so you cannot find points of intervention where we can get help for that person. That is probably the biggest challenge we have. Most of the people committing suicide are not talking to anybody; they are not going to anyone or doing anything, no one knows and it just happens.

**Madam CHAIR:** They are not in the system.

**Mr GUNNER:** It just happens and the best way of getting help is if someone at peer level or community level identifies it and gives them that help.

**Mr McIVOR:** Are you saying they are not in the system? They are not in the system because there is no system for them to be in.

**Madam CHAIR:** It is not just in our remote communities. The emerging number of suicides in the Territory is not only in our communities, it is in our urban centres and in our region. It is a major issue right across the board. With our communities Michael was right, those old men who are *nungkeri* or traditional healers down in the Centre - and we are not saying every situation is the same, but Warruwi is a small community with strong leadership and always has had that. That is why they got really pissed off with the federal government and the intervention because they put police there when they have never needed police before. They handled things their way under their law and it was quite a strong community and always has been.

However, when these youth suicides happen often the response is families will deal with that but we forget the kids in school and other places. It is looking at how we are responding to those schools and other places, not just for families but everybody else that is affected by that death. That is what we are trying to do. We know community control is emerging more and we have to give the communities some level of control to be able to deal with some of their issues. That came through very strongly yesterday,

**Mr GUNNER:** It has to be at community level.

**Madam CHAIR:** All the evidence we have received is to give the community the resources and control to be able to do that.

**Mr McIVOR:** Yes, that is big stuff.

**Madam CHAIR:** It is not rocket science stuff; it is what people have been saying for a long time. Hopefully, we can work towards it because it is a major issue. For me, what was frightening was we know the level of suicide happening in our communities.

I was quite confronted at the level of non-Indigenous kids - young people that were also part of the - sometimes you think it is just our problem, but then you peel back and look and it is youth at risk and we have to do something about our young people.

Thank you, Nathan. I hope you are going to join us for lunch.

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The committee suspended.

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**DEPARTMENT OF CHILDREN AND FAMILIES**
**Ms Clare Gardiner-Barnes, Chief Executive**
**Ms Joanne Townsend, Acting Executive Direct, Social Inclusion Policy and Program Division**

**Madam CHAIR:** On behalf of the select committee I welcome Clare Gardiner-Barnes, Chief Executive; and Joanne Townsend, Acting Executive Director, Social Inclusion Policy and Program Division, from the Department of Children and Families. I welcome you to the table to give evidence to the committee. 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 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 the committee to go into a closed session and take your evidence in private.

If you could state your name and the capacity in which you are appearing, and then you may like to make a short opening statement.

**Ms GARDINER-BARNES:** Clare Gardiner-Barnes, Chief Executive, Department of Children and Families.

**Ms TOWNSEND:** Jo Townsend, Executive Director, Social Inclusion Policy and Program Division, Children and Families.

**Madam CHAIR:** Clare and Joanne, I think you know all the members.

**Ms GARDINER-BARNES:** Yes.

**Madam CHAIR:** Would you like to make an opening statement, Clare?

**Ms GARDINER-BARNES:** In relation to the youth suicide concerns, this is an issue the Department of Children and Families takes very seriously. Of course, the main ambit of our direct service delivery in relation to child protection is for children 18 years and under. However, we can provide voluntary services to children in care over 18 who have been in care in the past.

It is an issue our staff are very conscious of, particularly in remote communities where there can be difficult access to mental health services from time to time. However, we have a mandatory reporting regime for child protection in the Territory which requires police, who are most often able to refer children who might be impacted by domestic violence, or school teachers or school counsellors who identify young people at risk or may have suicidal ideation, or health staff who have contact with young people who require mental health services, if any of those staff, as part of their job, are concerned about the welfare of a young person they can report their concerns to Central Intake.

Through that process of accepting that concern, it would be screened in if there was no parent acting protectively to support that child. However, if there is a parent able to support a child who has a mental health issue or is identified as suffering from some suicidal ideation issue, it would be left with the family. However, our department staff would make the referral process to Mental Health Services or another service such as a counsellor, headspace or the Alcohol and Other Drugs service.

We see it as part of our core business to offer prevention and early intervention programs. Where young children are suffering trauma or have been affected by trauma in the past, it is important that we continue to monitor their health and wellbeing and ensure there are NGO services available, particularly for children in care.

**Madam CHAIR:** Okay. Questions?

**Mr GUNNER:** I have a couple I am interested in. We heard from a couple of different witnesses when we first started the committee around training for health professionals, and how a lot of health professionals have a very good grounding, obviously, how to deal with physical ailments. However, most of them do not actually have mental health training and that part of the spectrum. What do you think about that? Where do you think we are going with that? Do you have any recommendations or suggestions?

**Ms GARDINER-BARNES:** One of the things the department recognised in our submission to the committee was that we could improve, potentially, our investment in training for staff, particularly for our frontline staff and foster carers who are working with young people and dealing with them in ongoing ways. There is potential there, across the NT, to enhance our capacity to ensure staff can identify the early warning signs and can put in place appropriate processes and strategies to support young people.

**Mr GUNNER:** That is gate-keeper type training for that level? Do you think we should be looking at upskilling - this probably comes solely outside your portfolio area, so apologies - nurses etcetera, to get them into Certificate IV - that was the course we were talking about - where they have that greater capacity? Should there be an expectation from us that, in some respects, health professionals emerge from their tertiary training with some of that training in the first place, rather than just the physical area?

**Ms GARDINER-BARNES:** One of the key difficulties for us, as an agency, is when young people suffer for a short time - for example depression. It is not likely they are going to be diagnosed with any mental health illness. So, having a broader range of professionals who can respond to their needs is a really important thing for us, as an agency, because we rely on many other agencies just to support our young people. So, training for health professionals would help fill that gap.

**Ms TOWNSEND:** If I could add. This is drawing on a previous role. There are a number of good suicide prevention/intervention courses around, and a number of our NGOs make reference to those - they are captured in their service agreements with us.

The difficulty is where people are presenting with complexities beyond that, and there would be a critical gap between the sorts of training you would want a direct youth service provider to deliver and a specialist mental health system, or a specialist system. There is something in the middle and that is probably a skills gap.

What do you do when you have exhausted your youth worker training in suicide prevention, but you have a level of complexity here that may not mean a threshold for a specialist mental health service? Workers with young people will talk about that concern. But, there is certainly training that is readily available.

The Department of Health does deliver a dual diagnosis course – across Alcohol and Other Drugs and mental health - but it is a limited course in the numbers. It is whether, in fact, it should be extended or whether people should ...

**Mr GUNNER:** That is the Certificate IV in Alcohol and Drugs?

**Ms TOWNSEND:** Yes.

**Mr GUNNER:** Yes. That came up in other testimony. Apparently, there is a similar path you can take. You can take that Certificate IV in Alcohol and Drugs or the Certificate IV in Mental Health.

**Ms TOWNSEND:** Yes, but there are some dual units that we deliver with mental health on dual diagnosis as a specialised course. But, its places are limited and I know the Department of Health, through Alcohol and Other Drugs program, have fought for a long time to keep that viable and going.

**Mr GUNNER:** I guess something that has been of great interest is those points of intervention. The majority of people who are completing suicide or attempting suicide do not have a point of intervention, so they have withdrawn from their family, they are not at school, they are not seeing a health professional, they are not playing sport. They do not have around them anyone or anything where there can be a point of intervention. There is no easy answer as yet. No witness has come forward explaining how to do it. However, when people come into your system through a notification, or someone has come across somebody who has notified, in some respects your people have the training. With the improvement of training in others, that would lead to more notifications which would then be a point of intervention where we can find people at risk. However, if they do not have that training they are not going to necessarily make the notification and get people in. That was a longwinded way to get there, sorry.

**Ms TOWNSEND:** Yes, the child protection threshold would be: are they at risk of harm from being in their family.

**Mr GUNNER:** Yes.

**Ms TOWNSEND:** That is where we get to the same stumbling block as many other services. They are saying the risk is not about their child protection status it is something else. What support is here? You are absolutely right, 17 to 24 is when people are getting access to means to harm themselves, whether it is better access to medications or vehicles, and they also no longer have school or families quite so wrapped around them.

**Mr GUNNER:** Yes.

**Ms TOWNSEND:** There is particular vulnerability there.

**Mr GUNNER:** Yes. We do not have an answer yet.

**Ms TOWNSEND:** My experience of working with young people is they form strong relationships with each other, but they are not necessarily very good at seeking help at that age.

**Mr GUNNER:** No. That suggests very strongly that the best solutions are going to be community-based or peer-based. In some respects that is where MindMatters or KidsMatter might be good, delivered at the right time, because hopefully they then carry that on with them.

**Ms WALKER:** Noting your recommendation around the need for interagency collaboration, which has come up time and time again, what is it currently that DCF is responsible for or owns in delivery of social and emotional wellbeing services, whether it is directly through the agency or outsourced to NGOs? Can you give us a brief summary, if that is possible?

**Ms GARDINER-BARNES:** It would be mostly through the delivery of services through our NGO sector, although there is some direct service provision in remote communities with our remote Aboriginal family community workers who have prevention or early intervention as part of their ambit. They would undertake wellbeing services and we are in the process of introducing a senior position in all the growth towns for a professional child safety wellbeing staff member who will cover the ambit of child safety and wellbeing areas and be a core person to offer interagency collaboration in those communities around the wellbeing agenda.

**Ms WALKER:** Those people are currently being recruited and rolled out into the communities, Clare?

**Ms GARDINER-BARNES:** Yes.

**Ms WALKER:** How many positions were identified?

**Ms GARDINER-BARNES:** There will be 20 all up, one in each community. We have recruited two at this stage and are in the process of recruiting a further five.

Jo, do you want to talk about the NGOs?

**Ms TOWNSEND:** Over $5m is invested in youth services across the NGO sector. I would be stretching it to claim they were all delivering social and emotional wellbeing.

**Madam CHAIR:** Is that just the Top End or is it …

**Ms TOWNSEND:** That is Territory-wide.

**Madam CHAIR:** Territory-wide. Was that $5m?

**Ms TOWNSEND:** There is over $5m. I can give you a more detailed breakdown …

**Madam CHAIR:** Yes, can we get that?

**Ms TOWNSEND:** … of what we are providing.

**Ms WALKER:** Is that Territory or federal dollars?

**Ms TOWNSEND:** Territory. There is another amount on top of that of youth homelessness services. There is a broad range of services. Some are youth diversion services and would be broadly classified as a youth justice kind of focus. There are youth camps, some youth development, drop-in centres and those types of functions. Very few of those services are providing direct counselling assistance for young people or more intensive therapeutic services. It is more a suite of diversion services that can provide more intensive interventions as required.

The services dealing with more vulnerable young people in the community are those being delivered through the homelessness services or the youth camp programs, of which there are three.

