COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

MONDAY, 17 MAY 2010

DARWIN

BY AUTHORITY OF THE SENATE

TO EXPEDITE DELIVERY, THIS TRANSCRIPT HAS NOT BEEN SUBEDITED

INTERNET

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

The internet address is:

http://www.aph.gov.au/hansard

To search the parliamentary database, go to:
http://parlinfo.aph.gov.au

SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Monday, 17 May 2010

Members: Senator Siewert *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Coonan

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Adams, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

a. the personal, social and financial costs of suicide in Australia;

b. the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);

c. the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;

e. the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

f. the role of targeted programs and services that address the particular circumstances of high-risk groups;

g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and

h. the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

WITNESSES

Committee met at 8.47 am

GRANT, Ms Laurencia, Life Promotion Program Manager, Mental Health Association of Central Australia

Evidence was taken via teleconference—

CHAIR (Senator Siewert)—I declare open this hearing of the Senate Community Affairs Committee. Welcome, Ms Grant. We have your submission before us. I invite you to make an opening statement, and then we will ask you some questions.

Ms Grant—Thank you for the opportunity to speak to the inquiry. I would firstly like to acknowledge the tradition owners of this land, the central and eastern Aranda people. For six years I have been working as the coordinator of the Life Promotion Program based in Alice Springs. During this time I have received information related to every reported suicide that has occurred in Central Australia. Approximately 80 per cent of all suicides here are of Aboriginal people, mostly men and mostly death by hanging. On average 10 to 12 deaths occur each year in a population of approximately 50,000. So the numbers are small but it is a very high rate. Most suicides seem to occur after a fight with a partner and are often associated with drinking alcohol. Some of these deaths occur in unsafe drinking locations on the boundaries of remote communities or in town camps in and around Alice Springs or Tennant Creek.

When relatives are questioned by the coroner's constable about the suicide, family members often claim that the death was impulsive and unexpected and that they did not notice any warning signs. I think this is an indication that many Aboriginal people living in Central Australia are exposed frequently to high risk behaviour, death and trauma and that they may not consider their lifestyle unusual. For this reason a relative who dies by suicide might not have been considered to have been at risk even though they may have an uncle in prison, a brother who died by suicide or an aunt who drinks heavily, et cetera. Statements by Aboriginal people might commonly discuss a night of drinking or even a full 24 hours of drinking, possibly an argument with a partner. Later somebody finds a member of the drinking party hanging. There is rarely any reflection on the additional underlying trauma that the deceased may have experienced over a lifetime that might have led to this incident.

Some men may be driven to suicide due to the shame associated with having being violent to a female partner and the potential risk of being charged or jailed or of losing paid employment or of losing their wife and children. The fact that so many Aboriginal people in this region might be at risk presents an enormous challenge for service providers who are attempting to monitor at-risk clients. It also presents a challenge for people who are trained to notice the warning signs for suicide.

The only data that we have to work with is data on completed suicide. That tells us that the highest risk group of suicide is Aboriginal men. We have no useful data on suicide attempts or other self-harming behaviour. Those people who try to end their lives on communities are not always reported to health clinics or mental health teams. The number of serious attempt suicides has not been recorded systematically, which is unfortunate because the population is small and this region could record this information through health clinics—if we accept that the numbers will not be completely accurate given the problems of defining a 'serious suicide attempt'. But

this information could assist with the monitoring of previous suicide attempters and it could provide information on the demographics of this group. The scarcity of services in remote communities can lead to a lack of reporting of suicide risk and reliance on family members to deal with this issue the best way they can. Depending on the severity of the injury, suicide attempts are commonly dealt with on communities rather than by transporting people to hospital in town. Most suicidal behaviour occurs late at night and emergency services are stretched. It is not uncommon to learn that a person who has died by suicide previously had a serious attempt, and yet may not have even been referred to the remote mental health service.

I hear anecdotally from workers that suicide threats are very common. Young people apparently threaten to kill themselves in order to get things that they want, such as money, the keys to the car and drugs. Aboriginal men will threaten to kill themselves if their wife walks out on them or if she takes the children away from them. This complicates any attempt to encourage workers and family members to take suicidal talk seriously and to respond when somebody is talking about suicide. The already overtaxed remote services, such as night patrol police, mental health workers, youth workers, teachers or health clinic staff, cannot always respond to the potential risk of suicide when the word is thrown around so carelessly and manipulatively. Family members on the receiving end of these threats are worn down by this behaviour as they are forced into an oppressive situation that is difficult to negotiate their way out of. Under duress they are expected to determine whether this behaviour will lead to yet another death by suicide.

Our organisation held a workshop on suicide as a threat in 2007. Many workers attending wanted to better understand the issue and wanted to consider strategies to support communities on this issue. It seems that there is a lack of information to help people deal with suicide threats. Family members fear the traumatic consequences of yet another death in their lives. They also fear being blamed for the deaths. Cultural payback can occur after a suicide. People get blamed for the death, especially those who are caught up in the final altercation with the deceased. Wives can be blamed for their husband's death, mothers can be blamed for their son's death and sisters and brothers get blamed for the brother's death. Payback is a frightening consequence of death in a community. This fact really complicates the problem of suicide and can prevent people from intervening when a person is at risk. This can also make the process of grieving difficult for a relative who is being punished for the death.

The system of monitoring suicidal people or people at risk who live remotely or in town camps is inadequate. In remote communities mental health specialists are mostly visiting services and they generally follow up on people who have been referred to their service. Generally, Aboriginal people from remote Central Australia are reluctant to talk about suicide and reluctant to tell mental health professionals that they are thinking about suicide or that they are worried for a family member who is thinking about suicide. They need to form relationships with non-Indigenous people before they will trust them to open up about an issue that is considered shameful, is associated with being mentally ill and can be seen as an indication of a weakness in the family. They may not understand how the non-Indigenous healthcare system can help them. Some Aboriginal people have certain beliefs about suicide. They might believe that if they talk about suicide, more deaths will occur or that the hangman or a bad spirit is responsible for the increased numbers of suicide or that a person has been sung to die by suicide.

Given the transient nature of some Aboriginal people—they can move between communities many hundreds of kilometres apart and between their communities and Alice Springs and

Tennant Creek—it can be difficult to find clients. Mobile phone networks do not service most remote communities so communication is very challenging in this region. Service providers cannot easily set up appointment times with clients. The models of clinical support need to accommodate the nature of remote communities so that clients are monitored more effectively.

The other issue is that suicide is a recent problem for Indigenous people here. Local police officers have told me that they remember attending their first suicide around 1980. So it seems that it has been difficult for Aboriginal people to fit suicide into their cultural understanding. The problem will not be addressed until more local Aboriginal leaders can stand up strong on this issue. Currently there are very few people who are doing this. It has taken us a long time to have Aboriginal people come to our small events for World Suicide Prevention Day held in Alice Springs, to have them speak up about their personal experience and to consider working as trainers in suicide intervention or to work in suicide prevention.

So Life Promotion, the program that I work on, began to focus on developing resources that would be useful to work with Aboriginal people on the issue of suicide. Suicide Story is a training resource that was developed over time through this program and as a result of input from local people, and we borrowed ideas from research developed by Ernest Hunter, Colin Tatz, the Dulwich Centre, Menzies School of Health Research and Tracy Westerman. It was driven from awareness that we needed to listen to how Aboriginal people understood this problem and what they were currently doing to support one another. We were aware that many Aboriginal people work hard to keep each other strong and to support one another in remote communities where there are few resources, certainly few after hours services and/or a complex mix of support services that are not well coordinated and are not always well understood by the local people.

In the case of suicide risk, supporting family members or others can be complicated by cultural beliefs, fear, anger, sadness, confusion and an unwillingness to talk about the issue. Nevertheless, Aboriginal people were the main resource for suicide risk in remote communities and consequently their stories could be shared with each other to strengthen their ability to support one another.

Basically, the objectives of Suicide Story are to provide knowledge about suicide to Indigenous people through the sharing of information from other Indigenous people. We are about to start trialling it this week. We received Commonwealth funding to help us to roll out this training and hopefully it will start the discussions happening for Aboriginal people in some of the remote communities around central Australia.

CHAIR—Thank you.

Senator MOORE—Thanks, Ms Grant. I am going to go straight to funding. Your submission ended with funding, so I thought I would go there. Your submission says that your program in the southern area has been funded by the NT government since it started. Is that right?

Ms Grant—Yes.

Senator MOORE—You comment that you are concerned the National Suicide Prevention Strategy may not have effective links to the local communities in terms of funding needs. Is that something you are able to talk about?

Ms Grant—When I wrote that submission—

Senator MOORE—I know it was before you go the last round of federal funding. Nonetheless, I am just interested in the concept of the focus of the national funding.

Ms Grant—People in the Northern Territory were disappointed that there was not more funding focused here, given the high rates and the complexity of the issues. We did feel that we needed long-term funding to really do something that was going to make a difference. My view is that my own program has been well supported, but it is one little program with me, one part-time worker and a worker in Tennant Creek. Apart from the funding that we have just received from the Commonwealth to roll out the training, it is difficult for me to say where extra funding should go. I sometimes feel that, if we could coordinate all the services that are currently operating, we might be doing a better job anyway without increased funding.

Senator MOORE—That is an interesting point and it is one that I have heard over many years in different areas. The Northern Territory, because of its particular geography and the client groups, has a whole range of different funding streams. I take it you are based in Alice?

Ms Grant—Yes.

Senator MOORE—In terms of the interagency cooperation and interagency networks, how is that operating?

Ms Grant—It relies heavily on someone being around for a long time. I have been here for six years and it is a full-time job to keep up with the changes in government funded projects.

Senator MOORE—It is a full-time job for us as well, believe me!

Ms Grant—I am sure. I coordinate a steering committee that is made up of all the key players that we think should have an interest in suicide prevention. We meet on a three monthly basis. In the drug and alcohol sector there are always different workers coming and going, but I try to keep somebody on the books from each organisation. It is drug and alcohol, FaHCSIA, child protection, Lifeline, the police, the education department et cetera. We have got at least 25 people representing different organisations, including all the Indigenous organisations.

Senator MOORE—From your perspective, is there any support from the federal government to actually do that coordination and interagency work? Everyone talks about it. There is not a policy document anywhere that does not talk about coordination but, in terms of actually doing it on the ground, is it part of anyone's job to do that?

Ms Grant—I think it could be focused on a lot more. I do not think so. I think the best placed organisations to do really good coordination are often in the non-government sector, which is not driven by a government agenda necessarily, and have someone who has good community development skills. Not everybody knows how to do this stuff well and I think that is often

overlooked. To actually keep people well informed about the area that you are working in, to engage people and consult with them on a regular basis and to hold useful meetings is a skill that not everybody has. At the moment I feel a bit frustrated that there are some organisations that used to run a youth network—we used to have big network in Alice Springs of all the people who were involved in working with young people—but that is not happening anymore. We also had a network that brought together all the players in mental health. Given that there has been a lot more Commonwealth funding going into mental health, we are finding out that CatholicCare do remote mental health work and family coping skills. The Royal Flying Doctor Service now has mental health professionals. It would be great to meet with all of those people so we know who is monitoring who and which communities we are all going to. That is not happening either. It used to be coordinated through the GP Network and I notice that you are talking to them today as well.

Senator MOORE—Yes. Is that particular role of coordination no longer being undertaken?

Ms Grant—Not that I am aware of.

Senator MOORE—Without putting words in your mouth, do you think that would be a good thing to have someone do something about sometime?

Ms Grant—Yes, absolutely.

CHAIR—On the last issue you were just talking about with Senate Moore, have you followed that up with the GP Network? Obviously we will.

Ms Grant—It is sort of my manager's role, and I have talked to her about it. We are all busy and we probably need to talk about it again.

