



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

**Public Hearing Transcript**  
10.15 am, Monday, 6 February 2012  
Katherine Town Council Chambers

**Members:** Ms Marion Scrymgour, MLA Chair, Member for Arafura  
Ms Lynne Walker, MLA, Member for Nhulunbuy  
Mr Peter Styles, MLA, Member for Sanderson

**Witnesses:** Mr Jim Sullivan

The Committee **agreed** to hear from the NT Early Intervention Pilot Program in camera.

NT EARLY INTERVENTION PILOT PROGRAM  
Ms Jeanette Callaghan, Program Coordinator  
Ms Lauren Moss, Resource Officer  
Mr Brent Warren, Superintendent NT Police

The Committee resumed the hearing in public.

KATHERINE YOUTH INTERAGENCY TASKING & COORDINATION GROUP  
Snr Constable Daniela Mattiuzzo, Chair  
Ms Kate Ganley, Secretary  
Ms Jane Hair, Manager Katherine Top End Mental Health  
Dr Jill Pettigrew, Psychiatrist Katherine Top End Mental Health

**MR JIM SULLIVAN**

**Madam CHAIR:** I apologise, Jim, we are starting 20 minutes late.

On behalf of the select committee, I welcome you to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome Mr Jim Sullivan to give evidence. Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee and for your submission.

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

I will ask you to state your name for the record and the capacity in which you appear, and will then invite you to make a brief opening statement to the committee. Before that, I will introduce members of the committee: Lynne Walker, who is the member for Nhulunbuy, and Peter Styles, who gets the gold star for beating all of us to the meeting this morning. Peter is the member for Sanderson, and me. I have to make apologies for Kezia Purick, the member for Goyder who, unfortunately, was unable to come, and also, the member for Fannie Bay, Mr Michael Gunner. My name is Marion Scrymgour; the member for Arafura.

Would you like to state your name, Jim, and if you want to make a brief statement please do so.

**Mr SULLIVAN:** James MacDonald Sullivan, farmer and cattleman. I came to the Northern Territory in 1964, so I have been here a long time. I will come to my submission shortly; however, I wanted to state a couple of things. First, I have no health qualifications at all; however, I am interested in the politics of health and the structure of health. They are the things I will address today and draw your attention to what I think needs to be looked at.

Suicide, in general, is a very difficult problem. There is probably no real answer, just a means of reducing it as much as possible. One of the great steps forward has been the Banned Drinker Register. It is going to have a great effect, and certainly is as we are seeing it today. It will impinge on domestic violence, which has a role in this.

I have an interesting hand up I call number one, which is research out of the United States showing childhood maltreatment reduces cerebral grey matter. I do not expect you to read it, but I hand it up so I am not giving you information that has not been substantiated. That is fairly interesting. There is more to it than that, but I have given you one page.

If you were to say health knowledge goes from one boundary fence to the other – I will wait until you finish reading it.

If you are saying your health knowledge goes from one boundary fence to the other but, in fact, there is an artificial boundary fence, and we only use the boundary fence from there to there, and what is outside is unacceptable in our health system – chiropractic, naturopath, spine manipulation – quite a lot of knowledge is there that is not being brought to bear. One of the things I think we need to do is to look at ways to bring that knowledge to bear in many areas. One of them is it will have an effect on suicide and, in fact, has a big role in our goals and places like that. So, I will come to that.

If you look at a cattle station and you see it is not paying, it is not much use running through the scrub looking for more cattle - fat cattle to sell. The problem lies way back, with calving percentage, mortality, back there. So, while it might appear that I am not really addressing youth suicide, I am addressing the problems that I think impinge on youth suicide.

There is an editorial in *The Financial Review*. I will just read one sentence of it:

*On 24 November 2011, turf wars between different health professions are still causing some of the biggest inefficiencies in the healthcare system.*

That is an editorial. It goes on with things. There is reason for us to be looking at our structure of health.

I had a man working for me once who a Catholic priest described as a 'bible basher' - and he was. If you went on his favourite subject he would go on for hours,. But, but when you got past that, you found out he was a first-class carpenter, shipbuilder, blacksmith, mechanic. So, name calling is very easy, and I will come back to that as part of my thing.

Now, I will come to my submission. I have put that in mainly just as a – well, first of all it was a draft, but our computer broke down so we had to put the draft in instead. So, there is a bit of rub outs and things on it.

Just the first paragraph is a little about myself and the significance of Aboriginals in the social factor. I put there the three major points that I wish to address – the holistic approach which is knowledge outside the square and the exclusion of that, and the medical courts. I think the medical courts are causing a lot of damage. They have been given a charter by the parliaments of Australia, and the civil courts will not touch them and will not deal with them. They are a suppressing innovation, and we need to bring innovation to bear in our health system.

I would like to hand up now No 3. There are two aspects to No 3. You saw in that submission that my daughter had a migraine. Well, in the end, she was getting migraines so bad that I was despairing. But, fortunately, I knew about Dr Milne, so I am handing up something on Dr Milne. He published four letters in *The Medical Journal of Australia*. Just at the top there you see that is 1969. I have only handed up the one letter, but there are three others.

When Dr Milne put the fourth one in, the editor of *The Medical Journal of Australia* wrote to him and said they did not want to hear anymore of this nonsense. So, obviously, the editor had been leaned on by the medical industry. But, Dr Milne did a lot of work and has shown what can be achieved.

There is another person there that can come up the same time, which is the cervical syndrome. This is a book that came out in 1956. A Professor Ruth Jackson at the Illinois University in the United States and she – that is only a cover, I just photocopied the cover. Dr Milne read her book and then he took on spinal manipulation and my daughter benefited from it.

It is one of the areas that we need to bring to bear in this youth suicide area, because if my daughter had gone on she could well have become a candidate for suicide. If Alan Bond's wife, who has recently committed suicide and had depression, had access to spinal manipulation there might be a 70% chance she would be alive today. There is a lot going for it.

Australia has a great healthcare system - I am on page 2 - it is excellent in the areas it is good at. However, the system fails in areas where people do not respond to drug-based medicine. My daughter did not respond to drug-based medicine, and many people do not – people who are involved in motor accidents. When my daughter had that accident was nothing was seen, but she was knocked out of plumb somehow and painkillers were not the way to fix it.

What I am suggesting, and pushing the hospital board and the health department to look at, is we establish an adjunct clinic; a clinic adjacent to the hospital system in which we bring to bear this knowledge.

It is no good forcing it into the hospital because there will be too much resistance; however, if we could have those things available - I will give you an example, the three people involved are Ruth Jackson, Dr Milne and Dr Gorman. Dr Gorman causes great consternation when you mention his name anywhere around. They say: 'That idiot. He is mad and has been deregistered', but when you get away from that and come back to what he has done, he worked for 10 years at a corporate medical centre in Sydney with 17 other health professionals for primary health, Bankstown. If you are in a big show like that with professionals and are incompetent you do not last. He lasted there for 10 years.

The average wait in that clinic was fifteen minutes. People walked in off the street to wait at the most 20 minutes. People were waiting an hour-and-a-half and two hours to see Gorman because he as bringing other knowledge to bear on the problem. That is what makes me think we could establish an adjunct clinic which attracts people out of our hospital, because people who do not respond to drug-based medicine are stuck in the system costing much money. If we could drag them across to the adjunct clinic we might achieve much going out to Aboriginal communities - they are often very violent and have many injuries and falls. Some minor chiropractic-type treatments would do much good.