**Ms WALKER:** The youth camp program?

**Ms TOWNSEND:** That is the youth camp program that was funded in 2008. It is part of the Youth Justice Strategy. There are three of those. One is delivered by Tangentyere, one is delivered by Balunu and one is delivered by Brahminy. They are, essentially, providing short-term residential options, but they are actually dealing with quite complex cases - children in some cases.

**Ms WALKER:** How are people referred into those programs?

**Ms TOWNSEND:** That can be referred through the Youth Justice Court. They can be referred through diversion programs, from police. They can be referred through us as a service provider, or they can be referred directly from parents. I know other programs like Alcohol and Other Drugs will also make referrals.

They accept a variety of referrals, and they make decisions around entry based on the cohort of kids that are presenting.

**Madam CHAIR:** Is Balunu still going?

**Ms TOWNSEND:** Balunu is still going. It is being led by Justin O'Brien at the moment.

**Madam CHAIR:** Is that right? What, from Jabiru?

**Ms TOWNSEND:** Yes.

**Madam CHAIR:** Is that where he is running it from?

**Ms TOWNSEND:** No, there was a media release in the paper recently about him standing in.

**Madam CHAIR:** Okay. I thought as a director.

**Ms TOWNSEND:** Yes, he is described as the Managing Director in the media release.

**Ms WALKER:** And where is this camp physically located?

**Ms TOWNSEND:** They have facilities over at Talc Head and they have an office based in Darwin - or a venue. It is more like an office.

**Ms WALKER:** Do their services tend to be fully subscribed? Difficult to get into?

**Ms TOWNSEND:** Yes, yes.

**Ms WALKER:** Is there any move afoot to increase places available or create new camps in other locations?

**Ms TOWNSEND:** Yes, there is a strong recommendation around expanding youth camp program in the recent review of Youth Justice. That is a recommendation that is being progressed as part of that regime.

**Ms WALKER:** Where does Brahminy operate from exactly? I have heard of it.

**Madam CHAIR:** Batchelor.

**Ms WALKER:** Right.

**Madam CHAIR:** Remember they had that program on ABC about it? It was quite a ...

**Ms WALKER:** Quite provocative the way it was presented.

**Madam CHAIR:** That is nicely said.

**Ms TOWNSEND:** And Tangentyere quite a way out of Central Australia. It was at Hamilton Downs, but it is not there now.

**Ms GARDINER-BARNES:** There is one additional service stream that the department is currently working on; that is, through amendments to our *Care and Protection of Children Act* to introduce therapeutic services through a Tier 2 secure care environment that could, potentially, be used by young people who suffers from suicide ideation or some other mental health issue. It is a short-term therapeutic model that will allow for them to be assessed over a period of time. We are currently finalising the model and finalising the bill for that to be introduced this year.

**Madam CHAIR:** Okay. When will you trial that, Clare. When will that be trialled?

**Ms GARDINER-BARNES:** There are two facilities, one in Darwin and one in Alice Springs, each with eight beds for young people.

**Madam CHAIR:** This is the secure care?

**Ms WALKER:** Oh one in Alice Springs and one in the rural area here.

**Madam CHAIR:** Yes. You know, 'not in my back yard' one.

**Mr GUNNER:** Something that came up yesterday in talking with Dr Bath in his role as the Convenor of the Child Deaths Review. He was talking about trauma and violence, essentially. By the time children get to school it is almost too late; they already have trust issues and so on. I am wondering if you had any comment or thought around that pre-five age group. In some respects that is again an age group before there is a formal point of intervention, when things can happen. Even for yourselves, you are relying on someone to notify, in a sense. I am just wondering if you had any comment around that?

**Ms GARDINER-BARNES:** Once again, the Remote Aboriginal Family and Community Workers play a key role in remote communities in assisting us identify potential children at risk. They often work in partnership with the health clinic, the school, the crèche, with safe places in those communities so they become aware of where children might be impacted by violence in the community. They can make a referral and require a request to service from our professional staff to come out and support them. Also, because they speak the local language, they have greater capacity to draw out from young people what the issues are.

It is an ongoing challenge for us as an agency to understand the extent to which, in remote communities in particular, young children are impacted until they meet the threshold for a child protection investigation.

**Ms TOWNSEND:** I reiterate the responses for that group are – there is a gap there, and it is a gap we would see as service providers as well. By the time we may be working with a child in the child protection system they may be very highly traumatised and that makes it difficult to find them a responsive carer and get good support for that carer and that child.

**Mr GUNNER:** Yes. It seems to always go back to this issue. You can break it up in different ways and different segments, but often the problem is people are not getting the help they need and often there is a very good service being provided somewhere, but the person is not accessing that service for whatever reason. Obviously, when you are talking about under five years, they cannot make that decision themselves. There is that grey area of how can you have that point of intervention which could lead to prevention. We seem to be constantly trying to find those points. The under five is concerning in a sense because, obviously, school is such a big thing and is very helpful. You can run many things through school and, while schools are doing really good things and there is only so much you can put on a teacher's plate, it is a dilemma if, by the time they get there, they are already suffering from trauma and are hard to help.

**Ms TOWNSEND:** It is often those formal contacts with school or some other kind of service which alerts child protection or brings the family to somebody's notice.

**Mr GUNNER:** Yes.

**Ms GARDINER-BARNES:** There are social and emotional wellbeing programs targeting the early years. One of the key issues would be how you roll that out in an early childhood setting and mandate that across the Territory when it is a for profit sector in the main and you have training issues for staff which are quite costly.

**Mr GUNNER:** Yes, and in some respects the solution is almost to go through a different approach. Dr Bath mentioned taking a tougher stance on domestic violence which, hopefully, leads to a better outcome at the other end. We are already doing that in a way.

**Madam CHAIR:** It brings us to the point where we had the CEO of the Education department before the committee, Clare, and we discovered there are only two schools in the Northern Territory …

**Mr GUNNER:** Two high schools.

**Madam CHAIR:** … two high schools that were using a program called MindMatters in secondary and KidsMatter in primary.

**Mr GUNNER:** That has been an interesting debate though, has it not? We have had witnesses present saying …

**Madam CHAIR:** Yes, whether it is voluntary or mandated or whether you …

**Mr GUNNER:** Yes, and if it is mandated it does not work as well so you want the school to take it on. However, if the taking on rate is too low, which is two high schools, then where is the …

**Ms GARDINER-BARNES:** It does require significant training and investment, and ongoing investment, so teachers feel comfortable taking on that role because it is outside their normal area of expertise. They need to feel they can have an expert go-to person on the school site and have access to appropriate materials that are also culturally appropriate for this Territory environment.

**Ms WALKER:** Given the availability of services to children vary from region to region - and I am not just talking about health and emotional wellbeing programs, but sport and rec and youth diversion services. Again that is an across-agency thing. We spoke yesterday with CAYLUS and NTCOSS about the value in the new technologies that might provide access. They, basically, said no it does not work, you need to have face-to-face on the ground there.

What strategies are in place to ensure every child does have access to these services, knowing the challenges that we face in the Territory? Does DCF have strategies to try to outreach into communities?

**Ms GARDINER-BARNES:** The closest type responsive service we have is the Mobile Outreach Service Plus, which is a counselling service we offer to children and families in remote who have been victims of abuse and have suffered trauma. We can provide a family-centred approach to managing and dealing with those issues. They are required to extend their services to 93 different communities across the Territory as part of their funding with the Australian government.

**Ms WALKER:** Who is that outsourced to, Clare?

**Ms GARDINER-BARNES:** That is a service we provide directly.

**Ms WALKER:** Yes, right.

**Mr GUNNER:** It was interesting because we had CAYLUS and NTCOSS say that the best, or in some respects, the only way they want to do it is face-to-face. Then, we had the Youth Round Table saying anonymity is really important, and accessing via Internet was actually the way they would like to access the service. But, by the same token, that means they are not necessarily getting the best.

**Ms GARDINER-BARNES:** No, and I think that is …

**Ms WALKER:** No, and NTCOSS was saying the reality on the ground in many communities is unreliable access to telephones. A public phone might be the only phone …

**Madam CHAIR:** Or the phone is busted.

**Ms WALKER:** … no Internet access, because it is just not there. If they may have access to it, it would typically would be through a school, but we are often talking about kids who are disengaged from the school community and, therefore, outside of being captured through there.

**Ms TOWNSEND:** It would be worth assessing the uptake of that technology, though, because there has been lots of reports of lots of concerns about texting. The technology is there in some instances, and being used for harmful things. The Office of Youth Affairs, which reports to me, has a strong view – and I think they do have some data about the number of people who have Facebook pages. I embarrassed to say, but young people are online; they are very connected - and it is all instant. I am not sure about the direct applicability to remote areas, but it is the case that there is quite a bit of technology in those remote communities. We certainly are not making the most of it.

**Madam CHAIR:** They have, let me tell you, in terms of Facebook …

**Mr GUNNER:** They are all on there.

**Madam CHAIR:** … and its access in the remote. It creates a whole nightmare on its own, basically, amongst some of those young ones out in the bush. You can almost track people. I look just on the Tiwi Islands, where I can track a number of young people on Facebook. The number of time I have rung health workers because people on Facebook are talking about suicide on Facebook. That is where you can pick it up. The couple of suicides in Darwin, people actually wrote that on their Facebook, and it was not picked

up until later. Facebook - we love it, we hate it. But, for the young people, that is their only method of communication.

I just want to ask about VSA. We had a representative from the West Arnhem Shire talk about –with the VSA, particularly on Gunbalanya. They had a full-time position - or they had a position there - and they were saying that position, even though the position is there, they had funding up until about 170?

**Ms KNIGHT:** Up to about 200 in 2008..

**Madam CHAIR:** Yes, and the funding has been pulled back to $47 000 per annum and they are saying that it is not sustainable given the problems that are escalating in Gunbalanya. Are you able to provide …

**Ms TOWNSEND:** Were they able to elaborate on where they were getting that funding from?

**Madam CHAIR:** It is NT.

**Ms TOWNSEND:** One of the things that has happened in - Gunbalanya was receiving youth diversion funding. They are still receiving that, but they are receiving it through Anglicare. I am speculating, but it may be that funding is being pooled with a couple of other funding sources and …

**Madam CHAIR:** Okay.

**Ms TOWNSEND:** There was some funding through Alcohol and Other Drugs for a position there as well so they may have been using - it is possible they were using different funding sources to craft positions. The funding DCF is giving them is secure. It is still going into that community and is about $130 000.

**Madam CHAIR:** It is $130 000.

**Ms TOWNSEND:** Yes, and it is for …

**Madam CHAIR:** Who is that paid to?

**Ms TOWNSEND:** That is Anglicare.

**Madam CHAIR:** That goes to Anglicare?

**Ms TOWNSEND:** Yes.

**Madam CHAIR:** Does Anglicare then outsource the program to the West Arnhem Shire?

**Ms TOWNSEND:** No, it is for the youth diversion program. That funding is to deliver youth diversion services, so young people who are formally diverted through the youth justice system.