CHAIR—In your submission you talk about Yuendumu as a community that is working on the issue and taking measures to address the number of suicides and following up—if I read your submission correctly—on people who have attempted suicide. What specifically are they doing that other communities are not doing? What makes them different?

Ms Grant—They have Mount Theo. You may have heard of the Mount Theo program.

CHAIR—Yes.

Ms Grant—It was set up as an outstation for young people who were involved in petrol sniffing. The community also have some incredibly strong leaders who have helped to establish that and also make sure that it continues. They have also had consistent non-Indigenous staff, which also makes a big difference. It is a really well-established program that has been around for over 10 years.

Within the Mount Theo program there seems to be these other factors. I have not been to Yuendumu, but I have had a lot to do with the workers out there. They tell me that they have a youth-mentoring program. They are training young Aboriginal people to be the next leaders in their community. They assist with monitoring young people who are at risk. There have been a number of suicides in the community or deaths by suicide in Halls Creek that impact on

Yuendumu because they have family there. When that occurs there is really good support for young people after the death. They also ensure they monitor other young people who are affected by that death. They are training these young people up to be leaders and also to have employment within the community and, hopefully, future employment prospects as well. It is all related to resilience and keeping them strong. But there is a lot more to it. I know that Brett Badger, who has been involved in that project, has written up a lot of material that can be accessed on the web.

CHAIR—The committee has been out to Mount Theo and Yuendumu several times, so we will keep following that up. Can I bounce back to the youth network issue? You said that they were not meeting anymore as well. Are there reasons for that?

Ms Grant—I do not know. It used to be coordinated through Tangentyere Council, with the CAYLUS program, which was the petrol-sniffing mob. Then headspace came along. We thought that maybe headspace could take a role in coordinating a network of youth workers or people working with young people. I am not quite sure if they have had the capacity to do that or if they see it as their role. So that is where it has been left.

Also, our program was originally a youth suicide prevention program. That was back in the late nineties. We used to coordinate a youth-at-risk network. This was before I started, but apparently it was extremely popular. I think that the whole issue of youth suicide can generate a lot more interest from workers. There is a large youth population here. But in actual fact, as you are probably aware, the statistics have changed and most of the people who are dying are actually men who are over 25.

Senator ADAMS—Thank you very much for your submission. On the change to the CDEP, do you think this is having any effect on the recent suicides at all?

Ms Grant—I think Gerard Waterford is up to speak next. He has a very strong position on men and employment and paid employment. He believes that a lot of men have been more at risk as a result of changes to CDEP and their loss of paid work until they get further employment, those sorts of things. He certainly has a major focus in his work on trying to engage Aboriginal men in meaningful activities and meaningful work.

Senator ADAMS—Something else we are finding—it is one of our terms of reference—is the perceived under-reporting of suicides by the coroner. Could you comment on that?

Ms Grant—I must admit I am not as familiar with the nature of the changes to the reporting, especially because the numbers here are so small. I think it is pretty accurate. I do not know that we are so concerned about the numbers of completed suicides. I do not think there would be a major change, given the changes to the coroner's reporting. I could be wrong, but we are talking about only 40 people a year in the Northern Territory—approximately. However, suicide will always be inaccurate. People lie on the train tracks and get killed if a train runs over them or people have terrible car accidents when they are very drunk. All of those deaths could be seen as possible suicides, but it is difficult to know. They have probably gone down on the record as accidents.

Senator ADAMS—What do you see is the solution to suicides in the area you are working in? Seeing you have been there for six years, where do you think you should be going?

Ms Grant—We are pretty excited about the resource we have developed. I know it is only one avenue but one of my beliefs is that unless Aboriginal people talk up strongly about suicide, no non-Indigenous workers are going to have any impact. I am a non-Indigenous woman trying to work in a field that is largely connected to Aboriginal men. There are lots of issues about me engaging with Aboriginal men and I really have to do it through correct protocol and correct channels. I have to engage Aboriginal men in this issue and they have to then be willing to deliver the training we have developed. For the suicide story, we did interview Aboriginal people about the issue. Some Aboriginal people have good knowledge about mental health and have been working in the field for a long time, so they had a lot of really useful information to share. That information is going to be passed on to other Aboriginal people. My feeling is that eventually we can step away and allow this to carry on. I feel we are on the right track with that resource but I am aware that it is one resource that has been developed. I know that we also need to work in with all the other organisations that are working in family violence, drug and alcohol and child abuse matters. All of those things have to be working well as well.

Senator ADAMS—So really the issues of leadership, for a start, and coordination are probably the key to getting everybody going along the same line.

Ms Grant—That is right.

Senator ADAMS—You were just saying that you are having to do the interaction with the senior men. Do you have a male counterpart working with you?

Ms Grant—I have a male worker, a non-Indigenous man, and that is extremely helpful but they are pretty rare in the community sector generally. Unfortunately, the non-government sector does not pay very well, so we struggle to get workers into the field who might have relevant professional qualifications. Government services can pay 20 per cent more than the non-government sector in this field. Usually the people who come into it have a pretty strong view about their willingness to work in the non-government sector. They are feeling that they might effect change more easily. However, when it comes to Aboriginal men, if they show any potential, they will be snapped up very quickly by government departments, which is unfortunate for us. Currently, we have no Indigenous staff in a staff of 16 in the Mental Health Association. So we rely on relationships with Indigenous workers in government departments and in Indigenous organisations.

Senator MOORE—When is the evaluation process for the program that you are operating due to kick in?

Ms Grant—This week. We are trialling Suicide Story this week in Alice Springs with some Aboriginal people coming in from Santa Teresa, Titjikala, Amoonguna, Hermannsburg—there are quite a few. The Centre for Remote Health will be coming in during that week to observe. They are not actually going to be doing any interviewing or anything like that. They then will come along to the next training session as well, which could be in Yuendumu or in Tennant Creek; we have not quite sorted that out yet. Then they will be running some focus groups with those participants to find out what knowledge they have retained, what they thought of the

training, whether they thought it was useful, whether it has made a difference when they have gone back to their communities and those sorts of things.

Senator MOORE—It will be interesting to see from the process what the feedback is, so we will look with interest at that.

CHAIR—To follow up on that last question: the Centre for Remote Health is coming in to observe the process; do I understand that they will be doing an evaluation as the program rolls out?

Ms Grant—Yes. They have had to get ethics approval to do this research; I think we are still just waiting on the final okay. I am pretty sure that it is going to go through. But, because of that delay, we have just had to reconsider, for this week, what they are actually allowed to do, and I am not quite sure if that means that the researcher is allowed to sit down with people at the end of sessions and ask questions about the training, then and there.

CHAIR—Thank you. I think those were all the questions we had and, as usual, we have run out of time. Thank you very much—we really appreciate both your submission and the time you have given us today.

Ms Grant—You are welcome.

[9.18 am]

WATERFORD, Mr Gerard Michael, Social Worker and Counsellor, Central Australian Aboriginal Congress Inc.

Evidence was taken via teleconference—

CHAIR—Good morning, Mr Waterford.

Mr Waterford—Good morning.

CHAIR—I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Waterford—Yes.

CHAIR—We have your submission. I would now like to invite you to make an opening statement, and then we will ask you some questions.

Mr Waterford—As we stated in our submission, there are some real problems and challenges in terms of what is happening here, particularly for Aboriginal men who are relocating into town from remote communities—often with English as a second language. They are relocating because of a lack of employment and options out there. They are coming into Alice Springs, where there is also a lack of options but where there is probably greater access to 'the party'—for want of a better term—alcohol and a lot of chaos. As a consequence, they often get separated and disengaged from their families, and they often struggle and commit suicide in town. Putting that submission together was a way of painting a picture of what is happening here and to explore what might be solutions.

CHAIR—Would you like to add anything else, or shall we go straight to questions?

Mr Waterford—I assume you have got the report. It is Monday morning here and I am probably much more coherent on paper than I am on Monday morning.

Senator MOORE—Mr Waterford, you mentioned the Life program and we have just spoken with the Mental Health Association of Central Australia. One of the things we talked about was the idea of funding for suicide issues in your part of the world and also coordination of existing services, which is a particular bugbear of mine. From your perspective of long-term work in the region with a number of organisations that are involved in some element of mental health and suicide work, is there any mechanism for those groups to work together and to coordinate?

Mr Waterford—Yes, there are a number of mechanisms that are operating at the moment. Everywhere there is a degree of specialisation and a degree of need for general services delivery—more of a primary family support sort of need. There is need for housing and there is need for supported housing. There is a need to perhaps explore some sort of greater efficiencies by better coordination. There is probably more of a need to look at base-level support services

for a number of distressed carers in quite remote and isolated communities and also how to provide ways for people to have meaningful lives where there is not much employment available—ways of looking at what gives life meaning, developing community leadership and providing support for people who are doing well.

I think that some of the coordination is not too bad at the moment. I wonder whether even greater coordination might lead to more meetings and fewer services. We also have a lot of recruitment problems generally in Central Australia and that is true of most of regional and remote Australia. What we have probably failed to do is to develop an Aboriginal workforce that can work well in this area and use them as the basis of our workforce into the future.

Senator MOORE—That is an ongoing issue, Mr Waterford. People have been looking at plans to develop training and independence for at least 40 years.

Mr Waterford—That is right, and I dare say it will be still an issue in the future. But it is well worth looking at some of the successes too. In home and community care and some of those education areas there have been a number of successes in supporting Aboriginal leaders or people with a lot of support and status in the community to be involved in the delivery of services.

What we have seen, I suppose, in the last decade perhaps is an increasing professionalisation of the delivery of a lot of these services and programs. We are required to employ so many psychologists and social workers to deliver services in remote communities, and, because of the language barriers and stuff like that and the costs of delivering services, we often do not have funding for the local facilitators of that service who more directly worked with communities, nor do we orientate staff in the same way, nor do we have community based people on very many communities. So there is a real gap in the 'what happens on the weekends and after hours' sort of service.

Senator MOORE—Certainly your submission looks at the core aspect of employment, and we have had a number across the country in that line. Do you have any thoughts you want to share with us about what we do with the employment aspects for people who are in a community or moving from a community into places like Alice because there is no effective work or things to do? What is the model that should be used to ensure that there is an option?

Mr Waterford—What we would like and what we have developed here in one of the communities—Santa Teresa, or Ltyentye Apurte—is a model where we have two trained male and female counsellors working with Aboriginal mental health and Aboriginal alcohol and other drugs workers. That is the sort of model that we think has a lot of promise, and that is where you can grow more skills on the ground. You can also look at a more strengths based approach where you develop the activity and other sorts of therapeutic interventions that people feel good and powerful about. That allows people to feel much better about what is happening in their community and their capacity to work well with their families.

We would like some of the programs that are in some ways similar to what used to happen 20-odd years ago, where people were more based in the communities, where they learned language a little bit more and certainly spent a lot of time learning the cultural orientation of working with those family groups in remote communities. We would like the resources to do that.

One of the challenges is that there is no housing out there, and the other challenge is probably that the shires in some ways—the amalgamations of councils up here—have seen that every local smaller community, or every Aboriginal community, no longer has a community council that meets and can make decisions in a whole lot of areas. That is causing distress. But the lack of housing means that actually recruiting and retaining staff out on lots of communities is almost impossible. If we do recruit and then have to move Aboriginal families from the community out of the houses to provide accommodation for our staff then you start off fairly much on the back foot with a fair bit of resentment about it.

Senator MOORE—Yes, and that has been an awful part of work in the communities as long as I can remember.

Mr Waterford—Yes.

