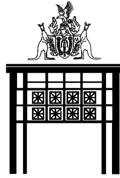

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

11th Assembly

Select Committee on Youth Suicides in the NT

Public Hearing Transcript
10.00 am, Thursday 10 November 2011
Andy McNeill Room, Alice Springs Town Council

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

Witnesses:
CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
Gerard Waterford, Social Worker/ Counsellor
Stephanie Bell,
Dr Boffa,

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA
Laurencia Grant, Manager Life Promotion Program
Claudia Manu-Preston, General Manager

NPY WOMEN'S COUNCIL
Angela Lynch, Manager Nunkeri Project
Toby Ginger, Traditional Healer
Linda River, Interpreter
Rupert Peter, Traditional Healer
Andrea Mason, Coordinator

TANGENTYERE COUNCIL
Leonie Sheedy, Coordinator Yarrenyty Arltere Learning Centre
Cate Ryan, Coordinator Hidden Valley Community Centre
Barbara Shaw, Mt Nancy Town Camp Resident and Community Advocate

MT THEO PROGRAM
Brett Badger
Aaron Bradshaw

LIFE LINE CENTRAL AUSTRALIA
Rob Loane, Director
Karen Ravel, Education and Training Manager
Jane Johnson, Chief Executive

Madam CHAIR: Is anyone else with you, Gerard, or just yourself? We had another person listed to appear with you.

Mr WATERFORD: My apologies, Stephanie and Dr Boffa were to discuss the Congress submission; however, there are a number of conflicting schedules happening today so you have me.

Madam CHAIR: We have some time between 1.45 pm and 2.30 pm if they want to appear. We will start with your submission.

On behalf of the select committee, I welcome Gerard Waterford to this public hearing into current and emerging issues of youth suicide in the Northern Territory. 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 the 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 to take your evidence in private. Could you please state your name and the capacity in which you are appearing?

Mr WATERFORD: Gerard Waterford, I am social worker/counsellor with Congress. I was also the Northern Territory Government representative on the national suicide prevention forum for experts in community, with another representative from Darwin, until about four years ago when we disbanded that committee.

Madam CHAIR: Thank you Gerard. Before I invite you to make an opening statement if you wanted to talk to your submission, I will introduce the members of the committee.

Mr STYLES: Peter Styles, member for Sanderson.

Ms WALKER: Lynne Walker, member for Nhulunbuy.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Madam CHAIR: Marion Scrymgour, Chair and member for Arafura. Would you like to make an opening statement, Gerard?

Mr WATERFORD: It is very timely to have this committee. Suicide in the Northern Territory is now very alarming and the personal consequence for families, and the work that happens, is catastrophic. We have had a whole series of young people suiciding here in recent times, which is a tragedy, including one yesterday. Many people will be a bit fragile today because of the suicide yesterday and the whole spate of suicides in recent times.

Mostly, the discussion paper that I put up to the committee, is one that has been around for four or five years. It was worked on with many Aboriginal workers and counsellors within the Congress social and emotional wellbeing program. It has been updated a little but reflects many of the ideas of that group of people, and I am here representing those views.

The thrust of the argument we are putting is, suicide is a response to people feeling hopeless and having no real pathway out of that despair. It is predominantly Aboriginal men who are born and grew up in remote communities – as you know it has been a difficult sort of pathway for many communities. The intervention has, and probably even more, the start of the shires, has impacted tremendously, particularly on some of the male employment programs.

Some of the opportunities people had to display leadership within their families to aspire to a good and rich life probably have - the perception for them, anyway – diminished, and it is a very difficult situation. As a consequence, many of them are coming into Alice Springs and other regional centres looking for work. They come as part of football teams, they come as part of a range of things, and there is no housing here. The housing is still a nightmare, so people are often homeless and often get drawn into, I suppose, a culture of drinking and, to some extent, having a social life that is associated with drinking.

Often the suicide deaths we see are impulsive - quite late at night, someone who is very intoxicated, who would not normally be considered at risk of suicide, ends up dying. Underneath the completed suicide stats is a huge other layer of self-harm and feelings of despair.

The discussion paper looks at how you invest in family leadership; how you invest in some of the communities and the aspirations of Aboriginal communities from remote areas; how people are making the transition to town and that is what is happening and has happened since forever, in recent times anyway; and then we need to look at services that can respond to the challenges they face to make that work, effectively.

The feel we have at the moment is that the level of homelessness and lack of people, young kids attending school, and some of the other social indicators of distress are not improving as rapidly as we hoped, and we need a series of initiatives to tackle some of those challenges if we are not to be sitting around in another 15 years talking about the same things.

There is a great deal of strength and resilience in the Aboriginal community and it is looking at the strength and leadership that is there and existing at the moment and using it as a framework for building initiatives that work. Some of it is a problem of service delivery in Alice Springs but, even more profoundly, the lack of services which are community based in remote areas where people are trying to create a good life for themselves. The lack of services out there, the support, feeling good about yourself, and feeling that you have power and control of your life and opportunities to exist in society need to be addressed. There needs to be a commitment, particularly of employing Aboriginal leaders in some of these programs, to build family strengths.

So, these are different ways we can take that forward. The alternatives of doing programs like these are often what we currently have, which is a range of services that are outreached, that are delivered, that have quite a large travelling agenda, but often have very little relationship to the people who are living in some of these communities. The service providers often have 5, 6, 7, or 8 communities they visit about every three months. That does not work particularly well and it is certainly not cheap. Investing instead in something that can build relationships in the community, can work with the community-based leadership, are the types of programs that we think will make a difference over time. Those programs, and suicide in particular, as we know from the Tiwi work and stuff like that, can often be very expensive on the Aboriginal community leadership in this area for many complex reasons. We need to ensure Aboriginal people working in this area are very well-supported and that the things that support them, that they are saying they need, are considered in the development, in the commencement of these types of programs over time.

Madam CHAIR: Thank you, Gerard. Now, I will open to questions by members of the committee. Do members have questions? Michael?

Mr GUNNER: It is a very good submission by the way, and thank you for your comments. They echo many things we have heard in Tennant and Darwin already. Sometimes it is hard to know where to start with the questions because there is so much to talk about, but in point 6 of your submission talking about primary care health services and alcohol and other drug treatments, now my understanding is there is a Cert IV in Alcohol and Drugs and a Cert IV in Mental Health. We heard in Tennant Creek yesterday about how a Cert IV in Mental Health could be a really good option in terms of upskilling primary health providers, whether it is doctors or nurses or whatever; it is often a missing skill. They might have an ability to treat physiology but not necessarily psychology. I was wanting to hear a bit more about your program here - where you are talking about people who are going out, the AOD workers, what type of skill base do they have to have that Cert IV Alcohol and Other Drugs level and what sort of support do you have around the Cert IV Mental Health and, possibly, an upskilling of Aboriginal Health Workers in that course?

Mr WATERFORD: There have been a load of people who have gone through those programs over time. There has been a lack of jobs often for them post training. Also for many people, and particularly people from remote areas, the Cert IV can often challenge their literacy and numeracy. One of the approaches we have been working on is to look at engaging with the senior people in the communities as to who they might choose to be a worker with families around alcohol and mental health, family support. On communities it is often the same vulnerable families who have multiple distresses.

Mr GUNNER: And that is in relation to the family group?

Mr WATERFORD: Yes, but maybe one of the initial stages can be to look at engaging with those leaders who already, within their own culture, have skills and an ability to make a difference in this area and from that, they can be support and be mentors for people who do programs like Cert IV and all the way through.

Mr GUNNER: I think that is almost a step beyond what I was thinking, which is important, which is about a trained person working with a family group, or an individual, or a family circumstance. But what I

was thinking was taking people who are already in employment - essentially providing an incentive for an ACPO or a nurse or someone to get that extra string to their bow, which is around mental health - and not take it for granted that just because you are a nurse and gone through a course, that you will necessarily have that mental health expertise.

Mr WATERFORD: I certainly think that with the training for some of the professional staff in these types of areas that complementing it with some more specific skills in the mental health and alcohol and other drugs is a great idea and should be supported, but some of the discussion that is about an Aboriginal workforce and how you would include, sustain, and grow up a professional Aboriginal stream of employment in this area, particularly on remote communities, because that is where you need it. They have the relationships, they are the ones who are already there and, obviously, it is their families that are affected in these sorts of ways. They have a deep commitment to making these changes and to being part of these sorts of programs and we need to find ways of including them and sustaining and supporting them in those roles.

Providing adequate training for Aboriginal workers in remote areas is difficult for people who are already stretched and busy out there to come in to training all the time because, almost invariably, the training is delivered in regional centres. That it takes a full day, sometimes more, to come in for training. The training is also out of country and context sometimes. So, it is difficult to make the training sufficiently useful. Within their priorities, training is often not their biggest priorities, particularly for older, senior people who are playing traditional healing roles in these ways.

Mr GUNNER: On that point, I know we were going to try and talk – you were going to try to arrange for us to talk to someone who is a traditional ...

Madam CHAIR: Yes. We were saying yesterday – and I know from experience - how hard it has been to try to get that recognition of traditional healers in that model. It has been a longstanding thing. It is an historical thing, rather than something that has just come up.

Michael, before I go to other questions, I welcome Stephanie Bell, who is the CEO of Central Australian Congress and Dr John Boffa. Thank you both for taking the time to come and talk to the committee on this most important subject.

Mr GUNNER: Can I just have one more question …

Madam CHAIR: One more, then I will go to Peter.

Mr GUNNER: In your submission, you looked at universal led home visitation and, then, building into day care. Just a question I have, which is one step back from that. I have ignorance on this subject – I have not had children yet or anything like that. I am not sure what happens around maternal health. Is there enough done for the primary care giver, the mother, at the time of birth; should we have at that stage - I understand you can do a mental health aid course that takes a couple of hours. Is there stuff that should be done at that point where you can get into the home visitation and day care?

Dr BOFFA: A person's home visitation happens from early pregnancy.

Mr GUNNER: Okay, yes.

Dr BOFFA: Yes, it does not start at birth. In fact, it has to start before 28 weeks, and the earlier the better. So, it is a service that starts in pregnancy and complements antenatal care. So, antenatal care is out there, by and large, but home visitation is not.

Ms BELL: The biggest issue is that it is not universal. So we are the only site in the whole of the Territory where that program is happening. It is a federally-funded program. We have had it for two years now, so we have up to 100 mothers engaged in the program here now. We are trying to use Alice Springs as a site to get it extended into the bush communities. That program includes mothers from Santa Teresa and Amoonguna. We have just recently tried to get the government to agree to Hermannsburg coming underneath that as well, but they have not agreed to that.

Mr STYLES: Gerard, when you were talking about the outreach services that occur, it was quite interesting, because I got off the plane and ran into someone I know who is part of that. They are just down there for a couple of days, and off they go. Then, they get in the plane and go back again. Do you see that as a bit of a problem and not quite appropriate? When we are delivering outreach services, it seems to me

that what you are saying is we need to send these people to do training out there as opposed to bringing these people in. How do you see the outreach services in their bang for buck, so to speak? Are we getting bang for buck with our outreach services, because governments will fund all sorts of organisations to do a whole range of outreach services? You just said that you saw a few little issues. Can you just elaborate on what you see as some of the problems and challenges?

Mr WATERFORD: In 20 years of working up here - a lot of it with the government as well as the Congress - the short answer is it is difficult to recruit and retain staff. If they do not have a relationship with the community, if they do not necessarily have the support of the clinic and local leadership then, often, those services are a very poor use of money, really. Certainly it is the idea of - which is a little like the work of life promotion and other groups here talking of suicide - their program was suicide talk which goes out and sits down with the whole community and some of the staff that are working intensively that are community based, which can often be school teachers, the Aboriginal Health Workers, the nurses and other staff, as well as with the families. There are much better ways to develop strategies within the community that are locally based and recognise the local issues and challenges.

Mr STYLES: Currently, is there a program where - if you have 10 different areas are 10 people identified as potential traditional healers? Is it possible to identify the up and coming ones because, as you said, some of the elders who have done this all their lives have someone come into town because they are busy doing all sorts of things. Are there people we can identify as a community, or someone who can operate in five different communities in that group? Is there a program where we can identify those people? It is a long-term program and would have to be funded over a long period of time to develop these people. It is not only in their natural environment, but getting them to Cert IV files and that type of thing. Do you see that as a possibility?

Mr WATERFORD: One of the things that happened post-shire was we worked intensively with some communities - Santa Theresa we obviously got involved with - and the same was happening with some of the other communities in identifying what the family leadership was more specifically, and working with them to build incorporated bodies that included all the families on different communities.

The answer is yes, it is very easy. Everyone knows who the people are that need to be involved in these things at a community level and it is very easy to seek that information from the community.

Mr STYLES: We do not have anything like that at the moment that you are aware of?

Mr WATERFORD: Yes, Congress men’s health works fairly extensively with a group of male leadership - senior people. All the clinics in remote areas have a group of people that are part of their advisory. Traditional healers are within every family group - whether they need more support and encouragement and all that type of thing.

Mr STYLES: The issue I look at is you said there are people out there who are very good at this and they are doing it now but have other things they have to do. I do not know what those things are, but should we not be looking at a system where we can support those people so one of the things they do not have to worry about is doing other things to sustain themselves. We could give them a job.

Mr WATERFORD: Often the role they are playing is as primary carers for whole groups of young Indigenous children, people - the very frail and aged that are often sharing the space, the housing on communities. I assume it is the same in the Top End although you get much more housing than we get.

It means you have very over-worked family leadership at the moment involved in supporting the kids and extended family after suicide and other bereavement and cultural roles that make it difficult for them to - often it is a matter of working with a group of leaders to find out who has the capacity to - it is not always them directly, it may well be some other younger person within the family to work in some of these roles and take over those roles.

However, we have not had sufficient money necessarily to employ them so often they become an added volunteer class.

Mr STYLES: We have heard evidence that volunteers are disappearing at a great rate; they are an endangered species because people are overloaded and are becoming stressed themselves and getting into the danger zone. They have so much to deal with they are becoming depressed. So, how do we look at encouraging volunteers?

Mr WATERFORD: Well, my role, prior to coming to Congress, was as a disability program manager down here, and aged care program manager. There has been some expansion in carer support programs, in town mostly, but they have not really gone much out of town. Very little that happens in terms of supported accommodation or disability extension programs go out into remote areas, or out of town. In fact, there are previous committees that have met about failures in the disability program.

Many of the frail aged are being cared for at home much more because that is where people want to grow old and die now, but they have high support needs. The clinic is often fairly overwhelmed with how much support they have to provide to families, but the families themselves are doing it 24 hours, seven days a week and are absolutely flattened by it. So, there is a need to address who is the carers in the community, and how do we actually support them.

Some of it is with housing; some of it is practical support with beds and the things that make up housing, the technical aids, such as access to better wheelchairs, to all those types of things. Not much has happened in the last 10 years in some of these areas, and that is creating much of the distress.

It is where do you start? But certainly I believe you need to invest in Aboriginal groups that have responsibilities in these areas and are keen to be participants and be involved in it, but who are very overwhelmed about how they find the time to be consistently involved, and who are not necessarily the candidates to do the Cert IVs and things like that because of their other commitments - difficult for them to get out from under that - but they are a group of people that you want to actually train up and invest in over time as well.

Ms WALKER: Thanks very much for your submission. It is very detailed and it highlights evidence we have heard over the last week or so that tackling the issue of youth suicide, and suicide generally, particularly amongst Indigenous communities, on so many fronts from out there at the pointy end, identifying those at risk and the day-to-day things in dealing with that, but also going back to the root cause of what this is and the complexities and years of policy that have impacted upon Indigenous communities. Just listening to you, Gerard, in your opening statement, talking about the impact of the intervention, the demands upon leadership, people who come into Alice Springs, dealing with homelessness, unemployment, the self-esteem issues, and everything that goes with that.

From what we have heard - and I know from my own experiences at Yirrkala and Gunyanara where, and we heard again in Tennant Creek yesterday – where there is success in turning around suicide, it is because it has been dealt with at grassroots level where Indigenous people are empowered with the programs to know best how to deal with it. So I am interested to see, in your submission, around empowerment and greater control, that you have made contact with the Family Responsibilities Commissioner in Queensland where that trial has been underway for a couple of years. Marion and I have recently met with the Deputy Commissioner, just as a matter of interest, about what they do and how it is working. So, in dealing with the issues, going to the root cause of how that can be turned around, I would be interested to hear more about how that model might work here in Central Australia, based on the experiences in Far North Queensland, and what it is you see out of that as being potentially workable for Central Australia.

Ms BELL: For us, the framework of the Family Responsibility Commission is around re-empowering Aboriginal people to be there as a part of dealing with the issues that impact in the community. So, giving responsibility back to the community and to some degree where – I mean customary law is another component of a possibility, similar to the Family Responsibility Commission, because it is about re-empowering Aboriginal people to then determine what the matters before them that they are confronting in the community can be best dealt with, which is really what Gerard is saying. That leadership is there; it is about the structure and the way in which the frameworks of - whether it is called a family responsibility or you look at customary law as a framework of leadership - that then establishes that kind of council, if you like, to put things in place that is going to contribute to the issues that impact in communities.

The stuff you are talking about, Lynne, is – the escalation of the social issues that we all experience, I think suicide is one of those peak issues that demands all of us to take action. But, you are dealing with decades of neglect across a number of fronts and trying to get policies and programs that support not just – it is about community capacity building that then creates the framework for the current issues that are impacting - but also much of our paper is about the need for all of us as governments to get the early childhood programs, because that is the long-term outcome you want. So, you have to be able to have capacity and funding that can address the immediate issue, but deal with the long-term outcomes that you want from our communities. Our families and communities themselves want to have the best for their

children, but much of that is reliant on services and programs that are there to enable community capacity and families to then take the responsibility they should to give that sort of future for their children.

The suicide stuff is just one of those – it has raised its ugly head because of the impact of all the other social disadvantage experience and that is a lead-up to all the other things that we all know; the underlying social determinants of poor housing, education access, good quality access to health care. If we can get the quality aspect of the health care services working, you can go a long way to addressing some of the immediate, but long-term dealing with also the immediate crisis, but also secondary and primary prevention, which is some of the stuff in our paper that we wanted to talk about.

Like the targeted family support programs and other strategy that is working really well here in Central Australia, where it does case management and provides early intervention and secondary prevention for families, dealing with the whole range of social issues and that seems to be having the kind of impact. So, whilst we are in a situation where there is a number of priorities and issues impacting on the community, there is a need to have a number of strategies in place, but we have to get to the primary prevention and the long-term outcomes and we are saying to you that the early childhood approach is where the investment has to happen if you want to make the long-term investment for children in the next ten years.

Do you want to add anything to that, John.

Dr BOFFA: In the evidence of the Australian Early Development Index scores which was done in 2009 on all kids in the first year of primary school - and there is a range of domains. One of them is emotional development and the kids in the first year of school are very severely impaired in that domain along the ------------10:44:08 language.

On the western side of the highway, you are talking about nearly 80% of kids being severely impaired in two or more domains and the research from Canada tells us those kids will not get through school. The only way they were going to get through school is if there were very intensive interventions in the first few years of primary school, which we do not have. So then, if we are going to make a difference – and that is important because that correlates as well with all the research that has come out in the last few years on some major long achievement studies showing children that are impulsive and lack self-control at age 4, they are also the kids that are going to have bad ADI scores. They are the kids that are going to go on and be much more likely to suicide and not just that, but drop out of school, suicide, get addicted to substances. So, that impulsivity and lack of self-control which develops very early is the precursor to all this.

I think 20 years ago we used to think when young people suicided they were often drunk, and people used to think alcohol made them impulsive, it made people who were not depressed get drunk, they had an argument and, then, suicide was an impulsive act that happened because they got drunk. It is now really clear that what comes before that is these young people are impulsive and lack self-control first, which predetermines addictions, which also predetermines impulsive acts like suicide - which is what it is.