**Madam CHAIR:** You have a VSA management plan in place in Gunbalanya, what …

**Ms TOWNSEND:** They always received some money through the (inaudible) implementation funds - a small amount - about $45 000. I am speculating that is the money that has remained and it is possible they were getting multiple funding sources from different departments and pooling it, but now they are going to different auspices.

**Madam CHAIR:** Can we get …

**Ms TOWNSEND:** Yes, so the money to the community has, technically, not changed, but the …

**Madam CHAIR:** The delivering of the program has changed.

**Ms TOWNSEND:** Yes.

**Madam CHAIR:** Okay.

**Ms TOWNSEND:** You probably need a brief from Health about the continuation of that.

**Madam CHAIR:** That comes under Health, it is not under …

**Ms TOWNSEND:** Yes, it is under Alcohol and Other Drugs in Health.

**Madam CHAIR:** Okay. I thought it was still under community ...

**Ms TOWNSEND:** I am drawing on historical knowledge.

**Madam CHAIR:** Yes, that is what I was trying to – when it was ...

**Ms TOWNSEND:** I am happy to share it, but they may not like it.

**Madam CHAIR:** Okay, that is good. We will follow-up with Health.

**Ms TOWNSEND:** Yes.

**Madam CHAIR:** I am trying to sort out the trail; that is all. Petrol sniffing has been a major issue since Christmas in the community.

**Ms TOWNSEND:** The other avenue is there are quite a few resources going into the community through DET, which you are probably aware of. It might be worth exploring with the child and parenting leader - there are a number of different resources for not just education, but for the broader children and family support coming through DET.

**Madam CHAIR:** They have taken over the crèche and stuff, have they not, too? Yes. No, it was specifically the VSA.

We had representations from some young people involved with the Youth Round Table as well. One of the issues raised was the perceived pulling back of resources to allow young people from a broader demographic to come in at regular times for meetings. They come in four times a year and they said there were signs that was going to be pulled back or to have those meetings happening consistently because of the reduction of resources from the government. Is that …

**Ms TOWNSEND:** There has been no reduction in the Youth Round Table funding. By the same token, there has been no increase. There has been no discussion about a reduction. In fact, I increased the budget allocation slightly to cover better remuneration in sitting fees to make it commensurate with other committees. However, I would say there may be a view that the cost of travel is increasing, but there has certainly been no reduction.

**Madam CHAIR:** You have had some dynamic representation of young people on that Youth Round Table and we have heard from them through this committee and travelling around.

**Ms TOWNSEND:** In the two years I have been there suicide, for that committee, remains a persistent interest. There are two members who are completing their reports from last term on suicide. It is something they feel very strongly about, and they did raise with the minister at one of their meetings. I would be hard pressed to find a member on that Round Table, from year to year, who has not been affected personally by youth suicide.

**Madam CHAIR:** They have come and presented to us, which was really good to hear from their perspective just what was happening on the ground. Because they come from just a broad demographic it has been great to hear from them.

Some of the statistics we got from Dr Bath yesterday I suppose astounded me. All the research and information you get is that suicide amongst young men is actually at an all-time high. Dr Bath was saying, with the Menzies report - I do not know if you saw the Menzies report that was commissioned by the Child Deaths Review Committee. That has been given to us …

**Mr GUNNER:** It is still in draft format, but we …

**Madam CHAIR:** Yes, and we said we would not put that report out because it is in draft form. We have Menzies coming this afternoon. But, in that report it shows a marked increase - an astounding increase - amongst young women, rather than young men.

In the child and adolescent and your youth programs, I see around the Territory - and it happens in our urban centres - we have Clontarf for boys and a number of programs that target young men, but we seem to be missing in the space of young women. It is not just in schools, it is out in the broader community. Does the department …

**Ms TOWNSEND:** We agree. Yes, those programs have had a lot of community support and a lot of Australian government – they are big partnerships. But, it is certainly the case that young women come off secondary in those programs.

**Madam CHAIR:** That is quite stark. We will have to get the women's movement happening again. Sorry, Michael.

**Ms WALKER:** Coupled with that as well is a continuation of the increase of teenagers becoming parents - ill-equipped with their own lives let alone to be able to be equipped to be a parent and look after children. We heard in Alice Springs - through Congress, was it Marion? - about a program they have that brings couples into a program from during early on in the early stages of pregnancy to provide that support to parenting and coping.

**Ms GARDINER-BARNES:** We are just in the process of starting up a program in Alice Springs for young parents and mums in care because, obviously, they are likely to have been victims of trauma themselves in their childhood. That is a residential program where they will be provided with on-site support, facilities, and therapeutic intervention as required to help them in their early stages of parenting, and developing good skills around home management and family support for women.

**Ms WALKER:** That is for young women who are in foster care themselves?

**Ms GARDINER-BARNES:** Yes, or are transitioning out.

**Ms WALKER:** Yes. How long can they be in that residential program?

**Ms GARDINER-BARNES:** That would be determined on a case-by-case basis really, what support systems are around them.

**Madam CHAIR:** How does that happen in our remote communities where foster carers are ...

**Ms WALKER:** Thin on the ground.

**Ms GARDINER-BARNES:** Potentially, those young mums could stay there before they transition back to the remote community as they left hospital, so they have some time and access to regular community health services, and feel more comfortable with their parenting and mothering, in particular. It is not something we would just have for Alice Springs' mums, but for the whole of Central Australia.

**Ms WALKER:** How long has that facility been operating?

**Ms GARDINER-BARNES:** It has just started.

**Ms WALKER:** Are there plans for one in the Top End as well?

**Madam CHAIR:** Or funding for …

**Ms GARDINER-BARNES:** It is a trial which became available because we had that facility which was not being used for another purpose and we could see the benefits of it being used for that.

**Ms WALKER:** That is good.

**Madam CHAIR:** Clare, a number of organisations have raised concerns regarding the number of young people with high needs being placed in foster care in the rural area given the lack of services. This is something Kezia, the member for Goyder, often - we talk about our remote communities, we talk about our urban centres, but there is a whole cohort in our regions and our rural area. What work is the department doing in relation to ongoing mental health needs of young people being placed in foster care in rural areas?

**Ms GARDINER-BARNES:** A recent suggestion which came up at a meeting I had recently with foster carers in Katherine, and Tennant Creek more recently, was they could access some of the mental health

services departmental staff were able to access as a result of experiencing a critical incident or participating in one. We are now in the process of broadening that contract we have for our own staff to include foster carers and respite carers who are working with, in some cases, very traumatised children to give them some improved skill base. Access to those services will expand right across the Territory. Potentially, there is a counselling service available for foster carers to help them down the track. It is a new thing we are looking at introducing directly after being approached by foster carers about it.

**Ms WALKER:** We have consistently heard through public hearings high praise for headspace as a service provider in Alice Springs and Palmerston, but that it is very stretched. In the rural area we had a meeting with a number of representatives from different organisations and Taminmin school was well represented. With that service fairly stretched for Central Australia and the Top End, there is the other unmet need in Katherine and Tennant Creek.

We are visiting Katherine next week and have been to Tennant Creek; however, it came up through the reps from the Youth Round Table as well that Katherine and Tennant Creek are crying out for something like headspace.

**Ms TOWNSEND:** I agree it is an excellent model and certainly an accessible model. They have worked very hard on its image. Yes, I agree, both those regions, particularly Tennant Creek, have been very outspoken about the need for a headspace.

**Ms WALKER:** Knowing they have an online service, it comes down to again people really – the preference being to have a face to face …

**Madam CHAIR:** Model of it, yes.

**Ms TOWNSEND:** Yes.

**Ms WALKER:** ... walk-in place that does not have mental health signage above the door and all the stigma attached to it.

**Ms TOWNSEND:** Yes.

**Madam CHAIR:** We went …

**Ms WALKER:** Discretely located so you can go in and out without …

**Madam CHAIR:** The aesthetics was friendly. It was probably the best session we had with a group of young men as well to gauge - we usually sit down with young women and talk to them so it was a fantastic session for us in Palmerston where there was a group of young men and we sat down in headspace and had a discussion with them.

**Ms TOWNSEND:** One of the things we did in the Alcohol and Other Drugs program, which is in a different department, was to allocate one of our psychologists - who are always very stretched - to be based there and support that work. It also gave an alternate place for young people we are working with to go, rather than coming into the Alcohol and Other Drugs clinical service which is not necessarily a place you want young people to hang around.

**Ms WALKER:** Yes, or going to see the school counsellor - that came up. In a school environment, people can see where you go through that door, and people are reluctant to use it for that reason.

**Ms TOWNSEND:** There are many ways to add to the capacity of headspace - I think. We are in the same position as a lot of service providers in that we are a service provider and we have the same limited referral options. So, we would see that as an incredibly valuable service but very limited.

**Madam CHAIR:** Clare, if we look at some of it – and we will need to talk to Health. I did not realise Alcohol and Other Drugs had moved across. If you look at a remote setting at a clinic, the first port of call a lot of the time are at clinics. The resourcing of those clinics - you talk to remote area nurses and managers at those clinics, and the demand just on the day-to-day acute staff - I do not need to tell you mob, you have seen it. This adds another layer in youth crisis. I know the departments have separated, but what is the working - I fear we have just become separate silos again in health. The whole issue of mental health is an important factor and it just seems to be lost out there somewhere.

**Ms GARDINER-BARNES:** The remote Aboriginal family community workers have a clear role in working with those other providers. It would not be unusual for one of those workers to go and spend the morning in a clinic, working with the staff in the health clinic and working out which babies are failing to thrive and what visits might be a priority. So, their spectrum is across the whole neglect, young people at risk, so they can then go and do any home visits and follow up around wellbeing that the clinic might identify in the first place, and just check out to see if everything is okay for that child and that family and report back into their team leader if they have major concerns they think needs to be followed up. They are a critical player in those communities. Once we have the child safety wellbeing officers, they will have additional supports on-site to perform those functions across departments.

**Madam CHAIR:** I declare my interest as a local member, I suppose, with this community. You will probably know straightaway which community I am talking about here. It had a very effective child safety unit and workers within that unit. There was an Aboriginal woman who was employed, and used to work with the clinic to do the 'failure to thrive' children. They had a cooking program that had referrals from the clinic. The department, as I understand it, had stopped the funding, which means this woman was no longer employed and the child safety program ceased to happen. Is it a case of the department ceasing the funding, or was it that just issues between Bawinanga and the department? Maybe I might have this discussion with you separate as a …

**Ms GARDINER-BARNES:** The funding did continue on.

**Madam CHAIR:** It has been continued?

Ms GARDINER-BARNES: Yes.

**Madam CHAIR:** To Bawinanga?

**Ms GARDINER-BARNES:** Yes.

**Madam CHAIR:** That is good to know. I will let people know because it was a successful program.

**Ms GARDINER-BARNES:** Yes, it was.

**Madam CHAIR:** I am glad that is back on, because there is a lot – I think in that community it was about 90% of some of those little ones were in the category of 'failure to thrive', so I am glad that is back on. It is good.