Senator MOORE—This is a bit off the track, Mr Waterford, but just in terms of the coordination of services this committee has done a fair bit with the intervention staff and the role of the business managers in some of the core communities—and all the issues around housing and everything that went with that. Some of that was very poorly done, as we all know, and we are working back on that. But, in terms of the process, is there any work on the mental health aspects and the kind of work that you are doing? Is there any linkage with the business managers in any of the communities on that aspect?

Mr Waterford—There has been very little work done by me. It might be more interesting to talk to some of the Santa Teresa counsellors, who, because they are based on the community, often get to build up a little bit more of a relationship with—

Senator MOORE—Santa Teresa has a business manager?

Mr Waterford—Yes.

Senator MOORE—Yes, I thought so; I just do not have my list with me. It is a community we have been to and it is not that far from Alice. They have a business manager, so you would think that somewhere there would be that link. It is something we have not followed up specifically, but some of the comments you have made have made me think about that, so we will do so with the coordinator who puts together those reports every six months about what is available in the audit of communities and things. It is a little jolt to us to follow up on these issues with them when we see them next.

Mr Waterford—The difficulty in most of the communities is that the business managers have been difficult to engage around health and other issues. It would be fairly difficult to engage anyway, and it is somewhat complex knowing who they need to engage with. You also have the shires here and a fair bit of resentment not just around the intervention but also around what is happening to what they used to see as their leadership that was running their program delivery out there, so it has not been an easy job and I suspect that is still a big issue. But it would be more interesting perhaps to talk to Chris Masters, who runs the health service out at Santa Teresa, or Chris Hawke, who runs our social and emotional wellbeing program.

Senator MOORE—With whom we have spoken in the past but not in this inquiry.

Mr Waterford—Good.

Senator MOORE—Thank you.

Senator ADAMS—Thank you very much for your submission. I would just like to ask you about the CDEP program and how you feel about that, especially the men.

Mr Waterford—We had a men's forum happening here last week. Most of the senior men in remote communities who were there said that the local employment of Aboriginal men on their small communities—who might have been employed on CDEP or in some other sort of CDEP and top-up, I suppose—has reduced by about 80 per cent and that lots of the young fellows, as a consequence of that, have moved into town. The movement into town has accelerated. Because of the shire stuff, there is one elected representative for a lot of the different, diverse and often disputing family groups out on those communities. What employment there is is now controlled pretty much by the shires, and the decisions that the shires make are based on the advice from one family, if they are not contracting in a whole lot of services. People are saying that the lack of employment within their own family groups is the biggest contributor to alcoholism, domestic violence, relationship collapse and the sorts of things that come into play when you are looking at suicide in town. No-one was all that fond of CDEP because of its limitations, but everyone is a little bit gobsmacked at losing all or such a high percentage of what were employment programs out there.

Senator ADAMS—What do you suggest would be the best way to deal with that issue, if you had the money?

Mr Waterford—I think there is capacity for perhaps those community business managers to more effectively get a group of stakeholders that replicate some of the functions of what used to be the community councils. This is assuming that there is no capacity to unwind the shire process. Anyway, you need a community leadership group out on each of those communities.

What you probably then also need to do is look at the development of employment streams within community services. You need to build capacity in the communities for employment in housing and then housing maintenance, given that there is going to be additional housing and a whole lot of maintenance. To do that you probably need to have community based tradesmen that can provide the mentoring, apprenticeships and traineeships sorts of options on the community.

It needs to be pretty hands-on because of the literacy gaps that a lot of the young people out there—and our older people, for that matter—have. It needs to work effectively with people who have good language skills and with some history of employment. It needs to follow some of the pathways that Centrefarm and other places which are developing industries in Aboriginal Australia are following.

Senator ADAMS—Are there any areas where you feel programs such as you have been talking about have worked? Could you point the committee to a community where they are really getting on with things and having some success?

Mr Waterford—Ilpurla is a youth program targeting petrol sniffers. That is employing quite a lot of local people and delivering support services from an outstation. Within some of the Aboriginal hostel initiatives there is a lot of employment. In a lot of the old home and community care and aged-care programs they are employing people to do cooking and personal care. They have trained those people over a long period of time to deliver those services. That has been effective. There are aspects of the aged-care facility at Docker River that would be worth looking at. I think some of the more contemporary horticulture initiatives through Centrefarm are also quite interesting.

Senator ADAMS—Whereabouts are Centrefarm working?

Mr Waterford—Centrefarm is working at Ali Curung, Ti-Tree and now down here. They have identified that there is an enormous amount of water that is available and sustainable for irrigation on Aboriginal land and they have negotiated with some of the large players across Australia in developing what they call a head service. They get access to a lot of the land to set up their things as long as they provide training and marketing support for local Aboriginal communities to get into the industry.

Senator ADAMS—In the area you are working in, as far as the reporting of suicides to the coroner, would you consider that it has been underreported?

Mr Waterford—Yes. Suicide has historically always been underreported because of the suspicion that I suppose most of the Aboriginal communities have about talking to the police and engaging with them about what is happening and the fact that culturally people are not allowed to talk about deceased people. There are a lot of reasons why unexplained deaths are not always attributed to suicide. It is often better to look at some of the self-harm stuff. What we would like to and are hoping to do through Flinders University here—Professor Tim Carey has done some work at Santa Teresa—is look at a number of the indicators. We think there would probably be a fair correlation between self harm, completed suicides, incarceration, domestic violence and family relationships. We want to look at a lot of those things, which are easier to get quantitative data on, such as hospital admissions for self harm, jail records and those sorts of things. We can probably get access to some of that data under our NT suicide prevention strategic plan, collect it and do some qualitative stuff with some of the individuals and families at Santa Teresa.

Then perhaps after that we can get a health evaluator to look at the impact of the program at Santa Teresa, which has now been going for about four years, and at some communities that are similar in lots of ways but have not had a program. We could look at imprisonment and hospitalisations and other sorts of expensive service provision areas and try to build an argument for sustaining that level of service across most Aboriginal remote communities in this transition stage, which may well continue for some time. In much the same way, lots of regional communities in New South Wales and Victoria have a lot of employment in the community sector—disability services and aged care services are provided by local people.

CHAIR—I would like to follow up on the CDEP issue and then look at the replacement—the Job Network processes that are supposed to have been put in place. Can I infer from your comments that they have not adequately filled the gap of CDEP?

Mr Waterford—In the initial stages of the intervention a lot of CDEP programs were closed down with no attempt to replace them at all. What then happened was that you dislocated a lot of men who had previously been employed and they often ended up without any form of employment and had to go back onto some sort of Centrelink payment. They often had to come to town to access that. Many became disenfranchised. It was sad really. It caused a lot of family problems, some of which we have documented. When CDEP came back in a different format, the number of jobs taken up by the shires, usually as the primary provider of CDEP, was not anywhere near the same order. Lots of the programs that had previously come under CDEP, which might have been more horticulture or not core business for the shires, the shires did not pick up. The community needed to have an incorporated body that was prepared to take on the CDEP responsibilities or those programs folded. I have no real in-depth sort of knowledge but my understanding from what the old men were saying last week was that a lot of those young people in particular ended up coming to town and drinking heavily. Here there is no real employment or training opportunities available for them. The work they were doing previously under CDEP in the community is not available anymore because they have private contractors coming in through the shire to deliver a lot of those services. Either that or the programs have been completely wound up.

CHAIR—With the new system in place CDEP has been changed again and Job Network has come in, in the various programs. They are not managing to improve the situation.

Mr Waterford—I have had no reports that it is working any better out there. Certainly last week people seemed fairly desperately unhappy about the whole failure of it. What effectively happens with the Job Network is that it implies people are obliged to come into town. In the past it was more of a voluntary thing. You could remain unemployed on the community. Now you are almost obliged to come into town. You are almost invariably contributing to the overcrowding in the town camps here or you are effectively homeless, if you are a young person coming into town. But you need to come into town or else you fail your activity contract with Job Network and Centrelink, and then you lose entitlement.

CHAIR—I know we are nearly out of time but I want to move to a new area. In your submission you talk about the limited access to crisis counselling and advocacy services, particularly for young people in remote centres. You also comment on lack of access to specialist psychological support. Are those services unavailable?

Mr Waterford—Mental health specialist services are always under a lot of pressure and Central Australia is no different. They are available on a three-month rotating contract basis. They are based in Alice Springs and they do regional and remote visits. They do not really get a chance to build up any relationship with the community because of the gap between visits. What usually happens when there is a crisis is that someone is evacuated into town at a cost and they are seen in town and then they are discharged back out into the remote communities. That is a fairly appalling sort of rehab model unless you have someone with whom you can do your discharge planning and set up something that might be a bit different.

What you also need is community based people who can pick up people at the earlier end of a crisis and be able to talk and advocate for services for that person, perhaps with the local clinic. That is usually not people with a major mental illness; it is usually people who are in some situational sadness or crisis. There are a lot of complexities in service delivery and suicide here

because of the impact of disabilities, trauma and stuff like that. Often people have quite poor impulse controls. Unless you are there and you are monitoring how people are going, you miss a time when they sort of tip over into being quite self-harming and requiring additional support, particularly if that happens after they have relocated into town. The crisis in the drinking circles in town is absolutely appalling and scary.

CHAIR—I will be asking the GP Network this question shortly too: how good is the use of the Better Access process and ATAPS? Is that effective at all in Alice Springs or the region?

Mr Waterford—The Santa Teresa project was originally funded under a sort of innovative ATAPS program. That was for $90,000 a year, and part of what has been a much larger program. It was a significant contribution that allowed us to start that project. I believe the review is not going to continue that innovation with ATAPS. The Better Access to Mental Health Program is what is currently delivering some useful services out in the western part of Central Australia. I believe lots of that is showing great promise. They have a good partnership with some of the narrative approaches—the Dulwich Centre. We are able to coordinate that with a number of other service providers. Some of it is fairly exciting. There are not enough of those sorts of things. What you can do with those sorts of programs, if they become fairly innovative, is that you can work with that leadership over time and develop relationships across families that allow you to work more effectively with local people on the ground and with the family leadership to sustain programs that keep people weller. I believe that is going okay, but talk to the GP Network. I think they are fairly happy with how that program is going.

CHAIR—I have run us over time, so I have to wind up, unfortunately. Thank you very much for both your submission and your evidence today. They are very much appreciated.

[9.51 am]

DAVIS, Mr Matthew, Aboriginal Mental Health Worker Program Manager, General Practice Network NT

FAIGNIEZ, Ms Alison, Chief Executive Officer, General Practice Network NT

HARRADINE, Miss Kathryn, Manager, Mental Health Programs, Health Services North, General Practice Network NT

KORNER, Mrs Susan, Deputy Chief Executive Officer, General Practice Network NT

CHAIR—I welcome representatives of General Practice Network NT. Witnesses have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission, which you have just tabled. We also have a rundown of your programs here. I invite any or all of you to make an opening statement and then we will ask you some questions.

Ms Faigniez—I will make a very brief statement and then hand over to Sue in her role as manager of health services for our program for the whole of the Northern Territory to say a little bit more about some recommendations. After that we will be very happy to take any questions from senators.

Thank you very much for the opportunity to present today and to provide a submission. As you will see in our original paper, GPNNT provides a range of health services across the Northern Territory in both urban and remote settings, including general practice, allied health recruitment and programs across the territory. Largely, our role is not to run health services in communities but to build on and enhance the core services that are already provided by general practices, allied health professionals, community control services and government clinics and health centres. We do this through shared programs and partnership agreements with all those other agencies.

We have four key points for this inquiry before I ask Sue to talk a bit more about it. One of our main concerns about mental health programs in general and in particular those related to suicide is that short-term, one-off programs can actually be quite damaging. Although put in place with the best intent, they do raise community expectations, and when a successful program is dropped or reduced it leaves people wandering what it was about. Also, there is often little time given for the behavioural change and the relationships that need to be built with communities to build confidence in an external organisation or external providers, particularly if those providers change, as happens a lot in the territory, where workforce turnover is quite considerable. So a lot of groundwork needs to be done before you can even start approaching the detailed implementation of an intervention in this sensitive area.