Regarding at-risk people, there are so many young people who are at risk at the moment because of what we have seen in the ADI scores; that if we do not get on top of that at a population level, there will still be a very large number of young people at risk. The risk profiles differ in different – it is very different in different communities. Those scores are not uniformly bad across the whole of the Territory, and there is a big difference between Alice Springs and remote areas. I think there are very big differences in the rates of suicides in different parts of the Territory. What we are saying in this paper is there are interventions that we know, despite an adverse social environment and, unfortunately …

Ms BELL: Can make a difference.

Dr BOFFA: … adverse social environment keeps coming on. Despite lots of, I suppose, good intentions to address that, it is still there. But, there are programs like home visitation, like the elders visiting program, two years of preschool - things that can be done. As Gerard said, if you have alcohol treatment programs, but you do not have supported accommodation - it all has to go together, because even our alcohol treatment program is dealing with parents who are addicted to substances, then their ability to parent their children, give priority and routine to their kids - put them to bed and all the things that matter in their development - is impaired. Getting parents off substance addiction requires alternative accommodation and our program we have here is limited in its capacity to achieve outcomes. It gets much better outcomes when it can find accommodation. To put someone who wants to get off grog or wants to overcome an addiction into a new housing environment makes all the difference in the world. It is not that you cannot have any impact without that, but you will not have the same impact.

So, in the paper we put all these things together. If our goal is to create a social environment that is more conducive to parenting the kids in early childhood, then there is a range of things we need to do to make that happen. That is why the whole package of measures we have in that paper is really relevant to the prevention of youth suicide. In some ways, the good thing about it is what you need to do to prevent youth suicide is the same thing we need to do to improve education attainment. It is the same thing we need to do …

Ms BELL: It is the same pathway.

Dr BOFFA: … to prevent chronic disease epidemic. With these early childhood programs, when you follow up kids at 18 and 25 and 30, the kids that have had that are physically more active, they are not overweight, they are retained in school, they are much less likely to have addictions, much less likely to have multiple sexual partners - a whole range of impacts.

As well, we have to address the crisis with interventions here and now. We need to be doing a lot more. As Stephanie said, the only place in the Territory where there is some programs in this area is here in Alice Springs. We have now documented, through the ADI scores, we have documented that the whole generation of kids going forward 10 to 15 years, without some very intensive interventions in the early primary years, are not going to do well in school, and are going to drop out and be in the same situation other kids are. So youth suicide becomes the symbol, if you like, as a wake-up call …

Ms BELL: Of all the other things that have not been put in place.

Dr BOFFA: … of all the other things.

Madam CHAIR: That have happened and it has just built up.

Ms BELL: Yes.

Madam CHAIR: That was good, John. That is certainly a theme. You are absolutely right that Central Australia is probably the only place at the moment where it is happening. Let me tell you, for someone from the Top End where we constantly are told of the Berrimah line - that everything happens up there - is not true. When you look at Central Australia and the investment and work that is being done by providers down here, it is actually quite substantial and groundbreaking. We need to harness and pull that together.

Ms BELL: Yes, we do.

Dr BOFFA: Yes.

Madam CHAIR: Whilst you are going to get different patterns of suicides and those …

Ms BELL: The strategies should be the same.

Madam CHAIR: The strategies will be the same, particularly that early childhood and when you contract those children. So ...

Dr BOFFA: We have had CAYLUS down here. They have not had that up there

Ms BELL: There is the petrol sniffing strategy down here, so ...

Madam CHAIR: Like Lynne, the Family Responsibility Commission - we had quite a long meeting with the Deputy Commissioner to look at the model they have over there. When you look at the levels of completed and attempted suicides in the Centre and then look at how many youth services are on the ground in Central Australia, in Alice Springs and the community - your submission is fantastic. It is comprehensive and brings much of that together.

Why are we not getting the outcomes we need for the money invested?

Ms BELL: As I said in Darwin, Madam Chair, it is a structural issue as well as a policy issue. The reason many of these providers exist is because they are given funding through various government departments but there is lack of accountability and coordination. That is a real issue that can structurally be addressed and the universal stuff is an issue around - the money is in the system, it is how the money is

being spent and how it is been distributed which comes back to policy, funding and working from a point of view of collaboration.

Even as a health service, we are limited in achieving and getting the kind of outcomes we all want. It is about collaboration and working in partnership with all agencies that have a role. If people are all operating on the premise of what they believe is the right thing to do for that client and it is not delivering any outcomes, the big question has to be asked. We have to get the parameters around what people are doing, how they are providing services and what kind of service model are they working on.

They are the kind of structural issues that really need to be...

Dr BOFFA: The service model issue is important. What is the evidence based on the service model? We know case management works, and we know that multi-systemic therapy works, but of all the youth services there are very few providing case management of the family and the young person. They are all intervening, they are all doing things, but there has not been much rigor applied to asking what service model is going to make a difference. Who is case managing? When you find young people in crisis or with problems, who case manages the family and what interventions are provided to the family? If you looked at that you would find everyone is operating in different ways. Everyone is caring for people but we need to do more than that, and with the investment ...

Madam CHAIR: You might have a multitude of service providers caring for one person and neither talking.

Dr BOFFA: .Yes. There is a paper by Haggerty and Hall in the British Medical Journal 2003 which said if you have three or more providers - multi-disciplinary care is a good thing, but if you have too many providers it achieves worse outcomes than a solo GP. If you have multiple providers all with different philosophies, all with different views of what they are trying to do, all working with the same family, it does not work. We have too many providers and rationalising that - it would not have to be Congress as the provider, but someone becoming the major provider with economies of scale with a consistent service model for all those youths would be a major step forward.

We have been calling for a review of youth services for many years but each review that happens does not bite the bullet and say there are too many providers, there are no economies of scale and no clear service model. There are very different approaches from different providers ...

Ms BELL: And different philosophies, some about empowering youth, which is fine.

Madam CHAIR: There was a recent review of the *Youth Justice Act* which took in not just looking at the *Youth Justice Act* and the Justice system, also services. Was there any discussion here amongst services to call for - we will have to look at some of that. Did you have any discussion?

Dr BOFFA: I am sorry I have to go.

Madam CHAIR: I wanted to talk to him about alcohol.

Mr WATERFORD: I personally was not involved in it. They are doing some work around conferencing. One of the problems in Alice Springs, and it is even worse in remote communities where - it is good to have some services and professional support so the work that is going in to support families and other people in the family leadership to actually work with their own young people, is not really happening. Some of that mentoring and support for Aboriginal men taking more of a role with some of the younger kids is not really happening. As a result, you often have a number of quite well paid, often an almost entirely white workforce chasing after a bunch of kids and rewarding them often for being troubled children, essentially. They get better access to a whole range of little presents.

Mr STYLES: On youth suicide, and suicide generally in Aboriginal communities, we have heard evidence from a number of people that until recently suicide trends were a taboo subject and it is something Aboriginal elders do not ever want to talk about. Have you found that?

Mr WATERFORD: It is certainly been an issue for 15 years, particularly with the Life Promotion program being run here for 12 years or so now, there has certainly been a discussion. I believe there have been some initial concerns by local Aboriginal community leadership, similar to the white community, about whether discussing suicide or naming suicide actually increases the risk of other people going down that same path. I believe that is a myth. Most of the leadership, as has been said in Tennant Creek forums and

here locally, where you can get hundreds of people turn up to discuss suicide and what is happening with their families, and naming it and wanting to be involved and part of the solution.

Mr STYLES: Given that one person yesterday was saying that it used to be taboo, but now it is not because it is confronting, it is right in their face and they have to confront it, so it is evolving how to deal with it.

Mr WATERFORD: I believe it has also been the work of Life Promotion Program and the suicide response meetings of inter-agencies at play here, where this discussion has been happening at a fairly active level on all levels within schools and communities, and it has actually been because of the work that has been done to engage the community on how they can participate in protecting people.

Mr STYLES: If they have not done that, when you talk about capacity building in the community, the program obviously is working and people are starting to do this, but how much depth in the capacity do you see out on these communities in relation to dealing with suicide in general but, in particular, youth suicide? And I suppose the following question to that is: how do we deal with that capacity and how do we do it in as short time as possible?

Mr WATERFORD: I believe there are a number of challenges, one is the analysis looking at where the completed suicides are happening and that often the person who commits suicide is actually from a remote area but they are living in town, so the support they have in terms of their family is not there.

Whilst suicide rates have not decreased - certainly not this year anyway - some of the work happening on the communities five years ago is starting to have an impact. The Tiwi stuff was starting to have an impact. The difficulty is you have a mobile population as people come into town, particularly young people, they do not have the same support from families, they are homeless, and they do get fairly desperate and it can happen fairly quickly. Building the capacity of the community to respond to something that is happening in town when they are out bush would be useful.

Madam CHAIR: I will just quickly get Lynne and then I will round this off.

Ms WALKER: I just wanted to ask you - knowing how important education is side-by-side with health and I did have evidence from the department of Education last Friday in Darwin because many people we have spoken to and who have given evidence have talked about the importance of schools being the place for promoting social and emotional wellbeing, both from little ones through to high schools. So, there has to be a very collaborative relationship between the health providers and the education sector. Can I ask you: 'How is your Congress' relationship with the education sector and that would include both DET and the independent schools sector in building that collaborative relationship?'

Mr WATERFORD: Social and emotional does a lot of work in schools. We have a youth program, but also there is a whole lot of stuff linked to schools, particularly some of the Aboriginal community-controlled. Yipirinya, who we often have done some fairly good work; in Yirara, we support some of their mentoring and provide a lot of the counselling there; Irrkerlantye, when it was going, we were very intensively involved in supporting that and thought it was a tragedy when that whole community education program stopped being funded. What is also happening though is each school these days have its own counselling service that is in-house and we tend to do more linked work. They also have home school liaison. What we often tend to be more getting referrals for is in complex families, the problems identified are a little bit in schools, but they are not actually educational problems; they are problems of housing, of family support, and that is where some of these targeted programs are making a big impact.

Ms WALKER: I certainly know through my own experiences in my electorate on Elcho Island, Shepherdson College is seeing some success because they are just working - all stakeholders in the community are just working as hard as they can together to get kids into school and to get the best outcomes for those kids and it is a community that is also obviously benefiting from SIHIP - where there are new houses coming on-line so we are addressing those issues at the same time as well. We have heard about a program in education that is federally funded at primary school level, it is called KidsMatter and at secondary level it is called MindMatters and they have had good success in the APY lands and currently in – what is the name of the community, Marion? It is Anangu, is it?

Madam CHAIR: Anangu, yes.

Mr WATERFORD: I think they were doing a lot of work in Indulkana at one stage and NPY.

Madam CHAIR: In the Anangu land, around that area.

Ms WALKER: They go to places where they are invited to come in rather than the top down approach.

Mr WATERFORD: MindMatters has been around for 15 years now and is a great program where it is implemented and does a lot of work with the whole family and school leadership. It is good, but it is a bit limited in how much resources it has, and in fact some of the work that was presented at the Principals Association meetings that fund them. That is probably what has led to a whole lot of the supports in schools – a bit disappointing in some ways how much resourcing they don't get currently in this area. You get the impression from talking to a few people that perhaps it has actually shrunk rather than grown. My wife is a teacher – I have to give her a little bit of credit. Anyway, school-based programs are very effective, good ways because the schools have a relationship with the child and the families, and it is an effective way of getting these programs on, and it needs a lot more work around bullying, cyber bullying, and all those sorts of things.

Ms BELL: For us, we interact quite well with the schools and I think it is about the schools and through the Education Department is getting better but they really are in a position where they can pick up these kinds of issues because the children are there a lot and they have to have that capacity and make the connection as well.

Madam CHAIR: Yes, a captive audience. How is your relationship with the acute service, mental health – the in-patient services in the hospital? As a primary healthcare service, does that work in a referral base following people through the hospital system?

Mr WATERFORD: Things have worked very well in there, particularly with a lot of the senior staff who have been around for a long time. At the crisis end it, they are under-resourced. They are flying in and out a lot of the nursing and crisis services. They do not have existing relationships with some of the individuals and families. They are under such stress they are actually not doing much other than checking in and giving people medication …

Ms BELL: Sending them back to us.

Mr WATERFORD: … and then sending them over. Sometimes the individual staff are skilled, but if they are just off the plane; they are a bit like what we were talking about with the fly in and fly out remote services. They do not have the capacity to do very much; often they cannot even find people.

Madam CHAIR: Stephanie, are you able to provide – sorry, I did not see in your submission. I know Congress not only runs the clinic here in Alice Springs, but you also provide remote services, or you look after a couple of remote clinics. Are you able to give us a snapshot - even if you send that through, if you can get someone from your organisation to just give us an indication of how your average services are from Alice Springs and some of those communities, that would be helpful.

Just following up, on what Peter was saying last week that it was taboo, or people did not want to talk about it. On the other hand, we have also seen where, not so much wanting to talk about it because many families have got like that because services, organisations, or the professional people have said: 'Do not talk about it because that will just make suicides worse, and it will bring on the copy cats and the clusters'. So, people have not talked about it for fear of that.

I do not know if it is the same down here. If you could just quickly tell us, do you get the same level of apathy where people just see suicides as a normal process? So, completed or even attempts is a normal process of one's life, rather than there is a real issue and a problem so we need to help that person? Do you get that down here?

Mr WATERFORD: There is a lot of exhausted people. Every suicide is a tragedy for a whole lot of people in the family. Their ability to cope is another layer of stress, and has led to people almost trying to avoid dealing with it at all. I do not know. Congress has run a series of forums for parents and other people bereaved after suicide. People are deeply traumatised by this issue, and there is some ...

Madam CHAIR: So, you do run that trauma counselling for those families?

Ms BELL: Yes.

Madam CHAIR: Oh, good. Okay.

Mr WATERFORD: We would like to do a lot more.

Ms BELL: We would like to do a lot more. My experience of it is that once communities are aware and they have gone through the trauma and grief, they are much more aware. Average people have very good grieving processes as well, and they cope and deal with that in their own cultural structural frameworks. But, as Gerard was saying, it is another level of stress and another issue people have to deal with on the day-to-day stuff as well. Once awareness is there, people do become much more proactive and they try, because they see the behaviours themselves - don't they? - across much of it. They try to then build strategies in that are going to assist with coping with it. This is where the role of services becomes really important around engaging the community, around the coping skills, and when to act and when to do things. Sometimes, as Gerard was saying, families are so overburdened and stressed that becomes a difficult thing for people to do.

Mr WATERFORD: Santa Teresa, for example, has a wonderful program that is an activity-based program with lots of levels, with some senior Aboriginal workers involved in it that engages people who are perceived as vulnerable to suicide, or just follow-up. It might be involved in hunting and traditional activities. They are working really well. It is a community …

Ms BELL: It is like a community watch strategy, isn't it?

Madam CHAIR: Yes.

Ms BELL: Mainstream has neighbourhood watch, communities can create that within the parameters of their community, which is quite different to neighbourhoods in suburbia. That is probably an equivalent, is it not?

Mr WATERFORD: Yes. Santa Teresa is comparatively well-resourced …

Ms BELL: Yes.

Mr WATERFORD: … which causes a little jealousy in the other communities.

Madam CHAIR: We might follow that up.

Anyway, thank you both for coming and thank you, Stephanie, for Congress' submission. It is fantastic; quite a detailed position.

Ms BELL: Okay. No worries.

Madam CHAIR: Thank you, we will get back to you.

Ms BELL: Thanks.

Mr WATERFORD: Thank you for seeing us.

Madam CHAIR: Thank you, Gerard.

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA

Madam CHAIR: On behalf of the Select Committee I welcome Laurencia Grant and Claudia Manu-Preston to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I apologise, we have run a little over time. I welcome you and thank you for coming today. We appreciate you taking the time to talk to the committee and look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the 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 and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding. I will introduce members of the committee and, after you make the opening statement, we will proceed to committee questions.

So, would you to please state your name and the capacity in which you are appearing for *Hansard* purposes.

Ms GRANT: My name is Laurencia Grant. I am the Manager of the Life Promotion Program that operates out of the Mental Health Association of Central Australia.

Ms MANU-PRESTON: I am Claudia Manu-Preston, and I am the General Manager of the Mental Health Association.

Madam CHAIR: Thank you. The members of the committee are;

Mr STYLES: Peter Styles, member for Sanderson.

Ms WALKER: Lynne Walker, Nhulunbuy.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Madam CHAIR: I am Marion Scrymgour, member for Arafura, and Chair of the committee.

Would either of you like to make a brief opening statement?

Ms MANU-PRESTON: We will probably both say something, but I would like to start by acknowledging and thanking the government for conducting this inquiry, particularly because it has been a core area in which this organisation has worked, particularly for the last 10 years. The work done related to this area has been in the broader context of mental health, in terms of our organisation. So, listening and reading through some of the submissions, clearly the outcome of suicide is a broader tragedy related to a number of issues and our work, particularly in mental health, has been around supporting people with mental health problems: health promotion, education and training, subacute care and the Life Promotion Program.

So we come to you with over 20 years experience in community mental health, and 10 years of our experiences and knowledge gained through the work of suicide prevention.

I will pass on to Laurencia.

Ms GRANT: I want to open by going back to some of the comments that came out when you were speaking to Gerard Waterford and the members from Congress.

I want to highlight that it is not really a surprise that suicide has been such a taboo subject, and if we think about our own – well, I will talk from my own experience and my own culture. I grew up in Melbourne, in a Catholic family, and when a person died by suicide it was not really talked about, and I believe we have come a long way, as non-Indigenous people, in regard to that for a range of reasons to do with a range of strategies that have been put in place around Australia, as well. But I believe for Indigenous people this is a new problem and this is something we have highlighted in our submission, and you have all seen the statistics, so it was an emerging problem that started in the 1980s, one Aboriginal person died in 1980 or 1981, and it moved up to about 35.

It is not surprising that Aboriginal people have found it very difficult to grapple with as a new emerging issue, just like they found it difficult to grapple with alcohol as an emerging issue in communities, and there is a lot of silencing.

I also wanted to raise the fact that suicides are not reported in the newspaper; it is not really talked about very much; there are not really images people see about suicide, whereas petrol sniffing was an image that was broadcast around Australia. The idea of seeing a young person with a petrol can to their face was very disturbing for many people and, while all of those discussions were going on, we slogged away in suicide prevention and we were very aware this is an issue that does not get nearly as much public attention.

So, that is part of the problem, and it is not really a job many people put their hands up for. I took on this role seven and a half years ago because it was about community development and it matched the skills I

had coming from Victoria, but when I arrived here I realised that I was like a newborn baby learning the ropes all over again in this context of work, and two Aboriginal people had been in the life promotion program before me. One of them, I think both of them were probably a bit burnt out. They left after 2002, which was the year we had the highest incidence of suicide, and some of those people were family for them and they needed a lot of time out from the whole area of work. In my experience, it is not a role that Aboriginal people easily embrace to work in. The fact that the program is called the Life Promotion program is a good thing. It is kind of disguising exactly what it is about. Many of my friends ask me – how do you stay in this work for so long? I do not think people fully understand how interesting the field can be as well. They think it is all about me dealing directly with frontline, people dying, and it is not like that at all.

I guess I just wanted to point out that it is not an area of work that people see as an attractive career opportunity.

Madam CHAIR: Thank you, Laurencia and Claudia, and you are absolutely right, and the more we can try to highlight this issue, the greater it can get governments to - in terms of policy and funding the resources that are needed to deal with this issue - is an important outcome. This committee is not a government committee; it is not and was not established by government, but established in a bipartisan way on the floor of parliament, so it is a parliamentary committee. It is bipartisan by both the ALP and the CLP because we feel this is probably the most important issue with trying to deal with it beyond party politics. We need to listen and come up with some better solutions than we have at the moment to try to work with the community to come up with some better solutions than we have at the moment because we are all affected by it.

Ms MANU-PRESTON: Sorry, that is what I meant in terms of the bipartisan approach, highlighting that suicide is a major issue, has been, and it is likely to continue if we do not give some focus to what we are doing and how we do it. The other point I would like to raise is the submission outlines clearly some of the areas in which we have been working, and some of the exciting work we feel we have been doing. Clearly, there is much more to be done and we have developed our submission in line with the Life framework which looks at three different levels of intervention: the universal, indicated, and selective. In terms of what we are doing, it is in a context of what is being developed nationally as the evidence base of how to approach suicide prevention. So, we are happy to hear your questions.