**Ms GARDINER-BARNES:** I think it was a timing issue around whether the funding was going to continue and, then, by the time it was guaranteed, that person might have found another job. It is the ongoing funding issue and the length of the contract that was the cause, I think.

**Madam CHAIR:** Still on that community, what work is being done? There have been a number of suicides at very young ages. What resources are going from your department into that community?

**Ms GARDINER-BARNES:** Because the majority of our remote resources are funded through the Australian government - through the NTER - all of those resources are due to end on 30 June this year. We are currently in negotiation with the Australian government to look at renewing those resources through Stronger Futures. Once we have been told - I understand it will not be too far off - we will be given the figure of what we are guaranteed into the future, we will look at priority communities across the whole of the Territory. That is certainly one we need to commit to and provide adequate resources for.

**Madam CHAIR:** What about those communities that are not seen as priority under the national partnership agreement, Clare? What discussions are …

**Ms GARDINER-BARNES:** Well, I guess …

**Madam CHAIR:** Do they get more of the same or is it …

**Ms GARDINER-BARNES:** We have an opportunity here to prioritise based on need and what the data says. It is about looking, at the end of the 30 June period, at where the investment currently is and where it should be in the future based on population, based on need, and what the data tells us around disadvantage.

**Madam CHAIR:** Is that the same for services to homelands outside the main communities?

**Ms GARDINER-BARNES:** At this stage we are using a hub-and-spoke model so, yes, it would impact on that.

**Madam CHAIR:** Are you able to provide to the committee - you could take this notice - what services are provided under the hub-and-spoke model to communities set down as priority communities?

**Ms GARDINER-BARNES:** Yes.

**Madam CHAIR:** That is just on youth services, Clare. What funding goes towards youth services under that hub-and-spoke model?

**Ms GARDINER-BARNES:** Yes.

**Madam CHAIR:** Any questions?

**Mr GUNNER:** No.

**Madam CHAIR:** Thank you.

**Ms GARDINER-BARNES:** Thank you.

**Ms KNIGHT:** I will e-mail you.

**Ms WALKER:** Thanks, Clare. Thanks, Jo.

**Ms TOWNSEND:** Thanks, Lynne.

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The committee suspended.

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**SOUTHERN CROSS CLINICAL PSYCHOLOGY**
**Dr John Rudge**
**Dr Ruth Rudge**

**Madam CHAIR:** On behalf of the select committee, I welcome Dr John Rudge and Dr Ruth Rudge 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 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 your obligation not to mislead the committee apply.

A transcript will be made for use in the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned about 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 and the capacity in which you appear. If you want to make a brief opening statement, you may do so before proceeding to the committee's questions.

I introduce Michael Gunner, who is the member for Fannie Bay, Lynne Walker, who is the member for Nhulunbuy, me as the Chair. I have to give apologies for Kezia Purick who is the Deputy Leader of the Opposition, and also Peter Styles, who is the member for Sanderson, who were not able to make this afternoons session. But, you certainly have us to listen to your evidence. Would you like to state your name and do you have an opening statement?

**Dr R RUDGE:** I have some initial notes here. There are a number of pages and we are happy to present this to start with, if you would like us to.

**Madam CHAIR:** You could either table it. One of the things if you wanted to say is any submissions or documents tendered to the committee can either be kept - if you do not want them published they will not be published but, if you provide them to the committee for our deliberations, when we are putting our report together and our recommendations, if you just wanted just your comments to be used as part of that, it can be, or it can be put on the committee's website if you wanted to.

**Dr R RUDGE:** They probably are the points we might like to talk about. I do not how you would like ...

**Madam CHAIR:** Just use them as a talking point, if you wanted to.

**Dr R RUDGE:** Okay.

**Dr J RUDGE:** Really, we are just interested just being as useful as we can be to the committee. So, really, the format - we have some things written down, but if you prefer to just ask us questions, it is really up to you.

**Dr R RUDGE:** I am happy to start with a bit of an initial – maybe a point form review of what we have written about.

**Madam CHAIR:** Well, I was just going to ask you, if you wanted to provide an overview of your work on the Tiwi Island, I suppose – I probably have an interest in that.

**Dr R RUDGE:** Initially, this talks about that. We are working in a number of remote communities and really engaging in on-the-ground, at-the-coalface work. We also run a practice in town and work with youth in all those locations. We are both clinical psychologists and we have a history of working in Katherine with Wurli. I did some suicide prevention, community focus work there, and John was with men's and youth doing counselling at Sunrise. We are quite experienced in working in similar areas in Perth for an extended period of time. John was in Justice and I was in youth suicide prevention down there, and also sexual assault and abuse.

We started offering a service out at Tiwi when we moved to Darwin in 2008. We started that service off our own bats, and started initially offering a bulk-billing service. So, it was a free-of-charge service and we just used Medicare. It is not viable to offer a service in such a fashion so, then, we were very much supported and encouraged by remote health doctors and also then by Red Cross in a short-term way. Now, we have been very pleasingly been provided funding through Specialist Outreach Northern Territory through the Health Department, and we offering a service at ...

**Madam CHAIR:** That is a Commonwealth program, is it not?

**Dr R RUDGE:** Yes. We initially started at Milikapiti. With the support of Red Cross we expanded to Nguiu and, now, we have a colleague who is offering a trial service out at Pirlangimpi. She is still under the bulk-billing system, but that is not a viable long-term way of offering a service. We also have requests for our services from pretty much all other remote health serviced communities.

**Dr J RUDGE:** And there are only two of us.

**Dr R RUDGE:** We are trying to get something happening at Daly River. We have our colleague, Fiona, also offering the service at Goulburn Island. We are hoping to bring her under the specialist outreach funding because she is still bulk-billing out there and it is not a long-term option.

**Madam CHAIR:** At the Warruwi one?

**Dr R RUDGE:** Yes. In 2011 we were also at Maningrida working with the child safety service there. Mulabung employed us to work with at risk young people and families, and young people who were not attending school and were at risk for a range of other reasons. We undertook that work until December. We are not doing that work anymore.

Basically, from what we can see there is - we visit fortnightly and we feel that is essential. It is the minimum to be going fortnightly so people get to develop a relationship with you, staff at the clinics get to know you - we are based in the clinics - and we also go to schools and do home visits. We have been going out since 2008 so people are really starting to be comfortable, make their own referrals and talk about family members that they might want us to see and so on.

**Madam CHAIR:** Fortnightly to where, Ruth? To the Tiwi Islands?

**Dr R RUDGE:** Yes.

**Dr J RUDGE:** Yes, it is two days a fortnight to Nguiu and one day to Milikapiti.

**Madam CHAIR:** Okay.

**Dr R RUDGE:** Fiona is going to Pirlangimpi as a trial on a fortnightly basis.

**Ms WALKER:** You are based in Darwin?

**Dr R RUDGE:** Yes. From what we can tell there is no regular psychology service going out to any communities. Ours, on a regular basis, is the only one we are aware of. One of the things that drove us was we were aware of how Medicare has made psychology so accessible in both rural and metro areas, and we found when we came here there were no psychology services available in a way that was going to be really helpful. That is what has driven us and continues to do so.

**Dr J RUDGE:** There has been a problem in the funding model which has led to a congregation of psychology practices in some metropolitan areas. It is very hard to get that funding decentralised.

**Madam CHAIR:** From the government?

**Dr J RUDGE:** Yes.

**Madam CHAIR:** In relation to Medicare and how it is …

**Dr J RUDGE:** Yes.

**Dr R RUDGE:** Yes, the way it is set up.

**Dr J RUDGE:** Yes, so nearly all the practices have been set up where they can make the most money.

**Madam CHAIR:** Why do the practices or psychologists, like yourselves - I spoke to the federal government looking at the health sector where MBS and PBS, particularly for remote, was cashed out on twice the amount of what they would normally spend. Maybe that is something that psychologists and people working in this field need to take up. Whether you have discussions with the department, with Menzies, with the Aboriginal Medical Service Alliance …

**Dr J RUDGE:** Since we have been here we have met with everyone we can. We average close to a meeting a week and the SONT funding is the best we have come up with by far.

**Madam CHAIR:** Which funding?

**Dr R RUDGE:** Specialist outreach funding.

**Dr J RUDGE:** Specialist Outreach Northern Territory.

**Dr R RUDGE:** Yes, I think it came out of the intervention and it is federal funding.

**Dr J RUDGE:** Yes, many people have said to us that we would be able to use the Medicare funding in the way it is used in metropolitan areas. The reality of working in communities is that does not work at all. We do much of our work as home visits. When we were working under Medicare we probably got paid for half the people we saw.

**Dr R RUDGE:** You have to have a GP referral before the provider can be reimbursed. That means you have to get a GP to spend an extended period of time with the person. A lot of GPs are resistant to that, especially in remote communities, because they have a lot of other things that are more pressing ...

**Dr J RUDGE:** And the referrals we got were not filled in properly so they had to go back.

**Dr R RUDGE:** So, then, there was no payment.

**Madam CHAIR:** But that is what I am saying: whether this dialogue needs to happen amongst psychologists with the broader health sector.

**Dr R RUDGE:** Well, I have tried to engage with Medicare, and there is a Medicare Red Tape Committee which is supposed to specifically address these sort of gaps. I got nowhere with those negotiations. I have gone to a lot of different federal members, I have engaged with federal departments and really got nowhere. I have gone through the Australian Psychological Society. We have put a lot of effort into trying to engage and put out there this enormous gap we are finding. I guess, as psychologists, we feel that psychologists can be very much involved in prevention of suicides so, if there are services there, then people have support to just feel supported, but also support to learn different coping strategies, to develop some hope, and bring positive things into their lives.

We think it is a really relevant service to be providing but, as I said, we seem to be the only regular psych service - and that is through a lot of effort. We got the funding through the Specialist Outreach - when did it come in? - October last year, after practising since 2008. That is not guaranteed funding. We do not have a five-year contract, so we have money until June. Hopefully, it will continue but we do not know. So, our services could stop in June.

**Madam CHAIR:** That has been a huge problem with this program for a long time, though. Obstetric programs in remote Aboriginal communities have been under this program for a long time, but it has just been short-term and when the need is there. It is a major problem with long-term sustainability.

Michael, you had a question?

**Mr GUNNER:** In your opening comments, you mentioned a program that has now ended that you were doing, where you were talking to students who dropped out of school. Is that right?

**Dr R RUDGE:** That was working with the Child Safety Committee you mentioned before, yes - and the school in that community.

**Mr GUNNER:** One thing we have been interested in is those points of intervention where you can provide help - and how often there is not one. The majority of people who complete suicide have not seen somebody.

Schools are, obviously, a common collection point but, then, people drop out. I think Menzies have joined us. One thing that was in their report and we discussed with Dr Bath yesterday, and are looking to discussing today, was the problem where people transit from school - whether they either drop out or complete. That is an at-risk area, so I am just interested in the program that you were doing, how you got into it, and how people were referred to you. If students dropped out of school, how was it that they were mandated or not mandated? How did you talk to them? How did it work?

