LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

11th Assembly

Select Committee on Youth Suicides in the NT

Public Hearing Transcript

10.30 am, Thursday, 3 November 2011

Litchfield Room, Parliament House, Darwin

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

Witnesses: JESUIT SOCIAL SERVICES
Delia O'Donohue, Manager of Learning and Practice Development
Louise Flynn, Coordinator of Support After Suicide

HEADSPACE
Amelia Callaghan, State Manager QLD, NT and WA

DARWIN REGIONAL INDIGENOUS SUICIDE PREVENTION NETWORK
Ngaire Ah Kit, Vice Chair
Julie Turner, Committee Member
Delsey Tamiano, Secretary

SALVATION ARMY HOPE FOR LIFE
Alan Staines, Director of the Salvation Army Suicide Prevention – Bereavement Support Services

PRINCIPALS AUSTRALIA
Jill Pearman, National Program Manager, MindMatters
Karina Stevenson, NT Project Officer, MindMatters
Vanessa Houltby, National Youth and Community Development Officer, MindMatters

Leonore Hanssens, Researcher

DARWIN COMMUNITY ARTS
Alyson Evans, Project Officer

Professor Colin Tatz, Author and Researcher

ABORIGINAL PEAK ORGANISATIONS
Paula Arnol, Chair AMSANT
Chips Mackinolty, Manager, Research Advocacy and Policy AMSANT
John Paterson, Chief Executive Officer, AMSANT
Ruth Barson, Advocacy Lawyer, North Australian Aboriginal Justice Agency

Jesuit Social Services
Ms Delia O'Donohue and Ms Louise Flynn

Madam CHAIR – Ms Marion SCRYMGOUR: On behalf of the Select Committee I welcome everyone to this public hearing into current and emerging issues of youth suicide in the Northern Territory.

I welcome by video conferencing, to give evidence to the committee, the Jesuit Social Services. In attendance we have Ms Delia O'Donohue, the Manager of Learning and Practice Development, and Louise Flynn, Coordinator Support After Suicide. 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 of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for the 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 say should not be made public you may ask the committee to go into a closed session and take your evidence in private.

I will ask each witness to state their name for the record and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding to the committee's question.

Would you like to introduce yourselves?

Ms O'DONOHUE: Delia O'Donohue, Manager of Learning and Practice Development. I would just like to thank you for this opportunity.

Ms FLYNN: Louise Flynn, Coordinator of Support After Suicide.

Madam CHAIR – Ms Marion SCRYMGOUR: Welcome to the committee. Would you like to make an opening statement?

Ms O'DONOHUE: Yes, Jesuit Social Services largely operates in Victoria, but we also have workers in Alice Springs who are working from a capacity building approach with the Indigenous community there. We have been working in the field of suicide prevention since 1995 through our dual diagnosis, counselling and outreach programs, and our art and music programs, and since 2004 through our Support After Suicide program.

We also, for the last three and a half years, have been funded through the improved services initiative, the federal government funding to skill up staff in relation to dual diagnosis. A large part of our approach around that has been dealing with the issues of suicide risk management.

Do you want to add anything, Louise?

Ms FLYNN: No.

Ms O'DONOHUE: Okay. We are happy to take questions now if you like.

Madam CHAIR – Ms Marion SCRYMGOUR: Before we proceed to questions, I will introduce members of the committee. To my left is Mr Michael Gunner, the member for Fannie Bay; Ms Lynne Walker, the member for Nhulunbuy, which is a remote seat in the Northern Territory; on my right, Mr Peter Styles, the member for Sanderson, which is an urban-based seat in Darwin. I have to put in an apology from Ms Kezia Purick, the Deputy Opposition Leader for the Country Liberals, as she will be a bit late. She will join us but she had a number of appointments this morning she could not get out of.

Would any members of the committee like to ask questions in relation to the opening statement?

Mr STYLES: Not at this stage.

Mr GUNNER: At the point of intervention, how do people get referred to you? If you could talk to us about your day-to-day operations in a sense, how do you interact with people? What is the first step? How do you actually get involved? If you could just take us through some of that basic stuff - I find that the most interesting.

Ms O'DONOHUE: Do you particularly want us to respond around our support after suicide program or our other suicide prevention programs as well?

Mr GUNNER: Your suicide prevention stuff. So, it is more about family members saying help, a child themselves, other programs, the identification side, like the early steps stuff.

Ms O'DONOHUE: Sure. Look in our *Connexions* dual diagnosis outreach and counselling program, a lot of our referrals are coming from youth justice, from mental health, from drug and alcohol services, some of them from word-of-mouth, the young people themselves are self-referring and in terms of the work that we do, we try to involve families where we can but we are really working at the hard end, so a lot of the time the young people are disengaged from their families and involved through the child protection system or with the youth justice system. In fact, Louise could you comment on your referrals to support after suicide?

Ms FLYNN: Referrals come to the support after suicide program through a wide range of services but mostly the coronial services, also from our website, and then schools, police, GPs, mental health, community health, so a very broad range of ways that people find their way to our particular program.

Mr GUNNER: And how do you find that first conversation? I imagine a youth justice referral is quite formal. But the school says to you, this person needs help or we would like your program to become involved, how does that first conversation go?

Ms O'DONOHUE: I guess it varies. Like there isn't a formula or a set way of doing some of these things. It depends. For instance, when we are talking about someone who has lost someone important to suicide, it depends who that person is, who else is around them still, what family or community is still around them so while we want to assist a young person, we also want a school community, a family, and broader community to be around them as well. So, with that first conversation; the first conversation may not even be with the young person, it may be trying to get a handle on what has happened, what else is relevant, who is important, so there is a broad range of things and then when it comes to talking to the young person, it might be also thinking through where that conversation needs to take place. Is it in a formal setting, is it at home, is it at school, or is it in a counselling room? It is much less likely to be, when you are talking about a young person, it is much less likely to be in a counselling room; it is going to be somewhere that is more comfortable and secure for them.

Mr GUNNER: What I am interested in is the earlier a cry for help is heard, the better. In what circumstances is it best for that intervention to happen and do you have any thoughts about, for example, in the school setting? Do you find that you have more success and more ability to help someone if identification comes out of a school setting? I would like some thoughts or some ideas you have around lessons you have learned about the best time, the best people to identify, that leads to the best success.

Ms O'DONOHUE: In terms of engaging young people who are at risk, what we have found is that it takes a long time. Some of these young people will not open up straight away so you really have to engage them around activity - activities that they are interested in. We talked in our submission about the importance of community development projects such as revealing the fascinations in them like art, like music, so you begin …

Mr GUNNER: Sorry, I did not mean to cut you off. I was saying your submission mentioned things like the adventure-based therapy groups. I was being conversational. Sorry.

Ms O'DONOHUE: That is okay. It is through those sorts of activities that you begin to develop a rapport with a young person and engage with them. Then, you can begin having the meaningful relationship. In terms of identifying whether they are at risk or not, we have discovered through our improved services initiative project that it is really important to, not only skill up clinical counselling staff around suicide risk management, but also your youth workers, your community development workers, your junior welfare workers so that they are all checking in on young people, and have the skills and ability to measure whether they are at risk or not.

Often, by the time they get to the clinical counselling staff, things are much worse for them, whereas if the non-clinical staff have the skills and ability to pick up on cue's early on. Then, the appropriate intervention can be put in place at an earlier time before the situation has become much worse.

Do you want to comment, Louise?

Ms FLYNN: One of the issues is, in a sense, you have two streams: a very clinical medical mental health response, then there is the community relationships; there is a connection and belonging. Sometimes, the mental health body might dominate, but it is a matter of having all those things in place; the sense of engagement so young people - because one of the issues in health seeking, young people will tend to go their peers before they will go to adults or other services. So, if you have a good level of engagement already in the school community, then it is more likely when these people are having difficulties or troubling thoughts or situations, that they will then seek help.

That is a background issue. It is like having the groundwork already done that is somewhat preventative, but it also makes it possible for people to seek help if they need it, rather than waiting for it to be a crisis, if that makes sense.

Mr GUNNER: That is excellent.

Mr STYLES: If you looked at all the services you provide - and I note on page 2 of your submission there is an outline of the programs you presently provide – roughly what percentage of all of that is early intervention?

Ms O'DONOHUE: Our community development work, our community programs, and some of the work we do in our outdoor experience programs are more early intervention. However, we are known as an organisation which very much works with people who are at the hardest end. So, much of our work is really at the tertiary intervention end rather than the early intervention end. Some of the work we do in those particular programs - community development, outdoor experience, and some of the training that support after suicide does, is at the early intervention end. Certainly, in the work we put in after suicide where we, obviously are dealing with people who have already lost someone to suicide and their risk is greater, we do consider early intervention important in that work.

Mr STYLES: That is post-suicide.

Ms O'DONOHUE: That is right.

Mr STYLES: So, you are talking about early intervention after someone has lost someone? You try to get in there as soon as possible to get that support service going and the rebuilding process?

Ms O'DONOHUE: That is right.

Mr STYLES: When I talk about early intervention in relation to prevention of suicide, my understanding of what you just said is you do not go right back to the beginning; there are other service providers who provide that general capacity building in young people to prevent them from actually getting to it. You, basically, are at the hard end, or the pointy end, as to where you provide your services. Is that the correct understanding? More of your services are provided towards those who are very close to committing suicide, or supporting those post someone who is actually a family member or friend? I just want to try to get the idea of where you guys are in relation to the service you provide.

Ms O'DONOHUE: It is reasonable enough to say that through our arts studio programs and our *Connexions* programs we are dealing with many young people who have identified mental health issues already, who have substance abuse problems already, and who we are concerned about their suicide risk factors. In terms of our support after suicide program, a very high percentage of suicides occur among those who are suicide bereaved. So we do see the work we do in that area is in fact preventative.

Mr GUNNER: That was a good point, I was interested in the last point you made. The bereavement services you do - what level of research you have done and what you have found about one suicide leading to more, intervention after that first one, and what success you have found in different ways.

Ms FLYNN: The literature and research acknowledges exposure, or knowing someone who has suicided, increases the risk of suicide. So any close knit communities are at risk of subsequent suicide. Sometimes that can be weeks or months, and sometimes it is a year or even 10 years where you have family members; father-son, mother-daughter, or two brothers, or uncles in the same family. Providing effective support after suicide is a really important part of any suicide prevention program and policy.

Some of the important features are to try to minimise the risk of a cluster of suicides forming, for instance in going to a school where there is potential for a subsequent suicide or where one has already started - where there has been more than one suicide in the school l- it is possible to reduce the risk of

subsequent suicides by looking at the school environment, how the previous suicides have been responded to, and putting in resources and support to the school community to then reduce the risk of subsequent suicides. That is work we are engaged in and also we consider that important within families.

Mr GUNNER: Your bush adventure therapy - who feeds into that? Do you target that at areas where you think there might be a cluster coming, or is that more about community building? How do you decide your bush adventure therapy, who goes into it, and where do you target it?

Ms FLYNN: With the bush adventure therapies, there is a range of groups of young people who go on those camps, but we support after suicide and consider them a really important intervention for suicide bereaved young people. The reason is we found young people - it is important to restore a sense of belonging and connectedness. After a suicide, young people feel very - often it is not just young people, but certainly young people feel quite disenfranchised, they feel different from their peers and they feel disconnected. Restoring a sense of belonging and connection is a really important part of that. Getting young people together with other people who have been through this experience is really important and we know they want to do it but do not want the formal setting of counselling and group work.

So in terms of going away on a four day camp with young people who have lost someone to suicide is about restoring a sense of connection, building relationships, getting a sense of achievement by doing tasks that are difficult, getting a sense of accomplishment. It is on a range of levels. It is a level of connection and belonging, but also a level of accomplishment and achievement. Also, their connection is really important in terms of breaking down the isolation and in disconnection that young people experience.

Mr GUNNER: It sounds like an excellent program. How do you work out which children go into it? So if someone suicided in a Grade 11 class, do you ask the children to volunteer, do you tap someone on the shoulder and say: 'We really think this would be helpful for you'? What was that step to get the people into the program, the identification, who is it?

Ms FLYNN: Yes. A lot of our contact in terms of coming into the camps would be sometimes through schools and sometimes through their parent, often a surviving parent, and it would be actually a series of conversations. So it usually takes quite a bit of rapport building before the camp.

Mr GUNNER: Yes.

Ms FLYNN: The people who run these camps are very professional, very experienced and highly skilled. While the program of the camp can look recreational, it has quite a strong underpinning of being very founded in strong principles of therapy. So it is not just a recreational camp. The people who run these are very skilled and professional in that kind of theoretical knowledge. So the young people who come along have been identified often by the school or the parent. It would mean quite a deal of – as I said - a few conversations mainly with the school, with the parent and with the young person talking through: 'What about this? This would be a good idea'. So it is quite a process, yes.

Mr GUNNER: So that comes after a series of conversations, like a culmination, in a sense, of where you are going. Then you have the bush adventure therapy. Then is that sufficient, or what sort of programs do you have after that? I guess when you spend four days with someone you learn a lot, so where do you go from there? Is it for public or individual?

Ms FLYNN: That's right.

Mr GUNNER: Yes.

Ms FLYNN: It is both those things. We do learn a lot from being with the young people for four days. We learn a lot more about their environment that they're living in and also just about them and what they might need. So we do follow up. We follow up individually with the young person and with their family, and that might be a series of meetings. So the three ways we do it: one is individually; one is we might create other opportunities for them to get together and to continue those relationships; and we also use the Internet by creating online groups for them to connect with each other as well. They also keep connected with each other like on Facebook and things like that, but we also do continue our follow up and engagement with them.

Ms O'DONOHUE: The research is very clear that you need follow up services for those types of programs. Just a short, sharp intervention is not sufficient.

Mr GUNNER: Yes.

Ms WALKER: It is Lynne Walker here, member for Nhulunbuy. I represent an electorate in North East Arnhem Land. Specifically within the Northern Territory context I see that your organisation does provide support services to Central Australia, to eastern and central Aranda communities. I am interested to know, just in general terms, what your presence is down there, either physically or virtual. You have just talked about the online community support that you provide, that has only been launched in September of this year, because as we know one of the big difficulties facing our remote communities is the time delay in getting access to support because of the remoteness compared to say urban areas. Can you provide a bit of background of your work in Central Australia?

Ms O'DONOHUE: We have two employees working in Alice Springs and very much in a capacity building role. They are working around issues of governance and leadership and helping the community to decide what sort of programs they actually want. We are not in there providing services ourselves. We are not one of the large organisations that is doing that. We do not see that as our role. We see our work in the Northern Territory more as providing support, providing advice, providing capacity building, where possible. Most or all of our programs are in either Victoria or in western Sydney. Do you want to comment on the online capacity?

Ms FLYNN: Because *Support After Suicide* has been running for seven years, we have built up quite a lot of experience and expertise in responding to what are the issues and experiences that are very difficult for people after suicide. So we have quite a lot of expertise there. So, we see that because many people – the rates of suicide are higher in rural and remote areas of Australia. Now, it was really important to have more available, so we saw the Internet as one way that that could happen so we have now just recently built an online community where people who have lost someone to suicide can get support. So, other people bereaved by suicide from around Australia are on that site and it is also moderated by staff and volunteers and I guess that depends on the Internet access in areas as well – that can be an issue.

Mr STYLES: In relation to the service you provide, obviously at the high-risk end, are you being forced to turn anyone away due to lack of staff or funding?

Ms O'DONOHUE: No. I think we are one of the few services that does not turn people away. Much of our work is done in the youth justice area and until now we have been reasonably well funded to do that and we have not had to turn people away. One of our main troubles is in terms of providing housing for young people who are no longer able to live at home. That is a real problem for the young people we deal with - the lack of suitable housing for them. But in terms of delivering case management services and other programs, we are not turning young people away. We do our best to work with whoever comes our way.

Mr STYLES: What sort of picture do you have in your head in relation to providing some sort of accommodation? Do you envisage or would you like to be able to provide more supported accommodation or a family group home type of thing where you have got a mum and a dad figurehead type of thing where these people can reside there for a while if they cannot live at home. What is your picture?

Ms O'DONOHUE: I think that the community adolescent placements, I do not know whether you are familiar with that model, similar to the family group home model on a small basis is ideal, but with the young people that we work with, often they are so troubled and traumatised that they can find it difficult to live in a family environment. If you get them early enough, that sort of modelling definitely would be ideal. We are at the current time applying for funding for two houses based on a lead tenant model. So, looking at having say four young people in a house with support from 9 am to 5 pm. We currently have two houses that support disabled young offenders and we need somewhere for those young people to go after they have been in the houses for the maximum period of time, which I think is around 12 months. Ongoing housing for those young people is a problem across the state of Victoria as I am sure it is in other states as well. Certainly, if you can get young people early enough, then I think a family group home model on a small basis, not on a larger residential unit basis, is the preferred model.

Madam CHAIR – Ms Marion SCRYMGOUR: If no other members of the committee have any questions, I would like to ask some questions.

My name is Marion Scrymgour. I am the member for Arafura so, like Lynne, we have quite big bush electorates – rural, remote, and regional communities. I was interested, like Lynne, in where you talked about Alice Springs. You were saying you have a couple of staff who work with a couple of those communities there to build the capacity of those communities. If that is not building individual families or doing the suicide prevention, or early intervention work but, rather, looking at the community development

and building that capacity, how much of that work then involves trying to get other service providers, within the Northern Territory context, to work with these communities, or to bring services into these communities? As Lynne said, in rural and regional communities, their isolation means, sometimes, getting services into these communities is a rarity.

Ms O'DONOHUE: Part of the work is certainly trying to engage with the other services, and also looking at what funding might be applied for. What are the programs the community themselves want so they are not just being imposed by government? What is it the communities themselves want? Then, what funding streams are available to try to access the funds for those types of programs? You are working from the grassroots level. Certainly, a large part of the role of those two workers is around engaging with services, but also skilling up the communities' leaders themselves around governance and how to deliver the community development programs.

Madam CHAIR – Ms Marion SCRYMGOUR: How effective is that, from your point of view, from your two workers? They must regularly report back on the effectiveness of trying to get those other service providers to work with the broader community. If we talk about strengthening communities and families, how effective is that?

Ms O'DONOHUE: I cannot comment on that really, other than to say that we see that approach as a better way to go than us going in and delivering services ourselves. We are in there trying to strengthen the capacity of services that are already there, and of the community that has invited us in there to support them. So in terms of the effectiveness, this is fairly new. We have only just recently started our work in Alice Springs, so that is something we are going to have to measure a bit further down the track.

Ms WALKER: How recent? How recent?

Ms O'DONOHUE: It has only been in the last 12 months that we have been working with them.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay.

Ms WALKER: What is your funding cycle for the service in Central Australia? Is it a two-yearly funding agreement?

Ms O'DONOHUE: I am sorry, I cannot answer that, I am not sure.

Ms WALKER: That is okay.

Madam CHAIR – Ms Marion SCRYMGOUR: Are you able to provide that to the committee? If you want us to keep that confidential, it would be useful in terms of funding arrangements and stuff and what is happening.

Ms O'DONOHUE: No problem. I am happy to provide that to you.

Ms WALKER: Thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you. The other area I was interested in was the dual diagnosis and the training your organisation provides. Just like the rest of Australia, there are dual substance abuse problems in communities. Have you brought any of that training into the Northern Territory, particularly in Central Australia?

Ms O'DONOHUE: Not yet, no. Our work in that area has been in Victoria. The learning for us from that has really been important for the training up both clinical and non-clinical staff. In working with Indigenous communities, we do have a program called Connect, which is working with Indigenous people who have been in the adult justice system there, and working with the staff of that program on dual diagnosis issues, we have really been trying to ensure that they are using appropriate screening tools for mental health. In fact, we are using a tool that has been developed by the Tiwi mental health team called Yarning about Mental Health, which has been specifically developed for use with Aboriginal young people.

In providing training, we have identified that training alone is not enough. Staff need good ongoing supervision focusing on their clinical practices and discussion of issues. Also, there is a strong need for vicarious trauma training for staff because often staff are as deeply affected by issues to do with suicide as the people in the community themselves. So, ensuring staff have sufficient support for their grieving and

have had training in vicarious trauma are all the important issues we have learnt about through this dual diagnosis funding.

Madam CHAIR – Ms Marion SCRYMGOUR: No one seems to have any further questions. Delia and Louise, thank you very much for taking the time to talk to the committee. If we have any further questions or follow-up, we have your contact details and will be in contact with you. As I said in my opening statement, a transcript will be made available for you to look at and will be placed our website. Would you like to make any concluding remarks?

Ms O'DONOHUE: No.

Ms FLYNN: No. That is all. Thank you.

Ms WALKER: Thank you for your submission and thank you for your time.

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headspace
Ms Amelia Callaghan

Madam CHAIR – Ms Marion SCRYMGOUR: We will go straight into our next one; headspace, Amelia Callaghan, Varsity Lakes, Queensland. Is that coming on?

We are going to have to conduct this hearing via the telephone because the video-conferencing is not working at the other end. It is working at our end but not working their end.

Amelia, thank you for appearing before the committee this morning. I am going to make a very brief statement. I thank you for coming before the committee today. We look forward to hearing from you. This is a formal proceeding of the committee under 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 hearings you are concerned that what you say should not be made public, you may ask the committee to go into a closed session and take your evidence in private.

I ask you to state your name for the committee and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding with the committee's questions. Prior to us going to that process, I will introduce members of the committee for your information.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, Amelia. I am the member for Nhulunbuy in northeast Arnhem Land.

Ms PURICK: Kezia Purick, member for Goyder.

Mr STYLES: Peter Styles, member for Sanderson.

Madam CHAIR – Ms Marion SCRYMGOUR: I am Marion Scrymgour, member for Arafura, the Chair of the select committee. Were you able to hear all of the voices of the members of the committee?

Ms CALLAGHAN: Yes, I was.

Madam CHAIR – Ms Marion SCRYMGOUR: Would you like to make an opening statement, Amelia?

Ms CALLAGHAN: First of all I would like to thank you for this opportunity to talk about this issue. We acknowledge the importance of youth suicide, particularly suicide in the Northern Territory and are keen to work in partnership and in whatever capacity we can to support the government there to address this issue.

headspace is a national youth mental health foundation and we were formed in 2005-2006 with federal funding. Since that time, we have opened 30 headspace sites throughout Australia and we have another 10 opening before the end of 1 January 2012. We have just announced another 15 headspace centres, so there are 55 announced to date and another 35 centres coming in the next couple of years.

headspace is often thought of as having two areas: the national office and also the headspace centres. The national office also undertakes a range of community awareness and health promotion activities, as well as having a centre of excellence for youth mental health, looking at the evidence around how we

support young people access the services and interventions and also training that we provide to service providers in the general community. Then we have the headspace services and the services – the national office funds those services through a lead agency which works with a consortium of local members. All of our headspace centres are for 12 to 25-year-olds and their families and are, in most cases, free.

In some services, they charge a very low cost but the headspace services in the NT are all free and the requirement is that they must have what we call the four core streams of service; so mental health, drug and alcohol, primary health or GP services, and social and vocational services with the goal of being an entry point for young people, so that all young people regardless of what they are presenting with, or what they are having concerns with, can present to a headspace centre and we will assist them either to provide support on-site at headspace or to link in with an appropriate service in the area.

Madam CHAIR – Ms Marion SCRYMGOUR: Amelia, thank you for your opening statement. Before I proceed to opening questions to members of the committee, I will inform you that this is a public hearing and we do have the media in attendance. At any time you feel that the evidence you wish to give, or any comments you would like to make to the committee, you would like them to be made *in camera,* please remember you can at any time request that to me as the Chair and we can go into private session, but this is a public hearing.

Ms CALLAGHAN: Excellent, thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: I will open to questions from members of the committee, Michael?

Mr GUNNER: I am interested about learning a bit more about e-headspace and the numbers you have participating in it and if you find the people who access that, would they be different to people who access traditional services. So, is this an alternate option that people you might not normally talk to now you can talk to, or is it more that it is just a different way of talking to people?

Ms CALLAGHAN: e-headspace was originally a pilot for the Western Australian drought-affected areas and we have only recently, in the last month, extended our e-headspace to be 12 hours-a-day every day of the year. So, we are pleased to be able to expand those services. It is slowly increasing in numbers, so the pilot demonstrated there was a need and that we were accessing young people that traditionally may have been resistant to accessing services and e-headspace is about being the first step. The goal of e-headspace is always to direct young people to face-to-face services but it can be what we call a 'soft entry' for young people so that they can engage in an online manner and start to establish a relationship with the service, and start to establish trust and, then, look at how we can support that young person to link into a youth service in their existing area.

Ms WALKER: Amelia, I was going to ask you what evidence do you have that this e-headspace service is being utilised by Indigenous youth in the Territory's remote communities?

Ms CALLAGHAN: I am afraid I do not have those statistics offhand, but I can certainly find those for you. Originally, my impression to date is it has purely been a pilot targeting the Western Australia area. But there was access outside Western Australia and national access but, it would be increasing since we have managed to increase our hours of operation and the number of clinicians that we have on hand. So, to date, it has purely been a pilot. We are happy to get the statistics about Indigenous access, and access from the Northern Territory for you and report those.