Madam CHAIR: Okay, and I hand to Michael and then Peter.

Mr GUNNER: I am interested in talking to you about your responding to suicide section of your submission. We heard evidence in Darwin and spoke to a few people about the importance of postvention and they spoke a lot about the difficulties of postvention: lack of information, that it can be treated as a crime scene initially until they know more about what is happening, that it can take months getting information out of a Coroner's office. It seems here though that you have a very good relationship, that you are finding out immediately about a suicide, and you all have an opportunity to go in early. There also seems to be a certain formality to what you do postvention, whereas much of the evidence we heard in Darwin was almost discouraging of a formal approach postvention. I am really interested to hear more about what you do, how you develop that relationship with the Coroner's office, what happens when you go in, and the conversations you have?

Ms GRANT: The response to suicide; it is interesting because when I took on this role I saw that was part of our service agreement with the NT government that we would respond to suicide, any suicide that occurred, and it took me a while to understand what that actually meant. There was already an arrangement, an existing arrangement, that took place and it was formally …

A witness interjecting.

Ms GRANT: Yes, it was formally strengthened through Sarah O'Regan, who worked as the NT suicide prevention coordinator. We went to the police down here with a new form. It was going to be the same form that is used in Darwin. It is great; we get the information immediately. Sometimes, the police officers change. Bruce Hosking was the Coroner's Constable here since the 1980s. It was fantastic; he was consistent, he had a list of people who he would send that information to. The information goes to me and Claudia, and a couple of reps in the NT government mental health service here in Alice. That is because, if it happens over a weekend or at night when we are not at work, their service has an emergency on-call service in case there is a crisis immediately after a suicide. From research, we know it is important families are given immediate offers of support ...

Mr GUNNER: Strong encouragement.

Ms GRANT: Yes. What we then do is we have a steering committee - I talked about this in the submission as well. It is made up of people who represent 30 different agencies and government departments. Those people are informed about the death. We are confidential about this information; we do not give too much detail in an e-mail.

Then, we invite people to come to a face-to-face meeting where we give more accurate details from the police report. Then, we find out if anyone has any other information. It is a fairly small population in Central Australia so, usually, the key Indigenous organisations - Congress, Tangentyere Council, NPY Women's Council, Waltja and a number of other people who have worked here for a long time, usually are able to – the deaths are usually Aboriginal men - share some other information about who the wife is, the parents, the children and, sometimes there are witnesses to the event. We sometimes get people to call in from the remote community if it has happened in a remote community. From there, we try to identify who is the most appropriate people to offer support. We do not go out - in fact, in my whole seven-and-a-half years, I have probably gone to one town camp. I never usually know the person personally; I do not have the relationship.

Mr GUNNER: How long would it take then, for that to happen - for the service to be offered? Then, how often is the service taken up?

Ms GRANT: Well, it is not just one service …

Mr GUNNER: There is four …

Ms GRANT: What comes out of that is one service - for example, the clinical mental health team will say: 'We were due to go to that community in four weeks; we will go this week. We will make sure our staff get to go out there and check in to identify if anyone else is at risk of suicide and, maybe, to do some medical follow-up and support'.

Ms MANU-PRESTON: The objective is to map who possibly is affected, who is the most appropriate support service, if there is any linkage within our current collaborative services. Then, they follow up with the family. This usually happens in the response within 24 to 48 hours. So, we get the information, then call the meeting and, then, who is the most appropriate to follow up.

Ms GRANT: It might be practical support; it might be providing food and blankets. We work with Salvation Army, or some of the Indigenous organisations often can provide that support. I guess the point is we do not impose anything on anybody. Nobody is going to turn up to sorry camp who are strangers to that family. That is not what this is about. It is really offers of support if it is needed and trying to contain the crisis that can happen after a suicide. Then, there might be long-term follow-up support.

Mr GUNNER: That seemed to be, when we were taking evidence in Darwin, where it was at; that you cannot mandate help, which we all understand we cannot mandate. But, there is that degree of to what extent is the service offered? Is it to provide someone with a card and follow-up later by giving that person a call? What we are hearing today seems to be a much better or formal way of structuring the offer of support or having someone on the ground, so there seems to that shades.

Ms MANU-PRESTON: We are saying we are concerned about that the long-term effectiveness - we deal with the immediate response and then do that mapping which is great. On an annual basis, we do an analysis of how many people have died by suicide and what the response was; which agency went and where we are reasonably confident that there has been a response. Our concern is for the ongoing long-term follow-up required for high risk.

Ms GRANT: And monitoring. It is very difficult for us, especially this year, with one suicide after another. We often get caught up in the next one. We have no capacity to keep going back chasing up agencies to see if they have done what they said they would. We rely on the goodwill of these people to get back to us and let us know.

Ms WALKER: You said completed suicides, is that attempted suicides as well for follow-up?

Ms GRANT: No, it is another story. Did you want to talk about that now or …

Mr GUNNER: I have one further question and then we might go to Lynne and attempted suicides.

Madam CHAIR: Well, Peter, and then Lynne, sorry.

Mr GUNNER: Sorry, I was taking over the Chair's role.

Madam CHAIR: Yes, come on, I have got to keep you on track.

Mr GUNNER: You talk here about the Australian government funded – they need to produce the guidelines. I am trying to get an idea of where this is at in the Territory because you say in your submissions: 'some issues raised in the Territory during consultations for consideration'. The first dot point seems to be happening; that is what we talked about in having a committee that was set up that would help guide that follow-up post-suicide. This seems to be a Central Australian thing that is happening at the moment, not a Territory-wide thing. Are these recommendations made for the Territory that are, at this stage, still recommendations or …

Ms GRANT: Are you talking about the clusters?

Mr GUNNER: Yes.

Ms GRANT: That was an Australian government initiative and Melbourne University won the tender to look at hot spots for suicide - places like The Gap, West Gate Bridge, putting up barriers, that type of thing, but it was also looking at clusters of suicide. They came to the Territory to consult with people in Darwin. They consulted with the Indigenous suicide prevention network in Darwin, our steering committee, and with some other people to find out how this might work, how it could be put into place and would it be relevant to Aboriginal communities. We gave them a crash course in the fact it is probably much more complicated than they realised as far as sure, there are small populations in remote communities, but there is no one authority able to pick up this document and implement it for their community. That was pretty clear.

Mr GUNNER: I was trying to ensure I understand where this is at. It seems to be that …

Ms GRANT: It is in a draft form and about to be finalised.

Mr GUNNER: Is some of that operating here now? For example, the last dot point is about the relationship with the coronial office which you seem to have here but we do not seem to have in Darwin.

Ms GRANT: Yes, that is true.

Mr GUNNER: I thought that was fascinating and answered many questions raised in Darwin, but they seem to be addressed much better here.

Ms MANU-PRESTON: The other benefit of that model is through these meetings the collaboration is one agency may visit the family but there may be other – like the Education department may say the child is at this school and will contact the counsellor. That mapping is done there and then as best possible because sometimes there is no capacity to do that.

Mr GUNNER: Lynne was talking about attempted suicides rather than this, but there were a couple of suicides at Nhulunbuy High School. It seems that this ….

Ms WALKER: Ex-students.

Mr GUNNER: Sorry, ex-students - and this formal approach sounds like it would have been a better way of dealing with that.

Ms GRANT: Yes, that is right. It is like Geelong High School where the four children died and this would be put in place and the principal would oversee ensuring it happens. It is a little trickier for a remote Indigenous community to get it, but we gave them some good advice. It is not to say it will not be useful.

I was also going to say on that response to suicide, employing Aboriginal people to assist with that process is really important. Also, it is not a good strategy to send them out to respond immediately either. They also have a very clear understanding of their role and which language group they fit with. It is not just a matter of having Aboriginal workers on board.

Mr STYLES: Laurencia, does the life promotion program incorporate things like the suicide ASIST program? Anglicare run – I have done it twice and it is great capacity building. How do you see our ability,

generally, as a Northern Territory community to help build capacity in remote communities where many suicide attempts eventuate? We have heard evidence that we have got to go right back to the beginning. So what are your views about how we, as a community, can build capacity?

Ms GRANT: Well, ASIST is a two-day intervention skills training program set up by a Canadian company that came to Australia; it is a great program and what it actually does is teach people that anyone can save lives; you do not have to be a mental health practitioner. Everyone should have some knowledge about this, and everyone should be able to identify warning signs and risk factors for suicide and they can all do something about it, and not to be afraid of actually saying the word.

We do deliver ASIST as part of our program. Suicide Story really developed out of the fact that we did not feel ASIST was appropriate for remote Indigenous communities, and when we invited Aboriginal people to Alice Springs or we took it out to remote communities, ASIST, it just was not working for many reasons. Many people wanted to share stories; English was not their first language, and there were many images that did not fit with the context of where they live, and sitting in a classroom setting for two days straight did not suit many of these people. So we started to do a great deal of thinking about that, and I know in Darwin they have done analysis of this as well.

We tried to work with LivingWorks, the company that developed ASIST, to develop something that was better suited to this context, and when they did not come to the party on that we started to talk to Aboriginal people here, and that is how it has developed over the last six years. So that is building capacity.

In a way it is one tool to help to do that, there are many other things that have to happen, but I guess what we are trying to do is start engaging with Indigenous people, with other Aboriginal people sharing their knowledge and understanding of suicide. Not to be afraid of saying the word; coming up with a word in people's language, using interpreters, using art and visual images are going to work much better with Aboriginal people, and it is really similar to ASIST. It is giving people possibly some new knowledge about what they might look out for in anyone in their families and community that might be at risk of suicide, what they can do about it, and how they might engage with some of these service providers that are coming into the community, as well.

So, I believe we are starting a discussion and, probably because of the work we have been doing, there are more Aboriginal people starting to talk about this issue. We have been to eight, nine communities already, we are about to go up to Darwin next week, and we are going to Maningrida. It is a start and it is not to say that many people in communities come rushing to do this program with us, there is still a great deal of fear and concerns about whether this is a good thing for them. Some people are still afraid of talking about suicide. There are many cultural beliefs and that is what we are learning as we go, we are trying to better understand how this fits within Indigenous culture, what their understanding of it is, and how we can work with that.

Mr STYLES: This is a point I raise with previous people about that culture and the taboo nature of suicide and you actually have to create words in local language to describe what this is and the reluctance to talk about it, and things like that. So, from my perspective, I see we have a huge problem of building capacity out there because it is not something they have had to deal with, or are willing to deal with, but suddenly they have got something that has not happened that often in Aboriginal community or, at least no one has acknowledged it, and suddenly we have this onslaught of suicides in this community.

Ms GRANT: I would not agree with that. These people have been living with suicide since, for some families in Central Australia, certainly since the 1990s; there would not be one family in Central Australia that has not lost someone to suicide. They have been living with it, they have been grappling with it, they have been figuring out ways to watch out for other people - that is what this program is telling us. We have been interviewing Aboriginal people; they do have a level of understanding and they have been trying to figure out where it fits and how they can save lives. So, I do not feel it is just this year that we have had the high rates; we have had high incidence of suicide for a long time.

Mr STYLES: I imagine, then, over about a 25- to 30-year period, then you go back into an Anglo-Saxon, where we have been dealing with this as a community for a long time and we have had mechanisms in place how communities and we actually have had to confront it. Whereas it seems like in the last 20 to 30 years, you have something that has really come on screen, that was not there before, and now we have to look at how we build capacity quickly into the community.

Ms GRANT: I think it goes back to that broader - and in terms of the Life framework - the universal, and what you heard from Congress before us, was the importance of the broader community context - housing,

family programs - that is about wellbeing and health. There is that whole area that this program and mental health has been trying to focus on those strategies that target the issue around suicide and the gate-keeping training is one aspect of that. We learn through our submission that what we would like to see is a few more not to focus just on youth, because from our experience the data shows for Central Australia, it is actually across the lifespan particularly for men - over 25 Indigenous men.

Our concern is that while youth suicide is a tragedy but, for our local situation, there needs to be a focus on those other high-risk groups, which are men; Indigenous males. In terms of doing things with children, yes, but actually it is in the family context, strengthening fathers' roles, families, that is never going to be addressed if we move the focus to children. We see a great opportunity and an important role in the family context and 25-above age group in terms of intervention programs, strengthening that role; that is going to help with youth suicide in the longer-term.

Ms MANU-PRESTON: Our concern is there will be a focus away from that cohort of people and therefore we are always imposing a model that is not about that natural network of family structure. That is really what we want to put to you in terms of programs more broadly, and then to suicide specialist intervention programs.

Ms GRANT: The other thing is that it is not going to happen in a hurry, even though it is decided that this year is the time to focus on suicide, it would be very concerning if suddenly we decided we are going to bring in a lot of big players from around the country to come and help us, just like the federal intervention. These things have been happening for a long time and yes, suicide is a new issue, but so is alcohol, domestic violence, child abuse, many things that have suddenly started to occur in Aboriginal families that were not once there.

Indigenous people have started to work in partnership with non-Indigenous people to find a way through that and if we expect this to happen in a hurry, we are going to be doing terrible programs that are not going to work. That is one thing that many people who have been working in Central Australia for a long time understand - the long-term commitment is going to make a difference, forming good, strong relationships, being persistent, and not expecting a quick solution.

Ms WALKER: Laurencia, I read with interest in your submission the reference to my electorate and the report produced by the former OIC, Tony Fuller, around suicides. There has been another report since then from his successor, but I think what you are saying is: that clear link where you have, between developing and funding evidence-based policy to attract funding to develop programs to deal with the issues, and then by contrast in the next paragraph you talk about efforts to collaborate with the Northern Territory government to get data from Alice Springs and Tennant Creek about suicide attempts. I guess that is a difficult area as well in that grey area between self-harm and attempting. Can you just tell us a little about your experience with trying to gather this data from the Northern Territory government?

Ms GRANT: That report that came out, Tony Fuller's report, I feel it gave a lot of weight to East Arnhem as far as it was a comprehensive report that showed there was high incidence of attempted suicides, suicide threats, and completed suicides. At that time in 2005, I remember asking the question. It was this report that then led to lots of funding going into that region. I still think that possibly may have been the case, but I never really got a clear answer on that…

Ms WALKER: I suspect it is, and I have never actually seen the figure of funding that it attracted.

Ms GRANT: Yes. We could have easily demonstrated, too, if we had a comprehensive collection of data, that we also were experiencing similar incidence of attempted suicides. We tried to figure out a way to, first, define what a serious attempt is. There are many spectrums of suicidal behaviour; there are many suicide threats. If the mental health teams responded to every suicide threat, they would be constantly going out to communities.

We spent many hours with our steering committee in 2005-06 talking about attempted suicides, and came up with definitions we based on other researchers around the country as well. Then, we thought where we could start was those people presenting to the Alice Springs Hospital in the A&E, and that data could be collected and at least we would have – even though we know that not all attempted suicides end up at the hospital. In fact, they say maybe 30% of serious suicide attempts.

We never got very far with it. This could be based on the fact that the mental health team in Alice Springs is very busy and they are caught up with a lot of clinical work. To actually get a commitment from A&E was going to have to happen from the high levels. The manager of mental health left - there was

probably many issues - and we felt we just came up against a brick wall. It was not as if the steering committee we have been involved with for many years still did not want it to stay on the agenda, but we got caught up in doing other work and we let it go. I was pretty interested to see that some data was released recently related to the federal intervention and the monitoring report.

Ms WALKER: Did you approach police with that data, given that they are invariably ...

Ms GRANT: Well, I do not think police actually could collect accurate data. I was just going to say the report that just came out recently related to monitoring of the *Closing the Gap* contained some data that showed the attempted suicide numbers have doubled since 2007. That suddenly led to many people saying it is related to the federal intervention; that these suicide attempt rates have gone up.

I argue that cannot be accurate information. I wonder if it is based on - I tried to find out about this - the calls that go to police that are related to suicide are considered a call-out to a suicide. That could have been in any spectrum of suicide behaviour. So, I am not convinced that is telling us anything really, that is accurate.

I guess we have grappled with where could good accurate data come from. It could be a collaboration of police, health clinics in remote communities, youth workers, or other people who know that someone has actually made a serious attempt on their life. I am amazed we have not really come up with a way of finding out how we can capture some of that information.

Madam CHAIR: That has been a major issue. I know that the Commissioner of Police did say that when we spoke to him last week in relation to the data. The information we got from the police - if you look at those statistics one would say: ‘My God, we have quite a crisis, particularly in attempted suicides in the Northern Territory’. He was urging caution because the data has not been validated – basically, what you are saying. It has highlighted to us that more research does need to happen, or someone needs to do a more in-depth analysis of that data across all of the sector people dealing with it.

Peter, sorry, have you finished?

Mr STYLES: Yes.

Ms WALKER: Michael was asking you about services following a completed suicide and I chipped in to ask does that apply to attempted suicide and you said that is another story. Can you give us a snapshot of that story?

Ms GRANT: It is an area - and I have put it in the submission – where we need to look at the level of support provided immediately after a suicide. Lyn Byers and Elira from the remote mental health team who work here claim they were not representing the Northern Territory government when they put this submission in. However, they highlighted some of the inadequacies of their own service - it is not possible for them, as fly-in fly-out workers, to get to a crisis of suicide immediately. Once a person is flown into Alice Springs they have sobered up or things have changed, the crisis has been alleviated and they are not able to monitor people well after they are discharged from hospital. We encourage people to ensure if they come across someone who has made a serious attempt, they keep them safe for 24-hours, whatever it takes to do that, and if you wait for the police and the mental health team to come, it might be too late.

That is partly what we doing with Suicide Story, letting families take some role in whatever it takes to keep that person safe. Safe houses might be an option to put a person in, but also to then engage the mental health professionals to assist with proper follow-up and assessment, looking at some of the underlying reasons for the suicide attempt, and flag them as people who need to be monitored. Many people die by suicide that have had a previous attempt and are never known to the mental health service. I do not understand how that can happen and how health clinics do not flag that a man was hanging from a tree a year ago and is now alive and still needs to be monitored.

Mr GUNNER: Can I ask a question following up on that? The attempted suicide part of your submission seems to be almost in the too hard basket at the moment - people have made it too complex. You previously commented about A&E specifically to data collection, but one thing we heard from Aboriginal peak organisations when they presented evidence in Darwin is they felt most people in the medical profession would be trained in how to fix a wound but not necessarily with the mental health side effects. Do you think when someone presents at A&E, having attempted and not completed, and are patched up and sent on their way - more needs to be done at that stage - how do we fix it? In your submission you talked about the complexities and difficulties but what is the solution? Should we be

looking at something similar to what you are doing around the completed suicides or is that too simple and you need something more complicated and case managed?

Ms GRANT: There has to be a better system of support sure, and perhaps A&E is not the best place, and hospital is not the best place always to take someone. Unless Aboriginal people are properly well supported with the Aboriginal liaison officers or traditional healers when they are presenting, the hospital may not be the right place.

Mr GUNNER: That is a trigger point?

[Editor's note: Break in audio from 11.54.01 to 11.55.21]

Ms GRANT (cont): …health professionals to come down to A&E to meet with them.

Mr GUNNER: So, there needs to be an improved formal protocol of that point, but then it is more than that, it is also when at the point of return and there has been a more formal approach when that person goes home?

Ms GRANT: That is right. If there is not a bed, if they have decided that they do not need to stay on the ward tonight, well, what happens to them?

Mr GUNNER: And at the moment the formal approach seems to be lacking – for some sort of accident, they get the right attention then and, then, later ...

Ms GRANT: Yes, look, I could not say for sure …

Madam CHAIR: Much of the time they are just pushed out.

Mr GUNNER: Yes.

Ms GRANT: I just believe we need to open up a discussion about it, and I guess that is what we have been trying to do. We have often said: 'Let us just bring it to the table and have an honest discussion about what is working and what is not with a whole lot of players.'

Madam CHAIR: The attempted suicide - we keep talking about completed and the attempted, I believe is a huge question and …

Mr GUNNER: Policy makers have to look at those points of intervention and then what the protocols are around it.