Going onto gaols, this is an acquired brain injury report from Tasmania. It is interesting, great swags of people in gaol have brain impairment of some sort. I have two marks here I will quote. I will read it in:

*One such study conducted by New South Wales Department of Juvenile Justice has found from a sample of participants – 242 - 84 of the young men had sustained head injuries in which there had been unconscious or blacked-out. Most were the result of being struck by an object or person, fights 63%, low falls 30%, memory loss 19%, and poor concentration 18%.*

We could certainly achieve something with poor concentration. This has many ramifications for the gaol system as well - if we could bring this knowledge to bear in the health system. That is the only factor I have to put in, but it is interesting reading.

**Madam CHAIR:** Jim, who wrote that report? Can I see it? We can give it back to you, but I want the title of the report and who wrote it.

**Mr SULLIVAN:** I have gone down a bit further - legal protection and the health system. The advice I have is some people in health are worried they can be sued. That is a serious impediment. If you are worried about getting sued, you will do a lot more than is necessary. We ought to try to think about giving people in the front line of health a better defence against being sued, and complaint.

I am not saying it should be overridden, but there certainly should be some better defences so that people do not feel obliged to give a test if they think it is not necessary, because they are very expensive. Somewhere along the line, we have to rein our health budget in. We all need to do something, and parliament needs to be looking at these areas where it can do something. I am thinking that is one area I would like parliament to give some consideration.

In Gorman's clinic, as I just explained, his pharmaceutical prescription was 80% less than the average doctor - and the tests were about the same. That is a bit extreme, but I am hoping if we can look at this we might be able to get a 15% or 20% reduction in pharmaceuticals. This would be a big saving for us. We certainly have to look at many areas where we can.

People say that spinal manipulation is very dangerous. Well, Professor Bonello at the medical tribunal hearing that I attended concerning Dr Gorman in 2009, stated:

*Associate Professor Rod Bonello of Macquarie University stated that spinal manipulation had a risk factor of one in 50 million.*

My understanding is anaesthetics have a risk factor of about one in two million. So, the mantra that it is terribly dangerous is not substantiated.

I spoke there about sacred cows, which comes to the medical courts. We have seen, in competition policy that has been for the last 30 years in Australia, a lot of these restrictions have been eliminated but the one area that has not been attacked is in health. The tariffs were reduced. Goff Whitlam made a start on that, Bob Hawke in another area, and foreign banks, and John Howard with gun control. There is an urgent need to rein in the sacred cows of medical courts. These courts are set up by parliament in all states to protect the public. However, they have been used to protect the medical industry from criticism and dissent, and the courts will not touch them.

I will just give you a reading here from a book that was written by Dr Gorman. He quotes a journalist's article ...

**Madam CHAIR:** Can you just quote what book you are reading that from, Jim, just so we can ...

**Mr SULLIVAN:** It is *The Great Australian Medical Scientific Fraud*. He is an odd bod, Gorman, as his title says. But, because a man is an odd bod it does not mean to say his knowledge is flawed.

**Madam CHAIR:** Yes.

**Mr SULLIVAN:** But I will just quickly read this one little bit.

**Madam CHAIR:** Yes.

**Mr SULLIVAN:** *What appears to herald the end of his battle is the decision of the New South Wales Supreme Court of Appeal that it will not intervene in the matter, saying it must be left to the medical profession to resolve its internal differences.*

The courts will not touch it. The journalist states on:

*He was found guilty of professional misconduct by that committee over the 60 Minutes program on the grounds that his peers of good standing disapproved of his actions.*

Let me turn it the other way and say your seat, as a parliamentarian, was in jeopardy because your peers did not like what you said. It would be a serious thing. Yet, that is what we have - our innovative doctors are under pressure there. We are seeing Gorman deregistered because the industry does not like what he says, which is a sad thing.

I will just read you one more piece of the information and this is to hand up; it is No 5. This is the New South Wales government Health Care Complaints Commission – *Mandatory Reporting - What Practitioners Need to Know*. I have highlighted the bottom of the page. They can be reported for practising the profession while intoxicated or with drugs or alcohol. No one will complain about that.

Over the page, engaged in sexual misconduct. No one can argue about that. Place the public at risk by being perhaps old and decrepit or have a disability, and that is fair enough too. However, here comes the blank cheque: place the public at risk of harm because the practitioner has practised in a way that constitutes a significant departure from accepted professional standards. That is a blank cheque. A medical court can interpret that as they see fit - there is no need for compelling evidence.

I am saying youth suicide is a big problem, and part of it is we need to put some pressure on our medical system - reign our medical courts in, and that is not going to be easy. However, one of the things I would like to see is a shot put across the bows of medical courts. Let me say how it should be done.

I would like to see the committee obtain the transcripts from those two tribunal hearings, Medical Board of New South Wales v Gorman 2009 and the Healthcare Complaints Commission v Dr Gorman in 2011 and send those transcripts to the legal department of the Northern Territory university and request they hire an independent barrister to look at those transcripts with two questions. Is there compelling evidence that Dr Gorman injured or maimed any person, yes or no, and is there compelling evidence that Dr Gorman has caused grievous harm to any patient, yes or no?

If it is yes, so be it. If it is no, because the decision of the Health Care Commission has a bearing on the Northern Territory -because these decisions anywhere affect doctors - the parliament, if it wished, could write to the Health Care Complaints Commission saying: 'Here is an independent assessment. Are we justified in continuing keeping this man unregistered?' What worries me is it is not so much the person, it does not matter about the person, but we have set a precedent that here is an innovator who can be put to the sword because people do not like what he says. As a nation, we cannot afford or allow our innovators to be put to the sword without compelling evidence. If he has been injuring people, fair enough!

If we get an adjunct clinic going, how are we going to get doctors to work on things like spinal manipulation? They will not come because their licence will be taken or restricted. This is a big area we could do much on.

That is about all I have to say. I am here to answer any questions you see fit.

**Madam CHAIR:** We will go to questions from the committee.

**Mr STYLES:** Jim, I would like to make a few comments. Thank you, you have given me much reading because you have raised some very interesting aspects on the lead-up to why people find themselves in a position where they contemplate – why they find themselves in a position where the brain stops producing all those feel good things and there is a slippery slope downhill.

I agree with you in relation to manipulation. I have heard much about that and believe it is something we should consider. No doubt, in our deliberations and in the final report, something will come out where we should look at the different ranges and perhaps do more investigation into that.

**Mr SULLIVAN:** Even if it goes no further, the fact it has been aired today is important because it is a start to holding the thing up to greater scrutiny.

**Ms WALKER:** Jim, your submission stands out from every other submission we have received in putting up a case for alternative methods of treatment. A member of my family is a doctor and has no faith

whatsoever in chiropractors. There is almost professional snobbery in the medical field. However, most definitely, what you are putting up as an alternative is most interesting. As Peter said, we will have a look at them and the reading – have a look at Dr Gorman and his work.

I would just like to ask you some questions more specifically, given you said you have been here since 1962?

**Mr SULLIVAN:** 1964.

**Ms WALKER:** 1964, all right - so 48 years. That is an awful long time in Katherine.

**Mr SULLIVAN:** No, part of it was Adelaide River, Tortilla Flats.

**Ms WALKER:** Okay.

**Mr SULLIVAN:** But I have been in the Territory.

**Ms WALKER:** What you have seen firsthand in this region - we have a few people coming to speak to us today; we have quite a busy agenda about youth suicide in this region. I would just like to hear a little more about what you see as the risk factors here for young people. You mentioned alcohol at the start.