**Dr R RUDGE:** How did we end up seeing them?

**Mr GUNNER:** Yes, basically how did it work?

**Dr R RUDGE:** We worked with the clinics - either doctors, nursing staff, Aboriginal health workers, mental health workers. The school was aware of our service so ...

**Mr GUNNER:** If a student had dropped out of school, what was compelling them, or in what way – I am just interested in how they accessed your services in a sense. They dropped out of school, what was the thing that then made them come and ...

**Dr J RUDGE:** They do not. They rarely come and see us, we go and see them.

**Mr GUNNER:** Oh, you go and see them. Okay

**Dr R RUDGE:** Yes. So, we will go out of the clinic ...

**Dr J RUDGE:** That is where our service is. It is quite flexible …

**Madam CHAIR:** But someone must have referred them?

**Dr J RUDGE:** Yes.

**Dr R RUDGE:** Yes. Clinic staff or parents talking to clinic staff, or that sort of thing. There will be a referral. Maybe a family member might bring the young person in, or maybe we might go out with a worker from the clinic and do a home visit.

**Dr J RUDGE:** But this is something that causes a lot of anxiety: that we, because of the nature of a number of things that are happening in the communities, we can go out and we will go to the school and to the clinic meeting and ask: 'Has anything happened?' Then, everyone will say: 'No, it has been a quiet week'. Then, you find out maybe that day, or a week, or a month later, that there has been a young person who has been actively suicidal. They may have even come to the clinic. There is not any really good systematic way of dealing with young people who are reported to be suicidal. There are massive gaps in the system.

**Dr R RUDGE:** Something …

**Dr J RUDGE:** It very concerning.

**Dr R RUDGE:** Something which changes that is being in the community and becoming known.

**Dr J RUDGE:** Yes.

**Dr R RUDGE:** That is what we have found. People have started to know we are there on a regular basis, know who we are, know our faces, and then family will speak to us, speak to us in passing, or they will speak to clinic staff and ask for a referral for a young person. This is where using the Medicare system in that situation is not useful at all. There needs to be an easy pathway where, if somebody has a concern about a young person - we see adults and whole families as well so we are not youth specific, but there needs to be that easy pathway. Young people ask, off their own back who are not attending school - also seeking us out, turning up at the clinic.

Sometimes there is some concern around privacy or not wanting – confidentiality - but often we do not find that so much. We find when there is that trusting relationship people are prepared to come and access you. We do not have a great deal of difficulty with people not - yes, that does not seem to be a big barrier for us.

**Dr R RUDGE:** I could give you a recent example. I was driving around with an Aboriginal Health Worker and he said: 'I think you should see such and such a young person. He came around to my house last night threatening to kill himself'. There were relationship problems and I was able to go and see him then. Much of it is in that context. It is being there on the ground and being able to respond to those things as they happen and to really make an evaluation of what is going on. Sometimes these things flair up very quickly and die down very quickly, sometimes there are much bigger underlying issues that require more …

**Mr GUNNER:** The best referrals are casual peer based or community based referrals in the community?

**Dr R RUDGE:** Not necessarily, but that is a very effective way of getting referrals.

**Dr J RUDGE:** Yes.

**Dr R RUDGE:** Sometimes it is the visiting doctor who will make a very appropriate referral, or the clinic manager or another staff member at the clinic who has had a young person in for a completely different reason and they will ask us to see that young person because of other issues that have come on.

**Ms WALKER:** You mentioned you do much work around prevention. In your view - I do not know if it varies from community to community - what are some of the best prevention strategies you see to be effective?

**Dr R RUDGE:** I would say having a service available is naturally preventative. Having a service people access at earlier stages of their stressful situation, in itself, is preventative.

**Dr J RUDGE:** Yes.

**Dr R RUDGE:** There are not services people can access in – as much as they need to be there. On services, perhaps it is a good point in time to mention services. In some communities there are many

services that visit. They visit regularly, and there may be a high rotation of staff. Although it looks like there are many people going out to communities and it looks like there are many services, from our experience those services are not necessarily really getting at the heart of the problem or really - often the frequency of visits will be because of funding.

**Dr J RUDGE:** The heart of the problem is really giving young people meaningful lives. It is really important for us to draw the distinction between reacting to someone who is suicidal but, then, really looking at the core issues of what is leading so many young people to become suicidal. They are the big issues. We are really strong in trying to work on some of those big long-term issues; things like positive connection with culture, good education, the link between education and employment, and good health outcomes.

These are the things that are really the factors that give young people resilience and that sense of hope, We run some groups and, with our young people, we like to really encourage in them some sense of vision of the future. We were really quite shocked with some of the young people we spoke to, compared with working in other areas, as to the little vision of the future they have. You ask them: 'What do you want to do when you grow up', and they had not even thought about it. We really like to get young people to think about a positive vision for themselves, for the future, and help them to work towards that.

That is in contrast to just actually dealing with the situation or crises. It is the work that really needs to be done if we are going to really make a difference.

**Dr R RUDGE:** You asked about prevention. Basically, having an accessible, known service that can be used before, perhaps, things can get out of control that staff can refer to when they notice very early signs, or increased stresses, in particular, in people's lives. that is more the clinical side of things. As John was saying, there is clearly the much bigger picture of prevention.

For example, we are aware of, and have been working with, groups of young people who have been drifting in communities, not attending school, engaging in much substance use, engaging in a great deal of unsafe sex. Those groups are very high risk young people. They are also dealing with all the other stresses that exist in many of their communities. We have seen those young people drift and drift - over a year's efforts trying to get 13-year-olds or 12-year-olds, for example, to be back attending regular school and, over a period of the year, that not happening ...

**Madam CHAIR:** That is not happening?

**Dr R RUDGE:** Not happening. There are multiple services that are trying to get kids back into school. It is really very often not succeeding. We had a large enough group of young people in those positions to be very concerning; that they are falling through the gaps. That is across a number …

**Madam CHAIR:** Where are their families in all of this?

**Dr R RUDGE:** Pardon?

**Madam CHAIR:** Were are their families, if the young people are falling through those gaps?

**Dr J RUDGE:** Often, the families are powerless to stop them and they are asking for help.

**Madam CHAIR:** Oh, okay.

**Dr J RUDGE:** In some of these cases, the young people are refusing to go to school; they are aggressive towards their parents – sometimes they are violent towards their parents. In some cases, they are attacking their parents for money for cigarettes and marijuana. They are asking for external help and it is not available.

**Dr R RUDGE:** There are other young people I am thinking about. Often, they are single parent families. Some young people I have been very concerned about had no carers – no designated carers. They had been in and out of contact with the department and they are floating in the community, using all those substances.

**Madam CHAIR:** And they would not even be engaged in the school system, either?

**Dr J RUDGE:** No.

**Dr R RUDGE:** No, no. Perhaps it is a little of a side issue, but the issue of getting kids back into the school system is, from our experience in a range of communities. not working well enough. There is too large a group of young people – quite a number under 15 - who are floating.

Recently, we had some parents say they felt very disempowered. Parenting is an enormous issue which needs much attention. The parents feel they cannot discipline the children. The children will be saying: 'You cannot hit me. You cannot do this, that or the other. I will report you'. The parents are powerless and the children are really in charge. They are not at school, they are not able to be disciplined, and are using many substances, particularly ganga. Many young people are smoking cigarettes as well. You know about that.

Empowering parents, putting them back in charge with more function in the family, with better management of stress, in the long term will decrease suicide rates. Good function in the home, empowered parents, kids back at school, yes.

**Ms WALKER:** While you are trying to provide a clinical service, do you see an interagency - it is sounding like you do not - in relation to interaction between the community, police, school, the health clinic, TOs, senior women, for that more holistic collaborative approach to dealing with the issue?

**Dr J RUDGE:** That is what we want.

**Dr R RUDGE:** It is the only way.

**Dr J RUDGE:** Yes, it is the only way to go, absolutely. We do whatever we can to promote that. At a wider level, we see the fragmentation, as everyone does, between different service providers as a huge part of the problem here. We have squandered resources everywhere. There are so many service providers. Red Cross did a review of services to the Tiwi Islands - which you are probably aware of - quite recently, and there were over 70 different service providers. How that has come about is probably historical reasons. However, the reality is having the money going to so many different service providers - most of it is squandered in administration and bang for your buck and services on the ground. There are not good outcomes.

**Dr R RUDGE:** That is not the fault of any of the service providers as such.

**Dr J RUDGE:** No.

**Dr R RUDGE:** It is the funding model. It is too complex; too fragmented. For example, we often imagine - we are psychologists so that is where we are coming from; however, perhaps out of all the funding that has been thrown across - we can only talk about Top End - we imagine if the funding was directed to five day a week psychology services in every community, and other services as well, perhaps five day a week social work and a range of other things. I have not gone into it in detail, but we feel that …

**Dr J RUDGE:** One of the realities of working with suicidal youth is it is not easy. Sometimes there is a belief that you can train people up to do this quickly and we have Aboriginal Health Workers and Aboriginal Mental Health Workers we have seen as clients who have been incredibly stressed and overwhelmed by the expectation that has been put on them. We see them as being expected to do the type of work professionals find difficult to do in a multidisciplinary team. It is not fair and it really worries us. We have seen people commit suicide because of that. It is very distressing.

**Madam CHAIR:** When we went to Alice Springs we saw how much - there are a number of services and funding sources for youth programs in Alice Springs and sometimes you can get an oversaturation, but when you look at how much of that money - what outcomes are we getting for it, which is why I am interested in talking to Menzies in the next …

**Mr GUNNER:** Alice seemed coordinated. There was a group, whose name I have forgotten, who seemed to have a coordinated response to say, for example, to postvention, whereas in Tennant Creek, of all the service providers there did not seem to be any level of coordination.

**Dr R RUDGE:** You mention that word 'outcome'. There is not, in the communities we work in, a coherent review really looking at - and I do not believe you need yet another review. What we know is in some communities many services appear to be going in and we know it does not look like the outcomes we want achieved. Health outcomes and mental health outcomes are not going in the direction we want them to.

Looking at outcomes from what is being provided is really important. I have not seen it happening in relation to mental health counselling services that are going into communities.

**Dr J RUDGE:** As a psychologist and in relation to the work we do with young people, it is really quite simple. We find many young people have a very poor problem solving capacity which leads to their suicidal behaviour. We work with them to - what we often see is when young people are faced with a difficult situation they will resort to substance abuse, self harm, violence and other similar behaviours. What we try to do and is reform life back for them and give them a way of working towards something more positive in a constructive way. That has often worked quite well and is not that difficult to do. It is just changing their view on life. When a difficult life event comes up, can you do something different to what you have done in the past? We try to work with them to do that. We have had some promising success with that.

Clinically, it is probably not that difficult and many young people I see just want to talk about the issues for them. There is the general empathic counselling component of the work, and there is the teaching some resilience - problem solving skills.