Mental health support across the Territory is not uniform in all communities. Some have very good regular services and services on the ground; other quite significant communities do not have much in the way of regular services. We would like to see services based on need and size

of community. The other thing is that we cannot just talk about Indigenous communities as if they are replicated across the Territory. There are significant differences, as I am sure you have heard from the community controlled sector. From urban to rural and remote communities, from the desert communities to Arnhem Land, they have very different ways of working and different needs. We are pleased that as an organisation we have been able to build a level of flexibility and variation in how we deliver those programs to meet those differing needs. Sue is based in Alice Springs and oversees the mental health programs there. Kath and Matt are based in the Top End. They will be able to give you an idea of those differences. I will just hand over to Sue for the recommendations.

Mrs Korner—Thank you, Alison. Building on what Alison has just outlined, the value of the longer term funding has really resulted in building resilience in the communities. Just as importantly, a lot of unmet and unreported mental health issues have been uncovered through sustained support to the communities. That is also leading to a number of community-led solutions to the problems. There is definitely some specific funding that we receive to deal with suicide prevention. However, it is also important to know that we are talking about delivery of mental health services in a broader sense. It is looking at people with diagnosed mental illness, but a key platform for the NT General Practice Network is also really looking at early intervention and prevention as well as sustaining. It is definitely important to be looking after people with a diagnosed mental illness, but a key platform for us is to try and get to the issues before they manifest themselves in a serious situation that requires people to be hospitalised.

Before I get onto the recommendations, I think it is important for me to say that we deliver mental health services in urban settings and in remote settings. In the urban settings we are mostly concentrating on Darwin and Alice Springs and to a smaller extent on the communities such as Pine Creek, Adelaide River and Santa Teresa. In the remote areas we actually deliver mental health services through ATAPS and also through the Mental Health in Rural and Remote Areas program to a number of clusters. We also have a number of Aboriginal mental health workers employed under our regional primary health services program. The detail of some of those particular programs is actually included in our submission. I think it would be good to move on to some of the recommendations that we have identified in our submission.

CHAIR—Go for it.

Mrs Korner—The first one, and we have spoken about it, is that the program duration needs to be appropriate and adequate for the development of the actual strategies to address issues such as suicide, depression, anxiety—the whole gamut. With ATAPS mental health treatment plans in remote communities, that is a really major issue. We need it to be much more flexible. You cannot always have a resident GP in the communities, so that should not be a blocker to people getting treatment. It needs to be a bit more flexible.

The next one is care coordination funding. For a large number of Indigenous people or people on low incomes, having to pay to see a GP is actually a major issue in terms of accessing services. Once they have been to a GP, they can be referred under ATAPS for a number of free sessions, but it is the first one that is the blocker. Most GPs do not bulk-bill.

The next issue is strategies to support GP services to become more accessible and culturally sensitive. If we look in the Northern Territory, there is a wide range of small general practices

with limited infrastructure to support Indigenous people and families in terms of some of the treatment modalities. Again, that is an important area and there is a blocker in terms of people coming forward to access services.

In terms of some of the services to remote communities, a positive behaviour specialist would also be good. I think that has come through in the work that we have been doing. It would be a very positive adjunct to the services that we are providing. People are starting to understand some of the situations and how to deal with them, but they do need a lot of assistance. Again, and this goes to the point that Alison made before, we do not have a uniform spread of services to all of the communities in the Northern Territory. Some are well supported and for some the support could be a hell of a lot better than it is.

The last point in programs and services is about a number of people who are released from prison. They get good services while they are in the correctional services area but once they are released that support falls away. We particularly notice that with clients in the Barkly region.

Going on to the training recommendations, again it is about the development and delivery of appropriate training resources. What we find is that some resources are developed in the southern states, and even if they are developed in conjunction with Indigenous people they are often not portable to the Northern Territory. We just have to make sure that those resources and supports are more customised for the needs of the people we are working with. It is not appropriate to assume that the others will be fine.

One issue that has emerged is that in each community in the Northern Territory you will find that there are some very significant people—often traditional healers or leaders, ngangkaris—who may not have the literacy or numeracy skills but who are so important to the community. They are often the people who the community elects to be the mental health workers. But a lot of the programs are starting to preclude these people from being recognised as Aboriginal mental health workers because they have not undertaken, completed or received the qualification as an Aboriginal mental health worker and would probably struggle to achieve that.

Regular and mandatory orientation is an important one. I suppose it is the same for other jurisdictions, but the orientation, understanding and cultural awareness of a lot of the people coming into the communities of the Northern Territory, whether they are health workers, police, teachers or others, seem to be variable and quite problematic. If someone is to be a permanent resident in a particular community, mandatory orientation, cultural awareness and mental health first aid are quite essential. These people are usually the first ones on the scene and they need to know what to do.

We have been rolling out narrative therapy to a number of communities in Central Australia. That is having an incredibly positive impact on the people living in remote areas in terms of what they are able to do in terms of self-help and sharing stories. It is something where people of their own volition go and share coping strategies with other communities. So that is quite important and should be rolled out through the Northern Territory.

The last point we have is about research to validate the non-clinical contributions to health and wellbeing. In a lot of the programs that we deliver, the information and the reporting are really about how well we are doing from a clinical perspective. There is not a great deal that actually

looks at the wider health and wellbeing of the individual and how that is being improved. Those are the issues that have emerged for us.

CHAIR—Thank you.

Mr Davis—I will very briefly talk about my involvement with the Aboriginal mental health workers in the Top End. It has been my privilege to work with some very gifted and committed community members there that have been nominated by the community and work in those positions. I would like to paint a picture of how flexible funding and flexible models of practice are a necessity there because of the difficulty in finding people that are prepared to step up and work in those roles. It is a very taxing role for them as community members. There is a lot of pressure that comes upon them. They take on a great number of burdens within the community. They know everybody in the community. They are related to many of them. Particularly when a suicide occurs in an East Arnhem community, they are related to or know the person. There is a lot of pressure on them, yet they show incredible resilience, commitment and a great deal of care for their community. It is not just a job; they genuinely care for the people that they work for.

It has been my privilege to be able to work with them and facilitate as much as I can flexible approaches to how they deliver their services in each community and to the different aspirations they have and the different programs that they want to initiate. It has been my pleasure to be able to try to facilitate the things that they want—for example, the community solutions at Galiwinku in supporting mental health clients who are in recovery and who are at risk of suicide. When they wanted to pursue literacy or sport, mental health workers have taken on a community development role in trying to strengthen them and prevent relapse by enabling them to move on to employment or helping them with other aspirations they have got. If you were to put that into a job description for the workers, I do not know how you would describe it. We are trying to incorporate that into the model of practice as a whole. It is not just trying to alleviate mental illness and when there is an absence of symptoms their job is over. They want to prevent relapse and encourage their clients to set goals and move on and enjoy a much greater level of wellbeing in the community.

The reality of working with these guys is that some of them have a lot of capacity and others do not, so we just have to be flexible with each community. We might have an ideal model that we want to implement in a community but it is very dependent on the capacity of the people that we can find to work in that role. When we get good people we really do everything we can to keep them in that role and support them. That is a bit of a picture of the reality of working with these guys.

Senator MOORE—I am interested in the concept you have of the flexibility of the model. You have touched on that, Mr Davis, and so has Ms Korner in her recommendations. The whole ATAPS program was based on the network going through GPs all the time. That was how it was developed. It was very strongly defended—a diplomatic way of putting it—that that would be the way it should operate. Within your network, which is working with the GPs, is there a willingness to have a look at a flexible process there? Certainly when that program was introduced, one of the strongest elements—and all of us were working on the mental health process at the time—was that it had to have the first stop being a GP before any other professional would be able to access the Medicare funding, which is kind of core to the whole

thing. It is getting the Medicare funding. I am interested to see whether the GPs are open to a more flexible process.

Mrs Korner—Can I answer that one?

Senator MOORE—Of course you can, Ms Korner—you have to jump in and say that quickly when you are on the phone. We will start with you and other people can jump in if they would like to.

Mrs Korner—Certainly with the model of ATAPS that we are using at Santa Teresa there has been a huge reduction in the number of suicides over the last three years. Fortunately there is a GP who has been in that particular community for that whole time. When we talk directly with the GP and the service providers, they would certainly be happy to look at a more flexible arrangement where initial referrals to an allied health professional could be done quickly, and then the GP would be happy to review those arrangements—not necessarily first but after the event—and be involved in the whole work-up of that treatment program for the individual.

Senator MOORE—But that could operate now, couldn't it? From my understanding of the ATAPS program and the way you describe it, it could happen now. You have spent a bit of time talking about making it flexible. What changes do you think should happen to make it work better?

Mrs Korner—The changes for us would be that it is more than working with an individual; you need to be able to work with the family and extended family of that particular group. A lot of the program is really about the one-on-one session for the individual, but group work would be key.

Senator MOORE—That is outside the current model, but it is not wildly outside. The initial referral process, which is the cornerstone of the current model, would be that a person who is accessing the scheme would be able to have their family involved rather than just themselves. So, instead of seven people from a family having to go to the GP, one person could go, and then what happened with that would be able to be developed in cooperation with all of them. Is that how you see it?

Mrs Korner—That is right.

Senator MOORE—That is a bit different from the line in the submission about making it more flexible. The other thing is that you have come out very strongly on an issue which this committee has struggled with for many years: the role of pilot programs. The example you have in one of the documents you have given us of the Daly River experience sums it all up. We have been working for years on diversionary programs, or whatever the current terminology for that is. That is, when you have a community that has lots of young people and they have nothing to do and no engagement, it is going to be more likely that they will not be well and will take on dangerous behaviours that lead to all kinds of problems. The way you very briefly described Daly River is that you had, through funding for a set period of time, the ability to get four young people into that community to work with the people, to engage and to look at future stuff. At the end of the funding period it stopped—no more funding, no more activities. Is that how it was?

Miss Harradine—What happened there was that the program took a while to get up and running.

Senator MOORE—As always.

Miss Harradine—We had a good 12 months there to bed down some really good processes to bring in some training for these young people and involve the youth. We had an excellent psychologist who was working with us. We had funding for him not through that program but through another program area, and we slipped him across. He used to go out a couple of days a fortnight, and he became an integral part of it. Towards the end of the program and of our funding, the NT government were going to take on that program. There was, I think, three days notice that they were not.

Senator MOORE—That would have been a budget decision.

Miss Harradine—The ramification of that sort of thing throughout the community is that people ask: 'What's the point? Why bother getting involved?' It caused more problems in the end for the community and, of course, for the poor clinic manager, who copped the brunt of it for a while. This is a prime example of that short-term bandaid type stuff. It has to be kept going somehow until the people can keep going by themselves. But there still needs to be the funding to keep it going somehow.

Senator MOORE—To the best of your knowledge, has any supplementary or different program now been started in that community? Typically, you have something funded for a period, it takes a while for it to get going—it always it takes a while for it to get going—then the funding cycle runs out, then there is nothing and then something else will come. In terms of ongoing coordination and engagement, it seems to be a really poor model of operation.

Miss Harradine—We managed to maintain funding for another few months for the psychologist to go out there, but he was leaving the Territory, which is often the case.

Senator MOORE—That is another ongoing issue, yes.

Miss Harradine—Unfortunately there was no-one to take his place. Apart from some Personal Helpers and Mentors funding and a little bit of youth funding that went out there, I do not think there has been a program set up out there to an extent that would build that resilience within the community and engage young people.