**Mr SULLIVAN:** Yes. I would like to see the banned drinking register become tremendously focused on domestic violence, because it is mostly alcohol that causes it. We should have a pretty short list and, the moment it breaches, the perpetrator is on it. That will help.

That first thing I handed up, domestic violence causes brain problems for children. So, these young people are coming up, probably have brain abnormalities of some sort or other. We are sitting them in gaols. I think we need to bring some other guns to bear in the gaol system and bring in some other knowledge in - chiropractors and things.

You and I could all go to a chiropractor, but a lot of people out there cannot - out in communities. Imagine if Elders or Landmark leaned on the Department of Primary Industry and said: 'We do not like you doing this'. They would be told to go and jump in the lake. But, that is what is happening by these medical colleges leaning on the Health Departments in Australia; that we do not want this in our system. Well, that has to be stood up against. This health knowledge has to be brought to bear - the full spectrum - and if they do not want to deal with it, as you say, that is fair enough. We are not making them do it, but I do not see they are entitled to say that people who feel the need cannot go across - Gorman's clinic at Bankstown showed people waiting an hour-and-a-half to see him. People are not silly; they know this man has something to say that is worth hearing.

I was very fortunate, I knew about Dr Milne. I was able to get daughter treated. But, if I had not known about Dr Milne, what would I have done? My daughter would be just in a great queue of people that is languishing.

**Madam CHAIR:** Any more questions?

**Ms WALKER:** No.

**Madam CHAIR:** Jim, thank you for all of the information you have tendered to the committee. Your name did sound familiar. I have met you in the past. When you mentioned Tortilla, it just jogged the memory.

Thank you. Like other members of the committee, you have given us substantial information to follow up and have a look at. When you mentioned the issue of acquired brain injury as an issues, that could not be more so. If you look at the prison population, a lot of people (inaudible). Many studies have shown an area that often goes under the radar is foetal alcohol. The issue of foetal alcohol and its impact on the Corrections system and a lot of those individuals in the Corrections system.

I could not agree more. When we are dealing with this stuff - whether it is chiropractic or naturopathy; we talk about the holistic approach and dealing with the whole body - we should be able to look at all of these areas.

I cannot give you any guarantee of following up these questions, but we will certainly look at the information. We will make the transcript available to you; if there is anything in the transcript that you need the committee to follow up. We will have a look at this information and we will certainly contact you. It is a good opportunity. You have it on the record and we will try to move forward with it.

**Mr SULLIVAN:** I think that is the vital thing. I am happy to leave that Tasmanian thing, I do not really need it - that prison thing.

**Madam CHAIR:** The report, yes. We could obtain a copy of the report. We could give you those reports back. I was mainly just wanting the report title and the year it came out, and who did it, so we could maybe just find that through the Parliamentary Library Service.

Thank you, Jim.

**Mr SULLIVAN:** Thank you, Madam Chair and committee. I have enjoyed being here. If you need me to come back at any stage I am happy to do so. At least it is a start to state my point of view.

**Madam CHAIR:** Of course, thank you,

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The committee suspended.

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#### **SESSION IN-CAMERA**

**Mr Brent Warren, Superintendent, Northern Territory Police**  
**Ms Jeannette Callaghan, Coordination Northern Territory Early Intervention**  
**Ms Lauren Moss, Resource Officer, NT Early Intervention Pilot Program**

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#### **PUBLIC HEARING RESUMED**

**Ms Kate Ganley, Secretary, Youth Interagency Tasking and Coordination Group**  
**Senior Constable Daniela Mattiuzzo, Chair, Youth Interagency Tasking and Coordination Group**  
**Dr Jill Pettigrew, Katherine Mental Health**  
**Ms Jane Hair, Community Mental Health Nurse, Katherine Mental Health**

**Madam CHAIR:** I just have to read a short spiel out, ladies. On behalf of the select committee, I welcome you to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome to the table to give evidence to the committee Ms Kate Ganley; Senior Constable Daniela Mattiuzzo, Northern Territory Police; Dr Jill Pettigrew; and Ms Jane Hair.

Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee, and look forward to hearing from you today. This is a formal proceeding with 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 what you will say should not be made public, you may ask that we go into a private session and that your evidence be heard in private.

I will ask each of you then to state your name for the record and the capacity in which you appear. I invite any of you to make an opening statement before proceeding to the committee's questions.

**Ms GANLEY:** My name is Kate Ganley, I am here as the Secretary for the Youth Interagency Tasking and Coordination Group.

**Ms MATTIUZZO:** Good morning. My name is Danni Mattiuzzo, and I am a police officer based in Katherine. We are members of the Youth Interagency Tasking and Coordination Group, of which I am currently the Chair.

**Dr PETTIGREW:** Jill Pettigrew, psychiatrist, Katherine Mental Health.

**Ms HAIR:** Jane Hair. I am a community mental health nurse for the Katherine Mental Health group, and the manager.

**Madam CHAIR:** Thank you.

**Ms WALKER:** I have already introduced myself.

**Madam CHAIR:** All right. Lynne Walker, Peter Styles, and my name is Marion Scrymgour, the chair of this important committee. I have to give apologies for Ms Kezia Purick, who is the member for Goyder, and Mr Michael Gunner, who is the member for Fannie Bay. Both wanted to be here but, due to other appointments, could not make it. You have three very keen members wanting to listen to you. Thank you. Would any of you like to make an opening statement?

**Ms MATTIUZZO:** Yes. Thank you for the opportunity to talk to you. I did not really know what to expect speaking before you. I am thinking that probably there is not a lot I will have to offer that you have not already heard. But, I felt it was important to actually have some face-to-face time with you. It is something that the four of us - and we all know each other and work together professionally - are very passionate about this issue, and want to show you that, for our region - Katherine and for the outlying communities - we see this as a huge issue. Not, just in suicide, but also in really high-risk behaviour and self-harm which I feel very passionately about needing to speak about it as well.

Youth suicide, for me, is not just about a death; it is about the events that lead up to it, and the attempts they make, perhaps, on purpose and sometimes not, that can lead to death as well.

**Madam CHAIR:** Anyone else, or can we ...

**Ms GANLEY:** Yes. Further to that, as our report outlines, we know the rate of suicide in Katherine is very high. What I find amazing is the lack of consistent statistics around suicide deaths in the Northern Territory, and for the Katherine region.

From our local service providers, for the year 2011, we were able to collect information on 10 deaths for the region, but the official statistics were three for the last five years. So, as you can see, there is a huge gap in what the National Coroner's Information Service is collecting and what we know is actually happening on the ground. I suggest to you that the problem is actually far greater than the official statistics report. What we need is a uniform place of collection for these statistics, and for it to be transparent and easily accessible by local services. We currently do not even know where we are at and we do not know how to benchmark our services if the information we are getting is so greatly inconsistent.

**Madam CHAIR:** Kate, one of the critical things – in all the submissions we have received, all the witnesses who have appeared before the committee, it is consistent across data and the collection of data, but data being relevant and accessible for people to be able to - we need to look at the research so we get the evidence, but also so it provides the direction for funding and whether you target - where are the hot spots and ...

**Ms GANLEY:** Yes, a way to go forward. I would suggest a peak body, and whether it is the National Coroners Information Service or whether you have a locally-based institute, whether it is Menzies School of Health Research or something that can break it down region by region as well. As you know, the various areas of the Northern Territory are extremely different and it is relevant for us, as service providers, and government agencies to be able to look at those differences.