Madam CHAIR: I believe we need to have a closer look at that, and maybe encourage the hospital system to talk to us.

Mr STYLES: The police, obviously, from what you are saying and what other people say, at the first point of call if someone is attempting or has attempted the first thing they do is 000, call the police, call the ambulance if you have to, but if people go to the hospital, that seems to be the logical place because police have other duties and there are pressures on them so they just want to get rid of, in a nice sense, but they need to process that person, get back and deal with backlogs and things that are coming up. So, that is a problem. Do we need to have - there are a couple of questions - we have translators on tap, like in town or …

Madam CHAIR: Interpreters.

Mr STYLES: Sorry, interpreters. We have interpreters. Do we need traditional healers? So if something like this happens, the first thing police say: 'Which area are they from? Can we get someone down to start to help those people?' So that Accident and Emergency do not just sit the person over there and say: 'Well, somebody is dying here. We have got to do this.' because there are competing interests. Do we need something like that?

Ms GRANT: There is a team of Aboriginal mental health workers and liaison officers, but I know that you are going to be speaking to NPY Women's Council who will be in a much better position to talk to you, and the traditional healers about their role in supporting people who are at risk of suicide. I am not really familiar with the process of engaging them in A&E when someone is at risk.

Mr STYLES: All right, so we can flick that to them?

Ms GRANT: I think so.

Ms MANU-PRESTON: In terms of the intervention, when you have a person who is at risk and the correct pathway in our current system is they go through an A&E, the supports which are available are the Aboriginal mental health workers, access to traditional healers. Now, how effective that is in that context we cannot say that it is not, but we do advocate those are the types of strategies that should be in place, that people are being assessed on what the level of risk is in their language and in their context. That way they can determine, the clinician or who is making the assessment, most likely a clinician, can get a thorough picture and a good outcome of what is actually going on for that person.

Ms GRANT: Also, I believe that people need to be able to …

Madam CHAIR: Thirty seconds, and not a long preamble, please, Pete and Michael.

Ms GRANT: … going into hospital is not always the best solution and workers need to go and do outreach work. So, if someone is suicidal in a town camp or in a remote community, these clinicians need to go to the place where they are.

Mr STYLES: So that is something that needs to be looked at. You were curious about the police numbers for 2007; I believe back then there was a shift in the actual response so that the Coroner actually had some words to say. Do you think the moment anyone even looks like they are suicidal it is put down to suicide and the police go to it, do you think that there is a covering to ensure all the bases are covered there?

Ms GRANT: Well, I would say some of that data might be someone calling up and saying: 'My brother is talking about killing himself.' So the police get called out. When they get there he might have been threatening suicide; I mean obviously he was, but it may not be classified as a serious enough suicide attempt for a clinical service to be called in.

Mr STYLES: But it goes on the stats, from the police stats.

Ms GRANT: For the police, but it probably does not end up as anything.

Madam CHAIR: Well, it has to. I believe it has to.

Ms MANU-PRESTON: Marion, can I just say one thing about the attempted suicide data because, as we have put in the submission, it is an area in which the research - and you saw in Menzies submission about the relationship of people that have been affected by suicide previously, the attempts, there seems to be a correlation with that, and that is the only way we feel there could be an adequate strategy put in place to support and identify these people that are high-risk, that have already been affected. We are not able to do that without quality information.

Ms GRANT: The only accurate data we have to go by is those who die by suicide, so we see this high-risk group that are Aboriginal males, but if we actually got data showing us who are the people who are attempting suicide, where do they come from, what age group are they, are they mostly women; we do not even know that. We are focusing much of our attention on those who have died and what we know from that.

Madam CHAIR: I could not agree more. That has been a major issue and one where we have certainly been saying that if we look at the cohort, or the number of people who have attempted, nobody has looked at - or who has followed them - from that point to have they completed suicide. It certainly is an issue and one we have picked up as a committee.

Can I thank you for the video. Valda Shannon yesterday talked about that so look forward to looking at this DVD and this book. I look forward to seeing you at Maningrida because that is in a community in my electorate which has had some horrific suicides in recent times. I am also a Tiwi person and, on the Tiwi Islands, it has been a major issue for a long time amongst my people. But they have been able to deal with it, so thank you both for appearing. This is short and the committee will need to look at coming and re-engaging again with people like you who do tremendous work and in these circumstances, so thank you, both for your submission and coming today.

NGAANYATJARRA PITJANTJATJARA YANKUNYTJATJARA (NPY) WOMEN'S COUNCIL

Madam CHAIR: On behalf of the select committee I welcome you all to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome to the table to give evidence to the committee representatives of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council, and we have Ms Angela Lynch, Mr Rupert Peter, Mr Toby Ginger, Ms Linda Rive and Ms Andrea Mason.

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 today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private.

I will ask 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 question. Can you please state your name and the capacity in which you are appearing.

Ms LYNCH: I am Angela Lynch. I am the manager of the Ngangkari project for the (NPY) Women's Council.

Mr GINGER: Toby Ginger. (Speaking in Pitjantjatjara).

Ms RIVE: I am Linda Rive the interpreter, and Toby just said he is a Pitjantjatjara man and works as a traditional healer with a group in the bush looking after our people.

Ms MASON: Linda Rive will be working this afternoon as an interpreter. There might be a bit of noise as we are talking as Linda also provides those comments back to Rupert and Toby. My name is Andrea Mason, coordinator of NPY Women's Council. I would like to provide some opening statements if I may. Yesterday we lost, through suicide, a staff member who had finished working at the Women's Council last month. This week on the lands we had a funeral for a family member who died as a result of suicide. Family here today are still in that state of grieving and are anxious about family and how family are.

I wanted to make those comments at the beginning and we talked generally about the way that word is used and bandied around in the community; it was both necessary and also very personal. At the moment it is very personal for staff as well as the people here today. So I just wanted to make those opening statements.

I will provide a very short background on the work of the Nunkeri project as well as the PSWB project we run with Women's Council, an emotional and social well-being project, and some contextual information. I really felt, in terms of the evidence to be provided to the committee, it would be done through the advice and context being provided through the Nunkeri and their work, and also the project. I will talk briefly and then they will talk about their work, and then we will perhaps open for questions.

Madam CHAIR: Could I just ask a quick question? When you say Ngangkari, Andrea, that is healer?

Ms MASON: Traditional healer, yes.

We have also provided to the committee a copy of the document which provides background information on the programs, on NPY Women's Council, where we work, and also recommendations and our understanding and the challenges around this issue of suicide, particularly in relation to young people. Women's Council has been working in the NPY region since 1980, and there are approximately 25 communities across the lands. The programs we deliver fall under nutrition, domestic violence, aged and disability care, care respite, youth services, and we also have the social enterprise Jumpy Desert Weavers and, also within those services we have these two projects: the emotional social wellbeing project, and also the Ngangkari project.

The PSWB project was established back in 1997 because the women of the region could see there were not adequate services to respond to mental health issues at that time, and then in 1999 the women felt that while the PSWB project was providing some good support into the lands and the people living in

communities, there was a gap around traditional healing practices being available to people living in communities, and so the Ngangkari project was formed in 1999.

We are very pleased at the Women's Council to have Angela managing that project. Angela also was one of the first workers to be employed at the Women's Council and has a long history of working Malparara, way that is working together with Ngaanyatjarra, Pitjantjatjara, and Yankunytjatjara people and non-Aboriginal people side-by-side, and it is very necessary, particularly for the Ngangkari project, that support is provided as well.

I also wanted to mention Linda and her work in translating today, and we would all know that the description and the way concepts are explained and delivered, sometimes English is not adequate, but I am really pleased that Linda has that ability and skill to be able to take the time to precisely and carefully do that translating work, because it is important for what we hear today.

Overall context: suicide is different in remote communities. We know there are underlying high levels of unresolved grief and trauma and, in saying that, talking about high levels of disease, accidents, death, incarceration, high levels of violence in our region, women are 60 times more likely to die as a result of domestic violence than elsewhere outside of the region. Small instances can trigger suicide; suicide has been normalised; threats are commonplace and, in terms of a picture, on Anangu and people living in those communities, there is a critical mass of weight bearing down on those communities and, it has been mentioned earlier, there is also a lack across the communities of consistency and uniformity of those fundamental building blocks being in place, so we are talking about housing, about policing, about health services, mental health services; it is patchy, it is not consistent across every community, and therefore it is important in thinking about how services can be provided that it needs to be considered whole-of-lands, rather than case-by-case.

Triggers are likely to include jealousy, domestic violence, loss of face, shame, cannabis is a huge issue, young people feeling they do not have a voice and listened to, and money issues. There are challenges with service providers in community in responding to suicide. When Women's Council was established in 1980, there was only one police officer permanently based in the region in 1980, and now we have police stations across the region; not in every community, but in major communities and critical points, and they are providing a valuable service. They are also helping to stem the flow of cannabis into communities and searching for people who run off into the bush threatening suicide.

Clinics also provide a valuable service. Some of the challenges for clinics in relation to youth suicide and suicide attempts are that they are not always able to take the time to do in-depth casework. Primary health care is the priority over community education and often clinics do not have mental health specialists available; often it is a visiting service.

In our region, 44% of people in the Lands are aged between 10 and 24. Our youth program works with young people across the four southern NT communities but also we have youth workers resident in Western Australia in two communities, and we have a visiting youth workers travelling down to South Australian Lands where they provide casework, recreation and diversionary programs, they encourage leadership and development, advocate for young people, and also are there to collaborate with other service providers.

It is the hard side of working with young people that our youth workers take on, but it is also recognising that there are also the more healthy, I guess, the more positive work that youth work is also encouraging. We also have a young women's conference every year to encourage young women to look positively at options, so it is the hard end, but it also is encouraging and looking for capacity building.

That is the overall context that I would like to put to the committee. We have some recommendations and those recommendations are listed in the document we provided, but I would like to now hand over to Rupert and to Toby to talk about the context of suicide. It is important for them to have more time for more questions as well and we will take on notice that question about the emergency department and also the support of Ngangkari when people do come in and the Ngangkari team do work with the staff at the hospital and they can talk about how that relationship is going, as well as the broader relationships across the region.

Madam CHAIR: Andrea, can I get that microphone moved over closer for recording purposes, that is all.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): The work we do takes us great distances, we travel across the country, and we see people in many communities across the area.

Mr RUPERT: (Speaking in Language).

Ms RIVE (Interpreter): Our work is very similar to the work a doctor will do, in that we go and see people who need us, who need help, who are sick. We offer them assistance and give them healing treatments in our own way, and then we will move on to another community. We will go around and people will be expecting us, or we will get called and will see people and give them treatments in a traditional way, Ngangkari way.

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): Our work is as a traditional healer, but we work in a different way. We work in a Ngangkari way, and that is what we are - we are Ngangkari. The word to describe our work and the work we do is the same word, Ngangkari, which is a healer. In English, the word is 'doctor' and doctor's doctor. But, we are Ngangkari and the healing treatments we do are called Ngangkari treatments.

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): Doctors in society have a lot of standing and the same in our society. Ngangkari have a lot of standing because we look after everybody, and everybody's health is in our hands. It was, once upon a time, 100% in our hands, and we were responsible for everybody's health once upon a time, and seen as some of the most important men in society, simply because of what we could do: look after people, heal people, give counselling and do really, really important work.

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): Before white people or trousers and shirts we lived a traditional way of life. There were no buildings and there were no white people and there were no doctors, just Ngangkari. We were the healers and we lived in dwellings - traditional dwellings like little shade shelters …

Madam CHAIR: Humpies.

Ms RIVE (Interpreter): You call them humpies, we call them wiltja. A sick person will be lying in there and a family member would call us. So, consequently, we were always on call and we would go to that dwelling and see that person.

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): Of course, that was in the past and everything is completely different today. Today we have buildings with walls and people in the buildings. We have clinics, hospitals, a lot of white people everywhere, different sort of work, doctors. But, we are still here and we are still doing our work and we still give healing treatments. But, we also have doctors as well.

Mr GINGER: (Speaking in Language).

Ms RIVE (interpreter): Despite any service that is available, Ngangkari are still very much on call, are still very much needed and required and very active still today. That is us, that is the work we do, as you can see we have the word on us, Ngangkari, and our work is still very much in demand and we are very busy all the time.

Mr GINGER: (Speaking in language).

Ms RIVE (interpreter): What singles us out and makes us so different are the magical invisible tools we have inside our bodies called mapanpa. In fact, you could call us mapantjara, the people who have mapanpa, and that is what we have to have to become a Ngangkari. Mapanpa is what makes a Ngangkari a Ngangkari.

Mr GINGER: (Speaking in language).

Ms RIVE (interpreter): Those mapanpa are very old, very ancient because our fathers have those same mapanpa and before them their fathers, our grandfathers, had those mapanpa and they got them

from Ngangkari in the past. So that same mapanpa is handed down; it is a continuum that does not break that is handed down to us and now we have got our mapanpa because we are Ngangkari. Those are really ancient tools and ancient skills that we have inherited and so we are still holding on to a very ancient tradition.

Mr GINGER: (Speaking in language).

Ms RIVE (interpreter): Another reference to the way we lived in the deep past was we were a very cohesive society and the way was always clear. The way things were done was always clear and we are talking about before anybody had any conception at all about white people. Our society was a really clear society with really, really strong Ngangkari but also a strong community.

Mr GINGER: (Speaking in language).

Ms RIVE (interpreter): That deep past was as old as it could possibly be, older than we can imagine going right back into time and we come from that. We come from that very old society, but then as time passed and time passed and time passed, life became what it is today and we were born into that. So, we have a slightly different perspective and here we are today born into this new way.

Mr GINGER: (Speaking in language).

Ms RIVE (Interpreter): When we were about this tall we began our training as Ngangkari and our old men trained us up and trained us up and trained us up. As we got taller and taller those old men got shorter and shorter until they sat down. Just before they died they bestowed upon us their mapanpa and then they laid down and died and passed away and became part of the past, and we became part of the present and part of the future. Here we are today and the life we lead today is more different than anything our grandfathers could have imagined, or the people in the past could have imagined. Because now we are working still as a Ngangkari, still holding that traditional power, but we are working in a completely different way - a novel way which requires us to now be part of a hospital system and understand and know all about modern medication, needles, injections, hospitals, and doctors. We are part of that system a little now, but still holding on to the old way. So we have a lot going on.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): Even though for us because we have inherited this way, the way was always clear, but in our lifetimes something else has come into our life that was unimaginable, and it is problems - big serious problems. A lot of problems have all surfaced in our own lifetime that we have never known about before. Today, we are seeing all around us these problems that sometimes confound us which is marijuana, drug abuse, and also hanging, self-hanging - people dying by rope, breaking their own necks, killing themselves - something we had never seen before. So, the way is not so clear anymore.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): Of course, not everything was perfect and people did have problems, and we know about that. But, we were always able to fix them because of our ability to see what was going on in people's heads and also to understand flow - flow obviously stemming from the brain is a big one and all those big veins and muscles and tendons, and so on that connect big parts of the body. We have always been able to see and understand and work on those strings, particularly if you have blockages, we are able to unblock, get people flowing and working better, and giving people an all-round general feeling of wellbeing, as well as counselling - cultural counselling.

But, when you have these brand new things that we have never really understood and are faced with now, which are problems generated by many other factors but also drug abuse like cannabis, alcohol, and other drugs affect people and affect the flow of people in a way that we have never ever been able to fix – we cannot fix it. Our ancient, traditional skills cannot allow us, or we cannot fix those things. We cannot stop them, we cannot heal them.

Part of my work is obviously to recommend that people see a doctor and we appreciate how well medication works and we encourage people to get on to correct medication, because that helps us, but the problems that happen for people, there are many problems that we cannot solve.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): You see us two sitting here, but we are not the only Ngangkari. Obviously there are many, many, many Ngangkari, but we just happen to be sitting here in this seat today because we are employed by the NPY Women's Council and we are the Women's Council's Ngangkari; a part of the Women's Council's program. We are representing all of our kinfolk who are traditional healers also and we are all in the same boat where we cannot assist problems to do with drugs and alcohol.

Madam CHAIR: Thank you, Andrea; Toby, you wanted to say something else?

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): The work we do, we are really skilled. We can do many things, but when you have drugs mixed up in the blood that goes into the brain, it does stuff, and we just cannot – we cannot help people basically. We cannot split their head open and look in. We can see, but it is not that we can assist people who are intoxicated with a substance; we have nothing in our background that we can understand.

Mr GINGER: (Speaking in Language).

Ms RIVE (Interpreter): If a brain is intoxicated or damaged through drugs and alcohol, we cannot help it, but whole body work we can do and anyone that is upset or in trouble, we can counsel and help, and we can soothe and heal, make people feel better. We can work on all the body. We can do all that.

Mr GINGER: (Speaking in Language).

Ms RIVE (interpreter): People get acquired brain injury too. We cannot reverse that, but our skills are very great, all the same. We can work on white people too because a body is a body.

Mr GINGER: (Speaking in Language).

Ms RIVE (interpreter): If someone was in the process of dying we could recognise that, so we would have to let them go, because if someone is dying, we know it and we will let them go, and they will die and we bury them. But, today, people are not allowed to just die and be buried; they have to have post mortems and they are chopped up and looked at and, then, a piece of paper is written, and it is written down as to the cause of death. Traditionally, we always knew, today we do not always know.

Mr PETER: (Speaking in Language).

Ms RIVE (interpreter): Rupert is saying do you have any questions you would like to ask?

Madam CHAIR: We certainly have a number of questions. Rupert and Toby. I thank the NPY for giving us this opportunity, because the issue of Ngangkar or traditional healers has come up in some of the discussions we have had both in the Top End and here. It was interesting listening to your knowledge. It is out of our knowledge base; you are the wise men and you know this stuff.

As members, we are interested in asking some questions. You have answered some of it; that when someone is sick from grog or from drugs, what role is there. That certainly has made it clearer for me, and I know for Peter and the other members. My electorate people - Aboriginal people I represent - often talk about their doctors and their wise men to help do some of this stuff. In Lynne's electorate, which is in eastern Arnhem land, they also talk about their doctors - not white doctors, our Anangu doctors. It does not matter whether you are in the Centre or in the Top End, you are held in very high esteem and are very important people. I will go to Peter who has a number of questions. Do you want to translate for us back to them, as we are going along?

Ms RIVE: Yes, a little. But, you are speaking pretty clearly and (speaking in language) they understand that level of language. If you could keep the language as simple as possible - simple and slow, good English.

Madam CHAIR: If we keep it like that then we can have that communication. Tell us if we are talking too high and you are not understanding. Linda, you can tell us and we will break that down because we want to get your knowledge, information, and comments on some of our questions.

Ms RIVE: Yes. The way we work is that I know what Rupert and Toby are understanding - and they understand a lot. But, I know when they are not and I will just whisper then. Okay? That is how I do it.

Madam CHAIR: Okay. Peter.

Mr STYLES: Are Ngangkari always men? Do you have women Ngangkari?

Mr PETER: (Speaking in Pitjantjatjara). Men and women.

Mr STYLES: When you pass down the knowledge and the skills, does it have to go through a family or can it go out to nieces and nephews?

Mr PETER: (Speaking in language).

Ms RIVE (Interpreter): Yes, in-laws, uncles, fathers and mothers - could be anybody.

Mr STYLES: Is it possible, if sufficient resources were put in, to expand the network - so get more people, more Ngangkari?

Mr PETER: (Speaking in language).

Ms RIVE (Interpreter): There is a huge number of Ngangkari many Ngangkari in the communities. Some Ngangkari are flat out busy all time but they work privately - they are not recognised or paid. Some Ngangkari are not working at all; they are just sitting down. We Ngangkari are really public Ngangkari on a salary and being funded, and write reports. There are different kinds of Ngangkari. Also, we have many trainees or apprentices.

Ms LYNCH: I also want to clarify where the support comes from. With Toby and Rupert, that funding comes from country health SA - their salary - but they travel across the region, not just in the South Australian lands. Funding for the women to come on board, which has only happened recently – we started talking about that late last year - that has come from Aboriginal and Torres Strait Islander Healing Foundation based in Canberra. We are only funded for 18 months.