Ms WALKER: That would be really helpful.

Ms CALLAGHAN: We would also anticipate that they would now increase, as we have increased our hours of service for e-headspace. It is now 12 hours a day that young people can access through headspace where, previously, it was a shorter period. We did only have three terminals operating previously; now we have up to five.

Ms WALKER: Which 12 hours of the day?

Ms CALLAGHAN: Twelve hours of the day.

Ms WALKER: Which 12 hours from when?

Ms CALLAGHAN: I am sorry, which 12 hours? It is different in the Northern Territory. In Victoria, it is 1 pm until 1 am, so that would be an hour-and-a-half behind for the Northern Territory – 11.30 am until 11.30 pm.

Ms WALKER: Yes. Can I just ask you another question about e-headspace? In trying to meet the needs of those accessing it - and I appreciate that this is a trial and very new in the Northern Territory - what do you do to try to make it inclusive, both culturally and also in overcoming language barriers?

Ms CALLAGHAN: All the headspace, or the e-headspace staff have just completed a range of orientation and training packages to look at making sure they are Indigenous and culturally appropriate and well versed. We also, if needed, use cultural interpreters or support around appropriate language for young people as well, as required.

Ms WALKER: Good, thank you.

Mr STYLES: In the submission on page 11, you have: *'headspace recommends that the committee …'* and you have two dot points there and Part B on that page says:

Programs and services targeted youth aged 17 to 25 years of age with particular emphasis on suicide prevention education and awareness in schools.

Are you talking about colleges and universities here? Because the actual age group there, 17 to 25, would appear to me to be like Year 12 and up into universities. That is the first part of that question. The second part is: do you have anything that is going to get back into anything like suicide awareness training? There is a program out there called Suicide First Aid. Do you have anything like that that you are proposing to run in the Northern Territory and, if not, how can we help?

Ms CALLAGHAN: In regard to the first question, universities and TAFEs or accessing young people through those areas. To date, that would be done through our services, Top End and Central Australia. At the moment, you are correct in that their current focus has been on high schools or colleges, and have engaged with universities and TAFEs as required. But, as yet, there is no formal partnership with them. We do have some national awareness campaigns that we target in universities, TAFEs, as well as public places like bus shelters, that sort of thing, to try to market or target mental health literacy messages to young people in that age range as well.

The suicidal awareness training: Top End headspace is doing some partnerships to do program management admin support for the collated services to run the ASIST suicide prevention training package, and also safeTALK suicide prevention training package. We are also in the process of developing a national training calendar which will include suicide risk assessment and intervention.

Mr STYLES: Thank you.

Ms PURICK: Amelia, one question following on from the e-headspace part of your submission. That is all on the Internet and e-mail, but do any services link to that where young people can get assistance using their mobile phones, particularly smartphones? Does it extend to a text messaging type of service?

Ms CALLAGHAN: Not as yet. There is a phone line component to e-headspace run out of headspace Parramatta that supports young people outside the hours e-headspace is operating. So there is a phone line component. In terms of the text component, that is yet to come on board; however, there are plans to develop an e-headspace application looking at how young …

Ms PURICK: Like an app or something?

Ms CALLAGHAN: Yes, looking at how young people might be able to use something like a headspace application to find their local headspace site, or text or make an appointment in that manner. The headspace sites do use text messaging so the headspace sites can send out text reminders to young people, or information about groups or programs they have coming up soon, or using text messaging to contact young people through the local site.

Ms PURICK: Okay, thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: Amelia, can I ask a couple of questions?

Ms CALLAGHAN: Yes, sure.

Madam CHAIR – Ms Marion SCRYMGOUR: In your submission you say young people between the ages of 12 and 14 were the single largest group to access headspace services in Central Australia, followed by 15 to 17-year-olds. What proportion of these young people were considered to have had suicidal tendencies?

Ms CALLAGHAN: Sorry, again I do not have that information off hand - the suicidal tendencies breakdown for that age group for that particular site; however, I can see if that information exists and report back to you.

Madam CHAIR – Ms Marion SCRYMGOUR: That would be good if you could take that on notice and provide that information to the committee. Did you want me to repeat?

Ms CALLAGHAN: I will just clarify that; so you are after information about the suicidal …

Madam CHAIR – Ms Marion SCRYMGOUR: In your submission you said 12 to 14-year-olds were the single largest group to access headspace services in Central Australia, followed by 15 to 17-year-olds. What proportion of these young people were considered to have suicidal tendencies?

Ms CALLAGHAN: I will get that information for you. I also note that information on page 9 is for quarter four of 2011. I also note that the data for the next quarter, the last quarter – July to September 2011 indicates there was an increase in the number of young people that were 15 to 17 years of age to 27%, and a decrease in the age of young people of 12 to 14. So the latest figures for the last quarter indicate in the age group of 18 to 25 – unfortunately we cannot break that 17 age group out of the 15 to 20 group - in the 18 to 25, 59% of clients accessing headspace Central Australia were in that age group.

Madam CHAIR – Ms Marion SCRYMGOUR: Do you have a breakdown? Where you have put that up against the national average as well - Central Australia, Top End and then the national average, do you have a breakdown of Indigenous and non-Indigenous? Does the data break down in those proportions or percentages?

Ms CALLAGHAN: I have the data for the last quarter, but I can also get it for you for the last year. The last year's statistics for Central Australia was about 43% of clients accessing Central Australia between June 2010 and May 2011 were identified as Indigenous. In the last quarter, 24% identified as Aboriginal but not Torres Strait Islander, and 76% presented as neither Aboriginal nor Torres Strait Islander. For the Top End, 16% in the last quarter identified as being Aboriginal but not Torres Strait Islander, and 1% identified as being Torres Strait Islander but not Aboriginal, and 69% presented as being neither.

Madam CHAIR – Ms Marion SCRYMGOUR: They are quite a high percentage. What then is the referral process from headspace if you are picking up – because you are saying between June and May – or up to 43% and you are talking in the context am I right, of Central Australia?

Ms CALLAGHAN: Yes.

Madam CHAIR – Ms Marion SCRYMGOUR: Who else is involved in the case management? I suppose they come to headspace; headspace will then either refer them to other service providers, alcohol and other drugs or the mental health. Is that the process? Are there any gaps or problems within that referral process?

Ms CALLAGHAN: We may refer to other services but we may also provide the services onsite. At Central Australia we have a GP who provides sessions five afternoons a week. We have a sexual health clinic in partnership with Family Planning Northern Territory one afternoon a week; and we have five different psychologists that we have onsite through the ATAPS, the Access to Allied Psychological Services funding as well as a part-time mental health nurse and other intake reception workers.

So a young person presenting at headspace will be given a thorough assessment. Depending then on the needs identified we will look at generally what services can we provide onsite for example; physical health, counselling, drug and alcohol. If a referral is provided then we will refer them to appropriate services, either within the consortium group who collaborate to run headspace Central Australia, or in the broader community.

Some of the gaps that were identified, or challenges at that particular site at the beginning of this year were at times working in with the state health departments and referring – there is still a gap between what can be provided to support our headspace centre, being an early intervention service and the threshold for acceptance into state mental health services, for example, or from the gap between the quite chronic, complex young people being sent to interstate health and the level of support that we can provide at headspace service. And also looking at the Indigenous work force. We would like to have Indigenous staff on staff at headspace central, but it is often difficult to recruit and to retain appropriate staff at those centres.

Madam CHAIR – Ms Marion SCRYMGOUR: We could go on but I am just conscious that Peter wanted to ask a question and then Michael.

Mr STYLES: I am just wondering if I may have missed this in the report. I am just trying to flick through it. Do you have a good record of what the drivers are of those particular age groups as to why they are contacting headspace?

Ms CALLAGHAN: The data around that is quite general. It says that young people are presenting for depression and anxiety symptoms, but it is not quite specific in terms of the data. The qualitative data or reports we are hearing from the centres is that young people are often reporting around grief issues and trauma, as well as social disadvantage as well as sexual health issues. I can also look at providing you with more detailed information around that if you would like.

Mr STYLES: That would be really greatly appreciated because in relation to planning and where I suppose government has put their dollars in a bang for buck so to speak, it is probably really handy to be able to have that sort of information so we can put some early intervention stuff in.

Ms CALLAGHAN: I would also add that what we can see more clearly is the services that we are providing at those sites. So the top services that are being provided out of Central Australia is care planning, so that can be coordinating our young people accessing services, medical check-ups, supportive counselling, relationship counselling, and cognitive behaviour therapy. At the Top End, the main services provided are client supportive counselling, care planning again, cognitive behaviour therapy and assertive monitoring of young people's mental health.

Mr GUNNER: My questions are following up from Peter's. I am interested in that point of contact. How do people know about headspace? How are they referred? How do they access you? Do you have information or advice on whether that first point of contact needs to be earlier? How would you make it earlier? How would you go about that? So how do they contact you, how do they know about you, and is it early enough?

Ms CALLAGHAN: In terms of referrals, we are quite proud of our statistics around this because what we know is that most people hear about headspace centres either through their own self-presentation or through a family member and friend. So it means that it is not just other services that are referring to us. It is 54% of young people presenting to Central Australia are self-referred, so the young people themselves are finding the service or talking to their friends and family and accessing the headspace service.

In Central Australia, the next biggest referral source is 27% for family and friend, and then 12% referred from schools. In Top End, it is 40% are referred from a family, friend, or neighbour; 20% are self-presenting; 14% have been referred through private medical practices, so we can see that we are clearly working in collaboration with the medical services in that area; and 5% from Top End are coming from schools. So, that is how young people are being referred to us. They seem to be hearing about headspace through - at this stage it is other friends and family members or other young people that have been through the service. It is not uncommon to hear young people come in and say; "my brother, sister, cousin, boyfriend, girlfriend came to your service and spoke highly of your service so now I am presenting". That is the biggest way that young people are hearing about the service.

As well, we have quite a large online presence through Facebook and Twitter and also through online advertising, but also we have community awareness campaigns, big posters, postcards, what is called d-cards, wallet cards, stickers, tattoos, a range of community awareness activities and resources that young people are hearing about headspace through those.

In terms of how they are contacting, making contact in a variety of ways, they can just walk in which is often very - particularly in the Northern Territory is often the way that young people are accessing this service rather than appointment-based services. They are often walking into a headspace centre and

accessing through a drop-in type model, or they access through the phone, or they can ring and make an appointment-based contact if they would like.

Mr GUNNER: Do you think that contact is happening early enough; that first contact is happening early enough?

Ms CALLAGHAN: Well, I think it is happening. I think we can do more to increase that, certainly around both of the sites run information sessions for parents as well. I think more work needs to be done with both young people and what we call 'first to know' communities like parents and teachers to recognise the signs. So if we do more work around educating young people about what signs to look out for, as well as those first to know communities, then we will see an increase of presentation occurring as a result.

Mr GUNNER: You list quite a number of barriers to accessing services in your submission, but how do you weight that? You have about eight or nine there, if not more, that you see as a barrier to accessing services. Do you see any one of those in particular as standing out? You mentioned there is a negative attitude of staff towards young people; how often would that occur, is that a big barrier or a little barrier? One of the recommendations is that we should address these barriers but nowhere does it really say which one is a genuine stand-out as a big challenge?

Ms CALLAGHAN: It is on page 12.

Mr GUNNER: On page 11 down the bottom, addressing barriers to accessing services, barriers include transport, cost, negative attitudes of staff, lack of knowledge about services, concerns about confidentiality and trust, a belief that family and friends can help more than health services, inadequately trained staff, previous negative experiences of health services, anonymity, environmental health services, anxiety, and embarrassment about disclosing issues; which are a very good range of problems in a sense, you could see how they might apply to different individuals at different times, but structurally trying to address that - that is a big list of things. I was wondering if you had any advice about which one of those, or how much any of those, are barriers?

Ms CALLAGHAN: Some of those we are actually already able to address or are addressing to some degree; for example, cost – so our services are free of cost. I think the two that stand out are access that is limited due to transport or location, so looking at models of outreach and what that might also look like in remote communities where we actually are not having it difficult to have a presence there. At this stage, we have established the sites in the Top End in Palmerston and in Central Australia in Alice Springs but we are beginning to look at models for outreach in remote communities and what that might look like and what resourcing and funding is available to provide those services – so, transport, location, access.

And then the second one would be around stigma, it would deal particularly around the stigma for young men. We know that young men, particularly in these two sites, are represented lower than other headspace sites. Looking at how we reduce the stigma for young men for accessing health services generally and mental health services as a part of that.

Ms WALKER: Those barriers certainly are not unique to headspace; they would be the same barriers I imagine every service faces in delivery.

Ms CALLAGHAN: Yes.

Madam CHAIR – Ms Marion SCRYMGOUR: You say in your submission, page 11, Amelia, that the current mechanisms funded by the federal government to access mental health services are not working in the Northern Territory. You quote an example of the requirement to have a mental health treatment plan through a GP is problematic. So, people then, are not eligible and are turned away. Is that a major problem? That is a remote NT problem, or are you are finding this in Palmerston as well - Central Australia and Palmerston?

Ms CALLAGHAN: It certainly is in both of those sites, and is more of an issue than in our headspace sites in other locations. For example, the funding we give to headspace NT, by the time we pay for all the rent and infrastructure, allows for a very small headspace-funded staffing component. We then rely on the private practice or medical benefit scheme workforce to supplement and provide additional services, as well as the ATAS funding in some areas. The lack of ability to access mental healthcare plans means that it limits the services that can be provided in those centres from MBF-funded clinicians. So, in some other areas where you are able to have a private practice workforce through both general practice and Allied

Health components, the service provision that is available at both sites is increased. That certainly is limited at these two sites because of the concerns around the mental healthcare plan limitations.

Mr STYLES: Amelia, it is Peter Styles again. Just on that, with the federal government's plan to change the structure of the GPs being able to refer people to psychologists and clinical psychologists, are you aware of the reduction in the amount of Medicare rebate for clinical psychologists?

Ms CALLAGHAN: For clinical psychologists? From the 12 to 18 sessions down to 10?

Mr STYLES: No, the actual amount of rebate. There is going to be a reduction in the rebate. My understanding is for most clinical psychologists - who are required to do all that extra study and time and have a different clientele base in relation to mental health - the rebate is going to be reduced where most of them actually just will not take clients from Medicare. Are you aware of that?

Ms CALLAGHAN: No, I am aware of the reduction in rebates for GPs providing mental healthcare plans, and the reduction of the overall session numbers for psychologists from 12 to 10, but I was not aware the rebates for psychologists was changing as well.

In our centres, we are lucky, at this point, that the GP sessions for both of our centres are in-kind, so NT Health provides the in-kind GP session at Top End, and Congress provides the in-kind GP services at Central Australia. So, we are lucky we had a change in the MBF for GP writing mental healthcare plans will not impact at this stage on this site. However, if those sessions were more adequately rebated, we would stand more chance of recruiting MBF GPs who might be able to provide services. Also, in our sites, we are needing to supplement, in many cases, the wages for our psychologists as an incentive to get them to operate at headspace centres outside of the MBF space already.

Mr STYLES: It is going to have a bit of an effect on young people who are trying to access not only psychologists but clinical psychologists. The number of clinical psychologists available for access is going to be reduced, which I think will have an impact. If you are not aware, I actually have some information if you would like to contact my electorate office, I am happy to provide you with any information you might like to get on that particular subject.

Ms CALLAGHAN: I will, thank you, Peter. Yes, we agree any reduction in MBF rebates for psychologists reduces the likelihood those practitioners will want to operate out of the headspace site given one of our aims is to keep our services free, or as low cost as possible. As those rebates reduce the need or draining on our resources to supplement that funding is increased, which means that funding does not go as far as it used to and we will possibly need to look at – we will have a reduced workforce in those centres as a result.

Ms WALKER: Can I ask a question in a very broad sense, Amelia? You are obviously a sizeable organisation; how important is it to your organisation to be aware of other service providers that are in a similar space to you in supporting young people?

Ms CALLAGHAN: It is extremely important; there is only a limited amount of resources. We need to work collaboratively to ensure we are not duplicating services and ensure we can share our resources to get the best outcomes for young people. We do that on a national level by working in partnership with a range of other services such as beyondblue or Orygen mental health, or the quite large mental health players, but also on the grassroots level all of our services are run by a consortium of local service providers with the lead agency holding the contract on their behalf. So we need to work collaboratively with those other service contractors.

Ms WALKER: You would be aware, for instance, that in Central Australia there has been a new service provider for the past 12 months or so, Jesuit Social Services, who provided evidence earlier this morning?

Ms CALLAGHAN: I specifically, from national, am not aware of that, but I would be confident that the Central Australian manager would be confident of that.

Ms WALKER: That is good. It is really important that these services are working collaboratively as opposed to competitively.

Ms CALLAGHAN: Yes, I agree.

Ms WALKER: Thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: One more question, Amelia. In your opinion, and whether it is headspace nationally or whether - if you have information from your Palmerston and also Central Australian office - everyone talks about social networking. There are positives and also negatives with the social network sites and the information that can come on these sites. In your opinion or from evidence given to headspace, have you seen any concerning or emerging issues from social networking in relation to young people and the link to suicides?

Ms CALLAGHAN: There are two parts of that. Most of our sites have social networking sites. We have learnt through that experience - we have developed social media policy and guidelines because we were, in the past, having young people post suicidal thoughts and messages on those pages which, unless you are moderating 24 hours a day, increases that risk. We now have quite strong guidelines about how those sites are set up, how we engage with young people and how to engage them appropriately through those networks.

I believe there is also an increase in cyberbullying which, in turn, leads to young people feeling quite high levels of stress, depression and anxiety. That is occurring through those social network pages, through Facebook and Twitter, and the other sites through social networking.

I am not specifically aware of the research or the data that links those issues with suicide specifically, but I can take that on notice and see if we have any information in that regard?

Madam CHAIR – Ms Marion SCRYMGOUR: That would be good to see if you have received any evidence, thank you. There are no further questions. I thank you for your submission and your recommendations to the committee to broaden the inquiry to include young people below the age of 17. The reason the committee was looking at - we can look at young people below the age of 17 although discussions with the Children's Commissioner, the child death review, looks at a number of those deaths up to the age of 16. Much of that information will be provided to the committee for its deliberations. Thank you for that recommendation.

The issue of young men as a priority group - I think all of us recognise that that is a cohort that we have some major issues with, and their resilience and their capacity to work some of the issues.

So thank you very much for your submission and for appearing before the committee. Do you have anything further you would like to add, or comments to the committee before we finalise?

Ms CALLAGHAN: I would just like to add that we are in the process of developing our Outreach to Schools program which is focused around suicide post-prevention in secondary schools which I know is really at the lower-end of your age limit. It is just that we are consulting locally on 1 December and 2 December with remote communities to work out what that model of support for the Outreach to Schools Suicide Prevention program may look like in the Northern Territory.

Madam CHAIR – Ms Marion SCRYMGOUR: Whereabouts are you doing that, Amelia?

Ms CALLAGHAN: That will be at the headspace centre in Palmerston.

Madam CHAIR – Ms Marion SCRYMGOUR: You did mention you would do some of that with schools in remote communities.

Ms CALLAGHAN: These are focus groups: 1 December is for urban services and on 2 December we are looking at focusing on services for remote locations and looking at how we can support those services to transporting to that focus group on the 2 December.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you very much for both the submission and appearing before the committee today.

Ms CALLAGHAN: you are welcome. Thank you very much for your time today.

The committee suspended.

Darwin Regional Indigenous Suicide Prevention Network
Ms Julie Turner; Ms Ngaire Ah Kit; and Ms Delsey Tamiano

Madam CHAIR – Ms Marion SCRYMGOUR: On behalf of the select committee, I welcome Ms Julie Turner, Ms Ngaire Ah Kit and Ms Delsey Tamiano to this public hearing into current and emerging issues of youth suicide in the Northern Territory. Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned that what you will say should not be made public, you may ask the committee to go into a closed session and 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, if you like, to make a brief opening statement before proceeding to the committees questions.

Ms AH KIT: My name is Ngaire Ah Kit, Vice Chair of the Darwin Regional Indigenous Suicide Prevention Network.

Ms TURNER: My name is Julie Turner. I am on the committee for the Darwin Regional Indigenous Suicide Prevention Network.

Ms TAMIANO: My name is Delsey Tamiano. I am the Secretary of the Darwin Regional Indigenous Suicide Prevention Network.

Madam CHAIR – Ms Marion SCRYMGOUR: Before I ask you to make an opening statement, I ask committee members to introduce themselves, both by their name and their electorate titles.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy**.**

Ms PURICK: Kezia Purick, member for Goyder.

Mr STYLES: Peter Styles, member for Sanderson.

Madam CHAIR – Ms Marion SCRYMGOUR: I am Marion Scrymgour, the member for Arafura and the Chair of the select committee. Would you, Julie, like to make an opening statement, or Ngaire?

Ms TURNER: Ngaire would because she is our Chairperson.

Ms AH KIT: I just want to say on behalf of the others, I feel very privileged and excited to be before you today to be part of the process to, hopefully, eradicate youth suicide throughout the Northern Territory. This is a cause that is very close to our hearts and as community volunteers, we have decided to band together and to work as one with our community members to see what we can do for our people to eliminate suicide as well.

Madam CHAIR – Ms Marion SCRYMGOUR: That is all you would like to say? I will open to the committee to ask any questions.

Mr GUNNER: I would like to know a little about what you do? How do you work? What are your priorities and how do you involve yourself - a little bit of background.

Ms AH KIT: I will give you some background on DRISPN. There was a Save our Children from Suicide rally held on the steps of Parliament House during the sittings last October when minister Vatskalis represented the Chief Minister and gave a lovely speech which was really great. That rally came about from a number of Indigenous youth suicides that had occurred previously, it got to at an alarming rate of one a week, and we were hearing stories which were devastating and really sad.

Ms PURICK: In Darwin?

Ms AH KIT: Darwin and throughout the communities as well.

Ms PURICK: In the Top End, though?

Ms AH KIT: Pretty much in the Top End, yes. That was really horrible and a group of concerned community members wanted to see what they could do to make a difference. They organised the rally and that is when it was brought to my attention that there were some people out there, our local people, who wanted to get out there and make a difference. We pretty much gained our name at the start of this year, 2011; we meet every month at Danila Dilba in the shops in Malak, our meetings are all open, we include everybody, we sit around the table to discuss issues and some strategies we can take on to promote suicide prevention within our community. One of the best things about the way the group operates is we invite stakeholders to the table as well. So we have people from Anglicare, headspace and places like that may come along and share all of their information.

One of the main things you need to know about DRISPN is we did not establish ourselves to reinvent the wheel. We are looking to throw our weight behind the cause with those people working day in day out, especially because we are volunteers, and they usually have more resources than us to tackle the situation.

Mr GUNNER: I am interested in those first points of contact and what sort of experience you have had through family and friends networks, how you have been working for the last year or so to identify people at risk or communities at risk, and how you go from that point on to say the service providers. I am more interested in hearing of your experience around those first points of contact.

Ms AH KIT: There are several different things we do. Like I said, we have our meetings which are open so we ensure we send those through our networks, word of mouth, text messages, all the social media avenues and we encourage people to come along and sit down with us. Julie and Delsey are fabulous at keeping our Facebook page up to date. We also link with other groups like the Brothers in Arms Facebook page. When we have our meetings, when we have information to share and things like that we ensure we try to keep the entire community updated.

One of the things we have not really stepped into the arena of is identifying people and bringing them in. Because we are not professionals, we have to ensure we do it safely. The last thing we want to do is push somebody over the edge. We have all had those experiences and one of the best things I have gained from the experience so far is getting the e-mails through our distribution network, the availability of training in mental health first aid and assist in suicide intervention, and being able to get yourself trained and then explain that to others and encourage them to join in. When we are out and about, and whenever we come across people who are not of sound mind, we might be able to share the information we have with them and let them know there are people in the community, it is community-driven, we are there to make a difference and if you are interested, I will pick you up - come along to the meeting.

Mr GUNNER: We heard earlier from headspace it was having significant self-referrals, so in some respects this is interesting to hear now where essentially, you are seeing a priority or real role for information sharing so people - you are not necessarily saying to person X they need to get help, but you are sharing information through your contacts and providing those people with the ability to make the decision to refer. Is that where you see your real role at the moment?

Ms AH KIT: On that, we organised a Walk for Suicide Prevention and Awareness event that was held on World Suicide Prevention Day, 10 September, and invited a whole heap of local service providers to set up stalls to bring information to people and stop relying on people to - assuming they are capable of walking into an office or picking up a phone, and that was really great. A number of people joined out network after that just to receive information, people sharing their stories about their hardship and putting their hand up to actually be out there to make a difference for someone else's life. So it is really heart-warming.