**Madam CHAIR:** Menzies mentioned a suicide register in their last submission they provided to us last week.

**Ms GANLEY:** Yes, that would be very valuable and for it to be broken down by region.

**Madam CHAIR:** Sorry, Lynne.

**Ms WALKER:** I was going to say exactly the same thing, Marion. I was just peaked at my notes from last Monday. Dr Gary Robinson and Professor Sven Silburn appeared before us and were taking about a suicide register in the Northern Territory, which received a bit of media coverage.

They also talked about the fragmentation of services as being an issue and everywhere we have been around the Territory that has come up. It is really important for us to be in Katherine and listen to you firsthand. In Nhulunbuy, in my electorate, there is a similar task force to what you had called YIN, Youth Interagency Network.

**Ms GANLEY:** Yes.

**Ms WALKER:** When we went to Tennant Creek there were a number of key people but not the link up between them.

**Ms GANLEY:** Not official.

**Madam CHAIR:** That was the first time they had actually met each other and realised what they were there for.

**Ms GANLEY:** The unusual thing about our Youth ITCG is it was formed out of a need and not out of any strategic framework or government policy that we would do this. Through our regular interagency tasking and coordination group, which is chaired by the Commander of Police, we identified a significant lack of coordination between youth services. As the secretary for that group, which was originally based with the Department of Justice, I was tasked with being the secretary also for the Youth Interagency Tasking and Coordination Group.

The trouble is, my position has now transferred over to the Department of Housing, Local Government and Regional Services and we are struggling to see the fit with me coordinating youth services because there is a need for it, but there is no dedicated position. Across the Territory, every region does youth coordination differently and that is an issue. When we are looking at coordination and responding the same in each region consistently we need to have consistent structures in place which we do not.

**Ms WALKER:** In Nhulunbuy the YIN is coordinated by Anglicare.

**Ms GANLEY:** Yes.

**Ms MATTIUZZO:** When we talk about data collection and being accurate, for me it is also really important to have data collection about attempts and not just follow through successful suicides.

**Dr PETTIGREW:** Completed is the word.

**Ms MATTIUZZO:** Completed, yes, I was looking at that, because successful is not a word we use.

**Dr PETTIGREW:** No.

**Madam CHAIR:** No, completed.

**Ms MATTIUZZO:** So completed suicides versus attempts, because ...

**Ms WALKER:** Versus self-harm.

**Ms MATTIUZZO:** Yes, and self-harm behaviour and self-harming. The self-harming behaviours plus the self injury young people are causing to themselves.

**Mr STYLES:** Yes, we had a lesson on terminology on day 1, if I recall.

**Madam CHAIR:** Yes, about completed versus - and it has been a great ...

**Mr STYLES:** It has.

**Madam CHAIR:** ... education for us.

**Mr STYLES:** My first comment is on the standard of the submission. It is very succinct and very good. I do not know the other three ladies here, but I would like to put on the record the long-term commitment by Danni in her work with youth.

**Madam CHAIR:** She is legendary.

**Mr STYLES:** It is legendary around the Northern Territory and you are to be congratulated. I am glad to see you chairing this and getting it on its way.

Do you have access to police records and information? I know you might Danni, but is that available to the community? I have heard it is possibly not. When you say access to self-harm attempts, people of committees and the mental health people can target, is that something that is available to you?

**Ms MATTIUZZO:** That is available, I guess by professional courtesy, through people like me and Superintendent Warren. I cannot speak for Superintendent Warren, but certainly I have heard him say that he is willing and happy to share information that is relevant to helping a productive outcome. I am the same. So, if an organisation has a need for information, then if it is appropriate and ethical and within the boundaries of how we work, I am happy to share that, and we will retrieve that information. But, as a general rule, no, it is not readily available and it is not readily shared.

**Ms GANLEY:** Requests for Police intelligence generally have to go through as an official request through Intelligence. It has to be put out in a vetted way. So, absolutely not.

**Mr STYLES:** I just as the question, and I might have to the good Superintendent sitting back there. Is there any protocols in relation to that, or does that, as you say, obviously comes out of professional courtesy, but an absolute necessity to identify people at risk? For the information that police come by, are there any protocols in place at this point in time where you should or can share that with a particular group of people, or is it something that is a bit loose?

**Ms MATTIUZZO:** We certainly share and have a memorandum of understanding with places like DCF and Mental Health. Obviously, the reciprocal flow of information has not always worked well there. But, no, not for, say, NGOs working in mental health services. Did you want to comment?

**Mr WARREN:** I probably concur with what you are saying. The data that I spoke about before ...

**Madam CHAIR:** You can come to the table if you want to.

**Mr WARREN:** I feel like I am invading someone else's submission.

**Ms GANLEY:** No, you are right.

**Madam CHAIR:** they are quite capable of saying you are to go. No, it is just for the recording purposes, that is all.

**Mr WARREN:** Regarding the data I shared before about the attempts that were recorded in Northern Command, that kind of data can be made available on a regional and Territory-wide basis if it is requested. It has certainly been - particularly for Arnhem Land - looked at in some detail by police.

There has been a number of projects done by OICs in Nhulunbuy, for example, who have looked at the high trend out there. I submit that there probably has not been many bodies that have asked for that kind of data in a coordinated way before.

We have had it available. The reason, I suppose, Danni and I share data locally is because we are involved in local committees like the ITCG and the Youth ITCG, so we share it in that mechanism. I may have taken some risk upon my own shoulders in facilitating that sharing process before, but I think our framework is if there is a need for it, if there are people's safety at risk, then it is appropriate to share.

We are probably getting towards the blurry edges of where that is appropriate now, particularly when you are talking about early intervention. You go from saying there is an immediate risk to someone's safety to saying there is a potential risk in the future. I know some of our health friends have probably found that blurry edge sooner than us, because they cannot say they need to contact police and share that information immediately because there is an immediate risk, but there would be certainly value in the police having a record that they are dealing with a youth who is at risk. But, because of that patient confidentiality issue, they sometimes reach that barrier where they are reluctant to go any further. That is understandable; they have their own framework to work in too.

**Madam CHAIR:** The police or the health?

**Mr WARREN:** The health agencies. This has come up very recently again. I was talking about volatile substance abuse and some of our colleagues in the NGO health providers have said they are aware of people who are engaging in behaviour. It would be useful to share, but they have had to get some clarification about what they can share. We are not talking about immediate risk stuff, we are talking about flagging groups who might need to be case managed or referred on to a rehab provider or something like that.

**Madam CHAIR:** But where does the flag go up with that, though? Let us explore a hypothetical on a 14-year-old young person. We will not even say the age. Let us just say a young person comes to the attention of the police, but is also FACS or mental health managed, but is also seeing an Aboriginal medical service in the town. What is the information sharing or the flag that goes up to say this child is at risk and someone needs to do something? What happens across those agencies here?

**Mr WARREN:** I will give the official first step and you can talk about the Youth ITCG.

**Ms MATTIUZZO:** Sure.

**Mr WARREN:** The very formalised information sharing is any child we come to deal with who is at risk we fill out a Child at Risk form. It is loaded into our database and is shared automatically with the Department of Children and Families. They would receive notification and we would see them as our government partner agency for any kind of response to a young person engaged in that kind of behaviour, but the case management that occurs around the Youth ITCG table is more comprehensive than that.

**Ms MATTIUZZO:** One of the things I felt strongly about today was celebrating successes and flying our flag. I am told constantly by people who come to Katherine as new professionals that they are amazed and astounded at how well we work within our agencies, both NGOs and government agencies. We talk about organisational silos, and we all work and become frustrated with organisational silos, but in Katherine the goodwill of professional organisations to share and work together is outstanding and needs to be celebrated because we are a shining - and not taking away from any other region and what they doing, but we are a shining example of how it can be shared.