Mr STYLES: How do we build a network? What I am hearing is Ngangkari are very important; they see so many things and it is very tragic for them to see the drugs and alcohol. How do we build in the communities a network where everyone feels very comfortable about passing information on as to who is creating the problem? I know from a police perspective, it is so difficult to get information as to who is bringing the stuff in and who is dealing in it. Unfortunately, my information is many Aboriginal people have been great entrepreneurs in dealing with marijuana and alcohol - more so marijuana.

What are their views on how to create a network where it is the right thing to do and it is accepted within the culture to dob in the drug dealers? That causes so many of the problems -If you can get rid of that.

Ms MASON: I will let the men speak in a moment; however, I will say the Women's Council had a long campaign of dob in the dealer - we promote that. That is why the Women's Council has been advocating for many years for permanent police in the Lands. While that coverage is not in every community, there needs to be a hub of services to do that. We promote and encourage members to report what they see to police. It often comes down to the response time, and also the movement and mobility of people as well.

Women's Council was instrumental in lobbying for the possibility of legislation to do with policing, to do with the reports. So, it is getting that message out but also seeing the results. The results, obviously, give people the courage to keep reporting. We have seen some good results over time but we need to continue doing that.

Mr STYLES: Thanks for that.

Mr GINGER: (Speaking in language).

Ms RIVE (Interpreter): Toby was saying those dealers do a really good job because we do not see them and we just do not know who they are. It comes in and comes in and comes in. We do not know who is doing it. Yes, we have asked for more police, we have more police, and they are doing a good job. We are glad they are there.

Ms MASON: With cannabis it is the issue of supply. When petrol sniffing was rife across Central Australia, Women's Council with CAYLUS and the group property trust advocated for the reduction and manufacture of OPAL fuel. The decrease in numbers of petrol sniffing from 2005 has been attributed to the

introduction of non-sniffable fuel. Cannabis is an issue of supply, but is also an issue relating to the way families care for each other, the challenge of families to dob in a dealer who is a family member, and to publicly say no.

Sometimes the impetus comes when there has been a death in the community or a serious event, which gives people courage to make a stand. I related that to domestic violence where there has been a homicide in the community. There has been a real push to try to improve the safety of women in communities. Yes, we continue to advocate and encourage people to do that - to dob in a dealer and provide the information either to the Anangu or the local police.

Madam CHAIR: Michael?

Mr GUNNER: You talked at the start about travelling very long distances. I was wondering how that worked? Is it like doing rounds? Do you respond reactively? How does that works? How do you know where to go and when?

Ms LYNCH: Are we are talking about management of centres where people go? We get many requests from family members in communities. These guys are based in Imanpa community, but we get many requests from the hospital or mental health team here. We get referrals through that so we are in constant contact and pass it on. It mainly comes from many people ringing up the community where they are and them responding to requests.

Ms MASON: One of the recommendations we are putting to the committee today is there needs to be almost three or four things working together to address mental health issues in the communities. You have a Ngangkari worker, you have a social worker and a project worker. There is the clinical work, but there are also a range of communities which have, at different times, stepped forward to provide help to communities at a community level and those are better resourced. Then we have communities where there is no amount of clinical support. Access to Ngangkari, even emotional and social wellbeing support comes down to those helpers in communities and often there is only one.

So, having those four components, working together is always the ideal. This year we, for the first time, have not been able to secure funding for our emotional social wellbeing project. Since 1970, that service has been provided in the NPY lands - that project. For the last two years we have had to really fight to actually get for that funding. This financial year we have not been given funding for that project.

Madam CHAIR: You have not been or …

Ms MASON: No, and we are still trying to lobby for a positive response to that funding. As a result, we have implemented, in Women's Council, a suicide register and an attempts register, so we can monitor and track that. Also, within our own capacity of advocacy, we provide support to communities where those incidents are occurring in the Northern Territory, South Australia and Western Australia. However, without that additional funding through the ESWB project, it makes things more difficult.

Madam CHAIR: You just said you got no funding for your emotional and social wellbeing project …

Ms MASON: That is right.

Madam CHAIR: …through ATSI. So that was specifically federal funding, which would go over those three areas. Do you have specific funding from each of the NT, South Australia, and Western Australia state governments? What is your component funding?

Ms MASON: No. There is a limited amount of funding for mental health services generally - through the GP networks, a limited amount of funding. So, with support for mental health it is looking at what is done in each jurisdiction. If there is a limited amount of funding there, going to the Commonwealth to see what is there. It is trying to plug in where we can. It is not looking at the ideal models and saying, 'This is what we need to fund in our field model', and then deliver that. It is individual organisations searching and trying to find that money.

For example, with the Aboriginal and Torres Strait Islander Healing Foundation which was established following those recommendations of the *Bringing Them Home* report, that is now been more of a recent opportunity for us to employ women Ngangkari which is fantastic. But, as Angela said, only for 18 months. As we know, with a lot of government funding and with us as NGOs, funding is not long term and it is

addressing, sometimes, medium- and short-term crisis and deep concerns. But, the long-term plan is what we need.

Ms WALKER: Thank you very much for coming to talk with us today. I especially want to thank Rupert and Toby for telling us the Ngangkari story. It is a very powerful story and it is really important for us to understand what traditional owners, Indigenous people, are thinking and how to deal with this. I want to apologise that we do not have more time; these meetings are so busy. I am sorry we are not on your country listening to this story. We try to when we can to get out on country but it is just not always possible. I am very interested – as Ngangkari you have a healing role, but does it also include a teaching role about helping, particularly young ones, how to live their life in a strong way, cultural way? Are Ngangkari working in schools to contact children, to tell that Strong Story about their people?

Mr GINGER: (Speaking in Language).

Ms RIVE (interpreter): Toby is saying particularly in our role of raising up our trainees and apprentices, Ngangkari. But yes, we do have a role as senior men. Yes, we do concentrate a lot on our young children, teach them as much as we possibly can - particularly bush ways and bush skills, traditional culture, law and culture, and songs and dances out bush - that is, obviously, a senior man’s role that we do, yes, definitely.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): Again, just making that point, there is a lot in our lives and in our work that is manageable and clear, and work where we are effective, and life is good and we are working well. But, there are some areas that are out of our control, and that are out of control, which is the three main drugs - marijuana, alcohol and petrol. That is out of our control. But everything else is manageable.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): Of course, that comes from out of our culture as well; it is not part of our culture. It is brought in by white people and impinges upon our control and our way through.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): White people's problems have affected us badly.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): So, the whole petrol sniffing problems have really gone down; it is really under control now. But, the marijuana problems are actually what seemed to be not such a big problem before, we have realised over the years is actually a really big problem.

And when drinking happens outside the communities - petrol is nearly finished but marijuana is very pervasive through ...

[Editor’s note: Break in sound from 13.07.24 to 13.07.55].

Mr PETER: (Speaking in Language).

Madam CHAIR: They have come in. I am afraid, Peter, I am not going to give you any questions because I have to wind this up. I am sorry.

Mr PETER: (Speaking in Language).

Madam CHAIR: I have to say thank you to both of you. Like Lynne, it is unfortunate we do not have a longer session to talk to you. It is a big problem. Even in the Top End, a lot of our old people, the issue of marijuana in our communities is a major issue, and we still need to look at that. I thank you and, hopefully, we get another opportunity to come back and talk to you, and with some women as well.

Mr PETER: (Speaking in Language).

Ms RIVE (Interpreter): We have our own bush plants – harmless bush plants.

Madam CHAIR: I know. We have harmless bush plants up that way, too.

Mr PETER: But this one here, I do not know.

Madam CHAIR: No, this other new one is no good for the brain. Thank you. Thank you, Andrea.

The committee suspended.

The committee recommenced.

HIDDEN VALLEY COMMUNITY CENTRE and TANGENTYERE COUNCIL

Madam CHAIR: I am sure you were here when I went through this official statement, but I welcome Cait Ryan, Leonie Sheedy and Ms Barbara Shaw from the Hidden Valley Community Centre and Tangentyere Council. Thank you very much. We will go straight into it, if you could just introduce yourselves for the purposes of our recording.

Ms SHEEDY: Thank you for inviting us today. My name is Leonie Sheedy. I am the coordinator of the Yarrenyty Arltere Learning Centre which sits in the Larapinta Valley Town Camp. I have been there for 11 years and the centre has been operating for 11½ years.

Ms RYAN: Hi, thanks for having us today. My name is Cait Ryan and I am the coordinator at the Hidden Valley Community Centre for Tangentyere Council, and I have been there now for just over six-and-a-half years.

Ms SHAW: Barbara Shaw, I am an Mt Nancy Town Camp resident as well as a community advocate. I am here on request, I guess, to share personal stories, as well as a town camper and a support for our organisation.

Madam CHAIR: Fantastic. Would any of you like to make an opening statement?

Ms RYAN: No.

Madam CHAIR: Okay, if you do not want to make an opening statement …

Ms RYAN: What we thought we might do today is just talk a little. We can only talk on behalf of our centres and what happens on our town camp. So, I will talk about what we do, and Leonie will talk about what she does and Barbara will talk ...

Madam CHAIR: That will be good if you can just do it quickly, because members of the committee will have questions.

Ms RYAN: Sure, absolutely.

Madam CHAIR: Thank you.

Ms RYAN: No problem. As I said, thank you for having me. I have been out at Hidden Valley now for six-and-a-half years which is, basically, as long as the centre has been running there. We run, I guess what you could call a multipurpose family resource centre. We work with all the families that live in the town camp of Hidden Valley, and we run programs and deliver services for those families.

I am just going to talk a little about the experience we have in our town camp and, then, you are welcome to ask questions afterwards as well.

We have many reasons that suicide occurs. Suicide occurs as a threat in our town camp, and suicide attempts also occur with young people and also older people as well. Today, I will try to focus on young people because I know that is your inquiry.

We know the reasons for this - and you have heard a lot of them today and they are really similar for us: alcohol and other drugs; marijuana is a huge leading cause for a lot of young people; housing issues; overcrowding; some of the conflict resolution; there is sometimes a bit of an issue around having the right

services to engage with families to solve conflicts before they become really problematic for families and young people think suicide is the only response they have left.

It is sometimes used as a threat as a response to family crisis. It can be as simple as someone saying: 'I really what you to turn down that music' and the response is: 'I am going to hang myself'. That sometimes is used as a threat, sometimes it is used as a serious attempt as well. Grief and trauma - we know many of our families, where there are mental health issues in the family, have a really good understanding of mental health issues. However, where there are new or underlying mental health issues families are not necessarily always aware of what is leading, what is triggering and what is causing - sometimes it means we are really late to find out about young people who are at risk.

When a crisis occurs, when an attempt is occurring within the town camp, we have a pretty prompt response. Obviously, we will call police straightaway. We will also call night patrol to respond because often the night patrollers will have a family relationship with that young person or they can bring someone in really quickly to assist us.

We will also call the CAT team. One of our difficulties is if it is not an immediate happening but is someone threatening and we believe it, we need to get that young person to a service rather than a service being able to meet with that young person and their family to discuss it on the ground with them.

We need to get young people to a hospital for a mental health assessment and to meet with the CAT team. After the crisis has occurred the long-term work needs to occur. We will often work with other case workers from other organisations who have a mental health understanding. Sometimes that service is not always available and sometimes we find young people fall through the gap so we do not know there has been an attempt, we do not know this young person is feeling this way, neither service provider has picked it up so we do know there are young people falling through those gaps.

We have our own qualified case workers but we find it would be really useful to have outside qualified case workers with experience with mental health issues who can really help young people, or those skills that are needed for young people that are attempting or considering suicide.

We do other family support and debriefing so we know how to respond to a young person. Sometimes, at the end of the day, we say: 'Gosh, that grandmother was there and we did not even offer her a cup of tea, we did not sit down'. We try to do that and spend the time with all the family talking about what has happened, what support they can give, and what the follow-up needs to be.

One of the concerns we wanted to raise was if a young person is attempting suicide, or considering it seriously, what is the response for them. We know we can get them to hospital. If they go to hospital and have a mental health assessment, my understanding is options for them are to stay on the medical ward with a security guard or go to Darwin to be appropriately supervised. I do not know many young people who would pick either of those options, and I am sure most would choose to go home where they are possibly not being watched and at risk as well.

It is very real and lived. For us it does happen but we, as a community centre, have a really preventative approach. Once it is really in the moment and is really happening, we need the support of other services to help us with that young person and their family.

Madam CHAIR: Does that happen?

Ms RYAN: Yes, it can be really hard. Sometimes I can ring other service providers and tell them what I need and perhaps that service provider is not able to provide that kind of support at that time.

Madam CHAIR: What happens with that young person then?

Ms RYAN: We can work closely with the family and identify the risk. If they are really at risk and we believe if we leave here today tomorrow they will be finished, we would get them to the hospital absolutely. However, generally speaking, families are really good at stepping in and saying: 'No, we will not leave them alone; we will stay with them and watch them the whole time'.

Madam CHAIR: Do you mind if we ask some questions on your – Leonie, go on.

Ms SHEEDY: I was thinking of a case too. My focus today is to take it back to the long-term approach that Tangentyere is very committed to supporting through our community centres. That really is about real and proper engagement and is what we still see; while the services in health have expanded in Alice

Springs - and having been there for 11 years I have seen a huge expansion - we are still struggling with engagement - real engagement - with families and communities on the ground. If we really want to make a long-term change, then that is what services have to do first of all.

Whilst we have therapeutic models that have been developed and talked about and discussed, unless they first of all invest in engagement - and that is a long-term relationship of listening to people and listening to what they are saying of their strengths, resilience, and their own situations – then, in my experience in the last 10 to 11 years has been there is no stick, and there is a mismatch of service and community and family needs.

When you were talking about how we respond and what happened last year; we had a situation where we had a series of copy cat suicide attempts within a family. That is what we do very well on the ground: we are there, we are with families. Where programs which employ local people in community, as well as non-Indigenous people - we work together with people on the gaps in service delivery in bringing in other services to work with family. When this happened and there was a critical need to respond to it, we called MHACA and all the different agencies, and sat down together to have a long-term response.

It was amazing how difficult it was for the services to be able to engage with the young families, the young people in the families themselves, because they had no relationships. While they were fantastic people, really well-meaning, we would bring them out and sit down, but young people did not want to engage with professionals who had no idea about who they were, and vice versa. It was really only a MHACA service with the suicide prevention story that Laurencia has developed that had some input into the whole of the family and community that we were able to work with, with the family. That was really bringing in a cultural person who had an authority with that young group of people, and had materials that had been developed in a way that had cultural input. That provided ability to identify issues for people to begin a working relationship to see what therapy is, what this therapeutic approach is.

We failed to find it in Alice Springs in a way that really could start working. I cannot stress enough how important I think engagement is.

Ms RYAN: One of the things we have noticed is part of that is any supported accommodation for young people who are in that age group from 13 up to, maybe it is 25, but definitely up to 18 - options for them if they are threatening suicide and they are not going to be safe at home, where there is no …

Madam CHAIR: Nowhere to take them.

Ms RYAN: … nowhere to take where they are going to be comfortable - they are not going to go to hospital.

The other thing is localised programs within a community. If people are delivering on community, they have a lot more support around them and families are much more likely to engage, and young people are more likely to get better outcomes. We know. Real engagement, as Leonie has talked about, we believe is really important. We believe the clinical need is very high. We agree that is totally needed, but not in isolation, it needs a holistic approach.

One of the bonuses about community centres is they can be really preventative so, yes, we can deal with the crisis when it occurs, to a degree, but in a preventative way. We hear about things before things happen, so we get the chance to step in and say: 'I hear you are having a hard time. Would you like to come …' It allows us that opportunity to do that with that engagement we have with families. Thank you.

Madam CHAIR: Thank you. Barb, did you want to …

Ms SHAW: My first job was working for Tangentyere CDEP under the youth program in the early 1990s. We worked with children from all our town camps, as well as visiting children from the bush. In the early 1990s there was a lot of youth suicide in our town camps. What we did was get the community involved and the families. That helped a lot, I guess, as the years went on. But, then came 2007 when the Northern Territory emergency was announced - I started travelling to communities and doing research on the intervention - many of the people were worried about youth suicide. So, I am here to share stories, I guess, and learn - talk about my experience.

There has been many attempted suicides, as well as threats. When it comes to threats, we need to take it serious. I know the police response was very bad in the early years of the intervention and, now that it is actually starting to pick up. When it comes to a domestic violence, it still takes a lot longer for police to

respond but, when it comes to threats of suicide and self-harm, the police are there straightaway. My experience was I rang the ambulance for one of my sisters-in-law - and when I talk about my family it is not just my immediate family, it is my extended, extended, extended family, like we all are.

One of my sisters-in-law started self-harm, so I rang up the ambulance to come and assist her in stopping the blood and everything like that. Three police cars turned up and I questioned: ‘What are you doing here? A person does not need to be locked up; she needs to be mended or healed in some way, taken to the hospital’. It was like: ‘Because she used a weapon to self-harm herself. We are here to control the violence, the situation that she was in’. By the time the police had got there, I had already settled her down, but she only just needed help with stopping the bleeding and whatnot.

But also our youth – I have baby cousins, brothers, and sisters out in the bush - when they come to town there is really no services for them here in Alice, Tennant Creek. When they do come into town, there is nothing for them, and then when the parents try to come in and get them or other guardians it is like - this youth mentality that they have now is: ‘You cannot help me and I do not want to go back out there, nothing out there. You cannot tell me what to do anymore’. So, then they start talking of threats. So, being a big cousin, what I did was slap one of my cousins over the earhole and he snapped out of it. Then, his nanna and grandpa come and got him, so he is right now out bush.

When they come into town where the alcohol is readily available, the drugs, the sniffing - just like the old people that were sitting here previous to us, we cannot help that, but we can help the spirit. Basically, that is what Nunkeries do. But then, even through our Alice Springs Transformation Plan, like Leonie and Cait talking about Larapinta and Hidden Valley, we just got a new one out at Karnte Camp, and that was worked on for years - my great grandfather trying to set that up for the southern camps.

At the moment I have been – our camp has been working with the Northern Territory government to try to put forward an alcohol management plan for our camps as well as the near-by camps. The main thing we need is a space where Aboriginal community members can come together and talk about many of the issues. When there is a death in the family. everybody mourns, so after somebody who commits suicide, they do not really talk about it as much, but if there is a space created for Aboriginal people to come together like the two community centres we have here in Alice Springs, that creates a space where people feel comfortable, where we can tap into other agencies and instead of us going to them at least they can have an outreach that will come to us and that is basically what happens with the two camps here already. Unfortunately, we have 18 town camps in Alice Springs, and there is just not enough space for our people to communicate and, I guess, work together with other agencies.

Ms SHEEDY: I was just going to contextualise the beginnings of Larapinta. At the time when I started it was considered the place with the highest instance of volatile substance abuse in Alice Springs. It was where young people gathered to sniff. There were extraordinary high levels of violence, young people in the juvenile system, a lot of children under the care of FACS, and teenagers did not have anywhere to take them into a safe place because they could not find places for them. At that time, it was anecdotally recorded that there was probably 98% of sniffing happening in Larapinta - a strong relationship with Hermannsburg community between the camp. It was the community that went to some of the youth organisations in town at the time, which were ASYASS, Tangentyere and Congress Youth. They sat down and said: ‘This community have been asking us for their own place, a localised place, because they are sick of people coming in and out and in out with no change’.

That was the beginning. The community, at the same time, said to Tangentyere: ‘We want a place for our people, our kids to grow up strong. We want our kids to have the same opportunities and we want some healing and nothing is happening’. It was a request and, when I came on board, a partnership began with education, so there was a school at the centre that went for eight years and there was a multi-generational approach from the community. They wanted the whole-of-family involved so they could all be involved in sorting out this problem, which was their way of doing it.

So, we sat in fairly poor conditions in that community centre and really just did nuts and bolts around each individual kid: where are they from; where can we get them back? It was the families’ work, the community’s work in identifying those programs and those solutions, and my constant lobbying to government and to organisations to bring in the resources to maintain that school that went for eight years and to also maintain all the other services and begin the wrap around services - the wrap around of social and emotional services because the school is never going to just answer that problem.