**Madam CHAIR:** What is emerging as a difficulty is knocking down the silos and getting people to communicate with each other and work together to deal with some of this. It is not rocket science. We have a core population and there are clearly some issues there. It is not that there is no money on the ground. It is hit and miss whether it is in town, whether it is in our regions, or whether it is in the rural area Kezia represents, our bush electorates or urban centres. That is something we have been working through and are getting to the point where we have to start pulling together this report and some deliberations. It would be good to continue the discussion, but I am also conscious we have gone over time.

You will get a copy of the transcript and if you have anything to add or you want to - when you notified you wanted to give evidence - if there was some information you wanted to submit to the committee you could still do that through the Secretariat. We have Katherine next, and are looking at trying to get back to the Tiwi Islands to have discussions there. Thank you for ...

**Dr R RUDGE:** Would I be able to make one more point drawn out of what was spoken about a little yesterday around mental illness and a concern of seeing young people as having a mental illness versus seeing young people living in the context of a great deal of life stresses? We feel that is a more - not denying mental illness and undiagnosed mental illness leading to suicide; however, where does the mental illness start? You have traumatic, almost toxic environments, with the family completely abused and neglected, substance use, and then you have young people presenting with symptoms of mental illness. If we were just targeting services to deal with mental illness we would be missing the most important part of the picture, which is where prevention is - making changes in the world, and the context these young people live in who end up presenting with mental health.

**Dr J RUDGE:** Making healthy places to live in.

**Dr R RUDGE:** I was listening to the comments from yesterday and felt that was a very important point to make. If your services targeted the individual you are missing the underlying causes of the issues. Sorry about that, I wanted to make that point.

**Madam CHAIR:** It certainly has been mentioned and we have raised the issue of post-traumatic stress and the layers that - often young people - people do not think trauma has been there because their families have been dealing with that trauma so it is transient.

**Dr J RUDGE:** We see young people who have experienced unbelievable amounts of trauma.

**Dr R RUDGE:** As you would well know.

**Madam CHAIR:** We will send the transcript to you and you can look at it.

**Dr R JUDGE:** If we want to lodge ...

**Madam CHAIR:** Julia will follow-up on that.

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The committee suspended.

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**MENZIES SCHOOL OF HEALTH RESEARCH**
**Associate Professor Gary Robinson,**
**Professor Sven Silburn**
**Mr Bernard Leckning**

**Madam CHAIR:** On behalf of the select committee, I welcome you to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome to the table Gary Robinson, Sven Silburn and Bernard Leckning to give evidence to the committee. 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 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 the committee to go into a closed session and take your evidence in private. I will ask each witness to state their name for the record and the capacity in which they appear, and I will then invite you to make an opening statement before proceeding to the committee's questions.

**Mr ROBINSON:** My name is Gary Robinson, I am Associate Professor of Indigenous Parenting and Family Research at the Centre for Child Development and Education at Menzies. I am representing the body of work we have initiated at Menzies dealing with suicide.

**Mr SILBURN:** I am Sven Silburn, a professor, and head of the Centre for Child Development and Education at Menzies. I have been there for three years. Prior to that I was at the Telethon Institute of Child Health Research in Perth. One of the jobs I had in Western Australia for 10 years was chairing the West Australian Ministerial Council on Suicide Prevention. I was also a member of the National Advisory Council on Suicide Prevention, and I have published in this area for over 20 years. I am here really supporting Gary and Bernard in the work they have done in reviewing data in the NT Coroner's Office.

**MR LECKNING:** I am Bernard Leckning, a PhD student. As Sven mentioned, I have been assisting with the work we have recently conducted investigating child and youth suicide in the Northern Territory.

**Madam CHAIR:** Thank you. The members of the committee are: Michael Gunner, member for Fannie Bay; Lynne Walker, member for Nhulunbuy; Kezia is the member for Goyder, and me. Would anyone like to make an opening statement and then we will proceed to committee questions?

**Mr ROBINSON:** I thought I would run us through the main points of our submission and some additional points. I have an additional document to hand over at the end, and am then happy to take questions. I am assuming Sven will jump in at any time to elaborate on anything I have said.

As you know, we were commissioned by the Convenor of the Child Deaths Review and Prevention Committee to compile a report on child and adolescent suicides in the NT from 2006 to 2010. That is a confidential report. I gather Howard Bath has summarised for the committee so we will not talk directly on some areas of the findings of that report. We will certainly comment on child and youth suicide more generally, based on our wider understanding of things and based on some of the literature and research we did in the course of preparing that report.

As we are all aware, the rate of suicide in the Indigenous population has increased steadily over the last 20-plus years since the early 1980s at least. More recently, there has been a noticeable increase in the number of deaths of children and young adolescents. That is what we were called in to examine.

It is noticeable in the data that, in some respects, the adult suicide rate in the Indigenous population may be stabilising, but it may well be there is a trend towards increasing numbers of younger suicides. That is yet to be …

**Madam CHAIR:** So, younger age?

**Mr ROBINSON:** Yes, whether there is a trend in the population as a whole towards younger suicides, whether there are specific reasons, and whether it is part of an ongoing trend towards child and young adolescent suicides.

This is something Annette Beautrais noted in New Zealand, for example, a similar pattern of stabilisation of adolescent and young adult suicides, but a rising number of child and young adolescent suicides, the greater majority of whom were Indigenous Maori youth. Out of her study of those deaths she argued very strongly for a closer investigation of the family and social circumstances of young people. As a result of our work, both drawing on work Sven has done over the years, and that I have done working with Aboriginal families, we certainly came to emphasise factors associated with a family transmission of suicide risk, which has a number of components.

There is the early childhood environment and the impact of toxic stress, impaired parenting and family difficulty in early childhood. We know the Northern Territory is subject to a rising rate of notification for neglect and abuse, and we have a long history of separation of children from their families. They are the types of things the international literature in general populations, as well as Indigenous populations, say place young people at risk of suicide and it can contribute to early onset of suicide.

There is a range of factors we think need further investigation. We also need to look at family processes and their relationship to suicide for young adolescents. Many adolescents and young adults may be in situations of conflict with their families, there may be relationships within their families that are stressful; perhaps a recent parent break up and marriage difficulties of the parents and so on. A range of these factors are clearly part of the risk profile for young people, along with the other things that we know are important, early substance misuse, and, especially for older adolescents and young adults, relationship problems.

In some of our work we noted that communities were struggling to get a grip on these issues and to have a language for talking about the new relationship problems of young people. Even with substance abuse problems, which are so widespread, there is almost no way of getting enough air to talk about it and respond in ways which are potentially going to be effective with young people.

We noted and we looked at, for example, the relationship between early school dropout and peer problems of young people and how that related to suicide. One of the things we noted was that there is a need to understand adolescent and young adult peer relationships differently in different contexts. They follow some different patterns. It may be quite a different picture in urban Darwin or Alice Springs, for example, compared with remote communities. The triggers and some of the patterns of communication involved may be quite distinctive, and we should not have a one size fits all to these types of issues. The issue of school dropout and the transition from school in remote communities may establish different risks for young people compared to places like Darwin.

In regard to the issue of contagion and imitation, we need to be able to look at the types of relationships involved in suicide clusters and at the ways in which the vulnerable young people are made more vulnerable by patterns of communication within their peer networks and patterns of conflict with their families. It is very rare that you will find an adolescent who is at risk of suicide and dropping out of school, where there is not also some kind of difficulty in communication with their parents, if not more severe problems in their families.

The rise in suicides, particularly Indigenous suicides, since the early 1980s and the fact our small piece of research last year gave us a handle on the specificity of problems at different ages made us feel we really need an exhaustive examination of suicides over the whole period. Much of the discourse about suicide is really picking up particular things, dealing with anecdotal evidence and things people with different windows on the problem see from their perspective. We think we really need to look thoroughly at the way suicide has manifested itself over the last 25 years, and to really tease out the different sets of risk factors and the different rates and incidences for different age groups across the population.

When we looked, for example, at the distribution of child and adolescent suicides it was quite conspicuous that it did not necessarily coincide with the highest adult suicide rates. It is not simply the case that if you have many adult suicides you are going to have many child suicides. We need to look at the risk factors for particular age groups. For example, there were none on the Tiwi Islands in the period we audited even though they were coming out of the most dramatic epidemic of any region in the Northern Territory.

There were some child deaths in very remote circumstances where there were very low levels of social capital – small, very isolated communities with few resources and not much going on. There were some in bigger communities with the largest number in Darwin. We need to not just look at the different age groups and where suicides are happening. We need to look at the different types of risk factors and potential

protective factors which might exist for people in different contexts across the Territory. We need to look across regions and see what the needs are and the possibilities for prevention.

One of the things we recommended was the formation of a suicide register which would have a number of functions. This is where I would like to hand over a further document to the committee. We began to look at this. We think it needs to be kicked off by a thorough investigation of all suicides over the last couple of decades, but we have been looking at the model in Queensland and we have established some links to look at collaborative research with the Australian Institute of Suicide Research and Prevention at Griffith University. We have been talking to Professor De Leo who heads AISRAP.

AISRAP maintains the Queensland suicide register, with funding by the Department of Health, and it has the strong support of the Attorney-General's Office and the Coroner. It provides for independent scrutiny of the evidence and includes some evidence derived from the Coroner's records - which is the most important body of data and records on suicides available.

**Madam CHAIR:** What happens with those deaths that are not subject to a coronial, Gary?

**Mr ROBINSON:** We will need to look at how we can access and identify those. We are speaking about that at the moment - the categories of accidental death that may not have been notified.

**Mr GUNNER:** Misadventure.

**Madam CHAIR:** Yes.

**Mr ROBINSON:** There are the ones the Coroner identifies as death my misadventure. They can easily be included when you are auditing things.

**Mr SILBURN:** I must mention, a few years ago in Western Australia the Department of Mental Health was interested in to what extent the suicide rates actually underestimated the problem. One of the things we did was for one year we looked at all the deaths by misadventure or where there was an indeterminate finding, but where, in all probability, given the circumstances, everything pointed towards the possibility of suicide but did not meet the legal definition beyond reasonable doubt. We looked at that increasing the percentage almost 20% and, when you looked at the risk factors for that group compared to the legally defined suicide, they were virtually identical but the particular circumstances meant the evidence was not available to reach a legal determination of suicide. That is an issue in every jurisdiction.

**Madam CHAIR:** Is that how the legislation is or just how they report?

**Mr SILBURN:** The legislation is slightly different in each jurisdiction and the National Coroners Information System is trying to get a uniform definition that allows for much clearer comparison statistics across jurisdictions. At the moment they apply a particular set of criteria slightly different to what the Coroner might be applying referring to the same information.

**Ms PURICK:** In the Western Australia experience those deaths by misadventure - did that also include single driver accidents crashing into trees?

**Mr SILBURN:** Yes.

**Mr ROBINSON:** People walking into traffic - those types of things are important to capture, particularly in places like Darwin, and that is where there may be many suicides masked. These would be accidents and may not even have been notified to the Coroner.