We might not necessarily have official ...

**Mr STYLES:** Recognition.

**Ms MATTIUZZO:** Well, yes, and pathways, but we do it very well because it is based on lots of goodwill and lots of ...

**Madam CHAIR:** And relationships amongst all of you.

**Ms MATTIUZZO:** Yes, and lots of fantastic relationships.

**Mr STYLES:** If that is a successful working model, would you believe a recommendation of this committee is we should get someone to look at the way you operate and then perhaps look at setting up a broad range of protocols as to how we might replicate that elsewhere in the Territory?

**Ms MATTIUZZO:** Yes. The other thing that ...

**Madam CHAIR:** A number of times I have said in parliament that people should look at the Katherine region for innovation and creativity - much good work happens down here.

**Mr STYLES:** That goes back to what Kate said in relation to coordinated outcomes. If you people have that type of success and have a range of coordinated outcomes through interagency cooperation, then perhaps we need to implement something like that elsewhere. Again, looking at the further sharing of information and also the legalities of that - I, having worked in similar areas, am very aware of the information sharing that is done by goodwill; however, you are moving into really dark grey areas as to whether or not you are crossing lines and you really have to put dark sunglasses on sometimes to succeed in saving lives, which is the ultimate goal of this.

**Dr PETTIGREW:** It comes down to trust; you have to trust the individuals. I have had adverse experiences in sharing information with what used to be FACS and is now DCF, but never with the police. The police, very much, are respectful of how they use any information we share and expect - and that works mutually, but I cannot say the same for family services who will, quite inappropriately, say things to

people that are inaccurate, misquoted, and lead to much destruction of what rapport one might have built up with a particularly difficult family in difficult circumstances.

**Ms GANLEY:** We touch on that in the report because that is unprofessional behaviour, perhaps, by people in an agency or a service you might say. One of the big challenges in the Northern Territory, as I am sure you are aware, is recruitment and retention of quality staff. In Katherine it is very difficult, more difficult probably than Alice and Darwin. I do not know if Nhulunbuy has the same issues. Often, what may happen is people are recruited to positions who may not necessarily have the professional qualifications, experience, or skills required to adequately do their job. That is okay because a part of a good recruitment is capacity to learn - whether they have the skills when they start, as long as they are supported through that to then be able to do that at some point in the future, that is a good way to go.

One of the real challenges of recruiting to Katherine is lack of available accommodation. I know Alice, Darwin, and Nhulunbuy all have the same problems. For the record, the rental vacancies in Katherine are 0%. There is just nowhere to place professionals or anybody - it is across the board lack of housing - and it really does impact on the quality of service provision in Katherine.

**Mr STYLES:** Nobody want to live in a motel room?

**Ms GANLEY:** No, surprisingly.

**Ms MATTIUZZO:** And following on from that, of course, you struggle with the retention or recruitment of professionals, but that flows on into overcrowding of houses. So, then, your 'at risk' children and young people are living in a house which - and I do not mean to; you have heard all this before I am sure. We bang on constantly about overcrowding in housing and lack of appropriate safe housing in communities. It is a local issue as well. You have 'at risk' kids who are living with 20 people. There may be drinking problems, there are attendance issues because they are tired because they have been awake all night with card playing or - I am sure you know all this, but it needs to be said. It is not only professionals without housing, it is actually just people without housing.

**Ms GANLEY:** And the youth suicide problem is not just about access to mental health, it is a part of a big picture problem that touches on everything.

**Ms MATTIUZZO:** You asked a question earlier about how we flag these kids and young people. One of the most practical on-the-ground ways these kids are flagged is the school-based nurse and the school-based police officer. Between those two positions - and I know they have been eroded drastically over the past few years - those two people in a school community are the absolute key to flagging 'at risk' kids.

That does not get you kids who are disengaged, but often the school-based nurse and the school-based police officer are actually working in the community as well to actually re-engage kids. Often, if they are not at school, they are noticed and flagged and brought to the attention of those two people. The erosion of those two programs has made a huge impact on on-the-ground welfare and pastoral care of young people.

**Madam CHAIR:** We have certainly been hammered by our colleague over there about that. We have also heard that in evidence, Daniela, when we have travelled around and taken evidence from other people. At the same time we have heard from a lot of young people, and it was interesting where they were speaking of their reluctance to go to the school-based nurse or the school-based counsellor because of where they are positioned. They were reluctant to go into that area because other kids, people will see them going in. So, there is a real reluctance, and it is just where they are placed, that is all. I suppose if they were put somewhere else, they would probably access the services, but they will not at the moment where the school has them placed. Lynne, did you have ...

**Ms WALKER:** I just want to ask you about the makeup of your group. There are four of you here today but, obviously, you have far more representation in the group across different agencies.

**Ms MATTIUZZO:** We have around 40 members. It is an open forum, so people do come and go. But, generally, it is a very stable group of people. It is made up of everyone from the Smith Family to Mission Australia, to Mental Health to DCF. It is very broad and we encourage anybody who has anything to do with youth to come along. For me, those organisations are very crossed over - they cross over and youth is not their primary focus but they see value in being part of the group.

**Ms WALKER:** Given the size of that group, how do you keep it focused to be a mix of information sharing - which is good - action oriented, and outcome oriented, as opposed to just a gabfest?

**Ms MATTIUZZO:** Our meetings average around 25 to 30 people and we meet once a month. Kate is very strict in keeping us on task at times, which is helpful. It is a long meeting, normally two to three hours, and we acknowledge that is a long time to sit, but it is once a month and we see the value in having to spend that much time.

We break off into sub-committees. If there is a recognised issue we say: 'Okay, who can problem solve and when can we meet at another time' to get the relevant to that issue people around the table and it works really well.

**Ms WALKER:** Yes, because you are covering a huge area.

**Ms MATTIUZZO:** Yes.

**Ms GANLEY:** And youth issues are everything. The most recent sub-committee was one to address programs available for early school leavers - people who do not have Year 10 or Year 12 equivalent or a Certificate II and how they are being serviced by job service providers or other services. Also, another subcommittee is organising National Youth Week. However, it is a real challenge to keep it action oriented.

**Ms MATTIUZZO:** Yes. One of our huge successes in the last 18 months has been the Youth ITCG recognised the holiday program for kids was lacking and there was a spike in antisocial behaviour and bad behaviour of young people during school holidays. We formed a group and have been running holiday programs for free in three communities close to Katherine and in Katherine.

In the last school holiday program which finished in January we had over 2500 kids attend for free and get involved in the ...

**Ms WALKER:** You do not have an NGO that coordinates that, like an Anglicare?

**Ms GANLEY:** YMCA leads that holiday program.

**Ms MATTIUZZO:** They led that program with lots of assistance from other service providers who give in kind support. Police give accommodation in kind as well as NTEIPP, the early intervention pilot program into binge drinking. They give staff on the ground time, so does Mission. It is very collaborative.

That is another one of the issues we identified as being a problem for young people and off we went into a smaller group to solve the problem.

**Madam CHAIR:** Are we able to get a list of your ...

**Ms GANLEY:** It is on the appendix of the submission. They are members who regularly participate. The e-mails go to a broader cross-section. For example, I regularly e-mail Kalano Aboriginal Community Association, sport and rec and various other agencies. They do not participate in the meetings but the information of what is happening is available to them.