Ms TAMIANO: The other thing we did as part of that walk is to develop a crisis information card with all of the local organisations and agencies that people can contact if they are in crisis, things like Lifeline, headspace, Kids Helpline, all those sorts of things which was a really good way of sharing the information as well.

Mr GUNNER: So anecdotally – I presume there are stats – but anecdotally you feel there is a real improvement in what people know and how people know they can access things. You feel yourselves within your community that the level of information has improved significantly, or do you think there is still a lot of work to be done?

Ms AH KIT: Just from my personal experience after joining DRISPN this year and attending the meetings, working with the stakeholders, doing my own bit of research and things like that, actually talking to people and sharing what I know, all of a sudden they are informed as well. Then you will run into people later at the shop and they will say: 'Oh, I ended up giving your information card to a cousin of mine in Tennant Creek'. I guess just doing what we can to help build that education in everyone else.

Ms WALKER: Ngaire, I understand what it is your group is doing and I think that is fantastic. One of the things that struck me when we formed this committee and the sheer number of submissions that we have received from service providers, within government and non-government organisations, you have to look at it all and you think: how are all these people connecting. I have asked the woman we spoke with before you appeared about what was headspace's role in understanding the proliferation of service providers. So given that you have just mentioned that someone has said that they passed this information on to a relative in Tennant Creek, you are a Darwin regional-based group but are you sensing a need for what you are providing as like the glue between the services to spread further?

Ms AH KIT: We would love to. We have been established for less than a year and we have kicked a lot of goals this year. I have already had phone calls from people in Katherine saying, 'Help us, we want to set up a group just like yours'. The thing that I have discussed with the committee is that we cannot really wait to get to a stage where we are three years down the track and a bit more setup and a bit more professional. Suicide is an issue that needs to be dealt with right now. So if they want to get it off the ground, all we can do is share with them our lessons learned. Ideally I would love to work with the committee to help set up Indigenous-specific ones for every community in every region just so they build their own resilience and are able to handle their issue.

Ms WALKER: Given that you are a volunteer organisation, and I am just looking at the production of something very professional like this, you have obviously received some support from Wesley Mission which I know is involved in other areas. How are you planning for that growth that has been put upon you?

Ms AH KIT: I guess one of the biggest things that we have been looking at would be the partnerships and community involvement. Suicide is everybody's business. We want to make sure that everybody understands that it is. So we are able to have a successful event not only from the funding that was given to us by Wesley Mission through their Lifeforce Program but on the generosity of our local businesses and local people. So I guess that is probably one of the best things about the group and that is what I would like to see take us through to the next steps and in helping everybody else setup. Everybody has to play a part in there. Hopefully we will see how we go.

Ms WALKER: Do you get requests from non-Indigenous people coming to you saying; is there something we can do for everybody?

Ms AH KIT: Definitely. I took about five or six phone calls and a couple of e-mails asking if non-Indigenous people could attend that event, our walk, so that was a definitely. Suicide does not discriminate and neither do we. We do not know about non-Indigenous people, their cultures that well. We know ours, we know our people. So that was our focus because many of our young people had taken their lives and we cannot standby and let it happen again.

So yes, definitely we are very inclusive and the majority, if not all, of our stakeholders that sit around our monthly table would be non-Indigenous. They are the ones with the expertise who work in that field so we welcome them.

Ms PURICK: Have you extended, or do you cover the greater rural area like the 15 Mile and Humpty Doo people, or are you just more Darwin and urban Palmerston?

Ms AH KIT: We are trying to focus on the Darwin area at the moment only because there is a Top End Suicide Prevention Network, so that is Palmerston and beyond as far as I know. We will try to link more closely with them to let them know what we are – but we usually keep each other in the loop.

Ms PURICK: Have you had discussions or does the Aboriginal Development Foundation come to your table as well, because they manage the different council communities?

Ms TAMIANO: Not yet.

Ms PURICK: Not yet.

Ms TAMIANO: Not yet, but …

Ms PURICK: Or, for example, a group like that?

Ms TAMIANO: Yes, next month we are organising with Wesley to have a strategic planning session with the network, and Wesley are going to come up and facilitate that so hopefully through that we'll probably be able to …

Ms PURICK: Scoop up all these other groups.

Ms TAMIANO: Yes. Look at what needs to be done and how we're going to do it and have a bit of a more coordinated approach.

Mr STYLES: First, a couple of things I would like to say. I would like to congratulate you guys. I went to the steps and saw that and then I went on the march. I have to say it was a huge success. I am sure there were a few surprised looks on a few people's faces as a result of the stuff you have achieved in the last 12 months, so congratulations to all of you and your committee.

My understanding is there are a couple of things - your aims and goals are to raise awareness and you have been very successful with that, both physically and also through Facebook and electronically, that you are all about reducing the stigma attached to talking about suicide and actually facing it and acknowledging that it exists and there is a referral system where, if people come to you, you give the information about everyone who is out there. Correct me if I am wrong, but my understanding is that the sorts of people who are going to you are not the people who just waltz into some professional's fancy suite. They are coming to you to seek some really early intervention stuff about friends who might be in trouble or people who are in trouble and looking to you guys to perhaps guide them and direct them. Is that picture right?

Ms AH KIT: Most of the people who have approached me are those who have lost somebody close to them through suicide. So I have been tackling it from that perspective and letting them know what service providers are available or what - you know - and just asking them if they'd like to be around people who unfortunately have also lost people, then feel free to come along to any of our events or our meetings and try to link in with people, but I guess they just want that personal communication. They want to be able to talk to somebody they know understands exactly what they've been through because that person's been through it as well.

Mr STYLES: So would you look at and say that is perhaps a very local way of supporting those people who obviously have a need, this is all post-suicide, when we've lost someone? Is that local, because some of the questions we've been asking is how to expand that service to cover other people? Do you see the ability to be able to keep that local and, as you've said, there's a group in Palmerston, there's a group in Darwin, do you see yourself mainly sort of strengthening your Darwin connections or expanding to elsewhere?

Ms TOMIANO: I guess we probably just need to see – at the moment we're just focusing on the Darwin region because it is too huge if we were going to try to spread our wings out further. Ideally we would like to be moving towards something like that at some stage down the track, because it is needed everywhere.

Mr STYLES: So would you see proving a model like yours, prove that it works and then actually it is almost like franchising that model, as opposed to you guys trying to look after the whole Territory, take the model and then get another group and another group and another group.

Ms AH KIT: That's exactly right.

Ms TAMIANO: That's what we have talked about.

Ms AH KIT: Get the local people on the ground, all of our resources, like a model of best practice.

Mr STYLES: Yes.

Ms AH KIT: And just get them to tweak it to suit their community, because every community is different, so just letting them know what lessons we've learnt and how we can support them whilst still remaining in Darwin.

Mr STYLES: We heard this morning that some of the research suggests that the close relatives and close friends of people who have committed suicide are at high risk, so these appear to me to be some of the people who you're talking to who need that support to help them get through those, so that they don't actually go the same way themselves. Is that picture – is that the way you see your group as being integral in providing that core support for people afterwards? What about before in relation to identifying people, are you finding that many people are actually talking to you who are contemplating suicide?

Ms TAMIANO: Yes, they're starting to.

Mr STYLES: Yes.

Ms TAMIANO: Since we have raised the profile of suicide prevention through the group, I think all of us have experienced experiences where individuals have either come to us or other people are contacting us and saying: 'I'm a bit worried about my friend' or so on and so forth. So, it has been happening.

Ms TURNER: The people who have contacted me leading up to those suicides are relations. I have actually gone out of my way. I have done a home visit to them, taken them resources, books, sat down shared a cup of tea with them, shared them my story, sat with them in their darkest hour, walked them through until they were safe, got that safe plan in place for that person. Yes, I do that a lot, just doing the home visits. Yes.

Mr STYLES: So, as part of that safe plan, you give them the ...

Ms TURNER: Handing out cards and all that, talking to the kids on the streets, the whole lot.

Mr STYLES: … cards for where they can get trained help …

Ms TURNER: Yes.

Mr STYLES: Very good. Thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: Go on, Michael. No, you can ask. I am going to ask - I will let you ask, then I am going to ask members of the network a series of different questions.

Mr GUNNER: You said earlier headspace, when you compare national statistics and Territory statistics, it is clear young men in the Territory have a problem about coming forward for help. I was wondering if you have any advice you can give about how we could reduce that stigma. That seems to be a clear need in the Territory.

Ms AH KIT: I have always been all for mentoring. I do think people need to have that one-on-one contact so. As Vice Chairperson of DRISPN, I would like to see more Indigenous men join our network, come to the regular meetings, and actually take it upon themselves to branch out and talk to young people. One of the best tools, I guess, we have come across would be sharing your story, being able to tell somebody exactly what you have been through in an open and honest way, so they can relate to it and then, free to build a bit of rapport with you and share their frustrations with you.

Mr GUNNER: Do you have men involved in DRISPN at all?

Ms TAMIANO: We have some young men - some young Indigenous men.

Mr GUNNER: Some, yes.

Ms TAMIANO: We have had interest from others as well. Through the Brothers in Arms group that I have just started, we have had more interest again.

Mr GUNNER: Would you be finding that, too, the most difficult thing to conquer is getting young men involved, young men aware and sharing information? Is that one of the biggest challenges?

Ms AH KIT: I guess you could say that. We are spreading the word about what we are doing and people are appreciative. It is just very hard to get them to the meeting. There is always going to be the blockages so, maybe, it is actually getting out there and holding their hand and walking them through that door, and sitting them down and just explaining to them there is only so much seven people sitting around a

table every month can do. We can all make a difference if we bring another person next month, and then another after that. We can go from there.

Mr GUNNER: Talking to headspace earlier, it seems to be that is an identified problem we need to take the challenge and work on: about how we can reduce that stigma. So, if you have any thoughts or advice you can give on how we can tackle that challenge ...

Ms AH KIT: At our walk, Michael, we had about six of the young Territory Thunder boys turn up, which was fantastic. Aaron Motlop was actually there at the walk with us so, as a follow-up from that, he actually had his face in the paper with that really brilliant article. So, it is just capitalising on those. We know they are interested, they have been there, they have shown their support, they are linked in with the Facebook pages. It is how we use their profile to support the cause and what can we do, what can headspace do, with them? We do not want to pull them straight into what we are doing and just try to keep ownership. They are high profile people, they should be out there.

Mr GUNNER: So, it is by using mentors or high profile-role models to break down those barriers and say: 'It is okay ...

Ms AH KIT: Yes, but not necessarily high profile; they can be the local role models. One thing I would love to be able to do while I am with DRISPN is to organise free community training in - I did - what was it?

Ms TAMIANO: ASIST?

Ms TURNER: ASIST?

Ms TAMIANO: SafeTALK?

Ms AH KIT: SafeTALK. I would love to be able to do a train the trainer, and train everybody in the northern suburbs in SafeTALK. I would do that out of my own pocket, out of my own time. To just be educated in the local lessons of picking up behaviour that is not normal and being able to walk them to the safe place and, as Julie said, put in that safe plan. That could be a huge resource. If you have one person in every family educated in that, and they are able to educate the others, I think we will see a huge turnaround.

Madam CHAIR – Ms Marion SCRYMGOUR: If I could just ask a series of questions for Julie. I was interested - and this may get personal, and tell me if you do not want to answer. Let me say I join with Peter and all members of the committee congratulating this network. Unfortunately, on 12th I was in hospital, and I missed that march. I have heard from Kim and a number of people who attended, just how good it was.

Picking up on what you said, Julie, often out of your own resource and your own time you go to different families and sit down and walk people through their darkest hours. Who then walks with you and gives you that support? Because it is a lot to have to sit down with someone and walk them through their darkest hours when they are dealing with this issue. I know you are all volunteers and there is a support network amongst you, but who then supports you guys to walk through that to give support to others?

Ms TURNER: I find the strength within myself to keep going every day. I guess losing my three children has given me the commitment and the passion to drive me even further to do the work I do. My phone rings 24/7 - all night. I receive phone calls from Germany, the United States, from Brazil. I am walking those people through their darkest hour, directing them to their nearest help centre, their crisis centre, because I tap into the international association for suicide prevention. Through that, I am able to have a database system on my computer where a lady in England contacted me the other night and I was able to give the local centre just down the road from her - she was not even aware that organisation was there - just for her and her people in her village in England.

Madam CHAIR – Ms Marion SCRYMGOUR: How do people find …

Ms TURNER: Through Facebook.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay.

Ms TURNER: Also through my work attending international suicide prevention conferences. My work is now implemented worldwide and recognised around the world. One of the things I did at the international

conference - five years ago now since my daughter passed - was the word 'commit'. I notice some of you are still using the words 'committed suicide'. When I approached the international panel I asked that we delete the word 'commit' in this context. They agreed to take this on board and, from my suggestion, that has been implemented worldwide, even in Australia, with media guidelines for all media within Australia – Mindframe - it is in their recommendations that we do not use the word 'commit' although I hear politicians all the time, even when parliament sat the other day, they were using the word. We do not use it any longer.

Ms PURICK: How do you describe it?

Madam CHAIR – Ms Marion SCRYMGOUR: What do you say?

Ms TURNER: You say: 'My daughter died from suicide' or 'completed' suicide.

Madam CHAIR – Ms Marion SCRYMGOUR: There is that subtle difference between 'committed' and not using the word.

Ms TURNER: The CEO from Suicide Prevention Australia, Dr Michael Dudley, came back from the United States national conference and rang Danila Dilba, because Danila Dilba rang me and said: 'Julie, Dr Michael Dudley said the first thing they did in America was mentioned your name, my daughter's name, and asked everybody to follow suit. Dr Michael Dudley said your recommendation is being implemented worldwide'. He said: 'I can testify that because I just came back from the American conference'. We no longer use that word.

Ms PURICK: Why is it the word 'committed'? Is the reasoning that you did not commit to killing yourself?

Ms TURNER: Many people bereaved by suicide find that word offensive because it is like someone will commit an offence - a criminal - and my daughter was not a criminal, neither were her friends, or the people who did the same as her. I said to the international panel do not dare suggest that or use the words 'commit suicide' because my daughter was not a criminal and she should not be even categorised that way at all. The whole international panel agreed and that is when they brought that in; in 2007 they brought that into, and that is written up in Mindframe's recommendation in Australia.

Mr GUNNER: I was going to ask you if a lot of your work is around postvention. Tragically, we heard earlier that often a suicide can be an indicator that there is going to be a potential cluster of suicides. Do you see a lot of your work with the grieving, with people where a suicide has unfortunately happened and then working with them and their families and friendship networks about making sure - or aware or inform them that there is not then subsequent suicides? Is that where a lot of your work is, with the grieving?

Ms AH KIT: Personally mine is. One of the main reasons I joined DRISPN was because when I lost my brother in 2007 I felt like there were no resources and there wasn't anybody that I could actually just sit down and talk to about everything. Nobody I was really close to had been through that and they did not understand. That was really, really hard. So when I heard these guys were forming a group that is what I wanted to do, that is how I wanted to make a difference. Unfortunately I was focusing on postvention and I just knew that it would happen again but I wanted to be there straight away for the family and talk to the siblings and say that I do not know everything, but this is what I went through, expect this, and can I hold your hand there, and if you need some time out come to my place. So yes, that was my big focus, postvention.

Ms WALKER: You said no resources, limited resources, but obviously what your work is borne out of, I am assuming, is an absence of culturally appropriate resources given that you are a product of an Indigenous background. In what way did that gap present itself in terms of the deficiency of culturally appropriate reasons?

Ms Ah KIT: I guess one of the biggest things for me, Lynne, would be that our mob was not using those services. So I do not know whether it is because the services were not delivered culturally appropriately, or whether they just were not accessible, or whether our mob just did not want to go there. So that is further discussions we have to have with a whole series of stakeholders. We have already had - I think it was Lifeline that wants to be able to talk to us about making sure that their delivery of services is culturally specific.

Ms WALKER: Does that include overcoming language barriers as well?

Ms AH KIT: Oh definitely.

Madam CHAIR – Ms Marion SCRYMGOUR: Following on from Lynne's question and your network, it is Darwin based and in terms of services, you have Aboriginal and non-Aboriginal non-government organisations. How many of those Aboriginal organisations are accessed by our people within the Darwin region to deal with these issues? Do you know? Amongst your network, do people talk about whether they access the various services?

Ms TAMIANO: We do not have any specific data on that. Only really around the table what the service providers talk about. I am not really sure.

Madam CHAIR – Ms Marion SCRYMGOUR: So you have both government and non-government that come to the network?

Ms TAMIANO: Yes. Mainly non-government.

Madam CHAIR – Ms Marion SCRYMGOUR: Non-government, not government. You don't have…

Ms AH KIT: We have Department of Health's Mental Health Unit that comes along.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay, so they attend the meeting on a regular basis?

Ms AH KIT: She has been there once. She has only just recently linked in, yes.

Ms TAMIANO: But it is mainly non-government that have been regular.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay. If we look at government, you say the Department of Health has just started. How about the Northern Territory police?

Ms TAMIANO: We did have. There was a lady coming from there but she was changing positions and in that transition we lost them. But they were initially part of the group.

Madam CHAIR – Ms Marion SCRYMGOUR: We can ask the Commissioner. When the phone call happens, it is police that have to actually respond to that and having police as part of that network to work through, particularly with the network of families, because I know having talked to police at various times, just even within my own family network responding to suicides that there is an element of frustration in terms of just trying to get information and work through with those young people.

When we talked to headspace and I know Michael asked this question - the percentage of young men - and I know you talked about Territory Thunder. What more do we need to do to get young men to these services. We have had Balunu. There has been Mudjimup. There have been a number of services that have been established to try to target our young men and yet we are still seeing a gap in that service. What do we need to do as a government, as a community – and it is not just our Indigenous men, it is our young men in general – the number amongst our Indigenous men is way too high. In your opinion, what do we need to do? If you were to say something, or send a message to government or to the parliament, what do we need to do and to pick up?

Ms AH KIT: One of the things when I am always looking for answers is I go straight to them and actually ask them: 'How can we help you?' I guess you would just have to hope that they are going to respond as well. But, the other things we have looked at is successful initiatives, models of best practice. You know what can we grab that somebody else is actually using that is effective for them or see how we can tweak it for our own.

Marion, you mention about Police being at the meetings, which would be fantastic. Again, through Wesley Mission, we were able to be linked in with the other Indigenous-specific suicide prevention networks around Australia. They have been up and running longer than we have, so they have got a lot of runs on the board, so we will be able to have a look at what initiatives they have in place and one of the great ones we have heard about is an information pack that all police in Victoria …

Ms TAMIANO: Wollongong it is, they are using it.

Ms AH KIT: … Wollongong, so all the police cars carry a suicide information pack, so whether there is an attempted or completed, they leave the pack straight away with the families. So the family knows the local service providers; there is a list of free and paid for services. We thought that was a great initiative.

Madam CHAIR – Ms Marion SCRYMGOUR: Where was that, New South Wales?

Ms AH KIT: Wollongong.

Ms TAMIANO: I think there are a couple of areas, but Wollongong is one of them that is using it and they have two different packs. One pre- and one post-.

Ms TURNER: And I think in Queensland - stand-by responses - all paramedics carry a little pack as well or even crisis card for suicide.

Ms TAMIANO: The other thing on the response there is – I don't know if you are aware of a program in Queensland. It is a Queensland Police initiated program called CRYPAR, Coordinated Response to Young People at Risk, so it is not suicide prevention specific but whenever they come across young people at risk - on the CRYPAR group there are all different agencies and so the police then make a referral with the consent of the young person to the appropriate agency who has to respond within 48 hours. So, it is a collaborative approach to responding to a young person in crisis. I think probably that sort of program we would need to look at to see whether it is something we could implement here. Because they have had great success with it.

Mr STYLES: In my former life, I was a community police officer, I worked in schools. I was part of a welfare team that consisted of school councillor; school nurse; assistant principal in relation to welfare; the person who ran the pastoral care groups; and the school-based police officer and there was one other and they were all called the welfare team. The first question is how important do you people believe, from your experience in talking to these people, how important is that welfare team in relation to early intervention to prevent people getting to that point where they want to take their life and secondly, how important do you see school-based police officers in schools to give young people confidence to go to school and not to be bullied - be it cyber bullying, physical, emotional, sexual or whatever? So there are two parts to that question; the first one is the welfare team.

Ms TURNER: Because I am not a qualified school teacher - yes, I just graduated two weeks ago. Yes, there should be a school-based program that promotes suicide protective factors, and also reduce risk factors for our youth in schools. I know within the Northern Territory we have KidsMatter which is aimed at primary school kids, and we have MindMatters which is aimed at middle school and senior – the higher – kids. There is also another successful model called SOS, which is Strength, Opportunity and Support. We should have some sort of resilient model, a school-based program, for suicide to help our kids through that. The role for the school-based constable - he plays a very important part because he is there to help the kids through those times when they need them, and to help promote, and all that.

Ms AH KIT: Yes, I agree. The welfare team is very important, especially in a young person's life. They spend a lot of time at school. Just making sure the welfare team members are adequately trained so that they can recognise changes of behaviour and possible risks, and things associated with that young person's personal life, as well, and be able to walk them through those steps or put a little safe plan in place for them as well. I just wanted to back Julie up on that. KidsMatter and MindMatters are fantastic programs that should be in every Territory school and to stop …

Ms TURNER: That is something you should look at with Gary Barnes, trying to get some sort of school-based program in there for our kids. As a teacher myself, I am happy to train the teachers on suicide prevention, and to help them to not only train the teachers but train the school counsellors, the staff, the whole lot - just doing ASIST programs, doing the safeTALK programs, doing the school-based programs. Even running parallel with that, I would like to see in the schools the school-based program made compulsory; that all schools do it. Also, make CPR a compulsory component along with this too, as part of the first aid, because it all just goes in together under the health curriculum.

Madam CHAIR – Ms Marion SCRYMGOUR: Do you think we forget schools in that whole process when there is completed suicides - that we forget …

Ms TURNER: Yes, because a lot of principals …

Madam CHAIR – Ms Marion SCRYMGOUR: … to pick up and target schools?

Ms TURNER: I have approached local principals myself, because I have actually written up my own teaching program for 10 weeks - a 10-week teaching program on suicide prevention and intervention. Many principals they do not want to know about it because it is just such a touchy subject, very sensitive. Again there is that stigma; they do not want to talk about it, they do not want to know, they want to sweep it under the carpet. But, it is our kids who need to know it. There are the kids in the schools who need to know it - not only the kids, but also the principal.

Mr STYLES: Are you guys aware of the program called Suicide First Aid that provides little packs? It is a two-day program where they train people. It is about identifying – I think it is the sort of thing you are talking about. It is used to train people to look for the signs.

One of the things I found very important is that when you talk of people who have committed suicide, if you talk to 10 people who knew that person, each one will say they did something odd. When you put them all together as a group the alarm bells should be ringing; when you don't, there are only little bells.

Suicide First Aid is about teaching people in the community. They are the type of things we need to look at; being able to get out there into the community so you guys can be trained, train the trainers, and just spread the word out. They give you a little pack - it is only a little thing that folds like this – which will give you the key things to look for so you should be asking people and spreading the word or, if you see people like that - and you guys have all been touched pretty closely. They are the type of things that, hopefully, your group, and this committee can make recommendations that we do those sorts of things.

Ms TAMIANO: That is the Anglicare ASIST program you are talking about?

Mr STYLES: Yes.

Ms TAMIANO: An awesome program it is.

Madam CHAIR – Ms Marion SCRYMGOUR: There are a number of other questions, like the suicide prevention plan, if you have had input into that. We might write to you and get some further input into some of the information we seek because I am conscious of time and we have been running behind.

Ms TURNER: Can I add one more thing? Coronial support. I had my own experience with this and it should be a culturally sensitive grief and support service that meets specific needs for the individual or communities, especially Indigenous people. Once the suicide is reported to the Coroner's office, within the first 24 hours they send out a person to touch base with that family. I found it was very culturally inappropriate - they sent a Balanda woman to see me. If any recommendations come out of this report I would like to see Indigenous people working with the Coroner's office to visit the Indigenous family in those first 24 hours. The NT Coroner's office, within the first 24 hours, either contacts you by letter or phone. For us, our mob, it is better to visit the home, face-to-face rather than by phone or letter. That is something to look into because what happened with my bad experience, I had to lodge a complaint to the NT Department of Health and that lady was removed immediately from her position because of the way she treated me and my bereaved family. It was the attitude and not having that cultural knowledge. She was so insensitive to our needs at that time, especially our first 24 hours when we were all up in arms.

Madam CHAIR – Ms Marion SCRYMGOUR: We will certainly take that on board and look at that recommendation, Julie. For Indigenous people, and families across the board ...

Ms TURNER: It should be an Indigenous psychologist/psychiatrist, or social workers.

Madam CHAIR – Ms Marion SCRYMGOUR: I have talked to a number of non-Indigenous families where there have been completed suicides and that insensitivity in dealing with families when they are grieving through this process is a major issue and needs to be looked at. We will take that on board and include that.