Mrs Korner—One of the things we were aware of and concerned about was the fact that there was not any absolute guarantee that the program would be sustained longer term. One thing we did put in place there was a HITnet kiosk. We put some equipment into the health centre so the young people could go and download health information that they needed. We have put that in place for the longer term, but it does not make up for the fact that there is not an ongoing program and no-one is there on a regular basis to work with the young people.

CHAIR—Are young people accessing online help services such as Inspire?

Miss Harradine—The reality is that they do not have access to a laptop or a lot of internet access. They use their phones for things a bit but, unless you actually have involvement from the community and people mentoring them and suggesting these things, they get more caught up with things on You Tube and stuff like that.

Ms Faigniez—In the bigger picture, GPNNT is hoping that, with the health reforms, we will be playing a lead role, maybe as the primary health care organisation in the Territory. If you look at the summary in the information on GPNNT, we are running at least 10 mental health programs. For a small jurisdiction that is a lot of different program reports to write. Each one has funding for a few workers to go across the Territory and spread the information. One thing I would look for is that that funding be pooled, that we be given a block of funding for community mental health, both urban and remote. Give us some outcome measures, some KPIs, and then let us work out how best to do things with our communities. We would stand a much better chance of sustaining these programs as communities indicate their needs rather than trying to provide a bit of everything to everybody and really not being able to do so.

Miss Harradine—The other point is that things that come from Canberra might be quite achievable in a different setting but up here we do not have access to services or qualified staff that fit within the criteria. So we then have to wait for variations to our contracts to get something on the ground that works, and that takes a long time.

Senator ADAMS—I would like to come back to the development of appropriate Aboriginal mental health worker qualifications, which is something I have been following up for a while. Have you had any success in trying to explain that this is a necessity and that higher qualifications are just not going to work for employing people in the way that they should be employed in a perfect world? Are you having any success with that?

Mrs Korner—The short answer is no. We have not been successful in getting an understanding about recognition of these particular people who may not pass the course simply on their numeracy and literacy skills. The only way we have managed to work with this is to engage these people as cultural consultants. But it is about semantics when you are trying to deliver these services in a way that is appreciated, recognised and understood by the people you are working with.

Mr Davis—In the Top End a number of our workers have certificates III and IV in Aboriginal mental health work. Under the new health training package they are unable to get units in mental health until they are further up in the Aboriginal health worker training package. But the mode of delivery is also critical; it is block release, and that works for the remote workers. There are online and distance learning options, but that does not work for any of our workers. They need to have a block release so that they can go for one week, which is similar to what they do at Batchelor, and then go back to their community.

Certificate III is our best shot. Any higher than that and we are setting them up to fail. I have sent many workers off and they have not been able to submit any of their requirements and have failed. Certificate III, delivered appropriately by block release, with plenty of wellbeing and mental health components, I believe would equip them for that position. If they have to aim for IV or diploma level, we have excluded most of them.

Senator ADAMS—So with the Territory, you have not had any success with them really understanding just what is needed on the ground?

Mr Davis—We have had to throw together the best training I could get. There was a lot of training through Aboriginal alcohol and other drugs courses that were available which had block release, so they could come in, spend three or four days training or a week and then go back. They were getting elements of that training, which was good generalist training in brief intervention and working with clients. I have not been successful yet in trying to find one in the Territory.

Ms Faigniez—You run workshops for them. You have one coming up, I think, for your workers?

Mr Davis—Yes. We provide a lot of informal training but there is no accreditation with it. Still some of our funding through the Mental Health Services in Rural and Remote Areas program phase 2 was linked to workers having qualifications and we have almost had to let go of some workers because of the insistence that they be qualified. We would have had to let those workers go and so we have had to shuffle it around. I aim to get them qualified but we cannot always achieve that.

Senator MOORE—The whole program is based on people having the appropriate skills and qualifications across the board, so what is the balance? Do you have each person being assessed themselves and getting some special programs so that they have proved on the ground that they have the skills? One of the ongoing issues with all kinds of funding is making sure that the services and the people involved are at a standard, so that just because you happen to be in the Northern Territory, there is no understanding that there is going to be any less skill. Are you saying that for people who do not have the background over many years—not having had access to education programs and not having language and literacy in particular—there should be an understanding in the system that they should have some kind of assessment based on what they are doing rather than on qualification?

Mr Davis—I think there should be some flexibility like that and it is also that they are working within primary health care teams; they are not independent, they are not overlooking clients who do need mental health interventions because they are part of team; they are not floating around on their own. The referrals are happening for the severe diagnosable mental health illnesses but a lot of the skills they are using day-to-day are peacemaking, facilitating and negotiation between clans and families and trying to resolve issues that reduce stress. They are the high-prevalence depression and anxiety issues which they are mainly being presented with. There is a relatively small number of clients who have severe mental illnesses. The rest have other illnesses that are more amenable to community solutions.

Senator MOORE—We have had this a lot and I am really reluctant to recommend changing a qualification based system on the basis that we have to have some understanding that there is generalist training, but you are saying that there could be an ability to assess individually rather than make a blanket change, that there be a subclause which says that in circumstances people can have the opportunity—

Mr Davis—That would assist us.

Senator MOORE—That would be better, thank you.

Miss Harradine—Also, going back to ATAPS, the ability to see clients on a referral without a GP would be helpful.

CHAIR—Like a nurse practitioner type of approach.

Miss Harradine—Yes, because out in community they are not always resident. Then, when they fly in once a week or once a fortnight, they are dealing with quite severe illnesses. The doctors in Darwin do not have time to sit and do mental health treatment plans. So what sounded good in one sense really does not work time effectively. Here in Darwin I have a psychologist who would gladly go out and see the town camp people and have group sessions with families, but under the current ATAPS arrangements we cannot assist those clients and pay our psychologist to do that. Hopefully, with the new-look ATAPS we might be able to have something more innovative.

Ms Faigniez—I think the other thing is that with the outreach model, if people access some ATAPS services through a visiting psychologist into a community, the important thing is what happens for the 24 hours a day when the psychologist is not in community. This is a role for the community mental health workers. They need to provide that ongoing support and ask, 'How are you tracking? Are you managing to take on some of the things you and the psychologist talked about? Would you like me to phone the psychologist for you?' Or they can just refer them back into the clinic. It is that liaison mentorship that the mental health workers that Matt is talking about can provide.

Miss Harradine—Also, in generic terms, in Darwin Access to Allied Psychological Services gave us money for a suicide prevention pilot that came attached to the A&E department. But, because we have such a high turnover of staff, the inability for me to get out and upskill workers all the time on the referral pathway led to our two psychologists getting all the referrals and not being able to deal with them. It became important for us to still run that service. We approached DoHA to do that through GP referral only. It was Christmas Eve when they got back to us on that. Everybody had gone on leave, so we had no solutions. It is that delay in allowing us to look like we are running an efficient service that leads to all kinds of things happening. We now do run it, under GP referral only, but it has not had the uptake it should have had.

Senator ADAMS—I have a question on the accuracy of reporting suicides, the coroner's reporting. Do you feel that that reporting system is accurate, or are there a lot of unreported suicides that have not come to the surface and that, as GPs, you see when you go to the communities?

Mrs Korner—There are a lot of reports where the cause of death is listed as accidental or some other thing. While the numbers are the second highest in Australia, they appear to be low because there are a number of deaths that are not actually being reported as suicides. It could be a car accident or something like that, whereas they are probably suicides.

Miss Harradine—If people lie on the road it becomes a road death rather than a suicide.

Senator ADAMS—The men's anger groups sounds like a really good program. How are you going with having that funded?

Mrs Korner—We are supporting that through the Mental Health Services in Rural and Remote Areas program, particularly in Central Australia. It is an excellent outcome. We have been able to establish men's anger groups. That was community led. The older men in the Hermannsburg, Haasts Bluff and Mount Liebig areas very much wanted to do this and it was starting to work really well. The younger men in the community felt that they would like to have their own particular group, because they were excluded from the elder men's. The flow-on from that is that the women would now also like to have programs where they learn better coping skills. Maybe the best thing of all is that in one of those communities children aged seven and under have established a new game called 'meetings'. The young people there have decided that they will have their meetings, they will run them and they will invite older people if they think it is necessary, but they want to kind of emulate what is happening with the elder people in resolving issues.

Senator MOORE—They are scarred for life once they get into that meeting methodology!

Mrs Korner—It is just amazing.

Miss Harradine—We also were running some programs through schools in communities in the Katherine area, especially around Minyerri. Our Aboriginal mental health workers were going out and spending quite a bit of time with high school kids, both male and female. That was really effective until we had a change in funding and service delivery.

Ms Faigniez—Sue, Senator Adams asked about the funding of your program. The men's anger management programs are not specifically funded for that, are they?

Mrs Korner—No, they are not.

Ms Faigniez—We have developed them out of a creative use of funding.

Mrs Korner—Part of the problem that we have is that a lot of the programs are incredibly specific and are really a clinical type of service. You have to do that; however, there is also a lot of benefit from doing early intervention and prevention and also from longer term follow-up and management with a number of people. We see success as preventing people getting to the point where they have to be admitted as an acute mental health presentation, yet at the moment the program pretty much wants to talk about only those people who have a serious mental illness and how they are supported and maintained. We do that; however, it is an opportunity too good to pass up when you can work with communities over a longer time to uncover a whole lot of unreported, undiagnosed mental health problems. We started off thinking there were a few people in the community who had been major referrals but who had not been actioned. Now when you look at the community you see that there is an awful lot that was missed before. That is the problem that is now starting to show in other communities. There are people who have been referred to mental health services because they definitely have a serious mental illness; the issue is that there must be an awful lot of other people who have not necessarily been identified and who are not being supported.

Senator ADAMS—Other witnesses have talked about coordination between groups, such as NGOs and the department. Could you quickly tell us how often you work with other groups that are doing much the same thing or if programs are being duplicated?

Ms Faigniez—You have hit on a real challenge for us. Working out with our partners who is going to do what takes up an inordinate amount of time, but there is still a lot of duplication. We actually have the crazy situation where the RFDS leases a room in our office in Alice Springs to provide mental health services into a community that we already provide similar services to because that is the way the funding went. For people with a mental illness in communities the real benefit is having consistency, having a person who can help them get through the numerous providers that they are referred to. That helps see them through it. Coordination on the ground for a person—having a care coordinator and supporter who can help them through and who is a constant in their lives—would be tremendous, and we are a long way from that at the moment while the funding goes so many ways. Each agency does its best, as we do, with what it has, but it leads to quite a chaotic situation for the clients on the ground.

Mrs Korner—Against that background, the way we have also approached it is to develop memorandums of understanding and service agreements to try to formalise coordination, relationships and who is doing what in some of these communities.

Senator ADAMS—You have to work a lot harder by the sound of things.

CHAIR—Thank you very much. We have gone over time deliberately because there was so much information we needed to get.

Ms Faigniez—We really appreciate having the time with you. Thank you.

CHAIR—Both your submissions and your time are very much appreciated.

Proceedings suspended from 10.41 am to 11.36 am

HENDRY, Ms Bronwyn, Director, Mental Health Program, Northern Territory Department of Health and Families

O'REGAN, Ms Sarah, NT Suicide Prevention Coordinator, Mental Health Program, Northern Territory Department of Health and Families

PARKER, Dr Robert, Director, Psychiatry, Top End Mental Health Services

CHAIR—I welcome representatives from the Northern Territory government. Witnesses have been given information on parliamentary privilege and the protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, though this does not preclude our asking you some penetrating questions on explanations of policy or factual questions about when and how policies were adopted. I invite you to make an opening statement, and then we will ask you some questions.