So, after eight years - and at that time those kids had been banned from all the schools in Alice Springs so they had failed; no school would take them. There was a significant number of kids at that stage who

had no schooling at all. We now know that petrol sniffing, was never petrol sniffing. I call it that because it is what we call it. However, it was actually always spraying glue in Alice Springs. Whilst OPAL fuel was a big effect on remote communities, it did not have the same sort of effect here, although it did help to alleviate some of the back and forth with visitors coming into town. We did a lot of work from that community going into remote communities talking to their communities - their people on the ground and their families coming in and getting kids and taking them out.

It has only been the programs I have seen where people have been involved from the grassroots of it in creating the solutions and identifying the problems, and being able to articulate and bring on board their own strength and resilience, where the long-term change is. I really cannot advocate enough that town camps are also areas where people grow up strong kids, are vibrant places. Yet, I feel they are just missed as communities in this big community development, although we do have a model. We really need this model to be properly resources. Now we do not have the school there, when the kids are finished in that school, the new generation – some of those kids have national benchmarks for reading and numeracy. We know that families want to maintain their kids in education. We advocate for them, but they struggle to maintain, to stay in the high school system. We know the kids we see threatening attempting suicide are the kids who are not in the school system, so the programs that go through the schools to address suicide attempts and not available to them.

At the centres now, we are providing programs to pick up those gaps of kids who are not involved in any other services. We just cannot say enough that these programs need to be funded on the ground in town camps.

Madam CHAIR: Thank you for that. I might quickly just open up if members have questions.

Mr GUNNER: You will be pleased to know you answered many of my questions during your opening statement around attempts and what is happening at the camp level. One thing you mentioned was threats, something we have heard about in different places. The example you gave was: turn the music down - threat. This was a resource from life promotion – I am sure you are aware of - came out of conversations in 2007. How good and widespread are resources like this, how helpful are they, and do you feel the threats are trending up or trending down? Behaviourally, are more people doing it now than in 2007 or earlier? Where is it at?

Ms RYAN: It can sometimes be episodic. Recently, there have been quite a few attempts so there are more threats. To be honest, a year ago for us was a nice period where there was not - our latest suicide threat was as early as yesterday and our attempt was about a month ago. In one of the other centres it was also in the last few weeks, and it has been problematic with people being hospitalised under the age of 25 but …

Ms SHEEDY: We had an amazingly quick response because there was a program on the ground that immediately got police out, identified the right services and could respond.

Ms RYAN: That book has been very useful for us. We were involved when that was being developed and it was really great resource when it came out.

There is also another resource around youth suicide I had from Laurencia – we have run with queries. One of the hardest things is we can get people to come out to the camp and talk to families, but it is about the quality of that service when they come. Not so much in relation to youth suicide, but I have had case workers from other professional organisations who have said: ‘I cannot find that young person so I am going to close this case’. They have been given a referral, they have a person, and I know where that young person is because I see them regularly, but they cannot find them because they do not have that engagement tool.

Mr GUNNER: It is more like ticking paperwork than …

Ms RYAN: Absolutely. There has been a massive boost in services and service provision for families in town camps recently, but not necessarily in quality. People can tick the box, yes, we did this but that person was not available.

Mr GUNNER: So threats, or a contagion like that, are clumping; they are not trend up and down. They are clumping and the best thing is quick response and hopefully a thorough response. Thank you.

Ms WALKER: That is interesting, because that was raised by Congress this morning. They highlighted they thought one of the biggest deficiencies where kids are falling through the gaps was dedicated case management. That would be the case for you, Cait?

Ms RYAN: Absolutely, and what I am finding is there are many people in town that are case workers but are actually support workers or family workers; they do not have qualifications in social work or that understanding of how important case work is. When something difficult comes up, like a young person threatening suicide, they might do the token thing they know they need to, but then they do not do the follow through. There is no follow-up because they do not understand the process and it is too daunting.

Ms SHEEDY: The longer term change really depends on people having opportunity to explore this and for whole families to be involved - sit down in places of healing. The need for healing is extraordinary. The complex grief and trauma that exists in camp families cannot be underestimated.

One of the most successful programs at Larapinta that continues is an art and craft program where we had eight years of really slow delivery from Batchelor, in partnership with us, of art and craft; however, people wanted to work, they wanted to heal, and they wanted to sit down in a safe environment so they could unwind and feel safe and promote safety and discuss the issues with their family. They did not want to go to a service and come back and do it, they needed to do it over a long period of time with a whole of family and commitment. That is what we did. We did that for eight years and have turned that into an enterprise which is really a healing centre in itself. We struggled to keep that going but, essentially, that is what it is. It is the leaders amongst those families that sit in that group and it provides healing.

Ms SHAW: Also, with families that come into town from remote communities who have other family members with mental health or suicidal threat problems, the services they were getting out in the bush - there is nothing out there for them.

One of my mothers-in-law - my brother-in-law has a mental health problem and, sometimes, he gets suicidal if he does not take his medication. So, the mother has to come in and sit with him in the hospital here, Ward 1, I guess, or the Mental Health Unit. But, then, when they are in town, that is the only service she has and the only place they stay is at my house or down the creek from my house. So, there is not much accommodation for families with that problem, even though we got Percy Court set up for it through the Alice Springs Transformation Plan.

But, for us to deal with that person's problems who have come in from the bush, us, as town campers, need to know the problems with that person, or the health issues he has, so we can sort it out as a community group in our town camps. If that person is going to come to our town camp all the time - and to go and get assessed every three months - then we also need to have that space where the parents or guardians out bush can come in and talk to us town campers, because a lot of our town camps are geographically mapped out so we all have family ties to different communities.

You had the example of Larapinta working with people out at Ntaria, then a lot of Central Arrente people live at Hidden Valley. Once we integrate and you have different communities going to one camp, then a lot of problems then began to swell in the camp like a festering boil, I guess. With community control programs, it is actually empowering our women, basically, because our women are the strength in our town camps. That is how our community centres were set up, because there was no places for our children to go after Larapinta.

A lot of the clients that Leonie and Cait deal with - I guess, during my spare time and school where I was supposed to be studying, I was actually teaching the kids to read and write. Now, they are responsible parents in their camps. That is how I volunteered my time to help my fellow town camp students who were going to mainstream schools. They are very good parents and they have brought up their kids the right way. But, at the end of the day, there is really the lack of resources and a lack of funding for the programs we need to get it together from our campers.

Madam CHAIR: We could continue talking, but I am also very conscious of time, and there are some members who have questions. One of the common themes we have heard is that from 4.35 pm all services in many our centres stop. A lot of the issues amongst youth or young people, or even older people, tend to happen around 5 pm or after 5 pm. As the sun starts setting, we know that there are problems. What are your operating times in Tangentyere?

Ms RYAN: We are funded 8.30 am to 4.30 pm. We have a youth night we run for 13 to 25 year olds on a Monday night that is funded. That is like a youth night café where young people can drop in, and it is on

Monday night when there is not a lot of other - there are quite a few youth services that run in the evenings in town, but they are Thursday, Friday, Saturday nights. Yes, so there is that.

Ms SHEEDY: We are also funded across the three community centres to deliver after-school programs which we are doing two nights a week after school. That is from 3.30 pm to 6 pm for …

Ms RYAN: Six to 12 year olds, yes.

Ms SHEEDY: Well, yes, six to 12 year olds, but it usually goes a lot higher and it also involves parents. We have been trying to develop programs beyond that with the Alice Springs Town Council for addressing chronic disease issues. Our case workers also work often out of those hours to address issues as well.

We really like to work towards those hours. The after hour, which we have also identified and community identify as well, we find it hard to find staff in Alice Springs, particularly to work for short periods in those after-hours programs. So, it is one of the challenges for us to find staff on the ground so we can do that, as well as the day work.

Madam CHAIR: So, if you are a young person living in one of these town camps – and you talked of the situation, Barbara. What happens after 5 pm? Is it the family that picks up or gets that person to the hospital - you were talking about that situation. Who picks that up?

Ms SHAW: I think the community does but for me, as running an unofficial safe house on my camp and having to deal with my family that comes in from the bush or my own family on the camps or the other camps, as well as family living in the urban setting, it is 24/7. Unless it is an emergency, not for a cigarette or whatever, but if it is an emergency, I will get up in the middle of the night and go and check things out. Like my mum and dad recently had a petrol sniffer go through their house without them even knowing. Mum was coming out of the bedroom, seen a petrol sniffer from a southern community, so we dealt with that through the cops, as well as through CAYLUS and CAYLUS does a lot of that support base for the people on our town camps, as well as the communities.

Ms RYAN: I do notice, in our camps particularly, the young people are really cluey. I have been in the town camp after-hours dropping kids after a program and there has been an incident and they have gone: ‘Ring the police’. I go: ‘What is the number?’ and they go: ‘000’, and I go: ‘Oh yes, sorry’. They know, they are pretty good at knowing and it is the young people often that are the ones stepping up going: ‘Right, we are ringing the police now’.

Ms SHAW: And they also, kids will pick up that there is a strange person over there, what can we do? When they come back and relay stories: ‘We have not seen him before and he looks very funny and making us feel uncomfortable’, then we get on top of it and go and see and say: ‘Hey, what are you doing, where you from, what is your name?’

Madam CHAIR: Peter, did you have any questions?

Mr STYLES: Just in relation to accommodation. Do you think – I have heard this for years: when regional and remote Aboriginal people come to town, there is no accommodation, so they just sleep it rough. What sort of accommodation do you guys need? Obviously, there are many NGOS that do not have the capacity to just go out and build whatever it is. What is it that you need, because it is my understanding is that if you give people a safe environment, where they can go and feel safe, there is a lot less stress on them, which …

Ms RYAN: There are two different accommodation things - one is those visitors who come in and need extra accommodation for a period for whatever reason; health reason or others. Then there is also a need for a supported accommodation for people like young people who are at risk of suicide, particularly for certain age groups. There is a refuge, but it is for 15 to 17 year olds. There is nothing currently for kids aged 11 to 15, who we know need some support and cannot stay at home and the family are happy for them to stay somewhere else but where can they go without a DCF Order.

That accommodation issue is quite big, I think.

Mr STYLES: So what is the size of that problem? In numbers, on the whole. Do you just pluck a number out of the sky that you think that might be…

Ms RYAN: Yeah, that is a really hard one. I would say probably for our camp, on any night, you would have at least one young person who could use that service. We are one camp.

Madam CHAIR: We could write as a committee to Tangentyere Council seeking that information because that would probably be a useful thing for us to get.

Ms SHAW: We did have two houses, two safe houses on the north side of town, but that is two houses, maybe ten beds a night, it is still not enough, especially with the transient …

Madam CHAIR: I have noticed time and time again and every time you come down there seems to be more and more country men from the communities coming in, Barbara, so if there are accommodation issues around Alice Springs, they must go into the town camps. That must add to the problems in the town camps. We may write to Tangentyere Council and seek that information. I think you also requested to put in a late submission, so we might just follow them up and get them.

Ms SHAW: With the Alice Springs Transformation Plan. They have actually put in a lot of submissions into the transformation, but just a lack of support for it.

Ms RYAN: Tangentyere has put in applications to ASTP, yes …

Ms SHAW: Yes.

Madam CHAIR: Support for what? Accommodation?

Ms SHAW: Accommodation, women's centres, community centres. We have been looking at that as well.

Ms RYAN: Some of that could be included in the submissions.

Madam CHAIR: In the submission. We may write to get those numbers because that is probably important.

Ms SHAW: We did do a mobility study in 2000 on the Aboriginal people coming in off the homelands and stuff like that - communities. That has actually increased. I live on a town camp; I have seen more people coming, and there is still not enough.

Ms RYAN: Yes, definitely with the new housing things are changing rapidly.

Ms SHAW: New housing; still overcrowding.

Madam CHAIR: Thank you. We will write and we will seek that information. We may even have another discussion with you on that.

Ms SHAW: Thank you for your time.

Madam CHAIR: Thank you for waiting and I know it has been a long wait. Thank you.

MT THEO PROGRAM

Madam CHAIR: We might get straight into the Mt Theo program.

Thank you, Brett and Aaron. I thank you for waiting - it has been a long wait. I will not go through the formal transcript. However, one of the important things from the official talk I must give is that if there is anything you want to say which you do not want to have made public - because the transcript and anything that you say will be made public - please let us know. Are you okay with that, Aaron?

Mr BRADSHAW: Yes.

Madam CHAIR: Okay. Rather than us going through this, if either of you want to say something quickly about …

Mr BADGER: Yes. First of all, thanks so much for having us here today. It is a pleasure to be here to try to offer our understanding and experiences of this serious problem. Listening to other people talk, there is a great deal of experience and knowledge and, hopefully, all of that can add up to something. As we noted in our submission at the start, our experience is just our experience of our program in Yuendumu. It is not a 'one size fits all', so it is just our offering of what we have been through.

I thought I would just go over some of the key points in our summary that related to our submission and, then, if you want, you can ask questions around that and talk to Aaron about some of those key things.

One of the key points of our experience has been we developed a specific and mentoring program out of existing program, so Mt Theo program has a range of departments dealing with youth services, including rehabilitation services at Mt Theo Outstation. Since July 2007, we developed a specific counselling program to deal with youth at risk, specifically emanating from a response to youth suicide. There were three youth suicides between 2005 and 2007, and it was very much a community response to that issue. So, it was not someone from the outside saying this is what needs to be done.

Quite literally, our counselling and mentoring program, which we call Warra-Warra Kanyi, began with the brother of a young man who had passed away. Literally, the day after that happened he came around to see me and said: 'We need to drive around and go and see the other young men and start talking to them about this because I am worried about them'. That was very much the genesis of the program.

That led to us developing a specific model which we felt was appropriate for our setting, which included a really heavy emphasis upon peer mentoring - which is how it started with that young man in particular. That is Aaron's job today as well; he works as a full-time youth mentor. That peer mentoring is incredibly important because of the ability for early intervention. We noticed you were talking earlier about the after-hours services, the key for us is on Saturday night at 1 am we have eyes and ears there through our peer mentoring network. These are the young people who know what is going on. We find about 85% of our referrals come through young people themselves, all through a peer mentoring network. There is an access issue which is opened by having those peer mentors in place.

A really important point about the peer mentors as well is they are not isolated. We have a professional counsellor on our team who cannot be here today, unfortunately, who coordinates the mentoring group along with Aaron, who is the only full-time youth mentor. It is a balance of that professional and qualified role, along with young local people and elders in the community creating a mix that hopefully accesses all the young people.

It is also worth noting the professional counsellor has been in the community for five years and has only been in this role for two years. She had been living in the community for some time while she was completing her studies and developed relationships within the community. Once again, the access was very high because she has very strong relationships in the community and very high levels of trust within the community.

We found, across our period from 2007 to 2010 when we were seeing significant reductions in attempts and ideation within the community, she was - the peer mentors, community members and young people themselves were coming to her. These were incidents the police and the clinic often had no knowledge of. If it gets past a certain point then, of course, those services are going to be involved but, at the general worry or ideation level or looking towards early intervention, these things that happen at 1 am - people were not calling the police. Families were sorting it out themselves or not, and come the morning when the storm may have passed, people were not going to the clinic and accessing those services.

It was the creation of a crucial link from our youth service team and our counselling team who could not only provide that service at 1 am, because we operate a 24-hour call out service, but also go to the clinic with that young person the next day and create that link as well. Quite often there might have been attendant issues that would involve the police as well, for example if there was a domestic violence situation. The creation of that link between the community and other agencies was really important in those services having access to the young people themselves.

The other point we wanted to stress was how important that crisis response service is. Ours is a 24-hour service basically because staff members such as Ruth, our counsellor, and Aaron, are prepared to do that. We do not have funding for them to be - our salaries are not commensurate with them working a 24-hour on call service or working seven days a week; it is because they are prepared to do that themselves. We try and have as much relief as possible. I have tertiary qualifications in psychology myself so sometimes I will relieve in those positions; however, it really is a measure of Aaron and Ruth, in

particular, that they are prepared to do that and their own sustainability, whilst that is an issue for us, is less important to them that the dealing with these issues themselves. That is largely based on the fact they are community members as well as working professionals. It is people worrying about their friends and family members.

The other point I wanted to make is from our experience - because our counselling team is based in a youth service team - is how important it is to have that ongoing care from our counselling team and also that we have positive referral processes. When Aaron and Ruth have worked with young people for a month or two months or whatever is appropriate in that case, they are passed over to what we call our Jaru Pirrjirdi (Strong Voices) youth development team which focuses on training and employment opportunities for young people. Part of the program of a counselling program for those clients is about creating pathways for those young people. We are not just going round and round in circles. It may as simple as getting them back to school. It may be getting them into mechanical training. We have put young people into the police, into ranger training. It brings us to those underlying issues of – and a lot of people have spoken about cannabis and that is a really serious issue we target as well - core issue of why is this happening in the first place. We feel that point of engagement and pathways for young people is a critical issue in that sense, so that young people are not engaging in substance abuse or domestic violence. Having a sense of purpose, a life pathway is critical in dealing with some of those issues. They were the few key point we wanted to make, so if you have any questions for …

Madam CHAIR: Aaron, did you have anything you wanted to add to that, or we will just go forward with questions?

Mr BADGER: I was just going to get Aaron to say if he is worried for someone, some of the things that he might do.

Mr BRADSHAW: When we are worrying about people who are thinking about suicide …

Madam CHAIR: We might just move that microphone. It is just so we can record.

Mr BRADSHAW: When we are worrying about people who are doing suicide they send me to go talk to them. I probably take them out bush to keep them busy, keep them happy, better than doing suicide and all that. We take them on a trip out bush, make sure they are not doing anything wrong, trying to do suicide and all that.

Mr BADGER: Aaron had asked me before just to read this quote he had made in the submission as well to make a specific point.

One of the roles Aaron plays, as well as crisis response, is taking some of the young people he has identified he might be worried about on bush trips, because it is about creating an appropriate setting for having those discussions. Coming into the clinic or even coming into our office where there are lots of people coming about and they might see you, there is a sense of shame. They are not necessarily appropriate settings for young men to sit down and talk about those issues, whereas going out bush and sitting down and cooking a kangaroo - that time where you have an hour or two while the kangaroo is cooking is the perfect opportunity to have those discussions. As Aaron said in the submission:

> *Sometimes it make two or three days of doing that before I'll ask the young fellow 'Do you want to tell me about what happened' and he might say 'Yes'. Then I sit quiet and listen and he might tell me everything.*

It is just making that point that these are not – in my western linear concepts – things that can necessarily be come at directly, sometimes it takes – once you are through the crisis phase, you need to be quiet and skilful in the way you engage with those young people, and you need to be appropriate. Sometimes, there are sideways ways of coming at that. Going out bush and not pushing on that issue, but creating a setting that is safe and culturally appropriate - it might take several goes at that before you can start hitting some of those underlying issues with that particular individual.

Madam CHAIR: All right. We might just open to some questions from the committee.

Ms WALKER: Is it predominantly males - young women as well - clients of the service?

Mr BADGER: Yes, of our client base from last financial year, we had 111 clients. This is not all suicidal clients, but in our counselling team. That ran at about 60:40 male, but suicide ideation and attempts was

about 75:25 - so definitely much higher in males. Whilst we have seen a general or a significant reduction from where we were in 2007, we did not have any female suicide attempts in that time, whereas that is something that has come about in recent years. With young women, more often that has emanated as self-harm than the male demonstrative 'I am going to hang myself' or something. It has been quieter notions of self-harm behind closed doors. So, we have seen differences there. Many of the underlying issues, or presenting issues for us in those situations have been related to relationship issues, so quite often there is a number of attendant factors involving a young man or a young woman and relationship issues, domestic violence, and jealousy are certainly huge factors which builds into, as a number of people have said already, about suicide as a threat as well. Notions of power and, for example, a domestic violence situation, the young man might be receiving a lot of anger and blame from a family in that situation and a way of shifting that context is to up the ante, like to threaten suicide, then make him a source of pity in that situation, or shift that anger and blame from him.