**Madam CHAIR:** And Katherine West, obviously, Sunrise, those health services?

**Ms GANLEY:** I am not sure if Geoff is on - some of them opt out of being provided information – do not want to know.

**Madam CHAIR:** They do not want to know?

**Ms GANLEY:** Yes.

**Madam CHAIR:** Even though they provide services within the region and ...

**Ms GANLEY:** That is right. Some services do not want to participate in these forums, and it may be because our forum is chaired by police or it may just be – I am not sure.

**Madam CHAIR:** It beggars belief and people then sit there and whinge and say they do not get information.

In your submission – sorry, did you finish?

**Ms WALKER:** No, go on, you are all right.

**Madam CHAIR:** Pete, are you right? Can I ask a couple of questions? Is that all right?

**Mr STYLES:** No problems, Madam Chair.

**Madam CHAIR:** Thank you.

In your submission you note a lack of Katherine based child and adolescent mental health professionals. Can you tell me how often Tamarind Centre staff visit Katherine?

**Ms HAIR:** They come down monthly for two or three days. We have funding for a position based in Katherine but that has not been – I do not know if the money has come through, it has not been advertised as yet. Again, it is going to be a problem finding somebody with the qualifications who wants to stay here.

**Madam CHAIR:** Come and stay in Katherine.

**Ms HAIR:** Yes, but that is the plan. They have a position and they have the money.

**Madam CHAIR:** For a full-time position down here?

**Ms HAIR:** Yes, in Katherine.

**Madam CHAIR:** Apart from visits, Jane, from the Tamarind Centre, what mental health services are available for young people in Katherine across the government and NGO sector? What sort of intersectoral collaboration is happening?

**Ms HAIR:** We have many non-government people who get funding, which is FAMS, Teen Health, Somerville. They actually get mental health funding but none of them actually specialise in youth, that I am aware of. We work with kids, frequently 14 and up. Then, child and adolescent will see anything from little, but also up to 18. But, we will consult with them and, if there is anyone we need to see in between their visits, we will follow up on them. They do a lot of the assessments for the Asperges and your infant stuff, which is a totally different world. We will not have specialists in that area.

**Madam CHAIR:** What happens in Katherine if you have a young person who is 'at risk'? What is your in-patient services? What is available for a young person? Nothing? So what happens; do they go to the hospital?

**Dr PETTIGREW:** There is no dedicated adolescent services.

**Ms HAIR:** They would go to hospital here and they would be transferred up to Darwin straightaway if they were having a ...

**Dr PETTIGREW:** No, they have to have a border. We have sent young people up. I point out that another group in our region that is sometimes overlooked but still very much a part of the community is the RAAF community. We have the children of RAAF members who often have suffered the dislocation of a lot of moves and that sort of disruption, plus we have very young members often sent to Tindal as first-out rookies, first time away from home, lack of family support, all that sort of thing, who certainly engage in some self-harming behaviours as well.

**Madam CHAIR:** How much time is actually dedicated to those families in the Defence Force because that is ...

**Ms GANLEY:** The Defence Force has a Defence community organisation, and two especially allocated social workers for the Defence community, as well as transition officers. So, they have a quite well resourced community organisation they can access.

**Ms MATTIUZZO:** Along with your comments about the kids, because of the location, sometimes the young people say is they do not want access that because other RAAF people will know they are accessing

that welfare. They are a fantastic organisation and I have worked with them a lot. They are very valuable but, sometimes, they prefer to go to the local organisation.

**Dr PETTIGREW:** I point out that DCO did not have a social worker based in Katherine for a number of years; they were relying on fly-in people from Adelaide or Darwin, which was not highly successful because their credibility was not particularly high: you are not here, you are not living, you are not walking in my shoes.

**Madam CHAIR:** The only reason I ask that was it is a huge problem. There is a lack of focus or support to Defence families. I know when I was working down here and we were looking at family violence programs, the biggest users of the system outside of the Tindal Base in town here were Defence families and, for obvious reasons, why they were not using those services out there.

So if the woman was 'at risk', certainly those children are then 'at risk'. That is why I just wanted to know whether that had any relevance. Maybe it has gotten better for ...

**Dr PETTIGREW:** Well, I have been here close on over 10 years now, and the situation in support in the Defence community has varied enormously. As I said, bereft of social workers for a long time; the uniform psychologist has come down from Darwin once a month or so. That can fall over because, if there is pressure of work in Darwin, then Tindal is the first thing that falls off the radar. Also, those people only see uniform members, so we always have to pick up the families.

**Madam CHAIR:** That is the area that is always – and it was a major issue years ago when I was down here.

**Dr PETTIGREW:** Well, Marion, it has not changed.

**Madam CHAIR:** Women and kids were just discarded. That is right. They protect the person in the force but not ...

**Ms GANLEY:** That comes back to another recommendation, accessibility of services that everybody can access. Sven Silburn would have talked about it in the presentation about population approaches. It is very well to have targeted approaches, but to make an impact you need to be available for everybody. If you are only going to target people you think are at risk and services are not readily available or well advertised - much of it comes back to professional delivery of services which may be for non-government organisations that are funded for mental health services. How do you know? There are no ads in the newspaper and there is no consistent way non-government organisations, in particular, are asked to advertise what services they provide and what funding they are provided. One organisation might be getting \$1m to address youth suicide. Does Katherine know about it? Does that 15-year old know they can talk to - we need to really look at as a government and as a community, we need to have expectations on our service providers that they are very clear in what they provide. And it is a little about competition; In bigger regional centres like on the east coast everybody who provides...they are into marketing and they put ads on the TV or will have client focused ways of communicating with their target group which might be population wide. However, in the Northern Territory if we do not have very experienced people in places or positions that matter you can have services operating that - they did not think to do a marketing plan and nobody is following up on it. It is a real trap, is across the board and quite prevalent.

**Madam CHAIR:** Yes, and that seems to be an issue all over, just trying to get transparency amongst organisations.

**Ms GANLEY:** Transparency sounds almost accusatory.

**Madam CHAIR:** Well, it is allowing the broader community to know what the delivery of that service is and what they are funded to do.

**Ms GANLEY:** Absolutely, and if we frame it in the way of appropriate marketing for a target group it is less accusatory and also gives them a direction to follow. Rather than being transparent, we do not need to see your financials on the website, but how about we know what you can do.

**Ms MATTIUZZO:** Madam Chair, you touched on the question - and we got a bit off track - about what happens to a child who is identified as having a serious attempt at suicide or in serious need of specialist mental health and needs to be transported. What happens is they need to be transported straight from

Katherine, from their home, from their family, yes, with a guardian, an escort, or a carer and are sent to Darwin where ...

**Madam CHAIR:** Does patient travel cover that? Patient travel covers it?

**Ms MATTIUZZO:** Yes, if it is an emergency they are transported without cost. Guys, jump in because this is not my area, but they then become disconnected and are left in Darwin. Regularly people, for whatever reason, who are in Darwin hospital or at the mercy of the system in Darwin, say they feel completely isolated because they get left, dumped and then: 'Okay, how do I get back? What do I do while I am here? What does my family do for accommodation?' It becomes a ...

**Madam CHAIR:** I would not mind going along this because you said at the start you are interested in self-harm and that statistic. We were a bit astounded when the Commissioner gave us the statistics on self-harm and the attempted ...

**Ms MATTIUZZO:** You could probably quadruple that at least when you think about underreporting.

**Madam CHAIR:** Yes, and that is what we - the number of people who are not in the system and are doing that outside. Perhaps Dr Pettigrew, or Jane, did you want to answer this, you could either do it *in-camera* or if you feel comfortable. You do not have to answer this. What happens when a young person is an in-patient and is sent to Cowdy, or to the in-patient services in Darwin? Is that person then discharged and sent back to Katherine?. What is the notification? What is the support services that then come back once that young person is sent out of the system?