Ms Hendry—I thank the committee for its invitation to attend the hearing and to make an opening statement on behalf of the Northern Territory government. I make this statement both as the chair of the NT Suicide Prevention Coordination Committee and as Director of the Mental Health Program within the Department of Health and Families. I would like to begin by reaffirming the NT government's continuing commitment, which we have articulated in our submission to this inquiry, to working towards the prevention of the tragedy of suicide across our community. In the time I have today I will briefly outline some of the issues we face in the Northern Territory, highlight some of the areas we are addressing and raise some issues for further consideration.

Suicide is a significant issue for the Northern Territory. It occurs across all demographics and in a range of locations from urban Darwin to some of the most remote regions in both the Top End and Central Australia. In the Northern Territory the annual number of deaths from suicide has increased substantially since the mid-1990s and, despite slight fluctuations from year to year, there has been no significant decrease in trend rates noted. This trend has gone against currently reported national rates. Combined data for the period 2004 to 2008 from the recently released Australian Bureau of Statistics cause of death data suggests a suicide rate for the Northern Territory of 22 per 100,000 compared to a national rate of 9.8 per 100,000 for the same period.

The higher rates of suicide in the Northern Territory have to be viewed in the context of a number of issues that affect the population. Demographically, the Northern Territory has a much higher proportion of Indigenous people in the population, a higher youth population and a higher male-to-female ratio than other jurisdictions in Australia. These demographics are of particular note when consideration is given to the fact that the highest rates of suicide in the Northern Territory are noted in two main groups: youth and adult Indigenous males and older non-Indigenous adult males between the ages of 30 and 55. The Northern Territory also has high rate of known risk factors for suicide, such as high rates of alcohol and drug use, crime, domestic violence, sexual assault, homelessness and unemployment as well as lower educational attainment and socio-economic status in significant proportions of the population.

In 2007, the Northern Territory government formed the NT Suicide Prevention Coordinating Committee, which is made up of representatives from the Department of Health and Families—including representatives from acute care, remote health, Alcohol and Other Drugs and NT Families and Children—as well as other government departments, including police, justice, education, Sport and Recreation, the Office of Indigenous Policy, Charles Darwin University and the Australian government Departments of Health and Ageing on the one hand and Families, Housing, Community Services and Indigenous Affairs on the other. The committee has developed the *NT suicide action plan 2009-11*, which was launched in March 2009 and recognised that effective suicide prevention required a shared ownership of the issues across government departments.

A report on the first year of activity under the plan is currently being drafted. Highlights include increased investment in suicide prevention training across the Territory, including the expansion of ASIST and SAFEtalk in the Central Australia region, funding for the completion of Suicide Story—a training resource for Indigenous communities which has been developed by the Mental Health Association Central Australia—and a series of workshops on managing self-harming behaviour in young people which have been delivered in all regional centres across the Northern Territory. This training program is currently being trialled in the more remote regions of the Tiwi Islands, Wadeye, Groote, Jabiru and Maningrida. In addition, the NT action plan reflects the strategic directions of both the Northern Territory's *Strategic framework for suicide prevention* and the LIFE framework, which will be adopted as a national framework.

The Australian government is a key participant in the NT Suicide Prevention Coordinating Committee, and the Northern Territory welcomes the development of increasingly collaborative relationships between the Australian government and the Northern Territory government on this issue. This has ensured that services funded by both governments complement each other and address the highest areas of need. This has been demonstrated through the recent funding by the Department of Health and Ageing to establish the OzHelp program in the NT, which will target both Indigenous and non-Indigenous males, principally in male-dominated industries. There are a number of other initiatives outlined in the Northern Territory government's submission before you which I will not detail here, though should the committee require further information we can certainly provide it.

There are also some issues that the Northern Territory government would like to raise with the committee here today. Smaller jurisdictions such as the Northern Territory are often greatly assisted by projects and resources that are developed at a national level; however, despite the creative adaptation by many local workers, many of these programs and projects are not really transferable to our particular population base. As a result, the Northern Territory is at times unable to access the same level of resources and support that is available to other jurisdictions. National projects that allow flexibility to develop programs or resources at a local level would be more beneficial and productive for jurisdictions such as this one.

Access to the range of potential research partners that may be available within southern states is also an area that is lacking in the Northern Territory, yet there are many areas that require further research. For example, although rates of suicide amongst Indigenous Territorians are higher overall, this behaviour can vary greatly between regions, with some regions experiencing no suicidal behaviour and others experiencing continuously high rates. Significantly more

research is required to determine why this occurs and whether there a difference in risk factors or protective factors among these communities.

The development of a national research agenda in consultation with local jurisdictions could provide some very productive partnerships among jurisdictions, local workers and research bodies. This would also assist with the development of rigorous evaluation processes for the often groundbreaking work that has been carried out by many local workers, particularly in remote locations. These workers have the added ability to provide advice and support to researchers on language and cultural issues. The sharing of research resources and learning among jurisdictions could also assist local understanding as to why rates of non-Indigenous suicide are higher than in the rest of Australia.

High rates of self-harming and suicidal behaviour in young people in the NT are an area of some concern. There are continual concerns expressed by professionals and parents about the current inadequacy of training programs in suicide prevention and intervention for young people under the age of 15. This is against a background of increased exposure of many young people to the issues through multimedia. For children and young people in Indigenous communities, the exposure to self-harming behaviour can occur at an even younger age, with children in some communities regularly witnessing suicide threats and attempts and, tragically, completed suicides. There is currently a very limited evidence base from which to approach the education of young people and children around this issue. Increased national direction and support in this area would be a very welcome outcome of this inquiry for the NT.

If there is a key message to provide to the Senate inquiry from the NT government, it is that suicide prevention is a responsibility of all areas and that there is a need for increased flexibility, additional support and a willingness to commit to an ongoing shared learning approach between cultures, jurisdictions and all levels of government if we are ultimately to address the tragedy of suicide. Thank you.

CHAIR—Ms O'Regan or Professor Parker, do you have anything else that you want to add as an opening statement?

Prof. Parker—No, but I am happy to answer particular questions by the committee.

CHAIR—We will have lots of questions.

Senator MOORE—We have a book which I do not have in front of me which shows everything that is funded federally at the moment, and there are pages and pages of things—there are federal suicide prevention and mental health plan funds. It does not matter; it is more as an example. You made a statement about things that have been created and may not work in the NT, so that you do not get your fair share. Can you give me any examples?

Ms Hendry—I guess it is not really a 'fair share'; it is more that they are not necessarily applicable, but I will get Sarah to elaborate.

Senator MOORE—I will go back to the *Hansard*, but I thought the statement related to the fact that national programs are developed and rolled out and you do not think the NT gets a fair share out of them. I do not want to verbal you.

Ms Hendry—Sorry. What I actually said was that we do not get access to the same level of support and resources because really they are not necessarily appropriate to our population.

Senator MOORE—Can you give us some idea about that? It is a big statement, when we have a National Suicide Prevention Strategy which involves every state. Where has the NT not been able to get appropriate access to services?

Ms O'Regan—I think it is often the case with national programs when they are first introduced—something like MindMatters, for example—that they start off with a focus on the non-Indigenous population. At the time, it is always stated: 'Later on, down the track, we'll do an Indigenous version of some of these programs.' That may or may not happen. Where it does, it is also not that simple to just do an Indigenous version of things. With Indigenous versions, what may be applicable down south is not necessarily going to be applicable in the Northern Territory.

We often get Indigenous resources which really are not Indigenous resources; they are resources with some pictures on them and maybe a little bit of easier wording, but realistically they are not an Indigenous resource. They are not in Indigenous language and they do not use terminology that anybody would even understand or recognise, and so they are really next to useless for using with Indigenous populations. They might be good for workers potentially to work with Indigenous people.

The suicide and bereavement support packs are another prime example of that. The Indigenous section in that—I know that was written by Tracy Westerman, and I have a lot of respect for Tracy—actually tells people what to do when someone dies. It tells Indigenous people what their responsibilities are. It tells them that when someone dies you need to go home for a funeral. When we reviewed that section with Indigenous people up here, they were going: 'What's this about? We know what we need to do. This is something that would be very useful for non-Indigenous people perhaps to know, but it's not necessarily something that we can use ourselves.'

So I guess there are a whole range of programs that potentially develop things with the best intent in the world but they are not actually usable on the ground for people who try and work with it. It is the same as programs like ASIST. Realistically, people do some fantastic work with ASIST, but at the same time, with a lot of these projects, you are not allowed to shift them around too much because obviously they have to worry about quality control. Once again, they are just not applicable in remote regions.

Ms Hendry—We have found that in our recent self-harm workshops we have had to adapt even what we have developed up here to make it more applicable in remote communities.

Senator MOORE—When you go back to the national level—because this is supposed to be a COAG process; the mental health and then, leading on, the suicide prevention process is a national plan—and give this feedback nationally, what is the response?

Ms Hendry—There has only been a recent getting together of the jurisdictions at a national level. It did occur some years ago, but it has recently been resurrected, which is fantastic. It was organised by DoHA. I think the second meeting, or perhaps the third, was last week. That is

really good. There have been committees previously that have provided advice, but they have not actually been representing jurisdictions; they have been individuals potentially in jurisdictions who have been on national committees providing advice, which is quite a different thing. I was at the last meeting, where we discussed a national approach and were laying some of the framework. I do not know about the previous one, which you attended—whether this was raised at that.

Ms O'Regan—Under the Auseinet program that used to exist, there was a really good network between jurisdictions and nationally which covered both promotion and prevention and early intervention into mental health and suicide. There was a lot of excellent sharing that took place between jurisdictions at that time. Unfortunately, until now, there really has not been that same kind of shared sort of network between jurisdictions and the Australian government at all levels, and I think that is something that has been missing.

Ms Hendry—But now it is very pleasing to see that it is happening again.

Prof. Parker—I will just give a bit of an informed comment about particular issues about the Territory. As you are probably aware, the director's statement gives an overall view. I suppose we have more Indigenous people here. We also have a lot more in the remote and rural areas, so we differ significantly from other states which have a heavily urbanised population in terms of transport, access to services or whatever. In trying to run a program in a place such as Ramingining or Numbulwar, which are Aboriginal communities that are serviced by plane infrequently, and being able to have continuity of programs there it costs us a fortune to fly people in and out and to maintain people in communities. There are housing issues. If you are trying to run a program in Sydney, you may have a worker who can go from suburb to suburb with a car, whereas the oncost of doing a similar program in the Territory is enormous compared to that, and it is significantly more difficult often to implement programs for that reason. There are often issues about continuity of staff, where you get staff changing every couple of months. Nurses sitting in remote clinics change frequently. Being able to get people to go and stay in remote areas to do resources is often quite difficult, often with the added issues of where you find houses for them and whatever. Those are particular issues for the Territory which mean that the normal parameters which run programs in large urban centres or possibly even larger rural centres are very difficult to maintain in the Territory. I suspect the director would say that we are probably not adequately resourced from the national bucket of money for the sorts of add-ons that are required to maintain appropriate programs for those sorts of issues.

CHAIR—I will just jump in on that one. What has been the response from the federal government when you have raised these issues?

Ms Hendry—I think there has been a very pleasing change in the last couple of years in terms of collaboration on suicide prevention. Prior to that, there was not a consistent effort to align what the NT government was doing and what the Australian government was doing in this area. Projects that tended to be funded were a few local projects, which obviously only have an impact in those small communities—if they in fact do. It has really changed in terms of us aligning what we do so that we are not duplicating. We are looking at a more strategic approach, not looking at just little isolated projects where someone has a good idea in a community and that gets funded. At that time also, given our high rate of suicide, we felt that we should be receiving a greater proportion of the funding. I think things have changed for the better.