It is a long-winded way of saying that the psychology of that situation, being able to read that situation, becomes incredibly important which – with local service angle, you can have that insight, and with the experience of like someone like Aaron; that is incredibly useful to know what is actually going on.

Ms WALKER: Can I ask also about the fact that you do provide a 24-hour service and this came up in Tennant Creek yesterday, because you mentioned that what Aaron gets paid is really not commensurate with what he does. Yesterday, it was brought up in the context of sport and recreation officers – a high turnover of those people in communities for various reasons, but the fact that their pay is not commensurate with what they actually do. It is a lot of afternoon and evening work, it is a lot of weekend work, and hence we see a turnover.

Would Aaron be prepared to tell the committee what your earnings are in that role?

Mr BADGER: (speaking to Aaron) she is asking about the money story. Do you want me to talk? She is asked how much you get paid.

Ms WALKER: If it is more polite for me to seek that information privately through inviting committee.

Mr BADGER: We can certainly provide that information to you privately.

Ms WALKER: It would be good for us to see what the salary is that goes with it.

Mr BADGER: It is interesting to note when you make that point about sport and recreation workers that because we run youth services in Yuendumu, Willowra, Nyirripi, and Lajamanu that is actually where the basis of our program came from. I was the Youth Development Coordinator at that time and basically what we were doing was starting to deal with these issues as well which is what led to us splintering that into a new and separate department because it was – like I had some training in that myself, but our other youth workers did not. So, it was youth workers acting as counsellors and they were doing amazing work with that but it was not something that they were qualified to do and it was far beyond the call of what they were supposed to be doing, so it is a real issue when there are not experienced people in place. You do often end up with youth workers playing those roles because they are highly trusted and have access to a lot of information about what is happening with young people.

Ms WALKER: So, if you are happy to supply that information on to the committee after this

Mr BADGER: Certainly. We can provide you with the funding information about our counselling and mentoring team if that would be useful to you.

Madam CHAIR: That would be really good, that would be useful, thank you.

Mr GUNNER: I thought it was a fascinating submission and somewhat like some of our other witnesses today. We have had questions answered here that we asked in Darwin - we had a couple of days of hearings in Darwin where there seemed to be a consistent theme emerged where you have services here, they were quite good services, and then you have the general community here, but it almost seemed to an accident if we were able to ID someone here and actually get them into the services they need, and 60% of people who had completed suicide just never presented, never interacted with the health system. So, how can we actually get the people help? Here, you seem to have had for quite a long period of time now a really good program that identifies people early, gives them support, has seen a significant reduction in attempts. For us as a committee - the lessons out there – how portable are they? Is it a benefit that you have a small community, you seem to have, unlike some other places, not had significant staff turnover.

You have actually had people consistently there for a long period of time and they empower communities. So, that is all great, but in some respects, what lessons can we take out of that, how portable are they?

Mr BADGER: I understand what you are saying, and appreciate that comment as well. The staff turnover is a huge thing for us, and we have spent a lot of time on recruitment. Basically, you have to get it right at that point. I have been at Yuendumu for eight-and-a-half years. Our counsellor has been there for five, and our CEO for nine - as well as, obviously, all our local staff. Similarly, with local staff it is about maintaining an appropriate work environment so people maintain long-term employment.

Within our context it is the culture of the organisation and the fact that the basis of – like Aaron and Ruth's willingness to work out of hours was because of the community's engagement with that issue. If you feel you are in it together, people are more prepared to go that extra mile. Whereas, if you are there – it is a delicate balance with things like money; you want to pay people properly, but you do not want it to be a motivation. It is a delicate balance again, but people like youth workers and teachers have a lot of information. It does not mean they should take on those roles but, quite often, you get pockets of information in communities that is not being shared. So, having some level of coordination – our police are excellent and our clinic is fantastic, but between us all, finding ways for us to bring that information together is crucial. Because our trust is so high with young people, the police and the clinic began working through us. So, identifying some kind of centralised source, a coordinated meeting - or whatever it might be that works - to share information with appropriate confidentially is probably an important way to do that.

In our experience, not only with suicide, but with issues like mandatory reporting, youth workers are a really important source of information. However, you need to cut them off at the right point so they do not become overburdened and overstressed with those roles.

Mr GUNNER: The other thing that I thought was quite interesting in your submission - and this came up in Tennant Creek - was where the general conversation around psychology and a six-year course interstate versus a Certificate IV locally, which is much more practical or gives you a lot of skills more quickly. I see Aaron is doing – I assume it is Aaron – is doing a Certificate IV in mental health. I am interested in how that decision came about and how you sourced it. It just seems to be a really good step.

Mr BADGER: To be honest, it has been a nightmare for us.

Mr GUNNER: It's been a nightmare?.

Mr BADGER: Yes, it really has. We have had excellent support from people like Laurencia and centralised agencies in providing training with suicide prevention, mental health, first aid. But, taking that next step has been really difficult for us. Basically, we are doing it through an online TAFE in New South Wales because it has been difficult to find something - and it has been difficult to find something appropriate. People do not like going away for long periods and …

Mr GUNNER: So to do a Certificate IV, not online but locally, you have to come into Alice and …

Mr BADGER: Yes, or Darwin.

Mr GUNNER: There is a challenge there we need to overcome.

Mr BADGER: Definitely.

Ms WALKER: The course you have identified does not actually require Aaron to have to travel; he can remain on country.

Mr BADGER: That is right, yes. Aaron is on this case, but for other staff members with our outstation team we are enrolling in a Cert IV at the moment, there are literacy issues, so we have identified the WELL program - workplace literacy. Training is a massive issue. Our only useful source of whitefellow education has been through Laurencia over the past couple of years and Craig San Roque – I am not sure if he is still here – is a consultant for us as well. He comes out and runs sessions with our staff.

Madam CHAIR: How much of that work is done with the school? Do you do any educational work with the school and the young people in the schools?

Mr BADGER: One of the things that were set up with the bush trips, if they are of school age – there is a high level of communication with the school, so if those young people should be attending school or are

attending school, then Aaron and Ruth will notify the school of their participations. The same with young people who are maybe residing at the outstation. They provide us with educational materials for those young people who are staying at the outstation.

Ruth, our counsellor, works in the school. They have a KidsMatter program, so there is a certain amount of education and prevention stuff there.

Madam CHAIR: We were wondering whether KidsMatter or MindMatters was in that. Mt Theo is a community that has been able to eradicate petrol sniffing - the education happened - and the dedication of elders in that community regarding petrol sniffing. All over the Northern Territory many Aboriginal communities acknowledged and recognised the work Mt Theo did with petrol sniffing.

I remembered going to Yuendumu and spending some time with the Mt Theo program, and one of the big things with petrol sniffing was education and the ability to get through to young people what was happening to their brains when they were sniffing. Why can we not get that through to our young people regarding cannabis use and alcohol and what it is doing to the brain, which is leading to attempted and completed suicides? Have you looked at that in the Mt Theo program?

Mr BADGER: Some of the things we found struck a chord with young people was pulling them back toward those core values of family and healthiness, particularly with young men with ganja - the threat towards mental health and being able to draw specific examples of that because we are in a small community. You can make reference to someone because it is not confidential, everyone has direct experience.

Being able to point to consequences is a really important thing. Our experience through 2006 and 2007, when we had those completed suicides, has been really powerful as well. To be able to take up that refrain of you: ‘You do not want to lose someone like your brother’ or be able to point to consequences has been the most important part of that.

We have spent some time in the last year trying to develop resources and have focused on cannabis with Lotti Robertson. Lotti and Edie Robertson have created a painting based around health concerns around ganja which is Warlpiri specific, and is basically about what happens to your brain and your spirit, in a Warlpiri sense. By the same token, our young people made a poster at our nightclub about what is wrong with ganja, so those local resources have become really important for us. However, the most powerful thing has been to point to direct consequences and we feel that has really helped promote the notion of early intervention amongst our peer mentors. The reason you knock on Ruth’s door at midnight is because you have a sense of where this could go if you do not.

We are focused on not only stopping young people from wanting to do it, but on the peer mentors having an understanding of that so they are more willing to intervene. There is a quote in our submission that families, including our mentors, are more willing to act themselves if they feel the support services are around them. If they feel they are doing it by themselves, they become disinclined to act because of the notion of blame, feeling much more isolated, and that it is all going to come on you if it goes wrong.

The courage and confidence to engage is based around knowing what can happen if you do not, and that there are relevant support services around you.

Madam CHAIR: Is cannabis use still a major issue?

Mr BADGER: Not as much as it was, and it fluctuates. In the last two years it has come down from what it was. It probably peaked two or three years ago, which is around when we started trying to focus on the suicide issue. It is one of those things that is beyond our control in the supply sense, as well. Supply is definitely something we work with the police on. Also, it is not a standing population so people come to Alice Springs and have those experiences here as well. Much of our client base does come from negative experiences in Alice Springs. One of the services we do is we come and pick people up from time to time if we feel like they are …

Madam CHAIR: And then take them back.

Mr BADGER: And take them back, yes. It is still a working issue, without a doubt. The other option we have is the outstation. For a more long-term rehabilitation program …

Madam CHAIR: They go out there.

Mr BADGER: … they go out to the outstation for a month or two and dry out.

Madam CHAIR: Thank you for that. We will follow you up with those other matters we talked about.

Mr BADGER: Yes, certainly.

Madam CHAIR: If there are any other questions or discussions we need to have, we will contact you, Brett, and follow you up again.

Mr BADGER: Thanks very much.

Madam CHAIR: Thank you very much for having the patience to wait as well.

Ms WALKER: And congratulations on your work.

Mr BADGER: Thank you.

Madam CHAIR: Yes, keep up that good work.

LIFELINE CENTRAL AUSTRALIA

Madam CHAIR: On behalf of the select committee, I welcome Karen Reval, Rob Loane and Jane Johnson. That helps having all those names up there. Thank you for coming before the committee today. I will not go into the long, drawn-out statement I usually have to read – I think we have done that - because it will be important to hear from you and any questions. The most important thing is if there is anything you do not want to have made public, please tell us and we will ensure it is not made public. Thank you for coming today and we look forward to hearing from you. Rob, do you have an opening statement?

Mr LOANE: I am Rob Loane. I am the Director of Lifeline Central Australia. Karen Ravel is the Education and Training Manager, and down from Darwin is Jane Johnson, the CEO of Lifeline in the Top End.

We appreciate being able to input to this most important inquiry, and regret we have not had the available resource for making a written submission. The time available and our resources just defeated us. We have, however, been able to view the submissions made by others, and welcome the opportunity to make ourselves known to members and to be available to answer any questions you might have. First, though, I would like to provide a brief overview and then make one recommendation.

Lifeline Central Australia is a small operation with funding support from the mental health program within the NT Department of Health. Our primary focus in the Centre is on providing education and training in suicide prevention and crisis counselling. While a small operation, we have managed to leverage substantial reach with our training. For example, over the past two years we have delivered and supported the delivery of LivingWorks, ASIST and safeTALK workshops, and our own two-day Accidental Counsellor program to around 1000 people from over 100 different agencies, with about 60% of these being organisations that have an Indigenous focus. About a third of participants have been Indigenous and we are committed to growing our engagement with schools and youth organisations.

As an overriding observation we generally agree with the issues raised and the recommendations in most of the submissions received so far. This is especially so with regard to recommendations for mapping services and for filling data voids in trying to better understand the true extent and nature of suicide in the Territory and the ideal mix, deployment, and coordination of integrated services. For the most part, in our view, the issues raised are not new to the field of suicide prevention. But they do remind us of the vast array of factors and complexities involved and some issues that are of particular relevance to the Northern Territory,

We believe the 2009 to 2011 suicide prevention action plan to be a good plan that recognises the need for effective cross-government and cross-sector input and collaboration in addressing youth suicide and suicide prevention generally.

We also acknowledge the Northern Territory government for taking the initiative of establishing a Northern Territory suicide prevention coordination function within the Department of Health, Mental Health program in 2006, and we would further like to acknowledge the efforts of Sarah O'Regan the inaugural Northern Territory Suicide Prevention Coordinator who held this position until recently.

As highlighted by this inquiry, given the volume of information and issues surrounding suicide prevention in the Territory, and the array of service providers and programs, we see the coordination role as requiring a dedicated team effort and focus to maximise effectiveness.

The timing of this inquiry and the information it has brought forward for consideration would appear to work in well with the pending review of the Northern Territory Suicide Prevention Action Plan and the development of the new plan.

It is our recommendation that the Northern Territory government give consideration to the formation of a dedicated Northern Territory Suicide Prevention Coordination team to develop, implement, coordinate, and evaluate a new whole-of-government Northern Territory Suicide Prevention Action Plan and that consideration be given as to whether the coordination function should continue to be placed within Northern Territory Mental Health or elsewhere within government to ensure the team carries the appropriate imprimatur for driving timely and effective cross-government and cross-sector input, as well as carrying the necessary funding influence.

With this recommendation the emphasis is on a dedicated resource purely devoted to suicide prevention activities and not sundry adjunct activities that may come its way.

Thank you.

Madam CHAIR: I thank you very much, Rob, and we will get into questions, but before I hand over, can I just make one quick comment and then I will hand over. You said the suicide prevention - a SWAT team for the Northern Territory, not necessarily sitting in health, but elsewhere. Are you able to elaborate on that - where?

Mr LOANE: We see it as important that the coordination happens. There is so much information to be coordinated and so many programs, that we believe' it need a team, rather than one person. One person was a great start. I do not know the workings of government intimately but, for it to be effective, we believe it needs to be a team with punch that has carriage across all the government departments and we just raise the question: is Mental Health the most appropriate department for that to happen or is there a better department? I do not have the answer.

Madam CHAIR: Okay, it is an interesting thought, given police also have an important role and others – where do you – I was just interested when you said that and where it would be placed. Do you have any questions, Peter?

Mr STYLES: When you said that your primary role down here is training; you said you train 1000 people. Do you actually run that crisis line down here?

Mr LOANE: No, we did until about two years ago.

Mr STYLES: Where does that go to now, does it go up to Darwin?

Ms JOHNSON: Well, the crisis service is a 24/7 telephone service and is actually a national service anyway. So, anybody who calls from anywhere in the NT will get picked up by the service - not necessarily from inside the Territory because, in fact, it is actually preferable to have the calls picked up elsewhere because you do not want the chance of speaking to your neighbour. A lot of our calls go down south and we take a lot of the calls from up here. But, it is worth knowing that across the Territory in the last month, 650 calls came from the Northern Territory. It is a high percentage of calls that come out of the Territory.

Madam CHAIR: How many was that, 600 and …

Ms JOHNSON: Six hundred and fifty.

Mr STYLES: In a month?

Madam CHAIR: In the last month?

Ms JOHNSON: In the last month.

Madam CHAIR: What happens with that, Jane? People ring and, if they have picked up a call where it is quite critical, it is then – what? - diverted to police and …

Ms JOHNSON: No, no, no. There is a very strict protocol followed with the calls. We follow the ASIST program that Karen is responsible for teaching down here. It is the same program that we use on the telephones because, in most cases when people are talking about suicide, talking is the answer - being able to talk through it. The intervention process is very powerful. It is actually very few calls that actually require an intervention by services.

Madam CHAIR: Okay, so you just talk them through it and then hope …

Ms JOHNSON: Yes.

Ms REVAL: Of all the calls that Lifeline receives each day, which is in excess of 1500 nationally, around 5% to 6% of those will be related to suicide in some way or form.

Madam CHAIR: Okay.

Ms REVAL: So, of those 650 calls, potentially 5% would have been related to suicide.

Mr GUNNER: Can you break that 650 down by community or town?

Ms JOHNSON: No.

Mr GUNNER: You cannot do that?

Ms JOHNSON: No.

Mr GUNNER: So, you cannot trace trends or …

Ms JOHNSON: We have the ability to trace a call if we feel there is a risk and the person is going to need to be found. We have what we call a malicious call trace button which we can hit, and the police can track that within minutes. We have used that successfully but, in most cases, the intervention and the talking is a powerful tool.

Mr LOANE: Not by fine detail, but in the Territory we can do region - we can talk broadly of coming from Central Australia or the Top End.

Mr GUNNER: I was just interested if that ever fluctuated, or if it was a consistent month to month where the phone calls came – if you had that data where the phone was.

Ms JOHNSON: In fact, the data collection system is being improved as we speak and, by next year, we will be able to focus that a lot more clearly.

Mr GUNNER: Because one of those things that has emerged is the data in this area is not always accurate or thorough, or it can have large caveats on it.

Ms JOHNSON: That is right. But, I will also tell you that, unfortunately – and it is not something we are proud of - the telephone counselling service is not terribly relevant to Indigenous communities for many reasons. One we have addressed recently in that we now have free calls from mobiles, whereas before you could eat up your whole credit. Now, Telstra and Optus have come to the party and …

Mr GUNNER: Is Lifeline looking at social media at all?

Ms JOHNSON: There is already an online …

Mr GUNNER: There is a model?

Ms JOHNSON: Yes, there is already an online trial going on.

Ms REVAL: Facebook, yes.

Ms JOHNSON: Yes, we are on Facebook.

Madam CHAIR: So you can talk online to somebody?

Ms JOHNSON: Yes.

Madam CHAIR: Okay.

Ms REVAL: There is also recently on Facebook if somebody indicates in some way that there is suicidal ideation, straightaway – I do not know how it works, I do not know the mechanics of it - Lifeline's number and support services will be directed to them.

Mr GUNNER: And that is 24 hours a day?

Ms REVAL: Yes.

Ms JOHNSON: And there has been a chat line trialled for the last four months which has been very successful. They are now at the point where they are going to be approaching the Commonwealth government for further funding.

Madam CHAIR: That was …

Ms REVAL: That is being accessed greatly by young people in particular.

Ms JOHNSON: That is right, yes. A much higher number.

Madam CHAIR: It was interesting when you talked about Facebook because there were three recent suicides by young men in Darwin …

Ms JOHNSON: The Brothers in Arms.

Madam CHAIR: Yes. Two of those young men had posted stuff on Facebook.

Ms JOHNSON: There was a magnificent drive earlier in the year - about April it was, because it was when our suicide garden was opened in the Botanic Gardens. There were three young men who suicided. They were very involved with a sporting group, and the group themselves put together the Brothers in Arm's website. It was a private invitation only, and it had 1300 members within days, just in the Territory. It was magnificent. But, that was a move of young people saying: 'Come on, we have to focus on this, we have to do something about this'.

Madam CHAIR: It is starting to become quite a big movement amongst young people …

Ms JOHNSON: Yes, absolutely.

Madam CHAIR: … and talking about, so it is a good. I have joined it as well, just to keep in touch with a number of people. A number of my family members have also gone through that, and they are all members of that. It is a good process.

Do you have any questions, Lynne?

Ms WALKER: I was just going to ask about the – in a way you have already answered it – difficulties of providing the telephone service to some of our remote Indigenous communities. I guess because of language factors. Also, they are often the people who most need it because of the tyranny of distance and access to services is through phone or Internet. What might be done to make it more effective or accessible for people, recognising there are a squillion language groups across the communities.

Ms JOHNSON: Training has already been pointed out by Rob and Karen, and I feel this is where the focus is important. Karen does a great deal of work with the ASIST program and other intervention stuff. She also has developed a wonderful thing called the 'accidental counsellor' which I have now unashamedly stolen and am delivering in Darwin with great success. That teaches people in everyday situations how you deal with people who are emotionally upset and potentially at suicidal risk. That gives people the feeling of:

'My God, if I ask the question and somebody says yes, instead of me asking what to do', you would know where to go with it. Peter, as far as I know, has done the ASIST course himself and used to carry his ASIST card in his wallet. I do not know whether you still do.

Madam CHAIR: Have you still got it.

Mr STYLES: Yes.

Ms JOHNSON: It is a very important thing to consider. If we have it understood more in schools, if we have peer training of students who can support other students, if we concentrate on protecting the people we have in the remote areas, even in Alice Springs, with better support and training. I now train the diploma seminars for the AIPC, the Australian Institute of Professional Counsellors - there is one here at the moment - to provide training for those people undertaking the diploma in Alice Springs and do not have the opportunity to have face-to-face training.