Ms TURNER: Remember with Suicide Prevention Australia, their statement for youth suicide - when you are talking about promoting in the media with ads on television, there are no Indigenous actors in those ads you see on television. So that is another thing down the track, we need to correct.

Madam CHAIR – Ms Marion SCRYMGOUR: Particularly as there are high numbers in the Indigenous area. Thank you very much, and if we have any questions we will follow up with you. Thank you very much

for appearing before the committee today. We will make a transcript available for you to look at and it will be put on our website once you have looked at it.

Ms TURNER: Thank you, Marion, too for using the words 'completed suicide'.

The committee suspended.

Salvation Army Hope for Life
Mr Alan Staines

Madam CHAIR – Ms Marion SCRYMGOUR: Hello.

Mr STAINES: Hello there, how are you?

Madam CHAIR – Ms Marion SCRYMGOUR: Yes, good. We are just waiting for one more member, Mr Staines, and then I will make an opening statement, and then invite you to make a statement. Then, we will take questions from the committee.

Mr STAINES: Okay, that is fine.

Madam CHAIR – Ms Marion SCRYMGOUR: I apologise for us being a bit late, we are just running behind time.

Mr STAINES: That is okay.

Madam CHAIR – Ms Marion SCRYMGOUR: We will start. The other member of the committee, Mr Styles, should not be too much longer.

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. To give evidence, we have before us Mr Alan Staines. 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 obligations not to mislead the committee apply. A transcript will be made for the use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private.

I will ask you 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. Before I do that, Mr Staines, I will ask members of the committee to quickly introduce themselves to you and state their electorates.

Mr GUNNER: Hello, Michael Gunner, member for Fannie Bay.

Ms WALKER: Hello, Alan, Lynne Walker, member for Nhulunbuy. We met in Darwin a few weeks ago.

Mr STAINES: That is right.

Ms PURICK: Hello, my name is Kezia Purick. I am the member for Goyder, which is a seat in the rural area just outside of Darwin.

Madam CHAIR – Ms Marion SCRYMGOUR: The other member who should not be too much longer is Mr Peter Styles, the member for Sanderson. Alan, I am Marion Scrymgour, Chair of the select committee, and I met you the last time you were in Darwin. Would you like to make an opening statement?

Mr STAINES: Thank you for the opportunity. The Salvation Army Hope for Life program has put in a submission. We realise there is real need in Darwin to reduce suicides amongst young people and one of our primary aims is to support this committee to bring in programs to help reduce this tragedy. When we see young people particularly, who are lost to suicide, it has a huge ripple effect across the community. The Salvation Army is committed to doing something, to really make a difference in the Northern Territory amongst all classes, including Indigenous communities in the north.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you, Mr Staines. We might proceed to questions for the committee.

Mr GUNNER: I notice your submission is heavily targeted towards postvention. Do you think that should be a priority for government and others in the sector, that immediate time post a suicide, to prevent a cluster of other suicides?

Mr STAINES: Yes, postvention is a major area we should be looking at in training because research has shown those bereaved by suicide are at nine times greater risk than the general community. With those bereaved people very little support is given to them by the general community. We have five major programs where we would like to assist the Northern Territory as well as the one for postvention. Postvention includes the Quilt Program as well as what we call the Living Hope Suicide Bereavement training. The Quilt Program - I spoke to quite a number of people when I was in Darwin recently. I was invited to come through the DRISPN group, the Darwin Regional Indigenous Suicide Prevention Network.

In the development of quilts, it not only helps those who are left behind – a therapeutic tool for them, it helps break down the stigma attached to suicide. To that end, we are hoping to develop two quilts in the Northern Territory. Each quilt has about 24 faces of people who have lost their lives - one for the Indigenous people and one for the general community. However, in our national quilt - most of you people would have seen the photo of our national quilt - there are 62 faces, most of those - 70% of those on that quilt are young people between the ages of 12 and 27. It is a major problem. The Salvation Army has been in the Australian community for well over 100 years. We have 900 centres across Australia. We have been in the Northern Territory for 50 years and we feel we can do much more in supporting your committee in the reduction of suicide.

However, when I was talking about the five programs we have what we call the QPR suicide prevention gate-keeper training which is like a first aid course in suicide prevention. We feel this should be one of the main tools to educate the community. Any member in the community can do a training program by one of our trainers or it can be done online through our web-based training program. The training program looks at the myths and facts about suicide, the warning signs, how to ask the question and refer, and how to offer hope and support for those contemplating taking their life.

The thing with most suicides, in many cases, people who contemplate suicide very rarely talk about it but will give warning signs. By asking the question - it might be a work colleague, it might be someone in the school, it could be a next door neighbour, it could be in the club - ask them are you thinking about harming yourself, or are you thinking about taking your life' that generally brings some type of response. When that response comes and the person really admits that they are contemplating suicide, well you can do something positive about it. So we feel it is a real opportunity to bring community awareness as it is not until after the event that a lot of the family and friends say: 'Well, I wish I had known these warning signs. I would have liked to have been able to do something to save a life'.

This is the major area that needs to be focused on as well as the Living Hope training program for those people working with the bereaved. Those who have been bereaved by suicide, they go through hell. In many cases there is very little support for them after the suicide because the stigma is still a major factor in suicides. This quilt helps to break down that stigma. In many cases, particularly when a suicide occurs in the home, it becomes a crime scene and people themselves are all suspect until proven otherwise. They are ordered from the home in most cases while the scientific people come in and look at all the aspects of the suicide to determine whether in fact it was a suicide and not homicide. One of the things we recommend too is help for the bereaved by providing a first response service for these people. In this tragedy, people do not know where to go to get help and there has to be education amongst these people who at that time are going through such a traumatic time. They do not know where to go, or what to do, and how to get help. So one of the things we are suggesting is a response team to go with the police to the scene of where a suicide happens particularly when it is in the home.

Mr GUNNER: We heard evidence earlier today that there is a much greater stigma amongst young men in the Territory than there is nationally about coming forward for help, or getting involved in programs or having an intervention. Do you find that yourself amongst your programs? Is there any particular program that you have that you feel actually works best with young men?

Mr STAINES: We have a lot to do with young men in homeless refuges and also with the unemployment of youth. There are so many different areas that affects a person to take their life, and it is not just one single factor. The Salvation Army has a range of programs in the community that works with these disadvantaged and high risk youth. This is a great thing about the Salvation Army: we have a broad cross-section of programs that can help young people. Not only will we be training for helping other people outside, but we will be upskilling our Salvation Army personnel. We have over 900 centres throughout Australia and we have some major centres throughout the Northern Territory where the Salvation Army is really involved.

The other thing that we can do with helping is our national Hope Line. It is not publicised enough and we can promote through the Northern Territory for those particularly who have been bereaved by suicide,

particularly those who are living in rural and remote areas where there is very little support. So by giving this toll free number 1300 467 354 people can phone up and talk to a trained counsellor 24/7 and get that support which is so necessary for those who have lost loved ones to suicide. That is another major thing that we would certainly be promoting the Northern Territory for people who have lost loved ones to suicide.

There are many different programs with the Salvation Army. Working with homeless people, with unemployed people, we are coming across people of high risk all the time and we have to upskill not only our Salvation Army but the general community to be able to look at these warning signs and be able to do something positive about helping these people knowing that they are at risk. I suppose with the training programs, it is a major part of education in the community and we feel this is a positive step in getting this QPR or Question Persuade Refer training as a community education first aid course.

Mr GUNNER: I am really interested in that first point of contact and postvention stuff that there is a tragic circumstance that leads to that, but you mentioned your homeless shelters and other things like that. At what point - sorry, I am trying to work out the best way the phrase this - I am just really interested in that moment when you first have that contact with someone who you believe is at risk and how that works practically in the shelter, how someone has that conversation; the circumstances around that.

Mr STAINES: Yes, just in the general community as well as the shelters - if you ask the question, as I say QPR only takes one-hour training program; it is a first aid course. But, if you ask the question: 'Are you thinking about taking your life or harming yourself?', and that person says: 'Yes, I can't cope', and it really provides the information, what sort of difficulties that person is going through, and there is a different assessment as far as risk but if they are at high risk, you have got to certainly do something positive about staying with that person and take them to the hospital, the psychiatrist, or the community health centre, and make sure they get the appropriate treatment. Sometimes it is necessary for them to be scheduled and put into psychiatric care until the psychiatrist sees that they are able to go back in to the community again. But, I think there has got to be greater education also amongst the emergency services personnel in hospitals. You know, the statistics show that those who have attempted suicide, go to the hospitals and are then released, in many cases, it is only a matter of weeks or months where they take their own life.

We have to do more in the follow up after a person is released from hospital because sometimes these people have got no support, they go back to a solitary lifestyle again, they are not mixing in the community, they do not keep their appointments for follow up, so we have to provide a greater education, generally, with hospitals and the doctors who are working with these people to make sure that we have better policies in place - that these people just do not fall through the holes, through the gaps, and take their life. When I say it is common - many people who are released from hospital after suicide attempts - within weeks or months they take their life. So, we have to do more in this area also.

Mr STYLES: Can you explain to me and perhaps the panel, where the greatest pressures are on your organisation when you look at suicide as a topic. There are obviously a number of services and a range of things that you provide to people at various stages. Where is the greatest pressure that is put on your organisation? Is it pre-, post-?

Mr STAINES: We are doing more in postvention in dealing with those who are left behind because, as I say, they are at very high risk of suicide themselves and you have got to be very careful in the way we treat these people and support them because as we all know, sometimes there is a copycat syndrome where families, close members of family, and also friends do consider taking their own life following the life of a close friend or a loved one. And so, we have got to be certainly aware of all the difficulties that face the community in general following the death of someone to suicide. See, it is a huge ripple effect in the community and this is where I think the Salvation Army can play a major part, because it is not only the family member, but you have the next door neighbour, the work colleagues, and the school personnel. There is a whole range of people who are affected through the death of someone through suicide. Principally, this is really, I suppose, emphasised with young people who suicide. Sometimes, it is through a young person who is at school. We know what sort of effect it has on the school community.

One of the recommendations we had in the report, was we mentioned about specific resources to help to inform parents about issues of suicide and how to refer their children to receive support. We have to do more in helping children, particularly with the pressures on kids at school. Sometimes sadly, there is that bullying effect, and I know of a number of young people who took their life following the bullying at school. There has to be, I suppose, greater understanding from the school personnel, and looking at the warning signs of kids - particularly in those areas where we know the kids are at risk of suicide through the likes of bullying - so there should be greater plans put in place, procedures to follow for school personnel where the

likes of bullying occurs, and just be aware of that person who is having that traumatic time through bullying, and what support they need.

The other thing is we have to increase the accessibility of information resources in remote areas. As I mentioned before, in a lot of these rural/remote areas, there is very little support. I suppose we can look at Indigenous communities where they are very isolated. Fortunately, the Salvation Army have, again, rural chaplains in rural/remote areas. We have the Flying Padre Services that go to these areas. Statistics show that suicide in rural/remote areas is very high because of the access to means of suicide. On most farms, they have guns and the ability to use these weapons to end their life. We have to certainly make provision for support in rural/remote areas. We feel the Salvation Army could play a major part in helping these communities in the reduction of suicide amongst their youth.

Ms WALKER: Alan, it is Lynne, I have a question for you. It is with regard to Hope Line. Just following on from what you just said, because I represent a very remote area in northeast Arnhem Land, some very isolated communities there. The reality is we need to look to telecommunications, web-based services to be able to reach people and provide them with a conduit to the services they may need. With Hope Line, have you captured data as to how many people in the Northern Territory access that service?

Mr STAINES: Yes, there are very few in the Northern Territory. It is a matter of getting this information out to the general community. The only reason why it is not used in the Northern Territory, I think, is because people do not know of its existence …

Ms WALKER: Yes.

Mr STAINES: We have to do more in being able to promote the line through various resources, services in the Northern Territory. Perhaps the government can help us do that. That would be a major support to those in the rural communities who, otherwise, would get no support whatsoever. As I said, it is a 24-hour, seven-day-a-week service and it is costing nothing. They can dial in toll free and speak to a trained counsellor to help them. It is vital that people in the Northern Territory become aware of this. I do not think there are many people using that service in the Northern Territory.

Ms WALKER: Yes. I ask you further to that, Alan, given the spread, the demographics of people across the Northern Territory, how well equipped would your counsellors on Hope Line be - if someone for whom English was not their first language phoned from Elcho Island, which is my electorate, how well equipped are your counsellors to deal with those calls and people from those backgrounds?

Mr STAINES: Our major service centres are in Darwin, Palmerston, Alice Springs, Katherine and Kununurra. We have rural chaplains that go to rural remote areas as I mentioned before. The Salvation Army also has an outback flying service known as the Flying Padre. This service provides support to remote communities and isolated people who live on stations across the top end of Western Australia and throughout the entire area of the Northern Territory. The work of the Salvation Army in the Northern Territory is quite diverse and includes a whole range of services to support people. The Salvation Army would see a primary objective in reaching for these people who have lost loved ones to suicide or those who are at risk of suicide to be able give them ongoing support and that necessary attention whenever it is needed.

Ms WALKER: Thanks, Alan.

Ms PURICK: Alan, I understand in Victoria, the government has either introduced or is looking to introduce legislation to make workplace bullying a criminal offence following on from the death of a young woman who took her own life because of a workplace bullying incident over a long period of time. Do you have a view on the merits of this kind of legislation?

Mr STAINES: I didn't quite catch that; what was the legislation?

Ms PURICK: I understand in Victoria they have introduced legislation, or going to, to make workplace bullying a criminal offence. This followed on from a young woman taking her own life because of an extended workplace bullying incident and I have a strong interest in this. I was wondering whether you, in your professional capacity, have a view on legislation that sends very strong signals that certain actions are not tolerated, because clearly, there is bullying in cyberspace with young people which has led to suicides and bullying in workplaces which has led to suicides. Do you have a view on this type of legislation?

Mr STAINES: I agree that we should be doing far more in addressing the issue of bullying in the workplace as well as in schools. I do not know whether that is best done through legislation. However, it is a prime objective that people should not be bullied and we know of recent deaths to suicide through bullying. I fully endorse any government initiative that would help save lives through stopping bullying in the workplace and the same applies in schools.

Ms PURICK: Thanks, Alan.

Madam CHAIR – Ms Marion SCRYMGOUR: Mr Staines, thank you very much. There are no further questions from the committee. If we have other questions or need to follow-up the committee secretariat will contact you. We will provide you with a copy of the transcript which you can go through and, once you have approved the transcript, we will upload that transcript onto the website for people to access.

Mr STAINES: One other thing I would like to mention is the quilts. I said we are doing two quilts for the Northern Territory, one for the general community and one for Indigenous, we were hoping many of those who participate in the quilts – we will be able to support them - partly sponsor them to the 3rd Australian Postvention Conference to be held in Sydney, June 2012. We have had, up to this stage, two national postvention conferences - first one in Sydney and in 2009 it was in Melbourne.

From 28 to 30 June 2012 we are holding the third Australian postvention conference where we will be having international speakers from all around the world coming to present, talking about not only those who are left behind and become suicidal, but talking about the school problems too, what young people are facing, contemplating the bullying issue. Not only that, we are hoping that through this that people in the general community in the Northern Territory will become more aware, in the educational awareness, by looking at this quilt, it will give them some indication and it's a wake-up call. Many people, when they see the quilt, the national quilt, stand back and are amazed to see so many young people who are on this quilt. It brings a realisation that we have to do much more in the prevention of suicide in helping those who are left behind because, as I say, many of them are at risk of suicide themselves.

I certainly would encourage any people in the Northern Territory who have lost ones to suicide to make contact with me in regards to honouring their loved one on this - whether it be the Indigenous quilt or whether it be on the general community quilt; we would love to try to assist them to get to Sydney or the conference next year. At the conclusion of the conference we have a healing remembrance ceremony which is really beneficial for those who have lost loved ones to suicide.

I thank you again for the opportunity of giving some information regarding the Hope for Life programs and I hope that we will be able to do something more positive in helping you in the reduction of suicides in the Northern Territory.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you. Through the various people who give evidence, we will certainly pass that on and will be in contact with you. So thank you very much Mr Staines for appearing before the committee and providing the submission from the Salvation Army in terms of what we need to look at, moving forward in relation to this issue.

Mr STAINES: Thank you very much.

Principals Australia
Ms Jill Pearman; Ms Vanessa Houltby; and Ms Karina Stevensen

Madam CHAIR – Ms Marion SCRYMGOUR: I take it we have Jill Pearman and Vanessa Houltby, is that right? How are you? On behalf of the select committee, I welcome you to the public hearing into the current and emerging issues of youth suicide in the Northern Territory and I also welcome Karina Stevensen who is here giving evidence as well on behalf of Principles Australia. 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. I apologise for the delay and the lateness of our call.

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 to use by the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask the committee to go into a closed session and we can take your evidence in private.

I will ask you each 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. After you do that, members of the committee will introduce themselves so that when they ask questions you will know who is asking those questions.

I invite you to say your name and the capacity in which you appear.

Ms PEARMAN: Thank you very much. I am Jill Pearman, National Program Manager for MindMatters, Principals Australia.

Ms STEVENSEN: I am Karina Stevensen, NT Project Officer for MindMatters.

Ms HOULTBY: I am Vanessa Houltby or Yarratja Houltby, as known in Central Australia. I am the MindMatters National Youth and Community Development Officer.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy in northeast Arnhem Land.

Ms PURICK: Kezia Purick, member for Goyder, which is an electorate just outside of Darwin that covers the rural area.

Mr STYLES: Peter Styles, the member for Sanderson. I have an urban electorate.

Madam CHAIR – Ms Marion SCRYMGOUR: My name is Marion Scrymgour. I am the member for Arafura and the chair of the select committee. Are you able to hear us okay?

Ms PEARMAN: Yes, thank you, we can hear you.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay.

Ms PEARMAN: Can you hear us?

Madam CHAIR – Ms Marion SCRYMGOUR: We can hear you. Would you like to make an opening statement?

Ms PEARMAN: Yes, thank you. I will be making the opening statement.

Thank you very much for the opportunity to speak to you today at this very important inquiry. MindMatters has been in operation since 2000. It is funded by the Department of Health and Ageing federally and is operated by Principals Australia.

What MindMatters offers is a framework of mental health promotion, prevention, and early intervention. We have project officers in every state and territory across Australia, and over about 80% of schools with secondary enrolment have actually accessed MindMatters training in some way.

Through the MindMatters framework - which it is a framework; we help guide schools in looking at how they have interventions, and how they actually will fit together in a mental health promotion way. We work from very much a protective factor base and a framework where we are working with schools to help build protective factors for young people. The research in this area is fairly clear; that when we build those protective factors we are working to ameliorate the risk when it comes to mental health promotion prevention and early intervention.

What we have done over a period of time is develop MindMatters since it was first introduced in 2000. We offer various levels of training to schools and, with that training, we actually help schools plan what they are doing in referral pathways. We also help schools look at where interventions fit. This is one of the challenges we find schools are facing right across the country: where do things actually fit together? What is the best way for us to approach this in a holistic, health promoting, positive way?

This is, I suppose, one of the areas that has actually led to us developing a process, which is what we have now, which is recognising MindMatters schools. These are schools that actually have taken on board

MindMatters as a whole-of-school approach and other interventions where they are showing improved outcomes for the young people.

Yesterday, we had an event for one of our MindMatters schools in another state in Australia and one of the schools receiving one of those awards spoke about the initiation of getting involved in MindMatters in 2005 was, sadly, the loss of one their Year 12 students through suicide. They could not quite believe it. This young person, to them, was not on their radar. What they do and how they do their business now within their school has changed dramatically. They have built a sense of connection, a sense of resilience and taken it forward.

In closing, MindMatters offers a whole range of training; however, what I want to highlight and what Vanessa and Karina will be speaking about further is a very important phase of our work and involvement of our whole school approach - building the partnerships and services with community that we need to have to make our initiative effective. We work with agencies like headspace, with Inspire Foundation, with service providers who help built those referral pathways in schools, and also with the involvement of community.

Thank you for the opportunity to speak with you today. I will now conclude my opening statement.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you, Jill. I will now open to members of the committee to ask questions.

Mr GUNNER: MindMatters is a whole-of-school program so you can talk with everyone in a class? It involves all the students?

Ms STEVENSON: When we talk about a whole school approach, it is around looking at all the aspects you need to implement mental health in the schools. We are looking at the classroom, how teachers are teaching and what they are teaching. We are looking at the environment of the school; how that school feels to walk in to, the communication you have with the front office through to the principal. Whether there is an environment of collegiality and help seeking in the school and, as Jill mentioned, that really strong engagement with community. It is an internationally recognised way that schools can start to think about how they implement mental health promotion in the school.

Mr GUNNER: One thing I am really interested in is that threshold - the point of first contact and how someone goes from being in a general cohort to at risk and whether or not identification happens. In practice, how does that actually work? Who makes the identification and other investigative work? Who is best at having that first conversation or identifying that? What has the most success and, at the end of the day, what happens?

Ms STEVENSEN: What we say as part of our training is that we do not expect teachers to become clinicians, but because students are at school every day they get to know students really well and can tell if there are certain behaviours that are changing, if their physical appearance is deteriorating, if there are darker things in their work, then their antennas might go up in that instance. What we hope is the school already has referral pathways in place where they will talk to a counsellor, a health-promoting school nurse, an AIEW or guidance person in their school.

It is about the teacher recognising and understanding that a young person might need help and then going through the school channels. If that young person needs further assistance, it is about already having that relationship with headspace or Anglicare or the mental health service in place so it is a seamless transition for the young person.

Mr GUNNER: Some of the evidence we have heard today has been in the Territory, compared to nationally, there is a much greater stigma amongst young men and that can be on application, or coming forward. Are you finding through your program there is a problem more amongst young men than others?

Ms STEVENSEN: It is not specific information that I have been told. Do you have a comment, Jill or Vanessa?

Ms HOULTBY: The work I am doing with Anungu education leaders and Anungu education workers in Central Australia, up until now it was predominantly with women. However, I have noticed since linking in with the Northern Territory group we have had a sway to engaging with young men and one young man in particular, Thomas Hampton, who is a Yankunytjatjara man. He is taking on the role as MindMatters education leader and is actually telling me that a lot of young men are talking with him about the importance of this work, and ways that they can actually be involved and start to drive forward positive leadership in

their community. That has been a recent uptake for me in having some more men involvement and presence with the work.

Mr GUNNER: Do you find there is anything that is consistently your greatest challenge when you first go into a school?

Ms STEVENSEN: Because we try to engage the whole staff, that is sometimes a challenge. We work with a core team which maybe an existing wellbeing team or a pastoral care team, or whatever the school has in place, but we also need them to drive it to some degree. But we also need the support of the executives, so the principal and the APs. At the moment we invite schools to engage with MindMatters. It is not mandated so we have agreed we are sort of visitors in there.

Ms WALKER: Having your years of experience in the APY lands in South Australia and now in Central Australia in the Northern Territory, how do you take that step into communities? Are you invited there?

Ms STEVENSEN: Vanessa, do you want to talk about the APY lands? I can add any ...

Ms HOULTBY: I missed the question actually.

Ms WALKER: It is just really inquiring around how you establish the relationship, how you identify the communities. Is it based on a community that has a certain amount of need? Do you make an approach to them? Do they make an approach to you? Does it come through from another body such as Department of Education or Health? How do you know where you are targeting your services to?

Ms HOULTBY: In South Australia, requests came through a school principal leader in regards to coming in and delivering training. This was back in 2004. But on further discussion with a principal in understanding what it was that he wanted to achieve, it became clear he wanted to strengthen the connection with community and his staff. We had to put aside the traditional, standard MindMatters training and just worked on strengthening conversations around wellbeing. Through that process, I became acquainted with many of the traditional elders and leaders of those communities, and made a choice to work with them on developing and delivering MindMatters through the school.

In regards to the Northern Territory, they heard of this work. We have been working now for eight years on developing the training and the resources. The Uluru-Kata Tjuta traditional elders made a decision to invest their rent money to implement MindMatters through their community. That has been a recent initiative started this year through Nyangatjatjara College.

For me, a really important part of the process is the right people inviting us into that space to work with them. So it is not like we have come in and imposed this, but in fact we have responded to a request to come and talk with them further about how we go about strengthening wellbeing and protective factors within our community, and ultimately addressing the issue of suicide. For me personally, I am hearing way too many cases of suicide on the land. It has come to the point now where we have decided we want to all come together with other services that are delivering programs and talk about what it is we are doing, how we can actually better coordinate that together.

The other issue of the community is too many different agencies and services keep going into communities to deliver whether it is crisis intervention services or programs, and it gets very confusing for these communities. So part of the strategy that we want to look at is how we coordinate our approach to providing a level of service and ultimately, identifying the key leaders who need to be involved in deciding how it is that we come into their community to be part of supporting them in addressing some of these concerns.

Ms PURICK: Just a short question - are you in all Northern Territory high schools, both government and independents, Catholic, Christian schools for example?

Ms STEVENSEN: Yes, in all sectors.