Senator ADAMS—Thank you for your presentation and your submission. I would like to go to triage for mental health patients in your emergency departments in Alice Springs and in Darwin. We have just heard evidence today about this—it was a dual diagnosis case: have you got people within the department where that person can be taken aside and not have to sit there for hours and hours and just be pushed around?

Ms Hendry—We have a pretty good through-put through our emergency department compared with other places. Obviously RDH is the busiest emergency department in the country and a significant number of mental health and alcohol and other drug presentations do go through there—also in Alice Springs. We have someone on duty from 7 am until midnight, at the moment. They are a specialist mental health worker, usually a nurse. They assist with the triage and with organising somebody's assessment and treatment through the emergency department. From around August we will be expanding that service so it is 24 hours and we will also provide a 24-hour telephone service for the rest of the jurisdiction. An additional $930,000 per year is being invested in mental health triage and response. So we are really hoping that that will make a big impact on people being seen in emergency departments but also provide specialist advice to regional centres and remote communities.

Senator ADAMS—And those that are self-harming? Are they dealt with?

Prof. Parker—I will add to the director's comments: we co-fund a consultation liaison psychiatric nurse during working hours at the ED. I think there has also been a drug and alcohol worker position developed at RDH in the emergency department. As a result of the initiatives the director has outlined, we have a fairly immediate response to people who have emotional/self-harm issues. In fact, I think the emergency department has been advertising that they have one of the best mental health responses in Australia—in trying to attract staff, given the issues of access block where you have people chained to beds for days at a time, as occurs in other hospitals. It does not occur in the Territory. What has been advertised is a good response by the emergency department.

Ms Hendry—And it was shown to be so in the NICS study as well, which RDH participated in. We had very good outcome measures or key performance indicators in terms of the benchmark of four hours in ED for mental health presentations.

Prof. Parker—People who do self-harm are usually put on a fairly high level of response and are generally seen fairly quickly by ED and by the consultation liaison team or the extended hours team—currently from about 0800 until about midnight. I would say that we have got one of the better responses to that level of distress.

Senator ADAMS—What about case management for those people? We have heard from different witnesses—it is not necessarily just here—that often case management for people who are discharged either from the justice system or the emergency department means they come out with no back-up.

Prof. Parker—It depends again on what case management means. I am the psychiatrist that looks after people presenting to ED with distress. There is a range of facts that impact on someone presenting with distress at a particular time. Some people have immediate emotional issues that require maybe some level of counselling. Some people have substance abuse issues

that require a level of counselling. Case management usually involves a more intense process with someone who has a range of disabilities and, probably, ongoing issues. Again, we have not kept statistics, but a large number of people only need to talk and review their mental health issues—whether they are depressed, psychotic, whatever—and some ongoing connection with someone. It may be a community service that specialises in counselling, it may be a drug and alcohol service. But that is not necessarily case management. I suppose it is the level of ongoing support that is important and it is the sophisticated assessment of that, but it is not a one-size-fits-all situation. While the end product, self-harm, is defined by certain indices, it is about a sophisticated assessment of those needs and the appropriate level of support. Very few people actually need ongoing high-level support.

Ms Hendry—Certainly we are expecting the new service to improve some of the things which I think are endemic, not just in mental health around the country but in other specialties as well, in terms of handover. We need to ensure that if people are assessed in ED and it is recommended that they go to a particular alcohol and other drug service, a GP or whoever it is, if they are not referred to specialist services, they are actually able to access those services, that an appointment is available, that they turn up and, if they do not, that follow-up occurs. With the expanded capacity, I think we will get a better response on the ground, but we are anticipating that we will get a much better follow-up of people exiting the emergency department, ensuring they get where they really need to go.

Prof. Parker—It is also worth adding that one continuing statistic for the Territory that seems to be problematic is that 60 per cent of people who complete suicide do not appear to have had any connection with any helping agency before the act. That has been an issue that came up in my research from the mid-nineties with coronial data, and from the data it seems to be a continuing issue. So only about a third of people who actually commit suicide have any contact with a helping agency before they act.

CHAIR—How many of those 60 per cent are from regional or remote communities?

Ms O'Regan—There would be just as many, I think, in urban areas that have a lack of contact with services. Most of the male non-Indigenous deaths that we see—and we have quite a high number in Darwin and surrounding suburbs—have had no contact at all with our service. They may have had some contact with a GP, but often there is no contact at all. They are generally people who are in full-time employment who perhaps have had a relationship breakdown, maybe some alcohol and other drug issues, but many of those people we never have any contact with at all.

CHAIR—So the figure of 60 per cent will be equal numbers of town based and rural and remote people?

Prof. Parker—Again, a lot of the Aboriginal mob who commit suicide may have had contact with some legal issues or whatever, because often it is alcohol based. There is often significant alcohol consumption. But in terms of helping agencies or therapeutic agencies—and it is probably spread across the rural and urban areas—it is a consistent figure. The research I did in the mid-nineties seemed to show that 60 per cent did not have any contact, and that was through coronial files. Further research down the track appears to keep that figure roughly at 60 per cent. That was about four or five years later, so it is a continuing figure.

Senator MOORE—How does that compare with the rest of the country?

Prof. Parker—I do not know.

Ms Hendry—I think it is a problem everywhere. Males have less robust health-seeking behaviours, I guess, and that is really why programs like the OzHelp program were started, initially in the ACT with apprentices. But we will have a much broader remit up here. Those males often do not seek help, so you really need to get into workplaces and other places where they are and try to give mental health promotional messages. Also, if people are struggling, we need to identify them and get them into appropriate services.

Senator MOORE—You have given information about Darwin. What about the other hospitals in the Northern Territory? What about the services particularly in Alice? We were in Katherine and they had issues there a couple of years ago. You have given us information about what services are available in Darwin. What about the other hospitals?

Ms Hendry—In Alice Springs we have an after-hours response, but it is an on-call response. Obviously the population is smaller and the presentations are less frequent than they are at the Royal Darwin Hospital, but they go into the ED. The ED just call a mental health clinician when they want somebody assessed.

For Katherine, Nhulunbuy and Tennant Creek, for the most part, we do not have an on-the-ground response. We have small specialist teams, and there really are not enough people to run a 24-hour roster; people would burn out very quickly. But the 24-hour NT-wide telephone triage service is designed to provide support to the health professionals working in those EDs and in communities as well as to the general public. If anybody is concerned about someone they can ring. So we are trying to provide additional expert advice, but in smaller places it is not possible to have that on the ground.

Senator MOORE—Is that what you were seeking, Senator Adams?

Senator ADAMS—It was, I suppose—to add to what I was doing. We have had evidence in several areas about the Aboriginal mental health worker qualification, and I want to come back to smaller remote communities. For someone to be employed they have to get certificate III or go on to get a diploma before they really can be recognised as a mental health worker. Is there any way or any type of funding you can get with a primary health team so that someone in their own community who has a certain amount of training can be employed to deal with the more pastoral issues with a family that is either bereaved through a suicide or having real problems with someone who has tried to suicide and not completed it?

Ms Hendry—We do employ people who do not have qualifications as Aboriginal mental health workers. It is different from the Aboriginal health worker qualification, which has a registration process. If somebody does not have any training, we will employ them and support them to do their training whilst they are employed. We do not have somebody employed in each remote community, though. We have people employed with our remote teams who service regions. We have people in the inpatient unit in Darwin, for example, and we have people in Alice Springs and in the forensics area and in various other places. At times those positions can be vacant; sometimes it is not that easy to recruit to those positions. We do not have people

based in all the remote communities who could actually provide that on-the-ground response all the time. We do have some people who we use to assist us to do our work in terms of cultural brokerage. They can show us where we need to go in the community, what the important relationships are and particular individuals we should speak to. Obviously translation and things like that can occur.

There is a new category of worker as well, called community based workers, as part of the extended primary health care service in remote communities. They go through all the certificate levels—II, III and IV—and can go on to specialise and get higher qualifications. Some of the basis of those qualifications will be generic and some will be specialty subjects that people choose to specialise in, and mental health has been prioritised for those. Obviously it depends on who in the communities is interested in doing that work and on what their experience and interests are. That has really only started in the past 12 months. Charles Darwin University has won the tender to provide that education. So, hopefully, things will improve in terms of having more people in remote communities in Indigenous employment on the ground and having the types of skills that you are describing. But you could always do with more.

Senator ADAMS—That is right. Some evidence was given that there are people available in the communities, possibly some of the older women, but having to go and get certificates is just beyond them. But they still have a pair of hands and they are really good people who could be doing a job.

Ms Hendry—Yes. That is what having community based workers is really meant to recognise—that people will have varying levels of educational attainment and also varying levels of interest in getting a qualification, particularly people who are older, respected members of the community. What they bring will be recognised, as will younger people, for instance, getting a qualification. So it is really meant to be as flexible as is possible in that community based workforce.

Senator ADAMS—Concerning coordination among the NGOs, plus the Commonwealth and Territory programs and the people involved, we have heard that there is duplication and also that they are not meeting the way they used to. That is probably talking about Central Australia rather than up here. In a lot of areas there seems to be duplication of other people's work. They do not know that this group is in there doing this. They go to a community and there are two other groups there doing the same sort of thing. What do you have in that respect? Do you get involved with any of that as far as the programs go?

Ms Hendry—I am not really sure what they are referring to.

Senator ADAMS—Probably a good example was the Flying Doctor Service in Alice Springs renting a room from the network of GPs and providing exactly the same service.

Ms Hendry—That is not quite accurate. The rural and remote services initiative is an Australian government funded program. The division of general practice was funded to provide that to a cluster of communities on one side in Alice Springs and the Flying Doctor Service has been funded to do it in different areas—that is my understanding. We were not involved in the decisions about what was funded and where. I have a particular problem with that initiative in that I think there is duplication and consolidation of the rural and remote services initiative and

the visiting health specialist mental health services would mean that there was much better coordination, much better efficiency and larger teams which could provide a whole range of services. There is confusion in communities about who should be referred to which service. Of all the COAG initiatives, the one which is most problematic to the Northern Territory and funded by the Australian government is the rural and remote services initiative. I think there is one example where it is working reasonably well but it has taken quite a lot of collaborative work to do that. I am sure there are efforts of collaboration in other areas, but I do not think it is an efficient use of the resources.

Senator MOORE—And that has been fed back to the minister?

Ms Hendry—I feed that back whenever I have the opportunity—on a regular basis.

Senator MOORE—That is fairly reasonable, considering who the minister is.

Ms Hendry—It is mainly fed back to the department and in any national forum such as the Mental Health Standing Committee or meetings between the Australian government and our—

Senator MOORE—Is that view shared by Queensland and Western Australia, which also have the service? It is one we have heard about. That is the first time I have heard that issue and, if it is confusing here, it should be in regional Queensland and in rural and regional Western Australia as well?

Ms Hendry—Regional Queensland has much larger centres so the opportunity to have more of a psychological based service and a specialist mental health service in those larger centres presumably is greater. It is a bit more like Darwin urban area in many of those communities.

Senator MOORE—WA?

Ms Hendry—Initially I know there was concern about the rural and remote services initiative I think expressed by all the jurisdictions but I do not have a recent update. So I would not be able to comment about—

Senator MOORE—But it is still a problem here.

Ms Hendry—It is certainly still a problem—not so much a problem but there would be a much more effective way of delivering services than currently and I do not know the view of the other jurisdictions on that.

Ms O'Regan—I might add to that. As far as some of the smaller regional areas I have been visiting lately, we have been rolling out the self-harming workshops and at most of those workshops we have been bringing together a base of people who are dealing with a lot of the same issues, and a lot of them are unaware of what each other do—and that is even within quite small communities. Even in communities where meetings are held, it is not always easy for people to get to those meetings. I think there is a lot that happens at local level that people could make themselves more aware of but do not—for a whole range of reasons. It may be just the fact that they all have so many pressures on their time; but it is a constant theme and it is always

quite surprising, especially when they are quite small communities, that there are a whole range of people who do not know what each other do.