**Dr PETTIGREW:** We have a video link with Cowdy every Tuesday morning. So, anyone who comes in from our region, we discuss. Sometimes we know them, sometimes we do not. There is always information sharing and there is always a lot of discussion around discharge. If we are not happy with the arrangements, then we are very vocal about that. If we think it is premature for someone to be discharged, then we very much make that case strongly and try to have as much set up so that it is an optimal discharge rather than a rapid discharge.

We have that with our rural team, so that people can manage our in-patients. That occasionally might break down if someone goes in on a Friday and someone shoots them out on a Monday before we have a chance to discuss it. But, our discharge arrangements ...

**Ms HAIR:** We try to keep that to a minimum.

**Dr PETTIGREW:** ... are very good, they are very detailed, and they are very thought out. And they are ...

**Madam CHAIR:** That is Katherine to Darwin. What happens when you are in a remote area setting?

**Ms HAIR:** Well, it is the same set up, so it is the same follow through.

**Dr PETTIGREW:** Yes, we ring. We are video linked, and they will ring the community and talk to the staff at the community. We will discuss how the community staff feel about having that person back, what the family situation is, whether the family is ready to take this person back in ...

**Ms HAIR:** Because, at the end of the day, the community actually manages these people. We only visit. We go out every two weeks, but that is only every two months, to every community. So, it is more of a consultation, liaison. We will see that person, but we cannot manage them, the clinic has to. We have to work very closely with that clinic to make sure they are managed appropriately and, if they have any problems, then they call us direct. If we are not available, we have a 24-hour thing now. So, the second come four o'clock, our phone gets transferred to the emergency CAT team. They have access to all the notes and all that. So, they always have somebody on the end of the phone.

**Madam CHAIR:** Okay.

**Ms WALKER:** That is a relatively new system, is it?

**Ms HAIR:** Yes. That has only been in for, maybe, a couple of months if that - the 24-hour thing. But, that is working ...

**Madam CHAIR:** That seems to be working all right?

**Ms HAIR:** Yes, amazingly well.

**Madam CHAIR:** Okay.

**Ms WALKER:** I have heard the same thing.

**Ms HAIR:** Yes. If someone gets discharged to a remote community, we try to get there. It only has to be reviewed within seven days, hopefully. If we cannot get there physically, we will definitely phone up the community. But, we try to get to that community as soon as possible after someone has been discharged.

That is all logistics. Do you know what I mean? We are not going to fly in for one person if they are stable, to say that we were there within a certain amount of time. With all that in mind, we do the best we can in that regard.

**Ms WALKER:** Can I just ask a question, Marion?

**Madam CHAIR:** Yes.

**Ms WALKER:** I know we are running out of time. Where there has been a completed suicide, what sort of services are available for the postvention to support the family?

**Ms HAIR:** What I find happens with suicides in that regard, if the family wants outside intervention, being the mental health team, we will go there. That rarely happens. The family will bind together with their own support systems. They do not want outside counsellors coming in at that time.

Quite often, we will be referred to see people after this has happened - two to three months, sometimes 12 months after the fact. But, there is certainly not a little team that runs out whenever there is a suicide. There is not a team that runs out. I think they have tried that model in the past. Community people do not want that. If anyone ever asks us to go, we will always go ...

**Dr PETTIGREW:** Which has happened.

**Ms HAIR:** ... straightaway. That is right. It does not happen all the time, it is not the norm but, if anyone asks us to go anywhere for any emergency, we will go straightaway.

**Dr PETTIGREW:** And it is not just suicide. If there has been ...

**Ms HAIR:** A sudden death.

**Dr PETTIGREW:** ... deaths through accident or some sort of post traumatic intervention. Very much, we try to have it as something requested rather than something we impose, which is in accordance with best post-traumatic interventions; that it should be a bottom up rather than a top down.

**Ms WALKER:** Yes, but in our very remote Indigenous communities, how do you know how people are travelling if they have not had the offer - if someone has not checked in with them?

**Dr PETTIGREW:** Well, we ring ...

**Ms WALKER:** Or are you telling me that out on the community there would be ...

**Dr PETTIGREW:** No, we ring the community, talk to staff and health workers: 'Okay, how is everyone going? What do you think?'

I went out to a community after a young girl had suicided and talked to all the kids in the school on one occasion. We had several meeting that day. We had a men's meeting, a women's meeting, and I talked to the kids in the school. I flew out with the Sunrise people. The nurse and Aboriginal health worker, mental health worker, drove out on the same day, and we picked up and addressed a number of people who were hurting very badly. We have the capacity to do that sort of response.

I know the child and adolescent psychiatrist who has been in the Territory for the last – most of this last year - did an intervention out at Groote, I think. They had some youth suicide there and did a community

intervention. There is the capacity to do that. Again, as I said, we try to have it driven by the needs of the community, as opposed to just a stock response.

**Madam CHAIR:** Peter?

**Mr STYLES:** No, I am right, thank you.

**Dr PETTIGREW:** We do put people in Katherine Hospital if we feel they can be safely managed in that environment. Given that much youth suicide is impulsive and driven by immediate circumstances, often if you can just withdraw the person from that immediate environment - even though we do not have designated beds, we have a good relationship with the hospital, good cooperation. If we feel they are manageable and the staff are feeling okay about safety, then we will have someone in for a few days just to allow for a reasonable assessment and to see if this was just a reaction to family rows or relationship issues, or whatever, and or if there is something more serious that can be better addressed in an inpatient environment.

We are aware that Cowdy is for the very severely ill people. There is not a less stressful environment, and we do not want to traumatise people who are naïve to that sort of ill health; to put them in that environment, if we can avoid it.

We often have people who are in a holding pattern for a couple of days. That gives us a chance to assess if there is a serious mental illness there, or whether this was more of a reactive problem. Much youth suicide is reactive. Of course, there are people who are reacting to psychotic phenomenon, and you cannot always tell that in the first interview. You just might not be able to pull all the information together.

**Madam CHAIR:** Just quickly, what are the main, I suppose, treatment facilities for substance abuse and young people in the ...

**Ms MATTIUZZO:** That leads exactly on to what I wanted to say. As Peter knows, I can talk underwater with a mouth full of marbles, and I have to say I am very good at it. One of the things I wanted to raise is I have a wish list quite long. One of them is that Venndale, through Kalano, is the adult rehabilitation centre.

**Madam CHAIR:** Yes.

**Ms MATTIUZZO:** I am not sure if you have heard from them during these proceedings, but they have applied for, and put a submission forward, for a youth building, youth facility, at Venndale to be co-located - appropriately collocated - and built, and specially designated to treat youth substance abuse issues. That is a mission ...

**Madam CHAIR:** Is that still under Kalano?

**Ms MATTIUZZO:** Yes. Casey Bishop, who is the manager of Venndale and has put a significant amount of work into that submission says that the submission went forward and had positive response, but has stalled. He does not know where that submission is, and they are busting to get moving on it if they can. Then, they can actually be a Katherine-based facility that actually deals specifically with young people and substance abuse which, of course, is a large factor in relation to self-harm and 'at risk' behaviours and successful suicide. Drugs and alcohol are often a factor in a successful suicide.

He spoke to us - and Superintendent Warren was present - at a meeting about volatile substances last week. He spoke openly about this and said: 'We have stalled and we do not know where we are at. We do not know where the problem is at, or approval is at. We are ready and raring to go. The plans are ready, we are ready to break ground, we just need the commitment'.