Ms PURICK: In all Territory high schools?

Ms STEVENSEN: All Territory schools are available and MindMatters is available to all of them.

Ms PURICK: But do they all do it? That's my question. Is your program in all our high schools?

Ms STEVENSEN: Not necessarily, no. I think about 64 schools in the Territory have engaged in the program over time, but it waxes and wanes.

Ms PURICK: So, do you do primary schools as well, or is it just in secondary schools?

Madam CHAIR – Ms Marion SCRYMGOUR: You said primary?

Ms STEVENSEN: Just secondary, so KidsMatter primary cover the primary schools.

Ms PURICK: Yes, and headspace and things. Okay.

Ms PEARMAN: It is Jill here, could I just add something to that. The framework and training we offer is there for schools to access. In the Territory, we have a fairly high amount of schools that have actually accessed training and, since 2007, we have been tailoring our work more to help schools in a very targeted way about making that framework happen. As we are doing that - I mentioned before about being recognised as a MindMatters school using a data-informed approach and that is happening on an increasing level nationally where schools are accessing it as a framework that they can actually hang other things off if you like, so it is helping them make sense of everything around them. That is one of the challenges for schools is because they have so little time, they are so time poor, it is actually helping them coordinate that. It is something that MindMatters works specifically on. The other aspect of that is what we are asking them to do and what schools are increasingly doing is looking at everything they do in their classrooms through a mental health and wellbeing lens, so the actual teaching and learning in the classroom is critical to how a young person feels about themselves, about how they go, and their connection with their peers. So, it is looking at everything we do and involvement of community is absolutely part of that as well.

Ms PURICK: If I could ask the question, and I guess it is probably just your opinion, have you found that where you have high schools that are absolutely bursting at the seams in regards to the number of students, teachers, cramped facilities, for example; does that lead to greater risks and potential risks with wellbeing issues? Do you have any data or have you done any work that says the school that is bursting at the seams and there is overcrowding, not enough teachers, or the teachers rotate more quickly than perhaps what people would like, does that lend itself to risks and issues with students wellbeing?

Ms STEVENSEN: There is research to show that it does not matter how big your school is, how many staff, geographically how big, as long as there is that sense of connection to teachers and to the school itself, then they do not matter so much. But, having said that I know that there are schools in the Territory that have over 1000 students and one school counsellor, which makes it very difficult for that counsellor to provide service.

Ms PEARMAN: I would like to add that the other aspect is that mental health is everybody's business and this is very much what MindMatters is about. Mental health is not just something for the domain or in the realm of the counsellor only. Karina made that point really well before; is that mental health has to be on everyone's radar, our teachers in schools are teaching our children every day and mental health and wellbeing has to be up front and centre and we know that mental health and wellbeing is absolutely entwined with academic achievement and they really have to live together for both to be successful.

So, what we are really trying to do and where schools will engage with us - and what we do know from the many hundreds of schools we are working with nationally, and all through the Territory, is that when schools are looking at these issues and, as Karina said, building connections with schools, building resilience, being clear with staff about what referral pathways are there, have good access to service, are looking to sustainability and wellbeing across the school, considering the health and wellbeing of the staff as well, we find that outcomes for students are different. And this is what MindMatters schools are reporting. They are reporting things like reduction in suspensions, improvement in attendance, a greater sense of a feeling of connection to the school, staff feeling happier, staff having less absentee days and this is some fairly clear data that schools are capturing when they have this on their radar, and they are planning in a very strategic way for the wellbeing of their whole school.

Ms PURICK: Just another short question. Does it cost the school to implement the program? It is a free program to them but, obviously, the government provides the funding to you?

Ms STEVENSEN: Yes, it is free to schools. I can be flexible about where the training occurs. For instance, I have been out to Maningrida School and Jabiru. Wherever the school is I can get there because, as you would understand, it is very hard for teachers to get release time.

Ms PURICK: Away from school. Thank you.

Madam CHAIR – Ms Marion SCRYMGOUR: I was just going to pick up on that with places like Maningrida. When you go out there and look at some of these remote settings and these schools, and the expectation on teachers, I suppose, to deliver, the day-to-day teaching, and the burden of everything else that goes on. When do you deliver the training? How many remote communities are you dealing with at the moment besides Maningrida where this program is going into - or remote schools, I should say?

Ms STEVENSEN: Not too many at the moment. It changes. When principals change, for instance, that can change. So Maningrida, Yirrkala – we have done a lot of work there. We also have an officer based in Alice Springs …

Ms PURICK: inaudible

Ms STEVENSEN: Yes, she has done a bit of work out in Mutitjulu, I think.

Madam CHAIR – Ms Marion SCRYMGOUR: Oh, yes.

Ms STEVENSEN: Yes.

Madam CHAIR – Ms Marion SCRYMGOUR: Is it just targeting these communities or these remote areas because of the prevalence of suicide, or where there has been suicide or…

Ms STEVENSEN: No, not necessarily. It is a request that has come from the school: 'We have these issues with young people and mental health, mental illness, and youth suicide. Can you please come out? We need to develop a proactive approach to building up the resilience in these young people'.

Madam CHAIR – Ms Marion SCRYMGOUR: So, in many of these communities – and I can only speak for one community here because that is in my electorate, but I know that one is in Lynne's – the MindMatters, you were saying, looks at the overall – and I think it was Jill who said looking at mental health holistically and de-stigmatising that whole issue.

In wraparound services, if you pick a community like Maningrida, who then does the report? If there are children with challenging behaviours and other things in there, is it the school that then refers to student, or do you do the referrals? Who then picks up that wraparound service around some of those children who have challenging behaviours?

Ms STEVENSEN: Generally, we would work with whoever is in the wellbeing team. That might be quite a small team in some schools, or it might just be one or two people. We would help them to establish processes in order to get young people the right services they need. We might bring out information about headspace or whatever is accessible - a lot of the e-help lines. But, it is still very much the responsibility of the school. We are just providing them with some …

Madam CHAIR – Ms Marion SCRYMGOUR: You are just resourcing them with their training and stuff?

Ms STEVENSEN: Resources, yes.

Madam CHAIR – Ms Marion SCRYMGOUR: Peter.

Mr STYLES: I would just like to make a comment, Madam Chair. I have worked with MindMatters and I can say it is an excellent program, and you should keep up the great work. We should give them a few more dollars so they can go a bit further.

Ms STEVENSEN: Thank you. We have a lot of school-based police constables who have done the training, which is great.

Mr STYLES: I was one of them.

Madam CHAIR – Ms Marion SCRYMGOUR: I think it is very important.

Mr STYLES: I do too, Madam Chair.

Ms SCRYMGOUR: If you have been on the receiving end of the training, and you say that it's good …

Mr STYLES: It is. It is a very worthwhile program.

Ms HOULTBY: Can I just value add something that is also happening with the communities I am working with in supporting young people who have behaviours or at-risk signs. Part of it is also working with, say, Aboriginal education workers to support them in feeling comfortable about how to make those links with those other agencies. In some cases, it is about external agencies coming into the school and building those relationships with the Aboriginal education workers and students as opposed to always expecting students will visit the clinic out in the community. In Central Australia, one of the challenges is breaking down that fear and stigma of accessing health if it is not for a physical problem. If there is a physical sign or symptom that is okay, but if not, if it is more to do with emotionally or mentally, they are not going to the clinic services to access support. So the AIEW's are now being trained to look out for those warning signs and, when they emerge, strengthen that support and connection for the young person to the right health person in the community. There still needs to be some work done there around bringing the health services closely connected into those school communities.

Mr GUNNER: This has been covered already, but what are the normal triggers that would see a principal or an AP ask you to go into their school? Is that a postvention thing, or what causes a principal to ask you to …

Ms STEVENSEN: It can be a range of things. It can be that trigger of a suicide or an attempted suicide or a large amount of self-harming in the school, which is quite a big issue here. Also, feedback from staff around the complexities of dealing with so many people in a classroom who might have emerging mental health problems. Many principals get it; they really understand that wellbeing is at the heart of education so unless you are feeling mentally well you are not going to be learning. Some people just get that connection.

Mr GUNNER: Sometimes a new principal could be the trigger point for MindMatters?

Ms STEVENSEN: Yes.

Mr STYLES: Can I add to that from a personal experience level? When principals have their area and group meetings these issues come up and are discussed and this actually works. When people find something that works it is discussed openly when schools start to have problems. This is very much word of mouth travelling around the community about what works and what does not, and this works. The principal has to get on board and find out about it.

Ms PEARMAN: Also, a comment on that; that is 100% right because in schools there is a growing feeling from principals and leaders in schools that we have to be proactive in this area. Much work has been done about the stigma and understanding around mental health and wellbeing and people now understand. I believe, from my personal experience of working with schools over a number of years, that principals and leaders in schools are seeing we want to grasp the nettle and want to be proactive in this rather than being reactive about something that comes up and looking behind that behaviour.

A behaviour might present, and rather than say that is misbehaviour and we will do something with that person - withdraw them - with the focus being on protective factor frames, how do we bring that person in and connect them. These are the outcomes schools are reporting. They are finding students who are disenfranchised and high risk.

As I mentioned earlier, we had an event and a principal presented a rap that four students had put together - two Indigenous students and two non-Indigenous students - and it was a powerful rap about being connected. The principal was saying that prior to being involved in MindMatters and the work they have been doing around the MindMatters framework, which is many activities, these students were very high risk - were not attending school. Now they are hooked in and hooked on. The rap they presented was really quite extraordinary and very moving. It was quite powerful knowing the story behind it.

Those stories for us and the people in our organisation; Principals Australia, are many and common now which I am pleased to say. I would like to see much more of that so we can make an impact and have an impact on the current figures that we are looking at when it comes to suicide. Hopefully, over time, we can make a difference with that.

Madam CHAIR – Ms Marion SCRYMGOUR: Vanessa, with work that you have done with the Anangu leaders in and around Central Australia, the Pitjantjatjara Yankunytjatjara area, and I think you said also were starting to work with Nyangatjatjara College near Uluru; you have been doing that for eight years. Are you having a look at evaluating the success of the work that you have done with those communities across those Central Australian communities, in terms of their effectiveness?

Ms HOULTBY: The work that I have mainly focused on in the last eight years has been what you would call development based-work. It has been predominantly with the South Australian Anangu education leaders in adjusting the MindMatters framework, in creating material, in putting together training workshops, and all of those have been developed and trialled with Anangu workers and community members. We now have a beautiful pack that they have given permission to be shared with other communities.

What we are now looking at is when the Nyangatjatjara College picked up that pack, and as I mentioned before Thomas started to use those activities and work with the school and the students – amazing outcomes in a short amount of time. What we are now looking at is that we want to collect data around that to show the changes and the benefits.

One of the strategies that we have in place is MindMatters has a series of wellbeing audits. One for communities – both the parent and community, one for staff and one for students. We are working those surveys through a process that they then become Anungu friendly so the language, the way the questions are posed, we are currently looking at setting up that process early in the new year.

The main thing there is that the community has a sense of buying in to this process because there has been previous experiences with surveying that has not gone over well in the communities. We want to make sure that we do this the right way, talking with communities about why we want to collect the wellbeing data. We want to show that by focusing on the MindMatters wellbeing framework and resources it does in fact have a ripple affect on attendance, on young people speaking up sooner about their problems, accessing the court, and hopefully reducing the statistics around suicide. That is the bigger goal but the main thing is we have buying from communities. They want to be part of this process and that is probably the biggest message that I have taken from my journey. I have been a learner in this, going in and actually listening to community and asking the right questions. If you ask the right questions, you may find that they already have some really good answers or ideas but no one supports them to bring them forward. That is what we have done. We have listened and we have supported them to bring their ideas forward.

Unfortunately, the Anangu education leaders could not join in today but they wanted me to express that they would be happy to talk with any of you further about the partnership that we have, and the work that we are doing. They are very passionate about this and they are making their own move to position MindMatters very strongly throughout their schools next year. I hope that answers your question.

Madam CHAIR – Ms Marion SCRYMGOUR: It does and we will certainly follow you up with that because it will be interesting to talk to them. One of the big issues that I see in many remote communities I represent, in particular around the schools, is bullying. Bullying is a major issue in many of the schools. Because of the consistency of that bullying, particularly amongst the various language and clan groups in those communities, that has actually led to a number of young people either attempting suicide or completed suicides.

That is why I am interested in this program in terms of building that capacity and that resilience to try to work through some of that, particularly within the schools.

Ms STEVENSEN: Can I just mention, one of the tools that we offer is a curriculum resource kit for schools. We have a booklet on how to work with students around stopping bullying. We have one on enhancing resilience. We have one on change, loss and grief, and understanding mental illness. Teachers can then take those lessons and run them with their students and that's a really valuable, practical part of what we do too.

Ms HOULTBY: And that's the part that the Anungu education leaders have been working on translating and adapting, so it becomes culturally appropriate. Probably the other important thing here is to also recognise that, especially with the Aboriginal community the school is connected with, that there is their cultural way, and how do we interweave that into the program, and that's what's happened on the land and it is critical. It's making sure that their approaches to health and wellbeing aren't ignored or superseded with other approaches, but in fact we bring it and we really strengthen it and through that school education system.

Madam CHAIR – Ms Marion SCRYMGOUR: One more and then I will have to hand over to Lynne because I have to race to another urgent meeting, but I will be back after that meeting. With the schools and the capacity building with school-based counsellors – so it's not just with teachers, it is also with your school-based counsellors – have you been able to do an audit across schools whether we have the appropriate levels of school-based counsellors in our schools in the Northern Territory? You said you work with 64 schools in the Northern Territory and each one of those schools has school-based counsellors or …

Ms STEVENSEN: Each of those secondary schools would have access to a counsellor. I think there's around 13 counsellors across the Territory, but just at the moment for secondary schools, although they are looking at supporting primary schools as well.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay.

Mr STYLES: Just a couple of questions. This is probably not the greatest question, but do you think there are enough school counsellors around the place?

Ms STEVENSEN: I think we could have many more. That would be great.

Mr STYLES: Everyone wants more of everything, but my understanding is that we do have a serious lack of school counsellors to deal with the number of issues that are out there for young people to deal with. Would you agree with that?

Ms STEVENSEN: Yes, we would say that, and we would also say that would free up school counsellors to do some more of the mental health promotion work, rather than just doing the pointy end and mental illness side.

Mr STYLES: And what importance do you put on the school welfare team?

Ms STEVENSEN: We love them. They are our champions in the schools.

Mr STYLES: On a scale of one to 10, with 10 being the greatest and one being the smallest, what rating would you put on the importance of a school welfare team in a school?

Ms STEVENSEN: I think 10.

Ms PEARMAN: Ten plus, I would say.

Ms STEVENSEN: Yes.

Ms PEARMAN: Ten plus.

Mr STYLES: It is just that I think it's important for this committee to understand how important those teams are and what they do in relation to prevention and early intervention.

Ms STEVENSEN: Yes.

Mr STYLES: And supporting …

Ms PEARMAN: And that …

Mr STYLES: … MindMatters. Go, Jill.

Ms PEARMAN: Absolutely. No, I was just going to say I think that is critical. All of our work in MindMatters, wherever we work, happens through a wellbeing team, a welfare team, a core team. They get called different things, but that team is absolutely critical to what happens within the school and it is that team that helps carve the change. In fact, it's the action of that team and their effectiveness that means that, yes, it is great to have more counsellors and that's very important, but it's that team that actually puts front and centre that mental health and wellbeing is everybody's business, every teacher, every person in the school, the person at the front desk, that person at the front, the secretary who is at the front desk when the student comes to school, how important that is, that relationship. That person is a person working for mental health and wellbeing. It's everybody's business.

The more we expand that idea and that culture within a school, the more you have – the less need you have, if you like, for the pointy end service and many of our schools have said we've made a very significant difference to, if you like, the middle 30% of students who are not really high, high support needs, but they are in that category of needing some additional help. Because our community is so focused on wellbeing for all, and each of us take that responsibility, that young person's walk is different because it is on everybody's radar in that school. They know that saying something to that student around 'Gee that is great work you are doing', or 'Gee, you did a great job with that', and allowing them opportunity for achievement and success, the colour of their day is different. That can make a very large difference to many young people. That is what is being reported back from schools.

Mr STYLES: Could I – go on.

Ms HOULTBY: The other piece of work that has not been mentioned is we have a youth empowerment process built in to MindMatters. That process is actually designed by young people from around Australia and is about their role and leadership in mental health promotion. It is probably one of the very strong pieces of work many of the schools around Australia are engaging with. It is centred around that belief that young people have to be at the forefront of this agenda. They have to take responsibility for being part of leading mental health promotion in their school.

Mr STYLES: Can I try to just encapsulate that in a picture that says if we, as a community, invest at the beginning at the front end, that is going to save us an enormous amount of pain and money and all sorts of things at the back end?

Ms HOULTBY: Yes.

Mr STYLES: You would say in these welfare teams, in things like MindMatters, if we, as a committee, make an investment there that we are going to save not only youth suicide but a lot of other things further down the track? Is my picture correct?

Ms STEVENSEN: Absolutely, yes.

Ms HOULTBY: Yes.

Ms WALKER: Which is why we have Families as First Teachers and those sorts of programs. I am really sorry. It is Lynne as Deputy Chair. Marion has had to step out to another committee meeting. I am going to have to wind up. I thank you for your submission and also for appearing before the committee today to provide evidence. So, Jill, Vanessa, and Karina, thank you very much. We could have talked for ages. I am an ex-teacher and am very much a believer in schools being at the centre of communities and community engagement.

However, we have run out of time; we are behind time. A copy of the transcript will be made available to you so you can review it and get back to our committee secretariat before it would be posted on our website. Again, thank you so much for your time today.

Ms PEARMAN: Thank you very much and good luck.

MS HOULTBY: Thank you.

MS STEVENSEN: Thank you.

Leonore Hanssens

Madam DEPUTY CHAIR: Let us start again. If you will bear with me, I have an official statement to read. On behalf of the select committee I welcome everyone to this public hearing into the current and emerging issues of youth suicide in the Northern Territory. I welcome to the table to give evidence to the committee, Leonore Hanssens. Thank you, Leonore, for appearing 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 by the committee and may be put on the committee's website. If it any time during the hearing you are concerned what you will say

should not be made public you may ask that the committee go into a closed session in order to take your evidence in private.

I will ask you to state your name for the record and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding to the committee's questions. Leonore, I will ask the committee members to introduce themselves.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy, acting as Deputy Chair during Marion's brief absence.

Ms PURICK: Kezia Purick, member for Goyder.

Mr STYLES: Peter Styles, member for Sanderson.

Ms WALKER: Leonore, if you could state your name and the capacity in which you appear and if there is an opening statement you might like to make.

Ms HANSSENS: Yes, Leonore Hanssens, Promote Life NT. I am a researcher and commenced a PhD with Charles Darwin University but have stopped for the time being, but I can deal with that later.

Ms WALKER: Would you like …

Ms HANSSENS: My submission carries on well from the MindMatters submission dealing with school-aged children. I have been looking at some of the data in relation to school-aged children aged 10 to 17 years of age. From 1991 to 2010, we have had 50 child suicides which range in age from 12 to 14; and there are six 12- to 14-year-olds; and the remainder are 15- to 17-year-olds. Some of the issues around child suicide are probably not being dealt with by this committee because when you put your ages up on the website, I think you said from 17 to 24. Was that correct? Youth suicide - you were not looking at the child suicide issues in the Northern Territory?

Ms WALKER: I would have to double check with our Secretariat in the terms of reference.

Mr KEITH: There is a focus on that age but it is not exclusive.

Ms WALKER: No, so it's not exclusive.

Ms HANSSENS: Not exclusive, okay then. I have some data from all age ranges. My research is specifically around Indigenous suicide as well. Yes, I have data from across the board.

Ms WALKER: If you have not already submitted that data but you would like to Leonore, we could certainly accept that.

Ms HANSSENS: Be happy to receive that? Okay. And so from ages 10 to 24, so that encapsulates that adolescent period, there have been 207 adolescent suicides in the period of 1991 to 2010. As I said, 50 of those are child suicides ranging in age from 12 to 17. There was also one child suicide aged 9 but it was not deemed a suicide. It was by the same method, and this is the interesting part about child suicides, they are all by hanging because this is a very accessible method to everyone. There is a contagion factor in that method of suicide which I am seeing through all the age groups from childhood right through to the elderly. So 100% of child suicides are by hanging. With adolescents, close to 90%, so that is the age range from 10 to 24.

So there are other methods used. So that is the contagion issue. The same method that is often used. It is often in the context of a suicide of an adult in a community, and the suicide of a family member or a community member seems to trigger their suicide. It is often around relationship issues. The breakdown or argument often triggers to suicide. So the issues that MindMatters will just deal with it are extremely important and to be able to maybe have a safe haven for some of the young people to discuss some of those issues around relationships and breakdown, and/or arguments within the family. The alcohol and other drug history, particularly the 15- to 17-year-olds. Not so much the 10- to 14-year-olds, but it is in the context of drug and alcohol within the family setting.

So those three main issues that my research has unfolded: the contagion effect of suicide particularly around method, and there is often a suicide in the family, community member which triggers their suicide attempt which is often fatal because of the fatal means that they are using by hanging; it is in the context of a relationship issues either arguments with the family, friends, girlfriends, boyfriends or breakdown of family where they are often homeless or without a stable family environment, so they are moving from family to family; and the alcohol and other drug history – 15- to 17-year-olds.

Suicide is a leading cause of death for children in the Northern Territory from the ages 10 to 17 years of age, and it is also a leading cause of death for the older adolescent group. There is a geographical distribution of suicide in young people. There is about a 50/50 split between urban and rural suicides. When I say 'urban and rural' I am really only meaning to Berry Springs. So the urban areas of Darwin, the urban areas of Alice Springs including the camps and then remote; so there is around about a 50/50 split.

Some of the risk factors that I have noted were gender, predominantly male, and age. With Indigenous young people we have younger suicides than non-Indigenous so we have got ages 12 and upwards. The regional and remote split, the low socio-economic status of most of the Indigenous youth suicides, we see mental health problems, behavioural problems, antisocial behavioural problems. Previous suicide behaviour, many of them have acted out their suicide behaviour prior to completing suicide or had family members attempt suicide. There has been a history of child abuse and precipitating incidents, so there has been this argument or problem in the family or with a relationship, a friendship, breaking down. There is often a FACS history and, as I mentioned, drug and alcohol and contagion. So, they are some of the issues in youth suicide. Any questions so far?

Ms WALKER: I am sure there are. Committee members?

Ms PURICK: Can I ask a question about what you wrote in your submission?

Ms HANSSENS: Yes.

Ms PURICK: And if it is not appropriate, tell me, but you say that the university withdrew your ethics approval. Why did you need ethics approval in the first place; I do not understand that, and why did they withdraw it because clearly your work is important?

Ms HANSSENS: The reason I needed ethics approval was because I was wanting to access the data to get the range of age groups from the National Coroners Information System. The data repository has since moved from just Coroners in their local jurisdictions who would have been the repository of all the data for the Northern Territory, to now a national database which is the National Coroners Information System and that is overseen by the Victorian Institute of Forensic Medicine in Melbourne.

Ms PURICK: So, it is because you are dealing with the subject material?

Ms HANSSENS: The subject material, yes, and also to refine some of my qualitative data - not just the quantitative number crunching - I also was hoping to interview families and/or professionals but who are also family members of deceased people.

Ms PURICK: Then why did the university change its mind?

Ms HANSSENS: The previous iteration of this committee apparently vetoed my research and there were some issues around collecting that sort of data that I just mentioned. I think in some ways they shot themselves in the foot because we probably – well, we still probably would have been here today because I do not think suicide is going to go away very quickly in the Northern Territory; not the rates that we have been seeing because they have just been too consistent. There have been waves, so there has been fluctuations annually, but we are still having a very consistently higher rate of suicide in the Northern Territory. But we could have found out a little bit more about the issues behind and because family members are often willing and able and wanting to share their information, particularly if they think it will help another family member not, in the future.

So, it was really unfortunate that the previous chair and committee decided to veto and then also working with the Coroner they wrote a letter to Charles Darwin University so I was not able to have ethics approval for the last stage of my research. So the first two stages in my research were fine, I got the quantitative data, I analysed it, and published it. But, the last part which I think was the most important part which is the psychological autopsy and really it was going to be in a culturally appropriate one, it was not going to be one like the Australian Institute of Suicide Prevention. Professor Diego De Leo has a standard

psychological autopsy interview schedule. I was not going to use something like that; it was going to be adapted and I was in the process of adapting it. I had my Indigenous reference group which had looked at it and we were polishing it, refining it, to make it more appropriate for the audience.

Ms PURICK: In your work that you have done - and I know your focus is on Indigenous people - has it extended or scooped up what I would call rural and remote, like the pastoral industry-type people or the farming-type people who are way out in the middle of nowhere? The little reading I have done is the more rural/remote you tend to go, the rates tend to go higher ...

Ms HANSSENS: Yes.