**Mr GUNNER:** Would a suicide register be a policy solution to that? The Coroner could still legally define things, but ongoing you have a great evidence pool for ...

**Mr SILBURN:** In Western Australia, we set up one more than 20 years ago which was maintained by the Ministerial Council for Suicide Prevention. It employed someone who was based in the Coroner's office but reported to us and we provided the data infrastructure to support that register. We helped the Coroner provide annual reports, and we had to deal with numerous ministerial inquiries and questions, and produce reports to monitor the trends. You can see sometimes when new risk factors come on the scene, like when methamphetamine suddenly hit the street, changes in suicidal behaviour. Those types of trends can be monitored.

**Mr GUNNER:** It is a register of suicide completions not attempts?

**Mr SILBURN:** It is based on completions and combines all the information in the Coronial files. It is data manually coded from the police records, the forensic pathology reports, the information from family and friends and other information that has been used by the Coroner in reaching the determination of suicide.

**Madam CHAIR:** When we first started this off we had a session with the Police Commissioner, and what was quite stark in those figures was the number of attempts and trying to - with all the discussions we have had with many of the experts and departments dealing with this issue, has anyone looked at how many of those people in the attempted suicide have completed.

**Mr SILBURN:** The thing with the proposal here from Gary ...

**Madam CHAIR:** Will this deal with it?

**Mr SILBURN:** Yes, because you have the possibility for data linkage now that is linking data confidentially across from different sources through the SANT Datalink service, it is possible to get a confidentialised analysis file that includes information from child protection, from police, from education and you can build a much more comprehensive picture about the history of each individual. It gives you a much more comprehensive picture of the problem, as it allows you to look at what the life course of this person has been – especially in relation to some of the early life experiences. The evidence from the United States where they have some very good longitudinal data and have good records about this is that many of these early life factors play a much more important role in increasing vulnerability to suicide late in life than has been previously realised.

The idea of a register is that it would expand what is currently available by manually going through the Coroner's records and you can code the information on a routine basis. It allows you to compare year to year, and it allows you to look at specific risk factors and get a much more complete picture of the whole issue.

**Mr ROBINSON:** The data linkage would add to the data available in each case - to what you find in the Coroner's records. We see building that around a suicide register would give us an enormously greater understanding of what is going on.

The other important benefit is that when we are thinking about agency practices, whether it is coronial or police investigation or follow-up services, these can benefit from research. Many Coroner's offices around Australia have access to research support that can help them understand context better, context of investigation, the role of new risk factors, and those types of things that have been mentioned.

For example, in Queensland since the 1990s, the police have administered a psychological autopsy questionnaire as part of their investigation. That is filed with the Coroner's records as part of the body of statements …

**Madam CHAIR:** Is that looking at the police investigating the case, or does that take in the whole profile?

**Mr ROBINSON:** No, it is the police interviewing family members and key people.

**Madam CHAIR:** Okay.

**Mr ROBINSON:** Imagine turning up to a suicide scene in a very remote community, what do you do? The key forensic problem is what happened, who is the deceased person, what is the cause of death, were any other people involved, and what other lines of inquiry should you take: for example with family members, with school teachers and so on. Looking at the example of practices of investigation in the Queensland model, we could look at possibly developing the research evidence to inform guidelines and protocols that might support police work.

We are not advocating that at this moment. We are saying that is one of the benefits from having the research capacity that is able to look at notifiable deaths, look at suicide deaths, and look at the qualities of evidence available to help us understand what happened. The Queensland model is strongly supported by the Coroner's office. It is funded by the Department of Health and it provides a range of functions. The Queensland Coroner calls their collaboration multifaceted and ongoing and they work on a number of fronts

together. The register also supports independent research capacity by other departments and research organisations as well.

We would see that as something to work towards to really help us understand better what is going on, but also to get a handle on targeting the specific underlying causes rather than just looking at a hot spot and all asking how to contain it; how to deal with this epidemic. We need to know what is going on behind the scenes; why those sources of vulnerability are there among young people in those communities. Of course, we need to then deal with the imminent risk, but we also think prevention needs to be looked at longer term in terms of how you are working with families, how you are looking at the risk factors in families and dealing with them before someone is committing or attempting suicide.

The evidence on that is extremely strong. Family transmission of suicide is an independent path, independent of family mental illness. It has a genetic component, but it is strongly related to suicidal behaviour on the part of parents and siblings. In turn, as Sven and I were saying earlier, these early childhood adversities that are behind many suicides begin with early stress, disrupted attachment, and a range of problems from early childhood.

In my practice I work with a parenting program on the Tiwi Islands and have done that for many years. We work almost every term, but not necessarily every term, with families who are dealing with suicidal behaviour on the part of the parents or an older sibling of the child that has been referred to the program. Families in many contexts, not just on Tiwi, are struggling with high levels of suicidal behaviour, and need positive strategies to deal with that. It is a bit left out in the discussion of risk factors. Let us respond to it. The families are struggling with significant levels of difficulty of the kind that the evidence suggests is a strong predictor of suicide outcomes.

For example, concerning child protection, is it is not just the kids who have been subject to neglect and abuse in their childhood who are at elevated risk of suicide. In fact, kids of parents who were subject to abuse in childhood are at higher risk of early suicide attempts in adolescence. There are chains of causations through family relationships we need to understand better. We are proposing our program of research as a means of getting a handle on these patterns of risk as best we can with the data we have and then, through some more targeted studies, looking more closely at particular how we can modify the risks through particular prevention initiatives.

Concerning the school based work - the need for school based prevention I heard mentioned before - we are looking at partnering with colleges to develop a program to identify kids at risk of dropping out and to provide mentoring and support. The secondary colleges on the Tiwi Islands, have partnered with Menzies and the Ted Noffs Foundation, in a funding submission to do this work.

One of the cautions is, that you may be able to screen and you may be able to identify kids at risk, but you also need to be able to engage kids through their peer networks rather than relying on an individualised treatment approach. Whether it is a question of substance abuse problems or mental health problems, we need to know what is going on in the families of young people and to look at how to mentor children through their difficulties.

For example, a young person who has been neglected and who is really not able to communicate with his own family but is living with other relatives and with mates is always going to struggle to stay engaged at school. We need to understand his history if we are going to develop an effective strategy to reduce the risk in that person's life and get him back on track.

**Mr GUNNER:** That is one thing I wanted to ask about in your research around schools. If I understood it correctly, you were saying the level of support a student receives during their school years is critical. There are studies around success and all that; however, it was the level of support they received during the school years that was critical.

**Mr LECKING:** Expectations for success.

**Mr GUNNER:** You say in the Northern Territory context it should not be assumed that the lower school retention achievement levels and lower expectations in some communities about academic success necessarily reduces the significance of school dropout and related conflict with families and the lack of support through this transition as a potential source of suicide risk.

Earlier in the paragraph you talk about level of support. The higher the amount of support for the school and support etcetera - is that where we have assumed success at school can be a problem? If you are

struggling to read, to write, and to get through your grades, are you saying an added element to that is the level of support received through school? In some cases there might be a high expectation on you to succeed and therefore the stresses put on you from your family - therefore you are not necessarily getting support from the family?

**Mr ROBINSON:** That would definitely be a problem. That particular problem of high expectation versus low support is more typical of non-Indigenous – perhaps some Indigenous families - but is more frequently talked about with non-Indigenous high achieving families putting pressure on kids. Part of the issue we have encountered is that there is a fairly crude perception that a large number of remote community kids drop out early anyhow. They drop out and go back to communities early - so why should we focus on school based measures? Many kids might be dropping out when they are 16 or 17, before we would really like them to. Is that a problem? We are saying yes, it undoubtedly is a difficult transition when you go from being contained at school and supported - whether you are in a residential college or a community school and then find yourself back in the community, adrift, in the process of dropping out and without many options.

So the problems are not necessarily associated with high expectations. This might be happening in a family with low expectations, or hardly any expectations at all, but we are saying this is a difficult transition. We need to identify what the risk points are. Your point about schools being key collection points - this is where the kids are - let us see if we can understand what is happening to kids before they drop out and go back home. Let us see what we can do then and, if it has a spin-off of keeping them in school longer, great. However, we also want to understand this risky transition when they go back to their communities and are lost and looking for an answer.

We know from John Taylor's work at Wadeye that young people are really struggling to get into anything much after school. There are not many alternatives in the sense of TAFE courses or being involved in work. We need to understand that transition from school to engagement in the community rather than say that school is irrelevant for remote kids.

**Mr SILBURN:** If I could add to that?

**Mr ROBINSON:** Yes.

**Mr SILBURN:** The point of vulnerability is when you start to drift and you are beginning to get into limbo. One of the things I noticed coming to the Northern Territory is certain services you would expect to be available are not available. There is no adolescent health service. There is no adolescent or youth heath service, which is particularly important for disengaged youth because no one gets them to the doctor. There is no mum or dad saying: 'You have an issue; you have to see the doctor'. You have to look at outreach models. Western Australia has a service called YouthLink which has a very active outreach component where they have mental health workers, youth workers, Indigenous mental health workers and they have been incredibly useful when there have been developing clusters. - in Kalgoorlie a few years ago there was a spate of suicides which really distressed the community and the Aboriginal mental health workers were able to go in, engage the family, engage the young people directly when you could not reach them through the family or you could not reach them any other way. That kind of service is really needed.

**Mr ROBINSON:** One of the cases we can talk about is on the public record. It was an inquest and the death was in 1999. Sorry, it was in Central Australia where the Coroner recommended the establishment of an adolescent health service. That case was about a young woman who dropped out early and was caught up in a whole range of dysfunction in the community. The community had been rocked by sex for petrol scandals, but the child was mobile and was seen by everyone and seen by no one. There was no coordination, no joint case management. There was a time when she was seen by Mental Health Services, but they thought they were seeing her for school attendance and had no awareness of the other range of problems they were dealing with.

There was child protection involvement - she was a notified case but the case worker was not given access to health records. This was an early case which really identified all the issues of coordination between services. The Coroner's response was to say an adolescent health service would aim - through an outreach model like Sven is proposing - to address those issues, to overcome this combination of mobility and avoidance of services. Young people do not like sitting around and being told what to do so you have to be able to track them, keep in touch with them and engage them in various ways. There are some quite distinctive challenges for work with adolescents that really need some dedicated thinking and resourcing.

**Mr GUNNER:** We had a similar conversation today around the transition from Corrections, another transition point. Again, that point of transition when you leave a structured environment and go into freefall almost.

**Mr ROBINSON:** Yes.

**Mr GUNNER:** Yes.

**Mr ROBINSON:** Yes, the same old problems start to come again and how do you get through that? How do you deal with that? There are plenty of cases on record where suicide has occurred after a number of imprisonments - young males in prison are definitely a group that needs specific measures.

**Mr GUNNER:** It was interesting talking to the previous witnesses about the outreach program they were trialling to the end of last year - they have stopped now - where they were visiting students at home who had dropped out of school who had to be identified. It seemed to be a complicated way to get there, but at least there was an attempt to do so.