**Madam CHAIR:** We might get someone to follow up. I do not think we have received anything from Kalano.

**Ms KNIGHT:** They have been invited this afternoon.

**Dr PETTIGREW:** It is very difficult finding someone who will take a substance-abusing person. We had someone from remote brought into Katherine Hospital - a young person. In addition to substance abuse, he was also doing the self-asphyxiation and had become quite compulsive in that, and was having seizures and was very high risk. We had him in the children's ward in Katherine Hospital and I was totally unable to get anyone in Darwin to take him. It was vetoed - would not have him in the children's ward in Darwin.

**Madam CHAIR:** They did not say what; they just refused to?

**Dr PETTIGREW:** It was that they considered it the responsibility of the psychiatry rather than us. I pointed out that this child needed to be physically checked out and have an EEG, and all that sort of thing. The response was all that can happen as an outpatient, which was not entirely true. He was, basically, someone who just got bounced between paediatrics and psychiatry. I pointed out that I did not think that Cowdy was the appropriate environment, and that it would be more appropriate to be in the children's ward.

People are very concerned about self-destructive behaviour, even though he was managed quite well in the children's ward in Katherine. I pointed out there was no real difference with being in Darwin or Katherine. Once in the children's ward, he was quite compliant and not harming himself, but I wanted a good medical paediatric review. That happened piecemeal over some time.

**Madam CHAIR:** Which is why ...

**Dr PETTIGREW:** This can happen: someone gets bounced between various specialities and no one wants to pick up the baby, so to speak.

**Madam CHAIR:** I am interested in the number of young people who have made attempts, and whether any of them were in that category and, then, ended up in the completed category because of falling through – they had just fallen through those gaps.

**Dr PETTIGREW:** Not that I am aware of. Once someone comes to our attention, we just keep hammering. I spent about three days, most of it on the phone, and ...

**Ms HAIR:** Much of the statistics are, but quite often, your completed suicides are people who have never sought mental health treatment in their lives.

**Dr PETTIGREW:** And everyone is surprised.

**Madam CHAIR:** I have heard that too. I am not saying they have - we have a lot of evidence from people who have come and said a lot of the completed is the first time they have come into contact with the health system.

**Mr STYLES:** It is running somewhere between 60% and 70%?

**Ms MATTIUZZO:** For completed suicides?

**Mr STYLES:** For completed, and they have never had contact with Mental Health Services? It is a fairly high figure.

**Ms MATTIUZZO:** Yes. Have they had contact with other before they have completed the suicide? Have they had other ...

**Mr STYLES:** No, not that I am aware of.

**Madam CHAIR:** No, a lot of the data shows that they have not had contact; it is the first time they have had contact. But, there is whole other group out there that we do not know anything about, particularly young people who are disengaged, as you said, from the school system.

**Mr STYLES:** Madam Chair, can I just - that is where you say you need to go right back and flag through people in the community who are out there and watching, and have a particular interest in those sort of issues, to flag through to professionals, where you can go and, perhaps surreptitiously, target those people and engage them in some way, shape, or form, to try to prevent.

**Dr PETTIGREW:** There are programs - and I have been involved with a number of programs both through Defence and in a civilian capacity, and the ASSIST which is the applied suicide skills, and the various offshoots of that. The premise of that is that anyone can learn enough to make an appropriate intervention and direct someone.

We really do need that to be supported and promoted, because there will never be enough professionals for everyone. You will not have youth specialists in Ngukurr, for example. Again, you need – every time I

run a course, we ask people, 'If you were suicidal who would you talk to?', and it is family and friends. That is who people go to first. Then, it needs someone there to pick up, and direct and guide them towards appropriate services.

**Madam CHAIR:** You are right. We have also heard communities saying to us about the whole issue of post-traumatic disorders and just the layers upon layers of grief that people are dealing with. People are feeling under siege all the time, particularly in remote Aboriginal communities where young people are using suicide as a threat to get money for access to drugs, for alcohol. It is overwhelming.

I have been at pains to try to say to people it is not just about Indigenous youth; there is a lot of non-Indigenous youth out there who are self-harming. There are all these ...

**Dr PETTIGREW:** Absolutely.

**Madam CHAIR:** ... issues about our young people. Let us all try to work together.

The committee, thankfully, we have left our politics at the door and said this is too important an issue; we have to try to do the best thing out of this, and we are hoping we will. Everyone who has given evidence - justice by the time we hand in our report in March. We want to see some good outcomes from this. What that will be - anyone who has come before the committee will get access to that report. There will be Julie and Russell ...

**Ms WALKER:** That is certainly helpful for us. As Peter said, it is a very succinct submission, in framing up some recommendations. It certainly helps us in drafting that report.

**Madam CHAIR:** Yes. I want to thank you. For us, it has certainly been a real journey and something - all of us have worked in and come across from various sectors. Pete in the police, Lynne in education, me in health, and the same with Michael, and Kezia as well who has a real interest because she holds a rural seat and, often, people think that rural areas are okay. But, that is where you get your huge spikes and real problems.

For all of us, we are keen to get some really good outcomes out of this. We will certainly feed back to you. It is not about blaming different people; it is about looking at the different gaps in both the NGO sector as well as government: what is that collaboration across those organisations, across our government agencies, but also what is that accountability across our NGO sector, and what sort of outcomes do young people get out of all this?

I thank you for your submission; it is good. Thank you for coming before the committee. Do you have anything else? Is there anything you want to add?

**Ms GANLEY:** Just one little last thing. Touching on those last topics of conversation, it does come back to family. Sven Silburn recently presented in Katherine on early childhood outcomes, and he did this document for Department of Education. It is about a population approach for early childhood. One thing that came out of that was that, obviously, was those first four years are very formative and really important for forming those good relationships within your family and with your parents. If, for some reason, you do not get off to the right start in those first four years, it can be extremely indicative of your propensity to engage in self-harming behaviours – basically, indicative of the rest of your life.

One thing Sven pointed out in that was the approach to a child in maternal health in the Northern Territory appears to be quite different to other states; that there is not a consistent approach with following up with pregnant women and, then, also mothers and babies. I think he said that in other states the ratio of child/maternal health nurses is one to one with other nurses. We do not have anywhere near that ratio in the Northern Territory. Basically, it is about providing mothers - every mother - with the support through the pregnancy and after the pregnancy to develop that good relationship with their child into the early childhood years, which then they benefit from for the rest of their life.

That is a building block. It is all very well; we can intervene on youth suicide and get them into rehab after they have been sniffing petrol and everything but, if we go back to the beginning, that is where we might make differences.

**Mr STYLES:** Did you put that under the heading of Early Intervention?

**Ms GANLEY:** Yes, that is early intervention. But, it is very early on in life. It is not about playing basketball at midnight.

**Mr STYLES:** It is the key words - early intervention.

**Ms GANLEY:** That is right.

**Madam CHAIR:** It is early childhood education ...

**Ms WALKER:** Congress in Alice Springs talked to us about a program they have, particularly those 'at risk', very young teenage parents who may not have had the modelling about how to parent ...

**Ms GANLEY:** Or they have babies because they want someone to love, because they never had someone to love before. Nobody loved them, so they have a baby thinking that they might get love from them.

**Ms MATTIUZZO:** Thank you for your time and for listening.

**Madam CHAIR:** Thank you. We will certainly provide that transcript. You can have a look at it and, if there is anything further you wanted to add on your submission, provide that back to the Secretariat. Thank you.

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The committee suspended.

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