Ms PURICK: For lots of reasons, I think. Did you do any work in that anywhere else?

Ms HANSSENS: I have looked at the data, most definitely, because I am looking at contagion effects. Whether the contagion originates within Indigenous settings and Indigenous families is not conclusive. It is often that the contagion can come from outside. There may have been a recent non-Indigenous suicide. It could be a youth suicide, it could be an adult suicide, but it has the effect of contagion and influencing the behaviour. If you look at the 1990s, we had a severe youth suicide crisis in the non-Indigenous population …

Ms PURICK: In the Territory or elsewhere?

Ms HANSSENS: In the Territory, as with the rest of Australia. That was a rural youth suicide crisis in the mid-1990s.

Ms PURICK: Was it mid-1990s?

Ms HANSSENS: Late 1980s to mid-1990s. Towards the end of that decade, services were set in place in mental health services, youth services, school services, MindMatters - all of these things have dramatically reduced non-Indigenous suicide in the Northern Territory. We have had a big win. We cannot say that it is all bad news; we have had some very big wins.

The interesting thing about our data in the Northern Territory it's changing in demographics. From one moment, we are seeing a high in the 1990s, we are seeing high non-Indigenous suicide across the age range, particularly elderly men. Okay? So, that is where the demographic skews to elderly men. But, our youth suicide was very worrying then.

What we are seeing in the Northern Territory; it is age specific now, but it has swung across to Indigenous people. So we still have the same rates, and this is what I was suggesting in my report; that the Indigenous rates increased and it has been hidden behind fairly stable high rates of suicide within the Northern Territory. It is just the pendulum has swung. We have high Indigenous youth suicide now, not non-Indigenous. So, we have made all those wins with non-Indigenous youth suicide, but we have the pendulum swinging to Indigenous youth suicide.

We need to have services. We need to have support mechanisms to support Indigenous youth and, then, mostly – as I said, 50% of them – are in rural and remote areas, so we have to have a look at some of those issues.

Many of them are out of the school system, even though their age range might indicate they should be at school, they are not at school. I just recently have spoken with Orygen youth health in Melbourne, and that is the elephant in the room; the truancy issues. I have mentioned to them we have children who should be in school – and I consider a 17-year-old still a child who should still be at school, and should be getting an education and/or a trade. But, they are not. So, how do we provide services? How do we provide some supports when MindMatters is not applicable because they are not in the school system?

Ms PURICK: It is just they have the right age.

Ms HANSSENS: Yes.

Ms PURICK: Okay, thank you.

Ms HANSSENS: And really, probably as they were saying earlier; to target the primary schools with Indigenous kids, getting MindMatters in really young with Indigenous kids. That would do very, very well in the Northern Territory.

Ms PURICK: Thank you.

Ms HANSSENS: Did that answer that question?

Ms PURICK: Yes.

Ms WALKER: Leonore, I was just going to add that, obviously, your research goes outside the Northern Territory as well. You made mention of the Coronial inquest into 22 suicides in the Kimberley region, which resulted in the Blank Page Summit. You have suggested that might provide a model of intervention for Indigenous communities in the Territory. What do you consider being the key elements of that model that would work?

Ms HANSSENS: Well, the community engagement. That is how it is fundamental. Community engagement is *par excellence*. It is the best practice model. Coroner Alastair Hope, when he did that investigation, involved the community, and he listened to the stories, the anger and the anguish. He did not try to shy away from any of the emotions attached to this suicide epidemic in the Kimberley region.

That has been a cry from some of the communities I have visited the Northern Territory. Indigenous elders want to hear what the coroner has to say because they see him as the repository of knowledge; he knows much about death and why people die because they are always getting coroners reports. The clinic is always receiving coroners reports and they are always sitting down with the family saying: 'Well, this is what the coroner said your relative died from' because it is important for them for payback, cultural issues around death, and any death, any sudden death because they have to incorporate it into their cultural reasoning and understanding. So, they see the coroner as a very important person and one they would like to hear from.

What impressed the people in the Kimberley so much was the fact the coroner went to speak to them; asked them what they wanted to do, how they felt they should address some of the issues. Of course, the women were very vocal around the alcohol and drug issues, especially the drug running and grog running to dry communities or communities where alcohol and drugs were restricted.

I was going to continue with – do I still have time?

Madam DEPUTY CHAIR: We have run behind, but we have another few minutes.

Ms HANNSENS: I wanted to mention that suicide with Indigenous people is age-specific. Looking at the data again, because I sometimes find it very difficult to understand why there is no suicide over the age of about 50 or 55. It is so rare. I keep looking through and thinking perhaps I have made a mistake, perhaps I have to re-analyse this data; however, there is no mistake. The oldest suicide in Indigenous settings is about 55 - that is what it looks like on a graph, and the little ones there are the only over 45. The rest are non-Indigenous suicides.

We are looking at very big skew, which leads us into the protective factors around suicide. What are the factors protecting these elderly men? We could also say: 'Okay, many of that age range are dying early from chronic disease' but a good proportion of them are very elderly or older men who are not succumbing to suicide like our non-Indigenous counterparts. What is happening? That could provide the key to the Indigenous youth suicide crisis we have at the moment - strengthening elderly men and getting the knowledge, understanding of who they are - because they have an understanding of who they are and their position in society. The younger men do not seem to have that same understanding of where they fit into society. My data shows the majority of suicides are in that 15 to 35 age range and most of them are married, unemployed and Indigenous.

Madam DEPUTY CHAIR: I think you mentioned in your research as well about the; coupled to that contagion factor is the belief that out of the despair there is a better life after death, there is something attractive about it. You have researched this in northeast Arnhem Land, big funerals are held for people - as a result of their actions their lives are celebrated and it gets tied up in that very wrong messaging.

Ms HANNSENS: That is more to do with the cultural aspects of death and dying. In some ways it could be used as a protective factor and could be used as an intervention, a form of intervention or reframing what has actually happened with this young person; the despair that this young person was in. I do not think we should try to intervene in any way in that cultural sorry business because it is very important particularly where it is in combination with their Christian spiritual beliefs as well. It is always very solemn, but it is also in some ways a celebration of their life.

That, inasmuch as I would not like to suggest that if people are providing big funerals - for example, there was a young boy of about 16 who died in east Arnhem. He was the traditional elder. He would have been in direct line to be the traditional elder and landowner in Yirrkala. He died in a traffic accident and they had weeks of celebration after his death, lots and lots of community celebration on the beach. It was a big ritual, huge ritual. There were attempted suicides after that, and some completed suicides after that. But I think what we need to do is provide particular interventions around that time of sorry business rather than interfere with the actual rituals that are around the death, just to provide specific support to the bereaved and to identify the risk factors around that time.

Madam DEPUTY CHAIR: Leonore, we are going to have to wind it up. Are there any closing remarks you would like to make?

Ms HANSSENS: Just about the clusters of suicide and the vulnerabilities of Indigenous people, so clusters of suicide, Indigenous settings of those who are vulnerable to suicide particularly in the 10 to 55 years age group. It is not age-specific as I have mentioned, and clusters occur at all age groups.

Really, it is the temporal proximity to the suicide victim, the geographic and physical proximity to the suicide victim that we have to take into account. The interpersonal familial proximity to the suicide victim – and that is very difficult to avoid in Indigenous communities because families are always connected so there is a strong sense and close knit society in Indigenous settings. The reach of news of recent suicide or sudden death; as this young boy's sudden death reached the whole of the Arnhem Land area everyone flew in for his funeral. So we have to think about those protective issues: interpersonal conflict, violence and sexual abuse; emotional payback and alienation and anguish; the history of substance abuse as I have mentioned before, and members of the drinking circles that I have spoken about quite a bit in my research; and the alcohol and cannabis availability and supply. We really do need some strong interdiction policies in the Northern Territory and that is a policing and Department of Justice issue. I know that they have done some very strong Enough is Enough but I think the cannabis supply is really the issue that we really need to knock on the head if we are going to see a reduction.

There has to be different interventions. We have done interventions for non-Indigenous youth, but we are going to have to think outside the square with Indigenous youth, so the availability and commonality of means. What can we do to prevent hanging? They have hung themselves with shoe laces so what can we do to prevent someone from hanging themselves? They can hang themselves with a bra strap on the door handle over there. Availability of lethal means is a very difficult one to tackle but as my research has said, 60% of them occur around the home so we actually have to look at strengthening the families within those sort of settings and behavioural contagion racism, unemployment, poor education and inaccessible mental health care.

The poor education, as I said the truancy issue is the elephant in the room, we have to get these kids to school and give them a meaningful life and employment. Poverty, economic deprivation, social fragmentation, and the social fragmentation is a big one as well in these Indigenous communities. So, persistent stress, irreconcilable loss, malignant grief and existential hopelessness, impulsivity, cultural reciprocity is a very, very key and important one. They feel very responsible for someone else's suicide and that often tips them over the edge. Responsibility to the deceased and the associated shame and blame and the psychosocial, emotional, spiritual, cultural vulnerability of suicide victims, the consequential depression, anxiety, and morbid depression and then following on with that is the psychosis that often tips them into the suicidal act. Thank you very much.

Mr STYLES: Is there is a connection between marijuana with these young people?

Ms HANSSENS: Yes.

Mr STYLES: I have not actually got through your whole submission here. Is that covered in here?

Ms HANSSENS: It isn't, no. It is covered in some other data that I have and papers that I have written, so if you want something particularly around …

Mr STYLES: When we are finished, if you don't mind, I will get that information from you. Thanks.

Ms WALKER: Leonore, thank you very much for your very detailed submission, as well as appearing before us today to provide evidence. We greatly appreciate your time.

Ms HANSSENS: Great, thank you very much.

Ms WALKER: Thank you very much.

Darwin Community Arts
Ms Alyson Evans

Madam CHAIR – Ms Marion SCRYMGOUR: I just have to read an official statement. On behalf of the select committee, I welcome you to this public hearing into the current and emerging issues of youth suicide in the Northern Territory.

I welcome Alyson Evans. Thank you for coming before the committee. 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 we will take your evidence in private. I will ask you to state your name for the record and the capacity in which you will appear today. I will then invite you to make a brief opening statement before proceeding to the committee's questions. So, if you want to state your name.

Ms EVANS: Alyson Evans.

Madam CHAIR – Ms Marion SCRYMGOUR: And you are here in what capacity, Alyson?

Ms EVANS: I am here to speak to you about a suicide prevention project that I have done in the past.

Madam CHAIR – Ms Marion SCRYMGOUR: Before I invite you to make an opening statement, I will get members of the committee to introduce themselves.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: And Lynne Walker, member for Nhulunbuy.

Ms PURICK: Kezia Purick, member for Goyder.

Mr STYLES: Peter Styles, member for Sanderson.

Madam CHAIR – Ms Marion SCRYMGOUR: My name is Marion Scrymgour, member for Arafura, and the chair of the committee. Would you like to make an opening statement, Alyson?

Ms EVANS: Yes, sure.

I am a project officer for Darwin Community Arts, and my background is I am a community arts worker through drama. I facilitate drama through emotional health projects, using theatre and drama as a way to raise self-esteem and tackle issues, mainly with young people. I am currently doing that for Darwin Community Arts and I have done for the past year, working with young people in Darwin and also in remote locations as well.

I am here today to speak to you about a project that I did in Wales when I was working for an organisation called Valley and Vale Community Arts. In 2007 and 2008, I was working in this borough called Bridgend, which is a pretty small borough. There was a suicide problem and, within two years, there were an estimated 25 suicides of young people. Being a very small area, this affected the whole community, and with many the young people I was working with, it got to the point where everyone knew someone who had committed suicide. In a small village where my office was based - this is the village of I

think just under 1000 people, there were four suicides. So it was, as you can imagine, a pretty devastating time.

I was working with young people in the borough at this time. I was employed to work there to run emotional health projects for 11- to 25-year-olds whilst this was happening. During my workshops these issues kept coming up because there was a constant new suicide. So, we would explore this through drama, through discussions, through making images, through role plays, and things like this. What kept coming up was the young people were saying: 'We want to speak about it, but no one will let us speak'. Because there was a lot of panic in the schools, many teachers were saying: 'No, let us not talk about it, let us just carry on' and there was nothing for the young people.

What I did, from speaking to the young people and asking what they would find beneficial, is I adapted a novel called *A Long Way Down* by the author Nick Hornby, which is based on suicide. I adapted that into a theatre play which was about 50 minutes, so it suited young people, and set it in south Wales. We then toured that to youth centres and community centres, to young people, where we performed the play - which was performed by local young people - and then facilitated a discussion at the end about the issues raised in the play. In the play there were three characters and each had a different reason as to why they wanted to commit suicide: the person who had done something wrong and could not see a way back; one person who had experienced suicide in her family and did not know how to deal with it. Nothing major happened in the play. There was no perfect happy ending, but they all found little ways to survive and to get together and pull in support. Yes, we performed that, then we facilitated a workshop at the end to encourage the young people to discuss what was going on and where to get help. We invited local counsellors and local help organisations to come as well to get discussion going amongst everybody.

We found that much of the feedback we had was the young people said: 'Yes, this is great that we can talk about it and we are allowed to say what it is we want to say, and to find out and just discuss it. That was really good'. We had service providers there and the young people. It opened up a forum as to what it is you need, because we found there were many people who sat around desks discussing and, then, there was young people and there not much of them coming together. So, that was really good.

The other feedback we had was it was good for the young people to watch something, and then discuss it. It was pretty beneficial rather than just being talked at, to visualise it, and think about it that way. So, that was a really good way to approach it: for them to sit and watch and then discuss.

Madam CHAIR – Ms Marion SCRYMGOUR: You said people say it is better not to talk about it, and that seems to be a constant theme of people particularly, experts in this field say: 'Don't talk about it because if you talk about it, it then escalates the problem and you get the copy cat'. Do you think part of the problem is we do not talk about it and we do not encourage the community to - let us get rid of the shackles and start looking at the issues so we can better respond.

Ms EVANS: That is definitely part of the problem. Many people are scared of how to approach it and are scared if they go in – let us discuss this suicide problem, people will say: 'Suicide, yes, I am going to commit suicide now'. If someone is struggling with it and it is on their mind, to openly discuss death would not necessarily lead to encouraging people to do it. It is beneficial because by talking about death it lessens confusion and opens up ways to learn: 'How can we get help, how can we get support' and we are sharing stories and not feeling so isolated. So yes, I think It's beneficial.

Ms WALKER: By sharing it through drama it is at arm's length. Dramas and plays are a great vehicle for dealing with some of our societal taboos. As an ex-English teacher, books and plays about drug addiction, domestic violence, rape – so I think your idea is fantastic. Is it something Alyson, that you are looking at potentially as a project while you are with Darwin Community Arts?

Ms EVANS: Yes, it is definitely something I would be interested in doing. I found from working with young Indigenous people the visual is something that works really well. My work is around emotional health and exploring feelings and behaviour patterns and things like that. To sit and discuss does not happen, to show something, to create a scene that mirrors real life, they are on it; everyone is on it straightaway, which I often find with young people.

Mr GUNNER: When you toured it, how many places did you go to and how many children/students did you end up talking to?

Ms EVANS: There were many. We did two tours because we did a first one to four venues - this was half way through the suicide program and many venues said no to having us because as soon as we said it

was about suicide they said no. We did four and during that time there were about 200 young people during that first one. Because of the success and the positive outcomes from the young people, people saw their children – young people's partnership wanted more so we toured again. We included colleges then so probably up to 250 to 300 that time.

Ms PURICK: What was the population approximately of the borough?

Ms EVANS: It would be thousands in the borough.

Ms PURICK: Percentage wise was a high level.

Ms EVANS: Yes, very high.

Ms PURICK: The book, Nick Hornby's, is that based on a true story or is it fiction?

Ms EVANS: It is fiction. When I thought a play would be a good thing, straightaway - for a split second I thought create a play about young people in Bridgend mirroring life but not this is your life is what really helped - leaving it blank. That is why the novel worked well.

Ms PURICK: Have you used the theatre you did there in the Territory? What you did there, do you think it would work here with some adaption?

Ms EVANS: I think a similar thing. If I was to do it for suicide I would probably change the story and would do more research to ensure it fits well so it is as beneficial as it can be. I have used similar in my projects where we used death to look at issues - I have done that here but not suicide.

Ms PURICK: When the experts analysed and studied what happened in the borough, did they come to any conclusions as to why young people were killing themselves?

Ms EVANS: No, there was much talk - it became a massive media thing and that was hugely blamed …

Ms PURICK: That contagion issue?

Ms EVANS: Yes, and it is interesting what the last lady said about the sorry business and seeing the big funerals, because a lot of my young people spoke about this: seeing the big media frenzy and Facebook and MySpace pages. When the young person died their pages went wild. A lot of young people I worked with expressed how some of the ones that they knew, like themselves, were bullied or were really shy and blended into the background and then they hung themselves. All of a sudden they knew that they had this big ...

Ms PURICK: Profile in death.

Ms EVANS: Yes. But there was no kind of exact reason why.

Ms PURICK: Okay. Thank you. It sounds terrific though.

Madam CHAIR – Ms Marion SCRYMGOUR: Arts is probably the best form of expression, I think. In terms of the Darwin Community Arts, how are you engaging or capturing these youths to encourage them to dramatise their feelings and stuff? Are you working with the schools?

Ms EVANS: Yes, mostly working with schools and, at the minute, working with disengaged groups, but through the schools.

Madam CHAIR – Ms Marion SCRYMGOUR: Are a lot of the schools receptive to engaging with DCA to get...?

Ms EVANS: Yes, they are, and the few who have been a bit uncertain when they have seen the progress of the young people throughout the workshops they are very keen now and see how beneficial arts can be in developing and welfare and things.

Mr GUNNER: We have heard a lot today about postvention and this fits into the classic category of we have the advice from a whole variety of different community groups, and they talked about the importance

prior to the tragedy of one suicide, having a postvention to prevent a cluster. This seems to fit into that category of doing that and doing it well.

Ms WALKER: And dealing openly with what would be a taboo subject.

Ms EVANS: Yes, that was the main point to this project - just to get it out there, get it in the open and get discussing.

Ms PURICK: Just one other quick question. When you talked about the authorities of the school said don't talk about it, we can't talk about loss and grief, do you think that was because there would be a view that a person who committed suicide because they were mentally unwell, and because they were mentally unwell somehow they were a bit of a looney, so let's not talk about that. Do you think it was that kind of thinking maybe?

Ms EVANS: Maybe. I think it was more along the lines of not knowing how to deal with it, so maybe if the teachers had the class and this big discussion happened, I think maybe that worry of not knowing how to deal with it…

Ms PURICK: They are not going to have the training to deal with it themselves.

Ms EVANS: Yes, and I think along the lines of just being scared to talk about it and not wanting these kids; 'Oh Miss so-and-so was talking about it today'. Yes, I think there is a lot of worry around the subject.

Mr STYLES: So do you see this is a very popular tool in relation to capacity building of schools and communities to actually handle and talk about those things?

Ms EVANS: Yes, this could be a very good thing. I know in Wales it is quite common to do projects like this.

Mr GUNNER: Do you think attitudes have changed? After you had done the second tour, did you feel the attitudes had started to change or only amongst those people you spoke to directly?

Ms EVANS: Around the suicides?

Mr GUNNER: Around the whole attitude towards talking about it, not talking about it, awareness.

Ms EVANS: Yes, definitely. From the teachers who came and some teachers brought school children - all the schools said no. We offered it to all the schools and they all said no. Some teachers who I have close relationships with brought children and they were like: 'Yes, this is what we need to do, we can spread that'.

Madam CHAIR – Ms Marion SCRYMGOUR: Alyson, in a lot of the evidence we have taken today, a lot of people have said that suicides particularly amongst young men or young males is a major issue. In terms of Darwin Community Arts and the program that you run, do you have engagement with many young men or young males?

Ms EVANS: I do in Darwin, not in my remote work, just in Darwin, I work a lot with these.

Madam CHAIR – Ms Marion SCRYMGOUR: So, with your remote work, where does that take you?

Ms EVANS: Pickertaramoor on the Tiwi Islands; Maningrida, Arnhem land; and Gunbalanya.

Madam CHAIR – Ms Marion SCRYMGOUR: All in my electorate of Arafura. We will have to have a chat. Very arty communities, that is all I can say. In many of these remote communities that you have talked about, you have no engagement with any of the young men?

Ms EVANS: No, just the women.

Madam CHAIR – Ms Marion SCRYMGOUR: But you do in Darwin, you said.

Ms EVANS: Yes.

Madam CHAIR – Ms Marion SCRYMGOUR: Anyone have any other questions? Thank you very much for appearing for the committee. We will make a transcript available to you, you can have a look at that transcript, and once you have had a look at it, the committee will then upload that transcript onto the website.

Ms EVANS: Great.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you very much.

Ms WALKER: Thank you Alyson, good luck with your work.

Professor Colin Tatz

Madam CHAIR – Ms Marion SCRYMGOUR: Professor Tatz, thank you, I do apologise, we are running over time. I just have a very brief official statement which I have to read prior to taking your evidence.

Prof TATZ: That is fine.

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

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

I ask 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?

Prof TATZ: My name is Colin Martin Tatz. I am a visiting Fellow of the Australian Institute of Aboriginal and Torres Strait Islander Studies. I am also a visiting Fellow in the School of Politics and International Relations at the Australian National University. My other capacity is that I am an author who has been involved in studies of Aboriginal youth suicide, in particular, since the 1990s. In that capacity I sent a formal submission to your committee about a month ago.

Madam CHAIR – Ms Marion SCRYMGOUR: Yes, thank you, Professor Tatz. I will get members of the committee to introduce themselves by name and their electorate and, then, if you would like to either make a brief opening statement. If you do not, we will then proceed to questions from the committee.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy.

Ms PURICK: Kezia Purick, member for Goyder, which is a rural area just outside of Darwin.

Mr STYLES: Peter Styles, member for Sanderson, which is an urban electorate.

Madam CHAIR – Ms Marion SCRYMGOUR: My name is Marion Scrymgour, member for Arafura and the chair of the select committee. Would you like to make an opening statement, professor?

Prof TATZ: Madam Chair, no, I do not think so. I believe we could usefully use the time. I think you all have a copy of my formal submission so, rather than waste any time on my part, perhaps you would just like to go straight into questions.

Perhaps I should ask if any member of the select committee has not seen the written submission I sent in?

Madam CHAIR – Ms Marion SCRYMGOUR: No, all members of the committee have had access to your submission you have provided.

Prof TATZ: Good. Well, Madam Chair, then if it is all right with you, perhaps we could just go to questions.

Madam CHAIR – Ms Marion SCRYMGOUR: Yes. Committee members? Michael.

Mr GUNNER: You talk a lot about the importance of sport and the link between sport as an alleviator or a preventer of suicide. You talk about the problems, then, in the off season away from sport. Do you have any thoughts around that off season?

Prof TATZ: Yes, there is a very serious problem, as I mentioned in the submission. When I was doing a lot of research across the whole of Australia in the mid-1990s, looking at sport and its relationship to Aboriginal juvenile delinquency, it was quite clear, and very stark in places like Geraldton in Western Australia and places like Port Lincoln in South Australia and, also, to a certain extent in the Northern Territory, that when the football - or whatever season, basketball season - was on the delinquency rates were almost invisible and, as soon as the sporting season came to an end, it all escalated enormously.

The problem about the off season is that we are, basically, confining ourselves to sport as something that is played between teams, and with boys and girls who have the musculature and the athleticism to participate in sport. But, as you will all appreciate, there is a great deal more to sport than just 18 players on one field - or 11 players on one field, whatever it is - and that is, the sole participants. There is organising to be done. There are future competitions to be organised. There is fundraising to be engaged in, in order to raise money for travel, for guernseys, for gear, for kits, and so on and so forth. There are newsletters that have to be written. There are fan clubs that have to be taken care of. There are various recruitment programs. There are specialised training camps. In other words, if we think outside the circle or outside the box for a moment, we will see there is much activity that could take place off season in readiness for the season.

One of the things I would like to say to the committee is whenever I, or somebody like me, talks about sport in the context of suicide, they think of Saturday afternoon or Sunday afternoon games with a limited season of four or five months of the year confined strictly to the young men and women who have the talent to play sport and that is the beginning and the end of it. Sport is a very complex system of organisation, administration, and it is the involvement of the non-players that is so important in this exercise.

Mr GUNNER: Did your research go into gender? We have heard evidence today that in the Territory, compared to nationally, there is a real stigma amongst young men coming forward to talk about suicide, be referred or have early intervention. Did your research go into gender? Do you find there is an equality of involvement in sport?

Prof TATZ: In the statistics nationwide, the female rate of young suicide is anything from one-third to one-quarter of that of the male rate. However, there is evidence to show - I do not have the figures to hand but they are easily obtainable - that female suicide rates, especially amongst the young, are increasing and increasing at a fairly alarming rate. It is not only true of Australian Aboriginal and islander people, but also in places like Guatemala, the Pacific, Samoa, Fiji, and among the Inuit I have studied in Canada.