One of the women with me last night is counselling for an organisation that has given her in-house counselling but she is paying to do the diploma out of her own pocket and having to do it in her own time. She is not even able to get study time because of the shortage of people. Staff in her area are willing to, but do not have the time or resources to relieve her.

That type of person is like the other couple we saw where the young man is working 24-hours a day. People cannot operate under those pressures, they need support and backup. We are burning people out too quickly.

Mr LOANE: In the Centre, people often say to us if there are people in need call Lifeline. It is not really appreciated how difficult it is with the language issues and, as you say, there are so many. Even to provide staffing to address the key languages and run a 24-hour service is a monumental undertaking. I doubt if there would be enough people to staff such a phone service so it really comes down to literacy, unfortunately. That is why, for us in the Centre, we changed our focus to education and training and believe we can have a greater impact that way.

Mr STYLES: You say you have trained 1000 people and a third are Aboriginal people, is that right?

Ms REVAL: Yes.

Mr STYLES: Do have a breakdown of where those people are from? Generally, is there are they spread across Central Australia or is it more Alice Springs?

Mr LOANE: I will let Karen answer, but we have targeted people who are already engaged with remote communities. We do not have the resources there, but we identify the people already engaged and provide them with the training.

Mr STYLES: Can you explain what it is you train them in?

Ms REVAL: There are several programs we run in Central Australia. ASIST is one you have done and you know is a two-day intervention workshop. I deliver that on remote communities with Indigenous people. It is not Indigenous specific. I am sure you would have heard of MHACA and their Suicide Story; however, I have done it in Amata, at Ali Curung and in Tennant Creek. I have not gone any further; they are the areas we are focused on. However, I recently ran an ASIST workshop in September and we had five people, four from Kintore and one from Mt Liebig. People will travel for those workshops.

We are not necessarily working with Indigenous people but, as Rob said, those who are engaging with Indigenous. We are equipping those people with the skills to at least have somebody in that community who is suicide aware and able to intervene if necessary.

What we have also done in town - we have many NGOs who come through, mostly who will come and do the ASIST training. It sells itself. The December workshop has been booked out for the last two weeks. I have a waiting list. It is a matter of keeping up with demand. We are quite limited with resources in other training staff. We call on our training partners and they come from MHACA, CAMHS which is the Central Australia Mental Health Service, we have a couple …

Mr LOANE: Congress.

Ms REVAL: Congress we also use. We have a little network of trainers, but we need to actually add to that to be able to spread the word more.

The other program we run very successfully down here as well is SafeTALK, which I am sure you have heard about, the half-day one. We have actually piloted that in schools. Three years ago, I chose St Philip's because my kids go there. I am well-known by the staff and students, so it was an easy link. We actually started with all staff. All staff were trained on a PD day. Concurrently, we had several workshops going, and we trained all the staff in SafeTALK. Using that SafeTALK program, we also had in the room six teachers we knew we had previously trained in ASIST, so we had the backup.

We then followed that through by inviting parents to a session. Out of a school of 600, I think we got about six parents. But, still, it was a start; the invitation was there. Then we left it with the school and said: 'If you wish we can do your students'. They took us up on that offer so, a month later, we trained about 90 Year 10 students. We had two sessions running concurrently, and we did them in the afternoon as well with the Year 10 students.

Ms WALKER: This was at the school in Alice Springs?

Ms REVAL: Yes, a school in Alice Springs.

Ms WALKER: Yes.

Ms REVAL: This was three years ago. We are trying to get the conversation happening. Because I have links with the school it was easy for me to have that conversation with the principal and explain how important it was.

Since then, we have done other workshops at St Philip's – we did their girl boarders, I think it was last year. We now need to revisit the school and say: 'It is a while now since we have done students, let us have a look at what we can do'. We are still having those conversations. We have also been involved at Centralian College. We did the same again with their Duke of Edinburgh students.

We are trialling SafeTALK with students, but we believe it has been developed for anyone over the age of 15. So, we thought: 'Let us try it. Let us trial it, see if it works; what does and does not, and what we can do'.

[In camera evidence given].

Ms REVAL: That is why the feedback from the students was really good. Rob actually went to see the Year 10 students two years later to get that feedback, to find: 'Okay, what was it like? What did you use? Have you used it since?'

Mr STYLES: Obviously, you are getting good feedback from kids, how is that feeding into getting them to participate in the ASIST program?

Ms REVAL: We cannot actually have any students participate in the ASIST program because that is for adults, 18 and over.

Mr STYLES: So, what about year 12 kids who are …

Ms REVAL: We have been doing safeTALK with them and that is something – the difficulty is when you are getting into the higher levels at school, where does it slot into the curriculum? Does it go into the psychology stream and we have found an avenue at Centralian by putting it in the Duke of Edinburgh program – but where does it sit?

The staff have all been trained and I think that is important for the staff to be trained and to know that it is not just safeTALK stuff, which is everybody, but you do have your people who are ASIST trained so there is a safety network within the school.

I would like to see more of it done with students and it took a while, probably took 18 months of slowly chipping away at one of the schools for them to take it up and say: 'Hey, let us do it with all our staff' and we have also provided six free places for them to attend ASIST, so we have got people on each campus. It is a slow process to change that thinking, that putting the idea – you talk about it, you put the idea in their head, all those sorts of myths we have had to debunk and then build on.

Mr STYLES: So, how do we get it further back; obviously in incremental stages, but how do we get the foundations back further in the school curriculum?

Ms JOHNSON: One of your submissions that had the woman that does the play about the four kids on the roof …

Mr GUNNER: The Community Arts Centre.

Madam CHAIR: The Darwin Community Arts Centre.

Ms JOHNSON: To me, that would start the conversation and start kids actually asking questions themselves, which would encourage the sort of stuff that Karen is talking about.

Mr STYLES: Do you see the ability to come up with something because from what everyone says, early intervention is the key to everything, so how do we get it further back so when you start building those foundations – do you see the ability to develop anything that comes before safeTALK?

Ms REVAL: I do not know. We work very closely with headspace and I refer and talk to kids all the time about going to headspace, going to headspace. Something that we talked about a couple of years ago with their previous manager was – what I would like to do – there is another program overseas called Signs of Suicide. It is an American program and I looked at – the thought I had was why do we not create our own scenarios because the scenarios we use in safeTALK are of adults. Why not create our own scenarios and then I thought of having drama groups and using drama groups in each of the schools, then using film crews from each of the schools, so there is an invested interest in wanting to watch it. The more people you show it to - it could be part of the curriculum, being film and drama or something. The topic being suicide, it would have to be very carefully scripted, but you have got so many people engaged and interested, everybody is going to want to watch it because they will want to see they did. They want to see their friends and the next year they will say: ‘Hey, did you see that’ and you could do it again and the discussion about suicide is being had; people are talking about it.

Mr STYLES: It has been had behind the scenes, but you get one suicide in a high school and every kid is affected; they want to know.

Ms JOHNSON: But they are not allowed to discuss it, Peter. This is the frustration – well, maybe down here they do – but, in Darwin, there is still the problem that they do not. I went out and did a safeTALK to Kormilda College teachers and they were frustrated because they were not encouraged to discuss openly with their children in the schools. It is still an issue.

Ms REVAL: I think it has been really good down here in that we have been chipping away at it slowly over a period of years and having links in with the schools and having school-aged children myself is a real asset to be able to say: ‘I will let my kids do it’; it has really worked. I was a teacher myself, so …

Madam CHAIR: People often forget about that school community and the impact that death has, or even an attempted suicide; the stigma of that.

Ms REVAL: I have actually said to the people: ‘Let us not wait until we have a suicide until we do something about it, let us do something, and prevent that first suicide from happening, so we do not have that contagion effect’.

Mr LOANE: Unfortunately, there is a dogma carried on from almost ancient times that you should not, under any circumstances, talk about suicide with children. Many of the now school principals and senior teaching staff have grown up with that, so there is a great reluctance on their part to be the pioneer and say: ‘We will talk about suicide directly in our school’.

While the programs such as MindMatters, KidsMatter, are great for building resilience and what have you, they shy away from direct mention. Yet, we see this as complementary. To me, it is a little like refusing to accept the world has moved on. We talk about new media but, for our audience, we are talking about it now. It is not new. To think we are sheltering them - we are not, so we might as well give them accurate information ...

Mr STYLES: Well, that is the same as sex education and drug education. Parents say ‘I do not like to teach my kids about sex education’.

Ms REVAL: Yes.

Ms JOHNSON: Yes, that is right.

Ms REVAL: If they know they will do it, you know.

Madam CHAIR: But they only have to turn on the TV and …

Mr STYLES: And they are the first girls who get pregnant.

Mr LOANE: Yes.

Mr STYLES: It is the same with drug education …

Ms JOHNSON: Yes, that is right.

Mr STYLES: The kids who succumb to – because they have no defence mechanism whatsoever.

Ms JOHNSON: Yes, can I give you an interesting anecdote? I delivered – and I suspect Karen has similar stories – an ASIST program to my student telephone counsellors. It is run over two days and we always get people to talk about how they felt about the previous day when they come in the next morning. One of the women had teenage boys over for dinner with her son and she decided, because we had mentioned about this difficulty of opening up in schools, to mentioned: ‘Do you get any of this? Do you get it talked about?’ The boys said: ‘No, no, no, they do not like talking about that, but we all know it happens’. One of the boys was very, very quiet. She pushed this conversation and he had actually been thinking about suicide. She feels that she got him to open up, and she probably made a difference to that boy.

Now, he may not have opened up – he may have gone off and just done it. So, there is a need for this - there is a need for this.

Mr LOANE: In introducing it to schools here and trialling it at St Philip’s, it was important knowing there is a reluctance in many quarters to provide this training. We did some research ourselves to find out what would be acceptable. We chose SafeTALK, not just because we are LivingWorks trainers, but it has been in use around the world and has been for some years, so there is some evidence base. That is what we have to be careful of when we select a program, and even in talking about what, creatively, we would love to be able to do. It has to have a firm evidence base and we believe that program has.

There have been situations in Australia where people have introduced programs, but they have not been evidence based, and they have not done the whole school community. So, we are encouraging people if they need help go off and seek it, but they have not provided the mechanism. We are lucky in town, we believe, because we have headspace here now too, which helps us resource …

Madam CHAIR: Yes, which is good.

Mr GUNNER: When we heard from MindMatters they talked about their model was they waited until they were asked by a school to come in because they found that is when they had the most success, because they were invited there, people were willing to take it on. I was interested when you were talking about chipping away and you finally got in. Obviously, the preference would be to have it quicker, but in that process, you got to the point where they then asked you when they were ready for it.

Ms REVAL: Yes.

Mr GUNNER: How successful do you think you would have been if you had gone in earlier?

Ms REVAL: I do not think it would have been as successful. We needed that time to present the information. I would go and see Brother Paul and we would talk about it and, then, I would just follow up with e-mails. The e-mails became more conversational. Also, within that school there is a school counsellor who I am friends with, and her son. It was helpful having her in there because she had lost someone very close to suicide. Having the school counsellor on side has really helped in every one of the schools.

In fact, what we have done, because I am a T for T instructor with SafeTALK, I conducted a T for T in Alice Springs here last year. We sponsored three people from Alice Springs to become SafeTALK trainers.

One was the school counsellor at St Philip's, the other was the school counsellor at Centralian, and also one of the teachers that is in St Philip's who has since moved - the whole idea being they are the people who have the connection with the students. If we can, as much as possible, have someone with a face that is familiar to them to train that material, then it might be easier to have those workshops happen more often.

Mr GUNNER: [Inaudible] because the theme has been …

[Editor's Note: Break in sound from 15.09.39 to 15.10.12]

Ms REVAL: And it has really worked well for us to go slow and steady.

[Editor's note: sound missing from 15.10.16 to 15.10.21].

Ms REVAL: … to keep bringing up and keep the topic alive has been really helpful.

Mr GUNNER: I cannot speak for other members of the committee but where I am heading, after hearing more and more evidence, is when we are doing our recommendations we will strongly encourage people to access many of these services. You cannot necessarily mandate a school to do this or a community to do that, but you have to get to a position where people are encouraged to walk with you and open up a few of these things.

Ms REVAL: Something I really promote in the workshops I do for all people is the availability of headspace.

[In camera evidence given]

[Editor's note: sound missing from 15.11.12 to 15.11.20].

Ms JOHNSON: There is already education occurring because I have been part of it. I worked with Catholic Care for a while delivering alcohol and drugs awareness to Indigenous men. It was quite a successful program.

There is a really good program running in Mount Gambier, South Australia. I have spoken to you before about this, Michael, and it is now running in Townsville where they train the more senior or the longer term prisoners in the system as almost an accidental counsellor like Karen trains. The advantage of this is when they learn the strength of what they are talking about and helping other people they take it back to their communities.

This idea of talking about it and supporting other people can carry into the communities. This has worked in Townsville and Mount Gambier. We know it works in the white community; they are starting to use it in the Indigenous community in Townsville. I believe there is a place for it here.

Ms REVAL: We have investigated that in Central Australia on a small scale. One of the teachers we trained in safeTALK at St Philip's moved - he visited the gaol and was dealing with youth so we thought we had somebody in there. He moved on recently, but we conduct regular safeTALK sessions with all new prison officers in training. That is part of …

Ms JOHNSON: So do I.

Ms REVAL: We have been doing that for about four or five years now. We also conduct promotional courses - any officer going for promotion must do a refresh so I have developed a shorter session for them. We have made contact with the chief psychologist at the prison to enable some - we have offered safeTALK to prisoners but, for whatever reason, we only had three or four apply and it was going to cause a few issues so we let that slide. However, we were looking at how we could get safeTALK happening with prisoners, particularly as they are about to leave gaol.

We have links with Mission Australia - they are in the same building. That is another avenue we can pursue for those who might be at risk, or even others within the system who would like to have that training.

Mr LOANE: As you were saying before, we are realists and understand we have to chip away. We cannot literally - it helps when you are invited and the strong word of mouth is helping you.

Ms JOHNSON: We had a joint submission with the prison and the Department of Justice to the Commonwealth for funding to do what I was talking about in prisons. Unfortunately, we missed out. Townsville got it and is doing very well with it.

Mr LOANE: Something very important to remember with the training we do, and I am sure others have mentioned, Karen was explaining the school teacher from St Philips who was working in the prison had been trained by us in ASIST and safeTALK, and we had some sponsorship for him. For those that might be forced to attend the training such as prison officers in training, Karen quite often has to explain to them it is not just for your working environment, it is for your everyday life wherever you might be.

Ms REVAL: That was brought home very clearly in the last three or four months. There was a prison officer who died by suicide and when I make that statement they are thinking: 'Yes, it could be one of us'. I strongly suggest: 'I know you have to be here, but you might save someone's life and it could be your own one day'.

Mr STYLES: Book me in for a course.

Ms REVAL: For which one?

Mr STYLES: Seriously, if I am talking to people I refer them straight through to Lifeline to book in.

Ms REVAL: In Central Australia Lifeline for Safe …

Mr STYLES: What about …

Madam CHAIR: Or even in Darwin, it is …

Ms JOHNSON: Well, the difficulty there is that we do not actually have the contract or the funding for it, Anglicare does.

Ms REVAL: Yes.

Ms JOHNSON: And I do not know how active they are in it at the moment.

Ms REVAL: Yes, very active, just contact …

Madam CHAIR: I am very conscious of time, but we are going to have a couple more hearing days in Darwin, and we also need to reconsider coming back down here - I know members are going to groan, groan - but it would be good to invite you to come and have a chat …

Ms JOHNSON: Yes, I am very happy to.

Madam CHAIR: … in a forum that we are trying to organise in the Top End to look at some of these issues.

Ms JOHNSON: I would be very happy with that because we do a great deal of work with suicide and I am now getting more success even in the Indigenous community because I am getting Indigenous people ringing me up and actually saying: 'I'm very worried about this person, how do I deal with them?' So I can talk them through the process.

Madam CHAIR: Yes, it would be good if I can get your contact details and we will contact you.

Ms JOHNSON: Yes, I have given my card.

Ms WALKER: I know communities out my way in Nhulunbuy, Yirrkala and, particular in Gunyangara also known as Ski Beach, have really welcomed the support from Lifeline and I am just so thrilled to hear, because I did not know until you told me, that there is now a free call from mobile phones …

Ms JOHNSON: Yes.

Ms WALKER: … because there was a constituent of mine who was working hard with Lifeline and got the wrist bands and she was promoting the service amongst Indigenous communities, but that …

Ms JOHNSON: Sorry, where was that?

Ms WALKER: Probably Ski Beach. Ski Beach or Gunyangara, as it is known.

Madam CHAIR: In Nhulunbuy or near …

Ms JOHNSON: I am going there next week; I am actually going for the first time next week to do talks. I am going to work with Rio Tinto …

Mr GUNNER: What day?

Ms JOHNSON: I go Wednesday, and I am there Wednesday, Thursday, Friday, and I have basically said …

Ms WALKER: Okay, so Thursday, the 17th, we are having public hearings.

Ms JOHNSON: Okay, well …

Ms WALKER: … on this very subject.

Ms JOHNSON: Yes.

Ms WALKER: There is a very successful group out there, the Galupa Marngarr Suicide Prevention Group run by Gaylee Marika. So, that is great. We will send you some details so you know where we are.

Ms JOHNSON: It is my first visit out there, but we have had a lot of contact with medical staff up there that are at risk of burning out because they have got no one to debrief, there is no-one to talk, so we can offer that …

Madam CHAIR: And that is a major issue with health staff in some of these regions.

Ms JOHNSON: Yes. I have got an extra counsellor onboard, so I can now offer that as a telephone service.

Madam CHAIR: We will get your details, Jane, and we will contact you and then we will certainly keep in contact, Karen and Rob, for down here.

Ms REVAL: All right.

Mr LOANE: Okay.

Ms REVAL: From some personal experience, another area that I think is worthy of consideration is a safe place for young people to be able to go when they are feeling vulnerable and have thoughts of suicide. You know what it is like when you get a toothache or an earache in the middle of the night. It is the same with suicidal ideation, it is the middle of the night, there is no one around, and no one is open. Personally I would like to see headspace be open 24 hours a day.

If there was a place where young people could go and just sit and feel safe until that moment of crisis passes and then could go home. The hospital is not the place for this.

Ms JOHNSON: No.

Ms REVAL: I was thinking, even on a community when someone is vulnerable and someone has identified that they need to feel safe, where could they go, whether it be the women's refuge or whether it be a safe house? On a personal level, I know I can help keep someone safe, but I have to work hard at it, and I have the skills. What about those who don't?

Madam CHAIR: People who do not have it.

Ms REVAL: People who do not have those skills, people who do not know where to go, do not know what to do - I do not know how it could happen, I do not know what it would look like – need a service or a place where young people can go. I have spoken to headspace very briefly, because I have connections there as well, and it would be really difficult. You do not want it to be a drop-in centre; you do not want it to

be overused, but a place where someone can go where they feel safe is all I am asking. Not the hospital - just somewhere where they can go.

Madam CHAIR: That is certainly an issue that has been raised with some of our remote communities and regions. We just need somewhere that we can take our young people, or our people, to just to sit down …

Ms REVAL: To feel safe.

Ms JOHNSON: We are not quite as important as that, I do not believe, but we were contacted by people who said they wanted somewhere to be able to go and remember the people they had lost to suicide. That is why we put our seats in the Botanical Gardens. I regularly walk my dogs through there and nearly every time I walk through, there is somebody sitting there, and I go over and talk to them and they are sitting there because they have lost someone to suicide. It is a beautiful, peaceful place under a Cannonball tree, but I guess they feel they can focus on their loss there and that is important when you feel like that.

Ms REVAL: We have someone who is feeling vulnerable and they express that to you; that is such a good thing to be able to say: 'I am feeling vulnerable, I cannot keep myself safe'.

Madam CHAIR: And how important it is Karen that people are able to say that to you because I know there are many young people - I had a nephew who we all thought was really good and his mum, who is my sister, who had completed suicide and we just did not; none of us could read the signs and his inability to communicate.

Thank you for sharing and we will make sure that your personal stuff is kept off the record and we will send a transcript and you can have a look at that. We thank the three of you.