As much as it is good to have somebody coordinating, I think there is also a responsibility by individual agencies that are working in communities to actually find out what each other do, and I think that does not always happen.

Senator ADAMS—It is called 'protecting their patch'. Coming back to the reporting: your figures are far higher than the actual reporting by the ABS and through the coroner.

Ms Hendry—No, in actual fact, when the ABS recently revised their data for 2007-08—the new data has only just been released—there was very little difference between what was published previously for the NT, what we know to be the figures from the NT, and the revised figures. I think we are very fortunate here; we have got a good relationship with the coroner, we are aware of all the suspected suicides that occur, and we also offer a response for people. The coroner's constables know to offer our services to people if they would like them. So in fact our figures are pretty accurate. There are obviously grey areas around single-car accidents or whatever in every jurisdiction, because you need to be able to make a determination on some reasonable evidence, presumably. But certainly there were inconsistencies with how coroners determined a finding of suicide in jurisdictions, which resulted in some other jurisdictions' figures changing quite markedly. But really in the NT it is small and we are aware of all the suspected suicides—of people who die. Obviously self-harming is a different matter altogether.

Senator ADAMS—The reason I am asking the question, of course, is that ABS statistics show that suicide has been reducing—as far as the figures go; therefore, there has to be some evidence as to what is being funded. So if you have got a reduction in that particular area, the programs may not be funded the way that we would hope they would be.

Ms O'Regan—Our statistics were not reflective of the national decline anyway. Our rates have been high and have fluctuated slightly, but they really have not decreased at all over that period. I know there has been a lot of conversation about the changing in reporting and whether there are more suicides than are actually reported. Obviously there are always going to be suicides, and I have had plenty of conversations with the coroner's department around the fact that there are probably lots of deaths that potentially were suicide but cannot be found as suicide because they basically do not meet the criteria or it basically cannot be proven. But I would probably say, on the other side of the argument—and I have not really heard this said—that there are also suicides that occur where potentially there was not a level of intent. So I am not sure whether they actually measure themselves out.

We have had a lot of discussion in remote areas recently around self-strangulation, which is something that happens in particular communities. Obviously a lot of young people do not realise how dangerous it is to put something around their neck, especially if they are on their own and they happen to tie it to something. They do not realise that that little rush that they were after could go very wrong if they fall forward, lose consciousness and die. I do wonder at times with some of the deaths that we do see as a result of suicide, particularly where it is hanging, what level of intent was actually involved there. I think you can actually look at it on both sides when it comes to reporting of suicides. There are probably suicides that we actually miss

because we cannot prove that they were; but there are probably deaths that we count as suicides where there was never a level of intent either.

Prof. Parker—Most of the suicides are fairly obvious. Some of them are slightly more subtle. When I was doing my review there was a particular person who tried to do sorry cuts on themselves and actually cut the wrong part of the body, so there was some question about intent. There was another situation where a young person was using a volatile substance to enhance their sexual experience and used too much of it and died. In most cases it is fairly obvious. In the Territory, we tend to have continuing issues. It is fairly obvious that a death was a suicide because of our significant predominance of hanging as a suicide attempt. It is fairly clear what the objective was. Occasionally there are subtle differences.

It is gratifying to see that there have obviously been efforts to improve the evidence base for suicide. I know that Suicide Prevention Australia has been making significant efforts to have a standard of reporting from police. One of the issues that were apparent in my review is that the actual datasets are produced by police, and most police who are attached to coroners' offices have no formal training in mental health or suicide prevention before they undertake the job. The quality of their information is the stuff that then leads into the national databases such as the national coronial datasets. I was very aware of a number of police investigations in my review of coroners' files that were fairly substandard. In one case, where a young man had died by self-immolation, by pouring acetone and lighting it, there was actually a letter in the file that gave a very clear indication that he was frankly psychotic when he did the act. It had not been noted. I do not think there was any mention of mental illness in the police report. Yes, there is going to be an attempt now to educate police to try and improve the quality of data coming in, and I think that ought to be a significant thing for the Senate to congratulate, because the quality of the reporting is very variable, and one important initiative ought to be a strong emphasis on education and the standardisation of police reporting of suicides.

Ms Hendry—I think it is difficult up here because if suicides occur in regional or remote communities then it is the local police who respond. Their experience with such matters would obviously be variable. I guess you rely then on the coroner to take the information that is provided and make a determination. But, in terms of consistency of stats, our information is consistent with the coroner.

Senator ADAMS—As far as the existing programs you have go, what would be the most successful ones in your opinion that really work and that perhaps should be continued? Probably the largest complaint about funding is the fact that you get three-year funding for a program, it takes you 18 months to get it established and get it going and then in the next 12 months it is going really well, and then the staff do not know whether they are going to be employed or not—whether it can be recurrent funding. What programs do you have that you consider really need to be looked at and kept going?

Ms Hendry—I will ask Sarah whether she wants to elaborate, but certainly I do not know, in the NT, in recent years—I do not know about before I was here; there might have been other programs—of really successful suicide prevention programs that have been discontinued. People who provide those programs obviously want them to continue, but I think there is very limited evidence quite often, particularly for ones that are locally based, of their efficacy. Maybe if they were funded over a number of years they might end up demonstrating some level of

effectiveness, but I think what we have tried to do—and it has only been in the last couple of years, so it is going to be difficult for us to do an assessment yet—is to take a much broader strategic approach.

The self-harming workshops, for instance, that Sarah and a couple of other people are doing around the NT are so oversubscribed. We got such a shock when we first advertised them in Darwin and Alice Springs. Triple the number of people that we could take applied for them. So we know that there is a big need in that area, and those workshops have been really well attended and the feedback has been fantastic, but it is too early yet to say whether people are going to feel more confident and whether it is going to make a difference for self-harming of young people.

Whether the OzHelp program targeting males proves effective in the Territory we will not know for a while. Mount Theo I guess is one of the locally based projects which have proved to be effective on a number of fronts in terms of petrol sniffing and building resilience in young people. There are some projects like that which have ongoing funding.

Ms O'Regan—Many of the programs that were originally funded, especially under the National Suicide Prevention Strategy, were small programs in particular communities. Not just in the Northern Territory but across Australia there was not a great deal of evidence to show that many of those projects were successful for a whole range of reasons—mainly short-term funding. Also, a lot of these programs were put into communities where there was not necessarily the infrastructure or the ability for professional support people to run programs. Basically we have learnt from that that realistically programs need to cover a much wider range of the population or they need to sit within bigger organisations that can support that particular program, so that infrastructure support is there too.

A lot of the programs that we fund, like the Life Promotion Program in Alice Springs, which sits within the Central Australian Mental Health Association, has that outward support from a much bigger organisation and then is able to do some really good work. I know that Laurencia was talking earlier about what they have produced. I do not know whether you have a copy of the DVD from that. I am quite happy to give that to you if you would like to take that away. This is an exceptional program. One of the things it highlights is that there is so much good work being done at a local level in the Territory. We often bring in trainers from outside but there is so much really good work happening at a local level, but it is really difficult to capture it without the support of a wider organisation that can support individual programs to produce this level of quality. We have put a lot of emphasis around training. Training is one of the few things which have a very strong evidence base in suicide prevention. So a lot of our money has gone into ASIST and SafeTALK, things like suicide story, the self-harming workshops that we are currently doing, which I am doing with the child and adolescent psychologists.

People have continually raised the fact that there has been a lot of training for suicide prevention but very limited stuff around self-harming behaviour in young people—cutting, burning and those sorts of things. We have taken that out to all the regional areas. We are now trying to adapt it into remote areas, which is an interesting experience in itself. We will be writing that one up because it just shows how difficult it is to move something from a regional area even into a community setting. A lot of our emphasis has been in putting things into training and also things like OzHelp. We are looking forward very much to that starting up in the

Territory. Once again, it is a program which will have the support of a much wider organisation and probably therefore has much more chance of success.

Senator MOORE—Who is supporting OzHelp?

Ms Hendry—The Australian government.

Senator MOORE—It is not through the trade union movement?

Ms O'Regan—No.

Senator MOORE—There is no involvement of the union movement in the Northern Territory?

Ms Hendry—They work closely with—

Ms O'Regan—Yes, they try to bring in the unions into all the workplaces. Rob, do you want to talk about Tiwi?

Prof. Parker—I was going to talk about some adjunctive factors that probably are quite difficult to target with government funding. I am happy to give the committee a couple of articles that I have helped produced, a recent one on mental health issues in Australian Aboriginal people generally and one which specifically looked at the Tiwi suicide intervention program which was written by Glenn Norris. I assisted with that and I can email them if the committee would like to receive those.

Concerning the key issues that I perceive have had an effect on suicide, the Norris program I thought was very effective. It relied on issues such as communication and community governance and was particularly assisted by alcohol policy and the Tiwi club had a forced introduction of mid-strength beer a number of years ago. That seems to have had a profound benefit for the mental health of the Tiwi population. Again, that is really an alcohol policy issue rather than a mental health issue but it seems to be crucial to the mental health issues of the community.

I think we are all aware of the issues in Indigenous disadvantage. For example, there is the issue of the number of people per house. If there are 20 people living in a house, people get very stressed—particularly if they are using substances—and are more prone to self-harm or committing suicide. I had to give evidence at a suicide coronial recently in East Arnhem, and I think every suicide that had occurred in East Arnhem in the previous number of years had occurred in the context of severe intoxication from alcohol. So alcohol is a significant factor leading to the distress that makes people to want to commit suicide and then, in the context of that, their committing suicide. Again, I suppose that is all being addressed through the COAG national Indigenous health reform agenda and so on; however, these all have an impact on suicide and an impact therefore on the issues within the Territory. If I can get an email address, I will send the committee a copy of those articles.

CHAIR—Sure.

Ms Hendry—I think we do need a much more robust evidence base, and it is a difficult thing to develop because you need to do it over a long period of time to see the impact of things. It is not easy to prove up small projects in particular over a short period of time. Having said that, many of them were probably never likely to prove up. That is the reality of it.

CHAIR—One of the programs raised with us that was stopped was the Daley River program. The evidence given to us was that that was proving to be a successful program and that it was about to be scaled up.

Senator MOORE—That was diversionary stuff.

CHAIR—Yes.

Ms Hendry—Sarah was sitting in the room then and mentioned that, and I was somewhat perplexed. That was a program funded by the Australian government through the division of general practice. Anything can be considered suicide prevention, and one of the other things we are really focusing on is the other government departments—such as police and Sport and Recreation and a whole lot of other departments—incorporating mental health promotion and suicide prevention into their day-to-day business, and they have been fantastic in terms of coming on board with that. That program in Daley River was one of the programs that had some good ideas about building resilience, but it was not necessarily really at the pointy end of suicide prevention.

I understood from the Australian government that it was only ever a time-limited project. Towards the end of that they did consult us and say, 'What do you think about Daley River; how do you think it's going?' But I was unable to give a considered opinion because I had not really seen any information that would tell me one way or the other how that program was going. Certainly we never considered funding it, and I have no idea where that idea came from. We were consulted, which is what tends to happen now—and that is fantastic—about whether it was a program worth continuing, but we are not funding it, so we are not in receipt of the reports and things like that that you might base that sort of decision on. It was a surprising comment, but I am not sure where it came from.

CHAIR—We could follow that up with the Commonwealth. Thank you very much. Both your evidence and your submission were very much appreciated. We really appreciate it when government agencies turn up, and the Northern Territory government is good at doing that.

Ms Hendry—We are. Thank you for having us.

Resolved (on motion by **Senator Moore**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.34 pm