Female suicide is tended to be written off as something not terribly serious in the sense you often get the comment in Aboriginal communities: 'She is just looking for attention, she is busy slashing up', but the slashing up is a very serious business. That phenomenon of girls engaging in self-harmful activity has increased noticeably. Yes, there is - I will not say anything like an equalisation between male and females, but the female rate is something we should not ignore.

Mr STYLES: Professor, cost considerations for families to get people into sport, what are your views on that? We get feedback through the communities that many people do not have the capacity to pay for sport, contribute, pay for the cost of transport; even transport itself is a problem.

Prof TATZ: This is a very serious problem and I am glad you touched on the question. Let me go backwards and say if there is $100 available to get any one young Aboriginal male onto a sports field, there is only about $1 to get a female onto the sports field. There is a huge disparity in fundraising, in sponsorships, in support systems for males as opposed to females. In my visits across many communities in Australia - I have visited something like 90 communities across the continent when I was doing the delinquency study, and later the suicide study in New South Wales and the ACT - you find there is an

enormous disparity that girls are forever having to hold chook raffles, the old ladies have to knit garments or make garments to support the team and so on. It is pitiful peanuts in comparison to the little that the males get.

We have an enormous problem, as you are aware in the Northern Territory, of remoteness and distance for teams to travel for competition. It is not unheard of that Aboriginal communities are allowed to play in a particular league provided they, the Aboriginal team seeking entry into that league, pays for the visitors to come to them and then they have to pay for themselves to go to the visiting teams. The question of transport, the question of access is absolutely central to the whole business of sport.

Let me make something clear from my submission to you, and it is for your earnest consideration: sport does not prevent suicide. Sport, by itself, cannot prevent suicide. The point I am making about sport is it is an alleviator; you touched on it earlier. It is confusing as to which member is which; however, you made the point that we are up against something quite serious here in relation to distance, and access is something that has to be really faced head on.

How do we do it? We have to have a number of governmental schemes that will provide at least the fundamental basis. I do not have any idea of what kind of a budget item it would be, but it is not going to be more than $1m, in having a subsidy scheme to enable Aboriginal community teams to go from one part of the Northern Territory to the other. For a team to organise itself from Yuendumu to go to play at Barunga, or for a Barunga team to come up to Darwin, or for a Darwin team to get out to Roper Bar, all of this costs a certain amount of money. I am suggesting that we might even think of something like an equity system that for every dollar that Aboriginal communities raise, the Northern Territory government has a fund that gives them dollar-for-dollar towards movement to contribute to continued sporting activities.

I want to also make as a central point about sport being an alleviator, is that it deflects students/young people from these kinds of suicidal thoughts when they have a sense of purpose. Sport gives people a sense of purpose and that sense of purpose is basically a present tense and a future tense oriented activity. When you think about sport you are thinking about next weekend's match, you are thinking about next month's match, you thinking about next season's match. One of the problems about suicide amongst Aboriginal and Islander youth in this country, it has no sense of the future. They only dwell in the past and in the present. We have to find a mechanism to get people to have some kind of future orientation that life has some kind of a future.

Ms PURICK: You commented about the lack of interest by the medical profession. What do we need to do to better engage them so they do take an interest and help everyone with social strategies?

Prof TATZ: Well to be flippant I would train them all over again. I have actually looked into the whole question of medical school curriculum. First of all, suicide has hardly ever been a topic in any medical curriculum in any of the medical schools in Australia. That is number one. Number two: if there is some attention to suicide it never ever separates Aboriginal and Islander suicide from mainstream suicide, which makes it some kind of a disaster in the making. Thirdly, when you train medical people, the whole, what I call bio-medical model - and that is not my term by the way, it is something that is commonly used in the profession - the bio-medical vision of all of us sitting in this room, you, me, is simply that their job is to locate the illness within the patient and to treat that illness within the patient. That is their job.

Now if you say to a doctor: 'Hey listen, what is wrong with this guy?', and they put the stethoscope on his lungs and they give him some tests and then they say: 'he has mesothelioma, he has asbestosis disease', what is the doctor's duty? The answer is to cure the lungs as best they can. The fact that the guy is going on working in an asbestos mine is irrelevant as far as they are concerned. I know that is being a little bit harsh, but basically the doctors are not concerned with the social, the historical, the geographic, the environmental, the legal conditions under which people are living. They are looking solely at disease and pay their attention to disease to the exclusion of all other consideration.

The problem with suicide as we all know, because there are libraries full of books about suicide, is that you cannot simply locate suicide as a medical condition or as a medical problem treatable by doctors. So what do we do? I think we just go on just talking and talking and talking and dripping away through committees like yours, like the Senate Committee on Suicide, like private writings of academics like myself, go to conferences, and trying to put the social causes of suicide on the agenda instead of just simply looking at a patient who may or may not have bipolar, or depression, or whatever.

Not an easy task, I can tell you.

Ms PURICK: Thank you Professor.

Mr GUNNER: Your submission goes to organised sport; do you see any value in the scratch match in the back yard?

Prof TATZ: Absolutely, you know one of the things about sport, and thank you for raising that; we all tend to think about sport as simply organised, competitive sport, à la the Australian Sports Commission or the Olympic Committees, etcetera. We have a very serious problem that Mr Crawford addressed recently in the Crawford report into sport. He upset sports authorities very much by saying: 'Hey listen, we have to start looking at community sport and community sport means all leisure and recreation and splashing in the pool, going on a camping hike, organising a food hunt, organising a whole host of leisure and other rituals that are common in Aboriginal communities that is as much sport as the Nguiu Football Final'.

So, we have to look at a way of addressing, not just for suicide reasons or obvious health reasons, number of illnesses that beset Aboriginal communities and believe me, there are a lot of them. We can start with heart disease and we could start with cancers, we could start with the ghastly figures of renal disease in Aboriginal communities, and we can certainly look at something that I have, I got it late in life is diabetes, in people - all of these can be addressed in part, not in whole, in part by a healthy physical regimen of some kind or another. That includes leisure and recreation as a relief from stress.

You will get a lot of endocrinologists who are prepared to talk to you very strongly about the role of physical health and exercise in people who have type 1 and type 2 diabetes. The diabetes rates in Aboriginal communities in the Northern Territory are astronomic, I can tell you that. So, at least we have the endocrinologists on our side and I am sure that the heart people, the cancer people, the kidney people, the respiratory lung disease people will give you the same information; that we have to get people moving, we have to get people to engage in a healthier physical lifestyle, which is not only diet, but physical exercise and recreation.

Madam CHAIR – Ms Marion SCRYMGOUR: Professor Tatz, if I could just ask a couple of questions. Thank you for your submission, it was interesting going through that submission. In your submission you were saying that the first reported suicide in the Northern Territory, which was actually in and around my electorate, the Liverpool River near Maningrida, was 1998. Then your submission touches on that then the levels of suicide escalated to a rate that was amongst the highest in the world by 2000. Within two years, it had gone from what you are saying was quite a low rate to being the highest in the world by 2000, and then by 2002 – so, intervening two years between each of those - Aboriginal male suicide rates in the Territory reached a staggering 66.3% per 100 000 compared to 10.3% on the national average. Are you able to provide that data? You obviously would have had access to data to be able to - I am not asking you to go right back to 1998 - but obviously, particularly from 2000, or just where you got the percentage of 66.3% on Aboriginal male suicides in the Northern Territory?

Prof TATZ: Yes Marion, if I could just put one thing to you. I am going to an Asia Pacific Coroners Conference in Noosa next week - that is why I am up in this part of the world - and coroners from all over the Pacific, New Zealand, etcetera, are going to be talking about what has happened since the Royal Commission into Aboriginal Deaths in Custody and what have been the major changes. One of the items for discussion over the three days amongst the coroners themselves is going to be the fact that the statistics on suicide generally, not just Aboriginal and Islander statistics, but the whole of the Australian community, are undergoing kind of a turmoil because there has been considerable under-reporting over the last 30, 40, 50 years.

We do not have time to go into the reasons for that under-reporting but there has been a revision in most coroners' statutes across the country. There has been a serious concern by coroners at under-reporting, there are efforts to improve police procedures, and forms, and protocols in analysing and defining whether a particular person has suicided or not. There have been changes in the attempt to overcome a really serious problem amongst Coroners; which is that Coroners are not allowed to presume suicide. So, very often, in the case of a clear-cut suicide - which, to me is a clear-cut suicide - this is a young boy, the only tree between here and Maningrida, he is on the wrong side of the road, there are no skid marks, and he is found dead with rosary beads in his hands and they say: 'Well, death by misadventure'. You cannot even presume suicide in circumstances such as this.

So, what you are getting now in statistics is an elevation. However, whether the elevation is because more people are committing suicide, or is it because the Coronial systems and the police systems of reporting are getting better and better? I suspect it is the latter.

What I am saying, on the other hand, is that until these revisions have begun to take place, there was a serious under-reporting of suicide. Whether you are talking about 10 as a national average, it was probably 15. I you were saying it was 66 in the Northern Territory, it was probably, in reality, something like 86. The truth of the matter is, from your point of view - and here I am 100% behind all your efforts in this regard - suicide was something that was, basically, unknown in Aboriginal communities before 1960. Some people have said to me: 'Colin, you are wrong, there must have been suicide; we just did not find it'. The answer is I have been through every set of records - the old Welfare Branch records, the old Mission Society records, the old police records. There was virtually no mention of the word 'suicide' before the 1990s. I worked in the Territory from 1961, right through to about 1984, on and off in various communities. Suicide was just simply unheard of.

What has happened is something has taken hold, in not just your community but right across Australia, right across the Pacific, right across Indigenous peoples, basically, the world over. It has become ritualised, it has become patterned, it has become institutionalised, it has become contagious, it has become – I hate that word – copycat, but there is simply a lot of repetition within family groups or within kinship groups or within friendship groups. Something has come seriously unstuck since the 1960s or the 1970s. All I can say is I do not know what has caused that – well, I think I know, but I do not have time to give you my lifetime's experience on this.

But, quintessentially, something has to be done to deflect what is happening. The deflection that I am talking about may not necessarily be sport, but it sure is ----------3:48:24 and fields. It is not psychotherapy discussions with consultants on a set time, in four months time in some psychologist's consulting rooms. We have to address a total societal problem, which is the problem that you are confronting at the present time. The question is: can we think a little more unconventionally; can we think a little outside of what I call this biomedical box?

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you, Professor Tatz. I do not think there are any further questions from the committee. I thank you for your submission. We will provide a transcript to you on your part of these hearings. Once you have gone through those transcripts, if you are happy, we will upload that transcript on to our website. If there are any questions the committee has, we will follow up with you on any further questions to your submission.

Prof TATZ: Thank you very much. Does that mean I have the chance to edit all the 'uhms' and 'ahs'?

Madam CHAIR – Ms Marion SCRYMGOUR: Yes, yes, you will have that opportunity. We will certainly follow up again with you because there is probably more in your submission and, if we had more time, we would certainly follow up with you. Thank you very much.

Prof TATZ: I will be back in Sydney on 11 November. You staff will be able to find me back in Sydney. I am more than happy to do this again or answer any general answering of any further questions. If I can help your committee in any way, I am more than happy to do so.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you. We will certainly be following up with the NT Coroner. We have actually written to the Coroner to touch on the issue of statistics and the way completed suicides are reported. Thank you.

Prof TATZ: Thank you very much everybody.

Aboriginal Peak Organisations NT
Ms Paula Arnol; Ms Ruth Barson; Mr John Paterson; Mr Chips Mackinolty; and Ms Stephanie Bell

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you for being so patient. I have to read a quick official statement and then we will get into it.

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 table Ms Paula Arnol, Ms Ruth Barson, Mr John Paterson and Mr Chips Mackinolty. Thank you for appearing before the committee today. We appreciate you taking the time to speak to the committee and look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will

say should not be made public you may ask the committee to go into a closed session and to 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 Ms Arnol, to make a brief opening statement before proceeding to the committee's questions.

Could each of you state your name and the capacity in which you are appearing for *Hansard* purposes.

Ms ARNOL: Paula Arnol, Chair of AMSANT.

Mr MACKINOLTY: Chips Mackinolty, Manager, Research Advocacy and Policy, AMSANT.

Mr PATERSON: John Paterson, Chief Executive Officer, AMSANT.

Ms BARSON: Ruth Barson, advocacy lawyer at the North Australian Aboriginal Justice Agency.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you.

Mr GUNNER: Michael Gunner, member for Fannie Bay.

Ms WALKER: Lynne Walker, member for Nhulunbuy.

Ms PURICK: Kezia Purick, member for Goyder.

Madam CHAIR – Ms Marion SCRYMGOUR: I have to put in an apology for Mr Peter Styles, the member for Sanderson. He has had to go to a quick meeting, but he will be back. My name is Marion Scrymgour, member for Arafura and Chair of the select committee.

Would you, Ms Arnol, like to make an opening statement?

Ms ARNOL: Yes, thank you, Madam Chair.

We thank the inquiry for this opportunity to give evidence. We make it on behalf of the Aboriginal Peak Organisations NT, an alliance of the Central and Northern Land Councils, the North Australian Aboriginal Justice Agency, the Central Australian Aboriginal Legal Service and the Aboriginal Medical Services Northern Territory. It is perhaps significant this is the first parliamentary inquiry at which APO NT has provided evidence given the importance of this issue to Aboriginal people.

We have provided a submission to you. I would like to make a short opening statement after which we are happy to answer questions from the select committee. The rate of suicide in the Northern Territory, especially youth suicide, is simply unacceptable. Between 2005 and 2009, the NT had the highest rate of suicides compared to other Australian states and territories. For this reason alone, suicide is a significant concern in the Northern Territory, particularly amongst Aboriginal people, but it goes much further than this. Aboriginal youth suicide is a cancer in our communities. In fact, it is difficult to comprehend a jurisdiction in Australia that is more conducive to our young people taking their lives. Our young people are subject to lives of poverty and disenfranchisement that on any measure are among the worst in the nation. The overwhelming evidence in that each of these social factors in public health terms, social determinants, are strong predictors of risk taking and suicidal behaviour amongst our young people.

Briefly, the social determinants of early childhood development, health, employment, housing, education and access to justice and social control are reflected in the social gradient of powers and ill health. The dice is loaded against our people from before birth, let alone before they grow up. One of the absolute consequences of Aboriginal people's position on that social gradient is that our young people take their lives. The grief that drives our young people to take such tragic steps both reflects and adds to the grief so many of our people experience, and it touches all of our lives. It simply goes against nature for parents to bury their children and mourn for the loss of the future of our people.

APO NT does not pretend that the solutions are in any way straightforward. Youth suicide is both a cause and consequence of much that bedevils our families and communities. What we do know is that just as the causes are multi-factorial, the solutions must be likewise. Solutions lie within our families and communities of course, but it goes beyond that. There also needs to be a social response. Although this is an inquiry of the Northern Territory Legislative Assembly and there must be research and action at a local level, responsibilities also lie with our national government in responding to this ongoing tragedy. We also urge the select committee to integrate their learning and findings with other key initiatives. There are too

many siloed approaches. In particular, we draw your attention to the findings and recommendations of Jodeen Carney's recent youth justice inquiry. We would also urge you to translate your findings into the proposed review of the *Child Protection Act*.

APO NT also proposes recommendations to address those factors to reduce the risk of associated suicides amongst young Aboriginal people in the Northern Territory. In particular our submission considers contextual and underlying risk factors for suicide and ways in which they may be managed to reduce the risk of suicide: measures relating to education and employment; the use of multi-systemic therapy to address numerous concerns that together elevate risk of suicide; the importance of cultural continuity and community control; the need for community development approaches to address suicide; the need to tackle alcohol and other drug use including the benefits of integrating alcohol and other drug and other mental health care into primary health care; and the impact of over-policing and the justice system on youth suicide. Thank you. We are happy to take questions.

Mr GUNNER: Much of the stuff we have heard today from previous witnesses has been about, and a lot of questions I have asked are about the threshold where you go from being a general cohort to being identified, and you are at risk, and then the treatment that you get, and what is that process where that person has had the conversation, the contact. We heard from MindMatters earlier about seeing that school context. Many of your recommendations go to the justice process like police and corrections, and there is a whole area of concern there about over-policing that you get to in detail. Is that also a period of time where there needs to be clearly better training or more awareness – depending on the person obviously – but having an awareness of that danger and being able to take that person, divert them properly, a consideration beyond the sentencing issues or the crime issues, but actually to that person's mental health and wellbeing at that point of initial contact.

Ms BARSON: Just so I understand the question correctly; you are asking along the lines of better, early intervention diversion strategies and addressing young people's need at the time of contact?

Mr GUNNER: Much of your submission is going to over-policing and – I am not saying they are genuine concerns - but a lot of the questions I have been asking about today is that really practical thing, that first step, the first point of contact with someone to say: 'I'm actually worried about you and you need to get help', or 'I will help you in this way'. At what point does that first conversation ever happen, whether it is in a school context or the family context? In this instance, like your submission recommendations around the justice system and just how do you see that working where you can help for the diversion?

Ms BARSON: In that context of the courts, and we included this in the submission and certainly spoke to Jodeen Carney's youth justice review about this, having mental health services available at the court, having mental health nurses. We gave the example of New South Wales and Victoria where there is a children's court clinic in Victoria and in New South Wales on hand mental health nurses. Often it just falls to the lawyer, or a prosecutor, or a magistrate to have an instinctive sense of; 'Is there something going on with this young person?' and obviously, we are not expert in that so being able to have an immediate referral point would be fantastic. Also, that expert knowledge can be included in the way that they are dealt with. So, if that expect knowledge comes back and says they have actually got an impairment or they are going through a significant emotional time in their life then that information can be used in sentencing but also in the process.

So, an example would be if a young person has an impairment or has a reason that they are not able to comply with a community work order or something, that knowledge is not necessarily fleshed out unless there is an expert there to do that, a mental health expert. So, we would very much support an approach to youth justice whereby on a youth justice sitting day, there is a multiplicity of specialists and services, so you can make referrals at that time. And, there is an additional benefit in that families often go as well not necessarily there to – for them to be going through court and so the family can be part of that referral process.

So it is not simply, we refer you to a service and you should make these phone calls, they are there at the time and they can be included into the process and the process inherently becomes more therapeutic.

Ms ARNOL: Can I just value-add to that, I am sure in your submissions that you would have seen lots of directions around brief interventions and upskilling and training of professional staff in their jobs around brief interventions. There is significant training around there. It could be customised in terms of the particular professional that you have got interacting with that young person at that particular time whether it is justice, whether it is education, so that could be a composite program that could be uniquely designed specifically for the Territory around those brief interventions.

Mr MACKINOLTY: And their argument is that is fully integrated into primary health care. The other side of the coin you are talking about, member for Fannie Bay, is areas where there are too many providers to the point where it is not just counterproductive, it can, in fact, be more damaging. For example, there is a community of about 600 people in Central Australia where there are something like 11 different agencies in the mental health, social and emotional wellbeing area stumbling all over each other.

Now the evidence is that this can, in fact, do more damage than not having anyone there at all. We have to get rid of this notion that in mental health services and social and emotional wellbeing services that there should be the competition of the perfect market, where as many people as possible should compete with each other. It is, frankly, nonsense.

So, as Paula just sort of said, and Ruth, an increased level of training - we have made recommendations on this to GPs and other clinicians including Aboriginal Health Workers - in recognising symptoms and dangers and so on is a really critical thing. As Professor Tatz said, suicide is virtually unmentioned in medical training and that is clearly absurd.

Ms WALKER: On that issue of proliferation of service delivery, from government services, from non-government organisations was very apparent and one of the key recommendations coming out of the *Growing them strong, together* report last year that out there in the communities they have just got duplication of service providers – I mean this is our first day of hearings …

Mr MACKINOLTY: There are 35 youth services in Alice Springs.

Ms WALKER: We have had an awful lot of submissions and that is the question I have asked a couple of service providers today - does headspace know about Jesuits in Alice Springs for the last 12 months and so – and are these groups that communities at grass-roots level want to work with on their community and feel comfortable and have ownership around driving that process with that service provider, I am not sure.

Madam CHAIR – Ms Marion SCRYMGOUR: Yes, Alice Springs is a classic. The number of services we have seen, the youth services in Alice Springs. If we look in the Top End, if only we could take some of what is there and put it up here. We often get accused of the Berrimah line but I think there are many more services in Central Australia.

Ms PURICK: Just a general question, I was just reading some of the case studies about the young children in Alice and their engagement or their contact with the police. We did hear earlier from one of the submissions about if someone suicides in the home they kick everyone out and potentially it can be a crime scene because they are not sure when they first come across the scene what has happened. Do you find in your experience that the engagement with police when there has been a suicide in a home is good, or are there are protocols that could be put in place, or the protocols that are in place are, perhaps, not good enough? Clearly, the police have to do their job but, perhaps, not considering the impact on the family at the death of the person who is in their family, then being told to get out of their house and cannot come back for a period of time. Is there anything we do not have that, perhaps, could be looked at to better the relationships?

Ms BARSON: I am not at all in the position to comment on police practices, approach to suicide. But, I will make a generic comment that, in general, cross-cultural communication, cross-cultural training for police would be fantastic and welcomed if increased. That would go for many mainstream services which are working with Aboriginal people in communities. Perhaps that is something that could be included in that cross-cultural training: how to respond appropriately to suicides; who are community contact people; how to work with elders to ensure there is culturally appropriate responses happening. That is a discussion I would think would be best placed to happen beforehand, rather than at the time of crisis.

Madam CHAIR – Ms Marion SCRYMGOUR: We have the Commissioner of Police, and we are trying to get the Coroner to come before the committee as well so we can put some questions to them in relation to that, because that seemed to come through in some of the submissions. Can I just go back and qualify regarding Central Australia and the Top End. Do you have anyone from Central Australia?

One of the things I am interested in, wanting to gauge, is when we look at some of the statistics in Central Australia, they are quite high. So is the Top End, but I will just stay on the Centre for the minute. Are the number of providers – and, as you said, Chips, sometimes a number of providers is not a good thing – and we have both government and non-government. I want to know, Stephanie, for the committee, what is that interaction and what is the outcome - not just for Aboriginal people in Alice Springs but the

region, within Central Australia? How does an Aboriginal person at Yuendumu, Mutitjulu, or Imanpa - those remote communities - access or have access to the mental health services in Alice Springs if someone has a problem? Who makes that phone call, and what is that response to those communities?

Ms BELL: Madam Chair, if I could, the first thing I would like to say is that the number of providers that exist in a setting like Central Australia is a direct result of government policy, and it is the government policy that allows these number of providers to get set up with no accountability. So, that is the first thing that needs to be taken into consideration; that these organisations just do not grow themselves, they are actually appointed and awarded funding to deliver certain services. The way in which that operates does a disservice to them, as well as the whole community. There is a responsibility here around the structure in the way in which services do develop.

One of the strengths of what AMSANT has been trying to achieve, particularly in Aboriginal health, is to get service providers to sit down and look at needs-based planning, and use that as a mechanism of determining how resources are allocated and, then, develop service models that are going to actually address the need in the community. That is probably one of the first things I would like to say that has really been a systems failure, if you like, in the sense that really creates the problem that leads to no accountability and no collaboration and cooperation to get focused on where the need is. That is an equity issue around resources in allocation, and it is about getting service providers together - and not just service providers but the government departments which is what we do under the Northern Territory Aboriginal Health Forum.

The fact that Central Australia has more resources than anywhere else is a clear example of poor planning. The distribution of the resources and how that is allocated really has to be seen as a critical structural change that needs to take effect, so that accountability comes in. As you are saying, define where the need is and take the resources to the need. Then, you get into what is going to be a good service model that addresses that.

There are two issues. What happens is we end up in a debate on the ground around who is to blame and who takes responsibility when, really, it is a structural and a policy issue. That is probably the first thing that needs to be looked at. Despite all the services in Central Australia, most suicides happen after 5 pm and the only people you can ring are the police.

In my local family community on one of the town camps we had a suicide recently, and the experience of family in relation to that suicide was the CIB came to the sorry camp people set up, sat down with people and had a conversation with people about it. The family was quite taken by the fact the CIB took that role of sitting down in sorry camp with Aboriginal people and talking about it.

The second experience of that recently is the police were called earlier, but their ability to respond is really not there - the capacity. That experience happened two weeks ago for me in our local community and it becomes an issue - as Professor Tatz says, it is a social issue and you have to get into a preventative framework around it – prevention and building capacity of health services to take that kind of role at the early childhood end. The thing we are recognising is secondary prevention in Aboriginal communities is very limited because the symptoms of diagnosis are quite different to any other population.

Depression is the mainstream pathway that defines somebody needs support - you plug in services, but in Aboriginal communities that is not what happens. It is all impulsive and is a very difficult thing to control. We are better off making investment at the primary prevention end.

Ms PURICK: Can I ask a question?

Madam CHAIR – Ms Marion SCRYMGOUR: Yes, before you do Kezia; Stephanie, I know you and for the record, for *Hansard* purposes, can you state your name and your position.