**Ms WALKER:** What has emerged from day one of the public hearings we have held - we have had several days and taken much evidence and had many submissions, is a proliferation of service providers in the area that are disconnected. The fact we compete for the funding dollars to address the problem and have so many service providers in that space yet continue to see the incidence of suicide increase tells us we are not going down the right path. It was articulated very clearly when I asked Dr Ruth Rudge what the best suicide prevention strategies were and she said: 'Well, by having the right service providers in the field and a strategic approach'. I also take on board the point in your paper about the need for evidence-based policy based on the data.

**Mr ROBINSON:** Ruth made the point about the problem of fly-in services: the reality is that in the Territory we are going to have to use fly-in services for many things. However, the key to it is getting the right combination of fly-in expertise and community capacity based on training and developing people who are in the communities a much greater proportion of the time than fly-in workers. This includes Aboriginal Health Workers and others. There has recently been a proliferation of fly-in services. It is discontinuous and fragmented; they cannot create rapport with people as they come and are gone again. The high staff turnover in those positions was mentioned earlier. There is almost no continuity and you cannot deliver a therapeutic service on that kind of discontinuous basis. On the other hand you cannot have the full complement of experts in every community, so we have to look at the right combination of fly-in fly-out and community-based capacity. We then seriously have to look at the challenge of coordination between these services because in fact the more services you have the more cracks there are for vulnerable people to fall through.

How to get continuity between the different providers in communities is a big challenge.

**Mr GUNNER:** A big concern seems to be you have the service provision here, whether it is proliferate or not, you have the general community here, and the great difficulty seems to be getting people who need the help into service. That point of intervention seems to be missing with the majority of people who complete suicide, not ever presenting to a health professional at all. They just live their life, it ends and we are not involved. How can you get someone from here, to here? It is obviously those things you talk about where you have continuity of someone in a community so they have familiarity. You get them at school, you get them somewhere, but there seems to be that - the people who are completing suicide are the ones who are dropping out, withdrawing, disassociating and we have to find some capacity to get them from here to here. Otherwise, everything else is pointless. If you cannot get them there it does not matter what we have done here to make the system better - if they are not getting into the system.

**Mr SILBURN:** In Western Australia, the issue of fragmentation of services is also a big problem, not only in the Kimberley, Pilbara and Goldfields remote areas, but even more so in the metropolitan areas. One of the main challenges the ministerial council had was trying to get a coherent framework, a common language and a common set of objectives that would be clearly understood across health, education, child and family services, the community sector and the Aboriginal community controlled sector. One of the last things I did before coming to the Territory was lead a state-wide community consultation process around a framework for suicide prevention in Western Australia for 2009-13 that has been funded to the tune of $13m. It has made a very clear requirement of departments that they have a responsibility in this area that they each have a separate but complementary responsibility and that they should each have ve someone designated who is responsible for the department's policies and practices in regard to suicide prevention and how they fit together with the overall State strategy.

**Ms WALKER:** Every department?

**Mr SILBURN:** Yes, and that is justice, police, health, education and the mining industry is very involved because of the issues with young men living in remote communities - with life skills.

**Madam CHAIR:** When was that put in place?

**Mr SILBURN:** It was put in place in 2009. I thought I had a copy with me but I do not.

**Madam CHAIR:** I wonder if we could follow-up with ...

**Mr SILBURN:** The other component of that was recognising there were very big regional differences, what was going to work in the Kimberly was not going to work in the southwest, and that you really needed to have a regional community-based suicide approach informed by local knowledge and local people who are based there and would continue to be based there to build that community capacity. Part of the funding is for a person to be the local coordinator who ensures the different agencies function together around the issue of suicide prevention.

Many of those communities hade committees already. They have a services committee, they have a safer WA committee, and it is the same people turning up to every meeting. The WA strategy funded a dedicated person to provde a local administrative support to these regionally initiatiated committees - instead of them having to buy into the time of each of those agencies. This is intended to give them some capacity to have a dedicated person avaulable do the leg work needed for more effective practice.

**Madam CHAIR:** Everyone knows that and we keep gathering the evidence, when do we get to a point - I worked in a health centre before I went into politics and listening to many of the players you get a sense of déjà vu. We know we need to communicate, we know we need to coordinate, and that is something we have to pull together and get some sense of. I like the idea of the register. Police have come up with the suicide kit - the booklet they hand out when a suicide - for police officers, but one of the things police were saying to us is they had no way to follow-up and see how effective that booklet was for families and services.

I support having a register people are able to access to inform services across government. This can bea good thing in getting an objective understanding of the nature of the problem. Having comparable data from year to year is important, as withouit that everyone seems to be all over the place with what the figure meant. We need consistency in the ways the data are recorded routinely so that emerging trends can be indentified early. There is also the issue of the time it can sometimes take for a final determination of suicide to be reached– in some cases two – four years - –so the reported figures for the total number of suicides in a year can appear to vary. years old.

**Mr SILBURN:** The other thing that came through with the community consultations in Western Australia was the fact suicide does not just impact on the immediate family, it impacts on whole communities. Communities need support to recover from bereavement overload and the normal social functioning coherence in a community becomes destabilised and sometimes it is the leaders in the community who people would be looking to for support to help them get through difficult times who have been affected themselves. There needs to be a capacity to support those people and to have an approach of suicide is everyones business and a sense of we are all in this together when community is affected by this. There is a real need to support and build the communities' capacity to respond, to deal with the immediate needs following , but also to set in place a process of community recovery, is very important. It was very important in Fitzroy Valley; it was important in the southwest a few years ago. There have been a few instances where that has happened and communities often do not have the resources to do that themselves; they need backup and support so they can do that community healing.

**Ms PURICK:** One of the other key items that came from a submission was some of our communities in the Territory are in a constant state of grieving. They lose this person so they grieve with that person. While they are still grieving for that person, something else happens so they never really get to the end of the tunnel to see the light because they are constantly dealing with a death in the family, or a relative, which does not necessarily happen in the urban communities.

**Madam CHAIR:** Which is why I keep pushing post-traumatic stress; it is in many communities.

**Ms WALKER:** It is not just grieving. Often, depending on the circumstances of the death, whether it be a suicide, a child has died, or a 40-year old has passed away suddenly, it is family arguments and blaming which results in conflict. I see it in my own electorate.

**Mr ROBINSON:** Yes, high levels of death and disability, mainly adult. Deaths in the older generation really have a big impact on the young people who feel abandoned and lost - it really exacerbates their crisis and conflict and so is definitely part of the problem.

One minor point around this is that although we need to think about these problems with services, it is quite possible that not all the problems are really about service delivery. Perhaps thinking about the issues of leadership and how to activate learning processes in the community is equally important. In a sense, communities need the opportunity to learn other perspectives on what has been happening rather than try to deal with old problems and have rebellions among the young people who say: 'No, this is the new generation'. There is an intergenerational stand-off in many communities. They are not talking the same language. How the communities access opportunities to learn about this? How can they take leadership and ownership of the problems at the same time as informing themselves about the issues?

Community strategies, whether they are called healing programs or whatever stamp each community puts on it, are very important. This issue of love relationships and conflicts, substance abuse problems among adolescents - how can communities come to grips with this, formulate ideas of their own, and take ownership of them? This has to be a priority: otherwise we are juggling service provision resources and taking the word of the providers that they are doing a good job without necessarily looking at the overall response.

**Madam CHAIR:** It is clear, Gary, things have worked. If you look at the Tiwi Islands, where nationally it was one of the highest for youth suicide – clearly, programs can work if you build that capacity and it is clear - what you did and the work that has been done for many years on the Tiwi Islands - we both know Tiwi is that old bull versus the young bull. The politics on the ground in communities where that transfer of leadership from the old to the young - as you say, there are many young men who, whilst not completing suicide, are attempting. The despair amongst many of the young ones - even though Tiwi is seen to have been the leader in reducing the number of completed suicides, it is still a major issue.

**Mr ROBINSON:** Yes, the problems are ongoing and …

**Madam CHAIR:** Yes.

**Mr ROBINSON:** Yes, and the particular issues such as young fathers, fatherhood, relations, relationship problems and the status of young men are all part of this. How do we keep encouraging and supporting communities to generate new ways of talking about this and giving young people a chance to participate in initiatives, take the lead, when much of the time they may be dismissed …..

**Mr SILBURN:** Could I, so it is on the record, undertake to provide you with a copy of the Western Australian Suicide Prevention Strategy.

**Ms WALKER:** Yes, please.

**Madam CHAIR:** We would love a copy, Sven. I used to have much dialogue with Dr Tracy Westermann, when you had that big spurt of hanging amongst young people in the Kimberley. That was many years ago. Is she still …

**Mr SILBURN:** She is mostly in the eastern states now, I believe.

**Madam CHAIR:** Okay. We would love to get that report from Western Australia. We will provide you with that transcript and you can go through it and have a look - we will upload it.

The documentation you have given us, like this paper, if you do not want it put on the web we will not upload it. Is that your wish?

**Mr ROBINSON:** At this point I do not see any problem with putting it on there. We already flagged that we are interested in this idea of a suicide register and the document does not go much beyond that.

**Madam CHAIR:** Okay.

**Mr ROBINSON:** I should mention that the research project mentioned there - we have received an expression of interest in funding support from the NT Department of Health, Mental Health Branch, to conduct an audit of suicides from 1990 to 2011. We are currently working towards a funding proposal to ensure that there would be the capacity to do the research. There is definitely strong support in government to understand the trends and underlying causes and to get some comprehensive baseline data.

**Madam CHAIR:** Well, that is good. One of the things I have noticed in both your submissions - and whilst people have gone to the heart of reporting and data, nobody has gone to the heart of the funding models that could be used in mental health. I look specifically in the health sector where NBS/PBS was cashed, particularly in the Northern Territory where you have high levels of chronic illness.

**Mr ROBINSON:** The thing is, can health carry the whole load? It has to be multi-sector; although health is probably still one of the strongest organisations with a capacity to build prevention. It does need to be thought out, but whether you can get more out of PBS with this I do not know.

**Madam CHAIR:** It needs the Commonwealth, does it not? Given it is Medicare, it is a whole different story. Thank you.

I want to move the minutes of 29 October, 3 November, 4 November, 9 November, 10 November - all the ones where did the trips - 17 November, 24 November and 2 December.

**Ms WALKER:** I will second it.

**Mr RUSSELL:** Madam Chair, I have one other issue which came to light when I was looking at the Tiwi Islands and holding meetings by teleconference. Standing orders provide that the committee can resolve to have meetings by teleconference. We have to resolve that first; we cannot do that without a meeting. Can we have a resolution that the committee can meet by telephone?

**Ms PURICK:** Sounds good to me. I support that.

**Madam CHAIR:** Yes, because Lynne will go back and we need to start getting this stuff done. That is good.

Thank you.

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The committee adjourned.

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