Ms BELL: Stephanie Bell, CEO of Central Australian Aboriginal Congress in Alice Springs.

Madam CHAIR – Ms Marion SCRYMGOUR: Thank you.

Ms PURICK: You made a comment which has given rise to some thought. It is probably more the health organisation part, do you have data or research that has been done which says in Aboriginal communities or perhaps in Central Australia - in the Territory let us say - depression and mental illness are at X, whereas in urban areas - we have data, I forget what the statistic is - they say one in four people in

this room will suffer from depression or is suffering from depression. Has that type of work been done to give the same facts, for what they are worth, about Aboriginal people?

Ms BELL: Some of the health services collect data around depression, but in the normal pathway of diagnosis it usually happens in the secondary tertiary sector, which is hospitals.

Mr MACKINOLTY: One of AMSANT's leading members in Katherine, the Sunrise Health Service, is starting to feed primary mental health data into the clinical information system they use. However, as far as I am aware as a specific program that is unique, although our clinical information systems have elements of mental health, they are not part of the NT KPIs are they? At this stage, the Northern Territory Aboriginal health key performance indicators, which are a set of 17 specific measures around health organisations and health, do not include mental health, AOD or any of those issues.

We argue that over time they should. We argue also over time mental health and AOD should be seen as part of the core services within primary health care. That is critical because we do not have the data.

Ms PURICK: It makes it difficult to respond to something or address an issue when we, collectively, do not have a good understanding of what is contributing to the problem.

Mr MACKINOLTY: Yes, and as Professor Tatz said, the general data Australia wide over suicide is very, very woolly.

Ms BELL: The coroners cannot get it right. That is another example of the system failure. However, the key is around these social problems needing social solutions. It is not a scientific biomedical matter.

Ms PURICK: Thank you.

Mr PATERSON: Madam Chair I would like to just pick up a bit more discussion around the service provider component for these services. Before Aboriginal Community Controlled Health Services, one criteria for Aboriginal Community Controlled Health Services in providing their respective services, is that they must be accredited to some minimum standard of clinical health care. In most of our cases, many of our members are accredited through the AGPAL accreditation system. I think governments need to consider prior to the allocation of funding, and we heard the number of youth services that are operating in a particular region, maybe it is time for government to set standards and a criteria around service providers. What do you have to do? What do you have to get to become accredited before you can become a service provider, particularly the services that are pertaining to youth suicide? That is perhaps one matter that can be considered for the sector and to avoid the duplication. We are hearing of 20 service providers fighting over delivering services to one particular community. Maybe that is something for governments to consider down the track.

Ms PURICK: Could I just ask, these 35 service providers, are they all manner of things like YMCA, YW, the churches, etcetera, St Vinnies?

Mr MACKINOLTY: Yes, and to be really crude about it, member for Goyder, a large number of them are funded on an historic basis because they ticked all the boxes the last quarter of the last year. They are not based on evidence of actually doing anything constructive, of outcomes that are producing evidence base. We have the situation very often, especially in the post-intervention Northern Territory, where FaHCSIA had a lot of extra money to float around, where the Aboriginal primary health care sector would not even get an opportunity to tender. With external tenders, a lot of national charitable groups would get them and then come to our services and say: 'Well, what do we do next?', which leaves a pretty bad taste in your mouth. It is not just an issue of a turf war. It is just if you want help, you want help that is creditable and accreditable. We are just not getting it in a lot cases and it leads to, as John was just sort of saying, a whole bunch of people who are doing programs for which there is no evidence they work but they keep getting funded. That is why we now have 35 services in Alice Springs. It is how good a submission you write; it is not on the equitability of the distribution of resources.

Ms PURICK: And also on the outcomes that you produce.

Ms ARNOL: And I think it goes back to Stephanie's point around planning. It goes back to that core integration of services so that you know what your population health issues are, you know what your public health issues are for that community in terms of your planning. Therefore you can coordinate integrated services and fund integrated services based on who has what accountability. You have a matrix of what services can be delivered, and you have accountability frameworks that actually keep organisations

accountable for the delivery of those services. It enforces and encourages relationships and partnerships because of joint case conferencing and coordination of patient or client care. That is a critical component that we lack in terms of funding, because we either over-pour resources into it, or it has got absolutely not enough resources.

Ms PURICK: Thank you.

Mr PATERSON: Madam Chair, I am just going to add a bit more. There is international evidence and national evidence that community controlled service providers are probably doing the job much more effectively than government providers. We need to ensure that governments, in allocating the resources, seriously consider those service models. Furthermore, where governments want to pursue allocating funds to non-Aboriginal – and let's face it, the greatest statistics here are showing that it is the Aboriginal kids that are much higher at risk of suicide – and we need to ensure that those non-government, where like I say where government wants to allocate funding to non-Aboriginal organisations, that they have Aboriginal representation on their governments arrangements as well.

This is why we were successful in the Aboriginal primary health care and the Aboriginal community controlled sector. You have health Aboriginal leadership driving the implementation, the design of programs and services – developing that policy around how those services are being delivered. This is why we are – I am not banging on how good we are - but I think we are making huge inroads given the limited funding we acquire from both governments. So there is that issue of supporting, enhancing, and strengthening those existing structures that we already have there.

You know, the Aboriginal community control sector, we have infrastructure, we have services and we have lots of those remote isolated communities throughout the Northern Territory and they should be supported and resourced accordingly.

Ms ARNOL: Can I just add that I think that we have an opportunity in terms of timing, that we have some changes affront in terms of stronger futures and the ceasing of the NTER and the…

Madam CHAIR – Ms Marion SCRYMGOUR: Well, it hasn't ceased yet. Don't be fooled into thinking it has ceased.

Ms ARNOL: … and the stronger communities. So, hopefully we will evolve into a better-integrated and better-resourced and more accountability on investment of funds around some of the stuff that we have been talking about. It gives us an opportunity and we will be lobbying, and strategically lobbying, so that we get some of the discussions we were talking about around justice, education, early childhood. These are key components for us to be able to close the gap in life expectancy but they are big issues in terms of housing, education, employment, sport and recreation, and social management.

Madam CHAIR – Ms Marion SCRYMGOUR: We all live and hope that the federal minister may do that. Member for Fannie Bay?

Mr GUNNER: I was just going to say apart from too many service providers, what do you see as the main barrier to someone in the general community getting help?

Ms ARNOL: First, if they have identified, I am just talking from my own personal experiences working with clinicians, is whether they self-identify and ask for the help. Then it is about who are their significant people that they are surrounded by and whether they are upskilled enough to be able to identify symptoms and signs. So, what training can we do in terms of allowing education and community awareness around what some of these early signs are and then where do they go for help. Because, like I said, at 4.30 to 5.00pm services shut down everywhere, even in Darwin, not just in Alice Springs, but Darwin as well.

So it is, okay then, how does the community, how do we kick in after that and what are the skills and the training we require to implement in our community to be able to engage and get someone past that stage.

Madam CHAIR – Ms Marion SCRYMGOUR: That is one of the things that is in our terms of reference that we will certainly be looking at. Paula, when you look across all of the Aboriginal organisations, our statistics in terms of Indigenous is the highest. If you look at the pool of funding that is provided across the Aboriginal organisations sector, what proportion is spent across these organisations that can look at the coordination or to look at how we do this better? It is one thing that we do need to look at and one of the things we will be looking at is the government system because we know that there are problems – there are problems across the government system, but there is also the other system that we need to look at as well.

Mr MACKINOLTY: The one thing you look at is the way the Northern Territory Aboriginal Health Forum has looked at the distribution of resources. The Northern Territory Aboriginal Health Forum is a collaboration partnership between the Commonwealth department through OATSI and the Northern Territory Department of Health and AMSANT is the peak body for our services.

Madam CHAIR – Ms Marion SCRYMGOUR: Do you have that report? Are we able to get access to that information? Does AMSANT have that?

Mr MACKINOLTY: I am explaining what the organisation is for those members who do not know. What they have developed is a funding formula that takes into account; need, remoteness, and access, or lack of access, to the English language.

What that has meant in primary health care is that - and this goes across not just our services but government services as well - some services that were only getting $300-odd per capita compared to over $2000 per capita, as of July 1 this year all the primary health care services across the Territory are getting around $2400 a year. That was a deliberate decision of actually distributing resources properly instead of having them totally skewed in particular areas. This has benefited government clinics, in fact, far more than ours because, as you may remember from your former life, you were pretty good at conning money in large amounts into certain services - acquiring money, sorry.

Madam CHAIR – Ms Marion SCRYMGOUR: I doubt that! I was waiting for you to finish because I was going to ask for that to be struck off the record or amended accordingly by Mr Mackinolty, otherwise he is going to be charged!

Mr MACKINOLTY: That is what I would say to things like social and emotional wellbeing money. At the moment, it is only the larger of our services that have the capacity to deliver that. Many of our smaller members, such as Ampilatwatja or Kintore are very remote and just do not have the capacity. If you look at our submission here, the appendix on our alcohol and other drugs policy actually talks about approaching things on a per capita basis and getting a bare-bones look at what a social and emotional wellbeing team might look like per capita. That is the way we have to start looking at things generally in the distribution of therapeutic services. That model should be looked at by the committee. That is just for AOD, but there is no reason why it cannot be applied across the board.

We have spoken to FaHCSIA about starting to look at similar things for other programs but, in our discussion with FaHCSIA, it was admitted by a senior official here in the Territory that not a single one of their programs could be properly evaluated except in a process terms; that is, we fed 300 kids breakfast and we employed eight women to do it. That does not tell us anything. It does not tell us whether the kids, in fact, were healthier or whether they went to school, or anything. Those KPIs I spoke about earlier are about gathering the evidence for what works and what does not work. That should be extended to emotional and social wellbeing things, then you do have the data that you were talking about, member for Goyder, earlier, so we know where to allocate resources.

One of the things you will be told about often in this - and this is a very good submission - is cluster suicides; so-called contagion of suicides and so on. When you know what your general pattern of funding and so on is, then you can respond to those sorts of spikes and emergencies. However, at the moment, because you have more evenly distributed people with skills, if there is a cluster of suicides in Central Australia as there is at the moment, which has spread into the APY lands, we do not really know enough to know what to do about it, and there are not enough trained people out there in the primary healthcare sector.

Madam CHAIR – Ms Marion SCRYMGOUR: Go on, Michael, and then I will ask a couple of questions.

Mr GUNNER: From earlier evidence, it was found that young Territory men have a much greater stigma when it comes to suicide, or coming forward, than young Australian men. We have asked various people about what we can do to address that, or find ways to help them. Through your recommendations which go a lot to the youth justice system, can I take it you are implying, in a sense, that the best way to tackle that is to improve the youth justice system? As I said, against those of Jodeen Carney's reforms?

Ms ARNOL: Our position would first and foremost be to avoid contact with the criminal justice system. If you see the criminal justice system as a potential risk factor in young people's lives, it is alienating, it is antisocial, it exposes them to a host of criminogenic factors, and it removes them from family, community

and other pro-social factors. If you see it as a risk factor, I consider the question needs to be why would you expose young people to that risk factor unless it was absolutely necessary?

Mr GUNNER: So, you are not capturing them before that point. That makes sense. It obviously, would be better if you could catch them earlier at school or in some other environment. They seem to be getting caught much more often for the first time at that point.

Ms ARNOL: That is right. There are also other ways such as an improved diversion system to divert young people, and police discretion in charging young people. But, then also, if they are engaged in the system, you have missed the crucial point of deciding not to expose them to that risk factor - they are already exposed to it - then having mitigate that risk factor. We would say sending them to prison exponentially increases that risk factor. So, investing in community-based sentencing options, community-based diversion options; our experience is that sentences such as community work orders are barely available on remote communities. If you live in Darwin you may have the opportunity to do that, but if you come from Ampilatwatja or Nguiu other communities it is often not the case.

You are heading up the sentencing scale from a fine, which young people cannot pay, so it is generally a good behaviour bond and you are taken into custody. Young people are being exposed to this risk factor at an exponential rate and that is validated by the statistics. The Northern Territory incarcerates young people at five times the rate of anywhere else, and Aboriginal people are over 95% of the Don Dale population.

For young people already in the system, having a youth justice system that is therapeutic, that is able to respond to their needs, that engages them rather than alienates them, that does not decrease their mental health, it does not ostracise them, they are not in front of a court that is demeaning, if this is able to engage them it would be a positive thing. We consider a way to do that is through a host of things: not always using English as a first language, better use of interpreters, including elders in the process and consulting the community around sentences so a young person is not just nodding throughout. The court proceeding - they are involved in it and understand the whole purpose of justice. So, making it meaningful and engaging the young people, not alienating or ostracising, in that way the youth justice system may not act as such a risk factor for young people. Does that answer your question?

Mr GUNNER: It does, in a sense. I feel like I am circling my point often today, but what worries me is you have the service provision here, the general community here, and how does someone from the general community who is at risk get into the system for help. I have asked this question of the service providers today and it seems to by accident that the two meet.

Ms ARNOL: By default.

Mr GUNNER: Yes.

Ms ARNOL: By some other incident.

Mr GUNNER: Yes, so in this instance there was point of interaction; however, what is worrying me ...

Mr MACKINOLTY: Paula is right, it is by accident and so on; however, for example, if there were to be better training for police in dealing with young people such that their instinct was not to slot them but to recognise - have training in recognising this person is 15-years-old, 17-years-old and is clearly drunk. It is an offence for a child to be drunk at that age - not an offence, but you are heading towards a serious problem. Instead of getting them into some type of therapeutic environment the response too often is a punitive one. It is a matter of people recognising across a range of areas to head, as Ruth was saying, towards a therapeutic solution rather than a punitive one. It is very difficult for the person who is suffering from emotional problems and so on to know they need help, to know to go to someone, let alone whether that is someone is there or not.

Mr GUNNER: That is the heart of it. Someone might at risk or of suicidal motivation - you are feeling isolated, you are separating from friend, family, community connections so how – as part of our recommendations as a committee, what can we do or say that will improve it beyond being an accident they can get caught up - that there is intervention.

In recommendation 14 around community engagement with the police - if the police officer is having a chat with somebody it is not about getting into the youth justice, it is about, at that point, making recognition and pointing the kids ...

Mr MACKINOLTY: Kids at risk are likely to be on the streets at night, are likely to be abusing substances. By the nature of life, coppers are likely to be the first people who run into them. By happenstance, the response should be different than it too often is.

Ms BARSON: Then, if a young person ends up in the youth justice system, having a system capable of responding to their needs. There is a good model in Victoria, the neighbourhood justice centre, where all services are co-located. You can refer someone to financial counselling or you can refer someone to family mediation if there is a domestic violence situation. They are all co-located and, in a youth justice sense, that would be mental health professionals and housing specialists. There could be space for the family responsibility services to be present as well. There is an opportunity to address all the underlying issues that are bringing the young person into contact with police in the first place. Ideally, that opportunity happens earlier. I take your point, absolutely on community, but as a last point it should at least happen when they come to the Darwin Magistrates Court.

Mr GUNNER: We have had these conversations with some people who were involved in the education system earlier and in some respects the answer was 'you are doing the class, you are doing the program', but what at point is someone actually identified?

Ms WALKER: Your second recommendation states to ensure positive rather than negative messaging around parental responsibility and school attendance. I couldn't agree more, representing a remote electorate where I see some amazing things that happen on communities and particularly in some of our schools. What ways do you see that we can promote that message other than shutting down some of our opposition members? Not you Pete!

Madam CHAIR – Ms Marion SCRYMGOUR: This is supposed to be bipartisan, so don't listen to her.

Ms BELL: Madam Chair, if I could just come back to Michael's point. I have been listening to what you have been saying, and trying to make the connections and joint the dots. I think it is very difficult to give a response to that because what is being demonstrated is that there is inequity of access to services across the entire Northern Territory. So it is very difficult to give a response and to try to correct that. The kind of work we are doing is to develop a model where universal access, no matter where people live, should be happening. That is the progress that we are trying to work towards.

We haven't got to a point. We have been dealing with just getting basic primary health care on tap and established. The kind of services that you are talking about, that we are all talking about, to address this kind of social issue, we haven't got to that point. They are there in the system but it is the way in which the system is working that then creates the barrier to access. So it is really hard to give a single answer to what you are saying because the inequity is so great in certain regions and areas that the limited resources that people do have in one environment cannot stretch to deal with this kind of onslaught.

That is probably the best response that I can think of. That is really the impact of why the level of suicide and where it is happening really has to be taken through a needs-based planning. Then you have to look at the – it is like the STI epidemic. It is like you have to look at the peaks and the troughs, where it is happening, where are you going to focus energy, because in areas where the peaks are happening the resources are not there to start with. So it just spills over and it becomes a full blown suicide.

So trying to give interventions in the area where it is happening and the diagnosis of it, the capacity and availability of services just does not exist.

Mr MACKINOLTY: I would not mind betting that there are more resources in, for that matter, between Fannie Bay and Goyder, just because that sort of urban/rural split, let alone remote Australia. So it really is very much about allocation of resources.

Ms BELL: The further you live the less you get and it is just one of those challenges that when these health statistics fly up in your face, we are all really trying to look at an ideal response.

Madam CHAIR – Ms Marion SCRYMGOUR: We have the Department of Health and Families coming before us and the CEO. Hopefully we can get some of the statistics. We have also written to Treasury to try to have a look at what the funding is across the Northern Territory and the different areas.

I just want to go back to Ruth in terms of the justice system, but I do have some questions about MBS/PBS which we have talked about this morning, Peter, when we took some evidence. That is a major issue if we look at the MBS/PBS proportion and split.

With the youth justice system, a young person coming into the system, just say NAAJA and the time you would see them is in the Magistrates Court, you represent the young person in court, you realise that young person has a problem, what then? NAAJA's role is then what? To then refer that person to another provider to …

Ms BARSON: That's right.

Madam CHAIR – Ms Marion SCRYMGOUR: Okay, and how successful is that?

Ms BARSON: We have no way of evaluating whether that referral is followed through with or not. I am not really in a position to comment on whether or not it is successful.

Madam CHAIR – Ms Marion SCRYMGOUR: Where can we get that? What we need to look at is if the young person is in the justice system, a referral has been made because they have a pre-existing condition and that referral has been made to that provider to deal with that. So, do you get what I mean? So, we are trying to look where the gaps are in those …

Ms BARSON: I actually thing the gap is before that, in that most young people who come to the criminal justice system, we would not know if they had a pre-existing condition but I suspect because there is just such a lack of service provision around mental health diagnosis on communities. So, it is not that they come into the system and, for example, I have worked in Victoria before and you have got this entire background of a young person and you know whether or not they are on the trajectory of depression or a trajectory of getting a mental illness diagnosis.

You would have no idea other than your own intuitive profession sense of that. Occasionally – and I was a youth justice worker in Alice Springs and I can't remember once this actually happening - but hypothetically you may get a particularly unwell young person who you would have a sense of what their medical history was but almost all of the time you have got no sense of that.

So, you are only making a referral on your legal knowledge really. You suspect that there is something going on with this young person and if you look at the doing time, time for doing report, the federal report into youth justice, they spoke a lot about foetal alcohol syndrome and how undiagnosed it was. And that can be so immensely frustrating as a practitioner because you have got a young person before you, and you have got a suspicion, but that is all and before a magistrate you can make that submission that you suspect that there is something going on, but that does not really carry any weight.

So, I think, and this is what we are really emphasise in the submission, much more research needs to happen and so into mental health for young people and also into the connection between mental health issues, suicide, and the criminal justice system because the implications of not having that information, I think are quite far-reaching. For example, if you have a 14-year-old or a 15-year-old who is suffering from foetal alcohol syndrome, but no-one knows about that; they don't have the developmental capacity to meet the requirements of an order, so if they have an order with 10 conditions on it that they have to meet and then they go home that day and they don't report the next day to Corrections, they come back to Court and they are ostracised in Court and they are yelled at by the Magistrate for not meeting that but no-one has actually gone back a step and said actually developmentally are they even capable of meeting this.

That type of infrastructure just does not exist in the system and that is why when we spoke to the Youth Justice Review we said often that young people are dealt with like mini-adults, there really is not the infrastructure to have the requisite knowledge or the specific needs of young people, so they are just dished out these orders and then they breach them all the time, and everyone sees that as delinquency. And, it may very well be, but it may also be that they have a host of underlying developmental organic issues that just make it impossible for them to actually comply with 10 conditions because they can't process that much information.

Madam CHAIR – Ms Marion SCRYMGOUR: Is that an issue that the - I suppose foetal alcohol has been talked about for some time but I know I met, there was someone, there was a Professor that had studied the justice system in America with the first nation and had come over and I know he was trying to talk to the Aboriginal Medical Services to try and get that similar research happening in the Northern Territory because I think there are many undiagnosed Aboriginal kids, or young people, out there with that.

Ms ARNOL: Some of the work that we should be doing as a community is around the services, the professional services that are there, and what are our collective brief interventions. So, what are our checklists so when we come into contact with young people or anybody, what are the skills that we require to do some visual brief interventions, some quick conservation, brief interventions, and then make some assessments in terms of what expert help do we require after that and I don't think there is enough of those earlier brief interventions that we are practising as a community, and taking responsibility as a community.

Madam CHAIR – Ms Marion SCRYMGOUR: I thank the Aboriginal Peak Organisation for your submission; it was quite comprehensive and will go some way in assisting us with our deliberations. We may, with many of the organisations that have put in their submissions - come back to you. However, we have a very tight time frame because we have to report back to parliament by February. We have Christmas and everything else in between, so we are pretty flat.

This morning, the member for Sanderson - and it was in one of the submissions - talked about the MBS and PBS and the need to try to get psychologists and other people recognised under the MBS and PBS regarding charges. As we understand, there are moves to reduce the Medicare benefits with that.

Ms ARNOL: Yes, the mental healthcare plans.

Mr MACKINOLTY: And not only that, but the Northern Territory has the lowest use in Aboriginal communities of PBS of drugs used in that therapeutic context. Consistently, in 15 years of monitoring it suggests that, despite the extra money that has gone into Aboriginal comprehensive primary healthcare and things like section 100, which is not even available in Darwin, the level of access to PBS has hovered around the 30% mark for the last 15 years. That means for every dollar that someone in Sydney gets, we only get access to 30¢ of it in the Northern Territory. PBS I was referring to. MBS is around the 50¢, 60¢ mark, and that has hardly budged over the last 15 years as well.

Similar figures were in the report just released this week by the Australian Institute for Health and Welfare, though that was not specific to the Territory. What it means is we do not have enough primary healthcare funds in the Northern Territory - and by a long way. That includes Darwin as well as the bush. We do not have enough doctors because that is what generates PBS, generates drugs, and so on.

I would have thought it was particularly of concern about the PBS in Darwin, where the Aboriginal Medical Service here, Danila Dilba, does not have access to S100 drugs. They, in fact, pay for it out of their MBS income ...

Madam CHAIR – Ms Marion SCRYMGOUR: It has been an historic thing.

Mr MACKINOLTY: What that means is the latest blow is the reduction in recognition of psychologists being able to access MBS. It has been cut really quite savagely.

Mr GUNNER: I was going to say, Marion, it would be really useful to catch up with APO again - tomorrow maybe. A lot …

Madam CHAIR – Ms Marion SCRYMGOUR: We are meeting with some of the organisations in Alice Springs, particularly the men's group and others. We will certainly be meeting with them. Then we have Katherine and, hopefully, Tennant Creek - and Nhulunbuy; I have not forgotten Nhulunbuy. Then, hopefully, the Tiwi Islands.

Mr MACKINOLTY: In Katherine, it would be really worthwhile if you did try to talk to Strongbella, which is the main male health group there. You can get hold of them through Wurli.

Madam CHAIR – Ms Marion SCRYMGOUR: We will get the Secretariat to follow up with the various organisations, as to who we should meet and who we should talk to.

Mr PATERSON: Just one final point around funding for programs that could really make an impact and provide some of these preventative measures and support for kids at risk. The issue we really have in this sector is time-limited funding or one-off funding or give this program, we will fund this little program. With most of our member services at the moment this is happening, and Strongbella is one of them. They get little piecemeal bits of funding. They do excellent jobs; they have the evidence and numbers to prove that it is a worthy program for further and ongoing investment – financial investment I am talking about. But, because they do not get that commitment around ongoing funding …

Madam CHAIR – Ms Marion SCRYMGOUR: It is hard to sustain.

Mr PATERSON: That is right; exactly. People get depressed; it brings stress on the organisation, stress on the workers and stress on the clients. Governments need to consider giving 10 year commitments to funding Aboriginal initiatives if we want to make any inroads, close the gap and get on top of youth suicide, kids at risk - the whole gamut. This piecemeal three year, six month funding arrangement does not work and it needs to be considered by all levels of government.

Madam CHAIR – Ms Marion SCRYMGOUR: We have to get beyond the slogans, John, that is right.

Thank you very much for your submission. We will be talking to your various member organisations in the different regions when we travel.

Thank you once again for appearing and everyone coming. Thank you.

The committee adjourned.
